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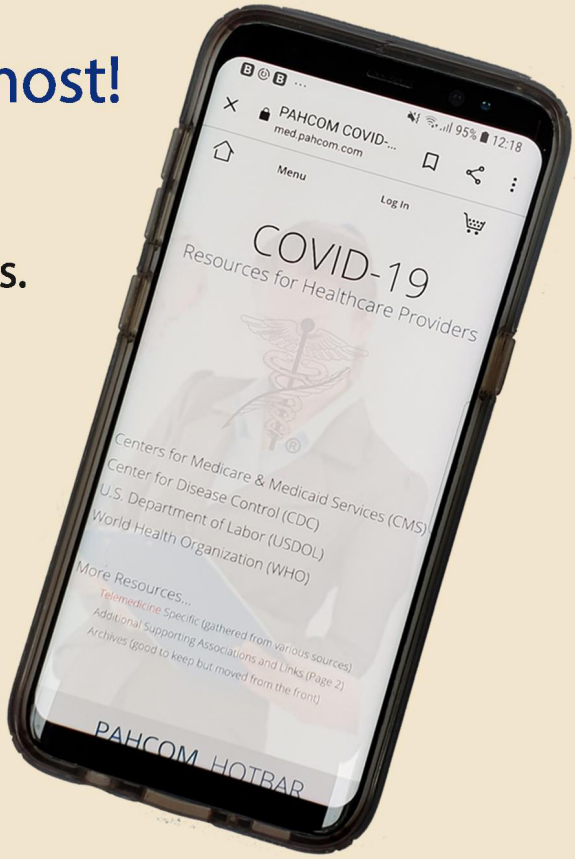

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CEO Letter

So much has changed since I last wrote one of these little notes for the magazine. COVID-19 didn't have its official name, people were laughing it off, China said they had it under control, and the U.S. response at the time was deemed racist or overkill. So much has changed, and so much has been relaxed. Has this situation brought out the good in the world? Too right! Has it brought out the bad? Yes, to that as well.

New "normals" are forming everywhere. Kids are home from school with remote learning becoming a staple for many parents. Parents are also working from home, and with that, new challenges and frustrations are rising. We'll get there. We just need to give ourselves some grace and flexibility to find our way through this quagmire of new responsibilities. And importantly, we need to give grace to our kids. They're resilient, but we will have to wait and see how this affects them in the long-term.

Each generation has had to face something unknown, preparing for "What-Ifs," and coping in the ways that make sense to them. My generation was on the tail-end of the Cold War and educated on nuclear bombs, with a running joke that cockroaches and our feet in the leather school shoes we wore would be the only things to survive a blast (long story, but Australian schools put a lot of emphasis on leather school shoes back then!). We turned out ok…or did we?

The point is that we, in the U.S., are in a way better situation than most of the world. Yes, our cases are still climbing (at the time of writing, the calls are that this week will be the worst for our nation; we lost 1,300 last night alone), but we have a wealth of educated people who have put their personal lives to the side and dedicated themselves to helping people through this horrid situation.

This is all so fluid and we can see that in the way that HHS and CMS are adapting and responding to calls to minimize red-tape and increase positive outcomes. How this will play out in hindsight is going to be interesting, so in the event there will be reviews and audits on down the line, be careful and make sure you're paying attention to what's being put out by the powers-that-be—and ensure you know and trust your sources.

Our lives will never be the same after this and we need to learn and implement some hefty changes so that next time this happens (and yes, it will happen again somewhere, somehow), we can meet it head on, standing tall, with our people as protected and healthy as possible.

Until next time, Storm

Storm Kulhan

BC Advantage is published bimonthly by Billing-Coding, Inc P.O. Box 80669 Simpsonville SC, 29680
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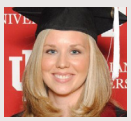

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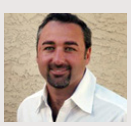

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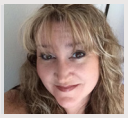

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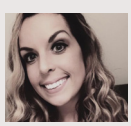

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FEATURES

EXPERT Contributors this issue

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

New CPT, HCPCS, and ICD-10-CM Codes for COVID-19 - Plus 30% Discount on 2021 Coding Books

There are five (5) new codes for reporting COVID-19. All of these codes are effective at this time for reporting COVID-19 testing procedures and testing results. Below the code list, you will find links for our 2021 coding and compliance products that will include all of these codes, plus many more.

CPT CODE (effective 2/2/2020)
87635 - Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique (full)

HCPCS CODES (effective 2/4/2020)
U0001 - CDC 2019 novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel

U0002 - 2019-ncov coronavirus, sars-cov-2/2019-ncov (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC

ICD-10-CM CODES (effective 4/1/2020)
U07.1 - COVID-19, virus identified

U07.2 - COVID-19, virus not identified

PMIC is offering 30% discount on all 2021 coding and compliance products using coupon code "HOORAH BC Advantage." www.pmiconline.com

How to Handle Social Isolation?

Staying at home without stepping out would be boring and stressful for many of us. But there are ways you can stay positive and be cheerful following these protocols:

- Have a regular schedule. Keep yourself occupied with some chres. Sometimes household works will also do.
- Do not get trapped into negative emotions, but rather spend time listening to music, reading, gardening, painting, watching movies, etc. Get back to your childhood memories.
- Eat healthy and drink plenty of fluids.
- Physical fitness is also important. Stay active and exercise regularly, indoors.
- Help the homeless or your neighborhood if they need your advise, food, or essentials. Be willing to share.
- As the disease is new and unknown, elderly at home will be confused and need help. Educate them about the pandemic and support them in their needs.
- Keep your children busy and allow them to do household chores, so they aren't bored since they may lose the ability to go out and play.

Source: Qwayhealth

QUESTION: A patient was seen via audio-video telecommunication, and the video portion stopped connection after five minutes due to weather, and we could not get it back up. We continued with the audio portion of the telehealth visit. Can we code for an office visit in this case?
ANSWER: Since the main focus of the visit was done without video chat capabilities, as mandated by the new waiver in Section 1135(b) of the Social Security Act explicitly allowing the U.S. Department of Health and Human Services (HHS) Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 Public Health Emergency, this visit would now revert to a telephonic visit, again, codes, 99441-99443, and time would need to be documented to enable the provider to choose the correct code. These are time-based codes.

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UnitedHealthcare Telehealth Services: Care Provider Coding Guidance

UHC clarified one-way video usage as a billable E&M office/ outpatient code, meaning if the patient does not have video, but rather audio only-, the provider can still report the E&M service code.

The following scenarios are intended as a guide to help you understand how UnitedHealthcare will reimburse telehealth services during the COVID-19 emergency period. You as a provider are responsible to ensure you submit accurate claims in accordance with state and federal laws and UnitedHealthcare's reimbursement policies. The scenarios are not intended to cover every telehealth service you may perform during the COVID-19 emergency period. As such, please see UHCprovider.com and UnitedHealthcare's reimbursement policies for Medicare Advantage, Medicaid and commercial. Medicaid state-specific coding

may apply and differ from those illustrated in these examples.

Fact Sheet: Expansion of the Accelerated and Advance Payments Program for Providers and Suppliers During COVID-19 Emergency

In order to increase cash flow to providers of services and suppliers impacted by the 2019 Novel Coronavirus (COVID-19) pandemic, the Centers for Medicare & Medicaid Services (CMS) has expanded their current Accelerated and Advance Payment Program to a broader group of Medicare Part A providers and Part B suppliers. The expansion of this program is only for the duration of the public health emergency. Details on the eligibility, and the request process, are outlined in this pdf DOWNLOAD. The information reflects the passage of the CARES Act (P.L. 116-136). **Download PDF at billing-coding.com/pdf/covid19-facts.pdf**

Here's a "cheat sheet" of the new diagnosis coding guidelines for COVID-19. http://www.billing-coding.com/pdf/COVID-19-guidelines-final.pdf

UHC - HIPAA-Approved Telehealth Technologies

The following platforms may be used during the current nationwide public health emergency: Popular applications that allow for video chats — including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype — may be utilized to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency.

Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.

These platforms are NOT approved: Facebook Live, Twitch, Snapchat, TikTok, and similar video communication applications are public facing and should not be used in the provision of telehealth to Optum Behavioral Health plan members by covered health care providers.
Source: UHC

Kareo Survey Reveals Coronavirus Pandemic Impact on Independent Medical Practices and Their Patients

Independent Medical Practices Rapidly Deploying Telemedicine to Offset Steep Drop in Patient Office Visits Due to "Stay at Home" Orders

April 6, 2020 – In a new survey conducted by Kareo, independent medical practices and billing companies shared the unprecedented challenges created for them and their patients by the coronavirus pandemic. Over 600 medical practices and 140 medical billing companies were interviewed by Kareo in late March. The research uncovered the immediate actions medical practices and clinics are taking to ensure patient access to care through telemedicine solutions with 75% reporting either a current telemedicine option or the intent to deploy one soon. The survey also highlighted the risks to patients and independent medical practices with 9% of respondents reporting practice closures with many more concerned about potential practice closures as patient office visits plummet due to "stay at home" orders and other concerns. As Kareo was publishing these survey results, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law, potentially providing a lifeline to the most severely impacted medical practices.

By mid-March, independent healthcare professionals were already facing the practice and personal impacts of the coronavirus pandemic, with 28% of practices only offering telemedicine visits and 9% of practices already closed, with many more concerned about the risk of future closure. While 63% of practices were still delivering on-site care, most of these practices were exploring options to move to hybrid or exclusively telemedicine-based care. Kareo's ongoing analysis of actual patient encounters across over 50,000 medical providers, found that by late March, independent medical practices have experienced an approximately 35% decline in patient volume, raising alarm around both the apparent inability for patients to access care and the operational viability of medical practices if this trend continues.

Kareo's research also highlighted the impact felt by the more than 5,000 medical billing companies across the country, with these service providers reporting immediate impacts on their businesses due to precipitous decline in medical practice patient volume. These companies play a critical role in the healthcare ecosystem by providing medical billing expertise that is essential for the financial viability of many independent medical practices. Financial risk to these service providers creates another risk for medical practices to manage as practice volumes ultimately return to normal.

To address "stay at home" orders and patient concerns about face-to-face medical encounters, healthcare professionals have rapidly turned to telemedicine solutions. By mid-March, fully 41% of independent medical practices reported offering telemedicine, up from 22% reported in Kareo's State of the Independent Practice Report in late 2018. An additional 34% reported current efforts to deploy telemedicine options, which ultimately will result in the vast majority (75%) of medical practices providing remote care solutions. In the third week of March, Kareo saw a 500% week-over-week increase in telemedicine visits while working to accommodate an over 3,000% increase in telemedicine adoption.

The easing of regulatory requirements related to telemedicine security and functionality allowed medical practices to access a broader set of possible telemedicine solutions, ranging from medically-specific options like Kareo Telemedicine that are HIPAA compliant and fully integrated with the broader patient engagement, electronic health record, and billing technology platform all the way to general video call technology such as Apple FaceTime. Easing Medicare, Medicaid, and commercial insurance reimbursement requirements for telemedicine also supported the rapid pivot to virtual-care and are essential in supporting the financial viability of medical practices and their supporting medical billers.

"Independent medical practices stand as the cornerstone of the U.S. healthcare system and are responsible for more than two-thirds of annual patient visits," said Dan Rodrigues, Founder and CEO of Kareo. "Yet our research shows that even doctors are not immune to the economic impact of the coronavirus pandemic. Telemedicine and the CARES Act provide critical lifelines to ensure independent practices remain available to their patients through this crisis."

There are several government programs that practices can take advantage of to ease financial burdens and maintain their current staff levels. Small business loans, tax relief, Medicare payment advances, and grants are a few of the options currently available. In combination, these programs can help ensure that independent medical practices and clinics emerge from the COVID-19 pandemic with minimal damage to the long-term viability of their business.

Source: Kareo.com

Public Health Emergency: Coding and Billing for the Care Provided

There is little sleep going on in the healthcare world right now! From the front lines of the first responders to the back rooms full of coders and billers. The whole world was thrown upside down in a matter of days! We now not only face the day-to-day personal living impacts of COVID-19, but as coders, billers, providers, and managers, we face the day-to-day changes of rules and coding associated with treating our patient base.

These sweeping and continuous changes in guidance have many of us concerned for the backend impact post-PHE (Public Health Emergency). Of course, we understand it takes time to create and modify such changes, but will ill-defined guidance result in recoupments of the payments that are keeping our practices afloat at this time?

During this PHE, CMS and many commercial carriers have relaxed much of the existing telehealth guidance. Many of these new changes are even being changed within a day or two of release.

This has led to many questions, such as the following:

- Which code set should I use?
- Can I use audio only?

- What place of service (POS) should I use?
- Must I use a modifier?
- How can an exam be performed virtually?
- What role does time play in the virtual encounter?
- What about teaching physician services?
- How can I avoid getting laid off?

CMS has released an Interim Final Rule (IFR) for treating patients during this PHE, which can be found by a simple Google search for "CMS Interim Final Rule." As is normal, there is a comment period that ends at 5:00 pm on June 1, 2020. However, the Federal Register has noted the IFR as effective March 31, 2020 with applicability of March 1, 2020, meaning that services rendered since March 1, 2020 are subject to these relaxations and guidance. The publication is 221 pages in total, but most of these questions can be answered with merely a few pages of guidance. As we discuss each of the questions noted above, the source page number(s) will be provided for your reference.

Which code set should you use?
Below, you will find a chart that identifies the distinguishing facts of each recognized telehealth service. The brief overview is:

- CMS relaxed telehealth services.
- There are reimbursable services for audio communication only visits, as well as services that additionally require video.
- Direct supervision can be met via video communication.
- There are certain billing specific rules.

Patient Portal with no audio or video required (pages 53-54)

AMA implemented codes 99421-99423 for online communication between a MD/QHP with an established patient many years ago, but few payors reimbursed this service. CMS has recognized this during the PHE as a reimbursable service, and in addition, CMS has also created the code set G2061-G2063 that is reportable for online communications between ancillary staff and the patient.

Both sets of codes indicate that the code represents all time spent for the patient by the type of provider of the same group, i.e., cumulative time, in the past 7 days (see time per code in the chart below). While most portals have video and/or audio capability, the code set was originally created for encounters in which a patient would have, for example, an email encounter with the patient. This explains why it is not a requirement of the code set.

Both AMA and CMS code sets indicate the codes are reserved for established patients only, and for many telehealth services, CMS has relaxed this requirement as noted in the paragraph that follows the 99421-99423 and G2061-G2063 guidance for reporting:

> *In the context of the PHE for the COVID-19 pandemic, where communications with practitioners might mitigate the need for an in-person visit that could represent an exposure risk for vulnerable patients, we do not believe the limitation of these services to established patients is warranted. While some of the code descriptors refer to "established patient," during the PHE, CMS-1744-IFC 54* **we are exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the code descriptors.** *Specifically, we will not conduct review to consider whether those services were furnished to established patients.*

Audio Only Services (pages 123-125)
Previously, CMS did not pay for 98966-98968 or 99441-99443 as non-face-to-face services were standardly a non-covered CMS service. During this time of PHE, CMS has relaxed this rule and allowed reimbursement for these services. The biggest difference between the two code sets is the rendering provider. In the chart below, you will note that 98966-98968 are rendered by Ancillary Staff while 99441-99443 are reserved for MD and QHP providers. Ancillary Staff are those individuals who provide services as part of the same Tax ID as the supervising provider, but CMS does not recognize them as billable individuals. The 99441-99443

telephone non-face-to-face service codes are to be used by MDs and QHPs (Nurse Practitioners, Physician Assistants, and Clinical Nurse Midwives).

The RVU allocation by CMS is consistent with AMA and noted in the chart below, but what is interesting is the RVU allocation for ancillary staff is the same as the code set for MD/QHP providers.

Audio & Video Services Required (pages 135-137)
In an effort to maintain continuity of patient care through this time of crisis with the easiest transition of billing/coding for these services, CMS has broadened the use of our outpatient/office E&M code category. What a relief this has provided to providers and their billing/coding teams! There are no new codes to figure out and no documentation modifications required. Rather, providers should continue to use the E&M service codes 99201-99215 as they would in their office, ensuring that documentation and medical necessity supports the level of service billed. The use of these standard office services has raised many questions about their virtual use. Let's provide Q&A for the common concerns:

- **Can new patient visits be performed?**
  Yes, this was an additional relaxation provided by CMS.

- **How is an exam performed virtually?**
  The provider can document visual exam findings just as they would in an exam room, as well as patient involvement. For example, the provider could document the patient respiratory effort (accessory muscle use or shortness of breath) and/or have the patient palpate their neck for swollen lymph nodes or palpate their abdomen for pain or guarding.

- **How is the documentation scored for leveling of the E&M service?**
  CMS has advised that we should base the level of service on the documented MDM or time, much like we will in 2021. The leveling difference between now during the PHE and the 2021 guidance is for now, we use the existing MDM rules and guidance. Therefore, during the PHE, we do not need to score the history or exam for telehealth services billed with the office/outpatient E&M code set. If, however, an encounter is billed based on time in lieu of MDM, we then use the 2021 definition of time. Therefore, the total time spent in conjunction with the encounter on that specific date of service may be combined toward the total time selected. Herein lies a concern, however. There is contradictory guidance in what total times we should use when selecting the level of service.

Within the IFR we find the following time guidance:

We note that ***currently, there are typical times associated with the office/outpatient E/Ms, and we are finalizing those times as what should be met for purposes of level selection.*** The typical times associated with the office/outpatient E/Ms are available as a public use file at: https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.

This policy CMS-1744-IFC 137 only applies to office/outpatient visits furnished via Medicare telehealth, and only during the PHE for the COVID-19 pandemic.

This creates confusion as there is certainly a discrepancy noted here. Here is a chart noting the differences in the AMA 2020 typical times, the times noted in the file provided by CMS, and the 2021 total times per AMA 2021 guidance (time range). Of note, it is recommended that each organization use the most conservative time for each level of service. The most conservative time would be the most time required to support that given level of service.

See table next page.

Place of service (POS) reporting (page 15)
This has been a point of confusion as CMS changed the original POS guidance. The IFR states that the encounter should be billed with the POS that the provider would have used had the encounter occurred outside of the PHE. Therefore, if your provider typically sees patients

CPT Code	Current Typical Time	2021 AMA Time Guidance	CMS Time File	Most Conservative Approach
New Patient				
99201	10	N/A	17	17
99202	20	15-29	22	23-29
99203	30	30-44	29	31-44
99204	45	45-59	45	46-49
99205	60	60-74	67	68-74
Est. Patient				
99212	10	10-19	16	17-19
99213	15	20-29	23	24-29
99214	25	30-39	40	40
99215	40	40-54	55	55

in an office setting utilizing POS 11, you could continue to use POS 11.

Modifier Usage (page 15)
This guidance was also updated by CMS within the IFR. Therefore, modifier 95 should be appended to all services rendered as a telehealth type of service.

Modification of Direct Supervision (pages 56-57)
The IFR states that direct supervision, during the PHE, can be met through telecommunications means. Below we will discuss this impact on teaching physicians, but here let's make this applicable to incident-to services. Services rendered by QHP individuals (nurse practitioner, physician assistant, clinical nurse midwife, clinical psychologist, or LCSW) can only meet incident-to rule specifications if the supervising MD is in telecommunications with the QHP at the time of the encounter. While this is possible, it seems unlikely that two providers would be involved in a telehealth encounter. However, if this occurs, then incident-to is met.

Teaching physician services (page 106 – 108)
The question quickly emerged about teaching physician services and if residents can provide telehealth encounters. The answer is a resounding yes, as made guidance through the IFR, provided preceptorship with direct supervision is met. As stated above, direct supervision throughout the PHE can be met through telecommunications applications that include real-time audio and video. Direct supervision through these specifications applies to services rendered in primary care exception areas, non-primary care exception areas, and also in reading test and imaging results.

The IFR includes many other rules and regulations that are applicable during this PHE, but these are the more pressing matters related to coding, billing, and documentation. Other services can be provided through telehealth means, such as ED visits, mental health services, and other therapy services. This article has focused on office/clinic visit services.

I mentioned at the beginning of this article a concern made by a nurse practitioner friend of mine, fearing lay off from the family practice that she currently works for. I bring this into the conversation of this article because with these CMS relaxations, which are also being followed by most commercial carriers, treating patients through telehealth encounters (upon consent by the patient) is not only a way to continue patient care and interaction, but also to keep clinical teams productive and billings consistent. Organizations are allowed to educate their patients on telehealth services in lieu of cancelling appointments. Upon verbal consent, the patient encounter can proceed as a telehealth service.

Daily, whether treatment related or geographical exposure, COVID-19 details are changing. Upon writing this article

today, national news is advising that our current PHE could linger until the beginning of June. Daily, we are being introduced to a new interim normal. Dedicate an individual on your team to begin a patient education initiative on telehealth services. Be creative, create a video for your website (everyone has a video camera on their phone), send out postcards, make patient calls, or reference CMS patient deliverables on how they can maintain chronic issues, treat acute complaints, and maintain their wellness in the safety of their quarantined home.

NAMAS has created a resource page with a wide variety of COVID-19 support. We are committed to updating this webpage and providing newsworthy blasts of information to all of our contacts. **Please visit this site at https://namas.co/covid-19-support/.**

Also, CMS published a wonderful video (approximately 16 minutes in length) outlining many of the details of telehealth services during the COVID-19 crisis. This video can be found at: https://www.youtube.com/watch?v=bdb9NKtybzo&feature=youtu.be

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Download this chart at https://www.billing-coding.com/pdf/namascpt2020.pdf

namas national alliance of medical auditing specialists

CPT Code	Brief Description	Time Required	Provider Type Allowed	Total RVUs*	New, Established, or Both	Audio, Video, or Portal Required	Audio & Video Required	Online Portal Required
98966	Telephone assessment & management	5-10	Ancillary Staff	0.4	Both	Audio	No	No
98967	Telephone assessment & management	11-20	Ancillary Staff	0.78	Both	Audio	No	No
98968	Telephone assessment & management	21-30	Ancillary Staff	1.14	Both	Audio	No	No
99441	Telephone assessment & management	5-10	MD or QHP	0.4	Both	Audio	No	No
99442	Telephone assessment & management	11-20	MD or QHP	0.78	Both	Audio	No	No
99443	Telephone assessment & management	21-30	MD or QHP	1.14	Both	Audio	No	No
G2061	Online digital E&M service	5-10	Ancillary Staff	0.34	Both	Portal**	No	Yes
G2062	Online digital E&M service	11-20	Ancillary Staff	0.6	Both	Portal**	No	Yes
G2063	Online digital E&M service	21+	Ancillary Staff	0.94	Both	Portal**	No	Yes
99421	Online digital E&M service	5-10	MD or QHP	0.43	Both	Portal**	No	Yes
99422	Online digital E&M service	11-20	MD or QHP	0.86	Both	Portal**	No	Yes
99423	Online digital E&M service	21+	MD or QHP	1.39	Both	Portal**	No	Yes
G2010	Evaluation of video or image not related to a previous E&M	N/A	MD or QHP	0.34	Established	Audio, Video, or Portal	No	No
G2012	Technology-based brief patient communication (virtual check-in)	5-10	MD or QHP	0.41	Established	Audio, Video, or Portal	No	No
99201	Telehealth E&M Service- Render & Report same as pre-PHE, but Include modifier 95 Straightforward MDM	MDM or Time 10	MD or QHP	1.39	Both	Audio, Video, or Portal	Yes	No
99202	Telehealth E&M Service- Render & Report same as pre-PHE, but Include modifier 95 Straightforward MDM	MDM or Time 20	MD or QHP	2.14	Both	Audio, Video, or Portal	Yes	No
99203	Telehealth E&M Service- Render & Report same as pre-PHE, but Include modifier 95 Low MDM	MDM or Time 30	MD or QHP	3.03	Both	Audio, Video, or Portal	Yes	No
99204	Telehealth E&M Service- Render & Report same as pre-PHE, but Include modifier 95 Moderate MDM	MDM or Time 40	MD or QHP	4.65	Both	Audio, Video, or Portal	Yes	No
99205	Telehealth E&M Service- Render & Report same as pre-PHE, but Include modifier 95 Typically not a telehealth encounter High MDM	MDM or Time 60	MD or QHP	5.85	Both	Audio, Video, or Portal	Yes	No
99212	Telehealth E&M Service- Render & Report same as pre-PHE, but Include modifier 95 Straightforward MDM	MDM or Time 10	MD or QHP	1.28	Both	Audio, Video, or Portal	Yes	No
99213	Telehealth E&M Service- Render & Report same as pre-PHE, but Include modifier 95 Low MDM	MDM or Time 15	MD or QHP	2.11	Both	Audio, Video, or Portal	Yes	No
99214	Telehealth E&M Service- Render & Report same as pre-PHE, but Include modifier 95 Moderate MDM	MDM or Time 25	MD or QHP	3.06	Both	Audio, Video, or Portal	Yes	No
99215	Telehealth E&M Service- Render & Report same as pre-PHE, but Include modifier 95 Typically not a telehealth encounter High MDM	MDM or Time 40	MD or QHP	4.11	Both	Audio, Video, or Portal	Yes	No

*Total RVUs, non-facility, national, par
**Follow-ups may be conducted over phone or email

YOUR ROADMAP TO NAVIGATING THE UPCOMING CHANGES

E&M CHANGE JUST AHEAD

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NAMAS E&M Comparison Chart

E&M Component	Didactic Definition	2019	2020	2021
Chief Complaint	Describes the reason for the patient/provider interaction.	No changes	No changes	No changes
History of Present Illness (HPI)	Symptoms that describe the nature and severity of the patient's presenting problem(s).	CMS now allows ancillary staff to document the HPI on behalf of the provider. The provider is responsible for verifying the accuracy of the collected information. Please note this is a CMS change and therefore you should consult individual commercial payers and state Medicaid programs to see if they are following CMS. Additionally, CMS now allows the provider to only document interval changes from the previous encounter. However, documentation requirements for specific numbers of HPI elements still apply.	No changes	HPI should describe the nature and severity of the patient's presenting problem(s) as medically indicated, but will no longer be scored for the purposes of the E&M documentation requirements. Please note it will still be needed to support medical necessity for the encounter.
Review of Systems (ROS)	Describes how each organ system is being impacted by the presenting problem(s) of the patient.	CMS now allows the provider to only document interval changes from the previous encounter. However, documentation requirements for specific numbers of ROS elements still apply.	No changes	ROS should specify whether organ systems are or are not impacted to demonstrate the complexity of the condition(s). This portion of the documentation will no longer be scored, but will still be needed to support medical necessity.
Past, Family, Social, History (PFSH)	PFSH indicates areas of concern within the patient's personal, social, and family history that could impact treating the patient's current presenting problem.	CMS now allows the provider to only document interval changes from the previous encounter. However, documentation requirements for specific numbers of PFSH elements still apply.	No changes	PFSH should be used to capture medically appropriate historical information, but will no longer be scored for the purposes of the E&M documentation requirements.
Exam	This quantifies the hands-on physical examination work performed by the provider, and may be documented using either 1995 or 1997 Documentation Guidelines.	CMS now allows the provider to only document interval changes from the previous encounter. However, documentation requirements for specific numbers of exam elements (e.g. bullets for body areas, organ systems) still apply.	No changes	The exam should be medically appropriate as determined by the provider of care. This component will no longer be scored for determining the level of E&M service, but it could still impact the level of service supported based on the medical necessity shown in the documented exam.
Encounter Diagnosis	This section credits the provider for each diagnosis treated, based on documentation during the encounter.	No changes	No changes	AMA E&M Guidelines indicate that only diagnoses documented as active treatment during the encounter will be credited for scoring purposes. The revised Table of Risk created by the AMA removes "additional work up" as a consideration for each diagnosis.
Data & Complexity	This section uses a point system to quantify the amount of work performed with respect to obtaining and/or analyzing medical data (such as diagnostic test results) pertaining to the encounter that goes beyond the physical exam.	No changes	No changes	The AMA has taken most of the elements from the Marshfield chart of Data & Complexity and incorporated them here. Changes include new requirements for specific combinations of different work elements to support a specific level of service.
Table of Risk (TOR)	In this section, the highest level of risk of mortality and/or morbidity posed by the presenting problems, ordered diagnostics, or ordered interventions, is identified and selected based on the entirety of the documentation.	No changes	No changes	The AMA revised the TOR, consolidating it into one column on the new MDM table, and this column now uses only the last column on the original TOR (treatment options for the patient).
Time	The use of face time spent with the patient as the determining factor in selecting E&M levels of service.	No changes	No changes	There are 2 changes: 1) The limitation on the use of time is deleted. Therefore, there will be NO requirement that the visit must be "dominated" by counseling and/or coordination of care. 2) Time spent now includes the rendering provider's total time spent on the day of the encounter, including non-face-to-face time spent on the specific encounter and patient.

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HTTPS://NAMAS.CO/2021-CHANGES

COVID-19 & Medical Practices:

Updating Protocols for Rep Engagement and Communication

As the world enters uncharted territory with COVID-19, we at RxVantage would first and foremost like to thank you for all that you do every day to keep us, our families, our friends, and our communities healthy and safe.

Our mission has always been to drive educational interactions between medical practices and life science experts with the ultimate goal of improving patient care. We have head from many practices how difficult it is to stay on top of the ever-evolving guidelines and best practices for how to provide excellent patient care in a pandemic. It is for this reason that our platform is (and always has been) free, to help you stay informed so you can focus on what matters most—your patients.

Below are some patterns we've seen emerging within our community of thousands of medical practices:

1. Ban on non-essential personnel: In communities with a large presence of COVID-19, many practices are temporarily suspending on-site appointments with non-essential personnel, such as life science reps and experts, most for 4-6 weeks. These restrictions are expanding across the country and treated as preventative measures in practices of all specialties. See below for a sample vendor/rep protocol that a large health system sent out to all of their reps.

Some questions to consider as you build a policy specific to your practice include: Are there any reps allowed in your practice, and if so, what safety protocols or social distancing measures must reps acknowledge and adhere to? What is the protocol (who and how) for requesting/approving reps to enter your office during this time? Do you have a plan in place to maintain communication with reps if visits are banned? If you are still accepting lunches, are there local restaurants that have pre-packaged options? How can educational materials be distributed if visits are restricted?

Schedule changes can be implemented quickly through free technologies, such as RxVantage. These types of automated tools send notifications to reps when appointments are canceled, and prevent new meetings from being scheduled outside of the office's unique policy. Practice managers and administrators that are able to leverage these tools can have confidence that the system is taking care of previously manual tasks, and allows them to focus their time and attention on other, more urgent, tasks.

2. Increased communication with life science reps: During the COVID outbreak, many medical offices have dramatically increased communication with their local reps. While reps and other industry experts might not be a first priority, they do represent a community that needs to be addressed—and the quicker that can happen, the better. Through RxVantage's online messaging platform, practices are efficiently providing real-time updates about evolving policies and protocols through group or individual messages. What was previously viewed as a nice-to-have feature to find and message the right reps as needed, has become an essential communication tool, overnight. Knowing that all reps receive their updates gives these practices further confidence that reps know how to act in their practice or not come in at all.

3. Scheduling sample drops: Practices that rely on reps for sam-

ples are developing new protocols to ensure their supply isn't disrupted. They are designating very specific times and appointments for sample drops and new locations where they will be signed for, depending on their physical office space. For example, some practices will designate 30-minute time slots twice a week, with instructions to use a side door or even stay in their vehicles. Ensure any sanitation or sterilization procedures are clear and followed, and consider designating a single staff member to collect the samples.

4. Remote meetings: Telemedicine is seeing a boom in the field, and many practices are also setting up phone or web meetings with nurse educators, reimbursement specialists, MSLs, etc. Many platforms are available to coordinate remote meetings, and Google & Microsoft are among companies providing free premium-level accounts during the pandemic to help people stay connected.

5. Universal COVID protocols: Some large medical groups and systems are rolling out these new protocols across all of their practice locations to ensure consistency of communication and enforcement of their policies.

Jeremy Gilman writes for RxVantage. www.rxvantage.com

As a free service, RxVantage has compiled sample policies, best practices, and insights from thousands of medical practices about updating and communicating protocols for life science reps. In this succinct, 15-minute webinar, learn about strategies to stay in touch with nurse educators, reimbursement specialists, and MSLs so they can continue to educate your care team and provide critical samples and resources.
https://www.billing-coding.com/tracking/rx.cfm

Download Sample Vendor / Rep Policy
https://www.billing-coding.com/pdf/ Sample-Vendor.docx

Sample Vendor/Rep Policy Update:

COVID-19 Vendor/Rep Visitation Protocol Update

[PRACTICE NAME] is strongly committed to the health and well-being of our patients, team members, physicians, and community. With a growing number of confirmed cases of Coronavirus Disease 2019 (COVID-19) in the United States, it is imperative we take action to provide appropriate care and a safe environment for our patients, visitors, and employees.

Effective immediately, we have adopted the following protocols to better protect our patients, team members, and visitors, and to help prevent the spread of COVID-19.

INDUSTRY EXPERT/REP GUIDELINES

- Until further notice, no vendor/rep shall make on-site visits unless an appointment is scheduled and pre-approved by [Practice Name].
- All on-site visits are covered under these guidelines, including meals, non-meal in-services, clinical education sessions, and sample drops.
- Visits will be requested through [rep portal name] by [Approved Individual].
- Sample drops are now limited to [Specific day and time] and are only approved if directly requested by [Approved Individual/Entity]. Sample drops will be signed for [New Signing/Location Protocol].
- All industry experts/reps must acknowledge the below guidelines.

We value our community of industry experts and will continue to need your support, expertise, and resources during this time. Any further updates to our policies and protocols will be communicated.

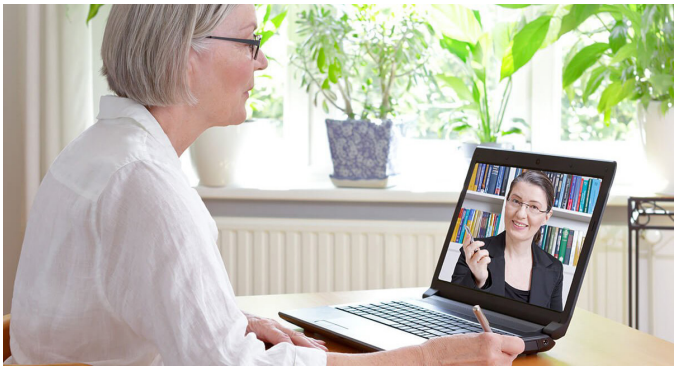
ACKNOWLEDGMENT

[Practice Name] asks for your diligence in this matter in an effort to keep our patients and team members safe. By acknowledging this policy, you attest that:

1. You have read, understand, and will strictly comply with these guidelines.
2. You will not enter our building if you have a fever, cough, shortness of breath, or respiratory illness, or have exhibited any of these symptoms in the last 24 hours.
3. You have not traveled internationally, been on a cruise, or traveled to or from a CDC-designated area with widespread or ongoing community spread.
4. You have not been in close contact with someone who has traveled internationally, been on a cruise, or traveled to or from a CDC-designated area with widespread or ongoing community spread.
5. You have not been in close contact with anyone with a confirmed case of COVID-19.

Please respond, "I acknowledge the COVID-19 Vendor//Rep Protocol Update."

Setting The Scene: Telehealth



- Minimize any potential distractions in view of the camera in your workspace. Similarly, encourage caregivers to minimize distractions in the room where the patient will be completing the session.
- Young patients say they prefer a "less formal" room set-up, so you may wish to avoid having a table between the patient and the video-recording device (or you and the video-recording device).
- Many seating arrangements can work for children. Children can sit next to the caregiver, between the caregivers, on a caregiver's lap, or in front of the caregiver in either their own chair or on the floor.
- Larger rooms tend to work best with younger patients, so they can move around. In addition, if a child's motor skills, play, exploration, and movements are being assessed, the room should be large enough for this activity to fit within the camera frame.
- Teens may prefer to be seen without a caregiver present. Use clinical judgment to ensure appropriate privacy is maintained (e.g., patient feels comfortable they are not being overheard). If a patient expresses any discomfort with full video, text/chat functions are available in some telehealth systems and may be useful for older patients (likely over 11 years old).
- Ensure your video is sufficiently "zoomed in" for the patient to see your facial expressions.
- Try to maintain a constant gaze into the camera, rather than frequently looking away at your computer or notes. • If you can, use picture in picture feature (e.g., where you can see both yourself and the patient) to see how you are being viewed by the patient, or if there is something distracting in the background (e.g., your cat!).
- Patients may enjoy using telehealth background features. This can support the patient's sense of control, by allowing the patient to choose the "location" for next session (e.g., in outer space or even upload a background picture of a favorite location).

Ways to Introduce Telehealth to Patients

The following recommendations must be adapted to the developmental age of the patient:

- Ask whether the patient has ever seen a doctor on a phone or computer. If the patient has not used telehealth, it may be helpful to refer to common lay technology (i.e. Facetime, Skype, or Zoom) and explain key differences.
- Let patients know why telehealth is being used. For example, "mental health clinicians are using technology to meet with patients during the COVID-19 outbreak so that everyone can stay as healthy as possible," or "I am using this so I don't have to use a face mask to see you today."
- Communicate to patients that the session is happening in "real time," if needed. You may demonstrate this by comment-

ing on the patient's gestures, or what they are wearing, saying that "everything you can see about me, I can see about you. For instance, you are wearing…" and "you just…" Children in particular seem to enjoy this exercise and proof that they are being seen.

- Discuss security, if needed. For example, teens might understand the concept of encrypted technology, which is the HIPAA (Health Information Portability and Accountability Act) standard. If younger children express any concerns about who else can hear or see them, it can be described as having an "electronic tunnel from the camera where the clinician is sitting to the one where the patient is sitting." Additional information regarding technological specifications should be available if requested. Some patients appreciate being reassured that the session is not "on the internet" in the sense that it can neither be openly viewed nor will it be placed online.
- It is important to inform patients if a session is being recorded. If you want to record a session, then you must obtain explicit consent from the patient. Teen patients who are recorded may appreciate information about what recorded information may be shared with their parent (e.g. substance use, sexual activity, etc.). As appropriate, provide information about mandatory disclosures. If sessions are being recorded solely for supervision purposes, this may also be shared with the family so as to diffuse any worry about loss of privacy.
- Establish a visual context of where you are sitting. Ask patients if they would like to see your office. Using the camera's zoom and pan features or manually moving your device, you can give patients a virtual tour of your workspace to assure them that no one else is present and to provide context to the clinical setting. After the tour, let the patient know that the camera will be zoomed in so that the patient can see your facial expressions.
- Discuss any technical difficulties noticed immediately as they arise during the introduction. For instance, if there is a slight lag in audio that makes it seem as if you and patient are talking over each other, you can suggest adding a small pause after each statement. Socialize youth to the videoconferencing system, and highlight that it might take time to acclimate to the technology and "not talk over each other."
- Give patients an opportunity to ask questions before starting the session. This may be especially helpful to younger and older patients who are not as comfortable with electronic media.

Source: researchgate.net

FBI Warns of Teleconferencing and Online Classroom Hijacking During COVID-19 Pandemic

As large numbers of people turn to video-teleconferencing (VTC) platforms to stay connected in the wake of the COVID-19 crisis, reports of VTC hijacking (also called "Zoom-bombing") are emerging nationwide. The FBI has received multiple reports of conferences being disrupted by pornographic and/or hate images and threatening language.

Within the FBI Boston Division's area of responsibility (AOR), which includes Maine, Massachusetts, New Hampshire, and Rhode Island, two schools in Massachusetts reported the following incidents:

- In late March 2020, a Massachusetts-based high school reported that while a teacher was conducting an online class using the teleconferencing software Zoom, an unidentified individual(s) dialed into the classroom. This individual yelled a profanity and then shouted the teacher's home address in the middle of instruction.
- A second Massachusetts-based school reported a Zoom meeting being accessed by an unidentified individual. In this incident, the individual was visible on the video camera and displayed swastika tattoos.

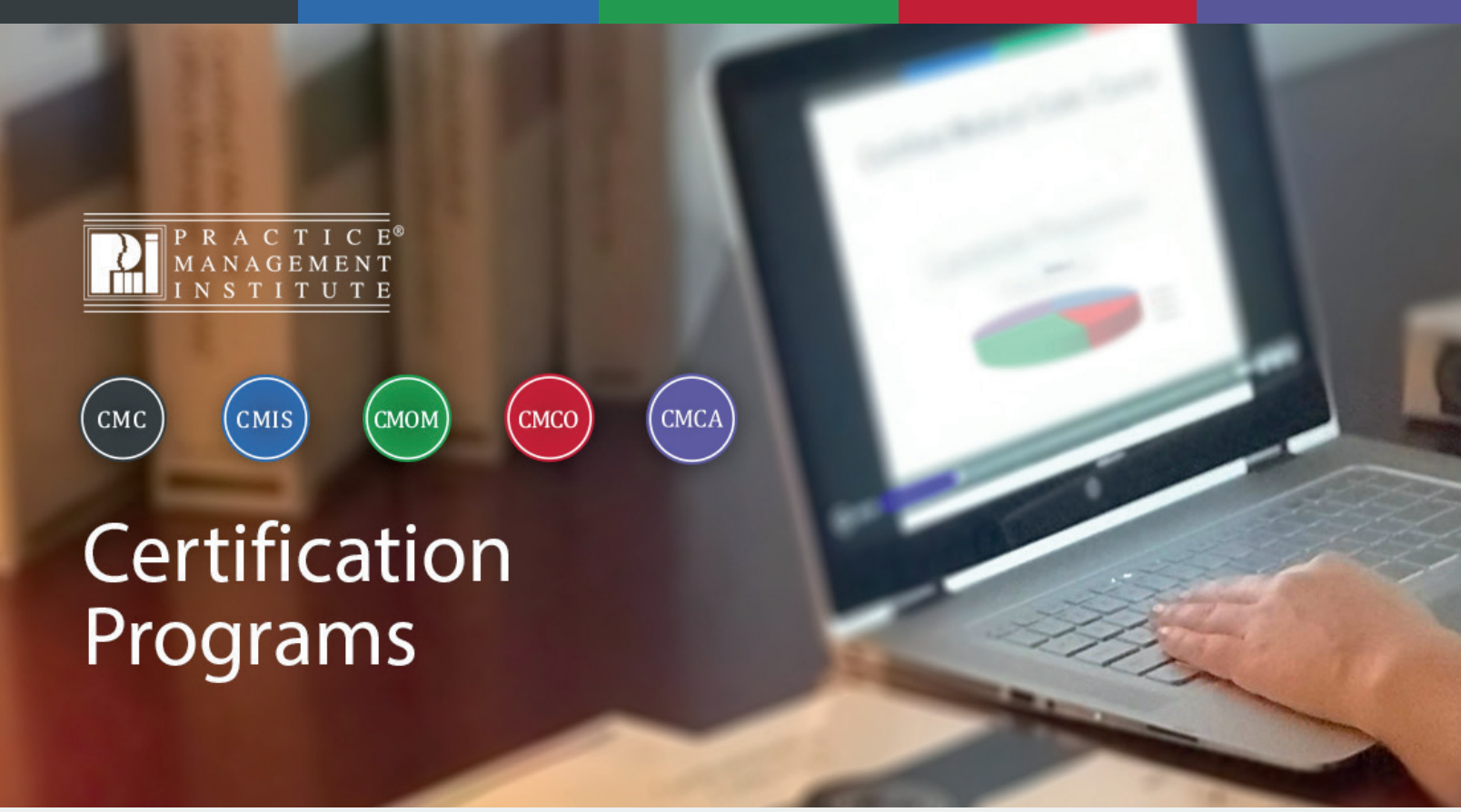
As individuals continue the transition to online lessons and meetings, the FBI recommends exercising due diligence and caution in your cybersecurity efforts.

The following steps can be taken to mitigate teleconference hijacking threats:

- Do not make meetings or classrooms public. In Zoom, there are two options to make a meeting private: require a meeting password or use the waiting room feature and control the admittance of guests.
- Do not share a link to a teleconference or classroom on an unrestricted publicly available social media post. Provide the link directly to specific people.
- Manage screensharing options. In Zoom, change screensharing to "Host Only."
- Ensure users are using the updated version of remote access/meeting applications. In January 2020, Zoom updated their software. In their security update, the teleconference software provider added passwords by default for meetings and disabled the ability to randomly scan for meetings to join.
- Lastly, ensure that your organization's telework policy or guide addresses requirements for physical and information security.

If you were a victim of a teleconference hijacking, or any cyber-crime for that matter, report it to the FBI's Internet Crime Complaint Center at ic3.gov. Additionally, if you receive a specific threat during a teleconference, please report it to us at tips.fbi.gov or call the FBI Boston Division at (857) 386-2000.

Source: fbi.gov



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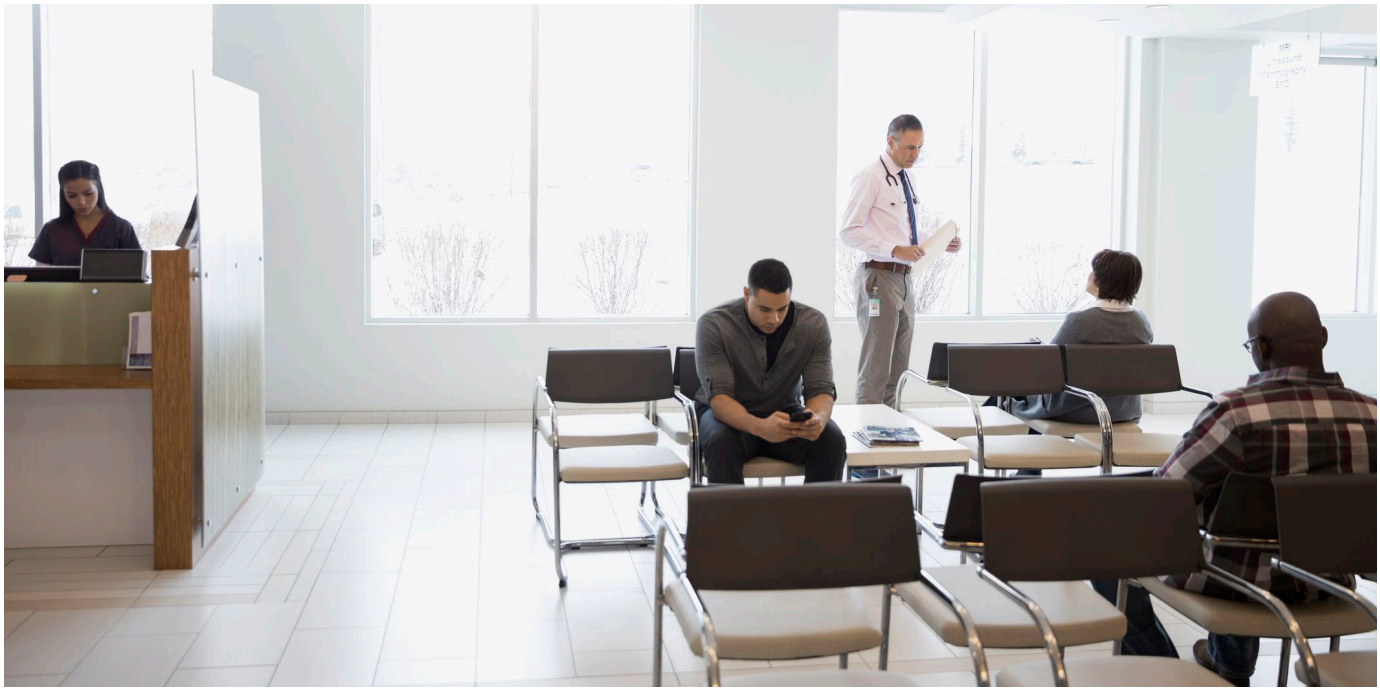
Transitional Care Management

There are three kinds of care for a Medicare patient after being an inpatient. They are Transitional Care, Chronic Care Management, and Complex Care Management. Each of these is a critical component of primary care that contributes to better health and care for beneficiaries.



Transitional care management (TCM) is the coordination and continuity of healthcare during a movement from one healthcare setting to either another or to home. It addresses the period between the inpatient stay and community setting. After a hospitalization or other inpatient facility stay (e.g., in a skilled nursing facility), the patient may be dealing with a medical crisis, new diagnosis, or change in medication therapy.

The discharge may be from:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation
- Hospital outpatient observation
- Partial hospitalization

After inpatient discharge, the beneficiary must return to their community setting, such as:
Home, Domiciliary Care, Rest Home, or Assisted Living Facility.

The requirements for TCM services include services during the beneficiary's transition to the community setting following particular kinds of discharges:

- Healthcare professionals accepting care of the beneficiary post-discharge from the facility setting without a gap

- Healthcare professionals taking responsibility for the beneficiary's care
- Moderate or high complexity medical decision-making for beneficiaries who have medical and/or psychosocial problems

These healthcare professionals may furnish TCM services:
- Physicians (any specialty)
- Non-Physician Practitioners (NPPs) legally authorized and qualified to provide the services in the State where they furnish them
- Certified Nurse-Midwives (CNMs)
- Clinical Nurse Specialists (CNSs)
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)

Note: CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services "incident to" the services of a physician and other CNMs, CNSs, NPs, and PAs.

One must furnish the required face-to-face visit under minimum direct supervision, subject to applicable State law, scope of practice, and the Medicare Physician Fee Schedule (PFS) incident to rules and regulations and may provide the non-face-to-face services under general supervision. These services are also subject to applicable State law, scope of practice, and the PFS incident to rules and regulations. The practitioner must order services, maintain contact with auxiliary personnel, and retain professional responsibility for the services.

Within two (2) business days following the beneficiary's discharge, a member of the practice must make an interactive contact with them and/or their caregiver via telephone, email, or face-to-face. You or clinical staff can address patient status and needs beyond scheduling follow-up care. Report the service if you make two or more unsuccessful separate attempts in a timely manner. Document your attempts in the medical record if you meet all other TCM criteria. Continue your attempts to communicate with the beneficiary until they are successful. If the face-to-face visit is not within the required timeframe, you cannot bill TCM services (for more information, see the Face-to-Face Visit section).

The provider must furnish non-face-to-face services to the beneficiary, unless you determine they are not medically indicated or needed. Clinical staff under your direction may provide certain non-face-to-face services.

Services Furnished by Physicians or NPPs

Physicians or NPPs may furnish these non-face-to-face services, such as:
1. Obtaining and reviewing discharge information (for example, discharge summary or continuity-of-care documents)
2. Reviewing the need for, or follow-up on, pending diagnostic tests and treatments
3. Interacting with other healthcare professionals who will assume or reassume care of the beneficiary's system-specific problems
4. Provide education to the beneficiary, family, guardian, and/or caregiver
5. Establish or reestablish referrals and arrange for needed community resources
6. Assist in scheduling required follow-up with community providers and services

Services Provided by Clinical Staff Under the Direction of a Physician or NPP

Clinical staff under the provider's direction may provide these services, subject to the State's supervision law, and other rules already discussed:
- Communicate with agencies and community services the beneficiary uses
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living
- Assess and support treatment adherence and medication management
- Identify available community and health resources
- Assist the beneficiary and family in accessing needed care and services

The 30-day TCM period begins on the beneficiary's inpatient discharge date and continues for the next 29 days. The provider must furnish medication reconciliation and management on or

before the date of your face-to-face visit.

The provider must furnish one face-to-face visit within certain timeframes described by the following two Current Procedural Terminology® (CPT) codes:

- 99495 – moderate medical complexity requiring a face-to-face visit within 14 days of discharge
- 99496 – high medical complexity requiring a face-to-face visit within seven days of discharge

CPT® Code 99495 – Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 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

CPT® Code 99496 – Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision-making of high complexity during the service period; Face-to-face visit, within 7 calendar days of discharge

Medical decision-making is selected according to the definitions in the 1995 and 1997 E/M Guidelines.

Telehealth Services

A provider may furnish CPT codes 99495 and 99496 via telehealth. Medicare pays for a limited number of Part B services a physician or practitioner furnishes to an eligible beneficiary via a telecommunications system. Using eligible telehealth services substitutes for an in-person encounter.

This list provides billing TCM services information:

- Only one healthcare professional may report TCM services.
- Report services once per beneficiary during the TCM period.
- The same healthcare professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. The required face-to-face visit may not take place on the same day you report discharge day management services.
- Report reasonable and necessary evaluation and management (E/M) services (except the required face-to-face visit) to manage the beneficiary's clinical issues separately.
- The healthcare provider may not bill TCM services and services within a post-operative global surgery period

(Medicare does not pay TCM services if any of the 30-day TCM period falls within a global surgery period for a procedure code billed by the same practitioner).

When one reports CPT® codes 99495 and 99496 for Medicare payment, do not report the following codes during the TCM service period:

- Care Plan Oversight Services
- Home health or hospice supervision: HCPCS codes G0181 and G0182
- End-Stage Renal Disease services: CPT® codes 90951–90970
- Chronic Care Management (CCM) services (CCM and TCM service periods cannot overlap)
- Prolonged E/M Services Without Direct Patient Contact (CPT® codes 99358 and 99359)
- Other services excluded by CPT® reporting rules.

What is Necessary for documentation of TCM?

At a minimum, document the following information in the beneficiary's medical record:

- Beneficiary discharge date
- Beneficiary/Caregiver interactive contact date
- Face-to-face visit date
- Medical complexity decision-making (moderate or high)

As healthcare moves from volume to value, TCM will be increasingly important. This service ensures that patients receive the care they need immediately after a discharge from a hospital or other healthcare facility. Continuity of care provides a smooth transition for patients that improves care and quality of life, and helps prevent unnecessary readmission, thereby reducing costs.

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.

"COVID-19"

Where We Are, Where Things Are Going, & Creating a Contingency Plan for the Future

Sean M. Weiss
Partner, Vice President of Compliance
CHC, CEMA, CMCO, CPMA, CPC-P, CMPE, CPC

The proverb, "The night is always darkest just before the dawn," meaning there is hope even in the worst of circumstances, is ringing true as we continue to trudge along this COVID-19 pandemic. Life is a giant lesson; we come into this world knowing nothing, and we sometimes leave it forgetting all that we acquired along the way. Emergencies, disasters, epidemics, and pandemics all mean that something bad is happening or has already happened.

To combat or deal with it, we must be resourceful, but more importantly, we must find ways to collaborate and cooperate with each other. COVID-19 has brought out the best (the dedicated men and women on the front lines in healthcare) and worst in people (e.g., https://www.justice.gov/usao-nj/pr/georgia-man-arrested-orchestrating-scheme-defraud-health-care-benefit-programs-related) and has shown us that even our government is vulnerable yet can come together when necessary as a unified body for the people as they did with the passage of the recent stimulus package (CARES) with a 96-0 vote.

Throughout this pandemic, I have learned new things or pulled from skills acquired during my 20s to aid not only my family who looks to me in times of difficulty but also clients who depend on me to bring a sense of calm and direction to their organization and to ensure they are doing the right thing and not making decisions in the wake of the moment that could have long-term, negative repercussions. I have also strengthened relationships with colleagues, my firm's partners, and members of the best professional organization someone can be a part of: The National Society of Certified Healthcare Business Consultants, or NSCHBC (https://nschbc.org/home). It is these small things that have allowed me to stay steady and full-speed ahead. I have taken time to read more than I ever have before, and faster. I have tried to find humor when appropriate and remain dignified at all times, regardless of a situation someone has put me in. I find solace in many words, including those of George H. W. Bush, "I do not mistrust the future; I do not fear what is ahead. For our problems are large, but our heart is larger." Regardless of your political affiliation, those words should ring true for all in times of crisis; I just wish they remained with us when times are good.

In a crisis, emergency, or pandemic, which happen from time to time like the one the world is experiencing right now with COVID-19, it is vital that you have preparedness, or what is better referred to as a Contingency Plan, in place. The question is, how do you prepare one, and how complex should it be? This article is structured to provide you with the steps necessary and what they consist of, but keep in mind that once a crisis hits, it's too late to start planning—as many are figuring out right now. However, we can take the lessons learned during a crisis and use those in the future to keep from making the same mistake(s) and being better prepared to deal with what comes our way.

To the bad news first (as if the COVID-19 pandemic wasn't enough), at the conclusion of this pandemic and within a year, insurance companies are going to engage in audits related to services billed throughout the crisis. This means, as with all documentation, it must be complete and legible, and most importantly, support the complexity of decision-making and the necessity of the service(s) being performed. This, however, is where it gets tricky, because there has been so much information flooding us that it makes it hard to know what to follow.

Here are my top five (5) recommendations:

1. Follow CMS Guidelines (even though they have to make frequent amendments) since they are the "Gold Standard" that pretty much all insurance companies emulate. Commercial payers, while they may follow CMS, often vary in their claims processing, so check their websites and press releases often;
2. The AMA, Management, and Specialty Societies do not set payment policy; thus, their releases are opinion(s) and hopes that insurance companies will adopt or consider their position(s);
3. Don't take the first piece of guidance issued as gospel, since it's certain to change. Stay current with all things COVID-19;
4. Don't cut corners on your documentation as audits are inevitable;
5. Don't take unnecessary chances; billing for services either not rendered or not rendered as the code description suggests will result in bad things happening to your practice.

The OIG has made it clear that they will seek out those who take advantage during this crisis, and along with the DOJ and/or AUSA, will prosecute to the fullest extent of the law.

As with all things, the threat of litigation during or following the end of the COVID-19 pandemic is a real possibility. Unfortunately, there are those who prey on the vulnerable and look for any opportunity to generate revenue. At DoctorsManagement, LLC, our goal and sole purpose is to empower providers to succeed and to mitigate risk at every turn. As such, it is our position that all practices, regardless of size, need to obtain Employer Practices Liability Insurance (EPL) ASAP. If your practice/organization already has it, it

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is our recommendation that you consider upping your current limits through a discussion with your licensed agent. There is an industry expectation on the legal side that there will be "an onslaught of litigation over the new leave policies in the FFCRA" (Amanda Waesch, JD/BMD). It is advised by both DoctorsManagement, LLC and the respected organizations with which we work and affiliate that providers **MUST DOCUMENT YOUR DECISION-MAKING PROCESS AND ALL GOOD-FAITH EFFORTS TO COMPLY IN YOUR SEPARATE COVID-19 COMPLIANCE FILE!**

Let's shift to Contingency Planning. I am and have been a "prepper" for almost two decades, and while many have teased me about it over the years, I stuck with it and held on to my training so that in the event TSHTF, my family and closest friends would be well protected and have the essentials to survive long-term if everything were to shut down. Part of my planning was to create a contingency plan so that each member of my family, whether they were at my home or in another location, would know the steps to take to ensure their safety and security until the all-clear was given. I am fortunate that in our family, my son is a First Responder (Firefighter/EMT), as is one of my brothers-in-law, and my son-in-law is in the Army Special Forces; and as such, they bring another level of preparedness to our family. Since this article is not about escape and evade or how to survive off-grid after a nuclear or biological fallout; I will focus on just the basic steps to follow in order to create an effective contingency plan.

In the book, The Art of War, Sun Tzu states, "Plan for what is difficult while it is easy, do what is great while it is small." As a Compliance Officer, my job is not only to focus on policy and procedure but to develop contingency plans for each of my clients based on their size and geographic location. It is critical here, just like with OIG Compliance, that it's not one size fits all. Each plan has to be tailored to the organization and the individuals that make it up, and since I cannot be there with them during a crisis to hold their hand step-by-step, they will have to depend on their training and what they retained during education sessions prior to the crisis to ensure they come out on the other side just fine.
Obviously, the bigger your practice, hospital network, or delivery health system, the more moving parts there will be, and the higher-levels of complexity there will be with your plan.

The key to creating a successful Contingency Plan is scalability. I think we have all learned a significant lesson with COVID-19, which is, no matter how small your company, how long you have been in business, and what sector you operate in, a contingency plan is an absolute must-have.

Being from Georgia, I am a meat and potatoes kind of guy, which means you can keep the sides of veggies for someone else; and that is precisely how I write.

So, let's get after it by focusing on the essentials of a contingency plan:
A contingency plan is nothing more than a set of steps that are in writing, much like your policies would be for OIG, HIPAA, OSHA, etc. The steps that your team must take during an emergency need to be written in plain text and in a manner that is easy to follow since they will most likely be used during the actual emergency. If you make things too convoluted or jargon-filled, people will improvise, and that is when things go from bad to worse. I tell my team that when they are writing a contingency plan, write it on the level of a 4th grader, since most people are not fully prepared for responding during an emergency. Remember, not everyone has served in the military—and specifically not in the Marines where they are taught to improvise, adapt, and overcome! Not everyone has received first responder training, so again, using the KISS (Keep It Simple Stupid) principle is a must.

As in life, there are always primary objectives (my adult objectives: education, marriage, kids, buy a house, plan for retirement, and have funeral arrangements in place—not necessarily in that order) and the same can be said regarding the establishment of a contingency plan:

1. Minimize damage and loss by containing the situation and slowing or preventing escalation.

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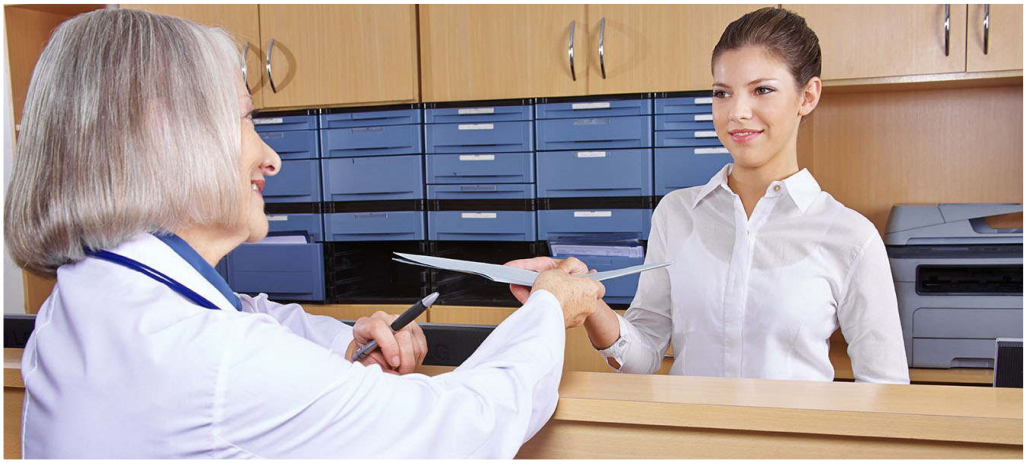

2. Continue to function as closely as possible to normal, while keeping in mind things are not normal.
3. You have to determine best how to work with those not prepared to deal with the crisis.
4. There is no "black and white" in crisis. Things remain fluid, and your plan must be able to adapt with the fluidness of the situation.
5. Create your contingency plan as soon as possible and ensure you have effectively communicated it to your entire organization. Monitor and update your plan often since things and environments are always changing. Take into account whether you are in a rural or urban area, along a fault line, or in a coastal area, as this will have a direct impact on your planning.

The "Keys" to contingency planning:

Safety

Safety should always be the number one concern of an employer. Safety of your employees and customers is paramount. Not everyone is blessed with common sense, and as such, it is critical that your staff knows exactly what to do or what is expected of them during an emergency. Establish a Crisis Team and appoint leaders and ensure they know their role and where emergency supplies are and how to use them in the event things escalate and people are injured. Depending on 911 during a crisis is foolish since these professionals are going to be stretched thin. Time is not your friend in a crisis, and quick, concise action will make all the difference between containment and escalation. The time to educate your staff is at the time of hire—or during the time most refer to as onboarding. Expecting folks to know what to do and how to do it during a crisis is unrealistic and is what leads to injury and/or death.

Communication

Remaining in control during a crisis demonstrates strength and brings a level of calm to those looking to you for leadership. During a crisis, it is possible that the power is out and typical phone (land and cellular) communications are not available. I believe every practice, hospital network, and delivery health system should have a satellite phone or something that converts their normal cell phone into a sat-phone or global hotspot. These items are not very expensive, nor are the plans. I use Somewear (https://www.somewearlabs.com/), which allows my cell phone to operate as a global hotspot when all normal communications are down. Remember, when there is a power outage, charging your cell phone is not possible unless you have a generator or a portable solar power panel kit (I use the ACOPOWER 120W Portable Solar Panel Kits, 12V Foldable Solar Panel with 10A Charge Controller in Suitcase), which there are many options available. Also remember, the ability to communicate during an emergency or crisis is critical. I encourage all of our employees to have solar rechargeable devices for themselves and to keep one in their car and one at home. These things are inexpensive, typically costing less than $50.00 (such as the Portable Charger RAVPower 22000mAh Power Bank External Battery Pack with 5.8A Output 3-Port (iSmart 2.0 USB Ports,) Compatible with iPhone and Android)—don't forget to keep it charged!

Make sure your employee phone list is updated on a regular basis, especially if you have folks coming and going. There is nothing worse than needing to contact someone and not having their number. Make sure the Crisis Team leaders have the most up-to-date phone list, and if possible, laminate it to protect it from elements such as rain.

Back-up and Recovery

It is never too late to begin backing up your data. If you haven't done it yet, what are you waiting for? All companies, especially in healthcare, have and store data. There is no argument that data is key to any company's survival, and without it, you're a dead stick. If you do not have a data backup and recovery plan, you need to call the folks at Sword and Shield or your General Liability Carrier for a recommendation. There is no time like the present to take that first step to security! If you lose power and you have a generator, you're in good shape. If you don't have a generator and you lose power, but everything is stored in the cloud, you're also in good shape. The bottom line here is that you need to do something so you are not left behind when things restore after a crisis.

Finances

"Cash is King" is what my late brother Michael would always say to me. The problem is paper currency during a crisis tends to not be worth the paper it is printed on. Diversification for businesses and personal finances is critical. Never keep all of your money in one bank or in one account, especially funds over $250,000. Unfortunately, banks today are paying pretty much nothing when it comes to interest, so you might as well keep a stash in a fireproof safe that is bolted into the cement ground in your house or office. Personally, I think $5,000-10,000 for a family of four is sufficient, and if used wisely, can last an extended period of time. Calculating for a business is much more difficult, and that is where your CPA should come in handy for small businesses.

Hospital networks and health systems typically cannot maintain the amount of cash that would be required to function on hand, but you can rest assure they all have a strong contingency and recovery plan in place for when a crisis strikes; but again, it is best to talk to your CPA and attorney about this one. Keep in mind that Uncle Sam likes his share, and ever since the Patriot Act was put into place, keeping cash in your safety deposit box at the bank is a no-no.

I talked about diversification earlier, which means you should own precious metals, such as gold and silver, and many of my clients have stashes of both and other precious metals in the event the dollar were to collapse. Right now is not the time to buy either, since they are commodities, and when the market takes hits like they have over the past three weeks, precious metal prices go through the roof. If you have a strong financial advisor who is able to forecast what the markets will do if they see a pandemic or other crisis is possible in the near future like COVID-19, they can move your position from stocks to municipal bonds to protect your wealth, and then once the markets recover, to avoid inflation, move your position away from the municipal bonds back to stocks. Again, this is something for your licensed and experienced financial investor to advise you on, but knowing what questions to ask will make the discussion that much easier. The bottom line here is you have to prepare for a rainy day!

The What Ifs

None of us has a crystal ball or are tapped in to Nostradamus, so being able to predict when and where a disaster will strike is impossible. However, even though none of us likes thinking about bad situations, thinking about some of the worst-case scenarios will ensure we are better—or as well—prepared as we can be in a crisis.

Some of the not-so-fun things to think about are:

- Natural Disasters (power outages, Nor'easters, ice storms, hurricanes, tornadoes, floods, earthquakes, etc.)
- Medical Pandemics (Influenza, Swine Flu, COVID-19, Ebola, Plague, etc.)
- Financial System Collapse
- Employee or Competitor Sabotage

The thing to keep in mind with a crisis or disaster situation is that no one knows how long it will actually last. Depending on the State or Federal Government to get it right should never be your first thought or hope. Yes, in times of crisis like COVID-19, we are all in this together, but truth be told, we are all primarily looking out for ourselves and our loved ones. Being prepared in the areas discussed (Safety, Communication, Back-up and Retrieval, and Finance) will ensure you minimize disruptions to your operations and put you in a stronger position to re-open when the all-clear is given. Working with your Crisis Team and talking through the "What Ifs" will go a very long way to ensuring cohesiveness with your team about how best to respond to a crisis. What you determine to be the steps taken in the various types of What Ifs addressed above should be clearly documented in your contingency plan and published for the entire staff to educate themselves on.

Once you have your plan in place, remember just like your OIG Compliance Plan, it needs to be a living, breathing document that adjusts as things change and the world evolves. At a minimum, you need to review your plan annually to ensure it is up-to-date (if you live in an area prone to natural disasters or strong winter storms or high summer heat, review your plan at the start of each changing season), and if you previously experienced an emergency or crisis, compare what you did to what you documented, and determine what worked and what didn't and then make the necessary adjustments within your plan. I say it all the time, "Everyone enters a fight with a plan until they get hit; then everything changes!" My point is that anticipating all the worst-case scenarios and "What Ifs" and applying common sense and easy-to-carry-out steps to first and foremost ensure safety, and second survival until things taper off, is the winning combination in your fight against a crisis.

Even with some of the bad news out there, I still believe that at the end of the tunnel, there is a light. The question is, is it a light leading us out of this nightmare, or is it the light of a train speeding toward us? Your efforts now and in the future will determine which light it is!

Sean Weiss, CPMA, CPC, CPC-P, CCP-P, ACS-EM, is a partner and Vice President of Compliance for Doctors Management. Sean has dedicated his more than 25 year career to helping healthcare facilities reduce the risk of noncompliance and achieve measurable financial results. An accomplished compliance and management professional, Sean has extensive knowledge of the inner workings of government agencies at both the federal and state level, including the Office of Inspector General, Department of Justice, and The United States Attorney's Office. www.doctors-management.com

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Everything You Need to Know About Co-Pay Accumulators

Since last year, CMS has proposed rules that would limit or eliminate the practice of applying the value of discount coupons for brand-name pharmaceuticals to patients' insurance deductibles. Now CMS appears to be moving forward with the controversial policy, which it says is intended to lower the overall cost of medications. Insurance companies support the idea. But many advocacy groups believe that it will present financial obstacles for patients, ultimately compromising quality care.

New 2021 Rules

As CMS reviewed its rules for 2021, it said that insurers on the ACA exchange can decide for themselves whether or not to apply the value of discount pharmaceutical manufacturer coupons to the deductibles of insured members. That includes assistance programs, copay cards, manufacturer coupons, or other copay assistance provided to patients to make brand name pharmaceuticals more affordable. Patients, particularly those with chronic conditions, depend on copay assistance programs. These programs are offered through some drug manufacturers, as well as nonprofit charitable organizations.

Debated Pros and Cons

CMS believes that this policy will motivate patients to

seek out generic alternatives, which will, in turn, lower the cost of pharmaceuticals. But under the revised guidelines, insurance companies will retain the ability to use co-pay accumulators even if there is no generic version of the drug available. Obviously that can create a greater financial burden for those patients who have trouble affording expensive brand-name drugs that don't have a generic equivalent. It may also mean that it takes longer for patients to meet their deductibles, increasing the amount they have to pay out of pocket.

Controlling Costs vs. Undermining Care

Insurance premiums and copays remain historically high, even for those Americans who do benefit from subsidies. How to reverse that situation is a complicated problem, and clearly there is strong disagreement between the parties who are involved and affected. CMS reasons that the value of the coupon is not a cost incurred by, or charged to, the insured enrollee, and therefore its value should not be required to count toward the out-of-pocket limit. Meanwhile, individual states still have the ability to prohibit the use of accumulator adjustment programs. Several states have already banned the practice, and more may do so in the coming months.

Shifting the Burden to Patients

These states observe that patients are often caught off guard when they are told that the assistance they receive does not count toward meeting their deductible. Patient advocates also say that insurance companies use co-pay accumulator rules to unjustifiably increase their profits. Insurers may get paid by pocketing the assistance payments, and then also get paid when patients have to co-pay because they didn't yet meet their deductible requirements.

The Bottom Line

While the CMS stance regarding co-pay accumulators is based on lowering costs, that view is challenged by real-world obstacles. Too often, the end result is that patients in need cannot afford to take medicines per their doctor's instructions, and disengage from recommended treatment plans. That creates a continued burden on the healthcare system, and potentially undermines the savings that the CMS strives to achieve. Time will tell, especially over the next year or two, whether the policy will work or require further revision.

Source: www.ntchealthcare.com

AHIMA's Perspective on Information Blocking Rule

Earlier this month, the Office of the National Coordinator (ONC) finalized the long-awaited information blocking rule in the 21st Century Cures Act. While we at the American Health Information Management Association (AHIMA) continue to review the specifics of the rule, it's important to note that we support the intent of the Cures Act and the ONC Information Blocking rule. That intent is to put patients at the center of care and to enhance the ability of patients to have access to their health information.

When the rule was proposed, we expressed concern about the lack of clarity and predictability around the definition of "electronic health information" (EHI), as well as the feasibility of operationalizing such a definition. We are pleased that in the final rule, ONC limits the definition of EHI to the US Core for Data Interoperability (USCDI v1) standard for the first 24 months after the publication date of the final rule. The USCDI standard, a modest expansion of the Common Clinical Data Set (CCDS), is a set of data classes and constituent data elements that are required to be exchanged under the rule.

We are also pleased ONC listened to stakeholders and that the finalized rule stipulates that beginning in 2022, the scope of EHI will be broadened to mean electronic protected health information (ePHI) as defined under HIPAA to the extent it is included in the designated record set. In other words, the definition of EHI represents the same ePHI that a patient would have the right to request a copy of pursuant to the HIPAA Privacy Rule. This is a definition that many health information management (HIM) professionals are familiar with and have experience in managing.

Privacy and Security of Third-Party Applications

Under the proposed rule, we also expressed concern that the rule did not include sufficient guardrails around HIPAA non-covered entities to protect the privacy and security of a patient's health information. Patients may be unaware that once they authorize a covered entity to push their electronic health information to a third-party app and such an entity is a HIPAA non-covered entity, the rights afforded under HIPAA no longer apply.

Additionally, patients could be unaware of how an app intends to use their health information, leaving them to the mercy of the app developer's terms of service and/or privacy policy unless an act on the part of an app developer meets the "unfair or deceptive acts or practices" standard under the Federal Trade Commission (FTC) Act. Failure to provide appropriate and transparent privacy and security safeguards could invite opportunities for "bad actors" to enter the market and potentially use such sensitive data for nefarious activities.

In the final rule, ONC has taken steps to address some of these concerns including clarifying that an actor educating patients about the privacy and security risks posed by a third-party app is not considered information blocking—as long as the actor provides accurate, objective, unbiased, fair, and non-discriminatory information about the third party developer or app that the patient chooses to use to receive EHI on their behalf. ONC also recommends a minimum set of best practices that all third-party apps' privacy policies and practices should adhere to.

Nevertheless, these additional safeguards fail to entirely address the protection of a consumers' sensitive health data once their data is pushed to a HIPAA non-covered entity. Consumers not only have the right to access their data but the right for their data to be kept private and secure. Congressional action may be required to enhance the protection of consumers' data once it is no longer covered by HIPAA.

Compliance and Enforcement

In September 2019, AHIMA and other provider groups sent a letter to Capitol Hill calling for HHS to exercise its discretion in its initial enforcement of the information blocking rule. The final rule stipulates that actors will have six months after publication of the rule in the Federal Register before they must comply with the information blocking rules.

However, it's important to keep in mind that the Cures Act gives enforcement authority of the rule to the HHS Office of Inspector General (OIG.) Under the 21st Century Cures Act, OIG is tasked with issuing civil monetary penalties of $1 million per violation to developers, health information exchanges, and health information networks found to be engaging in information blocking. OIG is also tasked with referring providers to the appropriate agency to be subject to "appropriate disincentives" under the law. Enforcement of these penalties will not begin until OIG undertakes a formal notice and comment rulemaking. Until then, actors will not be subject to enforcement penalties.

HIM professionals have an important role to play by bringing their facility into compliance with the information blocking rule. They should start the conversation now with their C-suite, IT department, and compliance teams to ensure they are ready when the rule goes into effect. HIM professionals should be prepared to use their expertise in this area to help bring their facilities into compliance under the rule.

Lauren Riplinger, JD, is Vice President, Policy & Government Affairs for AHIMA.org

Sharing of PHI with Large Tech Companies, Confidential Agreements, and HIPAA's Prohibition on the Marketing and Sale of PHI

As stated on Forbes, "The chief worry isn't about thieves getting their hands on lost or stolen devices, but the ease with which companies can gain access to the personal information." In the healthcare sector, protected health information (PHI) requires that certain measures be adopted, which include, but are not limited to the following: (1) express, written, patient consent; (2) a mutually executed business associate agreement (BAA); and (3) an annual, adequate risk analysis, as required by the Security Rule.

While it is not uncommon for healthcare entities, as well as business associates and subcontractors, to store data, including PHI, in the cloud, it is well established that the "conduit exception" does not apply; therefore, the aforementioned measures (i.e., BAA, patient consent, and risk analysis) are compulsory. This is because "the conduit exception is a narrow one and is intended to exclude only those entities providing mere courier services, such as the U.S. Postal Service or United Parcel Service and their electronic equivalents, such as internet service providers providing mere data transmission services." In the Federal Register, the U.S. Department of Health and Human Services expressly stated that, "an entity that maintains protected health information on behalf of a covered entity is a business associate and not a conduit, even if the entity does not actually view the protected health information." Therefore, it is imperative to appreciate that cloud providers and data centers do not fall under the conduit exception.

Recently, an article underscored the concern "that many health systems are working with large tech companies to store and analyze information under confidential data-sharing deals [without patients' knowledge or consent]." In late 2019, various Senators sent a letter to Google executives about the "concern over reports that Ascension has entered into a partnership that provides Google with health records of tens of millions of Americans without their awareness of consent." This is problematic on numerous fronts; however, the most significant may be that it constitutes the illicit marketing and sale of PHI.

The purpose of this article is to provide an overview of the prohibitions underlying the illicit marketing and sale of PHI, touch upon how courts are viewing the wrongful marketing and/or sale of PHI, and provide compliance suggestions. In sum, this is a topic that cannot be overlooked by covered entities, business associates, or subcontractors.

Analysis

A question that I am commonly asked is, "Is the marketing and/or the sale of PHI legal"? My answer always remains

the same, "It depends." The first step that organizations should take is to make sure that marketing is addressed in the required Notice of Privacy Practices and that both sales and marketing have a prominent place in an organization's policies and procedures. Not surprisingly, "The HIPAA Privacy Rule gives individuals important controls over whether and how their protected information is used and disclosed for marketing purposes."

What does my answer, "It depends," exactly mean?

Fundamentally, it means that there are nuances regarding utilizing PHI to market or actually selling patients' PHI. The three key items to address: (1) is the type of marketing which is linked to PHI permissible or prohibited; (2) have adequate disclosures been provided to the patients or other surrogate decision makers; and (3) have patients provided their express, written consent?

First, let's address marketing, which is attached to PHI. The Privacy Rule defines "marketing" as making "a communication about a product or service that encourages recipients of the communication to purchase or use the product or service." Generally, if the communication is "marketing," then the communication can occur only if the covered entity first obtains an individual's "authorization." Notice is different than authorization. Patients acknowledge that they have received a copy of the covered entity's Notice of Privacy Practices; however, the patient must separately authorize certain types of marketing and the sale of PHI. A common example of marketing where a covered entity would not need to obtain a separate written authorization is a physician's practice utilizing its patient list to announce the addition of a new piece of medical equipment or if it is made for treatment of the individual.

Examples of "marketing" communications requiring prior authorization are:

- A communication from a hospital informing former patients about a cardiac facility, that is not part of the hospital, that can provide a baseline EKG for $39, when the communication is not for the purpose of providing treatment advice.
- A communication from a health insurer promoting a home and casualty insurance product offered by the same company.
- "An arrangement between a covered entity and any other entity whereby the covered entity discloses protected health information to the other entity, in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service."
  This part of the definition to marketing has no exceptions.
- **The individual must authorize these marketing communications before they can occur. Simply put, a covered entity may not sell protected health information to a business associate or any other third party for that party's own purposes. Moreover, covered entities may not sell lists of patients or enrollees to third parties without obtaining authorization from each person on the list. For example, it is "marketing" when:**
  - A health plan sells a list of its members to a company that sells blood glucose monitors, which intends to send the plan's members brochures on the benefits of purchasing and using the monitors.
  - A drug manufacturer receives a list of patients from a covered healthcare provider and provides remuneration, then uses that list to send discount coupons for a new anti-depressant medication directly to the patients.

Second, let's consider the disclosure requirements to patients. A covered entity's Notice of Privacy Practices must state that any sale of PHI and certain types of marketing require an express, written authorization by the patient, typically on a HIPAA Authorization, which is in bold and gives the patient the opportunity to "opt out" of having his/her PHI sold or to receive certain marketing items. These parameters should also be defined in an entity's written policies and procedures.

Lastly, when is express, written consent required? "With limited exceptions, the Rule requires an individual's written authorization before a use or disclosure of his or her protected health information can be made for marketing."

The Authorization for a Sale must specifically state that the Sale will result in remuneration.

1. The sale of PHI was given additional emphasis in the Final Omnibus Rule, 78 Fed. Reg. 5566 (Jan. 25, 2013). Fundamentally, the sale of PHI equates to disclosure for remuneration. A sale of PHI occurs when there is direct or indirect remuneration, including in-kind remuneration.
2. The definition of a sale of PHI includes a transfer of ownership of the PHI, as well as disclosures of PHI based on an access, license, or lease agreement.

3. There are a number of exclusions to the definition of a Sale of PHI, including for purposes of (i) public health; (ii) research that is covered by HIPAA (e.g., clinical research) if the payment is a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI; (iii) treatment and payment; (iv) a sale and merger transaction involving the covered entity or the business associate; (v) activities performed by a business associate for or on behalf of the covered entity (or by a business associate subcontractor for or on behalf of the business associate) if the payment is for the business associate's performance of such activities (or for the subcontractor's performance of such activities); (vi) providing an access or an accounting to an individual; (vii) as required by law; and (viii) as otherwise permitted under HIPAA, where only a reasonable, cost-based fee is paid (or such other fee as permitted by law).

Adhering to these requirements is crucial, as the sale of PHI may serve as the basis of a False Claims Act (FCA) case. In United States v. America at Home Healthcare and Nursing Services, Ltd., 2018 U.S. Dist. LEXIS 2592 (N.D. Ill. Jan. 8, 2018) (hereinafter "America at Home"), the Honorable Robert John Blakely analogized violations of 42 U.S.C. § 1302d-6(a) to violations under the Anti-Kickback Statute in relation to the submission of false claims.

In America at Home, Judge Blakely upheld the relator's claim that "HIPAA violations under 42 U.S.C. § 1302d-6(a), which criminalizes knowingly using, obtaining, or disclosing an individual's identifiable health information without authorization" were substantiated by the facts that two individuals employed by the defendants "searched confidential medical charts at different facilities to collect the names of patients they could solicit for home health services (including unnecessary services)" (America at Home, p. 14). In turn, the defendants knowingly billed the government for medical services after obtaining patients' information unlawfully; and the defendants deliberately submitted claims and cost reports to the State of Illinois and the federal government that impliedly certified compliance with Medicare laws and regulations, but knowingly failed to disclose their HIPAA violations (Id.).

"If 'information that a hospital has purchased patients by paying kickbacks has a good probability' of affecting a payment decision, [United States v. Rogan, 517 F.3d 449, 452 (7th Cir. 2008)], then information that a home health agency has pilfered protected health data to solicit patients has a good probability of affecting payment decision, too" (Id.). Overall, failing to adhere to HIPAA's sale and marketing requirements could not only open an entity up to government enforcement actions by OCR, it could also result in significant liability under the FCA.

Conclusion

The sale and marketing of PHI will continue to get increased attention. Covered entities such as Ascension and its Business Associate, Google, in addition to having a business associate agreement in place, should confirm that patient consent was given in each circumstance that an individual's PHI was transferred to Google. Additionally, persons should always consider FCA liability, as well as enforcement actions by OCR. The best practice is to have all policies and procedures, disclosure forms, and conduct evaluated by counsel with experience and expertise in these areas on an annual basis or when a change in the law occurs. Overall, this is one area that cannot be overlooked.

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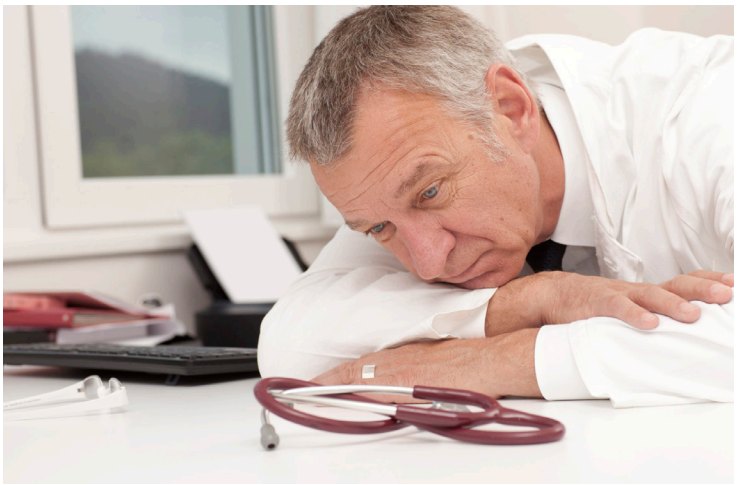
The 3 Greatest Obstacles Facing Private Practices and the Simplest Way to Solve Them

We all know that the need to maximize profits and volume has depersonalized the health-care industry. Effective and thoughtful medical care can't thrive in an environment overrun by payer politics and a business model built to push physicians to their breaking point.



When the number of obstacles facing the modern physician seems to grow every day, how do we adapt? Here are some of the major challenges private practices are facing and how to overcome them:

1. Private Practices are getting absorbed by the large health systems and there are fewer than ever before.

Independent practices have proved that they provide better outcomes at a lower cost than large health systems, but private practices are disappearing more and more each day. According to AMA's Physician Practice Benchmark Surveys, for the first time, physician-owned private practices are no longer in the majority. In 2016, 55.1% of physicians were working in privately owned practices compared to 60.1% in 2012. The reality for younger physicians is even bleaker with ownership among physicians under 40 being at about 27.9% (https://www.ama-assn.org/practice-management/economics/first-time-physician-practice-owners-are-not-majority). Why are medical professionals moving away from the private model?

As more boomer physicians retire, the latest generation is unlikely to take on the risk of running their own independent practice. For a newly trained, fresh-out-of-medical-school physician, positions in highly profitable hospitals offer too much stability and lucrative pay in the short term to turn away. With offers from large organizations that can help them repay their seemingly insurmountable student loans, it's easy to sign on the dotted line. But at what cost?

2. Physician burnout is real, and private practices are more susceptible to it.

Over the last few decades, the workload that is required of an individual physician has escalated dramatically without any corresponding increase of pay. Much of this uptick in workload can be attributed to the transition to inefficient and burdensome EMR systems. A study from Annals of Family Medicine concluded that primary care physicians spend more than half of their average workday on clerical work like documentation and data entry. With 6 hours of an 11-hour workday being spent on the computer rather than on their patients, it's obvious why we are seeing more and more physicians take their work home with them. (http://www.annfammed.org/content/15/5/419.full)

This administrative burden typically falls on the backs of physicians, and hiring extra hands to alleviate the weight isn't always a financially realistic option. To combat this, we should be looking for ways to maximize profit with a smaller pool of patients so physicians can focus their energy on providing the best care possible without being stretched too thin. This is where we can turn to the deep pockets of insurance payers for the answer.

3. Insurance companies keep growing in size and negotiating power.

Year after year, insurance companies have been absorbing their competitors and merging to maximize their own profits. By paying into lobbying efforts and playing the political field, they have leveraged themselves into a position where they can increase premiums at will while neglecting to increase the rates for the physicians. They claim that mergers help them reduce the cost of healthcare and eliminate waste, but in reality, they are shifting the costs to the providers while hoarding more of the profits for themselves. Insurance companies' profits keep skyrocketing and they are leaving the providers and patients that they represent in the dust. Over the last decade, inflation has risen by over 20%, while Medicare reimbursement has increased by less than 5% (NGA Healthcare 5 Year Forecast). Each year, payers are increasing their premiums by double digits, yet we rarely see these increases passed on to the physician groups.

The issue most physicians run into is the nightmare that is dealing with insurance payers. One of the major benefits of partnering with or being acquired by larger organizations is being able to avoid that headache altogether, but the solution is to hold payers accountable and negotiate your reimbursement rates.

The Simple Solution That Most Practices Neglect

Physicians need to understand they hold more leverage against payers than they recognize, even in a smaller group of physicians. More often than not, practices are shackled by contracts and rates that are far below market value. Physicians assume that these rates are set in stone, but securing a professional rate and contract negotiator would ensure that the physician stops leaving money on the table. Money isn't the answer to everything, but it is the solution to many of the problems that private practices are facing.

Most practices are not getting the rates they deserve. The key to obtaining better rates is finding an understanding of your leverage and holding the insurance payers accountable. Educating and empowering independent practices is crucial to leveraging a negotiation strategy with payers and is the simple solution to these three systemic healthcare problems that every private practice should pursue in order to remain independent.

Mary Ellam works with NGA Healthcare to support successful contract negotiations with healthcare payers and to ensure a profitable result on behalf of all physician clients. Find out more about Mary, NGA Healthcare, and their team at https://www.nga-healthcare.com/about/our-team/

Surprise Billing

Today I'm writing about a man, a man named Steve. Steve is married, has health insurance, and works for a local movie theater. One morning, Steve goes to work and his life takes a deep dark turn for the worse, because while showing the movie Dennis the Menace, Steve has a stroke.

Thankfully, one of his coworkers calls for an ambulance to take Steve to the emergency room at his local hospital, where he is admitted to the intensive care unit. Steve's wife meets him in the ICU and finds him conscious, but his speech so slurred that it sounds like he's having a procedure at the dentist. The movie theater owner just purchased health insurance through "ABC Insurance" for Steve and the other employees, but Steve is his only employee at the time. As you can imagine, Steve's wife, Brenda, is going to be asking a ton of questions.

Questions like, "How will the hospital bill be paid?"

The hospital bill will be paid by ABC Insurance. The hospital is contracted with ABC Insurance Company and the contract calls for the medical bill to be paid at 120% of the Medicare allowable. The contract with ABC Insurance is an HMO and there is no balance billing for Steve.

The emergency room doctor who saw Steve in the ER and ICU is also contracted, but with XYZ Insurance—not ABC Insurance. Their contract is also paid at 120% of the Medicare allowable.

Steve's wife goes to the Florida Medicare website where the website has the fee schedule available. The CPT code billed by the emergency room doctor is code

99285. The Medicare allowable for a 99285 is $179.47. The doctor is paid 120% of $179.47 or $214.80—that is the doctor's charge.

According to Steve's insurance, he must pay his copay of $20, his coinsurance which is 20% of $179.47 or $35.89, and his deductible of $100. Therefore, Steve's total out-of-pocket costs are $155.89. Steve can manage that, and he has a credit card to pay those out-of-pocket expenses.

The problem isn't with the hospital, or with the emergency room doctor. The visit will be paid by his health insurance, which is based on the contract between ABC Insurance and the hospital, and XYZ Insurance and the emergency room doctor. The problem is the 2-minute ambulance trip from Steve's work to the hospital.

The ambulance company is not contracted with ABC insurance, which makes the ambulance company a "non-par" or non-contracted provider. While having his stroke, Steve had no say-so with the ambulance company, and Brenda, Steve's wife, wasn't there when it happened, so she couldn't call around to find if there were any ambulance companies that were providers for his insurance. Effectively, Steve's wife was being held hostage by the ambulance company.

Now, as a non-par ambulance company, they don't have to accept Steve's insurance. Even though Steve has an HMO policy, Florida has an HMO law, Florida Statute 641.3154, which states: *If a health maintenance organization is liable for services rendered to a subscriber by a provider, regardless of whether a contract exists between the organization and the provider, the organization is liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider.*

Therefore, as a non-par provider, the ambulance company is not obligated to comply with the Florida HMO law, and as a non-par provider, the ambulance company can charge whatever they want, and this is when Steve gets a bill from the ambulance company for $500,000.

What happened to Steve is called Surprise Billing. Surprise billing occurs when an insured patient receives care from a provider that is out of the patient's insurance network.

With surprise billing, a patient can be billed for any amount that the out-of-network wishes to charge. The HMO contract is useless because there isn't a "contract" per se, but there is a contract that the ambulance company doesn't want us to know about that can help here. What is that contract?

The contract I'm referring to is between the patient and their employer when the employer is not church or government. This all sounds familiar because it is also a Federal law, and that law is called ERISA.

When Steve obtained insurance through his employer with ABC Insurance, he received from them a health benefit manual, also known as a Summary Plan Description.

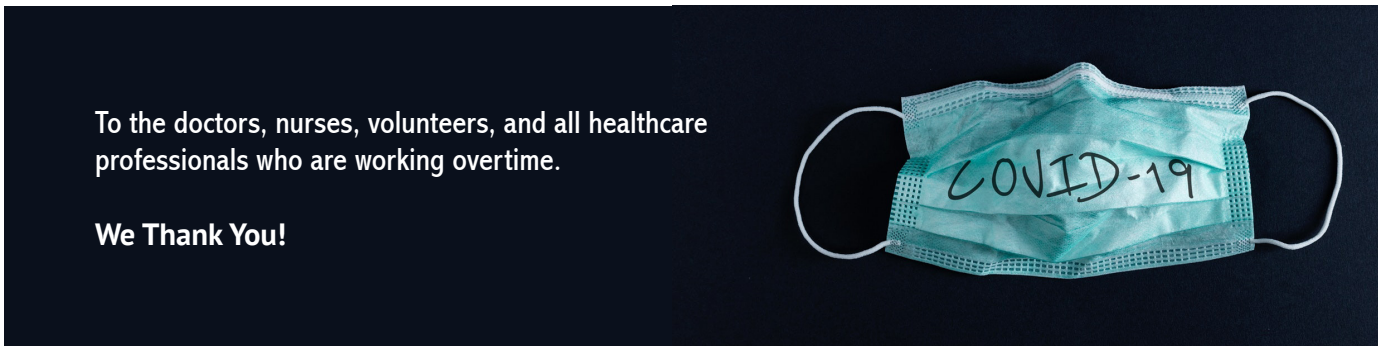
Under Steve's health benefit plan (which falls under ERISA since the movie theater is not a church or government organization), the health benefit for ambulance transportation defines the cost to Steve as $200 and not the $500,000 that the ambulance company wants to charge. As ERISA is a Federal law, the ambulance company is obligated to abide by that Federal law. Steve's health benefit manual documents the health benefit in the Federal ERISA regulation of 29 CFR 2560-503-1. Thus, the ambulance company now finds itself stuck with both a Federal law and a Federal regulation.

If the ambulance company wishes to keep pushing it, Steve can go to the ERISA Regulation 29 CFR 2560-503-1 where it provides him with an appeal of the ambulance charge of $500,000. 2560-503-1 states the following:

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures).

Steve is contacted by the ambulance company and they dispute any charge that is less than $500,000. However, Steve knows that the ERISA regulation states the following:

If an internal rule, guideline, protocol, or other similar criterion



was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;
(D) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Steve can obtain a lawyer to sue the ambulance company if they don't comply with the information outlined in his health benefit. He can also contact his State and Political leadership that his ERISA rights are at risk of being violated and go on to contact State, local, and National TV and News companies that would be more than happy to publish how the ambulance company may be violating Steve's ERISA health benefit and appeal rights. This would be worse than when Kris Kringle was up before the New York State Supreme court in the movie Miracle on 34th Street when he was told he wasn't Santa Claus.

The ERISA law and regulations are very powerful. But Steve can also take this a step further if he contacts the hospital where he was taken to be treated. He can look to see if the hospital has an insurance contract with the ambulance company, and he can find out if the ambulance company was obligated to provide ambulance services through the hospital contract. The hospital may have had a contract with XXX Insurance and that contract documented ambulance services through the hospital. If the ambulance company is billing Steve for $500,000, that may be a breach of contract with the hospital. The hospital contract may establish that ambulance service is limited to a charge of $500; therefore, the ambulance cannot charge $500,000.

Last, but not least, the State of Florida may have a contract with the ambulance company to provide emergency services to the State, and if there is a contract with the State, is billing Steve for $500,000 a violation of the State contract? The contract to provide ambulance services in the State of Florida may be limited to $1,000.00.

As you can see, Steve has many options available to him. He has his ERISA health benefit which is $200. He has an ERISA appeal of the ambulance charge of $500,000. He has the hospital CEO contract, which the ambulance company is obligated to abide by per a charge of $500, and he has the State of Florida contract where an ambulance company can only charge $1,000.

The ambulance company may say they are out of network, and as an out of network ambulance company, they may say that they are permitted to charge Steve for the $500,000 for his ambulance service. It's Steve who has his ERISA health benefit that is contracted by Federal law and he has a Federal appeal through the ERISA regulation.

Important to note, research reveals that most of the surprise billing is performed by emergency department physicians. The ED physicians are not contracted or participating providers, resulting in their insurance not being contracted. State law cannot be used because there is no official contract, but in reality, there is, and that contract is the patient's personal ERISA contract. The patient with these ED providers has Federal ERISA appeal rights. The health benefit cost is all that the ED providers can charge the patient for. If the patient visit is a health benefit, and the cost of the benefit is $100, that is all the ED providers can charge the patient. They may want to charge $500,000, but they're stuck with the cost of the patient's ERISA health benefit.
In closing, ERISA doesn't permit surprise billing; ERISA fights surprise billing.

Steve Verno, CMMC, CMMB, NREMT-P, CEMCS, CMSCS, was a Professor of Medical Coding and Billing Instruction at Florida Metropolitan University.

CMS Updates: COVID-19 - Dear Clinician Letter

Dear Clinician:

As you are aware, the United States is currently experiencing an unprecedented outbreak of the respiratory illness 2019 caused by the Novel Coronavirus (COVID-19). Given the potential effect this virus may have on our healthcare system, the Centers for Medicare & Medicaid Services (CMS) is working to ensure maximum flexibility to reduce unnecessary barriers to allow you to focus on your patients. It is important for you to know that the Centers for Disease Control and Prevention (CDC) is publishing reliable clinical guidance daily. CMS also has up to date information for beneficiaries and about its programs and response to COVID-19 on the Current Emergencies page. While we have more work ahead of us, we sincerely thank you for all that you have done and all that you will do on behalf of patients across the United States.

Accelerated and Advanced Payments: In response to the COVID-19 pandemic, CMS will provide accelerated payments to requesting providers and advance payments to requesting suppliers, including physicians and non-physician practitioners, who submit a request to the appropriate Medicare Administrative Contractor (MAC) and meet the following criteria:

1. Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's/supplier's request form,
2. Is not in bankruptcy,
3. Not be under active medical review or program integrity investigation, and
4. Does not have any outstanding delinquent Medicare overpayments.

CMS intends to provide assistance first to those providers and suppliers that experience increased demand and surge in patients. MACs responsible for processing accelerated/advance payment requests for different states, will prioritize those states that were hit the hardest (currently, these states are reported to be California, New York, and Washington). Most Providers and suppliers will be able to request up to 100% of the Medicare payment amount for a three-month period. However, Inpatient acute care hospitals, children's hospitals, and certain cancer hospitals are able to request up to 100% of the Medicare payment amount for a six-month period. Critical access hospitals (CAH) can request up to 125% of their payment amount for a six-month period. Based on this formula, qualified providers/suppliers will be asked to request a specific amount using an Accelerated/Advanced Payment Request Document provided on each MAC's website.

For complete details on the process, please review the following fact sheet. https://www.cms.gov/files/document/covid-dear-clinician-letter.pdf

Stay Healthy at home:

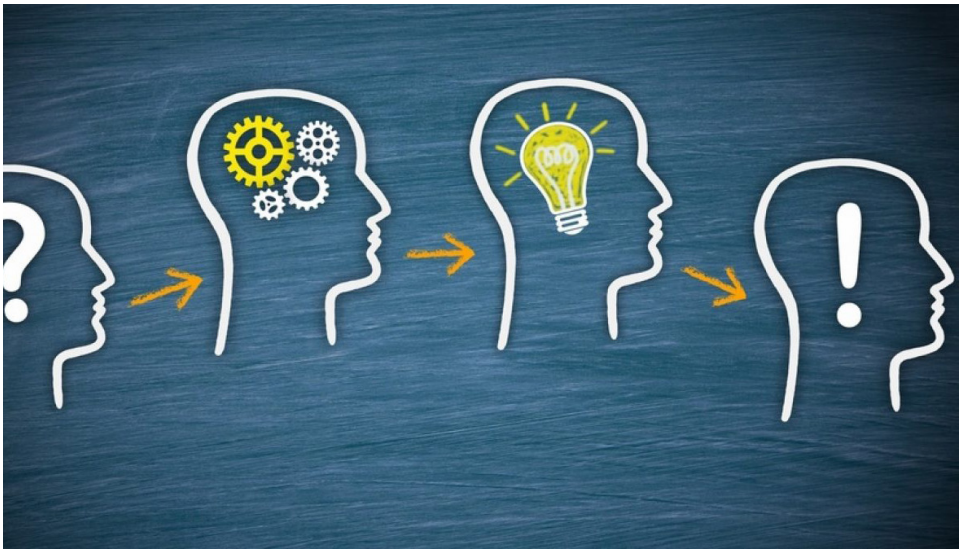
Its important to stay healthy under stay at home government orders, even if you can't get to the gym or have gym equipment in your home .

There are Household Objects to Use Instead of Dumbbells: - Milk Jug Filled with Water - Canned Goods - Water Bottles - Rice / Beans - Paint Cans - Books

Regina Mixon Bate, Author, National Speaker, Healthcare Consultant & Trainer, Serial Entrepreneur - https://www.ppsosgroup.com/

Bye, Bye to Another Decade

As we embark on another decade, it is a great time to step back, catch our breath, and take a hard look at our businesses. It may be a cliché to say that the older we get, the faster time seems to speed by—when I was a child, a day seemed an eternity—but now that I have matured (such a nicer term than "getting old"), even an entire year seems to fly by so quickly.



Reflecting back on 2019, how many items did you cross off your to-do list that you created last January? Or did you find that you just added more pages of "to-dos," and that your list is longer than ever? It's funny that with all the advances in technology the past two decades, we are still busier than ever. Why is it that even when a new time-saving invention is introduced, we don't take advantage of that newfound time to relax or do something fun—we just fill up that time with more stuff to do?

So, before another year passes us by, here are a few major areas that deserve your review and contemplation:

Personal Development: What have you done recently to increase your knowledge base? One element of success is predicated upon acquiring and honing additional skill sets. The more we know about a particular area, the better equipped we are to achieve success. Given the many hats we wear as business leaders, we must have an understanding of our major areas of responsibility. For example, I often hear that a company would like to grow by increasing sales. When I question what books or podcasts the company leaders have read or listened to or which seminars they have attended relating to sales and marketing, they give me that "deer in headlights" glare. Increasing sales is a two-step process. First, learn the proper techniques for prospecting, presenting, and closing; second and most importantly, dedicate time to practicing and implementing them.

Team Development: Have you encouraged the folks around you to improve their skills? As leaders in our industry, it is imperative that we help others grow. Those who work with us must continue to expand their horizons in order to remain assets to our firms. They need continual development relating to their Leadership and Customer Service skills. A fast track to success is to surround yourself with people smarter than you. If you and your second in command think exactly alike, then one of you is redundant.

Expense Reduction: Fact: a dollar saved drops directly to the bottom line. It is much easier to save a buck in expenses than to earn an additional dollar through increased revenue. The biggest expenditure we have in our business is personnel salaries and the various costs associated with our employees. However, very rarely have I seen productivity standards put in place to ensure a business is properly staffed. When I query supervisors as to the number of employees they have, the usual answer is, "Not enough." Proper staffing will dramatically improve profit-

ability. Investing your time to determine that you have the correct staffing level is priceless.

Process Improvement: If you are still doing things the same way you did them six months ago, you're probably wrong. The world is changing so rapidly that we must continually question all the processes in our operations. The most powerful question you can ask day in and day out is, "Why?" If you still believe the old premise, "If it isn't broken, don't fix it," or your mantra is, "Because that's the way we always have done it," trouble is lurking around the corner. Take the time to review and revise all the functions in your business. One area that is developing rapidly is the use of automated processes known as "bots." An example is that these software programs can automatically check eligibility and run claim statuses without human intervention. This is a huge time and money saver.

It's a new year and a great time to improve ourselves and those around us, plus we can shed bad habits. Remember, if you don't start today, before you know it, we will be flipping the calendar once again. And as always, I wish you continued success in 2020.

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

CDC - Handwashing

Germs are everywhere! They can get onto your hands and items you touch throughout the day. Washing hands at key times with soap and water is one of the most important steps you can take to get rid of germs and avoid spreading germs to those around you.

How can washing your hands keep you healthy?

Germs can get into the body through our eyes, nose, and mouth and make us sick. Handwashing with soap removes germs from hands and helps prevent sickness. Studies have shown that handwashing can prevent 1 in 3 diarrhea-related sicknesses and 1 in 5 respiratory infections, such as a cold or the flu.

Handwashing helps prevent infections for these reasons:

People often touch their eyes, nose, and mouth without realizing it, introducing germs into their bodies.

Germs from unwashed hands may get into foods and drinks when people prepare or consume them. Germs can grow in some types of foods or drinks and make people sick.

Germs from unwashed hands can be transferred to other objects, such as door knobs, tables, or toys, and then transferred to another person's hands.

What is the right way to wash your hands?

1. Wet your hands with clean running water (warm or cold) and apply soap.
2. Lather your hands by rubbing them together with the soap.
3. Scrub all surfaces of your hands, including the palms, backs, fingers, between your fingers, and under your nails. Keep scrubbing for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song twice.
4. Rinse your hands under clean, running water.
5. Dry your hands using a clean towel or air dry them.

CS 280522A