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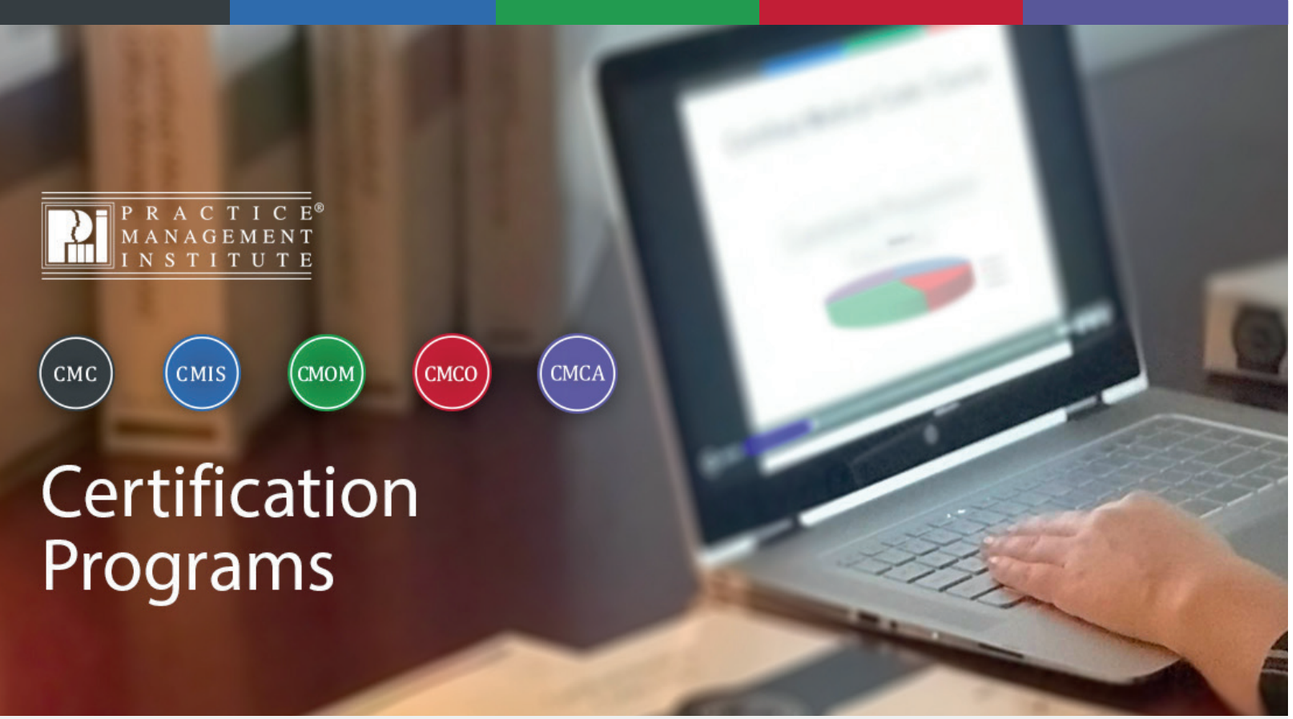
July / August 2020 | Issue 15.4

FACE-TO-FACE
Karen Blanchette
Executive Director, PAHCOM



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CEO Letter

Summer is here, and at time of writing this, our COVID-19 numbers here in SC (and several other states) are on the rise again. With all of us reeling from the past few months and the changes that we've all had to examine, learn, and implement into our daily lives, can we take comfort in knowing that we're more prepared than before and have the processes in place so that the focus can be on patient care this time around? There is no denying that, as a nation, we were not ready for such a public health emergency, especially one of this scale. There have been small hiccups, big hiccups, and huge hiccups along the way, but those who were charged with implementing solutions worked tirelessly to get it done, and lives are being saved.

Administrative professionals probably don't see themselves as heroes too, but it was hard work getting all of this in place so that the clinicians and clinical staff could focus on what they do best—patient treatment. Thank you for all that you have done and please pass on our thanks to your clinical staff, as well. It has been rough and it's not over yet.

With the relaxing of the stay-at-home orders in many states, patients are returning to practices, and new standards are being implemented to ensure safety for everyone. We have some excellent articles on reopening your office from a staff and patient perspective. I suggest taking a look and figuring out if you've missed anything. And maybe you have something to add? We would love to hear if you have figured out a new or better way of doing something that you could share with other BC Advantage members! Email us or comment on our Facebook page and let us know.

Other articles this issue include a great interview with Karen Blanchette, MBA, the Executive Director for PAHCOM. Who knew we had a world record holder in our midst? She lets us in for a quick look at her life and the lessons she has learned. I hope you enjoy it as much as we did.

We have other informative articles, with one focusing on Gastroparesis, just in time for Gastroparesis Awareness month in August. Another article is on automated dispensing cabinets! I love learning new things and always find the articles that are written by our outstanding editorial board so interesting. I hope you appreciate them all!

We want you to know that all of us at BC Advantage hold all of you up in the highest regard and pray for your safety and health. Be kind to one another. Life is too short not to be.

Until next time.

Storm Kulhan

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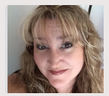

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NTC Healthcare. www.ntchealthcare.com

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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.

Where is the CCI Edit with Modifier 25 on E/M?

If you are not seeing a CCI edit when reporting an E/M code with a certain procedure, it may be that there is no edit. CMS does not have a CCI edit for every CPT code, however; there are still general coding rules that must be followed.

The use of Modifier 25 is one example that has general coding guidelines and rules, but there is not a CCI edit for every code it should be used with. This information can be found in the NCCI Edit Manual under Chapter I Section D, Evaluation and Management (E&M) Services. It is understood that an E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

NOTE: Some MACs, such as Palmetto GBA, state: "Modifier 25 should not be submitted with E/M codes that are explicitly for new patients only."

There are a few reasons CCI does not contain edits on this rule. One reason is all MACs do not have the same edits; NCCI does not contain edits based on certain rules because MACs have separate edits. NCCI contains many, but not all, possible edits based on these principles.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general, E&M services performed on the same date of service as a minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure, and shall not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedures do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

NCCI Policy: Chapter I Section D, Evaluation and Management (E&M) Services

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Christine Woolstenhulme, CMRS, is the Content Marketing Director for Innoventrum which includes Find-a-Code, ChiroCode, and InstaCode Institute. Chris.Woolstenhulme@innoventrum.com

CMS Downloads: 2021 ICD-10-PCS

The 2021 ICD-10 Procedure Coding System (ICD-10-PCS) files below contain information on the ICD-10-PCS updates for FY 2021. These 2021 ICD-10-PCS codes are to be used for discharges occurring from October 1, 2020 through September 30, 2021.

Note: There is no GEMs file. As stated in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49388), the GEMs have been updated on an annual basis as part of the ICD-10 Coordination and Maintenance Committee meetings process and will continue to be updated for approximately 3 years after ICD-10 is implemented.

We made the GEMs files available for FY 2016, FY 2017, and FY 2018.

An announcement was also made at the September 2017 ICD-10 Coordination and Maintenance Committee meeting that FY 2018 would be the last GEMs file update.

Downloads:
https://www.cms.gov/medicare/icd-10/2021-icd-10-pcs

2021 Official ICD-10-PCS Coding Guidelines (PDF)
2021 ICD-10-PCS Code Tables and Index (ZIP)
2021 ICD-10-PCS Addendum (ZIP)
2021 ICD-10-PCS Codes File (ZIP)
2021 ICD-10-PCS Conversion Table (ZIP)
2021 ICD-10-PCS Order File (Long and Abbreviated Titles) (ZIP)
2021 Version Update Summary (PDF)

Personal Protective Equipment (PPE) Burn Rate Calculator

Mobile app version now available
The Personal Protective Equipment (PPE) Burn Rate Calculator is now available as an app. Facilities can use the NIOSH PPE Tracker app to calculate their average PPE consumption rate or "burn rate." The app estimates how many days a PPE supply will last given current inventory levels and PPE burn rate. The app is available for both iOSexternal icon and Androidexternal icon devices. Visit the NIOSH PPE Tracker app page to download this free tool.

Visit CMS and Download:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html

innoviHealth® Launches HCC Coder – First Targeted Hierarchical Condition Coding Solution for Medical Enterprises

innoviHealth today announced the official release to the medical coding community of HCC Coder, its long-anticipated Hierarchical Condition Coding Software. HCC Coder is a powerful, unique, and easy-to-use tool that also includes Web or on-site training, and is backed by HCC-knowledgeable, US-based customer support. Very easy to navigate, most teams will be up and running on day one.

"HCC Coder, the diagnostic coding platform that finally gets HCC coding and medical coding risk adjustment, is now available to subscribe online," said LaMont Leavitt, CEO of innoviHealth. "Fast becoming the industry benchmark, our solution is smart, intuitive, comprehensive, and is vetted daily by thousands of HCC coders worldwide. Plus, it's backed by over 25 years of innoviHealth's coding, reimbursement, compliance, and content experience."

Review more at: innovihealth.com

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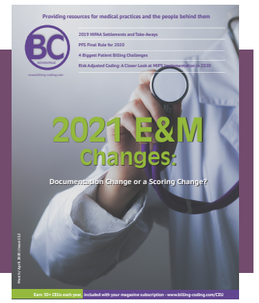


UnitedHealthcare Offers Special Enrollment and Reduces Administrative Requirements to Improve Access to Care and Coverage in Response to COVID-19

UnitedHealthcare announced today several updates to its programs in response to the COVID-19 national emergency. In addition to previously announced telehealth and virtual care expansion, the company will open a special enrollment period for some of its existing commercial customers to enable people to get coverage for their healthcare needs. The company is also further easing administrative requirements to access care through reduced prior authorization requirements.

"UnitedHealthcare is committed to helping people access health care to the fullest extent possible as we come together to address this national emergency," said UnitedHealthcare Chief Executive Officer Dirk McMahon. "We will continue to help people get coverage for the care they need, as well as ease care provider and health system administrative burdens."

Access to Coverage – Special Enrollment Period
UnitedHealthcare is easing contractual requirements for its fully-insured and level-funded customers to offer a special COVID-19 enrollment opportunity to allow employees who did not opt in for coverage during the regular enrollment period to get coverage. The enrollment period will be open from March 23, 2020, to April 6, 2020. Self-funded customers may choose to amend their eligibility requirements to align with this special enrollment period at their discretion. Customers can contact their broker, consultant, or sales representative to speak to them about the special enrollment period.

Reduced Prior Authorization Requirements
UnitedHealthcare continues to adopt measures that will reduce administrative burden for physicians and facilities to help members more easily access the care they need. This includes:

- Suspension of prior authorization requirements to a post-acute care setting through May 31, 2020; and
- Suspension of prior authorization requirements when a member transfers to a new provider through May 31, 2020.

We will temporarily suspend or relax additional policies as needed in regions where inpatient capacity is most compromised and most at risk. Providers should consult www.UHCprovider.com for specifics on UnitedHealthcare policies and guidelines.

Access to Testing and Medical Care
During this national emergency, UnitedHealthcare will continue to waive cost-sharing for COVID-19 testing provided at approved locations in accordance with the CDC guidelines. In addition, the company will waive cost-sharing for COVID-19 testing related visits, whether the care is received in a physician's office, a telehealth visit, an urgent care center, or an emergency department. This coverage applies to commercial, Medicare Advantage, and Medicaid members.

Access to Telehealth
To increase system access and flexibility when it is needed most, UnitedHealthcare is expanding its telehealth policies to make it easier for people to connect with their healthcare provider from home. People will have access to telehealth services in two ways:

- Designated Telehealth Partners – Medicare Advantage and Medicaid members can continue to access their existing telehealth benefit offered through one of UnitedHealthcare's designated partners without cost-sharing. Cost-sharing for commercial members will be waived through June 18, 2020. Self-insured customers may choose to opt out.
- Expanded Provider Telehealth Access – Through June 18, 2020, eligible medical providers who have the ability and want to connect with their patient through synchronous virtual care (live video-conferencing) can do so. Except for the waiver of cost-sharing for COVID-19 testing related visits, benefits will be processed in accordance with the member's plan.

Source: https://newsroom.uhc.com/news-releases/care-and-coverage-COVID-19.html

How Cloud Computing Is Connecting People

Amidst the Covid-19 Pandemic

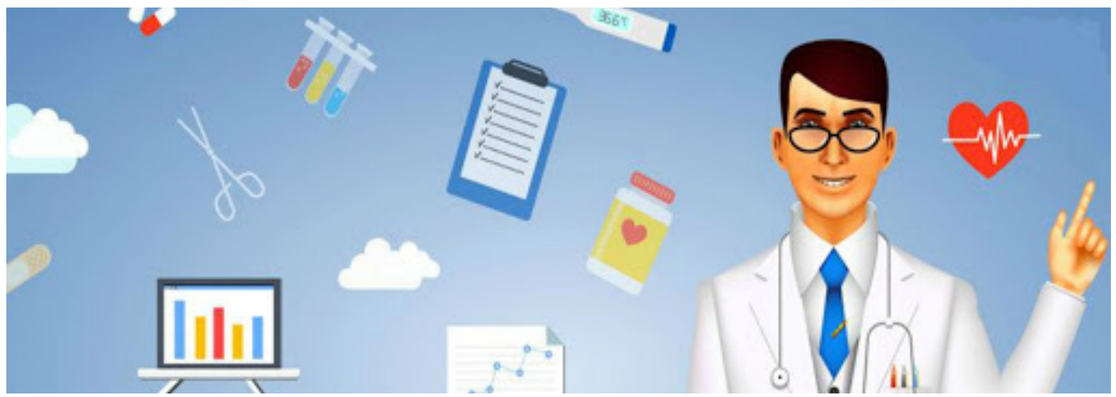
What was initially brushed off as an abnormal kind of flu soared into a global pandemic that has now affected almost every corner of the world. COVID-19 has exposed the global infrastructure, strategies of our policymakers, and also how challenging it is to fight a new virus without a suitable preventive vaccine or medicine.

As it rapidly spread across the globe and throughout the United States, the government declared shutdowns and social distancing to stop further positive cases. In an effort to maintain operations during the COVID-19 pandemic, experts in organizations started searching for all possible tools at their disposal, and this has brought cloud computing technology to the forefront for many organizations in terms of reliability, scale to handle and store massive databases, security, and flexibility. The technology also enhances the workflow efficiency in organizations. Along with document conversion, organizations are also adopting cloud storage facilities for storing valuable data, which increases the significance of outsourced solutions.

Cloud computing has enabled online education, work, meetings and conferences, people interactions, shopping, etc., in the comfort of our homes. The business of renting computing power has transformed into an enormous industry with Amazon and Microsoft leading the way. For instance, cloud computing services giant, Microsoft, has issued a statement claiming that in Italy, one of the worst hit countries and the new epicenter for COVID-19, it has seen an astonishing 775% increase of monthly users over one month in the use of its cloud services in areas from team calling and meeting. In addition to the adoption of the cloud, the shift to working from home has also given cloud-based services/applications a significant boost.

Recognize the Significant Role of Cloud Computing
From games to productivity apps and the software used by businesses and institutions, cloud computing plays a vital role.

- Cloud computing brings the digital world home – Services such as Amazon Web Services (AWS), Microsoft Azure, and Google Cloud facilitate to continue digital lives through applications like Zoom Video, Slack, and Netflix. Without AWS, people struggle to enjoy Prime Video or gaming platforms like Twitch as we move to digital forms of communication and entertainment. According to the New York Times, downloads of Netflix's app—a proxy for traffic from the streaming site—jumped 66% in Italy, according to data from Sensor Tower (an app data company). In Spain, they rose 35%. In the United States, where Netflix was already popular, there was a 9% increase.



- Enables rapid data – From big data to artificial intelligence, rapid data systems power things such as research, analytics, and manufacturing. Cloud technology platforms coordinate endpoints together, develop network uniformity, and do these tasks seamlessly so that solutions can quickly emerge for everyday problems and challenges. In today's world, driving back and forth to the supercomputer isn't a necessity anymore when the cloud itself is a massive supercomputer.
- Supports Health Services – According to a report by West Monroe Partners (a national management and technology consulting firm based in Chicago), the healthcare industry leads the finance and even the energy and utilities sectors when it comes to cloud use. In fact, many hospitals, healthcare institutions, and other government health service agencies have digitalized and brought their data to the cloud platform with an objective to optimize services and maximize patient outcomes. This early cloud adoption is a big benefit in the fight against the pandemic as it improves the ability to analyze relevant data. Cloud computing is more than just data storage as it also lowers IT costs for health facilities as they can avoid the need to train personnel, purchase equipment, and provide physical space for the IT people and hardware. Additionally, it eases interoperability by enabling data and system integrations. Furthermore, the cloud supports telemedicine. Remote data accessibility and interactive online tools make it possible for physicians and other health workers to provide services from a distance. Telehealth is becoming more useful as people try to avoid personal interaction with other people. It is useful for diagnosing certain types of conditions as well as for the processing of healthcare claims.
- Facilitates Remote Working – The work from home option has become a new trend amidst the wake of the pandemic and this has highlighted the benefits of using cloud computing with a large number of companies increasingly adopting the same. The option of working remotely has led to an unexpected spike in cloud usage, making it more expensive and complicated for companies to manage their internet infrastructure. In fact, companies like Microsoft, Amazon, and Google (the three major players when it comes to cloud computing platforms) may be hugely benefiting from the recent shift to work from home across the globe. However, these companies have been discounting their services, whereby they offer underlying infrastructure on rent to corporate networks. For instance, Microsoft has been pushing its messaging and collaboration tool—Microsoft Teams—which is a direct competitor to Slack. The total number of users on this messaging tool has increased by 37% last month, with at least 900 million meetings and call minutes every day.
- Enabling Dependable Online Commerce – In most cases, all online retailers rely on the cloud to operate, especially as they face a surge in transactions. Cloud hosting solutions are highly scalable, so a sudden rise in traffic is unlikely to disrupt business. In addition, cloud hosting providers are more equipped to handle cyber-attacks.

Modern organizations always rely on digital infrastructure to support their business. With the onset of restrictions that COVID-19 has created, more companies are recognizing the unquestionable value that cloud platforms deliver. The benefits of managed cloud platforms, such as improved network performance, greater data center resiliency, enhanced security, and reduced operational costs, are no longer seen as just marketing hypes as they work in real time. Improving the cloud's security has become a necessity due to evolution of cyber-attacks with more organizations turning to cloud-based technology solutions. To keep hackers away, security teams should implement measures to meet the increased regulatory demands. Security of information must be given top priority in all activities and processes, even when using outsourced professional data conversion services or any other such solutions.

One of the most incredible aspects about cloud-computing technology is the flexible options they offer, even more so now in this time of global crisis, when companies search for or want solutions which they can implement easily and test quickly. A vast, never-ending network of cloud-based systems enable the world around us to stay up and running in the midst of this pandemic, with very few hiccups. The rapid rise of telemedicine, an industry wholly enabled by secure cloud technologies, is a perfect example of the same.

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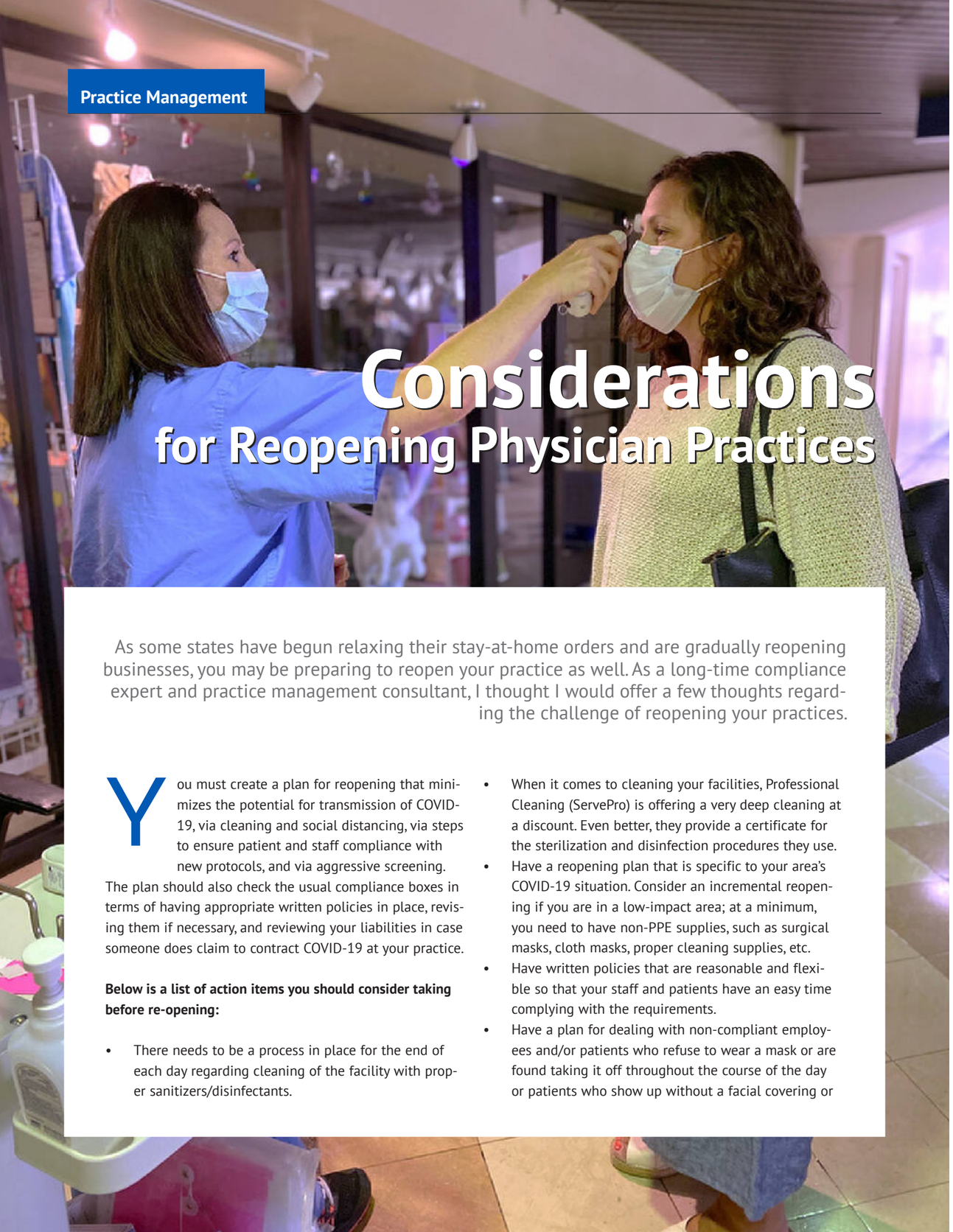

Considerations for Reopening Physician Practices

As some states have begun relaxing their stay-at-home orders and are gradually reopening businesses, you may be preparing to reopen your practice as well. As a long-time compliance expert and practice management consultant, I thought I would offer a few thoughts regarding the challenge of reopening your practices.

You must create a plan for reopening that minimizes the potential for transmission of COVID-19, via cleaning and social distancing, via steps to ensure patient and staff compliance with new protocols, and via aggressive screening. The plan should also check the usual compliance boxes in terms of having appropriate written policies in place, revising them if necessary, and reviewing your liabilities in case someone does claim to contract COVID-19 at your practice.

Below is a list of action items you should consider taking before re-opening:

- There needs to be a process in place for the end of each day regarding cleaning of the facility with proper sanitizers/disinfectants.
- When it comes to cleaning your facilities, Professional Cleaning (ServePro) is offering a very deep cleaning at a discount. Even better, they provide a certificate for the sterilization and disinfection procedures they use.
- Have a reopening plan that is specific to your area's COVID-19 situation. Consider an incremental reopening if you are in a low-impact area; at a minimum, you need to have non-PPE supplies, such as surgical masks, cloth masks, proper cleaning supplies, etc.
- Have written policies that are reasonable and flexible so that your staff and patients have an easy time complying with the requirements.
- Have a plan for dealing with non-compliant employees and/or patients who refuse to wear a mask or are found taking it off throughout the course of the day or patients who show up without a facial covering or with their children who are not being seen.
- Post your OSHA poster in a conspicuous area to demonstrate proper safety measures for patients and staff.
- Check with your local, state, and the federal government for compliance requirements (Executive Orders) that detail the type of surgical procedures your practice can furnish, especially if you are in a "Hot Zone."
- Make sure you have written policies in place for outbreak(s), pandemics, and/or emergencies (medical liability, privacy, safety, disaster recovery, etc.).
- Contact your Medical Liability Insurance Carrier to discuss if and how your front-line providers, those who treat patients with potential COVID-19, are protected. Congress has shielded providers from liability in certain instances (see section 3215 of H.R.748 – CARES Act).
- Consider implementing a telephone triage program to avoid unnecessary patient visits to the practice leading to opportunities for potential exposure.
- Screen all patients and employees each day prior to entering the building. Ask appropriate questions regarding self or mandated quarantine, travel during the past 14 days to another state or country, their mode of transportation (i.e. personal car, train, plane, etc.), whether they have been exposed to COVID-positive individuals, and if you have thermometers, take their temperature. Make sure you document everything and have patients and employees sign an attestation form to indicate the information they provided is accurate to the best of their knowledge.

As always, I am either working to create something or I try to find something that is top-notch so I do not have to recreate the wheel. The American Academy of Family Practitioners (AAFP) has created a great "Checklist to Prepare Physician Offices for COVID-19." While the document is only four (4) pages long, it is very comprehensive and you can use it to create a checklist that is the right size and fit for your practice. Stay healthy and well!

Checklist PDF: https://www.aafp.org/dam/AAFP/documents/patient_care/public_health/COVID-19%20Office%20Prep%20Checklist.pdf

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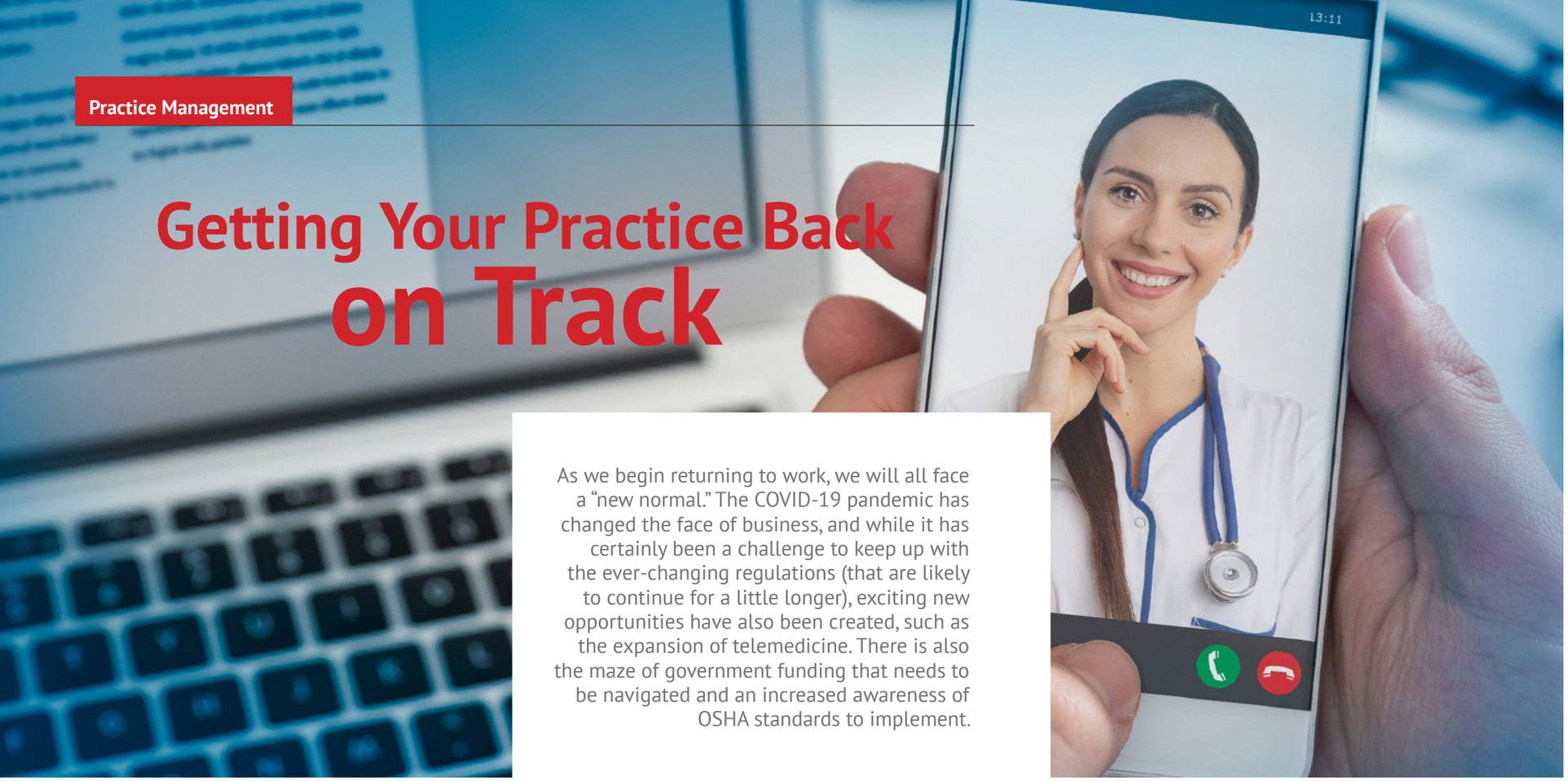
Getting Your Practice Back on Track



As we begin returning to work, we will all face a "new normal." The COVID-19 pandemic has changed the face of business, and while it has certainly been a challenge to keep up with the ever-changing regulations (that are likely to continue for a little longer), exciting new opportunities have also been created, such as the expansion of telemedicine. There is also the maze of government funding that needs to be navigated and an increased awareness of OSHA standards to implement.

Telehealth Expansion — Will it Continue?
The expansion of telehealth has created an opportunity for chiropractic offices to increase services. As we slowly get back to business as usual, some have asked if this expansion will continue. Telehealth has been growing over the past several years and many experts in the industry believe that this opening of the floodgate means that many payers will be more "open" to the idea of the benefits of this service. While I believe that the door will likely close on some services, I think that many services will still be able to be provided via telehealth.

While it's obvious that you cannot perform a chiropractic manipulative treatment (CMT) over the phone, there are benefits to adding telehealth services permanently to your practice. Use this time to review your options, prepare policies and procedures, obtain HIPAA-approved technologies, and properly set up ongoing telehealth services for your practice. Fortunately, many organizations have provided helpful information, including webinars; and our new publication, 2021 ChiroCode DeskBook, will include a new section on telehealth.

Government Funding Maze
There are a variety of funding options available, and trying to understand all of them, as well as your best options, might seem a little daunting. There are federal options (e.g., CARES Act, Families First Coronavirus Response Act), as well as state options. When it comes to navigating your options, don't forget to contact your state professional organization as they can provide excellent guidance. Keep in mind that if you ask five lawyers the same question, you are likely to get five different answers, so do your due diligence, ask questions, attend webinars, and be sure you document your steps in your Compliance Manual. If you don't have a Compliance Manual, now is the time to get that important task taken care of.

OSHA Requirements
OSHA tends to be the last thing that we think about when it comes to compliance, but it is necessary to understand these requirements. This pandemic has opened everyone's eyes as to why having an "Exposure Control Plan," an OSHA requirement, is so important. We need to assume that any individual entering the door is potentially infected. The ChiroCode DeskBook has included an OSHA Checklist for the last several years. The 2021 Edition will expand this section. ChiroArmor is currently running a significant special on their "OSHA Policy Manual & Training Program."

Additional Considerations and Helpful Resources
Remember that there will be some additional procedures that will need to be implemented to ensure the health and safety of your patients and your employees. These new policies and procedures will need to be included in your Compliance Manual, and employees should be trained and sign an acknowledgement of these changes. A legal firm has recommended posting patient notices on your front door as well as creating a "COVID-19/ Coronavirus Patient Notice and Acknowledgement Form" which outlines what your practice will be doing to protect them (e.g., patient screenings).

The following are some links to other helpful resources:

- COVID-19 Medical Practice Reopening Checklist by the Medical Group Management Association (MGMA) https://www.findacode.com/files/get.php?file=109946
- COVID-19: A Physician Practice Guide to Reopening by the American Medical Association
- https://www.ama-assn.org/delivering-care/public-health/covid-19-physician-practice-guide-reopening
- Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19) by the CDC https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html
- Safety and Health Program Self-Evaluation Tool, by OSHA, is a checklist to see how your policies and procedures measure up to required elements. https://www.osha.gov/shpguidelines/docs/SHP_Self-Evaluation_Tool.pdf
- CDC/EPA Guidance for Cleaning and Disinfecting Public Spaces, Workplaces, Businesses, Schools, and Homes https://www.environmentalsafetyupdate.com/public-outbreaks/joint-cdc-epa-guidance-for-cleaning-and-disinfecting-public-spaces-workplaces-businesses-schools-and-homes/

Also refer to the COVID-19 Preparedness Plan template and instructions. Your state or professional organization may have already created templates and procedures to make it easier to update your compliance plan. Go to https://www.dli.mn.gov/sites/default/files/pdf/COVID_19_business_plan_template.pdf to see one example by the state of Minnesota.

Wyn Staheli is Director of Research for Find-a-Code.
www.findacode.com

The 2021 ChiroCode DeskBook has sections on telehealth and OSHA checklists to help meet requirements and is available for presale at https://store.innovihealth.com/products/chirocode-deskbook-for-2021

Reopening America:

What Patients Should Know About Seeking Healthcare

As areas of the United States experience a decline in coronavirus disease (COVID-19) cases, healthcare providers and facilities are preparing to reopen to all health care services. During the height of the pandemic, many organizations had postponed non-emergency, non-COVID-19 care in order to ensure capacity to care for COVID-19 patients and to preserve supplies, such as masks and ventilators. Moving forward, hospitals and physicians must be prepared to not only care for COVID-19 patients (including any surge in cases), but also to resume all healthcare that was postponed due to the pandemic. Patients have ongoing medical needs, may require preventive services such as vaccinations, or may have rescheduled surgeries that were postponed due to the public emergency.

As a patient, how do you know when it is safe to return to healthcare facilities, and what should you expect when you do? Ultimately, patients and providers will come together to make the right decision for each patient when addressing their healthcare needs. Below are some recommendations to help guide patients as they consider seeking non-emergency treatment.

1. Do not postpone necessary care. Some patients have been delaying care for chest pains, stroke symptoms, or other signs and symptoms of potentially serious health conditions. Do not postpone care that is urgent or may lead to complications such as heart attack or stroke. Also, do not postpone necessary preventive care such as immunizations or cancer screening. Do not hesitate to reach out to your provider if you have any questions about when to seek treatment.

2. Is it safe to go to your doctor or hospital? Talk with your healthcare provider about your provider's facilities and the precautions they are putting in place to keep patients safe.

Healthcare providers are making preparations to care for you safely. By now, healthcare facilities should have established special procedures for cleaning and disinfecting. They should have updated waiting room guidance and created special places for COVID-19 and non-COVID-19 care within their facilities. All appropriate precautions should be made to ensure that care is as safe as possible for patients.

3. Consider telehealth or virtual visits. Patients may receive certain care by "telehealth" – audio or audio/visual care via your phone or computer. This reduces the risk of transmission of Covid-19. Ask your provider if telehealth visits are an option.

4. What to expect when you seek healthcare. To prevent you from getting COVID-19, or giving it to others, you may be asked to do the following by your provider:

- Wear a face covering. A facemask helps limit your risk of getting or spreading disease.
- Avoid crowded waiting areas. Sometimes you will be asked to wait in your car until your visit. Waiting rooms should have chairs spaced far apart to keep you and others safe.
- Limit visitors or people who go to your appointment with you. By limiting the number of people, your exposure becomes limited as well. Try to limit visitors or people who accompany you to visits to *one* person. Visitors should also wear a face covering
- Screen before entering a facility. You, and your visitors, may have your temperature taken, or be asked questions about your health status, before entering a healthcare facility. This is to keep you and others safe.
- Wash your hands often. Use soap and water for 20 seconds, or hand sanitizer when washing your hands is not possible.

5. Should I get tested for COVID-19 before seeking healthcare? Discuss with your provider if you should be tested before going for care. In some cases, such as before surgery, childbirth, or a procedure, it may be necessary to be tested for COVID-19. Some people have shown no symptoms for the disease but have been found to be positive. If testing is not available, in some cases, such as before surgery, you may be asked to self-isolate prior to your surgery to reduce the risk that you have COVID-19. If you *are* positive for COVID-19, discuss your options with your provider about the benefits of proceeding or postponing care.

Vulnerable populations: When possible, stay home. As much as possible, stay home, avoid crowds, and self-isolate. If you are at high risk for complications of COVID-19, it is especially important to stay away from others who may spread it to you. High risk patients, including those with underlying chronic conditions, such as high blood pressure, diabetes, kidney disease, or those who are over 65 years of age, should consider staying home whenever possible. When out in public, be sure to practice social distancing by staying 6 feet away from others.

Healthcare facilities, such as hospitals, doctors' offices, surgery centers, and all sites of care are reopening as appropriate, and as state and local conditions allow. Precautions are being taken to ensure your care is safe and that you are protected. Patients should have confidence in seeking care, and trust that your healthcare providers are doing their best to keep you, your family, and your community safe.

Source: CMS

Leading Your Team Through the Pandemic

12 Fundamentals All Healthcare Leaders Should Hardwire

We all know physicians, nurses, and other healthcare professionals are under extreme stress. Each day, they battle anxiety, depression, exhaustion, and trauma as they do their essential work. Their harsh circumstances can't be changed. But the way leaders lead can make a huge difference in how frontline workers cope.

In times of high stress, people naturally look to leaders for cues on how to feel and act. How present and visible you are, and how well you communicate, will determine how calm, focused, and engaged they stay.

What's more, leaders play a vital role in helping workers build up their resilience in ways that will serve them later.

It's true that some people burn out or suffer PTSD from wartime conditions like these—but many others don't. In fact, those who consistently take steps to build up their own resilience may later come to see that terrible circumstances were growth experiences.

We have spent much of our careers studying high-performance healthcare professionals and isolating the tactics they use to cope with stress and build up their resilience. We've also paid attention to what the best organizations and leaders do to help workers get through stressful times and grow stronger afterward. Here are a few of our insights:

Two Crucial Strategies for Organizations

One, make sure the right communication tools are in place. Leaders need to communicate clearly, consistently, and often with those they supervise, making sure they're focused on the right priorities and sharing vital information. This builds employee trust and reduces anxiety. Yet such communication doesn't "just happen"—it requires that organizations hardwire tactics that ensure the right messages are consistently shared with those who need to hear them.

These tactics might include forums like virtual town hall meetings, shift huddles, and leader rounding. This last tactic—in which leaders regularly "round" on employees and ask a situationally relevant set of questions—can be especially powerful.

Rounding gives leaders a chance to regularly tell employees that their safety, and that of their families and patients, is their number-one priority. Employees can't hear that too many times. Rounding conversations also give staff members a chance to ask questions, make suggestions, and give feedback. All of this helps people feel cared for and more in control.

Teach leaders the WIRED approach to engagement and resilience. "WIRED" is an acronym for what leaders should keep in mind in times of crisis:

W - Focus on wellness of your people. At minimum, this lets them know you care and provides needed support.

I - Solicit their input. What do they need? This boosts their perceived control and conveys a sense of respect. Both can help bolster resilience.

R - Recognize their contributions. Nothing energizes people more than hearing "thank you." This also boosts engagement and "organizational identification" (i.e., "I am proud to be a member of this organization").

E - Teach people what they need to learn in order to have efficacy (task-specific self-confidence). People tend to enjoy doing what they are good at doing.

D - Now is the time to heighten dialogue between leaders and the troops. Doing so helps to curb "institutional silence." This silence is a major cause of anxiety and is chronic in healthcare, even in the best of times—but in a crisis, it can be especially harmful.

Dos & Don'ts for Leaders

Do be as present as you can be—without overwhelming yourself. Team members are frightened right now, and good leadership is reassuring. It stands to reason they will want you around all the time. To a certain extent, times like these do call on leaders to be around more and to give more. On the other hand, don't let your team overwhelm you. It is reasonable to set limits and to kindly remind them that you have many responsibilities—but will always come back.

Do give employees a method to express concerns when you are not available. For example, let them know they can email you with concerns or suggestions. Address these issues when you can (not in real time). Explain how important they are to you, but make it clear when you will be available and what is in the scope of your leadership so their expectations are realistic.

Don't try to solve every problem and every concern. In particular, don't stress about issues over which you have no control. What you can do is offer to look for appropriate resources for problems that are out of your purview. Remind yourself that a good leader brings the best out of his or her team by encouraging and supporting them, not by taking on all their tasks.

Do openly celebrate team members' successes. This makes them feel good in the moment and also encourages creativity and industry.

Don't imply that any team member's question is trivial or repet-

itive. Openly acknowledge and appreciate raw and unfiltered concerns—they are windows into the souls of your team. Let them know their concerns are real and important. Then, place these concerns into a framework of what is known about the disease and what current best practices are being used against it.

Do share that everyone is currently battling through the "fog of war." Many questions are unanswerable. Many conceptualizations will need to be reassessed and revised—and it's the questions that will help develop the answers. Admit openly when you don't know the answer to a question and offer that you will see if you can find someone who does.

You may need to remind the team that there will be exceptions to every rule with regard to this virus. Assert that you have to go with the best knowledge to date and address what works in the majority of cases, all the time keeping an eye out for and flexibility in response to the exceptions.

Do find ways to bring the team together. In a time of bona fide crisis, bordering on pandemonium, it is good to resort to tried-and-true methods of sustaining resilience, team, solidarity, and unity of purpose. Sustaining important relationships is a foundation stone for maintaining individual and team resilience.

Team-building exercises are a wonderful method to effect this. Allow these sessions to be free-wheeling, and allow some expression of anxieties and frustrations, but also steer people toward realistic optimism and mutual support and encouragement.

Don't obsess over the news. Break away from it all with regularity. When you're at home, stay away from the news, the talking heads, and the ideological websites. Enjoy your respite. In fact, seek periodic respite during the work days (and nights). A few minutes of calm and peace will go a long way toward destressing the day.

Do practice "wartime rotations." Consider this: Those on the front lines of a war are not kept there permanently week after week, but rather are rotated out with frequency. For example, the frontline soldiers in the trenches of WWI were rotated to the rear echelon every other week. Wherever possible, consider rotations where providers can experience a calmer environment periodically during the most active months of this pandemic.

Do learn the fundamentals of resilience—and share them with your team. There are certain tactics that predictably help people manage their energy and protect their well-being. For example: recognizing and harvesting daily "uplifts," replacing catastrophic thought patterns with healthier ones, looking for the larger meaning of your work, and focusing on your physical health. Leaders can and should practice them regularly and urge employees to do so as well.

As you help your employees become more resilient, you may find this quality increasing in yourself as well. This is one of the gifts of being a leader. While none of us would have chosen to go through this terrible time, we can acknowledge that hardship potentially leads to growth. There is always something to be grateful for.

Gary R. Simonds, MD, MHCDS, and Wayne M. Sotile, PhD, are coauthors of Thriving in Healthcare: A Positive Approach to Reclaim Balance and Avoid Burnout in Your Busy Life (Huron|Studer Group Publishing, 2019, ISBN: 978-1-62218-108-7, $32.00), The Thriving Physician: How to Avoid Burnout by Choosing Resilience Throughout Your Medical Career (Huron|Studer Group Publishing, 2018, ISBN: 978-1-62218-101-8, $32.00), and Building Resilience in Neurosurgical Residents (B Wright Publishing, 2015, ISBN: 978-0-69244-951-6, $24.95).

Gastroparesis Awareness Month in August

Awareness about the causes, risk factors, and symptoms of gastroparesis is critical as early diagnosis makes treatment easier.

Every year, the month of August is observed as "Gastroparesis Awareness Month" in the United States. Also known as "stomach paralysis," gastroparesis affects the normal working of muscles (motility) of the stomach and delays or stops the movement of food from the stomach to the small intestine. Mild gastroparesis can be easily managed, but if the condition becomes chronic, it could lead to life threatening complications.

Sponsored by the International Foundation for Functional Gastrointestinal Disorders (IFFGD), Gastroparesis Awareness Month is dedicated to improving, understanding, and management of the disease. This is the time to focus attention on gastroparesis diagnosis and treatment and encourage preventive strategies to improve health-related quality of life issues.

When the stomach muscles are functioning normally, ingested food is crushed and pushed into the small intestine where further digestion and absorption of nutrients takes place. In people with gastroparesis, the stomach's motility is slowed down or does not work at all. This can affect normal digestion and lead to various symptoms and complications.

Symptoms and Causes

The signs and symptoms of gastroparesis include:

- Nausea
- Vomiting
- Feeling full early while eating meals
- Acid reflux or heartburn
- Abdominal Bloating
- Chronic abdominal pain
- Changes in blood sugar levels
- Loss of appetite
- Weight loss and malnutrition

Complications of gastroparesis include dehydration due to continuous vomiting, fluctuations in blood sugar levels, and acute symptoms which make daily living activities challenging.

The underlying cause of gastroparesis is not clear. Uncontrolled diabetes is the most common underlying cause of gastroparesis. When diabetes causes the condition, it is referred to as diabetic gastroparesis. The condition makes it more difficult for a person with diabetes to control their blood sugar. In diabetic patients, the condition appears as more of a neuropathy-based disease associated with damaged nerves, according to gastroenterologist Michael Cline, DO (www.clevelandclinic.org). One of the nerves that gastroparesis affects is the vagus nerve, which controls the movement of food through the stomach. Damage to the vagus nerve affects the functioning of the muscles in the stomach and other parts of the digestive tract. This will upset and slow down the movement of food through the digestive system.

In addition to uncontrolled diabetes, other potential causes of gastroparesis include:

- Persistent post-viral effects
- Connective tissue diseases, such as multiple sclerosis or muscular dystrophy
- Side effects from medications (such as antidepressants, calcium channel blockers, clonidine, dopamine agonists, lithium, nicotine, and progesterone) which slow intestinal motility
- Nervous system diseases (such as Parkinson's disease or multiple sclerosis)
- Hypothyroidism
- Damage to the vagus nerve caused during gastrointestinal surgery

Gastroparesis that does not have a known cause is called idiopathic gastroparesis.

There are about five million people in the United States living with the debilitating or life-threatening symptoms of gastroparesis, according to IFFGD estimates. Women are more likely to develop gastroparesis than men. In non-diabetic patients, the condition may have to do with acid reflux, which causes delayed gastric emptying.

Challenges of Diagnosing Gastroparesis

Diagnosis of gastroparesis begins with a physical examination and evaluation of medical history and symptoms. Certain blood tests, including blood sugar levels, may be ordered. To make a definite diagnosis, the physician may recommend imaging tests, such as gastric emptying study, upper gastrointestinal (GI) endoscopy, ultrasound, upper gastrointestinal series, gastric manometry, and MRI scan.

Early diagnosis makes treatment easier, which is why awareness about the causes, risk factors, and symptoms of the condition is critical. However, diagnosing gastroparesis can pose challenges. In the Cleveland Clinic article, Dr. Cline points out that primary care physicians and even gastroenterologists often tend to overlook or under-diagnose the condition. Gastroparesis may also be initially misdiagnosed as an ulcer, heartburn, or an allergic reaction.

Furthermore, it may be difficult to distinguish gastroparesis from functional dyspepsia as these conditions share several symptoms (e.g., upper abdominal pain, fullness, and bloating) and pathophysiological abnormalities (e.g., delayed gastric emptying, impaired gastric accommodation, and visceral hypersensitivity), according to an article citing from a lecture presented at Freston Conference 2019, sponsored by the American Gastroenterological Association (MDEdge Internal Medicine, September 4, 2019). The report notes that comparing the pathophysiologies of gastroparesis and functional dyspepsia can help differentiate these disorders.

Treatment of Gastroparesis

Maintaining adequate nutrition and incorporating dietary changes are the first steps in managing this condition. Patients with gastroparesis are advised to take small, frequent meals that are low in fat and fiber, and easy to digest. However, such a diet may not work for patients with comorbid diabetes, irritable bowel syndrome, or renal failure.

Treatment for gastroparesis would be based on the cause, and severity of symptoms and complications, and patient variation in treatment response. Medications may be prescribed to stimulate the stomach muscles and control nausea and vomiting. Gastroparesis treatment primarily aims to mitigate symptoms, improve malnutrition, and help the patient resume adequate oral intake of liquids and solids. Diabetic patients need to take steps

to control their blood glucose levels to reduce risk of gastroparesis complications.

According to an article published in AGA Perspectives in 2018, there is an increased recognition that gastroparesis symptoms may be the result of not only delayed gastric emptying, but also due to several motor or sensory disorders of the upper gut, particularly the stomach. Therefore, diagnosing the patient's symptoms correctly is an essential first step to treating the condition. The article notes that while new pharmacologic agents offer hope, off-label use of approved medications is the mainstay of current management, in addition to dietary interventions.

People with severe gastroparesis may be unable to consume any food or liquids. Surgery will be recommended in such cases, wherein a feeding tube (jejunostomy tube) is placed in the small intestine to deliver a specially formulated nutrient-rich liquid food directly into the jejunum, where most nutrients are absorbed into the body. If you are experiencing symptoms of gastroparesis, you should consult your physicians as early diagnosis is crucial to prevent or delay complications.

How to Document Gastroparesis

When documenting gastroparesis, gastroenterologists must include the associated causes, symptoms, diagnosis, screening tests, and treatment procedures. The ICD-10 diagnosis code for gastroparesis is K31.84. ICD-10 combination codes identify both the definitive diagnosis and common symptoms of that diagnosis. So, if the physician has documented a diagnosis of "type 1 diabetes complicated by gastroparesis," the encounter can be reported using a single code: E10.43 (Type 1 diabetes mellitus with diabetic autonomic [poly]neuropathy. E10.43 includes both the diabetic manifestation as well as the diabetes itself.

Two different conditions—bezoars and ileus—must be included as part of the coding. Bezoars refer to a solid mass of indigestible food material that accumulates in the digestive tract, causing nausea and vomiting.

Bezoars have to be coded as foreign bodies using ICD-10 code categories such as:

- T18.2 – Foreign body in stomach
- T18.3 – Foreign body in small intestine
- T18.9 – Foreign body in alimentary tract, part unspecified

Ileus is a term for lack of movement in the intestines that results in a build-up and blockage of food material leading to intestinal obstruction. This means no food material, gas, or liquids can get through.

The condition can occur as a side effect after surgery. If ileus is confirmed as a post-operative complication without obstruction, the following codes need to be reported:

- K56.7 – Ileus, unspecified
- K91.89 – Other post-procedural complications and disorders of digestive system

If the post-procedural ileus causes an obstruction with the physician documenting it as a complication, coders are advised to use only code:

- K91.3 – Post-procedural intestinal obstruction

August was officially designated as "Gastroparesis Awareness Month" on July 12, 2016 by the then U.S. Senator Tammy Baldwin (WI) introducing a statement for the record on behalf of the millions of Americans affected by gastroparesis.

During the month of August, the IFFGD joins with patients, family members, and caregivers to increase public awareness about gastroparesis. Last year, IFFGD President, Ceciel T. Rooker summed up the importance of educating the public about this often-misunderstood condition in a press release:

"When there is an absence of reliable educational material for chronic GI disorders, such as gastroparesis, it often leads to a lack of understanding, which can lead to misdiagnosis and misguided treatments. Educating the ones around us is just the first step to increase public awareness so that the needs of the patient community can be met."

People experiencing symptoms of gastroparesis should not delay consulting their physician as early diagnosis is crucial to prevent or delay complications.

Meghann Drella, CPC, is a Senior Solutions Manager at Managed Outsource Solutions (MOS), and is responsible for practice and revenue cycle management in the Healthcare Division. She has a formal education in Medical Coding and Billing and over 12 years of hands on experience in the field. She holds a CPC certification with the American Academy of Professional Coders (AAPC). Meghann has a strong understanding of ICD-10-CM and CPT requirements and procedures, and regularly attends continuing education classes to stay up to date with any changes. www.managedoutsource.com

Coronavirus & Telehealth Cheatsheet

innoviHealth®

Medicare-Approved Telehealth Services

Evaluation & Management | Other

Service Type	Codes
Evaluation & Management	99201-99205; 99211-99215
Prolonged E/M Services	99354-99357; G0513-G0514
Hospital (inpatient)	99221-99223; 99231-99233; 99234-99236; G0425-G0428; G0406-G0408; G0459
Observation Services	99217-99220; 99224-99226; 99234-99236
Intensive Care Unit (ICU)	99477-99480
Nursing Facility	99304-99308; 99315-99316
Critical Care	99291-99292; G0508-G0509; 99468-99469; 99471-99472
Home Visits	99341-99345; 99347-99350
Domiciliary, Rest Home, Custodial	99327-99328; 99334-99337
Advanced Care Planning	99497-99498
Annual Wellness Visit	G0438-G0439
Assessment/Care Planning, Cognitive	99483; G0506
Transitional Care (TCM)	99496-99497
Psychiatry	90785; 90791; 90792; 90832-90834; 90836-90840; 90845-90847; 90853
Psych/Neuropsych Testing	96130-96133; 96136-96139
Substance Interventions	G0396-G0397; G0436-G0437; G0442-G0447; G0442-G0447; G2086-G2088
Emergency Visits	99281-99285; G0425-G0427
Behavioral Assessments, Counseling, & Education	96156; 96158-96159; 96160-96161; 96164-96165; 96167-96168; 99406-99407; G0108-G0109; G0420-G0421; G0296
Physical, Speech, & Occupational Therapy	92507; 92521-92524; 96116; 96130-96133; 96136-96139; 97110; 97112; 97116; 97161-97168; 97535; 97750; 97755; 97760-97761
Nutrition Services/Therapy	97802-97804; G0270
ESRD Services	90951-90970 (90953, 90959, 90962)
Radiation treatment Management	77427

Telecommunication Services

Codes	Service Notes
Other (non-telehealth)	
G2010, G2012	Virtual Check-ins • New patient OR Established patient • Physician or NPP/QHP • Special rules apply
G2061-G2063* 99421-99423	E-Visits • G-Codes are reported by NPPs/QHPs • CPT codes reported by physicians • Established patients only • Time-based codes *Clinicians unable to bill independently (PT, OT, SLP, clinical psychologist) report these codes
98966-98968	Telephone Assessment & Management • Nonphysician practitioners/QHP only • Established patient, parent
99441-99443	Telephone E/M service • Established patient • MD/QHP/NPP • Special rules apply
Remote Monitoring Services	
99457-99458	Remote physiologic monitoring • Clinical staff, physician, QHP • Time based-per month • Primary and add-on codes
99473-99474	Remote monitoring BP device • Calibration, education & training • Data collection & physician/QHP report
99493-99494	Remote monitoring • Psychiatric collaborative care management • Timed based-per month

Place of Service (POS)

During the Public Health Emergency, the POS for telehealth services is reported based on individual payer preferences. Medicare prefers the POS as the place where the service would have taken place if performed in person instead of POS 02, along with modifier 95 to identify telehealth. Medicare patients may receive telehealth services from home.

Cost Sharing

Medicare Part B cost-sharing (coinsurance and deductibles) are waived between March 18, 2020 and the end of the Public Health Emergency for COVID-19-related testing (e.g., U0001, U0002, U0003, U0004, 87635, 86328, and 86769), or E/M services performed to determine if testing is needed, to order testing, or to administer testing.

See cms.gov/files/document/se20011.pdf for E/M Medicare Part B categories.

Telehealth (T) Modifiers

GQ	Remote monitoring services are part of a federal telemedicine demonstration project
GT	(T) Critical Access Hospital (CAH) method II claims
G0	(T) Service for diagnosis/treatment of acute stroke
95	(T) Identifies services not subject to cost-sharing due to COVID-19 waiver
CS	Cost-Sharing waived for COVID-19 testing-related services
CR	Catastrophe/Disaster-Related Service - NOT Telehealth – Part B claims
DR	Disaster Related (insitutional billing only)

COVID-19 SARS-CoV2 Specimen Collection & Testing

Collection*
- G2023 Home
- 99211 Office
- C9803 Outpatient (hospital)
- G2024 Skilled Nursing Facility

Handling/Conveyance
- 99000 Office to laboratory
- 99001 Other location (not office) to laboratory

Testing | Testing labs require CLIA certification
- U0001 CDC test (real-time RT-PCR panel)
- U0002 Non-CDC (any technique, multiple subtypes)
- U0003 Nucleic-Acid (high-throughput technologies)
- U0004 Any method (high-throughput technologies)
- 87635 Nucleic-Acid (swab)
- 86328 Antibody: Single step (reagent strip)
- 86769 Antibody: Multi-step

Laboratory Prorated Travel Fees

P9603 miles traveled

P9604 trip charge

*Report with codes G2023 or G2024

HIPAA Violation Waivers

HHS OCR plans to waive penalties for HIPAA violations resulting from the good-faith use of non-public-facing technologies during the Public Health Emergency (e.g., FaceTime, Skype)

COVID-19 ICD-10-CM Codes

- Confirmed case (symptomatic, asymptomatic, or presumptive positive) (U07.1)
- Symptomatic, not confirmed (report symptom codes)
- Contact with COVID-19 (suspected exposure) (Z20.828)
- Possible exposure, ruled out (Z03.818)
- Asymptomatic (none or unsure of exposure), ruled out (Z11.59)
- Negative COVID-19 but confirmed other condition or illness (report codes for other condition or illness)

E/M Key Components

Scoring is based on either the three (3) key components or time.

Three Key Components

1. **History:** CC, HPI, ROS, PFSH
2. **Exam:** Perform & document findings in the affected or related body areas or organ systems
3. **Medical Decision Making:**
   a. Number of diagnoses or problems
   b. Amount of data ordered or reviewed
   c. Risk of death, morbidity, loss of bodily function with the treatment planned

Time: Document the time spent face-to-face (or audio visually), including a summary of what was discussed, counseled, or any care coordinated.

COVID-19 Coding guidelines are changing rapidly. As of April 14th, 2020 this coding cheat sheet is current. Visit our Resource Page and verify codes at FindACode.com for continued current information.

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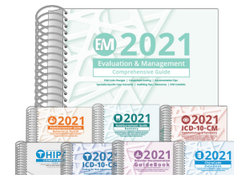
HCC CODER™ www.HCCcoder.com

FIND-A-CODE® www.FindACode.com



BC Advantage magazine is honored to interview Karen Blanchette, MBA, Executive Director of The Professional Association of Health Care Office Management (PAHCOM).

Learn here about Karen's commitment to PAHCOM's members, as well as her commitment to the industry. Not only is she Executive Director of PAHCOM, but as you read through this interview, you will also learn that she holds a world record, served in the Navy, was the first woman in the Navy to … well, we don't want to spoil it, so you will just have to read on to learn more.

We want to thank Karen for being a part of this issue and highlight our commitment to the non-clinical staff within a practice and the industry, emphasize the importance of being certified and maintaining further education. Every position you have in your lifetime is important to where you are today and your future.

Enjoy this interview and feel inspired to be the best you can be in work and life!

BCA: How long have you been in the healthcare industry?

KB: I began working at PAHCOM while I was still in college. At that time, I was stuffing envelopes and helping out at the conferences as an unpaid family draftee. Some of you already know that my father founded PAHCOM back in 1988 after his 30 year career in US Navy Medicine; first as a Hospital Corpsman, and then as a Medical Service Corps officer.

Following in his footsteps, I joined the Navy after obtaining my MBA and officially began my professional Navy Medicine career in 1991. In "sipping from a firehose" fashion, my first assignment was as administrative assistant to the Director of Surgical Services (DSS) at a large Navy hospital where I became experienced in handling surgical administrative operations. It was an amazing introduction to healthcare management that forever imprinted the physician's perspective for a strong foundation and future in the industry. My next experience was in the Patient Administration department at the same 500 bed hospital in Portsmouth, Virginia.

What I really love about the military is that the training process is purposeful, even though it is not always obvious. That first experience of working side by side with a top surgeon through all of the budgetary planning, staffing, managing the directorate, and interacting with other departments shaped my sensitivity to the priorities of the providers that guided my focus and efforts throughout my career, and to this day. It is easy to get swept into the chaos of the moment, but it is critical that clerical management stay grounded in our purpose to serve our providers so they can more effectively deliver the best healthcare to our patients.

BCA: What is your current role? How did you get to this position?

KB: I am the Executive Director of PAHCOM and celebrating my 11th year at the helm. PAHCOM supports solo providers and small group physician practices all across North America and in every medical specialty. I was fortunate to have served in Navy healthcare and of course, was mentored for many years by my father. His vision helped to bring distant practices together and began the PAHCOM Collaborative Network way back when no one even had internet. In those old days, it was

On the flight deck. Shirt colors determine job. Medical is a white shirt

far more difficult to connect, for example, physician practices trying to solve a problem in Connecticut with practices in Arizona that had recently experienced the same problem and had the answers. I learned from the best. It was very helpful that I had a well-rounded education and experience in healthcare, banking, logistics, and information technology. I am grateful that I had the opportunity to work in so many industries and am pleased to realize just how much those experiences support my role today.

BCA: Can you tell us more about your roles and career during your service? (BC Advantage staff thanks you for your service!)

KB: It was a pleasure to serve in our armed forces and I can think of no better training ground for healthcare management. I touched a bit on this in an earlier question, but I'll elaborate here. The military is excellent at process and training. They put you in situations where they know it will be challenging, but they give you support to achieve success. Then they move you to a different challenge that draws on earlier lessons, but still pushes you into more complex scenarios. Then another one. All the while, they are building a well-rounded and versatile tool for their machine. I know that sounds impersonal and it is. But military personnel are trained to have a primary purpose and the ability to swap out and fill in as the situation requires. The process creates higher efficiencies on a larger scale.

My job at the DSS is exactly like my colleague's job at a sister hospital DSS. We learn the same things and are on the same training program (even when it is not called "training," it always is). I feel that everyone is always in training of some kind. Personally, I went from an administrative assistant in the surgical department of a 500-bed hospital, to the senior medical administrator of a 5,000 crew nuclear aircraft carrier.

BCA: You were the first female healthcare manager assigned to an Aircraft Carrier. How did it feel to be the first and what was your experience in such a male dominated field?

KB: It was an honor to serve as the senior healthcare manager (MAO - Medical Administrative Officer) on USS John C. Stennis back in 1995. It wasn't easy winning the assignment as competition for combat ship positions among Medical Service Corps officers (male and female) is fierce. Most of us never see a ship, never mind a brand new aircraft carrier. With a 65-bed hospital onboard, outfitted to serve all kinds of patients in a host of unusual circumstances, it was a dream job. I was sent to school with submariners at the Naval Undersea Medical Institute (NUMI) to learn about radiation effects on humans and how to manage risks. As it turned out, part of my job was to lead the radiation health program for the ship (RHO - Radiation Health Officer). We had two nuclear reactors and thousands of sailors onboard, so it was a huge undertaking that included every person wearing thermoluminescent dosimeters (TLDs) to regularly track their radiation exposures. Of course, we also held drills for handling the unspeakable disasters that might occur. When you are out to sea, there is no referral to the specialist or hospital down the street to help you, so if we can't handle whatever it is, people lose their lives. But the military has a way of building camaraderie and strong team philosophies among troops. We know that our lives might depend on the guy sitting next to us. It is a captive audience. Rules are enforced and process efficiencies are attained.

BCA: Your experience in the Navy and in healthcare is a powerful statement for all women. Do you have some words to empower or inspire our readers in life and work?

KB: Thanks for this follow up as I almost forgot to touch on the "male dominated field" part of your earlier question. The military is a subset of our general population. Whatever issues are in the civilian sector, the military has them too. Inequalities of all kinds exist, and I would say are worse. Fear of retaliation is more of a factor when you can't just quit and go

Approving CEU and Webinar Associations

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

home. In the military, you are in for however long you signed up for, and if you're deployed, out to sea, in a foreign county, etc., you're at the mercy of your command. I tended bar all through college, before I joined the Navy, and because of that, I had been exposed extensively to cat-calls, sexual commentary, advances, etc. I think that I had experienced so much of it, that I could see it coming a mile away, and that enabled me to head it off and avoid a lot of issues before they started. I worked in a shipyard for a while. It was in a dangerous part of town with a lot of crime. Sailors were taught to buddy-up walking to your car, look strangers directly in the eye, carry your keys in your hand, etc. We've all heard of these self-defense and safety tips. I found similar steps taken to prevent and avoid sexual harassment were effective for me.

But there is more to the inequality than advances. Women are often assumed less qualified than their male counterparts; that's the type that bothered me the most. And I do feel it's a bit more prevalent in the military than in the civilian community. But the way to move the ball forward is to continue to lead by example. I encourage women to step up and excel at your profession. Be the change you want to see. Hold your head high and do an excellent job. Prejudice will not change overnight, but it will never change if we fail to demonstrate our value, over and over again. Sometimes it can feel pointless, but every baby step in the right direction makes a difference. This is where hindsight plays a strong role. Viewing the role of women today with the very limited roles available in the 1950s provides a realization that equality is moving forward. Change is taking place faster and faster, even though real progress takes enormous time and perseverance!

Fleet Hospital 5 training in Camp Pendleton

BCA: What have you learned about life and work from serving in the US Navy that you feel healthcare workers could benefit from?

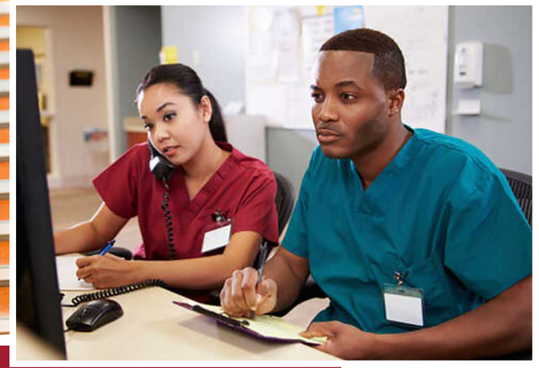
KB: Work ethics, discipline, "can do" attitude (credit Seabees). When you function as a team, there is no limit to your potential.

Also critical is process! Take time to create efficient processes and then communicate those to your team. The more procedures are documented in handbooks, the more consistently staff will perform (PDF, Google Drive, however you share documents). When we all sing from the same sheet, it makes a huge difference. I cannot stress that enough. The vast majority of failures I've witnessed are due to a lack of efficient process or training of staff to use the processes in place. If you're not familiar with Lean Six Sigma, I highly recommend looking into it.

BCA: As Executive Director at PAHCOM, what skills and assets do you feel make a great leader and practice manager?

KB: Recognize that unless you are the owner of the practice, you are the linking pin between senior management and the staff. Great practice managers communicate both up and down the chain of command. Listen to your team to both explain why procedures are mandated and garner ideas for doing things more effectively.

Demand integrity from yourself and those you work with. Always strive to increase efficiency. Never rest on your



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laurels, continue to learn each day, and deliver excellence to your customers (members, providers, patients). Love what you do and you will make a positive difference in the lives of those both up and down the chain of command.

BCA: What advice would you give to anyone in healthcare who might be considering serving in the US Navy or any armed services?

KB: Do it! There is no better place to gain a ton of experience in a short period of time. You will learn so much about yourself, building teams, realize that you can master things you never thought you could even survive, and become a strong and confident leader. Realize that the military has up-to-date medical technology training. Everything you learn is immediately applicable to the civilian healthcare industry. It is also great for the GI Bill and other veteran benefits after you leave the military. And for fellow veterans out there, the PAHCOM CMM exam is approved by the U.S. Department of Veterans Affairs for GI Bill funding (USVet@PAHCOM.com).

BCA: What advice would you offer someone thinking about starting a career and certification with the healthcare industry?

KB: Get connected with people doing the work you want to do. At PAHCOM, we have an Academic Credentialing Program (ACP) designed to expose students to the physician practice industry. As part of the program, we partner with colleges to facilitate teaching the Nine Domains so that new graduates are better prepared for the workforce. It not only benefits the students, it also benefits our member practices looking for qualified staff, and eventually, succession planning. The ACP is a tough program for the career minded and includes membership in PAHCOM. At the end of their program, students are able to sit for the Certified Medical Manager (CMM) exam, even before reaching the minimum experience threshold otherwise required. Those who pass are awarded the Certified Medical Manager – Academic (CMM-A) until full CMM experience requirements are met. The CMM-A demonstrates their commitment to the industry and a level of knowledge previously unheard of for entry level graduates. It gives them professional recognition as they launch their careers.

BCA: BC Advantage is a big believer in certifications and continuing education. Do you think all industry professionals should look to join an association like PAHCOM, and why?

KB: We agree 100% with BC Advantage regarding the importance of certification and continuing education. Collaboration, networking, access to resources, and staying in the loop within your region and specialty—all of that is necessary. Years ago, certification gave practices an edge. But today, it is a must just to keep up with the competition. Your practice is absolutely losing money if you are not investing in your team. Substandard clinicians can cause damage to your practice; most physicians understand that. But substandard clerical management can cause unnoticed damage, mostly in the financial arena. We see fewer physicians really recognizing that fact.

Our focus is on solo providers and small group physician practices. We help physician owners understand what their business responsibilities are and show them quality, yet inexpensive ways to address those responsibilities. Many think that they have to hire an MBA (which most can't afford), sell to a larger group, or merge with a hospital because of all the red tape of running their own business. It is extremely difficult to be a clinician and run the business. That's why PAHCOM was founded back in 1988.

The solution is simple. Hire a manger, appoint your spouse if you want to, it's fine as long as they are dedicated and willing to learn. By "dedicated," I mean full-time focused on your business. Too many physicians try to manage at night when the kids go to bed or on weekends. It is a very rare person that can be the best clinician and the best business manager simultaneously. Consider the revenue generation capacity wearing the clinician hat, then wearing the clerical manager hat. Clinicians perform the money generating activities of the organization. The clerical staff does not. Depending on your specialty and geographic location, a manager is paid less than 25% of a clinician's compensation.

Bringing in more revenue and keeping expenses low is important, but there's more. Practice management is a very broad field. In hospitals and larger practices, there are rafts of department heads for things like revenue management, human resources, marketing, etc. It pays to have at least one person dedicated to ensuring that your business isn't dropping any of these balls or bouncing from one fire to the next. A dedicated resource will plan, organize, direct, and control at the levels necessary to grow the practice.

Take a look at the Nine Domains of Medical Practice Administration (revenue management, risk management, human resources, finance, contracts, business management, technology & data, clinical performance reporting, and lastly, patient clinical education & practice marketing). These are the things the practice manager/administrator needs to be an expert in. Even if you're outsourcing some of the business, management should be knowledgeable enough to properly manage the outsource contract and periodically audit the work to ensure the quality your business demands.

Specific to your question about certification, testing for the right knowledge and skills is absolutely necessary to determine qualifications. This is the case across many industries and is certainly true in healthcare. Medical management has become more and more complex and absolutely requires a certain level of expertise in order to be successful. Proctored exams are the right way to test, so make sure you vet credentialing standards, process, and accreditation before choosing a credential. Of course, we recommend the Certified Medical Manager (CMM) credential and we invite you to look deeper into that credential as it is the most rigorous in the industry, tests on all Nine Domains, is nationally accredited, and it's proctored.

Don't worry if your favorite manager isn't quite up to speed on the Nine Domains. PAHCOM does not require certification to join the network. We can help your manager "get there." Empower them to begin fostering relationships with peers in physician practice management who freely share knowledge and support each other. Local competition often stymies sharing knowledge in the local community. The PAHCOM member communication network is national. Every day, a manager in New York freely communicates with another practice from a different state for specialty specific advice or help getting to the crux of a new law. They are not your competition. I was blown away by the collaboration I witnessed when I first started working full-time with PAHCOM. Coming from largely male dominated industries, I was familiar with professional associations, but never saw much to speak of regarding actual help from most peers. It's a beautiful thing to witness distribution of information for the purpose of helping one another and enriching the collective success of the group. It's a simple concept but one rarely seen in business. PAHCOM shares knowledge!

Lastly on this point, as a CMM, continuing education is required, but it is a smart thing to do whether you're credentialed or not. Organizations like BC Advantage offer excellent programs that keep us up to speed on best practices and changes in regulations. Practice management is a moving target and keeping your knowledge fresh is important. Check out the PAHCOM Education Calendar for a list of upcoming events, all relevant to the Nine Domains of Medical Practice Administration.

BCA: What were your thoughts on the Mercy, Navy's COVID-19 Hospital Ship, and the future of the ship and other floating hospitals moving forward?

KB: I was very proud to see Navy Healthcare stepping forward to assist in this crisis. When I saw USNS Mercy in the news, it gave me pause for thought and I reflected on my service. My experience was different, but nonetheless, images of the Mercy left me feeling nostalgic.

The Mercy is a 1,000-bed hospital compared to my 65-bed hospital on USS John C. Stennis. Of course, their mission is different as we were mostly an airport with a hospital designed to support our own ship's company (5,000 sailors who should be healthy unless there's an issue). Mercy is mostly a hospital with 80 ICU beds, 11 OR suites, 15 wards, and elevators for people. I emphasize the elevators because you don't get those on aircraft carriers. The only elevators we had were for jets and other heavy equipment.
The Mercy and the Comfort are state-of-the-art mobile hospitals with tremendous capacity to treat trauma patients. The future of the ships remains in the realm of supporting mass casualty scenarios anywhere in the world. Their ability to receive helicopter patients extends their usefulness well beyond the water's edge.

185 MPH world record in skydiving

BCA: Speaking of aircraft, a little birdie told us that you hold a world record in skydiving. Wow! Please tell us more.

KB: (Laughing out loud) You surprised me with that one. It is true, I have a lot of strong mentors and influencers in my life who made it possible for me to excel. Skydiving is about focus and discipline. Sure, it's exhilarating and initially terrifying. Skydiving is a fast sport where you depend on teammates to keep you safe as you all push to do things no one has ever done before. It is not unlike what is happening across the industry with telehealth and the PAHCOM community, sharing knowledge like never before, lifting each other up to succeed in unprecedented times, and ultimately to better serve our patients.

BCA: What are the main factors that have affected physician practices with COVID-19?

KB: Every solo and small group physician practice has experienced the emotional trauma of potentially being the source of the disease they are attempting to eradicate. For the first time, the doctors, nurses, and staff of small practices have had to recognize that they are each subject to contracting COVID-19 and spreading it to their patients. The focus of prophylaxis and isolation of potentially contaminated staff has affected every aspect of practice operations.

The major traffic factors include things like requiring that patients wear face masks, limiting the waiting room capacity to three patients, and prohibiting spouses and friends from accompanying the patients. The major clinical factors are accelerated inclusion of telehealth, and modification of health insurance policies such as Medicare. There are also business factors impacted by the reduced patient volume requiring applications for the Paycheck Protection Program, and economic impact payments.

All of these points are addressed in PAHCOM forums, some public and others for PAHCOM members only. If you're not a member yet, you might just pop over to the PAHCOM YouTube Channel or Education Calendar to see some of the resources we offer publicly (YouTube for archives of some of our favorite webinars and Education Calendar for upcoming webinars). Oh, and we also have a PAHCOM Podcast, Medical Management Radio. It is free to the public.

BCA: BC Advantage wanted to say thank you for your service and dedication to further education with the healthcare industry. Anything else you would like to share with our readers?

KB: You are welcome on both counts and we thank you for being important partners in our collaborative network. We were delighted to receive accreditation approval to finally offer CEUs on demand so that people with less flexible schedules could still access quality continued education approved for CMMs. We are very grateful to BC Advantage for being our first "CEUs On-Demand" partner and helping us kick off that program. There's still much work to be done.

PAHCOM celebrates 32 years of assisting small group and solo practice managers in their practice management efforts. It's not always been easy, but we've persevered and continue to lead the way with the highest integrity. Within our membership are many physicians who have expressed sincere gratitude for the existence of PAHCOM (some individually, others through their employee or spouse managers). I am personally proud of the hundreds, if not thousands of individual friendships that have resulted from our focus on sharing knowledge, and providing sincere, timely, and accurate information to our membership. And I'm excited about what the future holds for our profession.

I'll close with a quote from our founder. "Alone we are one; together we are PAHCOM" -Richard Blanchette Sr.

3 Ways to Automate Front Office Tasks

Healthcare front offices are a hive of nonstop, vitally important activity. Reception duties, appointment scheduling, coding and billing, and collection of patient information are just a few of the critical responsibilities shouldered by front office personnel. But when the front office staff is overwhelmed, the whole practice suffers.

Billing headaches increase. Collection costs rise. Cash flow deteriorates. Revenues evaporate. But there are three key ways that technology can cure all of these vexing and chronic problems, simply and affordably. That's because it's now possible to fully automate the most burdensome tasks of insurance verification, payment processing, and generation of invoices and monthly statements.

Automated Eligibility Verification

Especially these days, one of the most labor intensive hassles is doing eligibility verification for insurance reimbursement. Without verification, patients don't have a realistic idea what they owe or how to plan to repay those obligations. But making phone calls and chasing down insurance information to complete accurate verification is incredibly time consuming and inefficient. Oftentimes, data on file is outdated or incorrect. Practices can waste many hours trying to collect from pestered patients, only to find out that it was the insurance company's responsibility to make the payment.

Software systems to perform that work are the answer, because they automatically conduct verification while making billing more transparent and understandable. Batch requests can be processed overnight, for example, and eligibility information can be securely accessed and viewed 24/7. Patients appreciate the convenience, and front office staff members are free to focus on more pressing and valuable issues, like quality of care.

Payment Plans

Healthcare front offices can also significantly improve both collections and customer retention rates by offering patients the option of automated and personalized payment plans. Secure HIPAA and PCI compliant online payment platforms can accept virtually every form of payment, 24 hours a day, while facilitating both recurring and installment payments. Patients enjoy the convenience and financial flexibility, and 65% of those surveyed would consider switching healthcare providers if it meant an improved payment experience.

nearly **70%** of patients prefer to pay their healthcare bills electronically

Meanwhile, healthcare practices minimize payment cycle delays and reduce the need for costly collections. They also save money on every transaction, according to a CAQH index report. It revealed that electronic transactions can save a practice $3 each time they are processed, compared to doing the same tasks manually. That's easy money to add to the bottom line, while making life considerably easier for the front office.

E-Statements

Electronic bills and monthly statements are also less costly and more efficient. Perhaps more importantly, they address one of the biggest concerns that more than 90 percent of patients and providers share, which is security. Unfortunately, paper statements lack the security protocols of a cloud-based digital system.

Paper statements are labor intensive, bulky, and difficult to archive and safeguard for privacy and regulatory compliance. They also annoy patients who are accustomed to viewing statements and paying bills online in an e-commerce world. No wonder nearly 70 percent of patients prefer to pay their healthcare bills electronically, as confirmed by a 2017 InstaMed report.

Healthcare payment processing technology may not be able to fix the toner in the copy machine or add paper to the computer printer. But it could potentially eliminate those tasks from the front office workload altogether, through intelligent automation.

NTC Healthcare. www.ntchealthcare.com

Key Strategies for Improving Clinical Documentation in 2020

Precise, complete, trustworthy, and timely documentation is critical to validate services provided, reduce risks, and improve patient care.

With accurate clinical documentation, a medical billing company can help healthcare providers submit valid claims for reimbursement.

If the information presented in the documentation does not provide a complete and accurate picture of the care received by a patient or does not support the billing codes, claims may be denied.

While electronic documentation is designed to increase both the quality and the utility of clinical documentation, it has resulted in large volumes of data and repetitive information. Maintaining documentation integrity while using automated EHR functions has become a major challenge for physicians. The Centers for Medicare & Medicaid Services (CMS) is simplifying documentation through its "Patients over Paperwork" initiative, but the focus is still on quality improvement.

However, there are two things physicians should know about clinical documentation improvement (CDI):

- CDI is not about just ICD-10 or CPT coding, but about ensuring that the medical record provides an accurate picture of the patient encounter.
- CDI is not about providing more documentation; it's about improving the quality and value of clinical documentation and better using this documentation to improve care.

Here are 5 strategies that experts recommend to improve clinical documentation in 2020:

- **Tell the patient's story:** The clinical record should tell the patient's story in as much detail as is required to ensure seamless care. The documentation should communicate the patient's past and present health information and medical treatment to other clinicians. Providing a summary of previous history and its impact on treatment options would be useful. The documentation should also convey the physician's thought process about the patient's care. For instance, accurately portraying a patient's comorbidities is essential to ensure high-quality care for chronic diseases.

- **Use the SOAP documentation method to add narrative to the record:** Instead of just checking boxes in the EHR, physicians can still use the traditional SOAP documentation to add their narrative to the record. The Rheumatology article notes that including the physician's assessment and rationale would prove valuable to support the plan of care and demonstrate medical necessity for services provided.

- **Supplement E/M templates with free-form text:** The medical record should indicate the correct E/M level that best describes the service provided. The nature of the presenting problem and the complexity of medical decision making are key considerations when choosing the E/M level. However, standard EHR systems feature documentation templates for the four E/M office visit levels that make it easier to get higher levels when the medical necessity might not be there. Experts recommend supporting EHR templates with using free-form text to describe the nature of a visit. For instance, even one or two lines can add detail and integrity to the note by stating what is unique to that patient visit.

- **Think twice before using the EHR copy-paste function:** The ECRI Institute warns that poor use of copy-paste can affect clinical documentation quality by:
  - Introducing new inaccuracies
  - Facilitating the propagation of inaccurate information
  - Allowing the creation of internally inconsistent notes, and
  - Resulting in lengthy notes that may obscure important clinical information
  - Best practice is to perform a mindful review to ensure that the documentation is not redundant and reflects the current situation

- **Capture new findings and relevant information:** In addition to pertinent facts, physicians need to document new findings and impressions. This includes diagnosis, positive exam findings, pertinent negative exam findings, and significant abnormal test findings. Physicians need to use their clinical expertise to translate findings into diagnoses (www.hospitalist.com). This may result in more clinical documentation and the use of more diagnostic codes.

The ICD-10 official guidelines address coding for uncertain diagnoses, with different rules for inpatient and outpatient coding. Hospitalists can offer an uncertain diagnosis for a condition that is suspected as being present: If the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," "compatible with," "consistent with," or other similar terms indicating uncertainty, code the condition as if it existed or was established. In the ICD-10 guidelines for outpatient settings, CMS states: "Do not code diagnosis documented probable, suspected, questionable, rule out, compatible with, consistent with, or working diagnosis or similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for the encounter or visit, such as symptoms, signs, abnormal test results, or other reason for the visit."

The goal should be to ensure clear, accurate, concise documentation that conveys the patient's story and treatment plan to other caregivers. The physician should make sure that fellow clinicians reading the note understand their thought process and why those conclusions were drawn so that they can continue to provide the right care. A monthly or quarterly documentation self-audit of a select number of patient records can help identify any issues and drive improvement.

Excellent documentation is important for superlative patient care, compliance, medico-legal, utilization review, and accurate reimbursement. Outsourcing medical billing and coding is a practical option to ensure accurate ICD-10 and CPT coding to submit accurate claims and improve cash flow.

Meghann Kiernan writes for Outsource Strategies International. www.outsourcestrategies.com

Appreciating the Importance of Including Automated Dispensing Cabinets in HIPAA Risk Analyses

According to Taber's Cyclopedic Medical Dictionary (2017), an Automated Dispensing Cabinet (ADC) is "a cabinet or drug storage device or that electronically dispenses medications in a controlled fashion and tracks their use, replacing or supporting the traditional unit-dose drug delivery system" (Venes, p. 222). ADCs are often integrated with electronic health record systems or medical information systems for the purpose of patient care and oversight of prescription drug utilization for both controlled and non-controlled substances.

The use of ADCs is not new. In fact, they have been around in hospitals for as long as diagnosis related groups (DRGs)—since the early 1980s. Ambulatory surgery centers and physician office-based surgery practices also utilize ADCs. As the utilization of ADCs grew in the 1990s, a multitude of studies related to the safety and efficacy of the machines on patient care were conducted. The studies illuminated the following issues: mislabeling of drugs; improperly filled dispensing cabinets; lack of safety record procedures; large numbers of doses dispensed; and the ability to override system access tracking.

It was not until 2005 that the Drug Enforcement Agency (DEA) permitted pharmacies to install ADCs, such as Omnicell and Pyxis, at long-term care facilities (70 Fed. Reg. 25462-25466, May 13, 2005). In light of the opioid crisis, there is concern of the ADC override features available on different machines when a drug is removed by the caregiver before the pharmacist receives, evaluates, or enters a drug order. Some caregivers are not getting pharmacy approval and are merely dispensing the drug. Additionally, many anesthesia departments have their own ADCs, which contain a vault of controlled substances, due to the nature of this area of medical practice.

The lack of access control logs, overrides, and integration with electronic health records can be very problematic in terms of patient care, diversion of medication, and misstated patient records. Hence, the relevance of ADC to a risk analysis (often called a risk assessment) is required under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191) and the related Security Rule.

Analysis

The requirement for conducting an annual risk analysis falls under the umbrella of the Security Rule at 45 CFR § 164.30(a)(1)(ii)(A). As the U.S. Department of Health and Human Services, Office for Civil Rights (HHS-OCR) articulates:

> Conducting a risk analysis is the first step in identifying and implementing safeguards that comply with and carry out the standards and implementation specifications in the Security Rule. Therefore, a risk analysis is foundational, and must be understood in detail before OCR can issue meaningful guidance that specifically addresses safeguards and technologies that will best protect electronic health information. (hhs.gov)

In essence, the Security Rule indicates that a risk analysis is the foundational element for evaluating a variety of technical, administrative, and physical safeguards to ensure that the confidentiality, integrity, and availability of the information remains intact. It requires covered entities, business associates, and subcontractors alike to "implement policies and procedures to prevent, detect, contain, and correct security violations" (45 CFR §164.308(a)(1)).

The Security Rule and OCR cite to the National Institute for Standards and Technology (NIST) publications. NIST defines confidentiality, integrity, and availability as follows:

- Confidentiality – "preserving authorized restrictions on information access and disclosure, including means for protecting personal privacy and proprietary information";
- Integrity – "protection against unauthorized modification or destruction of information"; and
- Availability – "timely and reliable access to and use of information.

Both the Privacy Rule and the Security Rule leave no ambiguity that certain technical, administrative, and physical safeguards are required in order for an organization to be considered compliant with HIPAA, the Health Information Technology for Economic Clinical Health Act (HITECH Act), and the related Meaningful Use attestations, which enables hospitals and providers alike to receive large sums of money in the form of incentive payments, which are like grants. Given that patient information is entered into an ADC and transmitted to an EHR (or vice-versa), the confidentiality, integrity, and availability of the PHI is required to be assessed in accordance with the Security Rule.

In late 2016, the Joint Commission conducted a field review of all proposed revisions related to medication management. As a result, crucial final standards emerged, which include the following: record the date and time of any medication administered in the patient's clinical record; implement comprehensive policies and procedures that articulate the categories of medication overrides that will be reviewed for appropriates and the frequency of the reviews when ADCs are used; and incorporate "wasting" of medications to the related policy and procedure that addresses the control of medications between when they are received by an individual healthcare provider and when they are administered, how they are documented in the patient chart and appropriate facility log, and the appropriate process for disposing of the waste, as well as accurate billing of the medication. All of these items identified by the Joint Commission are a fundamental part of the risk analysis.

Conclusion

Overall, it is imperative for those persons conducting an adequate Security Rule risk analysis to include any ADC in its evaluation of maintaining the confidentiality, availability, and integrity of the PHI in relation to technical, administrative, and physical safeguards. Appropriate items to evaluate in relation to an ADC include access control logs, policies and procedures, penetration test results, software patch updates, wasting of medications, and the related billing, as well as the amounts of medication dispensed.

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5 Ways

the Patient Portal Benefits Providers During a Pandemic

The use of digital and virtual medical services has skyrocketed during the coronavirus pandemic. The ability to communicate with and treat patients remotely is essential to the fight against COVID-19, and tools like telehealth and the patient portal have proven themselves extremely valuable.

In order to stop the spread of the coronavirus, symptomatic patients need to stay away from the public, out of medical facilities, and in their homes until they are no longer able to transmit the virus to others around them.

Having a quality patient portal in your organization's tool belt is essential to maintaining high levels of communication between patients and their physicians during a time of extended self-isolation. It is extremely valuable to stay connected to high-risk and non-emergent patients so that they continue to engage with your practice once the pandemic has come to an end.

COVID-19 Patient Portal Benefits

1) Send and Receive Secure Messages
The communication tool found in most top-of-the-line patient portals has served as an incredible tool to improve patient engagement and keep patients involved and active in their own medical care. The ability to send and receive secure, password-protected messages through the duration of the coronavirus has been an invaluable tool to making sure your non-COVID patients feel heard, understood, and seen by their medical providers despite current circumstances.

With a quality patient portal, patients can ask questions about the coronavirus, how they should be responding, and what they should do should they come into contact with the virus at any point. This ability to quickly communicate with one another helps to limit fear and anxiety during times of isolation and provides patients with the tools they need to stay engaged with their physician remotely. It also helps to cut down lengthy phone call conversations and protect your practice's time.

2) Share Important Data
Your patient portal can also function as a useful means to communicate important data and developments related to the virus and how your practice is responding to it. Many providers have delivered messages about new COVID restrictions and how their practice is taking action to prevent the spread and growth of the virus with their patient portal.

A quality patient portal with a mobile app helps to alert your patients when you have communicated a new development to them so they can keep track of the details. These messages might inform patients on the importance of staying home, utilizing virtual visits, messaging their provider, or requesting prescription refills.

3) Prescription Refills
With a patient portal, providers can also limit phone conversations with patients and their pharmacists when it comes time to refill prescriptions. Patients can log on directly to their patient portal, request a refill, and work with their pharmacy to find a pick-up time that works for them.

They no longer need to call your office, wasting valuable time that your organization needs to focus on emergent situations. The patient portal helps do this without compromising the current relationship between your practice and its patients.

4) Share Documents
During a global pandemic, the relay of important forms, patient data, and health information is extremely valuable to streamline processes as much as possible. With the patient portal, providers are able to quickly share forms and other important documents that patients need to continue receiving important care, like registration and intake forms.

Digital intake is possible with a quality patient portal, enabling your patients to complete important documentation remotely, and having that data uploaded directly into their chart for their next in-person or virtual visit.

5) Increase Your Value
Lastly, implementing a quality patient portal will monumentally increase the value of your practice in the patient's eyes. Patients value the easy access to information and communication that the patient portal creates. With this tool, the patient can take ownership of their personal health, create and set goals, and work with their physicians to live a healthier life.

By implementing a quality patient portal, your practice can not only work with patients more effectively throughout the duration of the pandemic, but also continue to increase patient engagement once it has ended.

Kimberly Von Feldt, iSalus Healthcare.www.isalushealthcare.com

Medical Office Managers

Do You Know Your Legal Obligations in Relation to the Coronavirus Pandemic?

Five Steps to Safety

The rapid spread of the coronavirus across the U.S. and many parts of the globe has drawn quite a bit of attention to employee safety. As business leaders look over their employee policies and procedures, they may begin to wonder about legal risks that a pandemic may expose them to. Medical offices are no exception. OSHA requires every employer to have policies and procedures to address the pandemic spread of viral illnesses such as the flu or coronavirus. A review of your policies and response plans now is essential.

Nearly every country has laws in place to help make sure that workers are protected from physical harm at their places of work. In the U.S., the Occupational Safety and Health Act of 1970 (OSHA) ensures protection under the Department of Labor. If an employee becomes sick because their employer failed to follow safety guidelines, the employer may be subject to legal penalties.

As an employer, paying attention to employee safety and compliance will help keep your team safe and minimize

risk in your medical office. Start by ensuring your office is following these five steps described below to stay safe during the COVID-19, aka coronavirus, epidemic.

Appoint a Leader to Stay Well-Informed
Assign a lead safety officer whose responsibilities include seeking out reliable information on public health and keeping up with all official requirements and recommendations by local, state, and national authorities. This person must stay informed about public health updates related to the coronavirus outbreak from the Center for Disease Control (CDC) and the World Health Organization (WHO). OSHA has published a comprehensive Guidance for Preparing Workplaces for COVID-19.

To safeguard against legal action, medical offices need to be able to prove that employee policies have stayed in close alignment with recommendations by the authorities.

Communicate With Your Employees, And Pay Attention to Hygiene
Medical offices need to be able to demonstrate that they have taken every effort to provide employees with good information about how to prevent the spread of the infection, and have also given them the ability to act on the information provided.

Organizations need to educate employees about how the coronavirus spreads and about the symptoms of infection. They need to educate their employees on public health guidelines and tell them where further official information is available.

Employers also need to put in place measures that help employees follow guidelines to lower the risk of infection in the workplace. For instance, they need to be provided with handwashing facilities and/or hand sanitizers, and employers need to make sure to have doorknobs, water coolers, and elevators disinfected. Better yet, offer remote work and shift work where possible.

Workers need to be told about the kind of COVID-19 infection symptoms they should watch out for. If they have a medical vulnerability to infection, or if there are members of their families with weakened immunity, those workers need to be provided with enhanced protection. Moreover, when staff members appear to suffer from symptoms, they should be asked to stay at home to not bring the infection to work.

Be sure to utilize multiple channels of communication to help ensure the message is communicated—via email, social media, intranets, handouts, postings, etc.

Put Restrictions in Place Regarding Employees Returning to Work
Restrictions about who should work and who should stay at home must be based on fact, by applying official guidelines, and with the guidance of a medical professional. Restricting employees from returning to work based on their ethnicity or their country of origin could set you up for discrimination lawsuits. However, if an employee has recently traveled to an area where the virus is prevalent, CDC current recommendations are to avoid human contact. Make sure to carefully follow these guidelines that clearly state when potentially infected employees will be allowed to return to work. Document all communications with employees in this case.

Review Your Leave and Pay Policies
Employers need to consider whether they are legally obligated to provide employees with days off if they come down with a COVID-19 infection. You need to carefully think about whether your current policies need adjustment in light of the epidemic. Refer to the Americans with Disabilities Act, the Family and Medical Leave Act, and the Workers' Compensation Rules for your state. If there are exclusions relating to COVID-19 in the insurance policy that covers your workers, you should be aware of them. For instance, if your employees have travel insurance, you should know that many of these policies exclude infections related to pandemics.

Employers should also consider whether they need to expand the protections and benefits provided, rethink income protection policies that they have for workers on leave, and adjust benefits for employees who run out of sick days.

It makes sense for employers to err on the side of caution rather than simply doing the minimum necessary under the law. For instance, if an employee goes on a personal trip to a country where the coronavirus epidemic is widespread, having that employee return to work upon completion of the trip may put at risk everyone who is at work. You may need to offer the employee paid leave to stay on at home, even if you are not legally required to. If you don't, and if infections occur at the company as a result, you could be exposed to lawsuits.

Keep Your Employees' Privacy in Mind
Employers should be clear about the kinds of protection they need to have in place for employee health data that they hand over to the authorities for public health purposes, should the information be required. In most cases, even states with rigorous employee privacy rules do allow employers to disclose health data when the government requests it.

Finally, you need to make sure that your office has a plan for the worst-case scenario. If key decision-makers in your medical office should contract the infection, you should make sure that you have succession plans in place. Should the epidemic lead to a need to furlough or lay off employees, you need to follow all legal requirements. The law prescribes formal procedures for businesses to stay in compliance when they lay off certain numbers of employees.

Being a medical office manager can be a challenging position. Planning ahead for every kind of scenario can help your business stay clear of legal challenges as you deal with the direct consequences of the epidemic.

PMI helps you plan ahead; our Certified Manager Office Manager Certification program offers the practical administrative skills needed in today's medical offices. Click here to learn more and take our free online assessment.

Nancy Clements is Director of Marketing Communications for Practice Management Institute (PMI), a leading provider of continuing education and certification for medical office coding, reimbursement, auditing, and management professionals. Visit pmiMD.com to find training to fit every need. Contact info@pmiMD.com to bring training to your office or organization.

The Coronavirus Pandemic has already made changes to our way of life, with some being for the better, and some for the worst. Prior to the pandemic, we thought nothing of going to our favorite restaurant, buying groceries at the local supermarket, enjoying a cup of coffee at a coffee shop, and going to see a first run movie. Now? It is quite different.

Where I live, the entire complex underwent complete quarantine, closing the library and common areas, prohibiting social functions for birthdays, and also not even allowing home visits by doctors, nurses, and other medical staff. We had to wear face masks as some other residents had medical conditions that getting Covid-19 could have exacerbated. Some of my fellow "inmates" did not feel like conforming to social distancing rules. Some completely refused to wear a face mask at all. Some cut holes in their masks to go to the smoking area, rendering their mask completely useless.

My son and I used to go to see a first run movie at our favorite movie theater, but now the same theater uses their parking lot to show movies while you stay in your car. Once where drive-in theaters in my area were almost extinct, the same drive-ins are making a huge comeback—bringing families back. They too are following social distancing rules where you pay for your movie via your cell phone, concessions are delivered to your car by a masked and gloved employee or (at our local one) you can bring food from home and pay a small fee for the clean-up. My son has also invited his friends to his backyard where he has been showing movies, and contacting and supporting local restaurants to provide home delivery service while they are not open for dine-in service.

I am due to have a routine quarterly examination at the beginning of June for a health condition, and as a result, I have to have lab tests prior, so that my primary care physician can let me know the good, bad, and ugly of my test results. One of the social distancing rules to minimize risk was to not go to your doctor unless you were sick, but rather than terminate my appointment, I plan to meet with my primary care provider using Skype. Honestly, it doesn't matter to me if I am physically at the doctor's office for this appointment or if I stay in my pajamas and have my doctor visit my home virtually via Skype, but I'm thankful that my health benefit plan will pay for the telehealth visit.

As a speaker for healthcare events and conferences all over the country, social distancing is going to make all kinds of changes to how it all works now. It is not cheap to bring a speaker in for an event like the ones I have attended in the past. The event organizers provide (and pay) for accommodations for each speaker, and in some locations, the hotel requires a set number of attendees to stay in-house for the event. The speaker usually pays to take a flight to get to there—and don't forget the extra fee that airlines charge for luggage. Upon landing, there is a need for a rental car unless the hotel already has ground transportation, and if you rent a car, some hotels charge parking fees. A while back, I attended a conference in Chicago and was charged $50 to park my car, even though I did the parking myself! Airport shuttles are an option, but also have a cost and take longer as they usually visit several hotels in one trip. Meals at a conference aren't cheap either, and some conferences are good about feeding you during breaks, but sometimes selections don't take dietary restrictions or preferences into account, so allow for the cost of meals as well.

It is also costly for someone to attend a conference, because, depending upon location, there is the cost of flights or travel, ground transportation, and meals, let alone the actual cost of the conference, which in some cases, is a lot. I decided to attend a local conference one time, and I had to join the organization just to attend the conference. That was $600. The cost at the conference was $100 per hour subject and they had 8 hours of subjects, costing a total of $800 for just one day of attendance. That was a lot of money back then and still is, especially in this current environment.

Technology changes all of that. Recently, my wife was asked to attend a meeting at a conference in Orlando, which she would normally drive (we live in FL), but due to the pandemic, the meeting style was changed. So instead of having the conference in a room in a hotel or center face-to-face, she was able to attend via Skype from our living room. She used her Kindle Fire (which had a camera) and was able to avoid all sorts of costs. The final cost for the meeting was $0 for everyone—and no one needed to wear face masks.

With social media and meeting platforms such as Zoom or Skype, the days of going to Las Vegas for a national conference, the way we did for many years, will likely change. This pandemic has shown us that there is a new way, or at least another way, of doing things. Technology has also changed the way we are able to do our patient visits. Now, for some appointments, I won't have to drive the 25 miles from my house to my doctor's practice and sit in a waiting room waiting. My doctor can open Skype and he can conduct my patient visit from his office or his house to my house. Thankfully, Medicare will pay for telehealth services, and the expert on this is our friend Don Self (www.donself.com). You can also go to the Medicare website for additional information: https://www.medicare.gov/coverage/telehealth
While the pandemic has made many changes to the way we live our lives, we don't have to be miserable while in quarantine/self-isolation. All of my grocery stores have become experts with social distancing and (at the time of writing) there haven't been any food shortages. However, if anyone has any TP to spare, message me for my address! (Just kidding!)

I follow the CDC guidelines for social distancing, which means I wear a face mask, use soap and water on my hands, and after my wife and I finish our grocery shopping, I put all of our clothes in the washer and dryer, along with our used face masks. I don't put my hands on my face and I only go to my doctor when I am truly sick. The smokers who refuse to follow social distancing rules in my complex call me a "Covidiot" because I wear my mask and wash my hands and use hand sanitizer when I come back into my apartment. I do what's right for me and my family. If they become sick (and I am not wishing that on them), I will remain healthy—and I promise not to laugh or call them names in return.

My grandparents survived during the Spanish Flu Pandemic in 1918. I plan to survive the Coronavirus Pandemic of 2020 and will wear the term "Covidiot" with pride because prevention and protection promote survival.

Never Give Up and Never Surrender.

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

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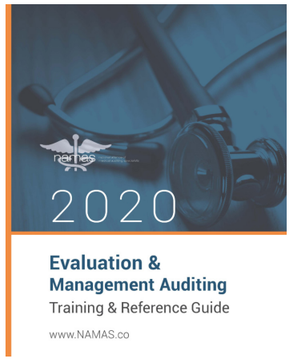

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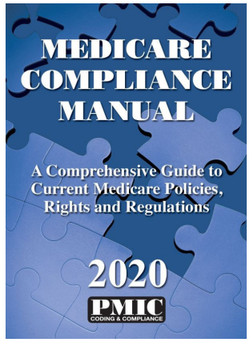

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