Providing resources for medical practices and the people behind them

BC ADVANTAGE

www.billing-coding.com

Thoughts Had ... Lessons Learned®

The Future Ain't What It Used To Be

July / August 2021 | Issue 16.4

CEO Letter

So, we are around 16 months into the biggest PHE that we have had in our lifetime, and our workplaces are forever changed. Our staff is still working a hybrid model of home and office, which has its pros and cons, and we are putting some serious thought into how we move forward as a company and what it will look like in the years to come. The pandemic has shown us all various work options for those who don't need to have face-to-face interaction with customers/stakeholders, and I believe that many have come to enjoy this flexibility. As we head into the summer vacation months, many parents and caregivers will be challenged with having the kids home while maintaining a workload level that works for employers. It takes organization to balance work and life, and being at home 24/7 is no different. Good luck to those of you navigating this time.

So, in keeping with this theme, our cover article, written by L.E. Shepherd, discusses these challenges with working from home, along with many other great insights that I'm sure you will enjoy. And since we're discussing "enjoyment," I would like to ask those of you who are dealing with Zoom meetings, how is it all going? I, for one, am an email guy with the occasional phone call for clarification purposes, but I know many are going from Zoom meeting to Zoom meeting with a schedule that exhausts me just thinking about it. I get the convenience of it all, but there is a point where it's too much, don't you think? Betty Hovey from Compliant Health Care Solutions covers this in her article this issue; "Is Zoom Fatigue a Thing?" is a great read and will hopefully resonate with some of you.

Other highlights in this issue include a great article written by Dr. James Dunnick and Dr. Laura Dunnick about coders in the work-place and the difference they can make to revenue when properly utilized. Another is by Dave Jakielo with his thoughts on things we can fix in healthcare. Debbie Jones is back with a great article on assistants in surgery, Rachel Rose writes about the physician open payments program, the PAHCOM national board is back with Part 6 – Clean Claims, and we welcome three new writers with their contributions: Andria Jacobs writes about Telehealth, Sonal Patel discusses data and how it helps empower your practice, and Richard Bailey writes about managing insider threats in healthcare.

As always, it's a jam-packed issue full of interesting articles that I know you will enjoy.

Until next time, always choose kindness.

Storm Kulhan

Update!
Sorry folks, we have a correction for Issue 16.3's article Evaluation and Management -Unraveled - Part One. The article incorrectly had G2112 as the Medicare code for additional 15 minutes beyond the time of service. It should have read G2212. We apologize to you all for any inconvenience caused and encourage you to view the corrected article online.

BC Advantage is published bimonthly by Billing-Coding, Inc P.O. Box 80669 Simpsonville SC, 29680
Phone: (864) 228 7310 Fax: (888) 573 7210 email: subscriptions@billing-coding.com / www.billing-coding.com


editor
Amber Joffrion, M.A.
editorial@billing-coding.com


ceo - publisher
Storm Kulhan
storm@billing-coding.com


coo
Nichole Anderson, CPC
nichole@billing-coding.com


subscriptions manager
Ashley Knight
ashley@billing-coding.com

advertising
sales@billing-coding.com

Subscriptions:
To start a new subscription, please visit
www.billing-coding.com/subscribe

Renewals:
Keep your rate locked in for life!
www.billing-coding.com/renewals

Change of address:
Email - subscriptions@billing-coding.com
or call 864 228 7310

CONTENTS

MAGAZINES | CEUS | WEBINARS

JULY / AUGUST 2021 - ISSUE 16.4

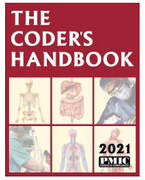
COVER

Thoughts Had ... Lessons Learned®:

The Future Ain't What It Used To Be

FEATURES

OTHERS



The Coders Handbook 2021

Medical Necessity Leveling Charts

EXPERT Contributors this issue

Dr. James Dunnick graduated from Indiana University with a double major in Chemistry and Biology, placing on the Dean's list. He graduated early from the Indiana University School of Medicine, placing in the honors division. He is boarded in Internal Medicine and Cardiology with over twenty years of clinical practice experience. He has published articles and presented nationally on clinical topics.

Dr. Laura Dunnick graduated Magna Cum Laude with a Bachelor of Science from McNeese State University. She then completed a Doctorate of Physical Therapy degree from the University of St. Augustine for Health Sciences, graduating with high honors and an Outstanding Leadership Scholarship.

HIPAA Compliant Hosting by Atlantic.Net™ is SOC 2 and SOC 3 certified, HIPAA and HITECH audited, and designed to secure and protect critical healthcare data, electronic protected health information (ePHI)m and records. We are audited by qualified, independent third-party auditing firms to demonstrate our leading security and compliance services. For more information, visit https://www.atlantic.net/hipaa-compliant-hosting/

Betty Hovey, CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I, is the Senior Consultant/Owner of Compliant Health Care Solutions, a medical consulting firm that provides compliant solutions to issues for all types of healthcare entities. Chcs.consulting

Andria Jacobs, RN, MS, CEN, CPHQ, is the chief operating officer for PCG Software and has more than 25 years' experience in the healthcare industry, encompassing both administrative and clinical arenas. Prior to joining PCG, Ms. Jacobs was the administrative director, medical management for VertiHealth Administrators.

Dave Jakielo is an International Speaker, Consultant, Executive Coach, and Author, and is president of Seminars & Consulting. Dave is past president of Healthcare Business and Management Association and the National Speakers Association Pittsburgh Chapter. Sign up for his FREE weekly Success Tips at www.Davespeaks.com. Dave can be reached via email Dave@Davespeaks.com; phone 412-921-0976.

Debbie Jones, CPC, CCA, has a passion for writing about medical coding and healthcare and is the writer behind Medical Coding Buff. www.medicalcodingbuff.com

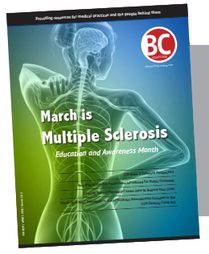
PAHCOM National Advisory Board: Coley Bennett, CMM, CHA; Crystal Burning, CMM; and Kim Krause, CMM. www.pahcom.com

Sonal Patel, CPMA, CPC, CMC, ICD-10-CM, is an independent healthcare coding advisor, auditor, and compliance consultant dedicated to transforming physician and hospital coding and compliance practices into ones that optimize revenue and alleviate risk. She is also an avid creator, content developer, and host of the Paint the Medical Picture Podcast series.

Rachel V. Rose, JD, MBA, is an Attorney at Law, in Houston, TX. Rachel advises clients on healthcare, cybersecurity, securities law, and qui tam matters. She also teaches bioethics at Baylor College of Medicine. She has been consecutively named by Houstonia Magazine as a Top Lawyer (Healthcare) and to the National Women Trial Lawyer's Top 25. rvrose@rvrose.com. www.rvrose.com

L.E. Shepherd, Jr., BS, MSA, has successfully provided comprehensive business advisory and management services to the healthcare industry and others for over 30 years. With his comprehensive business experiences and extensive speaking engagements, along with his many years of relationship building in the healthcare industry, Mr. Shepherd brings a unique perspective and set of skills to solving the complex business problems facing physicians, businesses, and the healthcare industry today and tomorrow. www.medbizonics.com

Christine Woolstenhulme, QCC, QMCS, CPC, CMRS, is the Support Manager and Content SME for innoviHealth findacode.com

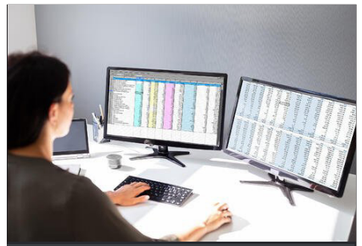


GET PUBLISHED

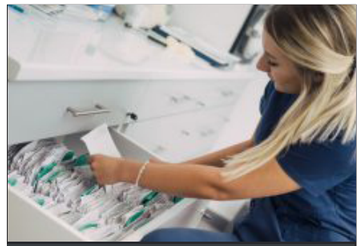
We are always interested in hearing from any industry experts who would like to get published in our national magazine. Email us at editorial@billing-coding.com to request a copy of our editorial guidelines and benefits.

Webinars & CEUs - www.billing-coding.com

COVID-19: Workplace Safety, OSHA Updates, and Return to Work Issues
CEUs: 1



1, 2, 3's of Coding, Billing, & Auditing
CEUs: 1



Have No Fear: Auditing to Benefit Physicians, A Step Towards Proactive Compliance
CEUs: 1

Healthcare's Enterprise Cyber Risk Management Imperative
CEUs: 1

CEU Reading Package 86
CEUs: 1

CEU Reading Package 85
CEUs: 1

BC Advantage Webinar Library

$0 (Member Price) Included with subscription

The Fast, Easy, and Affordable way to earn your CEUs each year!

BC Advantage provides FREE CEU approved webinars to all of our magazine subscribers. Gain important industry knowledge in your own facility, office, or home, presented by leading industry professionals.

Access all CEUs / webinars online now!

View 30+ CEUs and webinars online now at billing-coding.com/ceus

American Academy of Pediatrics Develops Coding, Billing Guidance for COVID-19 Vaccine Services

As the COVID-19 vaccine becomes available to younger patients and more pediatric practices provide the vaccine, it will be important to know how to code and bill properly for vaccine administration, including for patients without insurance or on Medicare.

The Academy has developed the COVID-19 Vaccine Administration: Getting Paid website, http://bit.ly/AAPcovid19coding, to guide members through the coding and billing process. The website will be updated when COVID-19 vaccines are granted emergency use authorization and when the American Medical Association develops new Current Procedural Terminology codes.

Resources on the website guide members on how to bill private payers, Medicaid plans and Medicare. If a patient is dual eligible for Medicare, and Medicaid, the practice will bill Medicare for the COVID-19 vaccine.

Pay attention to your COVID-19 vaccine claims. Report any payments for vaccine administration that are below $40, the value assigned by the Centers for Medicare & Medicaid Services, to the AAP Coding Hotline (see resource).

Do not report the CPT product code unless instructed by the payer. The COVID-19 immunization administration codes are specific to the manufacturer and dose. Therefore, some payers may inappropriately believe the vaccine product code is unnecessary since it is not a billable service and deny the claim.
Source: AAP.org

DOJ Announces Coordinated Law Enforcement Action to Combat HealthCare Fraud Related to COVID-19

The Department of Justice today announced criminal charges against 14 defendants, including 11 newly-charged defendants and three who were charged in superseding indictments, in seven federal districts across the United States for their alleged participation in various healthcare fraud schemes that exploited the COVID-19 pandemic and resulted in over $143 million in false billings.

"The multiple health care fraud schemes charged today describe theft from American taxpayers through the exploitation of the national emergency," said Deputy Attorney General Lisa O. Monaco. "These medical professionals, corporate executives, and others allegedly took advantage of the COVID-19 pandemic to line their own pockets instead of providing needed healthcare services during this unprecedented time in our country. We are committed to protecting the American people and the critical healthcare benefits programs created to assist them during this national emergency, and we are determined to hold those who exploit such programs accountable to the fullest extent of the law."

Additionally, the Center for Program Integrity, Centers for Medicare & Medicaid Services (CPI/CMS), separately announced today that it took adverse administrative actions against over 50 medical providers for their involvement in healthcare fraud schemes relating to COVID-19 or abuse of CMS programs that were designed to encourage access to medical care during the pandemic.
Source: DOJ

LIFETIME GUARANTEE

Have you heard about our lifetime guarantee?

If you stay an active subscriber with us and never let your subscription lapse, we will never raise the price of your subscription. That's right! You will pay the same price per year, every year, as long as you renew your subscription BEFORE it expires! It doesn't matter what the price becomes in the future, you keep that pricing with us forever! Isn't that awesome?

It's our guarantee and commitment to you, our loyal subscribers!

Learn more: https://www.billing-coding.com/lifetime.cfm

Critical Care Billing Errors Rank High on the CMS Improper Payment Report

Are the claims your office is submitting for critical care really subsequent hospital visits? According to the 2020 Medicare FFS Supplemental Improper Payment Date Report (Report), Critical Care hospital visits, the improper payment rate is approximately 20%! Critical care is also ranking in the top 5 types of services with upcoding errors for Part B claims.

According to the Report, the first hour of critical care, code 99291 has an overpayment rate of 19.7%, based on 269 claims and 310 line-items reviewed. What is the accuracy or error rate for your providers? Do you know? Is it time to find out? First, know the rules – download this educational article "Is it Really Critical Care?" to help your hospitalists, intensivists, coding, billing and CDI professionals learn more about appropriate coding and documentation for codes 99291 and 99292.
Source: https://aihc-assn.org/

Centralia Police Department's K9 Samson Awarded 'Healthcare for K9 Heroes' Grant

Centralia Police Department K9 Samson is among the recipients of a "Healthcare for K9 Heroes" grant from a national organization.

Vested Interest in K9s is a nationwide charity based in East Taunton, Massachusetts, with a mission to provide bullet and stab protective vests and other assistance to dogs of law enforcement and related agencies throughout the United States.

The nonprofit is continuing its "Healthcare for K9 Heroes" medical insurance program, which covers annual policy premiums. Since 2016, the charity has donated over $173,000 toward medical reimbursement programs for self-funded K9 units.
Source: chronline.com

Apple Unveils New Health Features Aimed at Patient-Doctor Data Exchange

https://www.apple.com/newsroom/2021/06/apple-advances-personal-health-by-introducing-secure-sharing-and-new-insights/

Welcome to PMI's Medical Office Management Assessment!

Learn More & Earn More! The medical industry is constantly evolving. How are you able to keep up after your formal education ends? Don't let these progresses in your field leave you regressing in your position. Take the first step in becoming a CMOM today! See if you're ready and take our free assessment today. https://info.pmimd.com

The Fight for ICD-10 Codes for Dravet Syndrome: What Families Need to Know

After years of advocacy efforts led by the Dravet Syndrome Foundation (DSF), during the most recent round of revisions, the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS) created new International Classification of Disease codes — known as ICD-10 codes — for Dravet syndrome.

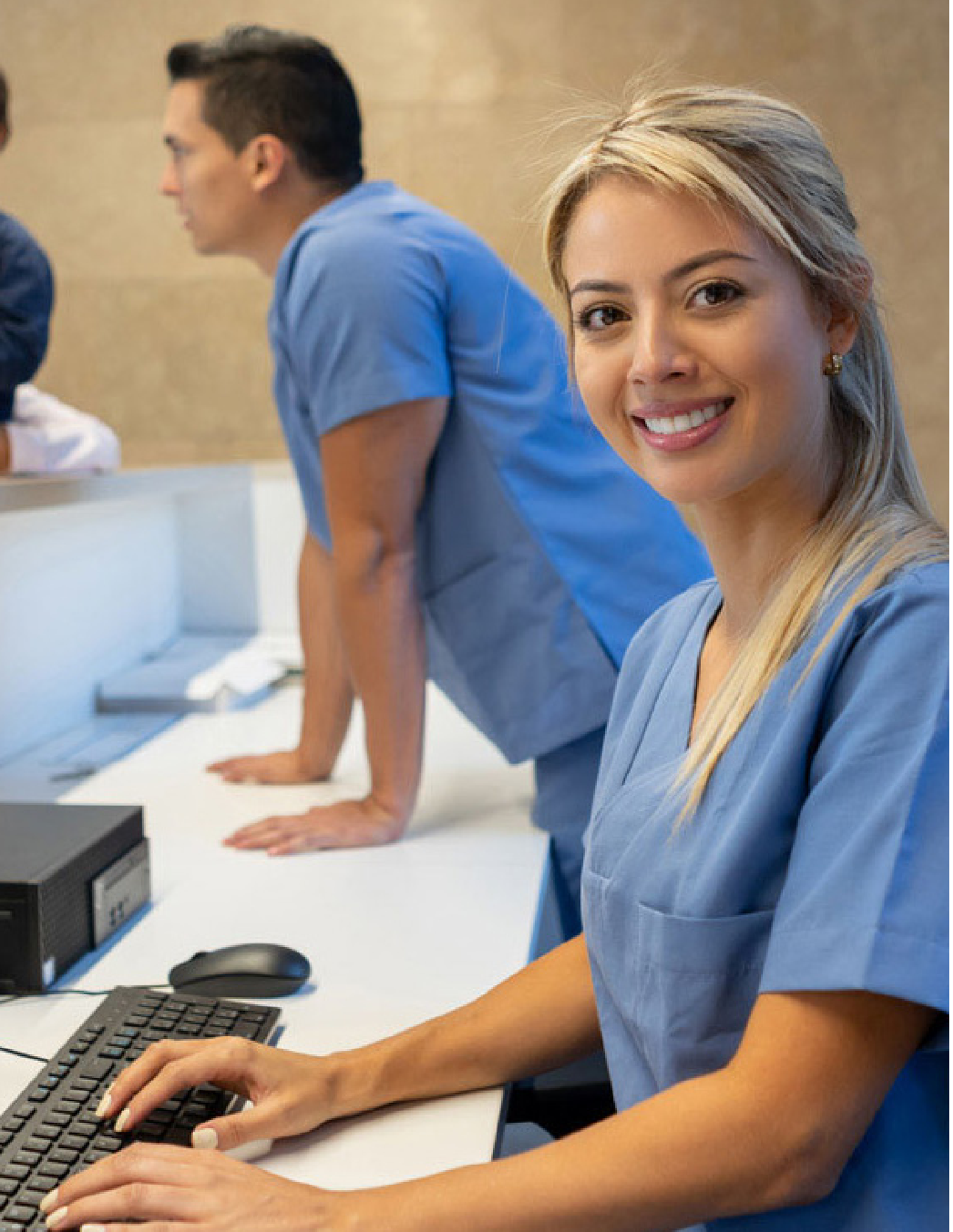
When ICD-10 was first issued, it included no designated code for Dravet syndrome. The condition was instead lumped under the code for other epilepsy and recurrent seizures.

"That code's pretty nonspecific," said Hood. "It could be applied to a variety of different epilepsy syndromes."

Now, thanks to advocacy efforts from DSF and members of its medical advisory board, the following ICD-10 codes have been adopted in the United States:

- G40.83 Dravet syndrome
- G40.833 Dravet syndrome, intractable, with status epilepticus
- G40.834 Dravet syndrome, intractable, without status epilepticus

Source: Healthline



The Coder:

The Hidden Revenue Generator

Businesses must reduce expenses and increase revenue to maintain growth and a competitive position. The medical field is a business with multiple added issues. Businesses face the expenses of rapidly increasing technology, an aging population, an ever-demanding expectation, and changing payer rules that risk delays, denials, and audit exposure.

While costs must be controlled, cost cutting alone cannot keep a facility open. This will require looking in depth at the income stream. The revenue cycle must not just be protected, but enhanced. Enhancement is best accomplished by providers. Not by relying on patient contacts or procedures, but by optimizing documentation to ensure full reimbursement and prevent denials.

Was the most accurate ICD-10 code utilized? Did it correctly identify all the resources used for the care provided? Was the claim submitted within an appropriate time frame? Will the providers' documentation support the level of service and procedure fee claimed? Will the facility or provider—after receiving payment—survive future audits, avoid fines, and manage to keep the payment?

All departments are crucial to a hospital's function and optimal patient outcomes. However, not all departments are revenue generating. Classic revenue-generating departments, for example, may be radiology, cardiology, orthopedics, or outpatient diagnostic services.

These strongly revenue-generating departments must support the other hospital areas that are not routinely self-supporting, as well as departments that provide non-billable services. It is important to not only optimize the current revenue departments, but also develop new departments that can provide revenue. Facilities often do not realize that a non-revenue-generating department can transition to revenue generating. Understandably then, this transition is under-utilized. The long-term potential of failing to make these changes is a daily reimbursement loss.

The goal in working with hospitals and providers is to implement a process that allows for not only rapid

coding of claims, but also ensures claims are accurate and have an improved chance of surviving a future payer audit. This process can improve quality metrics, reduce delays, prevent denials, provide an accurate bill that includes all services rendered, and shift accounts receivable in a favorable direction.

The first step in creating a process to assist facilities is to identify the problems each individual facility and staff are facing. For example, providers have limited knowledge of coding guidelines. Exposure to ICD-10 and evaluation and management (E/M) levels is brief, limited, and under emphasized. This puts the responsibility for reimbursement in the hands of the coders and requires them to read and audit each claim. Working powerfully against this effort for accuracy, compliance, and maintenance of the revenue cycle is the great pressure coders have to code a high volume of charts per hour. This economic loss is worsened with the frequency of coders and billers often being physically located away from clinical areas (reducing their access to providers for clarifications) or outsourcing of the service.

The first step in addressing these problems is to look at provider education for compliance. The providers' first goal must be to provide quality care. This quality care commonly follows treatment modalities, or algorithms, called "best practice pathways." Their goal is to ensure each patient is receiving the most up-to-date and most successful treatments.

However, in order to accurately reflect a diagnosis and treatment, providers must document charts using words and phrases that match coding manuals. This coding and billing documentation wording is ever changing, and likely different than both the wording taught to providers in their training and different from the communication used between providers.

Providers may not need to use these specific words to take good care of the patient, or accurately record what they have done. This is a source of significant provider resistance. However, providers must use these words to be compliant with payers, ensure optimal revenue generation, and receive appropriate credit for quality metrics.

Evaluation and management (E/M) is the system used by payers to turn a physician's cognitive problem solving and diagnostic skill into reimbursement in dollars. The reimbursement amount is determined by the provider's E/M level selection, and the selection level is determined by the documentation. This applies to all patients—office, nursing home, hospital-based patients, as examples.

Requirements for what must be documented in the note vary based on the level of claim submitted. When using electronic health records (EHRs), there are strict rules for how data must be recorded as well as what data must be recorded. Records that do not pass payer audits are susceptible to losing already received payments, as well as interest, penalties, and fines.

Physicians who dictate procedures must do this in compliance with current procedural terminology (CPT) and healthcare common procedure coding system guidelines (HCPCS). Documentation that does not meet guidelines gives the payer the opportunity to at least delay payment as more information is requested, or deny payment if information is recorded incorrectly.

Routinely, the CEO/CFO is not aware of the audit risk exposure of their employed physicians and facility fees. This is placed at risk by poor provider documentation. Is medical necessity demonstrated? Was this procedure, imaging, or laboratory test needed? Would the payer agree that the outpatient chart documentation supports the service? Appropriate documentation will answer yes to all of these questions.

Outpatient ancillary services are a crucial part of a hospital's revenue. To lose any portion of this due to poor provider documentation can be a crippling loss and, perhaps more importantly, an avoidable loss with provider education.

Another common problem is matching the expectations of CFOs to the realities of day-to-day practices. The concept of coding charts at an increased speed is valid. Nothing is as important as revenue cycle management. Without that, doors do not stay open. But coding charts quickly may result in errors or decreased optimization and lead to audit exposure. It does not help the health of a system to have a policy that increases future audit risk.

This is becoming increasingly worrisome, especially for administrators, as they are being held personally responsible for the facility's compliance errors. With enforcement definitions of "knowingly" being defined as "knew or should have known," the accountability has moved from providers, to coders, and now on to the CFO and by extension the CEO.

The solution rests with team building. The personnel, from provider to coder to biller to C Suite, must all understand they are intertwined. All must buy in and understand the current expectations for documentation and coding. The way to increase the volume of charts that may be coded per hour is to educate the provider about what the coder needs. If the provider can understand the concept of putting what the coder needs where they need it, the speed of claim submissions, and more importantly accurate claim submissions, will increase.

ICD-10 CM has approximately 70,000 diagnosis codes compared to 14,000 in the prior ICD-9 CM version. HCPCS now has nearly 90,000 codes compared to 4,000 in ICD-9 CM. Strict coding guidelines govern which code to apply, the order the codes are to be sequenced, which extra codes should be added, and if modifiers are appropriate. This requires coders to go through specific and extensive training to understand all of these variables.

The provider does not need to understand ICD-10 CM at the level of the coder. The providers do, however, need to be aware of the information the coder needs, respond quickly to coder queries, and learn from each interaction. In educating providers on ICD-10 CM, it is important to stress guideline rules rather than the providers' desire to try and memorize "my top ten" diagnosis codes. The concepts of with and without, code also, code first, and code to the highest specificity need to be understood in a more global fashion. Understanding the detail needed by the coder allows the provider to record that information level of detail.

When the provider can begin to understand what the coder needs to see in the documentation, the provider can begin to record that level of documentation. The coder then can much more rapidly select the most specific, most accurate, and therefore the most defensible code. The proper code survives an audit. The provider now has started that first step in becoming part of the solution.

Provider buy in is crucial to success. To develop provider buy in, they must be shown the "what is in it for me" concept. It is very helpful to equate chart audit passes and chart audit fails with dollars won and dollars lost. This includes not just immediate economic loss but the risk of inviting further scrutiny.

Coders are too often located physically away from the providers—the people with whom they need to have the most interaction. This simple fact of distance reduces communication, reduces code selection accuracy, and leads to coders having the perception they are not integral to the process. This is an issue that must be resolved.

GROUP SUBSCRIPTIONS

Give access to your entire staff to all features of BC Advantage.

5 - 10 Staff - $60.00 per staff
11 - 20 Staff - $50.00 per staff
21 - 30 Staff - $40.00 per staff
31 - 50 Staff - $30.00 per staff
51 - 100+ Staff - $25.00 per staff

Please visit www.billing-coding.com/group for more information.

The tremendous specificity of ICD-10 is such that coders will need to query providers. As providers learn more, they will have more detailed questions. They are far more likely to ask the question, and subsequently learn from the answer, when they can quickly have face-to-face access to coders. The provider must understand the coder is his/her greatest ally. Relationships must be established.

For providers to be part of the solution, they must want to be part of the solution. To accomplish this, they must understand the problem, understand that improved effort is needed, and understand the help available to them. Understanding their personal economic loss and showing the economic loss that documentation errors place on the hospital is integral to accomplishing this goal.

Providers must recognize the economic realities of documentation. Recognize that they influence their own, their partner's, and their hospital's solvency.

Now to the importance of queries. Sometimes, it is overlooked that queries must be submitted to the providers in an appropriate and non-leading form. But there is an even greater problem: the provider's absence of understanding the importance of the query itself.

This is most evident in the queries' responses, or routinely, lack of responses. When the queries are not answered, the needed information is not received. Often, they are answered, but the answer still does not address the issue in question. This results in the coder then making a "best guess," which is unlikely to be the most appropriate selection or an audit defensible selection. Further, it increases coder frustration and reduces the likelihood of sending the next needed query.

When a provider receives a query, it is in their own best interest not just to respond, but to actually meet with the coder. They can then understand the query need, learn how it improves claim accuracy, reduces delays and denials, and improves a given provider's quality metrics. Provider realization that the query is a positive toward their income and metric evaluations will improve the provider/coding/billing success moving forward. This development of a symbiotic relationship may be the single most important benefit for the hospital and the providers.

When providers have reached the understanding of the coders' value to the individual provider, quality accelerates. Coders are happy to teach and be recognized for the value and expertise they bring. The successful provider will understand the need to develop documentation that is compliant with the current rules and regulations of healthcare and reimbursement. An understanding that their personal economic and metric rewards are a function of this compliance is a motivating feature.

The only way to provide communities with healthcare and jobs is to keep facility doors open. By educating providers and support staff, leaders can build increased compliance and improve both economic and healthcare metrics.

Finally, the importance of team building cannot be over-emphasized. Coders have to be recognized by providers as integral to the overall health of the system. The value of a compliance consultant is not just to show areas at risk, but to also offer a potential plan for the resolution of these risk areas. The team of providers plus coders will allow for quick clarifications and subsequently the most appropriate billing to be submitted. This will improve on-time payment, enhance the revenue cycle, and help protect against future audits.

Dr. James Dunnick graduated from Indiana University with a double major in Chemistry and Biology, placing on the Dean's List. He graduated early from the Indiana University School of Medicine, placing in the honors division. He is boarded in Internal Medicine and Cardiology with over twenty years of clinical practice experience. He has published articles and presented nationally on clinical topics.

Dr. Laura Dunnick graduated Magna Cum Laude with a Bachelor of Science from McNeese State University. She then completed a Doctorate of Physical Therapy degree from the University of St. Augustine for Health Sciences, graduating with high honors and an Outstanding Leadership Scholarship.

Shining Light on the Physician Open Payments Program (f/k/a "Sunshine Act") and False Claims Act Violations

As part of its obligation to implement Section 6002 of the Affordable Care Act—the Physician Payment Sunshine Act ("Sunshine Act"), in February 2013, the Centers for Medicare and Medicaid Services (CMS) released the final regulations for implementation. The fundamental premise behind the Sunshine Act was to promote greater transparency and shed light on financial relationships between doctors and manufacturers of covered drugs, devices, biologicals, and medical supplies (collectively "Manufacturers").

Teaching hospitals or academic medical centers have a similar requirement.

The reporting requirements, which stem back to March 31, 2014, are as follows:

- Physicians and teaching hospitals are required to annually report to CMS gifts and "payments or other transfers of value" they or their immediate family members receive from Manufacturers; and
- Manufacturers must collect and report data to CMS.

As Peter Budetti, MD, then CMS deputy administrator for Program Integrity stated, "Disclosure of these relationships allows patients to have more informed discussions with their doctors."

On November 13, 2014, CMS published in the Federal Register that they, "have organized these reporting requirements under the 'Open Payments' program. … The implementing regulations, which describe procedures for applicable GPOs to submit electronic reports detailing payments or other transfers of value and ownership or investment interests provided to covered recipients and physician owners or investors, are codified at § 403.908." Subsequently, the vernacular changed from the Physician Sunshine Act to the Open Payments Program.

Certain types of payments to physicians, hospitals, or other healthcare entities by persons seeking to utilize those payments in exchanges for referrals or product utilization have been prohibited for nearly 50 years under the Federal Anti-Kickback Statute and for nearly 30 years under the Stark Law. The False Claims Act has been around since 1863 and all of these laws are considered significant fraud, waste, and abuse laws with which every healthcare industry participant should have familiarity.

The purpose of this article is to highlight two recent False Claims Act case settlements, which involved allegations of violations of the Anti-Kickback Statute (AKS) and the Open Payment Programs (OPP).

Analysis

The False Claims Act (FCA) is the Federal Government's primary tool for combating fraud and returning funds to the federal fisc. Two recent case settlements highlight the OPP's role in FCA cases.

On October 29, 2020, the DOJ announced that Medtronic USA, Inc. ("Medtronic") agreed to pay $9.2 million to settle FCA violations based on the violation of two laws: (1) the AKS; and (2) OPP. The OPP portion of the settlement was $1.11 million, which "requires medical device manufacturers like Medtronic to disclose to CMS certain payments or other transfers of value to a physician like Asfora." The allegations were premised on Medtronic's payments to the physician's restaurant, knowing that these were kickbacks in exchange for referrals, and underreporting the payments to CMS. As Brenna E. Jenny, former HHS Deputy General Counsel and CMS Chief Legal Officer indicated, "CMS' Open Payments Program is intended to promote transparency and accountability in the healthcare system. Manufacturers that misreport their financial relationships with healthcare providers erode the integrity of the Open Payments Program and will be held accountable." Hence, underscoring the importance of truthful disclosures to CMS.

Again, on May 19, 2021, the DOJ revealed that a French medical device manufacturer, Medicrea International and its American affiliate, Medicrea USA, agreed to pay $2 million to resolve civil FCA allegations for violations of the AKS ($1 million) and OPP ($1 million). The DOJ not only restated the goal of OPP in creating transparency, but also relayed that "The settlement follows the Senate Finance Committee's March 2019 request that HHS-OIG and CMS investigate Open Payments Program non-compliance and pursue enforcement." It further indicated that it is incumbent upon Manufacturers to ensure timely and accurate OPP reporting of all applicable payments—whether direct or indirect, in cash or in kind. This second settlement underscores the notion of heightened scrutiny related to OPP violations in connection with FCA cases.

Conclusion

Acting U.S. Attorney for the Eastern District of Pennsylvania summed it up best: "This case [Medicrea] demonstrates the Department of Justice's commitment to ensuring that medical device manufacturers do not use improper relationships to influence physician decision-making and are transparent about the benefits that they provide to physicians." These cases should serve as a wake-up call to Manufacturers' compliance teams, as well as defense counsel who could be called in to represent companies once the government initiates its investigation. Whistleblowers' counsel now has another established tool in their arsenal and it is likely that OPP violations will be pled conjunctively with AKS violations, as the basis of FCA cases.

Rachel V. Rose, JD, MBA is an Attorney at Law, in Houston, TX. Rachel advises clients on healthcare, cybersecurity, securities law, and qui tam matters. She also teaches bioethics at Baylor College of Medicine. She has been consecutively named by Houstonia Magazine as a Top Lawyer (Healthcare) and to the National Women Trial Lawyer's Top 25. She can be reached at rvrose@rvrose.com. www.rvrose.com

Getting Paid for Assistants at Surgery: Modifiers 80, 81, 82, and AS

When a surgical assistant is called in to help with part or all of a surgical procedure, that individual's portion of the work needs to be reported with the usual CPT code, along with the appropriate physician modifier to show the status of the assistant.

Payment for a surgical assistant, or assistant at surgery, is based on the CPT coding guidelines and the policies set by Medicare and non-Medicare payers. The operative report must also include the name and title of the surgical assistant, the specific services performed, and the reason they were medically necessary. Without this critical information, a third-party payer will likely deny the claim.

Primary Surgeon's Responsibility

The primary surgeon has the responsibility to determine and request the assistance of a qualified practitioner at surgery and to determine the level of care the assistant will provide. The decision on the type of professional who may be asked to assist in the surgery may be based on local resources and the characteristics of the patient. For some surgeries, a second assistant at surgery may be necessary.

Surgical Assistant Definition

According to the American College of Surgeons (ASC), "The first assistant in a surgical operation should be a trained individual who is able to participate in and actively assist the surgeon in completing the operation safely and expeditiously by helping to provide exposure, maintain hemostasis (prevent or stop the bleeding), and serve other technical functions. The qualifications of the person in this role may vary with the nature of the operation, the surgical specialty, and the type of hospital or ambulatory surgical facility."

The surgical assistant also performs preoperative and postoperative duties to ensure proper patient care. During a surgical procedure, the assistant works under the direct supervision of the primary surgeon and in accordance with hospital policy and relative laws and regulations.

The first assistant at surgery should preferably be either a qualified surgeon or a resident of an approved surgical training program. If these assistants are unavailable, other qualified physicians may be called on to lend a helping hand.

There are times when nonphysicians, such as surgeon assistants (SAs) or physician assistants (PAs), may be needed as first assistants. These individuals must have the appropriate surgical training, be credentialed by the appropriate local authority, and may not operate independently.

Registered nurses may serve as first assistants if they have specialized training. They may not function in two different capacities simultaneously, however, such as a scrub nurse and instrument nurse while serving as a first assistant.

What is a Modifier?

A modifier is a two-digit code that may be appended to CPT or HCPCS Level II codes. It conveys to the payer additional information about a procedure or service performed by a physician or other qualified healthcare provider as to how the code descriptor has changed but not enough to alter the definition or code. According to the CPT coding manual, a modifier is also used by healthcare professionals to effectively respond to payment policy requirements established by other entities.

Assistant Surgeon Modifiers

Modifiers used to report surgical services performed by an assistant include CPT modifiers -80, -81, -82, and HCPCS Level II modifier -AS. These modifiers are added to the same CPT procedure code that the primary surgeon uses. The modifier tells the third-party payer of the assistant surgeon's status.

CPT modifiers -80, -81, and -82 and their descriptions are listed in Appendix A of the CPT coding manual as:

- Modifier -80, Assistant surgeon: Surgical assistant services may be identified by adding modifier -80 to the usual procedure number(s).
- Modifier -81, Minimum assistant surgeon: Minimum surgical assistant services are identified by adding modifier -81 to the usual procedure number.
- Modifier -82, Assistant surgeon (when a qualified resident surgeon is not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier -82 appended to the usual procedure code number(s).

HCPCS modifier -AS and its description is usually listed in an appendix of the HCPCS Level II coding manual as:

Modifier -AS, Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery: When a physician assistant provides a helping hand at surgery, HCPCS modifier -AS would be appended to the CPT code, rather than modifier -80.

Modifier -80: An assistant surgeon actively assists a primary surgeon for all or a significant portion of the surgical procedure. When modifier -80 is used, the third-party payer usually pays 15 to 30% of the usual charge for a surgery; however, not all payers allow for an assistant surgeon for all procedures. Before performing a surgery, a pre-authorization should be completed to find out if the payer will reimburse for the assistant surgeon.

Modifier -81: Although not commonly used, this modifier is used when a minimum assistant surgeon provides services for only a portion of the procedure. These services are less extensive than those described by modifier -80. Many third-party payers do not reimburse for a minimum assistant surgeon. Medicare rarely pays a minimum assistant surgeon, and that is only when medical necessity can be proven. The payment for a minimum assistant surgeon is usually 10% of the usual charge for a surgery.

The CPT coding manual defines a minimal assistant surgeon as a physician acting in a minimal capacity. However, some third-party payers define a minimal assistant surgeon differently. They consider a minimal assistant surgeon as a nurse practitioner, physician's assistant, or other specialized clinical nursing personnel. For this reason, the coder should be sure to check with the third-party payer before reporting modifier -81 for individuals other than a physician.

Modifier -82: This modifier is used when the hospital where the procedure was performed is affiliated with a medical school and has a residency program, but no resident is available to assist at surgery. These hospitals provide surgical training to their residents, who are physicians, in return for providing assistance to physicians. Medicare does not pay for an assistant surgeon if the hospital has a residency program. Supporting documentation must indicate that the patient's condition required an assistant surgeon and that a qualified resident was not available.

Modifier -AS: Coders should review the CMS Medicare Physician Fee Schedule (MPFS) to determine if a procedure is reimbursable when performed by a surgical assistant. Some non-Medicare payers do not accept modifier -AS.

Medicare as the Payer
CMS has developed the Medicare Physician Fee Schedule which specifies the services they cover. It also indicates which procedures are eligible for payment when performed by an assistant surgeon.

The coder enters a CPT code into the Fee Schedule, and one of the following Assist-at-surgery surgical indicators are provided:

2: Assistant at surgery may be paid
0: Additional documentation is needed to substantiate medical necessity
1: Assistant surgeon will not be paid
9: Assistant surgeon concept does not apply

So, let's assume that the documentation states that an assistant surgeon assisted the primary surgeon in performing a single lung transplant, and the correct CPT code is 32851, Lung transplant, single; without cardiopulmonary bypass. The coder could enter this code into the Physician Fee Schedule, and a table would appear with the CPT code listed (32851), along with a short description (Lung transplant single), and the assist-at-surgery indicator (2). Indicator "2" means that Medicare allows for payment for a surgical assistant in this procedure. The coder would then report 32851 with the appropriate modifier appended based on the documented surgical assistant's status.

Non-Medicare Payers
Non-Medicare payers have their own payer policies, which may be different from the policy set by Medicare. United Healthcare's Reimbursement Policy states that the standard reimbursement for eligible assistant-at-surgery services, which are provided by a physician (MD or DO), is 16% of the allowable amount. The standard reimbursement for eligible assistant-at-surgery services, which are provided by a healthcare professional, is 14% of the allowable amount. A physician assistant, clinical nurse specialist, or nurse practitioner is someone who does not have an MD or DO degree/designation. A surgical technician assisting at surgery is included in the reimbursement to the facility and is not separately reimbursable.

Documentation
Although there is no guarantee of payment for an assistant's efforts, including certain information in the operative report certainly increases the chances. The primary surgeon's operative report should explain the services performed, and the individuals, including credentials, who performed them. The body of the report should indicate the specific responsibilities assigned to the assistant surgeon in which he/she actively participated during the surgical procedure, and the reason assistance was needed. In addition, all services performed by a surgical assistant must meet the criteria for medical necessity and must be included in the documentation.

Modifier Exercise
Using what you have learned about modifiers -80, -81, -82, and -AS, identify the modifier in the following questions:

1. Dr. Blue serves as a surgical assistant to Dr. Green in a coronary artery bypass graft procedure. The patient experiences complications during the procedure. Dr. Green requests that Dr. White come to the operating room to help with the surgery to stabilize the patient. What modifier would be used to report Dr. White's part of the service?
2. Patient presents with a lung hernia that is bulging through the chest wall. It requires immediate repair. This is a teaching hospital, and the residents on call are busy assisting in other procedures. Therefore, the primary surgeon requests the assistance of another thoracic surgeon for the procedure. The assistant surgeon would report his portion of the procedure with which modifier?
3. A physician assistant is asked to assist at surgery. What modifier is used to report the physician assistant's services?
4. A primary surgeon performs a posterior cervical arthrodesis at C5-C6. The assistant surgeon helps in holding the vertebrae in place and with harvesting and placement of the bone graft. What modifier would the assistant surgeon append to the CPT code to report his part of the procedure?

Answers:
1. CPT modifier -81
2. CPT modifier -82
3. HCPCS modifier -AS
4. CPT modifier -80

Debbie Jones, CPC, CCA, has a passion for writing about medical coding and healthcare and is the writer behind Medical Coding Buff. https://www.medicalcodingbuff.com/

Evaluating the Promise of Telehealth:

Pandemic Physician Practice Lifesaver Gives Way to Billing, Regulatory Scrutiny

During the worst of the global pandemic, telehealth likely saved many physician practices from financial ruin. Telehealth also kept patients from risking their lives trying to access routine medical, occupational, and mental healthcare.

Federal payers relaxed HIPAA rules to allow the use of Zoom and other common videoconferencing technologies during the public health emergency (PHE) and expanded the telehealth categories covered under federal plans. Many private insurers followed suit, with some even covering patient deductibles and co-pays for select services.

Telehealth visits have slowed as the pandemic ebbs and patients are increasingly comfortable seeking in-person care, but relaxed rules are expected to remain for a period after the PHE ends. However, while telehealth visits are down, enforcement efforts are ramping up, including audits of telehealth claims.

Telehealth is likely here to stay, so physician practices must fully understand the rules regarding use of the technology, including the potential billing and coding ramifications. And that starts with having the right claims software that quickly changes in response to new, deleted, and revised billing rules.

Telehealth Visits, Claims Skyrocket During Pandemic

From the time the country first shut down in mid-March 2020 through October, nearly 25 million Medicare recipients received telehealth services, and an additional 35 million Medicaid and CHIP beneficiaries received telehealth services last year. Telehealth visits comprised nearly 30% of total outpatient visits between mid-March and mid-June 2020, a 23-fold increase from January 1-March 17, 2020. As a percentage, younger adults used telehealth more often than older patients, with nearly 39% of patients ages 30-39 using telehealth, compared with 24% of those 65 and older.

Telehealth claims submitted to private payers skyrocketed more than 8,000% in April 2020 compared to April 2019, with telehealth representing 13% of medical claims versus 0.15% the previous year. Private insurers moved in conjunction with federal payers in relaxing rules governing telehealth. The Centers for Medicare & Medicaid Services added more than 140 covered telehealth services during the pandemic to accompany the roughly 100 already covered. In addition, the Department of Health and Human Services eliminated penalties for HIPAA violations that occur during "good faith" use of telehealth during the pandemic.

Even before the pandemic, healthcare consumers of all ages were becoming more tech-savvy, checking their symptoms before visiting a physician or researching alternative treatments following a diagnosis. The pandemic has accelerated this trend—especially as seniors sheltered in place and visited their grandkids and their physicians by Zoom and other videoconferencing technologies.

Bad Actors Get in On the Action

Increased incidents of fraud, waste, and abuse often follow increased access to care, and telehealth expansion is no exception.

More than 345 people across the country were charged in September with healthcare fraud that amounted to more than $6 billion in alleged losses, according to the U.S. Department of Health and Human Services Office of Inspector General (OIG). Nearly 90 of those arrested and $4.5 billion in losses are linked to alleged telehealth fraud. Overall, more than 100 licensed medical professionals were arrested during the operation. In April, a patient recruiter in Florida was sentenced to 10 years in prison following his conviction for healthcare fraud and other charges related to a telemedicine scheme involving genetic testing.

The OIG announced in February that it would conduct a series of audits to gauge the efficacy of care delivery, program integrity, and billing for a range of telehealth services, including home health and behavioral health. Specifically related to billing, the audit will focus on: whether home health services have been properly administered and billed; provider billing patterns for telehealth; provider compliance with telehealth under the PHE declaration; and creating a profile of providers that may pose a program integrity risk. Results are expected late this year or in early 2021.

Previous OIG reviews of telehealth services conducted prior to the PHE showed a 31% error rate, so it's not surprising that telehealth is receiving renewed scrutiny given its increased usage during the pandemic.

Best Practice Recommendations for Providers

In a March report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended extending telehealth expansions after the public health emergency ends so it can study the issue for up to two years. It recommends continuing Medicare coverage for telehealth services, regardless of recipient location, as well as audio-only services around which there is little data. Controversially, MedPAC advocates a return to payment based on the Physician Fee Schedule (PFS), which would reimburse for distance telehealth at a lower rate than in-person visits.

For many physician practices, telehealth will continue to be an important revenue source, but you don't want to run afoul of OIG or private payer audits. Follow these six steps to help protect your practice.

1. Conduct an audit to ensure that all telehealth visits are medically necessary and properly documented.
2. Evaluate your billing practices to determine whether claims properly and accurately match up to patient records.
3. Ensure providers are properly credentialed/licensed.
4. Determine whether your telehealth solution conforms to HIPAA requirements. Although privacy rules have been relaxed during the PHE, they are expected to return once the emergency has eased.
5. Invest in robust billing solutions that are constantly updated and reflect applicable day-by-day billing changes.
6. Carefully review CMS guidance to ensure your practice is compliant and ready for any upcoming rule changes.

Andria Jacobs, RN, MS, CEN, CPHQ, is the chief operating officer for PCG Software and has more than 25 years' experience in the healthcare industry, encompassing both administrative and clinical arenas. Prior to joining PCG, Ms. Jacobs was the administrative director, medical management for VertiHealth Administrators. Previously, she was an independent consultant in ambulatory care and practice management, where her clients have included hospitals, physician groups, and the University of California, Los Angeles.

Best Practices for Managing the Insider Threat in Healthcare

The effects of the COVID-19 pandemic have forced changes in many aspects of society. Two areas that have seen significant change involve how people work and obtain healthcare. Remote work and healthcare solutions were adopted wherever possible to slow the spread of the virus by limiting face-to-face contact.

In this article, we will look at the best practices healthcare organizations can use to minimize the security risk posed by insiders. In many cases, insiders pose the greatest threat to an enterprise since they possess important information in how it operates and where its weaknesses may lie.

Cyberattacks in the Healthcare Industry

Cyberattacks affecting the healthcare industry have increased tremendously since the start of the pandemic. The attacks can be made via multiple methods, with ransomware being one of the most popular. Ransomware, which is a particularly nasty type of malware, attacks an organization's databases. It encrypts the data and holds it for ransom, usually requested in some type of cryptocurrency. Botnets, remote code execution, and dedicated denial of service (DDoS) attacks against healthcare organizations are also happening with disturbing frequency.

A common characteristic of all cyberattacks is the need for the perpetrators to gain access to resources in an organization's IT infrastructure. Sophisticated cybercriminals research their targets and choose victims who cannot afford to lose access to their data. Healthcare providers, especially those involved in emergency measures designed to address the pandemic, are prime targets for unscrupulous hackers.

Organized teams of hackers employ multiple steps in planning and executing an attack.

- **Reconnaissance -** Steps are taken to get to know the target and how they operate.
- **Weaponization -** Phishing emails or fake web pages are created to attempt to gain access to secured systems.
- **Delivery -** Phishing emails are sent, and fake pages are posted to trick unsuspecting employees to open an attachment and launch malware.
- **Exploitation -** Hackers start collecting passwords and other credentials sent to them by the malware and use them to explore the network and its current limitations.
- **Installation -** Hackers will install a persistent backdoor to the compromised system to ensure future access.
- **Command and control -** In extreme cases, hackers can take control of the entire network and lock out authorized users.
- **Action on the objective -** Once command and control is achieved, the hackers can pursue their objective which may be stealing information, installing ransomware, or disrupting mission-critical systems.

Malicious insiders can be involved in any of these steps. An attack initiated by an insider can skip the first three steps and start directly exploiting sensitive systems. Untrained or careless insiders can also inadvertently contribute to an attack's success by clicking on links in phishing emails.

Insider Threats to IT Security in Healthcare

Insider threats can originate from five different types of insiders:

- Careless workers who may unintentionally bypass security and privacy measures resulting in a data breach.
- Inside agents are employees who have been coerced, recruited, or bribed into stealing data from an organization for a third party.
- Incompetent third parties or partners can put healthcare data at risk through improper security procedures or negligence.
- Disgruntled employees or those who are leaving soon may be tempted to take private data with them when they go.
- Malicious insiders working by themselves are hard to spot and pose the greatest challenge to security teams in the healthcare industry.

Insiders pose specific threats to IT systems that can be difficult or impossible to fully address. As can be seen from the steps required for executing a cyberattack, using an insider considerably streamlines the process. A malicious trusted insider may eliminate the need for reconnaissance, weaponization, and delivery by using authorized privileges to directly exploit IT resources. This is extremely hard to stop before the fact and may be difficult to detect through standard security monitoring.

The following are some key findings from a Varonis sponsored report on security in the healthcare industry:

- On average, nearly 20% of files are open to all employees in a healthcare organization.
- Over 50% of organizations have more than 1,000 sensitive files open to every employee.
- Almost two-thirds of organizations have 500 or more accounts with passwords that never expire.

These statistics are extremely troubling from a security perspective. They illustrate the critical nature of implementing enhanced security measures across the healthcare industry.

Best Practices to Manage Insider Threats

Many of the insider threats faced by the healthcare industry are also problems for other market sectors. A major distinguishing factor impacting healthcare is the critical and sensitive nature of their IT systems and the data they store. In addition to sensitive personal health information (PHI), payment details and financial records are also stored in healthcare databases.

The following best practices will help strengthen security and

protect sensitive information resources in the healthcare field:

Implementing the Zero Trust Security Model

The Zero Trust Model was introduced by John Kindervag of Forrester Research in 2010. The model provides an innovative way to approach the security of computer networks and their supported systems. This security model eliminates the assumption that internal network traffic should be trusted, and treats all traffic as being potentially dangerous based on the following observations.

- Insiders cannot be implicitly trusted.
- Data packets can never automatically be trusted. Since there is doubt as to their origin, every packet needs to be seen as potentially harmful.

It is important to note that Zero Trust is a philosophy rather than a technical solution. Zero Trust outlines three core principles to address security weaknesses:

1. All computing resources need to be accessed securely.
2. The concept of least privilege needs to be enforced.
3. Network traffic needs to be monitored and verified in real time to protect the environment.

Focusing on Security Awareness

Hackers try to gain access to systems by compromising the weakest links in the organization's security. These are usually the people who have direct or indirect access to sensitive data. Security awareness involves an understanding of the organization's data resources and how malevolent actors may target unsuspecting employees.

Many employees may not be aware of how to defend themselves against phishing campaigns. Security training can help limit, but never eliminate the dangers of targeted phishing. A single mistake or lack of judgment can result in serious consequences for a healthcare provider.

End-To-End Data Encryption

Encrypting sensitive data is an accepted technique for protecting it from unauthorized use. Fully encrypting data in transit, in use, and at rest can become complicated, especially when multiple environments are involved. Healthcare organizations need to ensure that all data is encrypted end-to-end whether on-premises or in the cloud.

Data Classification

Classifying data based on its degree of sensitivity will assist in efforts to protect it.

Not all data needs the same level of protection. Most organizations need between three and five data classifications and should implement minimum handling requirements for each class.

Monitoring Mobile Device Access

The increased reliance on mobile devices by patients, providers, and workers in the healthcare industry has introduced new security risks. An authorized mobile device in the wrong hands can quickly lead to the loss of sensitive information and a costly data breach. Healthcare organizations need to find the right balance between the functionality of mobile and telehealth solutions and the security and privacy of their sensitive data resources.

Conclusion

Managing the insider threats to the healthcare industry demands a multi-faceted approach that implements strong protective policies and trains employees on the fine points of security awareness. Failure to address these issues leaves healthcare organizations vulnerable to attacks from both internal and external sources.

HIPAA Compliant Hosting by Atlantic.Net™ is SOC 2 and SOC 3 certified, HIPAA and HITECH audited, and designed to secure and protect critical healthcare data, electronic protected health information (ePHI)m and records. We are audited by qualified, independent third-party auditing firms to demonstrate our leading security and compliance services. For more information, visit https://www.atlantic.net/hipaa-compliant-hosting/

Thoughts Had ... Lessons Learned®

The Future Ain't What It Used To Be

Telecommuting

My title for this article is attributed to a purported Yogi Berra saying. I met Mr. Berra when I was twelve (12) but never heard him say that. I cannot decide whether the above word, telecommuting, is an oxymoron (self-contradictory) or just moronic (stupid). The general definition of telecommuting is, "the practice of working from home, making use of the internet, email, and the telephone."

The generally accepted definition of commuting is, "travel some distance between one's home and place of work on a regular basis." I believe this definition conflicts with this new made-up word and is an indicative symptom of the language wars being waged in our society now. It's not just about semantics. It's about accurate communications. We used to call working from home "working from home" or "working remotely." If you don't physically travel, then I don't think you are commuting. But, that is just me and the IRS. If you can send yourself to work through a telephone line or over the internet, then, "Beam me up, Scotty." However, I do not think the IRS will allow me to get reimbursed for the business mileage between two (2) work locations.

For the purposes of my article on "The Future Ain't What It Used To Be", I will use the antiquated term, "remotely working," to mean a physician employee, or someone else, performing services for the physician practice somewhere other than in the physician office where hands-on patient care is being directly provided. People have been remotely working for physicians for years with services like segregated call & scheduling centers, billing offices, etc. And, many sales people out there have always "worked from home." So, the so-called telecommuting ain't nothin' new, and the future might be what it used to be.

The "traditional staffing model" for a physician office has been for the physicians/providers, practice staff, and patients all to be in the same facility when care is delivered. Even if the practice had multiple locations, there was always clinical support staff and some clerical support staff

at each location. There are some other different types of staffing models that are usually due to practice size. In the "old days," the majority of the practices were five (5) physicians (providers) or less and all were in the same location. Everyone showed up at the same time and at the same location, and all the work was done in the same building. No one worked from home. That has changed and will continue to change. This article will provide a general overview of current and future practice operating dynamics.

COVID Catalyst

I do not believe it is an overstatement to state that in my observations, the COVID pandemic has had the greatest impact on the U.S. labor market since the Great Depression. In some ways, it will have a greater lasting impact than the Great Depression because the Great Depression ended, and things went back to "normal." I do not see the COVID effect on this country, or the world, ever ending, and things ever going back to "normal." The economic, structural, and philosophical changes that have occurred and will continue to occur have been so drastic that a new societal paradigm around the world has occurred that will be permanent. This also has significantly and permanently changed the healthcare delivery system in this country. Just for the record, I do not like the word paradigm. I just could not think of any better word. I suppose I could have used "standards," but that word is less accurate because a far more dramatic change has occurred than the word standard connotes. What is happening to the United States society and its economy is both evolutionary and revolutionary. It is permanent and continuing to evolve. It all has changed the definition of, meaning of, and approach to healthcare and the healthcare delivery system.

Patient Care Delivery Models

Before looking at remotely working, we need to look at the Patient Care Delivery Model (PCDM) during and after COVID. Forgive me for the PCDM acronym, but for brevity, I will use PCDM in the remainder of this article. There may not be an after COVID from a disease timeline perspective just as there is no after flu or many other permanent and seasonal disease timelines for other viruses. The healthcare industry is already talking about annual booster vaccines. Part of the COVID effect appears to be the learning to live with and the treatment of COVID since it does not appear at this time that any of the vaccines are preventing COVID infections, just reducing the illness severity according to most of the published literature on COVID. Uniform COVID treatment protocols have yet to be developed. Unfortunately, there is still a lot of unknowns about COVID and the effects of COVID and the vaccines now and in the future. In addition, new strains of COVID are continually arising. What is known is that all of this has changed how people live day to day now and going forward, which has a direct impact on the practice of medicine at the provider, staffing, and patient levels. It also impacts the healthcare access issues.

The PCDM had already begun to morph toward telemedicine/telehealth prior to COVID. I will not explain in this article the difference between telemedicine and telehealth. There is a difference between them. However, the two (2) words are used interchangeably now in communications. This takes us back to the semantics language war. I will use the term telemedicine because I think it more accurately reflects a provider delivering healthcare advice over the telephone and the internet.

One report from the telehealth company, Updox, shows many statistical changes to telemedicine demand since COVID. Updox used the Fair Health, Black Book Research for much of its statistics. (This is not an endorsement of Updox, just a reference source. There are numerous other telemedicine/telehealth companies out there, such as Teledoc, Amwell, and First Stop Health—all of whom I have had communications with over many years.) According to Updox, telemedicine delivery and use has increased almost 1,400% since COVID started.

Other statistics provided by Updox about telemedicine include the following:

- 83% of patients felt the quality of care in a telehealth visit was as good or better than an in-person visit
- 76% of patients prioritize provider access over human interaction
- 90% of patients no longer feel obligated to stay with a provider that can't offer a satisfactory digital experience
- 96% of employer health plans are expected to adopt telehealth

The most important statistic that I am directly experiencing when working with practices is the fact that Medicare, Medicaid, and most of the commercial insurance carriers are now all paying for telemedicine services. Many states are requiring insurance companies to make telemedicine a "covered service." Of course, employers and individuals will have to pay more in premiums and cash for this privilege and convenience, even if they have no other choice. In the past, most telemedicine services were considered "non-covered services." A physician could not get reimbursed for the Telephone Consult CPT Code. Medicare considered some telemedicine services as "medically unnecessary." (Refer to one of my previous articles for BCA Magazine, titled, "Follow the Dollar.")

There is one other significant change that is driving the change in the PCDM: technology. Technology is getting better, faster, cheaper, and more ubiquitous. When people consider the time, hassle, and costs of getting from point A to point B anymore for anything, it is no wonder that there is a shift to "online living," whether it be for banking, shopping, exercising, school, healthcare, etc. You can even buy a car online now and have it delivered. Since you aren't going anywhere, anymore, I don't know why you would need a car. You can just put on your headset and take a virtual vacation. The visual is here now; the sensory is coming.

Remotely Working

As I previously stated, I use the term "remotely working" or simply "remote" to refer to a physician practice staff person who is not located in the "clinical site" when performing their tasks to support practice operations, but in some other location. For the remainder of this article, I will focus on the "employee home" as the location where the staff person performs their support duties for the practice since that is where the greatest change in physician staff working locations has occurred under COVID. There are four (4) basic work groups in physician office staffing. Each one of these groups has a subset of "staffing positions" with various "duties" and "tasks" to be performed on behalf of the practice and patient care. The subsets will not be covered here.

The groups are:

- **Providers –** Direct primary patient care
- **Clinical Support –** Provider patient care support and some patient care
- **Front Office Support –** Direct patient interactions, onsite patient and information flow management
- **Back Office Support –** Administration, compliance, accounting, scheduling, patient billing, marketing, etc.

It is somewhat obvious from the above which groups or possible group subsets can work remotely/virtually and which will need to be onsite to provide direct patient contact and care. One of my favorite, all-time quotes (author unknown) is: "T'would be trivial to state the obvious were it not for the universal neglect thereof." I have made a living stating the obvious. However, if a practice were to be doing only "telemedicine," then everyone could be a virtual avatar and work from wherever. We saw this years ago with the development of offsite radiology coverage and readings by physicians. The physician worked from home, and from the other side of the world. The company Nighthawk was an early adaptor of this form of telemedicine/telehealth process with locations in the United States, Australia, and Switzerland. Telemedicine can be done without face-to-face video with the patient, or with each other. Telemedicine psychotherapy was also an early entry into the telemedicine market.

Again, it should be obvious that there are certain patient care services that cannot be delivered virtually and there must be direct face to face and touching and contact with the patient. Surgery comes to mind. Although, remote robotic surgery may not be far in the future. The application of remote patient care by medical specialties and medical service lines is a discussion for another article. In addition, the willingness and ability of a patient to participate in "self-care" will also be a major factor on the amount and success of the future of telemedicine. Many patients are doing their own EKGs on their cellphones now. We have seen during this COVID pandemic that because of fear and legal deterrents, many patients needing care stopped seeking care, and many healthcare delivery systems stopped offering care. It does not matter what your politics or beliefs are on the COVID issues, the lack of patients needing care, seeking care, and the healthcare system suspending care has caused the death of tens of thousands of people—probably hundreds of thousands. There has to be a better way to manage healthcare during a pandemic fear crisis.

Remotely Working Factoids

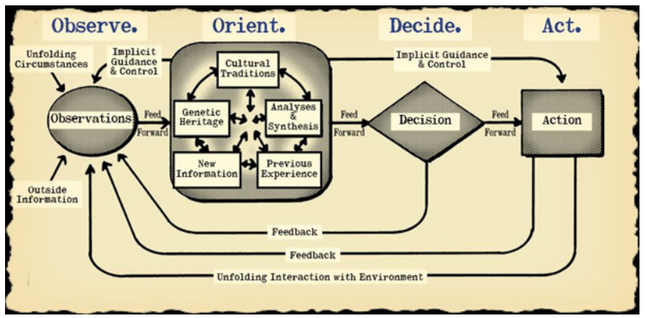
My question to physicians is not whether they should allow their employees to work remotely, but why they have employees in the first place. There are other options. Again, that's a separate article. The usual answer I get from the physician is, "I need to be in control, so they do what I tell them to do." I doubt that really happens anymore. When I ask physicians why they don't permit their employees who can work from home to work from home, the usual answer I get from physicians is, "I need to keep an eye on the employee to make sure they are working." That never happens either. If it does, the physician is not optimizing revenue and providing optimal volume and quality of care to the patients. If the practice is not structured in a way that regular analytics reporting doesn't put the physician in control and tell the physician how much and what quality of work an employee is doing without having to have the physician or an office manager stand over employees and monitor their performance, the practice operations are broken and need to be fixed. The real issue regarding remotely working by practice staff is HIPAA.

It is difficult enough to do HIPAA compliance in a controlled environment. It becomes almost impossible in an open environment like an employee's home. HIPAA applies no matter where a patient's Personal Health Information (PHI) is being handled. It is my observation that probably 90%+ of all physician practices are not 100% HIPAA Compliant. It's like many other regulatory requirements and compliance issues of physician offices, such as OSHA, etc. There is no 100% compliance at any time. The government regulators cannot get to everyone, and there is a certain amount of "look the other way" attitude if the infractions are not flagrant or patients don't complain. When PHI is moved out of the traditional physician office and allowed to be taken "remotely," regardless of where, this becomes a red flag issue for regulators. COVID requiring PHI to be handled remotely regarding patient care has created an identifiable target for enthusiastic HIPAA regulators. The number of HIPAA violations and fines on remotely working with PHI has increased exponentially. The fines are in the hundreds of thousands of dollars. It will continue and get worse. It's a revenue source now for our government who is exponentially printing money and increasing the U.S. debt. Again, not a political position, just a statement of fact affecting the regulatory and economic impact COVID and the government response is having on physicians and remotely working. (Remember, "Follow the Dollar.")

Where Is It All Going?

Again, I think the physician is asking the wrong questions about whether practice employees should be allowed to continue remotely working. The real question for the physician is: Will you be able to find and retain any quality employees to work for you from any location? If the government keeps paying people more money not to work than an employer can afford to pay an employee to work, then the question of remotely working becomes a moot point since there will be a shortage of employees to work from anywhere. When you pay farmers not to work/plant, we have a food shortage. When you pay people more not to work than to work, we have a labor shortage. In addition, the family dynamics for everyone has been so negatively affected by the COVID response that new family life models are having to be created just for individual survival. The physician employee may not have a choice of coming to the office because of the required homeschooling and prohibition of outside the home and inside the home childcare. There are many other COVID policy dynamics now that are limiting everyone's life choices and that has completely devastated "business and life as usual."

I wrote an article for BCA Magazine in March of 2017 titled, "An Alternative to Private Practice Extinction." I suggest you go back and read it. I need to write a new article titled, "The Exit Strategy for Private Practice." The short answer regarding whether physicians should allow employees to work at home is yes, if circumstances for survival requires it, and it is done effectively, and in compliance with HIPAA. The bottom line is the physician may not have a choice. The real answer is that remotely working is just a Band-Aid on a life-threatening wound. Every practice and healthcare delivery system in this country is going to have to be reengineered to meet the "new normal"; I hate that phrase more than I hate the paradigm word.



Rapid and good decision making on many issues is what is needed now by physicians and everyone else. I was in the Air Force (not as a pilot). We had the "strategic command" and the "tactical command" because the first is "future" and the latter is "now." The current situation for physicians requires tactical action now for survival in the current COVID combat situation. However, strategic planning is needed by physicians for the permanently changing dynamics in the Healthcare Delivery System War. I recommend that you look up "OODA Loop" by Colonel John Boyd, a USAF Fighter Pilot. He died in 1997 and is buried in Arlington National Cemetery. You will notice that OODA Loop is not about bombing people, but about ongoing good decision making to accomplish specific objectives, whether in combat, business, or life. Apply OODA Loop to practice decision making and you will get an optimal outcome and answer the question of whether you should allow practice employees to remotely work or not. I previously included this diagram in the BCA article I wrote in May 2018 titled, "The Business of Medicine." It is well worth a revisit. Especially in these trying and challenging times. Remember, "Management by Objectives, Not Whims."

Conclusion

My philosophy in business and life is based on the quote, "Give a person a fish and you can feed the person for a day. Teach the person to fish and the person can feed themselves for a lifetime." I am trying to teach physicians how to fish instead of just giving them a fish. As always, I welcome your criticisms (constructive or not) and your insights. I encourage you to email me with your questions at leshepherd@medbizoncs.com. Thanks for taking the time to read this. See you next issue.
L.E. Shepherd, Jr., MSA, CHBC
CEO –MedBizonics

L.E. Shepherd, Jr., BS, MSA, has successfully provided comprehensive business advisory and management services to the healthcare industry and others for over 30 years. With his comprehensive business experiences and extensive speaking engagements, along with his many years of relationship building in the healthcare industry, Mr. Shepherd brings a unique perspective and set of skills to solving the complex business problems facing physicians, businesses, and the healthcare industry today and tomorrow. www.medbizonics.com

Is Zoom Fatigue a Thing?

Have you ever felt lately that your day is one big Zoom call? You have not left your desk all day, your eyes are burning, and your brain is too foggy to concentrate anymore. You pray that no one saw you doze off for 10 minutes while the CEO was speaking.

When you first started working from home, it was great; you had a 3-minute commute to work to your downstairs office, you always had snacks within reach, and you did not have to worry about looking professional every minute. But now, you always feel tired, and if you have to listen to any more of people's private conversations when they think they are on mute, you will scream! This article will discuss the reality of Zoom fatigue and ways to mitigate its effects.

From Live to Live-ish

As a healthcare consultant, prior to the pandemic, I spoke live at many seminars and conferences, as well as attended many in person. Presenting in front of an audience is something that I really like to do; answering attendees' questions and seeing that they are understanding the concepts fuels me. I would give and attend webinars online, but everything else was in person. The pandemic changed it all suddenly.

Once the public health emergency (PHE) was declared, onsite work stopped, onsite workshops stopped, onsite conferences stopped, and everyone had to rethink service delivery. If I was not onsite, I worked from my home office, so I was used to working remotely. I performed many audits remotely, sometimes even logging in to the client's system with no records being physically sent. But now, everything had to be done remotely. Zoom (or Microsoft Team or whatever system your employer used) became an essential tool. This seemed to be the answer to everyone's problem. Then the PHE went on, and on, and on, and we are still under it today. For many people, the novelty of Zoom has long worn-off and is starting to have some negative effects.

Zoom Fatigue

The Psychiatric Times defines Zoom fatigue as the "tiredness, worry, or burnout associated with overusing virtual platforms of communication" (Lee, November 2020). Stanford has actually created a ZEF Scale (Zoom Exhaustion and Fatigue Scale) to measure the effects of overuse of video conferencing (Fauville, G., Luo, M., Queiroz, A., & al, 2021). The study revealed five dimensions of fatigue: general, social, emotional, visual, and motivational. After all questions are answered in the survey, the user is given a ZEF overall score, and separate ones for each of the dimensions. The score ranges from 15 (the least fatigue) to 75 (the most fatigue). If you are interested in taking the survey to find your ZEF score, visit http://comm.stanford.edu/ZEF. It will also provide a ranking against the other survey respondents (76th %, etc.).

Common side effects of Zoom fatigue include mental fog, eye irritation, stress, social detachment, frustration, irritability, and physical tiredness. Why is this happening?

There are many factors, but I will cover a few.

1. **Technology:** Ever been on a call and really wanted to make a comment? You wait your turn, then unleash your profound musings for all to admire—only to find you were on mute and no one heard a thing you said. Or have connectivity issues? You have been waiting through a long call to hear one person in particular speak. When it is their turn, you get closer to your screen and turn the volume all the way up so as not to miss a thing—only to have your screen freeze or the call dropped.
2. **Speech Flow:** You have patiently waited your turn to speak; you unmute yourself and start to make your points—only to have another person begin to speak overtop of you because they also had a comment. Or have awkward pauses? Everyone that is not speaking has muted themselves and multiple people try to unmute themselves to speak, causing a silent delay. For those who are not preparing to speak, this may be seen as a negative response to the prior speaker.
3. **Body language:** You are trying to intently listen to the speaker; you lean into your computer and have a steady gaze on their image as they present. Unfortunately, you come off looking hostile. Instead of having your whole body to read, video conferencing offers a limited view of just your face, or head and shoulders. If you are one of those people that looks unhappy when your face is resting (an acronym exists, but is not appropriate in this context), you can be perceived as angry, bored, or uncaring.
4. **Too Much to See:** Have you been on video conference calls that are in Gallery (you know, like the Brady Bunch squares) instead of with the Speaker showing only? Your brain does not know where to look first. Is someone wearing a Hawaiian shirt in the lower left corner? Is that person in the upper middle using a disco ball background? Did you just see your colleague's cat fall off a table in the back, or their 3-year-old run by in his "God Give Me's" (that means naked)? It can be like watching a big Hollywood Squares with all on the screen at once (for the younger people, Google Hollywood Squares, or ask a coworker). Trying to pay attention to the speaker but seeing all the other things going on in the periphery is difficult.
5. **Too Much to Hear:** Have you been on more than one call where someone inevitably thinks they are on mute and unloads a vocabulary best used in adult, private company only? There was an elementary school district meeting in California in February in which the board members were caught live making comments about the parents before the meeting started officially. One board member was using expletives in her comments, while another one stated that parents were upset about virtual learning just because they wanted their babysitters back. About 7 1/2 minutes into the conversation, someone realized that they were being transmitted live and every parent that was logged in to the

call could hear them. The meeting was abruptly cancelled. The video was uploaded to YouTube with calls for resignation of the board members. As a speaker, it is very distracting when trying to deliver a presentation and multiple people do not mute themselves and various sounds of music, conversations, and noises can be heard.

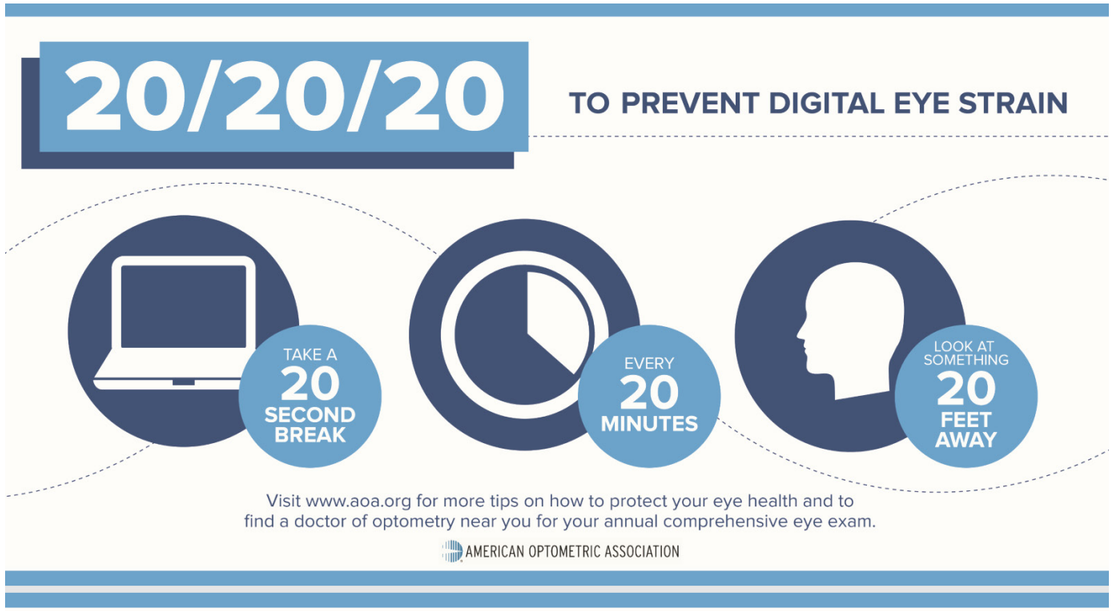
What To Do, What to Do?

A Psychology Today article discussed Zoom fatigue and gave 10 tips to help prevent it (Wel, M.D., M., November 2020). Some of them are common sense things, such as keeping the camera at eye level, so it mimics a live meeting, mute your phone, and close all other tabs so things are not popping up while you are trying to pay attention. I think scheduling of meetings is also particularly important. Don't book yourself back-to-back with long video calls. Make sure you have time to get up and walk around a little, so you are not stuck at your desk all day with no breaks. Even at conferences, there are times between presentations for people to visit and walk to their next meeting room. Try to schedule some meetings on the phone instead of virtually. When you were at an office, did you conduct every discussion staring someone else in the face? Probably not, so do not feel the need to do it when working remotely. If you are attending a meeting, but not presenting, turn off your video and mute yourself unless you need to make a comment. Propose or consider having a "Zoom free" day to give everyone a break. A final tidbit is to make sure that the lighting is good for video calls. I have been on many calls where the speaker looks like Dr. Claw from Inspector Gadget (again, younger readers may need to Google this one, although it is more recent).

Final Words

Participating in video calls all day long is exhausting; give yourself a break. Take a look at some of the issues and suggestions in this article to consider things you may not have realized could be causing you Zoom fatigue. At some point (soon, I hope), we will all be face to face once again.

Betty Hovey, CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I, is the Senior Consultant/Owner of Compliant Health Care Solutions, a medical consulting firm that provides compliant solutions to issues for all types of healthcare entities.
Chcs.consulting



Take Your Data Back:

Empowering Healthcare Practices, Systems, and Providers

It's safe to say: today's data in healthcare is big. Physicians, practices, and systems generate massive amounts of data that capture not only detailed patient care, but also corresponding billed claims to insurance carriers, radiology images, electrocardiogram readings, clinical trial data, and so much more.

As our practitioners and scientists continue to score higher and higher achievements in research and development and new technologies, and deliver medical breakthroughs, it is the volume and variety of data that will undoubtedly continue reaching new heights, as well.

Analyzing healthcare data has tremendous advantages. Here, big data analytics have improved system processes and reduced healthcare spending at the granular level in many hospitals in recent years. Advanced analytics can further isolate administrative, clinical, and financial data sets to provide greater insights to the holistic health of an organization. In addition, the onset of the SARS-CoV-2 pandemic has allowed for even more opportunities to utilize data to benefit patient outcomes and allow for more transparency in healthcare.

Physicians and their support team can also strive to be not only generators of the data sets, but they can also serve as keen data analyzers as well. This ability to take back the data, so to speak, is crucial when today's climate is rampant with data miners focusing on healthcare claims data that reflect high levels of billing errors. It is crucial for physicians and other qualified healthcare professionals to protect themselves and their practices from potential financial loss. This can be achieved by taking back the data and performing self-audits.

The ability to self-audit claims against documentation should be a critical component of a practice's overarching compliance program. Self-auditing allows for identifying deficiencies in documentation, coding, billing, and thereafter implementing corrective action before the insurance carrier and data miner have a chance to get involved. Further, looking at the data internally can help improve patient care, as well as identify areas of continued educational opportunities for both the healthcare professionals and support team, alike.

This strategic approach of self-auditing is one that is preventive in nature, similar to one's mammogram screening or annual preventive physical examination. The benefits and desired outcomes are identical in each—full disclosure now of current holistic status of the practice, and the body, respectively.

There are many avenues to take when conducting a self-audit. A good start involves running monthly reports to identify and quantify types of services. If the volume of evaluation and management services are all at a level 4, this would warrant a self-audit to help justify the medical necessity and clinical rationale for this higher level of service. It is important to remember variety and individualization. All patients are unique; therefore, all documentation should be unique and individualized to support the code level abstracted for the claim. But of course, there are unique practices, those seeing only very sick patient populations with multiple chronic conditions, multiple problems. These types of practices need to ensure medical records reflect the greater acuity so a post-payment audit can be handily defended.

Another example of what items to self-audit includes modifiers. When tracking and trending data internally, isolate the modifier 25, or the modifier 59. These are the most-commonly overused and abused modifiers simply because of lack of proper appendage, lack of appropriate use, and lack of supporting documentation. These modifiers are used for evaluation and management services and procedural services, respectively. They are not interchangeable. It's critical to avoid appending modifiers to simply bypass insurance carrier transaction editing system (TES) edits to obtain reimbursement on multiple line items on billed claims.

And finally, organizations should be conducting self-audits when there are new changes, new codes introduced quarterly and yearly. January 1, 2021 saw the biggest overhaul to the evaluation and management set of current procedural terminology (CPT) codes specific to the office and outpatient settings in over twenty years. It's vital to identify if practices are abstracting the correct CPT codes by ensuring documentation is accurately supporting the new guidelines and code definitions for time-based leveling or medical decision making.

After the self-audit process is completed, it's important to correct any deficiencies identified by sending out corrected claims (within timely filing requirements for each insurance carrier) and perform any provider attestations or addendums to reflect documentation improvements were made, as well. The repeated process of self-auditing throughout the year helps physicians and qualified healthcare professionals maintain an understanding of their revenue cycle, the financial health of the practice. The continued maintenance and performance of self-audits also aids in lowering the risk of recoupment when the practice receives notice for a post-payment audit.

Taking the data back is a powerful strategy that aligns providers as champions of compliance and allows them to rightfully be analytical stewards of the many forms of patient data that they generate.

Sonal Patel, CPMA, CPC, CMC, ICD10CM, is an independent healthcare coding advisor, auditor, and compliance consultant dedicated to transforming physician and hospital coding and compliance practices into ones that optimize revenue and alleviate risk. She is also an avid creator, content developer, and host of the Paint the Medical Picture Podcast series. https://podcasts.apple.com/us/podcast/paint-the-medical-picture-podcast/id1530442177

Clean Claims:
Part VI of the Back to Basics Series

Back to Basics is a series presented by your PAHCOM National Advisory Board.

Charles R. Swindoll, American author and radio personality, famously said, "The difference between something good and something great is attention to detail." When we think of revenue cycles, he is absolutely correct! According to the American Institute of Compliance, most medical practices have gross collection percentages between 75% - 85% on average. But with some reorganization and increased scrutiny, we can turn that good enough percentage into something great. Working with your billing team to develop an appeals and denials policy can recoup missing money for work already done. But your billing team is not the only staff who can assist in your endeavors to reclaim your lost income. Your front office staff is more than just the face of your business. They play an integral role in ensuring claims get paid the first time and on time.

First, let's define what precisely is a "clean claim" and why it is so important. A clean claim is a claim that has no errors or omissions and can be processed without additional information.

According to Rev Cycle Intelligence, a clean claim contains all the following correct information:

- Each procedure code has a supporting diagnosis code that is not expired or a deleted code.
- There are no potential issues or questions regarding medical necessity.
- The patient's coverage was in effect on the date of service.
- The patient's insurance covers the service provided.
- The claim submission includes all the required patient information, such as full name, mailing address, and date of birth.
- The claim identifies the payer, including the correct payer identification number, group number, and mailing address.
- All required claim information is in the correct field.
- The claim is submitted within the timely filing window.

Making sure a claim is paid the very first time it is submitted is crucial to successful Revenue Cycle Management. The time and effort used to appeal denied claims can be significant, especially considering producing a clean claim the first time may only take a few small changes to your current system. To ensure that their claims are clean, most practices are using a scrubbing software that is usually Correct Coding Initiative (CCI) compliant. Unfortunately, CCI compliance may not be enough. Having the ability to include advanced edits specific to your practice is extremely important. Remember, the goal is to be paid on time every time for the work your staff has already done.

Next, let's look at the methods that can help reduce errors in the first place. We call them medical receptionists, front desk associates, administrative team, or patient access team. They have a myriad of names for one of the most important jobs in our industry: data collection. According to Novitas Solutions, a Medicare Administrative Contractor for Centers of Medicare and Medicaid Services, some of the common reasons why they deny claims are administrative. Errors like incorrect patient demographics, transposed number/letters, no signed Advance Beneficiary Notice (ABN), and of course, no response to Requests For Information (RFI) can ruin your revenue cycle and have your billing team wasting their time and energy on appeals. Ensuring that our data collection is flawless is a major component to clean claims. Make sure your front desk staff members understand the importance of their jobs. They are data collection all-stars, and we could not get paid in a timely fashion without them.

Lastly, and almost as equally important as data collection, is developing a strong system to address denied claims. I like the Track, Trend, and Repair process. This process requires that I know the reasons why my claims were denied. I track that information on a simple spreadsheet (although there are software systems that will do it for you). I use that spreadsheet to discern the trend in denials. Are my claims being denied because my office has missed Request For Information filing dates? Perhaps they are being denied because the claim was a duplicate or a crossover claim, or the insurance policy was not active for the date of service. Knowing the reasons why my claims are being denied affords me the opportunity to repair my systems.

For example, if the RFIs were not sent for denied claims that happened during my biller's vacation, I know that I need a better system of coverage for when my biller is out of office. This is a training and coaching opportunity and a reasonably quick fix. Another more complicated example would be the provider not in network at the time of service. In my home state, our Medicaid Managed Care Organizations sent out letters saying the longstanding regulation that requires a Primary Care Physician to be selected by the recipient, prior to any services being rendered, was waived due to the Public Health Emergency (PHE). The theory was that by allowing recipients to see any physician without having to update their insurance would give them more options for care during the PHE. I kept a copy of that letter mostly because I have been in the industry long enough to know shenanigans when I see it, but primarily, I knew they would deny the claims and we would have to prove we were complying with their order. We sent those denied claims back with a copy of that letter and received payment albeit late and with extra effort.

By focusing on the details of data collection, sending clean claims, and tracking, trending, and repairing any denied claims, we can positively affect our revenue cycles. While getting it right the first time is optimal, we do not live or work in a vacuum. Life happens and sometimes things go awry. Our best course of action is to be prepared to successfully appeal denials by having strong systems in place to ensure we are living up to our contractual agreements and being paid appropriately.

PAHCOM National Advisory Board: Coley Bennett, CMM, CHA; Crystal Burning, CMM; and Kim Krause, CMM.
www.pahcom.com

Fixes for Healthcare: *PART ONE*

Many people talk about our dysfunctional, broken, out-of-control healthcare system, but few offer ideas to try to minimize the bureaucracy, reduce the administrative burdens, and change the economic incentives.

Not much ever changes for the better, because of all the special interest groups and humongous profits available for Pharmaceutical Firms, Third Party Insurers, For-Profit Hospitals, etc.

However, in this article and my next, I will present some timely, concrete ideas that should be considered as possible improvements to the current healthcare maze we find ourselves struggling to get through.

First, there should be a mandatory National Fee Schedule, the same price paid for every CPT code by every payer with an adjustment allowance for geographical differences. Obviously, an office visit in Cedar Rapids, Iowa should not be reimbursed at the same level as one performed in San Francisco, California. However, we need to eliminate that a simple office visit, a 99212, can have a payment range between $50 to $75 dollars depending on how good of a negotiator you are with the various third-party payers. I have seen payment variances for the same CPT code even when independent practice providers are in the same medical office building.

A National Fee Schedule would eliminate the need for the provider to negotiate with a plethora of third-party payers, and more importantly, it would not financially penalize the patient if the provider is out of network.

Secondly, another royal pain plaguing our system is known as Provider Enrollment, which is required by each third-party payer, and states that a provider aims to be considered a participating provider, with expectations of receiving direct payment. My idea is that if a provider has been approved, enrolled, and received a National Provider Identifier (NPI) from Medicare, every other third party must honor that and cannot require the provider to jump through their bureaucratic hoops to be deemed participating. The NPI should work with every third-party payer.

Next, we should eliminate the requirement for individual state licensures. A radiologist is a radiologist is a radiologist; why should they need to complete individual applications for each state in which they want to practice? According to the AMA, state licensing boards and statutes can be complex and vary from state to state depending on each jurisdiction's resources, regulations, and state laws.

Let's license the provider at a national level that will allow them to practice anywhere in the United States and their territories.

Lastly, we need to put some teeth in the Price Transparency laws. There is no other industry where you do not know what the service or product will cost until after you have made the purchase. Even the auto repair shop I go to calls me with an estimate so I can authorize the repair before I must take out a second mortgage. Some providers have gotten on board and do inform their patient what their co-pay and deductible amounts will be before rendering services, but this is a minority of providers. And we are all clueless about ancillary services, such as lab tests, radiological services, anesthesia charges, etc.

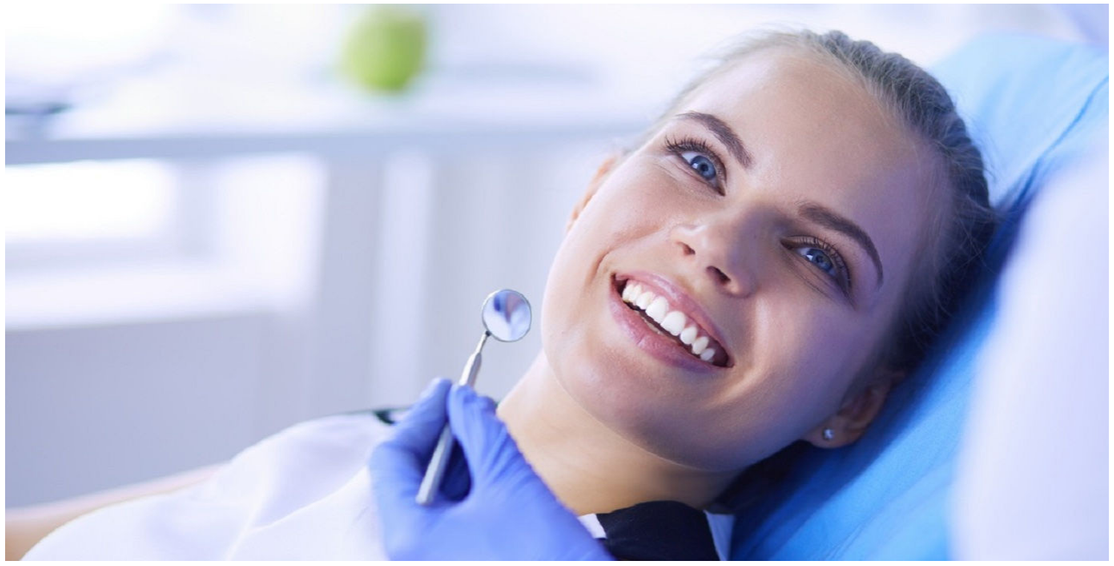
We always hear about how the number one cause of bankruptcy in the United States is medical expense. How can we allow our friends and neighbors to be destroyed economically because they are facing a devastating disease or suffered a tragic accident? I think before we worry about forgiving students their college debt, we should use that money to assist people who face staggering hospital bills. Going to college was a choice and you knew the price tag. Having a serious illness or an unfortunate accident was not that person's choice.

Above, I have described four problematic issues we have with our current healthcare system and some possible solutions to rectify these situations. It seems all we do is debate what we could do, and no one is willing to take any action because it may have a negative impact on them and their specific interests.

Well, if we do not start taking some action and begin eliminating the bureaucratic hoops we all have to jump through, our fractured system will only get worse and worse. Why don't we become proactive and start fixing the problems before the entire system implodes?

Dave Jakielo is an International Speaker, Consultant, Executive Coach, and Author, and is president of Seminars & Consulting. Dave is past president of Healthcare Business and Management Association and the National Speakers Association Pittsburgh Chapter. Sign up for his FREE weekly Success Tips at www.Davespeaks.com. Dave can be reached via email Dave@Davespeaks.com; phone 412-921-0976.

Since When did Dental Claims Require Diagnosis Codes?



The objective of the Accountable Care organization is to integrate and consolidate patient care management to improve patient outcomes. Changes and coordination of dental and medical care are already becoming more apparent when dental offices are being required to bill a patient's medical plan for dental visits due to an accident, trauma, sleep apnea, cancer treatment, or oral surgery.

Several states are currently mandating the use of ICD-10-CM codes reported along with the dental codes. For example, Arizona requires a diagnosis code reported on a claim form if the reason for the visit is an underlying medical condition. Check with your state Medicaid for requirements with ICD-10-CM codes reported on a Dental claim form.

In addition, other government payers require the use of diagnosis codes such as BCBS Federal; it is expected for other payers to adopt the use of ICD-10-CM in the future. Check with commercial dental plans on policies requiring the use of medical diagnosis codes. The ADA form has a place to report up to 4 diagnosis codes with a diagnosis pointer indicating the treatment line it is referring to.

The benefits of providers reporting the treatment associated with ICD-10-CM will support areas such as the capture of clinical data, which will assist in supporting evidence-based benefit plans. Healthcare recognizes the relationship to the oral-systemic connections and the need for additional dental services for patients with certain medical conditions.

There are many resources to get your practice started using ICD-10-CM codes; keep in mind there are 69,000 ICD-10-CM diagnoses. However, Dental offices will only use a fraction of these codes, so don't let the complete set of diagnosis codes overwhelm your staff.

Dental providers will mainly code from chapter 11, K00-K14 Diseases of oral cavity and salivary glands. Take a few minutes to get familiar with the different sections used when reporting ICD-10-CM codes; it is not as complicated as it may seem.

Christine Woolstenhulme, QCC, QMCS, CPC, CMRS, is the Support Manager and Content SME for innoviHealth.

Find-A-Code is a product of innoviHealth Systems, Inc. FindACode.com is an online database of medical billing codes and information. People use Find-A-Code to assign codes to medical diagnosis and procedures in order to be reimbursed by insurance companies and Medicare. FindACode.com is a quick and easy system that uses a simple search to return accurate information. Rather than searching through 10 or more books, Find-A-Code has combined the information into one simple search. www.findacode.com

K00.0	-	K00.9	K00 Disorders of tooth development and eruption
K01.0	-	K01.1	K01 Embedded and impacted teeth
K02.3	-	K02.9	K02 Dental caries
K03.0	-	K03.9	K03 Other diseases of hard tissues of teeth
K04.01	-	K04.99	K04 Diseases of pulp and periapical tissues
K05.00	-	K05.6	K05 Gingivitis and periodontal diseases
K06.010	-	K06.9	K06 Other disorders of gingiva and edentulous alveolar ridge
K08.0	-	K08.9	K08 Other disorders of teeth and supporting structures
K09.0	-	K09.9	K09 Cysts of oral region, not elsewhere classified
K11.0	-	K11.9	K11 Diseases of salivary glands
K12.0	-	K12.39	K12 Stomatitis and related lesions
K13.0	-	K13.79	K13 Other diseases of lip and oral mucosa
K14.0	-	K14.9	K14 Diseases of tongue

Approving CEU and Webinar Associations

BC Advantage is proud to offer CEUs to the following leading associations. All of the associations listed below offer unique and professional certified courses and certifications. Please take a few minutes and visit each one and let them know you are a BC Advantage member for any discounts offered.

AAPC	www.aapc.com
American Dental Coders Association (ADCA)	www.adcaonline.org
Association of Health Care Auditors and Educators (AHCAE)	www.ahcae.org
American Health Information Management Association (AHIMA)	www.ahima.org
American Institute of Healthcare Compliance (AIHC)	www.aihc-assn.org
Association of Professional Medical Billers & Administrators (APMBA)	www.theapmba.com
Association of Registered Healthcare Professionals (ARHCP)	www.arhcp.com
Healthcare Billing and Management Association (HBMA)	www.hbma.org
Medical Association of Billers (MAB)	www.mabillers.com
Med-Certification	www.med-certification.com
National Alliance of Medical Auditing Specialists (NAMAS)	www.namas.co
Professional Association of Health Care Office Management (PAHCOM)	www.pahcom.com
Professional Healthcare Institute of America (PHIA)	www.phia.com
Practice Management Institute (PMI)	www.pmimd.com
PMRNC	www.billerswebsite.com
QPro	www.qpro.com

NEED CEUs?

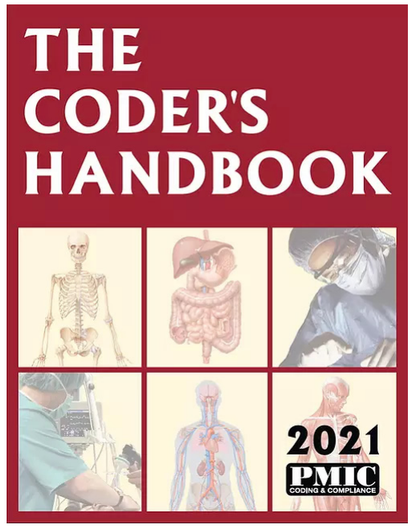
EARN OVER 30 CEUs each year

at no additional cost to your magazine subscription!

https://www.billing-coding.com/ceus

New product discounts and Reviews

Title: The Coders Handbook 2021
Price: $99.95
From: https://www.pmiconline.com/

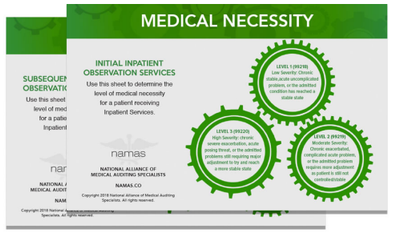


What is the follow-up period for a specific surgical procedure? What does the acronym "ECCE" stand for? What is the proper sequencing of multiple ICD-9-CM codes? Can I bill separately for medical supplies with this procedure? How do I report an "add-on" service properly? Are the services of an assistant surgeon paid for this procedure?

Every day, you have to find the answers to dozens of questions like these before you can complete your coding — frequently consulting several references to find the answers you need. With our comprehensive reference, the answers to coding, terminology, and coverage questions like these are right at your fingertips!

The Coder's Handbook includes over 1,100 pages packed with information designed to save you time, help you code faster and more accurately, improve your reimbursement, and reduce your audit liability.

Title: Medical Necessity Leveling Charts
Price: $5.99
From: https://shop.namas.co/



Acute & Chronic Problems
Medicare equates the medical necessity of the patient to the overall complexity of the episode of care according to the documentation the provider chose to include. This tool will make it easy to teach auditors, coders, and providers how medical necessity is analyzed through consideration of the presenting problem, according to the documentation, and allocate the risk of the service to thereby assign the correct level of E&M service.

These make great pocket guides for your providers!

Other Charts:
Emergency Department Services
Inpatient Services

Have a new product or want BC Advantage to list your company / products here?

Send us your information and interest to sales@billing-coding.com

Magazines | CEUs | Webinars
www.billing-coding.com

New subscriptions
www.billing-coding.com/subscribe

Renewals (Keep your rate for life*)
www.billing-coding.com/renewals

SAVE TIME
SAVE MONEY
EARN YOUR CEUS

Simply subscribe or renew your BC Advantage Magazine subscription online today, for ***ONLY $79.95 per year*** and receive instant access to all approved CEUs and webinars at no additional cost!

Don't wait! Visit https://www.billing-coding.com

30+
APPROVED
CEUs & Webinars

* Must stay current / ** CEUs available over a 12-month period.