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CEO Letter

Here we are. 15 years. As we move into our 15th year of printing BC Advantage magazine, I wanted to share my sincere thanks to everyone. I mean it. Everyone.

We have been blessed to have met so many wonderful people during our time at conferences and meetings and our success has been because of each and every marvelous person we have come across. Our readers (you!) are passionate about their careers and most have an undying thirst for knowledge and information that helps both them and their employers. Our editorial board members are equally as passionate about providing articles that are timely, well-researched, and brimming with information that helps our readers. We are nothing without them.

I remember our first issue, when the night before we were scheduled to go to print, we had creative differences with the graphic designer. The cover story was about medical records security during a hurricane or other serious natural disaster. Our graphic designer was going through an "arty" phase and wanted to invert the colors, so the entire page had the hurricane's white clouds in black. It was hard to tell what it was and didn't match well with the story, so there were some choice words (he is no longer with us), but we needed to run with it due to poor timing. My wife still refers to it as the worst cover picture ever.

Our first conference was with Optum at Caesars Palace in Las Vegas, where we based when we originally started the company. We dragged boxes of magazines across the main gambling floor, ruining luggage wheels (yes, we put the boxes in our old luggage – doh!), and learned a lot. We got every magazine out that day and met so many wonderful people. Everyone was friendly, helpful, and eager to provide feedback and advice or answer questions. We met Sean Weiss that day, and the rest, they say, is history.

There are so many people who have helped us these past 15 years and all deserve a mention here, but there are some who have been around in some way since the beginning and helped in ways we could have never expected. A special thanks to Sean Weiss, Steve Verno, Marge McQuade, David Jakielo, Kathy Young, Suzanne Lappen, Liz Jones, Nancy Clements and the PMI crew, Julie Orton Van, Darlene Boschert, Merrilee Severino, Tammy Harlan, Sherri Poe Bernard, Robin Linker, Mindi Rothans, and James Summerlin. To those I may have missed, I apologize. I appreciate you more than I can ever explain.

Finally, I want to thank our current team—Nichole Anderson, Amber Joffrion, Ashley Knight, and Merrilee Severino. You are all so important to our success.

I can't wait to see what the next 15 years brings!
Until next time, Storm

Storm Kulhan

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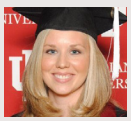

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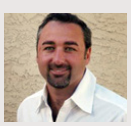

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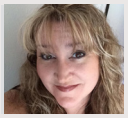

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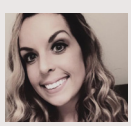

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Falsity and the False Claims Act

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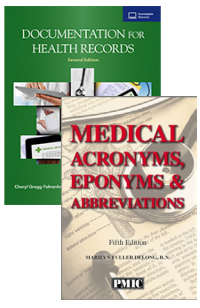

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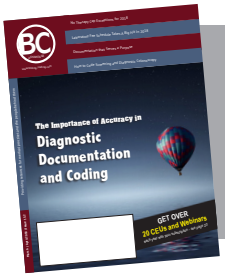

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Hospital Group Pays Millions to Settle HIPAA Case

A hospital group serving Virginia and North Carolina has agreed to take corrective action and pay $2.175 million for failing to notify HHS about a HIPAA violation, according to an HHS news release. Sentara Hospitals, which is comprised of 12 acute care hospitals with more than 300 sites, made the payment to the Office of Civil Rights (OCR) at HHS to settle possible violations of HIPAA breach notification and privacy rules stemming from an April 2017 incident. At that time, HHS received a complaint that Sentara sent a bill to a patient with another patient's protected health information. Further investigation found the hospital group mailed 577 patients' protected health information to wrong addresses, but they only reported the incident as a breach affecting eight patients, the release says. Sentara believed, incorrectly, that only breaches that included information on patient diagnosis and treatment needed to be reported to HHS. The hospital group refused to report the breach even after being explicitly advised to do so by OCR, the release says.
Source: medicaleconomics.com

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University of Virginia Doctors Decry Aggressive Billing Practices By Their Own Hospital

Prominent doctors at the University of Virginia Health System are expressing public outrage at their employer's practices to collect unpaid medical debt from its patients.

A Kaiser Health News report in September showed that U-Va. sued 36,000 patients over six years for more than $100 million, seizing wages and savings and even pushing families into bankruptcy. Like many physicians who work at U.S. medical centers, the U-Va. doctors said they had little idea how aggressively the hospital where they practice was billing and pursuing their patients for payment.

Although the health system has announced some interim measures to scale back collections practices, some of the system's most senior physicians are now calling for U-Va. to stop suing its patients altogether. And they are urging the pursuit of an "immediate solution" to address the national epidemic of health-care debt.

Source: Washington Post

Amazon Lets Doctors Record Your Conversations and Put Them In Your Medical Files

Amazon's next big step in health care is with voice transcription technology that's designed to allow doctors to spend more time with patients and less time at the computer.

At Amazon Web Services' re:Invent conference on Tuesday, the company is launching a service called Amazon Transcribe Medical, which transcribes doctor-patient interactions and plugs the text straight into the medical record.

"Our overarching goal is to free up the doctor, so they have more attention going to where it should be directed," said Matt Wood, vice president of artificial intelligence at AWS. "And that's to the patient."

At last year's re:Invent, AWS introduced a related service called Amazon Comprehend Medical, which "allows developers to process unstructured medical text and identify information such as patient diagnosis, treatments, dosages, symptoms and signs, and more," according to a blog post. Wood said the two services are linked and can be used together.

Source: cnbc

Kareo Sells Managed Billing Services Business

Kareo, the leading provider of cloud-based clinical and business management software for independent medical practices and medical billing companies, recently announced the sale of its revenue cycle management (RCM) services business unit to a leading independent supplier of outsourced medical billing services, Health Prime International. Kareo will now fulfill the growing demand for outsourced medical billing services exclusively through its leading network of over 1,500 medical billing company partners. This shift in strategy enables Kareo to increase its focus on building the industry's leading cloud-based software platform for independent medical practices and the billing companies that serve them.

Source: prnewswire.com

Creating an Auditing Superhero - www.billing-coding.com/auditing-files.cfm

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Risk Adjusted Coding: Clients Need Information

There are four components to the Medicare Incentive Payment System (MIPS): Quality (45% of total score), Promoting Interoperability (25% of score), Improvement Activities (15% of score), and Cost (15% of score).

The Final Rule, published November 15, 2019, will take effect on January 1, 2020. The clinician's eligibility for MIPS will not change for CY 2020. The exemption also remains with the low volume threshold and eligible clinical participants.

Cost is calculated from claims submitted and is based on two parts: cost measures that assess the beneficiary's total cost per capita of care (TPCC) during the year, or during a hospital stay, and/or during the newly added 10 episode-based care. The Total Per Capita Costs for all attributed beneficiaries (TPCC) measure is a payment—standardized, annualized, risk-adjusted, and specialty-adjusted measure that evaluates the overall cost of care provided to beneficiaries attributed to clinicians, as identified by a unique Taxpayer Identification Number/National Provider Identifier (TIN-NPI).

Each patient is attributed to one TIN-NPI for the performance year, using the following methodology:

- If the patient received primary care services (see list below) from a PCP, NP, PA, or CNS, the patient is attributed to the PCP, NP, PA, or CNS who provided the plurality of primary care services during the performance year. The level of primary care services is determined by Medicare allowed charges.
- If the patient did not receive any primary care services

from a PCP, NP, PA, or CNS during the performance year, the patient will be attributed to the non-primary care physician who provided the plurality of primary care services.

- If two providers tie for the largest share of a patient's primary care services, the provider who performed a primary care service most recently will be attributed.

CMS is changing the attribution methodology for TPCC to more accurately identify clinicians who provide primary care services. TPCC requires a combination of (1) an E/M service; and (2) general primary care services or a second E/M service from the same clinician group with the addition of service category exclusions and specialty exclusions. Specifically, certain candidate events are excluded if they are performed by clinicians who (1) frequently perform non-primary care services (for example, global surgery, chemotherapy, anesthesia, radiation therapy); or (2) are in specialties unlikely to be responsible for providing primary care. The medical attribution will be different for individuals and groups and will be defined in the applicable measure specifications of primary care to a beneficiary (for example, podiatry, dermatology, optometry, ophthalmology).

The revised total per capita cost measure continues to use payment standardized prices to account for differences in Medicare payments for the same service across Medicare suppliers for all services included in the measure, including for Part B drugs. The total per capita cost measure focuses on primary care by design and includes all costs to provide a broad assessment of a clinician's management of the overall health of a patient, rather than a specific condition. In managing a patient's complete health, clinicians measured under the total per capita cost measure are incentivized to conduct patient follow-up, coordinate care among specialists, offer necessary referrals, and actively diagnose patients. Clinicians managing patients' care are the focus of this measure and are compared to their peers performing similar roles.

WEBINAR
& CEU ALERT

The New, Personal Audit Threat: Targeted Probe and Educate (TPE) Audits

Attendees will learn about the new Medicare Administrative Contractor (MAC) Targeted Probe and Educate (TPE) audits and significant risks to not only reimbursement by provider's Medicare credentialing and licensing.

Presenter: Stephen Bittinger, our presenter, is an attorney with the Nexsen Pruet's Health Care Practice Group.

Length: 60 Minutes

Cost: FREE to all members

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Medicare Spending per Beneficiary, Now Known as Medicare Spending per Beneficiaries Clinical (MSPB-C)

The revised MSPB clinician has been refined to ensure effective attribution and compare similar clinicians. This is achieved by distinguishing between medical episodes and surgical episodes and risk adjusting for these episodes. These refinements allow for more accurate comparisons of predicted episode spending as clinicians are compared to other clinicians treating patients with similar characteristics, rather than being compared to all clinicians.

The changes to the attribution method of the revised MSPB clinician measure involves the use of separate attribution methods for medical and surgical episodes to identify the clinician(s) responsible for providing these different types of care and properly capture costs for more or less expensive episodes. The new methodology shifts attribution of episodes toward specialties that are more likely to be involved in managing the course of a patient's care, rather than attributing clinicians who do not provide the overall care management for a beneficiary. Additionally, the risk adjustment for the revised measure is compared within each Major Diagnostic Category (MDC), and not between medical and surgical episodes. It is possible for specialties such as pathology to be attributed the revised MSPB clinician measure, as long as the pathologist is involved in the inpatient care of a patient and meets the attribution requirements.

The MSPB clinician will have a different methodology for surgical and medical episodes. There are no changes for attribution in episode-based measures (existing and new). The revised MSPB clinician measure assesses the cost to Medicare as a result of the services performed by an individual clinician during an MSPB clinician episode, which comprises the period immediately prior to, during, and following a patient's inpatient hospital stay. The measure was refined to exclude a defined list of services that are unlikely to be influenced by the clinician's care decisions and that are considered clinically unrelated to the management of care. The service exclusion rules are defined specific to the MDC of the index admission and were developed with expert clinical input from the MSPB Service Refinement Workgroup. Clinicians can choose how to participate in MIPS and have the option to report as a group or as individuals.

Under the revised MSPB clinician measure, an episode can be attributed to multiple clinicians or clinician groups. The measure calculation risk adjusts each clinician's or clinician group's observed costs for patients with the same observable characteristics among their peers, rather than to a pre-defined standard. Given that the inpatient hospital setting is an important contributor to overall Medicare spending, gauging the efficacy

of this spending requires measuring the cost performance of clinicians providing care at hospitals. The MSPB clinician measure provides valuable context for such progress in efficiency by measuring costs of care from a holistic perspective at the beneficiary level.

The ten episode-based measures added for 2020 include Acute Kidney Injury regarding inpatient dialysis, Elective Primary Hip Arthroplasty, femoral or inguinal hernia repair, renal dialysis access creation, Inpatient chronic obstructive pulmonary disease (COPD) exacerbation, lower GI hemorrhage (applies to groups only), lumbar spine fusion for degenerative disc disease 1-3 levels, lumpectomy Partial Mastectomy, simple mastectomy, non-emergent CABG, and renal or ureteral n\stone surgical treatment. The case minimum is still at 10 for procedural episodes and 20 for acute inpatient medical condition episodes.

Facility-based measurement scoring will be used for your Quality and Cost performance category scores when you are identified as facility-based, and:

- You are attributed to a facility with a Hospital Value-Based Purchasing (VBP) Program score for the 2019 performance period; and
- The Hospital VBP score results in a higher score than the MIPS Quality measure data you submit and MIPS Cost measure data we calculate for you.

Maxine Lewis, CMM, CPC, CPC-I, CPMA, CCS-P, is a member of the National Society of Certified Business Consultants and is a nationally recognized lecturer, author, and consultant in the healthcare industry, combining more than 40 years of practical experience in the medical office with an in-depth understanding of coding, reimbursement, and management issues of the medical profession.

PFS Final Rule for 2020

As the Final Rule was released earlier this month, we have updated our summary to include the most anticipated topics for the upcoming years. These policies will go into effect January 1, 2020, except for the evaluation and management changes scheduled for 2021. Should you require additional details or contact information for CMS, we encourage you to visit the full document at https://federalregister.gov/d/2019-24086.

2 2020 Conversion Factor – $36.09 (up from 2019 at $36.04)

Evaluation & Management Services

The new and established evaluation and management (E/M) CPT codes continue to take another shape as expected. In the previous payment model for 2021, CMS was ready to collapse levels 2-4 to a flat rate and introduce two new G codes, increasing payment for specialty complexity (per-visit resources), and time. Public commenters and stakeholders both felt this methodology was still overly complicated and not solving the problem of lessening the burden of coding and documentation. The intent of the code set was revisited and yet another new method has been introduced and will further revise as below.

Final CY 2021 total time and RUC recommended work RVU

Changes for 2020:

- 99201 will be deleted from the new patient code set.
- Levels of service time increments and RVU values will change based on RUC recommendations (see table below).
- Elimination of history and exam as a factor in the level of service for new and established E/M codes (this is still unclear if this will span into

other E/M categories beyond 99211-99205).
- Providers will have a choice of using time or medical decision to select a given level of service.
- A new prolonged code will be introduced, 99XXX (increments of 15 minutes) for time over and above the maximum code (99205 & 99215) for additional effort both face-to-face and non-face-to-face time (.61 work RVU).
- Revision of HCPCS code GPC1X for visit complexity will now cover both primary care and specialty services. This has been revised as "visit complexity inherent to evaluation and management associated with medical care services that serve as the continual focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition." Terms within this definition will likely gain more clarity in the 2021 final rule.

Telehealth & Virtual E-Visits

CMS finalized new HCPCS codes to temporarily house the new opioid disorder management code sets. These will expand the access for patients whether visits take place in the office or through telehealth. Note that these services require face-to-face interaction and can be delivered by individuals who are qualified to provide the services under state law and within their scope of practice "incident to" the services of the billing physician or other practitioner, as per CMS.

Three new codes will be valid for 2020:

- G2086 - Office-based treatment for opioid use disorder, including the development of the treatment plan, care coordination, individual therapy, and group therapy, and counseling; at least 70 minutes in the first calendar month (7.06 work RVU).
- G2087 - Office-based treatment for opioid use disorder, including care coordination, individual therapy, and group therapy, and counseling; at least 60 minutes in a subsequent calendar month (6.89 work RVU).
- G2088 - Office-based treatment for opioid use disorder, including care coordination, individual therapy, and group therapy, and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure) (Add on code - .82 work RVU).

Three new CPT codes will be available for 2020 to use for e-visits. These are patient initiated digital communication visits and can be billed by a physician or qualified healthcare practitioner. CPT code definitions will enforce the 7-day rule (not relating to a previous or leading to a follow-up evaluation and management visit). The codes require permanent documentation storage in an EMR or similar type record. These cannot be combined with other virtual check-in visits and do require a waiver to notify patients of their cost-sharing portion. CMS announced blanket waivers for virtual and e-visits are acceptable for a period of one year.

New Codes:

- 99421 – On-line digital E/M service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes (.25 RVU)
- 99422 - On-line digital E/M service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes (.50 RVU)
- 99423 - On-line digital E/M service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21+ minutes (.80 RVU)

Supervision for PAs

CMS finalized the regulation that Physician Assistant (PA) supervision will now be governed and in accordance with State Law as opposed to current Federal standards. In absence of a State Law, CMS rules would apply and require that the supervision be evidenced by documentation in the medical record as to the relationship of the PA working with the physician. The revision will allow states to tailor and control the use and supervision of PA services. Although public comment pushed back on CMS standards and documentation requirements, the final rule did clarify that the supervision relationship is evident by documenting at the practice level (scope of practice and working relationship), as opposed to the individual medical record. This would apply to all types of services within the scope of State Law, specialty, and practice.

Student Documentation
CMS has finalized the rules around defining "student" and how this applies to usable documentation within the medical record. The revision includes PA, NP, CNS, CNM, CRNA, and APRN along with medical students who may document and contribute to the billable portion of the attending's or supervising provider's progress note. Rather than re-documenting, the billing provider can review and verify (sign & date) the documentation as part of the final note. This revision is intended to reduce the amount of documentation presently required under current guidelines.

Transitional Care Management (TCM)
Good news for providers using TCM codes: CMS finalized not only an RVU increase for TCM services, they also approved unbundling 17 services (see table below) that might be performed during these episodes of care. As part of an outside evaluation, CMS concluded transitional care codes were both underutilized likely due to the administrative burden in documenting and undervalued. The table below represents the codes being unbundled starting 2020. The RVU value will increase - CPT code 99495, moderate complex to 2.36 and 99495 high TMC 3.10. Definitions of the CPT codes are set to remain the same.

- TCM 99495 - services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least moderate complexity during the service period; face-to-face visit within 14 calendar days of discharge.
- TCM 99496 - with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least high complexity during the service period; face-to-face visit within 7 calendar days of discharge.

TCM - Services Unbundled for 2020

Chronic Care Management (CCM)
CMS has monitored the use of these codes and determined that utilization has reached about 75% of what they anticipated under the PFS. For the upcoming year, they are finalizing only one new G code G2058 to account for chronic care management clinical staff time, each additional 20 minutes (work RVU .54). This code will be capped for use, only two times per service period, per beneficiary.

CMS will not be adding the proposed G codes to redefine Complex Chronic Care Management. CPT 99487 will still be defined as: Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established or substantial revision of a comprehensive care plan; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by physician or other qualified healthcare professional, per calendar month. Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately – (1.0 work RVU). The new add-on code would be as 99489 - each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month (List separately in addition to code for primary procedure) (.50 work RVU).

A further revision defining a typical care plan was also approved to eliminate redundant language. CMS is also clarifying the fine print, that the elements of the care plan are suggested and not always required and would be at the discretion of the provider and specific to the needs of the patient.

The comprehensive care plan for all health issues typically includes, but not limited to:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions

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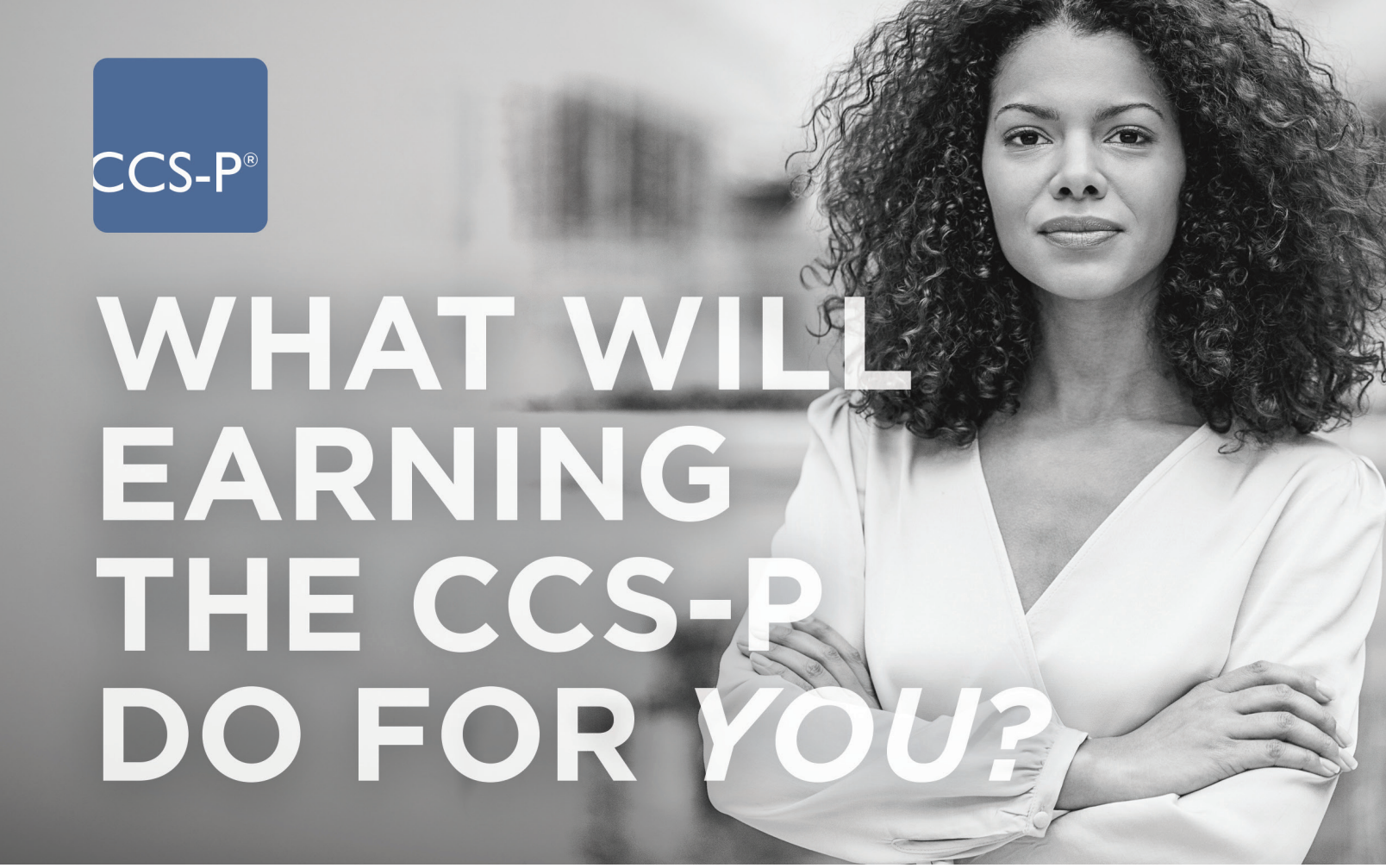

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Principal Care Management
A new subset of the CCM codes will be implemented for 2020, providing coverage for managing one chronic illness (vs. multiple) by specialists. These codes can be used during the same episode of care as primary care (managing multiple chronic problems).

Principal Care Management codes are defined as: G2064 at least 30 minutes of physician or other qualified healthcare professional time per calendar month with the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan; the condition is of sufficient severity to place patient at risk of hospitalization or has been the cause of a recent hospitalization; the condition requires development or revision of disease-specific care plan; the condition requires frequent adjustments in the medication regimen; and/or the management of the condition is unusually complex due to comorbidities – (1.45 work RVU).

HCPCS code G2065 would cover clinical staff time, yet without the option of add-on time like the other CCM codes. Code definition is proposed to read: Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan; the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization; the condition requires development or revision of disease-specific care plan; the condition requires frequent adjustments in the medication regimen; and/or the management of the condition is unusually complex due to comorbidities – (.61 work RVU).

Emergency Room Services
Although there were multiple CPT sections revised for 2020, Emergency Room E/M's work values are set to increase for 2020 (CPT Codes 99281, 99282, 99283, 99284, and 99285). Based on the CY 2018 PFS final rule, CMS determined these codes might not be appropriately valued based on the full resources involved with patient care. For CY 2020, CMS has finalized the RUC recommended work RVUs of 0.48 for CPT code 99281, a work RVU of 0.93 for CPT code 99282, a work RVU of 1.42 for 99283, a work RVU of 2.60 for 99284, and a work RVU of 3.80 for CPT code 99285. CMS will not be making a recommendation to increase the practice expense related to these five codes.

Jana Weis, BA, Dip Com, CPC is the Principal at Gill Compliance Solutions based in the Northwest. Jana is a renowned compliance coding professional with a bent for ingenuity and innovation. Her pursuit of leading technological healthcare solutions, in addition to her 20+ years of experience in medical coding and compliance, led her to form Gill Compliance Solutions (GCS) in 2010. Her expertise in healthcare consulting leads physicians and hospitals, regionally and nationally, through the complex world of compliance to accurately report and monitor coding compliance practices. www.gillcompliance.com

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ICD-10-CM Official Coding Guidelines: Supplement Coding Encounters Related to E-Cigarette, or Vaping, Product Use

The purpose of this document is to provide official diagnosis coding guidance for healthcare encounters related to the 2019 healthcare encounters and deaths related to e-cigarette, or vaping, product use associated lung injury (EVALI). This guidance is consistent with current clinical knowledge about e-cigarette, or vaping, related disorders.

As necessary, this guidance will be updated as new clinical information becomes available. The clinical scenarios described below are not exhaustive and may not represent all possible reasons for healthcare encounters that may be related to e-cigarette, or vaping, product use. Proposals for new codes that are intended to address additional detail regarding use of e-cigarette, or vaping, products will be presented at the March 2020 ICD-10 Coordination and Maintenance Committee Meeting.

This guidance is intended to be used in conjunction with current ICD-10-CM classification and the ICD-10-CM Official Guidelines for Coding and Reporting (effective October 1, 2019). See https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf. The ICD-10-CM codes provided in the clinical scenarios below are intended to provide e-cigarette, or vaping, product use coding guidance only. Other codes for conditions unrelated to e-cigarette, or vaping products may be required to fully code these scenarios in accordance with the ICD-10-CM Official Guidelines for Coding and Reporting. A hyphen is used at the end of a code to indicate that additional characters are required.

General Guidance

Lung-related complications

For patients documented with electronic cigarette (e-cigarette), or vaping, product use associated lung injury (EVALI), assign the code for the specific condition, such as:

- J68.0, Bronchitis and pneumonitis due to chemicals, gases, fumes and vapors; includes chemical pneumonitis
- J69.1, Pneumonitis due to inhalation of oils and essences; includes lipoid pneumonia
- J80, Acute respiratory distress syndrome
- J82, Pulmonary eosinophilia, not elsewhere classified

- J84.114, Acute interstitial pneumonitis
- J84.89, Other specified interstitial pulmonary disease

For patients with acute lung injury but without further documentation identifying a specific condition (pneumonitis, bronchitis), assign code:

- J68.9, Unspecified respiratory condition due to chemicals, gases, fumes, and vapors

Poisoning and Toxicity

Acute nicotine exposure can be toxic. Children and adults have been poisoned by swallowing, breathing, or absorbing e-cigarette liquid through their skin or eyes. For these patients, assign code:

- T65.291-, Toxic effect of other nicotine and tobacco, accidental (unintentional); includes Toxic effect of other tobacco and nicotine NOS.

For a patient with acute tetrahydrocannabinol (THC) toxicity, assign code:

• T40.7X1- Poisoning by cannabis (derivatives), accidental (unintentional).

Substance Use, Abuse, and Dependence

For patients with documented substance use/abuse/dependence, additional codes identifying the substance(s) used should be assigned.

When the provider documentation refers to use, abuse, and dependence of the same substance (e.g. nicotine, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

- If both use and abuse are documented, assign only the code for abuse.
- If both abuse and dependence are documented, assign only the code for dependence.
- If use, abuse, and dependence are all documented, assign only the code for dependence.
- If both use and dependence are documented, assign only the code for dependence.

Assign as many codes, as appropriate. Examples:

Cannabis related disorders: F12.---

Nicotine related disorders: F17.----

Specifically, for vaping of nicotine, assign code:

- - F17.29-, Nicotine dependence, other tobacco products. Electronic nicotine delivery systems (ENDS) are non-combustible tobacco products.

Signs and Symptoms

For patients presenting with any signs/symptoms (such as fever, etc.) and where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms, such as:

- M79.10 Myalgia, unspecified site
- R06.00 Dyspnea, unspecified
- R06.02 Shortness of breath
- R06.2 Wheezing
- R06.82 Tachypnea, not elsewhere classified
- R07.9 Chest pain, unspecified
- R09.02 Hypoxemia
- R09.89 Other specified symptoms and signs involving the circulatory and respiratory systems (includes chest congestion)
- R10.84 Generalized abdominal pain
- R10.9 Unspecified abdominal pain
- R11.10 Vomiting, unspecified
- R11.11 Vomiting without nausea
- R11.2 Nausea with vomiting, unspecified
- R19.7 Diarrhea, unspecified
- R50.- Fever of other and unknown origin
- R53.83 Other fatigue
- R61 Generalized hyperhidrosis (night sweats)
- R63.4 Abnormal weight loss
- R68.83 Chills (without fever)

This coding guidance has been approved by the four organizations that make up the Cooperating Parties: the National Center for Health Statistics, the American Health Information Management Association, the American Hospital Association, and the Centers for Medicare & Medicaid Services.

Source: CDC.gov

American Medical Association Approves New Category III CPT Codes for Coaching

The National Board for Health and Wellness Coaching (NBHWC), a nonprofit subsidiary of the National Board of Medical Examiners (NBME), announces the American Medical Association's (AMA) approval of new Category III Current Procedural Terminology (CPT®) Codes for health and well-being coaching effective January 1, 2020.

BHWC and the U.S. Department of Veterans Affairs (VA) successfully applied for the creation of these new tracking codes, utilizing the NBHWC standards. VA will be tracking the use of the coaching codes to evaluate the effectiveness of coaching as a part of the Department's whole health system of care. This data could support Category I approval.
Professionals certified by NBHWC or NCHEC (The National Commission for Health Education Credentialing, Inc.) can use the new codes. Over the next few months, NBHWC and NCHEC will develop guidelines on use of the new codes for National Board Certified Health and Wellness Coaches (NBC-HWCs), Certified Health Education Specialists (CHES®) and Master Certified Health Education Specialist (MCHES®), physicians and other healthcare providers, healthcare systems, and payers.

NBHWC and VA anticipate the use of the codes will increase recognition of Health and Well-Being Coaching as a valuable service. VA will use the codes

to track coaching services delivered by VA-trained "Whole Health" coaches who are National Board-Certified Health and Wellness Coaches. VA coaches are vital members of the healthcare team, helping veterans get healthier and better manage chronic issues such as diabetes, pain, and depression.

"The new codes reflect what research is demonstrating: coaches have expertise that helps patients step into more active roles in their own care. NBHWC is optimistic the new codes will increase utilization of this service and support needed reimbursement in the near future," explains Ruth Wolever, Ph.D., and NBHWC board member. Wolever and VA physician Dr. Kavitha Reddy and her team shared a vision for advancing this work. Dr. Reddy led the application process for new CPT codes.

Well-trained and certified health and wellness coaches—with expertise in patient-empowering communication and behavior change—engage patients to develop and implement a personal vision and plan for optimal health. With the coach's support, patients cultivate the internal motivation, confidence, and resources needed to start and sustain behaviors shown to prevent or treat chronic disease and improve health and well-being.

Healthcare professionals are required to meet unified training and education standards and complete national examinations (that typically support state licenses) to be eligible to deliver healthcare services using CPT codes. In the absence of state licensure, NBHWC and NCHEC have, on behalf of their fields, developed independent national standards and certification for health and wellness coaches and health educators.

NBHWC and the NBME partnered to combine NBHWC coach training standards that emphasize live coaching skills training, mentoring, and skills assessment with NBME's 100-year history of delivering medical licensing examinations.

The AMA defines a coach as a non-physician healthcare professional certified by NBHWC or NCHEC.

The approved Health and Well-Being Coaching Category III CPT® codes will be in effect for five years, but are renewable. These temporary codes are intended to support the wide utilization and data collection, with and without reimbursement, required for AMA approval of Category 1 codes.Reimbursement by payers of Category III codes is optional starting January 1, 2020. Payers typically wait until codes have Category I approval to begin reimbursement.

The Category III Health and Well-Being Coaching Codes include:

- 0591T Health and Well-Being Coaching face-to-face; individual, initial assessment
- 0592T individual, follow-up session, at least 30 minutes
- 0593T group (two or more individuals), at least 30 minutes

National Board for Health & Wellness Coaching (NBHWC)
NBHWC and the National Board of Medical Examiners (NBME) launched national standards and national board certification for health and wellness coaches in 2017. There are currently 2,300+ National Board-Certified Health & Wellness Coaches (NBC-HWC), practicing across healthcare, employee wellness programs, and in the private and public sectors. For more information, visit https://nbhwc.org.

4 Biggest Patient Billing Challenges

The healthcare industry has no shortage of challenges, and revenue cycle management is no exception. A survey of healthcare organizations identified several such challenges with patient billing in particular. Self-pay patients are on the rise, and so too the importance of patient collections continues to increase. Fortunately, many of these problems have solutions just waiting to be implemented.

Challenge: Estimating Patient Financial Responsibility

Patients who are surprised by a larger-than-expected bill are less likely to pay promptly, as their budgets will need to absorb the hit. One of the best ways to avoid surprising patients with unexpected medical bills is by providing them with an estimate of their financial responsibility before care is provided. Healthcare organizations should build in automatic eligibility verification and cost estimations by routinely using software with these capabilities either prior to or at the point of service. Copay expectations should also be made clear to the patient, and these should be collected in full at check-in.

Challenge: Educating Patients about their Financial Responsibility

Many patients are confused or overwhelmed by insurance coverage and medical billing. Especially given the rise of high-deductible health insurance plans, patients are assuming a greater share of

healthcare costs. Healthcare organizations should anticipate common points of patient confusion and have infrastructure in place to support patients in understanding the responsibilities they will take on. This education can range from identifying a need for insurance pre-authorization to providing financial counseling and offering alternatives to lump-sum payments.

Challenge: Patients Who Take a Long Time to Pay

A 2016 survey of healthcare organizations found that slow-paying patients posed a significant challenge to their businesses, but more than half of those organizations surveyed did not submit electronic statements to patients, more than half did not offer automated payment plans, and only 35 percent of the respondents retained payment cards on a secure system. It is not surprising that patients will take a long time to pay if the billing system lags behind the digital experience that consumers expect and that modern technology easily supports.

Challenge: Patients Who are Unable to Pay

Of course, there are the patients who take a long time to pay … and then there are the patients who never quite get around to it. The approaches to the previously discussed challenges will also help with patients who would otherwise likely have difficulty paying. In addition, it is important to make patient collections simple, direct, and timely. Ensure that patients are offered a wide variety of payment options to remove barriers to payment. Many healthcare organizations collect partial or full payment prior to providing patients services, or another option is storing a payment method for automatic payments in accordance with a payment plan decided on in advance of services being provided.

With all these challenges, the solutions seek to leverage available software tools and maintain good patient relations through transparency and clear communication. The earlier challenges can be identified and intercepted, the better the outcomes will be.

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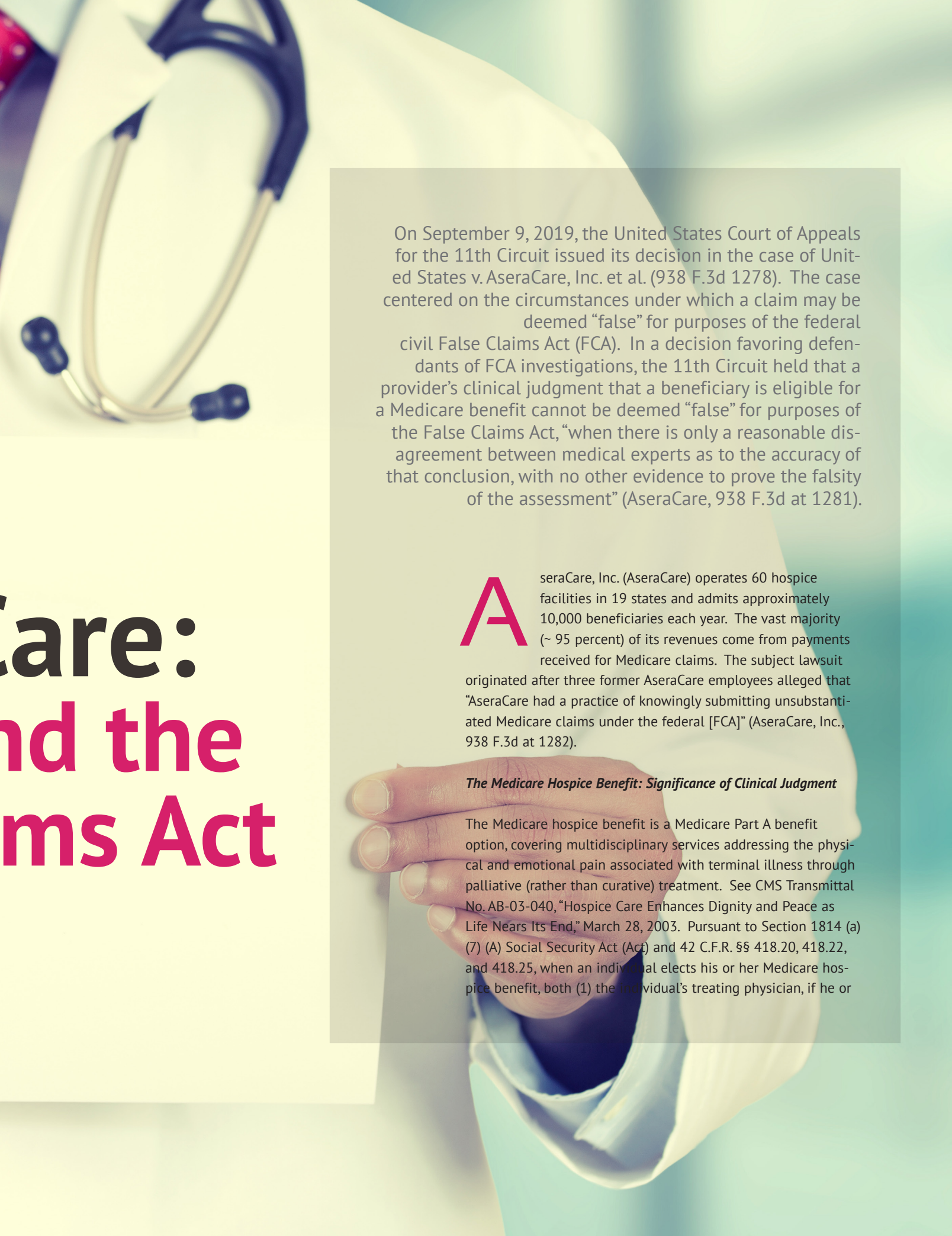

Care: nd the ms Act

On September 9, 2019, the United States Court of Appeals for the 11th Circuit issued its decision in the case of United States v. AseraCare, Inc. et al. (938 F.3d 1278). The case centered on the circumstances under which a claim may be deemed "false" for purposes of the federal civil False Claims Act (FCA). In a decision favoring defendants of FCA investigations, the 11th Circuit held that a provider's clinical judgment that a beneficiary is eligible for a Medicare benefit cannot be deemed "false" for purposes of the False Claims Act, "when there is only a reasonable disagreement between medical experts as to the accuracy of that conclusion, with no other evidence to prove the falsity of the assessment" (AseraCare, 938 F.3d at 1281).

AseraCare, Inc. (AseraCare) operates 60 hospice facilities in 19 states and admits approximately 10,000 beneficiaries each year. The vast majority (~ 95 percent) of its revenues come from payments received for Medicare claims. The subject lawsuit originated after three former AseraCare employees alleged that "AseraCare had a practice of knowingly submitting unsubstantiated Medicare claims under the federal [FCA]" (AseraCare, Inc., 938 F.3d at 1282).

The Medicare Hospice Benefit: Significance of Clinical Judgment

The Medicare hospice benefit is a Medicare Part A benefit option, covering multidisciplinary services addressing the physical and emotional pain associated with terminal illness through palliative (rather than curative) treatment. See CMS Transmittal No. AB-03-040, "Hospice Care Enhances Dignity and Peace as Life Nears Its End," March 28, 2003. Pursuant to Section 1814 (a) (7) (A) Social Security Act (Act) and 42 C.F.R. §§ 418.20, 418.22, and 418.25, when an individual elects his or her Medicare hospice benefit, both (1) the individual's treating physician, if he or

she has a treating physician, and (2) the hospice medical director must certify his or her belief that the individual has a limited life expectancy of six months or less if the terminal illness were to run its normal course. In subsequent benefit periods, only the hospice medical director must recertify his or her belief that the individual has a limited life expectancy of six months or less. Pursuant to both Section 1814 (a) (7) (A) of the Act and 42 C.F.R. § 418.22 (b), a certification is "based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." The regulations require that a hospice certification include "clinical information and other documentation that support the medical prognosis."

Importantly, the Medicare hospice benefit is not a six-month benefit. The Medicare hospice benefit is provided to beneficiaries for specified periods of time known as "election periods." Pursuant to Section 1812 (a) (4) of the Act and 42 C.F.R § 418.21, a physician may certify a patient as eligible for hospice care coverage for an unlimited number of election periods. However, each election period requires that the physician certify his or her belief that the beneficiary has a limited life expectancy of six months or less. "The Medicare program recognizes that terminal illnesses do not have entirely predictable courses; therefore, the benefit is available for extended periods of time beyond six months provided that proper certification is made at the start of each coverage period" (CMS Transmittal No. AB-03-040, "Hospice Care Enhances Dignity and Peace as Life Nears Its End," March 28, 2003).

Section 1871 (a) (2) of the Act states that unless promulgated as a regulation by the Centers for Medicare and Medicaid Services (CMS), no rule, requirement, or statement of policy, other than a National Coverage Determination (NCD), can establish or change a substantive legal standard governing the scope of benefits or payment for services under the Medicare program. However, in lieu of binding regulations with the full force and effect of law, CMS and its contractors have issued guidance that describes criteria for coverage of selected types of medical items and services in the form of manuals and local coverage determinations (LCDs). In the subject case, the CMS contractor with oversight over AseraCare, Palmetto GBA, issued LCDs setting forth coverage guidelines for hospice services. AseraCare physicians used such LCDs, in part, but not exclusively, in making prognostications for use in their certifications of the beneficiaries' hospice eligibility (AseraCare, Inc., 934 F.3d at 1283).

The False Claims Act

The False Claims Act imposes civil liability on "[a]ny person who… knowingly presents, or causes to be presented, a false or fraudulent claim for payment" to the Federal government or who "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim" (31 U.S.C. § 3729 (a) (1) (A)-(B)). In addition, FCA liability also may attach where a person falsely asserts or implies that it complied with a statutory or regulatory requirement, and it has not so complied. See Universal Health Servs., Inc. v. United States ex rel. Escobar, 136 S.Ct. 1989 at 999 (2016).

The FCA defines knowingly to include "actual knowledge," "deliberate ignorance," or "reckless disregard" (31 U.S.C. § 3729 (b)). Proof of "specific intent to defraud" is not required; however, liability does not attach to innocent mistakes or simple negligence (Urquilla-Diaz v. Kaplan University, 780 F.3d 1039 (11th Cir. 2015)).

Allegations Against AseraCare

In its complaint against AseraCare, the Government alleged that AseraCare knowingly employed reckless business practices to admit, bill for, and receive reimbursement for false claims (i.e., claims for hospice services rendered to Medicare beneficiaries who were not eligible for the Medicare hospice benefit) (AseraCare, Inc., 934 F.3d at 1284). Notably, the Government did not allege (1) that AseraCare billed for "phantom patients;" (2) that the hospice certifications and recertifications were forged; or (3) that AseraCare employees lied to or withheld critical information from certifying physicians (Id. at 1285). Rather, the Government asserted that AseraCare's aggressive business practices (i.e., imposing monthly quotas for patient intake, resulting in rubber-stamped certifications without a review of the underlying records) resulted in AseraCare admitting beneficiaries who were not, in fact, terminally ill and therefore did not meet hospice eligibility requirements (Id.).

District Court Proceeding

In developing its case, the Government identified a sample of 2,180 beneficiaries that had received hospice services from AseraCare for at least 365 continuous days. The Government selected a sample of 223 beneficiaries from the universe. The Government's physician expert witness reviewed the medical records associated with the sampled beneficiaries (but had never seen or treated the patients). Using the LCDs as his guide, the Government's witness alleged that 123 beneficiaries were ineligible for the Medicare hospice benefit. If it prevailed on this sample, the Government intended to extrapolate those results for a "statistically valid set of additional claims within the broader universe" (Id.)1 The Government also sought to introduce

1 Note that CMS and its contractors routinely use statistical

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sampling for overpayment estimation in the context of post-payment audits. There is a question as to whether such "estimation" is appropriate in the context of FCA, where each finding of a "false claim" may result in treble damages as well as a penalty of approximately $11,000. See https://www.justice.gov/civil/false-claims-act. Courts are split as to whether statistical sampling may be used to calculate FCA liability. See e.g., Vega, Milene, "Should Statistical Sampling be Used to Prove Liability under the False Claims Act in Healthcare Fraud," Southern California Law Review, Vol. 91, No. 3, March 2018. evidence of AseraCare's business practices, alleging that such practices led to physicians "rubber stamping" certifications without reviewing the associated medical records, and therefore admitting non-terminal beneficiaries (Id.).

AseraCare moved for summary judgment on the basis that the Government had demonstrated neither (1) the "falsity" of any of the disputed claims; nor (2) that AseraCare had any "knowledge" of the alleged falsity (Id.). The district court denied AseraCare's motion for summary judgment, because it found that questions of fact remained (Id. at 1286).

AseraCare's moved for bifurcation of the trial. Over the Government's vehement objection, the district court agreed to bifurcate the trial into two phases: (1) Phase One would address the falsity of the claims at issue; (2) Phase Two would address the AseraCare's knowledge (Id.). In so ruling, the district court noted, "while 'pattern and practice' evidence showing deficiencies in AseraCare's admission and certification procedures could help establish AseraCare's knowledge of the alleged scheme to submit false claims—the second element of the Government's case—the falsity of the claims 'cannot be inferred by reference to AseraCare's general corporate practices unrelated to specific patients'" (Id. at 1287).

During Phase One of the trial, the district court allowed the Government to present evidence of AseraCare's business practices, but only to contextualize its allegations of falsity. Principally, the Government presented physician expert witness testimony that the medical records did not support that the beneficiaries were hospice eligible, based on a "check the box" application of the LCDs. AseraCare next presented its physician expert witness testimony, arguing that the beneficiaries were hospice eligible based on the entirety of the beneficiaries' clinical presentations (e.g., medical histories, constellation of medical conditions), and based on the physician's personal history treating terminal patients (Id. at 1288).

At the conclusion of Phase One of the trial, the jury was instructed to determine which expert was more persuasive, with the less persuasive opinion being deemed "false." In particular, the jury received the following instruction: "A claim is 'false' if it is an assertion that is untrue when made or used. Claims to Medicare may be false if the provider seeks payment, or reimbursement, for health care that is not reimbursable" (Id. at 1288-1289). The jury largely sided with the Government, determining that 104 of the 123 beneficiaries were not hospice eligible, and therefore that the underlying claims for those 104 beneficiaries for which AseraCare received reimbursement constituted "false claims" (Id.).

AseraCare again moved for summary judgment. AseraCare argued that it was entitled to summary judgment as a matter of law because the court had articulated the wrong legal standard in its instructions to the jury. The district court agreed: "As the court worked through AseraCare's challenges," it "became convinced that it had committed reversible error in the instructions it provided to the jury." The district court determined that proper jury instructions should have included: "(1) that the FCA's falsity requirement requires proof of an objective falsehood; and (2) that a mere difference of opinion between physicians, without more, is not enough to show falsity" (Id. at 1290). The district court found that a new trial was warranted to correct this error (Id.).

The court next considered, sua sponte, "whether the Government, under the correct legal standard, has sufficient admissible evidence of more than just a difference of opinion to show that the claims at issue are objectively false as a matter of law" (Id.). Following briefing and a hearing, the district court found that the Government had not introduced enough evidence of the falsity of the claims. In particular, the court found that the "Government has failed to point the court to any admissible evidence to prove falsity other than Dr. Liao's opinion…" (Id.). "The Government… presented no evidence of an objective falsehood for any of the patients at issue" (Id.). Therefore, the district court found that the Government could not prove falsity as a matter of law and issued summary judgment in favor of AseraCare (Id.). The Government's appeal to the 11th Circuit followed.

11th Circuit Proceeding

"Medicare claims may be false if they claim reimbursement for services or costs that either are [1] not reimbursable or [2] were not rendered as claimed" (Id. at 1291 citing United States ex rel. Walker v. R&F Props. of Lake Cty., Inc., 433 F.3d 1349 at 1356 (11th Cir. 2005)). In AseraCare, there was no question that the hospice services were rendered. Therefore, the sole question for the 11th Circuit to decide was whether the claims were reim-

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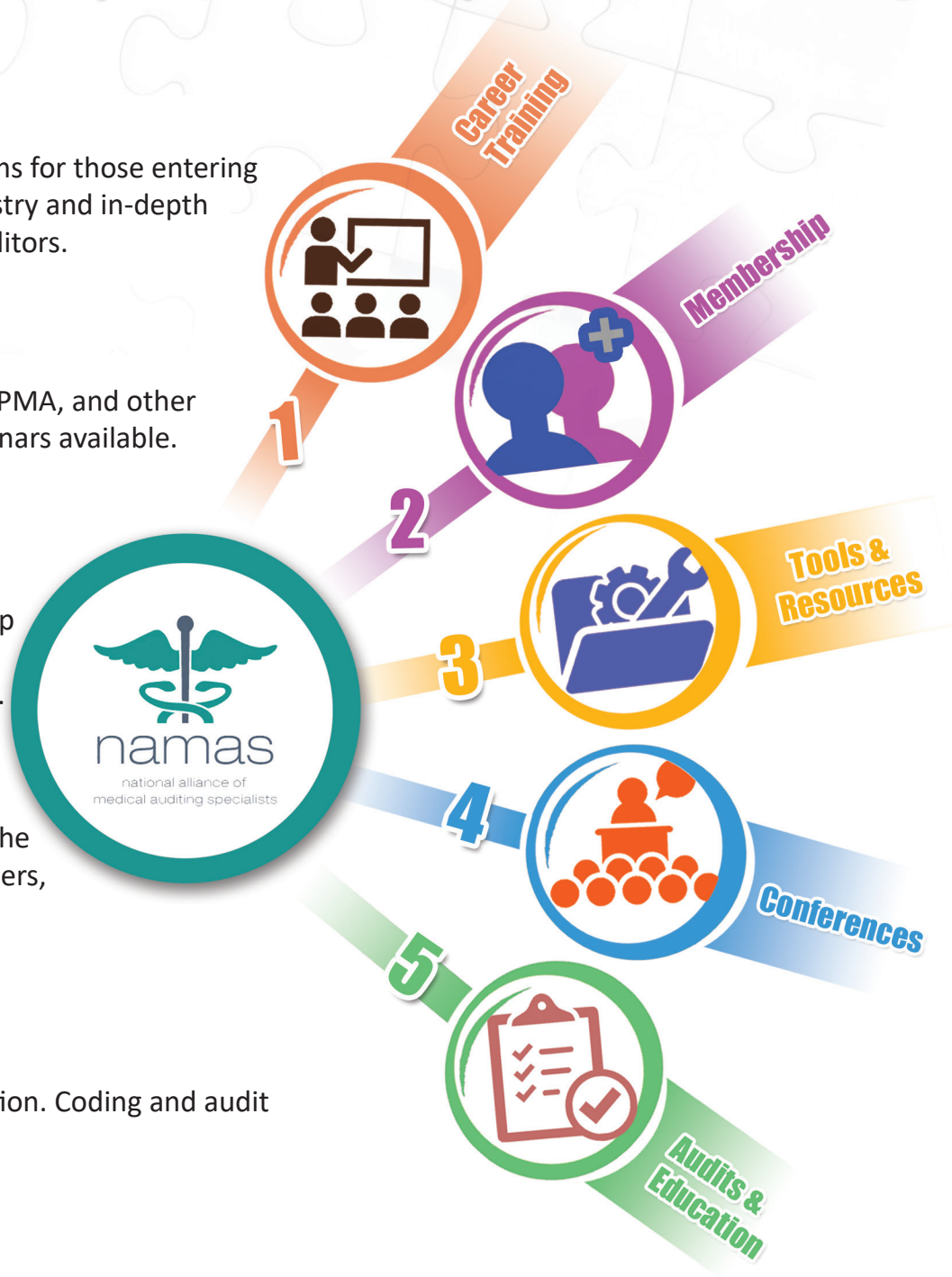

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bursable (i.e., "whether AseraCare's certifications that patients were terminally ill satisfied Medicare's statutory and regulatory requirements for reimbursement. If not, the claims are capable of being "false" for FCA purposes") (Id.).
After describing the statutory and regulatory framework for hospice eligibility, the 11th Circuit found that, "[t]he relevant regulation requires only that 'clinical information and other documentation that support the medical prognosis… accompany the certification' and 'be filed in the medical record'" (42 C.F.R. § 418.22).

In this context, the 11th Circuit found that there are two separate representations embedded in each claim for hospice reimbursement: "[1] A representation by a physician to AseraCare that the patient is terminally ill in the physician's clinical judgment, and [2] a representation by AseraCare to Medicare that such clinical judgment has been obtained and that the patient is therefore eligible" (AseraCare, Inc., 938 F.3d at 1295-1296). In the case at hand, the Government alleged that AseraCare "'submitted documentation that falsely represented that certain Medicare recipients were 'terminally ill,' when in the Government's view, they were not." However, the Government did not allege that AseraCare submitted claims when the physicians had not formed a clinical judgement as to the terminality of the beneficiaries, or that AseraCare violated claim submission requirements. The Government's allegations that the claims were "false" were based entirely on the accuracy of the physicians' clinical judgments. Noting that, "physicians applying their clinical judgment about a patient's projected life expectancy could disagree, and neither physician… be wrong," the 11th Circuit held that a claim cannot be "false" triggering FCA liability "if the underlying clinical judgment does not reflect an objective falsehood (Id. at 1296-1297).

The court noted that examples of an "objective falsehood" could include situations in which: (1) the certifying physician did not review the patient's medical records; (2) the physician did not subjectively believe a beneficiary was terminally ill, but nonetheless certified the beneficiary as eligible for the Medicare hospice benefit; or (3) no reasonable physician would believe a beneficiary's condition was terminal based on the underlying medical records (Id. at 1297).

In summary, the 11th Circuit held:

[I]n order to properly state a claim under the FCA in the context of hospice reimbursement, a plaintiff alleging that a patient was falsely certified for hospice care must identify facts and circumstances surrounding the patient's certification that are inconsistent with the proper exercise of a physician's clinical judgment. Where no such facts or circumstances are shown, the FCA claim fails as a matter of law (Id.).

As the Government was precluded from introducing evidence surrounding AseraCare's business practices surrounding certification in Phase One of the district court's proceeding, the 11th Circuit remanded the case back to the district court for consideration of all of the evidence submitted below. However, the 11th Circuit also cautioned that such evidence must be linked to the specific 123 claims at issue. "The linkage is necessary to demonstrate both falsehood and knowledge" (Id. at 1304).

Conclusion

Although AseraCare's holding is specific to hospice claims, this case will likely have implications for providers and suppliers subject to FCA investigations outside of the hospice context. If the Government's alleges that a provider or supplier's clinical judgment is unjustified, and on this basis alleges the FCA has been violated, AseraCare's analysis may be used to demonstrate that the Government's allegation, without a correlated allegation of objective falsehood, must fail as a matter of law.

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AHIMA Leads the Way on Data Collection Best Practices for LGBTQ Patients

The American Health Information Management Association (AHIMA) welcomes and supports the November 2019 call by the American Medical Association (AMA) for fully inclusive electronic health records (EHRs) for transgender patients.

AHIMA has long recognized this need and formed a LGBTQ volunteer work group in 2014 that has published articles and Practice Briefs to inform health information management (HIM) professionals on this important issue. The organization has also delivered presentations nationwide on the topic of best practices and known challenges when collecting and managing sexual orientation and gender identity (SOGI) data in the EHR.

"How Inclusive Is Your Health Data?" in the January 2020 issue of Journal of AHIMA illustrates this need for change. Our HIM and clinical professionals struggle with data collection due to the fact that many systems do not allow for standardized SOGI data collection. EHRs must be inclusive and allow for the collection, processing, safeguarding, and managing of patients' protected health information (PHI). Some EHR vendors have updated their modules to capture data such as pronouns (he/him, she/her, they/them), preferred name, sex assigned at birth for transgender individuals, an

anatomy or biological inventory to inform clinical decisions, and legal sex to inform workflows such as coding and billing.

Since registration or patient financial services are typically the first point of entry for patients seeking care, the evaluation of collecting SOGI data is extremely important. Sensitivity training, including cultural competence for all members of the healthcare team, will assist with understanding why SOGI data must be collected. This area is known for high staff turnover rates, therefore iterative training is mandatory.

The following example, adapted from an AHIMA LGBTQ work group article published in the Journal of AHIMA, aids in illustrating the need for staff training and inclusive EHRs:

A transgender individual seeks medical care from a provider who does not have an inclusive EHR and staff have not been provided sensitivity and cultural competence training.

On this day, the male-to-female (MTF) patient uses their new name, although it has not officially changed so there is no legal documentation such as a driver's license. The patient is registered under "male" using their "legal name." The patient asks the nurse to document their new name and pronoun in the chart. The nurse complies, although they do not relay the information to the physician as it is a very busy clinic day and they are moving on to see the next patient. The physician enters the room and uses the wrong name to address the patient because the information is not readily seen on the chart due to lack of inclusive data fields in the EHR. The patient asks the physician to please use this name and associated pronouns, but already feels uncomfortable and disrespected.

Not only does this example show the wrong way of treating our patient populations due to lack of proper technology and training, but there is a clear potential for patient misidentification. If the patient presents for a follow-up visit and uses their new name and pronouns, the registrar could easily perform a search and not find the patient's unique health record and then proceed with creating a new record. Subsequently, this turns into a patient safety issue when the patient receives a service such as a scan or laboratory test under a new identity that correlates with a different sex at birth leading to the potential for false results or inadequate care.

Enhancing the healthcare environment for LGBTQ patients will contribute to improved patient care and safety where patients will be more willing to share their personal information in a welcoming, respectful, and confidential environment. An inclusive EHR will advance the goal of delivering quality and safe healthcare for this patient population.

Julie Pursley Dooling, MSHI, RHIA, CHDA, FAHIMA, is the Director, HIM Practice Excellence, AHIMA. www.ahima.org

8 Tips to Establish High Levels of Patient Satisfaction at Your Practice

Patient satisfaction is vital to the growth and success of your practice. The industry is changing and so is the way your patients continue to be happy with their medical care. Here are eight important steps to take to make sure your practice is maintaining high levels of patient satisfaction in 2020.

1) Reminders

Whether or not your patient remembers to come to their appointment or even pay their bill is tied to many different points of frustration. When a patient forgets their appointment, they often accrue unwanted fees or a lapse in important treatment. When this happens, it can decrease overall patient satisfaction, as well as patient engagement. Missed appointments also lead to an increase in wait times that frustrate the patients in your waiting room. Introducing text, email, and phone call reminders are the best ways to make sure you are reminding and engaging your patients so that they can avoid these disappointments.

2) Patient Portal

A quality patient portal is one of the top means of improving patient satisfaction within any practice. Increased access to information and improved understanding are two things that greatly impact how your patients view your practice. With a quality patient portal, providers can increase patient satisfaction by helping individuals better understand their personal health information, their medical bills, and much more.

3) Visit Alternatives
Becoming more and more relevant each day, patients are seeking medical visit alternatives from their providers. This is seen most from millennial patients who are looking for their providers to offer telehealth and e-visits as options in their care continuum. Offering telehealth at your practice will greatly impact patient satisfaction by offering your patients a convenient way to visit with their physicians during their on-the-go life.

4) Accessible Patient Payments
One of the most prominent contributors to decreased patient satisfaction is the dreaded medical bill. Medical bills are often avoided, unpaid, and unknown for patients who do not plan for their medical costs. The more informed your patients are in regard to their medical bills, and the more options they have to pay them, the more likely they are to make a patient payment and be satisfied with the process. A way that providers can increase patient satisfaction in this area is to introduce more options to make payments. This should include billing integration into your patient portal to allow patients to make payments by credit card online, over the phone, or in person.

5) Payment Plans
For patients who are not financially prepared for unplanned medical expenses, providers must inform them of their options. Most of the time, this means making sure your patients have manageable opportunities should unexpected costs arise. Payment plans are a great way to make sure your patients do not become overwhelmed by medical expenses and to maintain higher levels of patient satisfaction.

6) Chronic Care Management
For your patients battling multiple chronic conditions, coordinating their care and keeping track of all the details can make them immensely unhappy with their medical processes. When their care is not coordinated, it can lead to duplicate testing, unmanageable appointments, and dangerous conflicts in their care plans. By offering Chronic Care Management, providers can not only increase patient satisfaction for these individuals, but also improve the quality of the care they receive, while also increasing revenue.

7) Online Engagement
Providers should make their best effort to create a sense of community with their patients in order to increase patient satisfaction. When your patients are happy with the level of attention they are receiving from their provider, they are more likely to leave a positive footprint online or in person. Engage your patient base via email to keep them up to date on what your practice is offering. Providers who want to boost patient satisfaction, even more, should reach out to patients this way on birthdays and holidays as well.

8) Reduce Wait Times
A reduction in wait times and an increase in one-on-one time is one of the best approaches to increase patient satisfaction. This is achieved in combination with offering visit alternatives like telehealth and reminding your patients of their appointments. It is also achieved by introducing tools like digital patient intake. A digital intake process helps your patients enter all important information prior to their visit, reducing the time spent on this in the office. This process not only reduces wait times, but it also improves the accuracy of the information, as well as the efficiency of your staff's time.

Kimberly Von Feldt writes for iSalushealthcare.com.

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2019 HIPAA Settlements and Take-Aways

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") are two of the pillars that form the foundation of a patient's privacy rights in relation to his/her protected health information ("PHI"), as well as the obligations of covered entities, business associates, and subcontractors to ensure the confidentiality, integrity, and availability of the data.

This is also a good time to remind providers that a deceased individual's PHI is subject to HIPAA for 50 years. With the exception of reporting requirements under law or a coroner's report, a surviving family member or legally authorized executor may obtain copies of the decedent's PHI under these two conditions: (1) treatment purpose of another individual if one provider is requesting it from another provider; and (2) "treating a deceased individual's legally authorized executor or administrator, or a person who is otherwise legally authorized to act on the behalf of the deceased individual or his estate, as a personal representative with respect to protected health information relevant to such representation." Hence, whether or not a person is deceased for less than 50 years or a person

is living, there is still a requirement to disclose PHI to an appropriate and authorized person.

The purpose of this article is to highlight the variety of settlements that occurred between the U.S. Department of Health and Human Services ("HHS") and persons that violated either the Privacy Rule and/or the Security Rule.

Settlement Analysis

There are three settlements of particular importance, of which covered entities and business associates alike should take notice.

Bayfront Hospital (September 2019)

In the first settlement of its kind, OCR announced a settlement with Bayfront Health (St. Petersburg, Florida) for $85,000 for denying a patient's access to her medical records.

> OCR initiated its investigation based on a complaint from the mother. As a result, Bayfront directly provided the individual with the requested health information more than nine months after the initial request. The HIPAA Rules generally require covered health care providers to provide medical records within 30 days of the request and providers can only charge a reasonable cost-based fee. This right to patient records extends to parents who seek medical information about their minor children, and in this case, a mother who sought prenatal health records about her child.

This serves as a wake-up call for providers. Patients have a right to their medical records and there are ramifications for not providing it.

The University of Rochester Medical Center (URMC) (November 2019)

As one of the largest providers in New York, the University of Rochester Medical Center ("URMC") should have implemented the requisite technical, administrative, and physical safeguards.

> URMC filed breach reports with OCR in 2013 and 2017 following its discovery that protected health information (PHI) had been impermissibly disclosed through the loss of an unencrypted flash drive and theft of an unencrypted laptop, respectively. OCR's investigation revealed that URMC failed to conduct an enterprise-wide risk analysis; implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level; utilize device and media controls; and employ a mechanism to encrypt and decrypt electronic protected health information (ePHI) when it was reasonable and appropriate to do so. Of note, in 2010, OCR investigated URMC concerning a similar breach involving a lost unencrypted flash drive and provided technical assistance to URMC. Despite the previous OCR investigation, and URMC's own identification of a lack of encryption as a high risk to ePHI, URMC permitted the continued use of unencrypted mobile devices.

As a result of its non-compliance, URMC settled for $3 million, primarily for not encrypting mobile devices or conducting an annual risk analysis.

Conclusion

The privacy and security obligations under HIPAA and the HITECH are not going away. And, as states add new laws regarding privacy and the risk assessments that go along with them, the spotlight is only going to intensify. The easiest place to start to mitigate the risk of a reportable breach and a potential monetary payment to OCR is to make sure that your organization and your business associates have the following five items in place annually: (1) risk analysis; (2) training; (3) adequate policies and procedures; (4) encryption at rest and in transit; and (5) current Business Associate Agreement. Doing so can save time, resources, and reputational costs.

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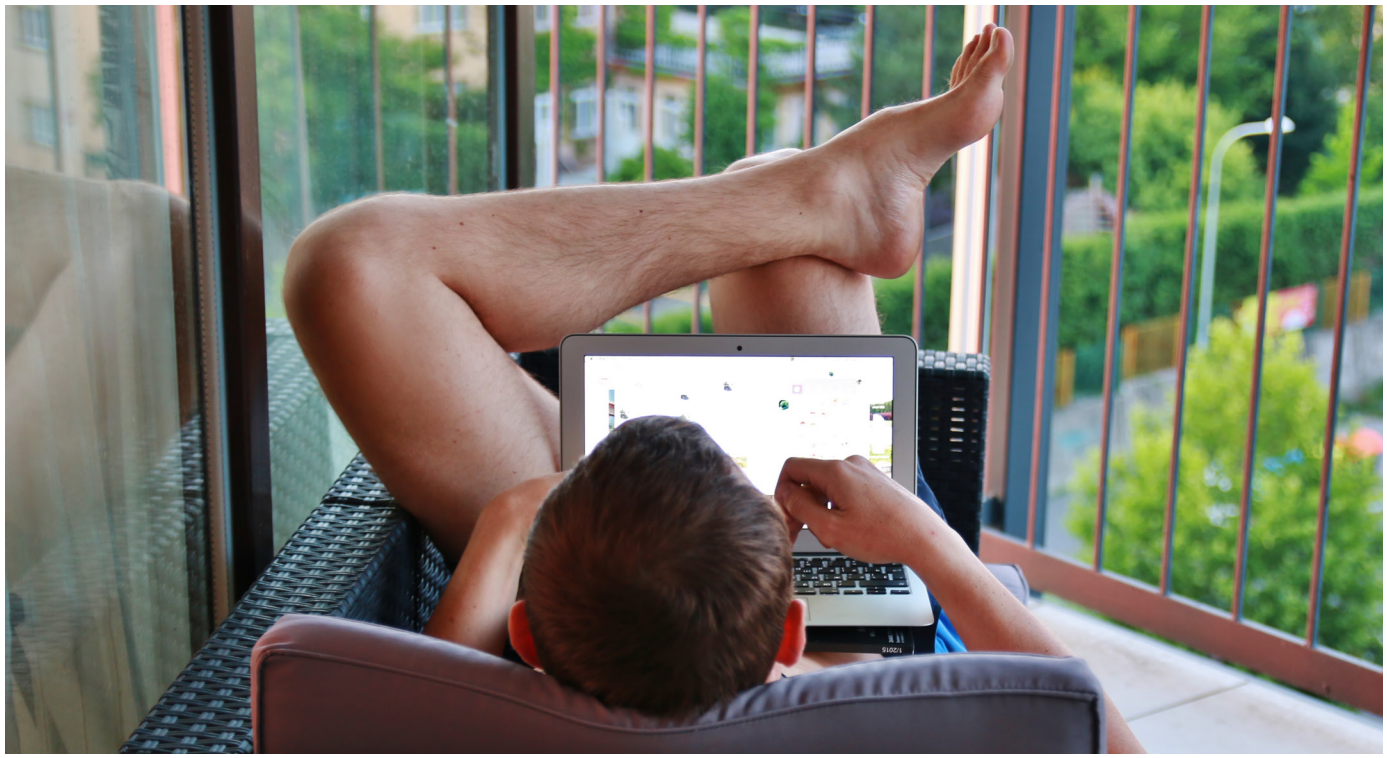
Is it Time to Allow Revenue Cycle Employees to Work from Home?

Within the next few years, managing revenue cycle employees from their homes might be normal business practice for many healthcare providers. As a result, revenue cycle managers may find themselves forced to respond to an all-new set of needs and concerns from their staff. This report explains what telecommuting is, describes the pros and cons of telecommuting, and describes the challenges of managing revenue cycle employees working from home.



Some facilities—such as the Cleveland Clinic—enable employees to telecommute and perform patient pre-registration, scheduling, and financial counseling. Other facilities—such as Texas Health Resources, which operates 25 hospitals—has a virtual office revenue cycle which is now 100%.

A common perception of the telecommuting worker is a slacker who enjoys the luxuries of home while "working." However, some studies have found that telecommuters work more hours than traditional office workers.

Working from home requires a different skill-set and work ethic than working in-house. A productive in-office employee might not be productive at home—and vice versa. A magical employee who is productive regardless of loca-

tion does exist, but not everyone may be as adaptable.

This article includes tips for managing telecommuting employees.

The Pros: What is Great about Telecommuting Work

The benefits, or pros, of working from home range from higher productivity to reduced office-space costs. Many people believe that working from home means higher productivity. This is because there are fewer distractions from office politics and socializing.

When you open your revenue cycle department to telecommuting workers, your potential talent pool expands immensely. If the best candidates do not live within commuting distance and are not willing to relocate, your department can still benefit from their skills. This can be very beneficial to rural hospitals that find it challenging to find and hire local talented staff.

You won't have to worry about a commute. Not commuting every day not only saves the employees hundreds of dollars a year, but also greatly reduces their stress for the workday ahead.

More productivity time. The hour to get ready and commute is directed toward project management or team conversations.

Flexibility for working parents. More family time increases the quality of life for employees and their families.

Employers who offer telecommuting opportunities appear more appealing to new employees and, additionally, reduce the turnover rate of existing employees.

The Cons: Challenges of Telecommuting Work Arrangements

It is much easier to get your point across while directly viewing materials with someone. Interactions can be quicker and more straightforward in person, and it is also easier to explain and resolve different viewpoints face-to-face.

Staff management is always a challenge, but managing remote staff is even more so. Thoughtful planning, clearly communicated expectations, and a system of monitoring are required elements to ensure high productivity and quality of reviews.

All PHI must be encrypted before being transmitted. This can either be through the company's Intranet or using the internet email encryption. HIPAA primary and secondary rules do not prohibit remote access, but they do require that organizations implement appropriate safeguards to ensure the privacy and security of protected health information (PHI).

A remote manager's worst nightmare is the idea that an employee is running personal errands on the company dime.

Often, remote employees get little recognition. Ideas suffer from lack of feedback and brainstorming. Innovation is not time-bound to a clock, and when employees only have an hour here or there scheduled for brainstorming, the process can lose its energetic excitement. People who are not around each other long enough do not collaborate on ideas naturally.

Tips for Managing Remote Employees

- Have clear productivity goals. As a revenue cycle manager, your primary concern should not be to manage tasks since employees know what to do. Once you give them instructions on the goals and objectives, have faith that they can fulfill the role they were hired to do. Instead, your focus should be on setting productivity goals, and on results and outcomes.
- Use different channels of communication. You

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should ensure that employees can get in touch with you using different modes of communication, ranging from HD video conferencing (such as having staff meetings with Skype in Outlook) and phone meetings, to simple (IM chatting or emailing). This will ensure that employees can communicate about different aspects, ranging from assignments to a personal issue.

- Having remote workers clock in and out, attend video meetings, and copy you when submitting their work makes them more accountable.
- Review VPN logs to discern just what, exactly, remote employees have been doing.
- You need to have a clear policy on teleworking. This policy must outline risks that remote workers have and emphasize how to reduce those risks.
- Deploy consistent security measures. You need to implement basic security measures for laptops, such as full disk encryption, malicious software protection, VPN, firewall, and content filtering.
- Provide guidance, communicate, and take responsibility for managing people.
- Work with human resources to ensure workers' compensation will cover your employees in their home environment. It is a good idea to develop workstation design guidelines and offer a home inspection.
- Ask all of the workers who will be working at home to sign a written telecommuting agreement.
- Automate end-user security protocols, giving your IT department complete access to telecommuting computers in the network.
- Provide administrators with the ability to control and manage telecommuting computers from a virtual desktop, while granting personal computer users virtual access to their office desktops.
- Prevent users from bypassing password protection in the event a laptop is lost or stolen.
- Extend password protection to other commonly used mobile devices, such as USB flash drives or portable hard drives.

The important thing to remember about managing employees who work from home or in global offices is that, at the end of the day, you are looking for the same things from them as you are from your in-office employees: productivity and reliability.

There's no two ways about it: the whole world is your office now, but without the right tools for the job, you will not be able to take advantage of this exciting new telecommunication environment.

Jim Yarsinsky, CRCE-1, is the founder and engagement partner for Zinserv Healthcare. Jim is a revenue cycle turnaround consultant with more than three decades of experience. Zinserv Healthcare's mission is to be the recognized leader in providing healthcare providers, and their affiliates, with the best revenue cycle professionals on an expedited, interim basis, anytime and anywhere. www.zinserv.com

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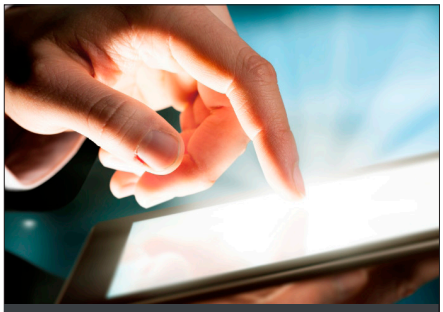

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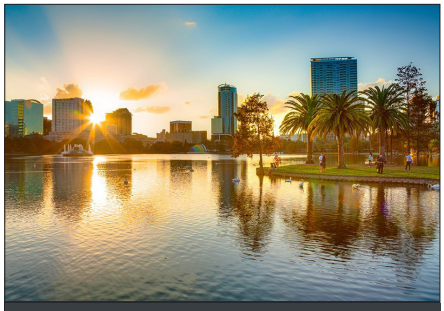

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6 Steps to Start Writing and Managing Your HIPAA Policies and Procedures

Policies and procedures are the backbone of your HIPAA compliance program. They direct your entire team on how to carry out the standards of the HIPAA privacy, security, and breach notification rules.

Policy management is the process of creating, distributing, and updating policies and procedures within an organization. No matter how you maintain your policies and procedures—on paper or in electronic form—you must have a policy management process.

Here are six steps to get you started:

1. Write Your HIPAA Policies and Procedures
Your policies should establish the following:

Purpose. All policies and procedures are written with a specific purpose in mind, such as meeting a goal, implementing a standard, or providing instructions. You should place the purpose of the policy at the beginning of the document, so the reader understands why the policy was written.

Scope. Who does the policy apply to? Is it written for a specific department or the entire organization? Does the policy apply in all situations or only in specific situations? Identify the scope of the policy early on in the document.

Procedures. Procedures are the substance of the policy. Here you spell out the "how to" of the policy—the actions employees or the organization should take to meet the requirements of the policy. Procedures should be clear and concise, using short sentences and common words that everyone can understand.

Definitions. Some policies include very technical terms. Most of the time, the recipients of the policy will understand the terminology. However, keep in mind that people in the policy review process may not have the same knowledge as the person who carries out the procedure.

Ambiguity or misinterpretation can work against your policies. Therefore, you should include a section that defines technical terms, so everyone is clear on what the policy means.

2. Make Policies and Procedures Available to Staff
When you create a policy, you must communicate it to the staff members responsible for carrying it out. Too often, managers develop procedures to help their staff carry out a task but fail to communicate the procedures to their staff! Therefore, make sure you communicate your policies and procedures to your staff, as well as make the documents available so your team can see and use them.

3. Train Staff on Policies and Procedures
You can't assume that your staff will understand their

responsibilities or know how to complete tasks required by your policies. Besides making policies available to staff and communicating policies to them, you must go a step further and train them on your policies. Training staff on policies means equipping them to carry out the procedures as they are written.

4. Develop a Review and Approval Process
Policies aren't written in a vacuum. They must be reviewed and approved by others above the policy writer's level. For example, a department head may write a policy, which the director then reviews and sends to the board of directors to give the final approval.

Regardless of your organization's structure, you should record the individuals involved in the RAF process (review, approve, finalize) within the policy. This gives legitimacy to the finalized policy.

How Often Should I Update Policies and Procedures?
Policies change over time, and with good reason. When your working environment changes or there's a change to the regulatory requirements, you may need to revisit your policies. Additionally, some policies are designed to meet state or federal statutes. Therefore, it's important to keep the policies up to date and keep a record of how the procedures meet state or federal requirements.

5. Maintain Version Control
Version control means you can revisit previous iterations of the policy. HIPAA requires you to maintain your policies' version history for six years. However, some states require you to retain your policies longer.

6. Use Templates/Software to Streamline Policy Management
We know the frustration of juggling binders packed with documents. Policy management can quickly become a tangled mess of papers and deadlines. That's why we recommend using some type of resource—such as templates or software—to ease the burden of writing and managing your policies and procedures.

In our HIPAA management software, HIPAAtrek, you can build out policies and procedures, see definitions at a glance, train your staff on policies, manage the RAF process, and maintain version control, all from a centralized location.

In Summary
Policies and procedures are the backbone of your HIPAA compliance program. They direct your entire team on how to carry out HIPAA standards. To get started on your policy management process, we recommend the following six steps:

- Write your HIPAA policies and procedures
- Make policies and procedures available to staff
- Train staff on policies and procedures
- Develop a review and approval process
- Maintain version control
- Use templates/software to streamline policy management

To learn more about how you can use HIPAAtrek as a policy management tool at your organization, contact us at support@hipaatrek.com.

HIPAAtrek has three of their policy templates available for free on their website. Go to hipaatrek.com/resources/policy-templates/ to learn more about:

- Business Associate Contracts
- BYOD (Bring Your Own Device)
- Media Disposal

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Many Choose to Believe Mistruths

How many times have you repeated a belief that was not true? Perhaps you told your children that if they go swimming within 30 minutes of eating that they could cramp up and die? Maybe you told your kids that they should not swallow gum as it will stay in their system for 7 years, or a watermelon seed swallowed will grow a plant in their tummy? It could be that you refuse to let your children drink coffee as you've repeated that it will stunt their growth. Have you ever told your kids that crossing their eyes risks them getting stuck that way? It's ok. You're not alone.

Now most of us know that these examples are false, but if you don't believe me, look them up. Many things in life that you've believed really have no basis in fact, and yes, we are all like that in some ways. My mother had me convinced that going out in the rain would give me a cold. I believed her. It wasn't until I was an adult that I found out that when it's raining out, folks stay inside more, and that is what gives them a cold as they're spending more time around people spreading a virus! It wasn't the rain. Yet, how many have repeated the myth that going out in the rain gives you a cold?

Unfortunately, sometimes our beliefs are harmful to either ourselves or our employers. For instance, many believe that if a person writes on the front of a check "paid in full" that if the doctor endorses the back and deposits it that the patient no longer owes a balance. That is not true either.

Most billers, coders, and managers believe that if a carrier has a doctor sign an agreement saying they have a 90-day timely filing period that the doctor cannot get paid on claims filed beyond 90 days. They do not realize that the agreement limiting the timely filing only applies on less than 20% of the claims filed to that carrier, and more than 80% of the time, they may have 6 months or a year to file. That is because most people (including attorneys) are

ignorant about ERISA laws when it comes to medical claims.

Perhaps 90% or more of billers, coders, and managers believe the lie that all doctors make less money on Medicare patients than they make on non-Medicare. While that may be true of some specialties, it's definitely not true of family practice and internal medicine clinics that are doing what Medicare wants them to do. The uninformed will point to a code, like 99214, and say, "This proves Medicare is less profitable as BCBS pays $123 and Medicare only pays $111 for that code." It's folks that like that who are hurting their practices as they reinforce the belief that primary care doctors lose money on Medicare. It's sad that they don't realize what harm they are doing to the clinics, which is similar to what they are doing when they don't know ERISA rules.

Recently, I posted a long dissertation to about 60,000 readers proving that doctors, doing what Medicare wants done, will average between $1200 - $1600 a year in Medicare Part B payments while most people younger than Medicare end up bringing in an average of less than $300 per year. Many people misunderstood and only read part of it as they thought, "That isn't my experience—so he's wrong."

They are correct that it wasn't their experience; less than 2% of primary care physicians and their managers, billers, and coders have studied this and are doing what they should be doing. 98% of primary care doctors are missing it, so the people thinking, "That's not my experience," are right. It's not. But, I'm right also, in that if the primary care practice is following the Medicare guidelines and doing what is best for the patient and the practice, then their income on Medicare patients will be 4 times what it is on commercial patients. It's too bad that people are still cutting the end off of their ham….

A man in Ohio was watching his wife cook and she cut the end off of a ham and then placed the ham in a pan, poured an orange juice and brown sugar mixture on it, and put it into the oven. He asked her, "Why did you cut the end off of the ham?" She answered, "My mother taught me to cook ham that way, so I've always done it that method."

A couple of days later, his in-laws were visiting, and he asked his mother-in-law why she cut the end off of her ham when cooking it. She replied, "My mother taught me to cook ham that way, so I've always done it that way."

That perplexed him, so he immediately picked up the phone and called his wife's grandmother and asked her the same question. Granny thought for a minute and then said "You know, I haven't cut the end off of my ham in a very, very, long time. In fact, I stopped doing it that way after Pops bought me my larger cookware."

Many of you still "cut the end off of your ham" because your granny's pan was too small, or do other things the way you've always done them—even though the old way may not be needed any longer. Many believe things that are not quite true any longer.

Medicare has added so many things that they want done on Medicare patients and they pay great for those things that it makes my job so easy now. My guarantee to doctors is simple. If I can't help them increase their annual clinic income by at least $20K a year, they don't pay me for my hour consult. It has become so easy to do that with family and internal medicine doctors, because their manager, their biller, and their coder have all given them so much misinformation in the past by telling them to see more commercial and reduce the Medicare patients.

In doing these hour-long analyses with several doctors a week for more than four years, my experience is that 90% of doctors can easily increase their income by $70,000 to $210,000 a year net by doing what Medicare wants. It's easy, and it has proven correct in every case so far where doctors listened to me and followed the guidelines. One can learn from it, or one can choose to stay ignorant about it and continue hurting the clinic.

It's time to get bigger cookware.

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Data Is Not Enough; Clients Need Information

There are still some dinosaurs in this wonderful world of Medical Billing (as an example, me!). My career has spanned over five decades, starting in Hospital Patient Accounting—what it was called before the current term of Revenue Cycle Management. I think the title was changed to help bolster salaries.

As I reflect on the beginning of my career, I remember daily posting hospital charges on an NCR bookkeeping machine (which was just a glorified cash register) to individual paper patient ledger cards.

The hospital UB claim forms were prepared on an IBM Selectric typewriter, which was hi-tech compared to the manual Royal typewriters scattered throughout the office. If you wanted a copy for your records, you better not run out of carbon paper.

We have come a long way in the past 50 years when we look at how we try to obtain reimbursement for medical services. Unfortunately, however, our industry is on a snail's pace, compared to every other industry, when it comes to developing and adopting technology to vastly improve the process.

We may have gone from reports printed on three-part

green bar computer paper to now emailing electronic PDF files, but many times, the data remains the same. It's a mountain of numbers jumbled together that may be indecipherable to anyone but a senior actuary.

We should move past the days of just reporting on:

- Gross charges;
- Total payments;
- Amounts written off as a contractual allowance; and
- Bad debts

Today's practices, to be successful, need information that enables them to maximize their effectiveness and efficiencies. Some ways to accomplish this feat are to proactively track changes in modalities, payer mix, and RVUs.

One example of why it is important to monitor changes in payer mix is what happened in one of the primary care practices I was managing. The largest employer in town decided to switch insurers, which changed the coverage for hundreds of their employees. The practice participated and had agreements with both the previous third party and the new payer providing coverage. Therefore, patients were not impacted by the switch.

Yet, the previous insurer agreement called for payment at 185% of Medicare, while the new insurer's agreement, which had been in place for years, only reimbursed at 130% of Medicare. When the practice originally decided to participate with that insurer, their covered lives in the town were miniscule, so the practice didn't really weigh any economic ramifications, thinking it was such a small amount of covered lives, so no big deal.

However, given the change in reimbursement for many of their patients that went from 185% to 130%, it's the first time I can recall that the doctor was actually right when they said they were working harder and getting paid less.

This fiasco could have been avoided if we were just paying attention to a payer mix report/pie chart each and every month. Shame on me and lesson learned. We eventually lost the confidence of the client, because they figured that if we missed this, we would miss something else, and they moved on.

Another important data element that needs to be turned into information is reporting on referring physicians. If you are still in the dark ages and just telling your client how many patients or the total gross charge amount that is coming to their practice from a doctor, you are not helping the practice. You should also include payer mix and dollars collected from those patients.

I've seen an instance in practice where they thought their top referring doctor was a superstar, but when we started reporting payer mix and actual collections, we found that he was only sending a majority of low pay/no pay patients, and his more affluent patients were being referred to his sister-in-law.

If there are multiple providers in a practice, it may be imperative to track individual productivity to ensure the practice is maximizing their resources. You need to account for and report on unused appointment slots, canceled visits, and patients who end up being no-shows.

I realize that many of today's legacy Practice Management systems may not have the capability of reporting on the above-mentioned elements, nor can they produce charts and graphs which are visually easier to interpret versus only numerical representations. For this reason, if your system can't turn data into information, it is mandatory to invest in what is most commonly referred to as BI, or Business Intelligence, software. (To learn more about BI for Medical Billing, just Google it.)

I know you want to provide the best service as possible to your client, so remember that it's not just about data, it's about information.

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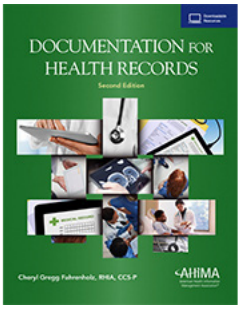
New product discounts and Reviews

Title: Documentation for Health Records, Second Edition
Author: Cheryl Gregg Fahrenholz, RHIA, CCS-P, president of Preferred Healthcare Solutions, LLC.
Available from: www.ahima.org
Price: $99.95



Documentation for Health Records, Second Edition, explains the importance of accurate and timely health record documentation. This textbook addresses fundamental health record documentation requirements and practices a variety of healthcare settings. This new edition expands topics such as information governance, electronic health records and health IT, clinical documentation improvement, and more.

Key Features

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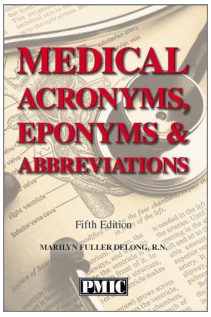
- Covers documentation in ambulatory, home health, hospice, and long-term care settings

Title: Medical Acronyms, Eponyms & Abbreviations, 5th Edition.
Author: Marilyn Fuller Delong, R.N., B.S.N., M.A.
Available from: www.pmiconline.com
Price: $24.95



Medical Acronyms, Eponyms, and Abbreviations provides a comprenhensive listing of the most common acronyms, eponyms and abbreviations used in the medical profession, along with clear and concise definitions. This book is an invaluable tool for everyone involved in learning, reading, writing, or interpreting medical terminology. The new 5th edition includes hundreds of new medical acronyms, abbreviations, and eponyms with the complete terms that they represent have been added to the completely revised fourth edition.

The book covers all medical specialties plus the areas of nursing, administration, quality assurance, diatetics, pharmacy and lab.