In another strong sign of support and loyalty, all members of the PHLIP liability program have declared they will renew their membership for the 2017-18 policy year.

“The PHLIP liability program works because our members take an active interest in risk management. Thanks to their successes, we are able to deliver competitive rates, personalized group self-insurance coverage, disciplined underwriting, and exceptional claims and risk management services,” says Brian J. Teusink, CPA, CCM, AIAF, president & CEO at PHT Services, Ltd.

Palmetto Healthcare Liability Insurance Program (PHLIP) was founded in 2001 in response to the growing need for a stable source for professional and general liability insurance for South Carolina hospitals and health systems. Operating as a Risk Purchasing Group pursuant to the Liability Risk Retention Act of 1986, PHLIP serves its members by providing access to group self-insurance options as an alternative to commercial insurance. PHLIP currently offers its members group self-insurance alternatives for healthcare professional & general liability and medical stop-loss coverage.

PHLIP’s liability program was established in 2001 and is offered through its wholly-owned subsidiary, PHLIP Segregated Portfolio (PHLIP SP), which operates as a segregated portfolio within Preferred Healthcare Liability Insurance Program SPC (PHLIP SPC), a Cayman Islands-domiciled class B insurer. PHLIP SPC is also a wholly-owned subsidiary of PHLIP.

PHLIP SP is a leading provider of liability insurance to the state’s healthcare industry. Its focus on patient safety, coupled with specialized risk management services, emphasis on prompt event reporting, early resolution, and superior claims administration, ensures that its members have the best possible solution for their liability reduction needs. Liability claims administration, underwriting, and risk management services are provided to members of PHLIP SP under a contract with PHT Services, Ltd. and through business alliances with other best practices companies.
Despite a strengthening economy and high job rates, most U.S. workers are unlikely to see sizeable increases in their salaries for 2018, according to new research from PHTS strategic ally Aon.

Aon’s 2017 U.S. Salary Increase Survey of 1,062 U.S. companies, projects the increase in base pay is expected to be 3.0% in 2018, up slightly from 2.9% in 2017. Spending on variable pay is expected to be 12.5% of payroll – a decrease to levels not seen since 2013.

“The economic outlook for most industries continues to improve with increased demand for goods and services and stronger job creation, but companies remain under pressure to increase productivity and minimize costs,” explained Ken Abosch, broad-based compensation leader at Aon. “As a result, we continue to see relatively flat salary increase budgets across employee groups, with most organizations continuing to tie the majority of their compensation budgets to pay incentives that reward for performance and business results.”

Workers who are not high performers may see an even smaller share of the compensation pie in the coming years. According to Aon’s survey, more than two-thirds of employers are taking some type of action to increase merit pay differentiation in 2018. Among those:

• 40% are reducing or eliminating increases for lesser performers
• 18% are using a more aggressive, highly leveraged merit increase grid
• 15% are setting more aggressive performance targets

Salaries by Industry and Geography
Workers in most U.S. cities can expect to see salary increases in line with the national average for 2018. However, some may be lucky to see higher-than-average increases in variable pay. These cities include Houston (14.7%), New York City (14%) and Philadelphia (13%).

Aon’s research also shows variation by industry. Workers in the automotive (3.2%), computer (3.2%), accounting/consulting/legal (3.3%) and telecommunications (3.2%) industries are expected to see higher-than-average salary increases in 2018, while workers in education (2.7%), construction/engineering (2.8%) and medical devices (2.8%) are expected to see lower-than-average increases. Variable pay budgets by industry vary widely, ranging from 19.3% in the pharmaceutical industry and 16.4% in banking/finance to 5.3% for workers in the healthcare/medical services field.

“The decrease in projected variable pay spending for 2018 illustrates the power of variable pay to act as a buffer to safeguard organizations from incurring increased costs when results are below expectation,” noted Abosch. “But this also signals a more pessimistic view of corporate performance in the coming year.”

For another view on interpreting Aon’s Salary Increase Survey results, view its Pay Insights blog at https://www.globalcompensation.net/blog/building-a-salary-increase-budget.

From the Commission
On the SC Workers’ Compensation Commission website last month, the following announcement was posted:

“At the Business Meeting on August 21, 2017, the Commission approved revisions to the Medical Services Provider Manual (MSPM) to reflect 2017 Resource Based Relative Values (RBRVS) issued by the Center for Medicare/Medicaid (CMS) and the American Medical Association’s Current Procedural Terminology (CPT) Codes. The Conversion Factor will remain at $50. The effective date is September 1, 2017.

The Commission also approved the following:
(the page numbers referenced are in the 2016 MSPM)

Travel Reimbursement (pages 32, 367, & 417)
Physicians may be reimbursed for travel associated with depositions or other medical testimony at actual cost.

Drug Screening (pages 289-290)
Includes services codes and guidelines for presumptive drug testing pursuant to the CMS and provides a link to the CMS Local Coverage Decision (LCD) revision 8.

Biofeedback (page 368)
Biofeedback training (CPT Codes 90901 and 90911) may be provided when it is medically necessary and approved by the employer/Carrier, with limitations. Language is continued on page 4
Role of video analytics and security on campus and in hospitals

By: Kenneth Bukowski, Vice President, Vertical Markets, Allied Universal

The following is an excerpt from an article which appeared in the August 2017 issue of Campus Safety Magazine.

More and more schools, universities and hospitals committed to ensuring their campuses and communities are safe are looking to align with contract security partners who can provide efficient and effective security solutions while reducing overall labor costs. How can these institutions ensure maximum priority for safety and security while managing restrictive budgets? Integrating video analytics into the security officers’ response tool-sets enables hospitals, colleges and universities to be more proactive, preventive and strategic.

“In the era where the ‘Internet’ is king, video analytics have become a topic of excitement, confusion, and deliberation,” according to Ty Richmond, President, National Accounts and Integrated Systems Technology.

Read the entire article, which explores video analytics and its impact on your security program, at this link: http://www.campussafetymagazine.com/technology/officer-video-analytics.

Video Analytics Offers Real-Time Perimeter Detection

“Real video analytics focuses on analysis and classification of a live video stream,” says Richmond. “A security camera is designed to act like a human eye and it captures images in real time as a data stream. Video analytics examines the new information and compares it to pre-classified objects based on a variety of metrics that are contingent on the sophistication of the analytics. Good video analytics allows for a custom-tailored approach to creating protocols for when, why and how to be notified.”

True video analytics are not merely simple motion detection cameras. They are more intelligent and operate in a manner that also analyzes information as opposed to simply detecting motion or pixel change. This permits a higher level of customization and a more significant reduction of false alarms than previous technologies. The value is largely focused on receiving real-time alerts when the analytics are triggered, and eliminating as many false alarms and false positives as possible through proper setup.

Allows Hospitals to Save Money

Video analytics in hospital settings can result in capturing video that mitigates the expenses associated with prescription drug theft, fraudulent accident or injury claims. Drug diversion can occur in the pharmacy as well as many other areas of a hospital. Video analytics can be set up to immediately take notice if someone lingers continuously in one spot, returns to the pharmacy repeatedly, or conceals drugs in a pocket or coat, for example.

Healthcare facilities use patient observers, or “patient sitters” that are assigned to monitor at-risk patients who may be suicidal, mentally confused or agitated. The sitter’s primary role is to notify staff when patients engage in behavior that could result in injury such as pulling out their lines or getting out of their beds. With video monitoring and analytics, trained security personnel can observe multiple patients and alert staff when intervention is needed, thereby eliminating the need for a costly patient sitter.

The optimal value of video analytics is applied through real-time monitoring. End-to-end solutions that pair remote video monitoring combining analytics with other traditional services such as access control, intrusion alarm monitoring, and conventional security services are solutions that are defining the future of physical security. The right utilization of security solutions can maximize capabilities, increase response time, and improve cost control.

About the author: Kenneth Bukowski is Vice President, Vertical Markets, Allied Universal, the largest provider of security services in North America. Learn more at www.aus.com.
Cathy Redmond-Dilligard, claims consultant, attained 19 years of service on September 2.

**DATEBOOK**

**October 3**  
“Hot Topics: Vaccination, Marijuana & Opioids” (audioconference 1:00-2:00 p.m.) [HortySpringer] +

**October 12**  
17th Annual SC ACHE Leadership Conference*  
Columbia, SC

**October 15-18**  
ASHRM Annual Conference & Exhibition (PHLIP liability program members only)* (Invitation Only)  
Seattle, WA

**Oct. 29 - Nov. 1**  
Estes Park Institute Conference (EPI) ++/+  
San Francisco, CA

**November 7**  
“On-Call and EMTALA Policies” (audioconference 1:00-2:00 p.m.)  
[HortySpringer] +

+ To register or for more information, call 800.245.1205

* To register or for more information, visit www.phts.com or contact Janine Wall, ARM, AIS, GBA, director of marketing at PHTS, at jwall@phts.com

++/+ To register or for more information, visit www.estespark.org or call 800.727.8225

From the Commission - continued from page 2

Included to clarify CPT codes do not include a time element and they should be used once to identify all modalities of biofeedback training performed for that date of service, regardless of the time increments or number of modalities.

**Over-the-Counter Preparations (page 368)**

Language added to clarify over-the-counter (proprietary) preparations dispensed by the provider must be preauthorized prior to dispensing.

**Initial Assessment (page 412)**

Providers CPT codes for billing initial evaluation for physical therapy evaluation or occupational therapy evaluation.

**Multiple Procedure Reduction (page 413)**

Provides codes subject to the multiple procedure reduction. CPT Modifiers – 51

**Multiple Procedures (page 413)**

Provides South Carolina specific instruction and CPT codes for second and subsequent procedures therapy.

**Air/Ground Ambulance Transportation Service (page 421)**

The Commission will follow CMS guidelines and Ambulance Fee Schedule for air and ground ambulance transportation services. Reimbursement is based upon the lesser of the submitted charge or current Medicare rate.

**Compound Drugs (page 611)**

Includes language to require preauthorization for each dispensing of compound drugs.

**Anesthesiology Rates (page 54)**

CMS approved additional modifiers to anesthesia rates in May 2017. The following additional anesthesia claims modifiers will be included in the MSPM:

- **AD** – Medical Supervision by a physician; more than 4 concurrent anesthesia procedures
- **G8** – Monitored anesthesia care (MAC) for deep complex, complicated or markedly invasive surgical procedures
- **G9** – Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition
- **QS** – Monitored anesthesia care service
- **QY** – Medical direction of one qualified non-physician anesthetist by an anesthesiologist
- **QC** – These services have been performed by a resident under the direction of a teaching physician

The Commission approved creating an ad hoc advisory committee to review the current state and federal regulations regarding the use of telemedicine in workers’ compensation and recommend if any changes are needed to the MSPM.

The Commission also approved an evaluation and update to the fee schedule to include the 2018 Relative Values and CPT Codes to be completed no later than May 31, 2018. The anesthesiology rates will be reviewed at that time.

Upon publication by Optum, the MSPM will be available at the following link: [https://www.optum360coding.com/Product/46611/].“