Providing resources for medical practices and the people behind them

BC ADVANTAGE

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September is

Rheumatic Disease Awareness Month

Sept / Oct 2020 | Issue 15.5

CEO Letter

Well, well, well. We've reached September and I have to ask, are you having fun yet? I don't know about you, but 2020 is going down as the craziest year in my lifetime! There are so many things happening (some good, some bad, some very ugly) and I am seriously struggling with overload. With the kids going back to school (at time of writing, our schools are going back one day per week with reduced size classes based on the first letter of their last names), most parents are wondering if they're doing the right thing, vacillating between keeping kids home and sending them on a daily (some may say hourly) basis. These decisions are not easy, and we, as parents, must do the right thing for our family and not beat ourselves up based on what others are or are not doing. There is no "one size fits all" approach to how we cope with these stressful times, so do what's right for you and don't allow the criticism of others to affect you. This should be across the board, as well, with other decisions that we are making for ourselves. Do what is right for your family.

With these immense pressures and decisions we are all faced with, our mental health is taking a beating. Whether you know it or not, we are all operating in a heightened state of emotions and thoughts, which long-term is not good for us, neither physically nor mentally. Are you taking some time to give yourself a breather? A moment of stepping away and letting a song, poem, nature, etc., give you moments of mental relaxation and pleasure? When was the last time you "grounded" yourself by walking on grass barefoot, allowing the earth to settle your heart and soul as well as your body? This may sound like poppycock to some of you, but getting back in touch with nature is a great way of giving your mind and body a treat that it so desperately needs. We all need to relax our brains, calm our hearts, and trust in ourselves right now.

We are not in a sprint but instead a marathon, which means that if you don't take some time now, you run the risk of wearing yourself down to the point where sickness (of the body and mind) will take over, and recovery will be longer and harder. If you can't get outside, take a meditation or prayer break at your desk. Give yourself 10 minutes to get to a relaxed state where your breathing is replenishing to your body and your mind is calm. Try it. You deserve it. You got this!

I know this isn't my normal kind of introduction to the magazine, but this is more important during this unprecedented time. You are important and I want you to be the best that you can be. For yourself, and your family.

Until next time. Be kind to one another.

Storm Kulhan

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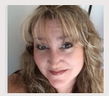

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CMS & CDC Announce Provider Reimbursement Available for Counseling Patients to Self-Isolate at Time of COVID-19 Testing

Provider counseling to patients, at the time of their COVID-19 testing, will include the discussion of immediate need for isolation, even before results are available, the importance to inform their immediate household that they too should be tested for COVID-19, and the review of signs and symptoms and services available to them to aid in isolating at home. Information and resource links are available in the Counseling Check List.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Counseling Check List

- ☐ Discuss the need for immediate isolation, even before results of the test are available.
- ☐ Advise patients to inform their immediate household/contacts that they may wish to be tested and quarantine as well. Review locations and people they have been in contact with in the past two weeks.
- ☐ Review the signs and symptoms of COVID-19.
- ☐ Inform patients that if positive, they will likely be contacted by a public health worker and asked to provide a list of the people they've been with for contact tracing, encourage them to 'answer the call'.
- ☐ Discuss services that might help the patient successfully isolate and quarantine at home.

Further information is available through the links below:

Overall: https://www.cdc.gov/coronavirus/2019-nCoV/index.html

Testing: https://www.cdc.gov/coronavirus/2019-ncov/testing/index.html

3 Steps to Take While Waiting for Your COVID-19 Test Results: https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/318271-A_FS_KeyStepsWhenWaitingForCOVID-19Results_3.pdf

Symptoms: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

Self Care: https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/index.html

Care at Home: https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html

Contact Tracing: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/contact-tracing.html
https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/overview.html

- Communication Toolkit: https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing-comms.html
- Consumer Page: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/contact-tracing.html
- FAQs: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Contact-Tracing

House of Representatives Votes to Remove Ban on HHS Funding a National Patient Identifier System

The Health Insurance Portability and Accountability Act (HIPAA) called for the development of a national patient identifier system. As the name suggests, a national patient identifier system would see each person in the United States issued with a permanent, unique identification number, similar to a Social Security number, that would allow each patient to be identified across the entire healthcare system in the United States. If a patient from California visited an emergency room in New York, the patient identifier could be used to instantly identify the patient, allowing the healthcare provider to access their medical history. Currently, the lack of such an identifier makes matching patients with their medical records complicated, which increases the potential for misidentification of a patient.

The extent to which records are mismatched has been shown in multiple studies. For instance, in 2012, a study conducted by the College of Healthcare Information Management Executives (CHIME) found that 20% of its members could trace an adverse medical event to the mismatching of patient records. In 2014, the Office of the National Coordinator for Health Information Technology (ONC) found that 7 out of every 100 patient records were mismatched. Between 50% and 60% of records are mismatched when shared between different healthcare providers. A study conducted by the Ponemon Institute suggested 35% of all denied claims are due to inaccurately matched records or incomplete patient information, which costs the healthcare industry around $1.2 million each year. *Source: hipaajournal.com*

Whistleblower Suit Claims Cigna Overbilled Medicare Advantage by $1.4 Billion

A whistleblower lawsuit made public on August 4, 2020, claims Cigna Corp. overbilled Medicare Advantage by more than $1.4 billion by convincing nurses to diagnose policyholders with overstated medical problems. The suit contends that between 2012 and 2017, Cigna-HealthSpring, a Cigna division, billed for medical conditions that did not exist, were not recorded in any medical records, and were not based on any clinically reliable information. The whistleblower, who works for a Cigna contractor, represented himself when filing the lawsuit. *Source: https://www.jdsupra.com/*

Pallone Announces Investigation into Health and Dental Insurance Companies' Business Practices Amid Covid-19 Pandemic

Energy and Commerce Chairman Frank Pallone, Jr. (D-NJ) released a statement announcing the Energy and Commerce Committee will launch an investigation into health and dental insurance companies' business practices following reports that many of the companies are recording record profit margins during the COVID-19 pandemic:

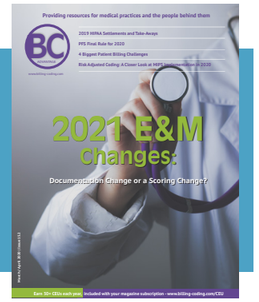
"While the American people grapple with an unprecedented crisis, health and dental insurance companies appear to be making record profits as millions of people forego care and avoid doctors' offices.

"Although the Affordable Care Act requires many health insurance companies to limit their profit margins and issue rebates to consumers, I believe insurers should be doing more to help enrollees and providers immediately. This assistance could be through premium reductions, extending policies to eliminate cost-sharing for COVID-19 treatment through the end of the public health emergency and extending low or zero interest loans to community providers.

"I'm also deeply concerned by reports that many insurers are denying coverage for COVID-19 tests while sitting on large cash reserves. Large scale testing is the only way we can get beyond this crisis, and insurers who are imposing restrictions on coverage of COVID-19 testing are making this task harder. This is unacceptable.

"In the coming days, the Energy and Commerce Committee will send oversight letters to a series of health and dental insurance companies seeking answers to a variety of questions. I want to know if they're in compliance with existing statute requiring COVID-19 testing be free of consumer cost-sharing for all patients and how they intend to use their profits to help the American people during this time of crisis."

Source: https://pallone.house.gov/



Inadequate Edits and Oversight Caused Medicare to Overpay More Than $267 Million For Hospital Inpatient Claims with Post-Acute-Care Transfers to Home Health Services

What OIG Found

Medicare improperly paid most inpatient claims subject to the transfer policy when beneficiaries resumed home health services within 3 days of discharge, but the hospitals failed to code the inpatient claim as a discharge to home with home health services or when the hospitals applied condition codes 42 (home health not related to inpatient stay) or 43 (home health not within 3 days of discharge). Of the 150 inpatient claims in our sample, Medicare properly paid 3; however, it improperly paid 147 with $722,288 in overpayments. Medicare should have paid these inpatient claims using a graduated per diem rate rather than the full payment. Based on our sample results, we estimated that Medicare improperly paid $267 million during a 2-year period for hospital services that should have been paid a graduated per diem payment.

What OIG Recommends and CMS Comments

We recommend that CMS direct its Medicare contractors, for the claims that are within the 4-year reopening period, to: (1) recover a portion of the $722,288 in overpayments identified in our sample; (2) reprocess the remaining inpatient claims in our sample frame with an incorrect patient discharge status code or condition code 43 to recover a portion of the estimated $225.7 million in overpayments; and (3) analyze the remaining inpatient claims in our frame with condition code 42 and recover a portion of the estimated $40.6 million in potential overpayments. Also, we recommend that CMS correct its related system edits, improve its provider education related to the Medicare transfer policy, and use data analytics to identify hospitals disproportionally using condition code 42. Finally, we recommend that CMS consider reducing the need for clinical judgment when processing claims under the post-acute-care transfer policy by taking the necessary actions, including seeking legislative authority if necessary, to deem any home health service within 3 days of discharge to be "related."

CMS concurred with all but our last recommendation and described actions that it had taken or planned to take to address the recommendations. We maintain that CMS should further explore reducing the need for clinical judgment when processing claims under the post-acute-care transfer policy and revised our recommendation to have CMS consider this change.

Source: OIG

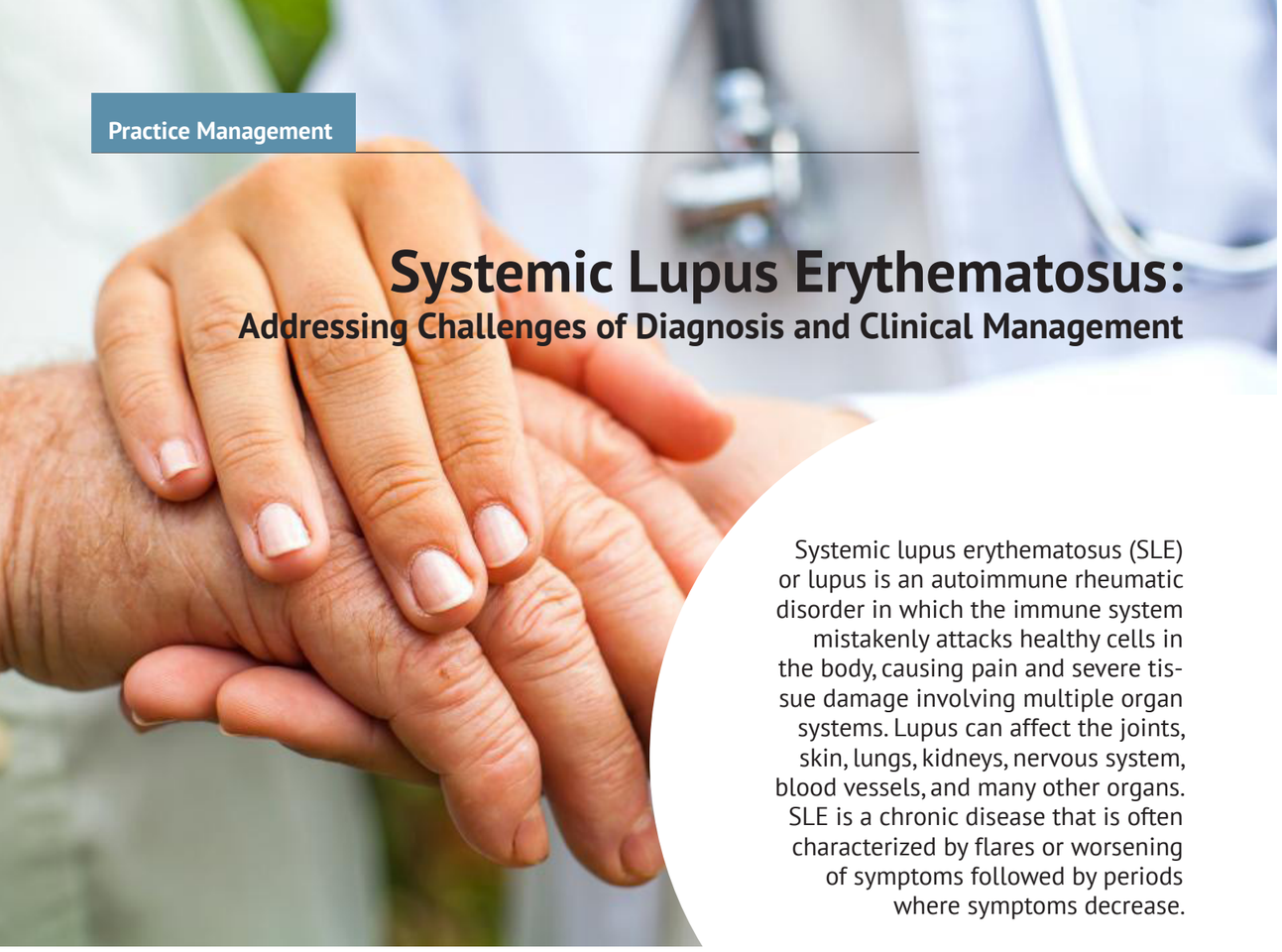
Baltimore City Professional Counselor Pleads Guilty to Felony Medicaid Fraud

A Randallstown woman pleaded guilty to one count of felony Medicaid Fraud for submitting claims that caused the Maryland Medical Assistance Program to reimburse her more than $18,000 for services she did not provide.

Baltimore City Circuit Court Judge Althea N. Handy sentenced 40-year-old Roshun J. Harris to five years' incarceration, all suspended, five years of supervised probation, and ordered Harris to pay restitution to Medicaid in the amount of $18,408.79.

As part of her probation, Harris is prohibited from working for any provider in a federally-funded healthcare program for five years.

Source: baltimore.cbslocal.com



Systemic Lupus Erythematosus:
Addressing Challenges of Diagnosis and Clinical Management

Systemic lupus erythematosus (SLE) or lupus is an autoimmune rheumatic disorder in which the immune system mistakenly attacks healthy cells in the body, causing pain and severe tissue damage involving multiple organ systems. Lupus can affect the joints, skin, lungs, kidneys, nervous system, blood vessels, and many other organs. SLE is a chronic disease that is often characterized by flares or worsening of symptoms followed by periods where symptoms decrease.

Types and Prevalence of SLE

There are four types of lupus: systemic lupus erythematosus (SLE), the most common type; cutaneous lupus, a type that causes skin disease; drug-induced lupus, a disease caused by certain prescription drugs; and neonatal lupus, a rare disorder that affects infants whose mothers have lupus.

- **Systemic lupus erythematosus (SLE):** This is the most common type of lupus. As its name indicates, the condition can affect tissues anywhere in the body. Organs affected by SLE include the skin, heart, lungs, kidneys, joints, and/or nervous system.
- **Cutaneous lupus:** This skin disease causes sores on areas exposed to the sun, such as the face, ears, neck, arms, and legs, which can cause permanent scars. According to the Lupus Foundation of America, about two-thirds of people with lupus will develop cutaneous lupus erythematosus. There are three categories of cutaneous lupus:
  - **Acute cutaneous lupus:** This type causes the red sunburn-like butterfly rash that appears on the cheeks and across the bridge of the nose. The rash may also appear on the arms, legs, and body. Though these lesions don't cause scars, they are usually very photosensitive and cause changes in skin color.
  - **Subacute cutaneous lupus:** In this kind of cutaneous lupus, rashes appear as red, scaly skin or as red, ring-shaped lesions. The rashes are seen on the arms, shoulders, neck, and other body areas that have been exposed to sunlight. Though lesions can become discolored, they do not cause scars. Like acute cutaneous lupus lesions, subacute cutaneous lesions are also sensitive to light.
  - **Chronic cutaneous lupus:** Also called discoid lupus, this type is characterized by disk-shaped, round lesions and can cause skin discoloration, scars, and hair loss. About 10 percent of people who have discoid lupus go on to develop lupus in other organ systems, and they would already have symptoms of systemic lupus.
- **Drug-induced lupus:** This disease is caused by long-term use of certain prescription drugs and can cause pericarditis and pleurisy. Medications linked to this condition include hydralazine (for high blood pressure or hypertension), procainamide (for irregular heart rhythms), and isoniazid (for tuberculosis). The symptoms of drug-induced lupus are similar to those of SLE, though the condition usually doesn't affect the organs. It can take months or years for the symptoms to develop, but they typically disappear within weeks of stopping the medication that causes the condition to develop.
- **Neonatal lupus:** This is a rare disorder that affects infants whose mothers have lupus. Symptoms seen at birth include skin rash, liver problems, or low blood cell counts, but these usually go away completely after six months. However, newborns of women with lupus are at greater risk of developing congenital heart block, a serious symptom which causes a slow heartbeat. Congenital heart block is a chronic condition and the child will need a pacemaker.

About **1.5 million** Americans have some form of lupus

According to the Lupus Foundation of America, about 1.5 million Americans have some form of lupus and about 70 percent have SLE. In a 2008 report, the National Arthritis Data Working Group estimated a prevalence of 161,000 cases of definite SLE and 322,000 cases of definite or probable SLE (www.medscape.com).

While anyone can develop lupus, certain people are at higher risk for the disease, such as women of child-bearing age, and people who have a family member who has lupus or another autoimmune disease. Some individuals are born with a tendency toward developing this condition, which may be triggered by infections, stress, certain drugs, or even sunlight.

There is no permanent cure for SLE, but correct and timely treatment can help relieve symptoms, reduce inflammation, and minimize organ damage.

Challenges Involved in Diagnosing SLE

Patients with suspected SLE should be referred to a rheumatologist to confirm diagnosis and ensure ongoing care. The rheumatologist will conduct a detailed clinical history and examination to identify the relevant signs and symptoms of SLE. Standard diagnostic tests used include:

- CBC with differential
- Serum creatinine
- Urinalysis with microscopy
- ESR or CRP level
- Complement levels
- Liver function tests
- Creatine kinase assay
- Spot protein/spot creatinine ratio
- Autoantibody tests

Imaging studies, such as joint radiography, chest radiography and chest CT scanning, echocardiography, brain MRI/MRA, and cardiac MRI, may also be used to confirm diagnosis.

However, like many autoimmune diseases, lupus is challenging to diagnose accurately as symptoms of lupus are also found in many other conditions. Survey data published in Lupus Science & Medicine indicated that disease heterogeneity and the lack of a clear disease definition are among the top barriers to advancing lupus care (www.healio.com).

"Lupus is an autoimmune, autoantibody-driven disease," says Karen H. Costenbader, MD, MPH, a well-known rheumatologist, lupus advocate, and Chair of the Lupus Foundation of America (LFA)'s Medical-Scientific Advisory Committee. Speaking to Rheumatology Advisor, Dr. Costenbader stated that antinuclear antibody test is not a good diagnostic test since this antibody is not very specific for lupus. Other autoantibodies are also seen in lupus, in addition to pathologic findings in the kidneys, on the skin, or in other organs. Dr. Costenbader pointed out that acumen and experience are needed to diagnose the disease by putting the entire picture together and ruling out other possible conditions.

Signs and Symptoms

Lupus can cause different symptoms, depending on the part or parts of the body it affects. The most distinctive sign of SLE is a facial rash (that resembles the wings of a butterfly unfolding across both cheeks) that occurs in many but not all cases of this disease.

Common signs and symptoms of lupus include:

- Severe fatigue
- Headache
- Joint pain, stiffness, and swelling
- Swelling in the hands, feet, or around the eyes
- Skin lesions that appear or worsen with sun exposure (photosensitivity)
- Sensitivity to light
- Hair loss
- Anemia
- Blood-clotting problems
- Chest pain when taking deep breaths
- Dry eyes
- Discoloration of the fingers when exposed to changes in temperature, or during stressful periods (a condition known as Raynaud's phenomenon)

The symptoms of SLE may be mild or severe and may occur suddenly or develop slowly. Many symptoms of lupus are similar to those of other diseases, such as arthritis, fibromyalgia, and diabetes. As discussed above, all of these factors make it very difficult to diagnose lupus.

Treatment

Due to the multisystemic nature of the disease, healthcare providers from different specialties may be part of the lupus healthcare team, depending on the affected organ system. In addition to a rheumatologist, the team may include specialists in fields such as infectious disease, neurology, pulmonology, cardiology, gastroenterology, nephrology, dermatology, hematology, and obstetrics.

There is no complete cure for SLE, but treatment can help ease symptoms. Treatment modalities mainly include nonsteroidal anti-inflammatory drugs (NSAIDs) for joint pain and stiffness, corticosteroids (to minimize the immune response), antimalarial drugs (for skin and joint problems), and immunosuppressants. Treatment recommended will depend on the type and severity of symptoms and which parts of the body SLE has affected.

Treatments are most effective when you start them soon after symptoms develop. Prevention of lupus involves avoiding/reducing sun exposure, getting adequate sleep, and taking the recommended medications.

ICD-10 Codes for Systemic Lupus Erythematosus

There are different ICD-10 codes to report systemic lupus erythematosus. These codes differentiate between drug-induced lupus and lupus with organ or system involvement.

M32 Systemic lupus erythematosus (SLE)
M32.0 Drug-induced systemic lupus erythematosus
M32.1 Systemic lupus erythematosus with organ or system involvement
M32.9 Systemic lupus erythematosus, unspecified
M32.10 Systemic lupus erythematosus, organ or system involvement unspecified
M32.11 Endocarditis in systemic lupus erythematosus
M32.12 Pericarditis in systemic lupus erythematosus
M32.13 Lung involvement in systemic lupus erythematosus
M32.14 Glomerular disease in systemic lupus erythematosus
M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus
M32.19 Other organ or system involvement in systemic lupus erythematosus
M32.8 Other forms of systemic lupus erythematosus
M32.9 Systemic lupus erythematosus, unspecified

The ACR's guidelines for using these ICD-10 codes for lupus are as follows:

- For drug-induced lupus, the documentation should specify the drug. If another organ or system is involved, that organ or system should be documented (e.g., endocarditis, pericarditis, lung involvement, glomerular disease, tubular-interstitial nephropathy, or other organ involvement).
- Combination codes allow for reporting the diagnosis and capture an underlying condition or complication. The clinician should ensure that the documentation specifies the link between the two conditions using terms, such as "with," "in," "due to," or "exacerbated," when appropriate. For instance, ICD-10 code M32.11 denotes endocarditis in systemic lupus erythematosus.
- M32.9 Systemic Lupus Erythematosus, unspecified can be used to report lupus, as it is the only code in the category for just lupus without organ involvement:
  - M32.9 Systemic Lupus Erythematosus, unspecified
  - SLE NOS
  - Systemic lupus erythematosus NOS
  - Systemic lupus erythematosus without organ involvement
- M32.10 Systemic Lupus Erythematosus, organ or system involvement unspecified should be used if the findings at the time are nonspecific, and the patient may need further evaluation.
- Codes M32.11–M32.15 are used to specify organ involvement.
- M32.19 (other organ or system involvement in systemic lupus erythematosus) should be used to specify a medical diagnosis of other organ or system involvement in systemic lupus erythematosus which is not listed in the category.
- M32.8 (other forms of systemic lupus erythematosus) is used when the provider does not know the nature or specifics of the condition.

Improving Diagnosis and Care

The Addressing Lupus Pillars for Health Advancement (ALPHA) global consensus initiative that validates known challenges in lupus is a major step toward implementing strategies to address the concerns around this complicated disease. This global council led project identified the 5 top barriers to improving outcomes in lupus as: clinical trials, biomarkers, diagnosis of lupus, differentiation of its subtypes, and outcome measures for the disease. The council calls for a concerted effort by lupus clinicians, researchers, policy makers, and other stakeholders to improve understanding of the disease to guide development, diagnosis, and treatment, and provide patients with access to timely, high-quality care.

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Big Changes are Coming in Payment and Documentation Guidelines

The Centers for Medicare & Medicaid Services finalized their Fee Schedule, which included some significant changes to reimbursement and documentation requirements for evaluation and management, also known as E&M office visits. Although most of the changes will not be taking effect until Jan 1, 2021, the time to begin preparing is now.

CMS had delayed E&M coding reforms, particularly because many doctors were balking at the changes that included transforming the now-used five-tier E/M system into one that has blended payment rates for outpatient and office visits being billed at the second through the fifth levels. The goal of these changes is to help reduce the red tape that often leads physicians to burnout, but many worried about potential unintended consequences, leading to the delay. However, 2021 is coming, the changes are still scheduled, and it is time to start preparing.

2021 Changes to Documentation Requirements
On January 1, 2021, providers will be offered the flexibility to document level two through five E/M outpatient and office visits in the following ways:

- Time
- Using 1995 or 1997 Documentation Guidelines for E&M Services
- Medical decision making

For providers who document based upon the time they take, they will need to document medical necessity, as well as the face-to-face time spent with a patient. If the visit is a level 5 established patient visit, then the time spent on coordination of care and documented counseling has to exceed 20 minutes, and for a level 5 new patient visit, that coordination of care and documented counseling time has to exceed 30 minutes.

To document using medical decision making (MDM) or the 1997 or 1995 guidelines, minimum documentation for outpatient/office visit levels between 2 to 4 are required, meaning providers must document:

- Problem-focused history not including social, family, or past history, or a review of systems.
- Limited exam of the affected organ system or affected body area
- Very straightforward MDM that is measured by minimal risk, data review, and problems (two out of three)

For physicians documenting on MDM alone, only documentation that supports straightforward MDM is required.

Reimbursement Changes for 2021
Significant changes are coming for provider reimbursement in 2021, as well. This will be done by consolidating payments for the E/M levels 2 through 4 into one rate (there is one rate for established patients and one rate for new patients). However, separate payment rates for both level 5 and level 1 visits will continue.

These new rates were calculated by CMS by considering the utilization rate of these outpatient/office E/M services between 2012 and 2017, calculating a rate weighted by the frequency at which these services are billed currently.

New Add-On Codes for 2021
New add-on codes are coming for 2021, as well, and they're designed to help reimburse physicians for outpatient/office E/M levels 2 to 4 for patients who require more complex care, since the resource costs of those visits are often not fully captured within the proposed single payment rate that will be coming in 2021. The new HCPCS add-on Level II codes include:

- Code GPC0X - Non-procedural Specialty Care Complexity – Complexity of the visit that's inherent to management and evaluation associated with specialty, non-procedural care, including interventional pain management, neurology, endocrinology, infectious disease, pulmonology, urology, endocrinology, cardiology, psychiatry, rheumatology, obstetrics/gynecology, otolaryngology, nephrology, and hematology/oncology.
- Code GPC1X – Primary Care Complexity Code – Complexity of the visit that is inherent to management and evaluation associated with primary medical care services serving as the ongoing focal point for all additional healthcare services.
- Code GPRO1 – Extended Visit Code – Used for additional time for evaluation and management services offered in outpatient or office settings when the visit requires direct patient contact of between 24-69 face-to-face minutes for an existing patient, or for new patients, 38-89 minutes. Should be listed separately in addition to the 2-4 outpatient/office E/M visit.

Also, do not forget that physicians can also use the psychotherapy services code (+99354) or prolonged E/M services code (+99355) with all outpatient/office E/M visit levels.

Preparing for 2021
Although there is likely to be some clarification coming from the CMS before 2021, there are still some things that can be done now to start preparing for these upcoming changes. One of the best ways to prepare is to ensure providers are educated in the coming changes. While these changes are designed to help reduce the documentation burden on physicians, that will not work if they're not aware of the new guidelines. Providers must understand the requirements for time-based reporting and be aware of the newly changed MDM table that includes simplifications and clarifications from the MDM table being used currently. Practices need to start educating providers now on the new documentation requirements and on how the new payment schedule will work to prevent mistakes that result in denials.

Patrick Dougherty is the General Manager at M-Scribe. Patrick has worked in the RCM field for 20 years. He was the founder and CEO of his own billing company before joining M-Scribe three years ago as the GM and VP of Business Development. Patrick enjoys golf, traveling, and spending time with his family in North Georgia. www.m-scribe.com

At M-Scribe.com, we're here to help, both as you move into 2020 and as you prepare for the upcoming changes in 2021. We specialize in medical billing and coding, and we're here to help. Our experienced staff stays on top of the latest payer guidelines, ensuring you minimize missed payments and lost claims. Contact us today at M-Scribe.com, by email, or by calling 770-666-0470 to learn more about how we can help you in the coming year.

COVID-19 or Not:

The Anti-Kickback Statute Remains a Tool of Choice for False Claims Act Violations

The COVID-19 pandemic has not diminished the focus of the U.S. Department of Justice ("DOJ") and whistleblowers, who are known as "Relators," from bringing and enforcing claims that violate both the federal Anti-Kickback Statute (AKS) and the False Claims Act (FCA). For decades, healthcare providers, medical device, and pharmaceutical companies have been the subject of multi-million dollar penalties for providing improper remuneration (aka "kickback") to providers in exchange for increased utilization for certain products or services.

The inception of the Affordable Care Act (ACA) gave even more "teeth" to the AKS. Specifically, ACA's language states, "a claim that includes items or services resulting from a violation of [the Anti-Kickback Statute] constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of Title 31 [the False Claims Act]." In other words, this change makes the AKS a "per se" violation, whereby claims submitted to federal government programs, including Medicare, Medicaid, and TRICARE that violate the AKS automatically constitute false and fraudulent claims under the FCA. Therefore, it is unsurprising that despite the COVID-19 pandemic, the focus of the DOJ in settling FCA cases with underlying AKS violations remains a top priority.

A covered healthcare provider, as well as core FDRs (first tier, downstream, and related entities), involved in administering goods or services to Medicare Part A and Part B beneficiaries, is required to undergo fraud, waste, and abuse (FWA) training. Prior to January 1, 2019, the Centers for Medicare and Medicaid (CMS) required "health care providers participating in Medicare Advantage and Part D Plans to complete CMS-issued general compliance fraud, waste and abuse training." Despite this requirement being removed by CMS, it is notable that Plan Sponsors "can still include compliance training requirements in their provider contracts." During the course of my practice, I have witnessed first-hand that the government takes FWA training seriously. Whistleblowers are often asked if they have undergone such training, and the frequency of the training. On the flip-side, undergoing annual FWA training could be considered a mitigating factor when a defendant's counsel is negotiating with the government.

The purpose of this article is to highlight recent settlements in order to reinforce the importance of risk mitigation through fraud, waste, and abuse training.

Analysis

The range of penalties that arise from FCA cases involving AKS violations varies greatly and depends upon the number of factors, including the amount of the kickbacks, the ability to pay, and the length of time that the fraud has been perpetrated. Below, three recent settlements are highlighted to provide a semblance of the types of conduct that interests the DOJ.

- July 1, 2020 - Novartis Pharmaceuticals Corporation paid over $642 Million to resolve two separate FCA settlements. The first settlement of $51.25 million to resolve allegations that it paid the copays of government program beneficiaries in violation of the AKS. The second settlement of $591,442,008 to resolve allegations that doctors were paid kickbacks to induce them to prescribe various drugs. The lawsuit is United States ex rel. Bilotta v. Novartis Pharmaceuticals Corp., Case No. 11-cv-0071-PGG (SDNY).
- July 6, 2020 – Dr. Bibi Tasleyma Sattar, as well as her practice, paid $210,000 to settle allegations involving AKS and FCA violations stemming from accepting payments for patient referrals, which were disguised as a $25 per patient "process and handling fee." Notably, in connection with this scheme, three other individuals were indicted by a federal grand jury on December 11, 2019. If indicted, the three individuals could each face up to five (5) years in federal prison.
- July 10, 2020 – Universal Health Services, Inc., UHS of Delaware, Inc., and an individual UHS facility, Turning Point Care Center, LLC, agreed to pay $122 million to resolve alleged violations of the False Claims Act for a combination of the following: paying illegal inducements to federal healthcare beneficiaries; billing for medically unnecessary inpatient behavioral health services; and failing to provide adequate and appropriate services. The kickback portion of the settlement related to Turning Point's providing free or discounted transportation services to Medicare and Medicaid beneficiaries to induce them to seek treatment at its facility.

These three settlements illustrate that AKS violations are a focus of the DOJ. As Byung J. "BJay" Pak, U.S. Attorney for the Northern District of Texas stated, "Our office remains committed to pursuing unlawful arrangements that undermine the integrity of federal healthcare programs."

Conclusion

Enforcement of the submission of false and fraudulent claims to federal programs in violation of the FCA with underlying AKS violations remains a priority. Paying inducements, whether in cash or in-kind, directly or indirectly, to increase utilization of a medical service or product, continue to be an area of focus for the DOJ and whistleblowers. As a "per se" violation, once the underlying AKS violations are established, FCA liability quickly follows. Providers and vendors alike should take prophylactic measures like FWA training seriously in order to stave off potential violations or reduce the severity of a penalty.

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Contracting & Credentialing:

The Often-Neglected Keys to Practice Success

Independent practices have been facing unprecedented challenges, especially in today's pandemic-based reality. Two of the most fundamental aspects of starting and running a practice are often the aspects that most practices ignore: payer contracts and credentialing.

Despite their essential nature, many practices put these tasks last on their respective to-do lists, but there is a better way of doing business. Making sure these two elements are addressed in a methodical, data-driven, and thoughtful manner is key to every practice's long-term success.

Payer Credentialing: Administrative Headache, Payer Cost Saving, but a Keystone Habit

Before a provider can see their first patient, they must sign a contract with each payer and undertake a time-consuming and redundant administrative process called "Credentialing." Instead of taking a proactive approach to handling this, most practices tend to be reactionary with their credentialing notices from the payers and their expiration emails. Instead, this process should be a major focus of the practice.

An inefficient credentialing internal process can reduce your revenue potential anywhere between 5%-10%. For a sizable practice, that can equal thousands of dollars in lost revenue.

Why are health plans constantly checking and rechecking a provider's credentials when they are already licensed in the state and have their CAQH profiles? The answer is that asking providers to perform redundant credentialing paperwork is a money-saving strategy for the payers. The payers know that a certain percentage of the providers will forget to stay credentialed, make mistakes, or not confirm they have been credentialed when the payer "loses" the paperwork. In each of these instances, the payer refuses to cover any procedures or encounters that occur during the period that the provider isn't credentialed, and therefore saves them significant amounts of money at the provider's expense.

How are physician groups supposed to recruit providers and grow a practice if it takes 6 months to get providers credentialed? Credentialing can be a cumbersome, time-consuming, and error-prone task. Not to mention, the individual most-often tasked with credentialing in the office is usually an entry-level employee and experiences a high turnover rate. One straightforward solution is to outsource credentialing. This can be a great way to ensure the task is handled, and there is continuity in the process. Always shop rates and find a group that comes highly rated. If they cannot provide a wealth of references, move on quickly.

If you are going to keep credentialing in-house, make sure to task someone dependable with the task that has the bandwidth to constantly track all the credentialing timelines and deadlines. Maintaining some sort of spreadsheet or online tracking tool will also ensure you are staying up-to-date with your credentialing needs.

Payer Contracting: Keeping an Eye On Your Reimbursements

Contracts are the most important element of your practice and predictor of future success. They dictate aspects around expanding locations, hiring additional providers, bringing on partners, and how profitable your practice ultimately is. Many providers think their contract isn't something they have the power to alter, as they have no leverage, it would be too costly, or too time-consuming. The payers bank on this perception to maintain poor reimbursement rates for most private practices and use those poor rates as yet another cost-saving mechanism in their ever-increasing systemic waste.

It is overwhelming when going up against your payer organizations and the maze of gatekeepers, legal departments, and advanced software they have at their disposal. Much like credentialing, there are two broad solutions for obtaining better reimbursement rates: Assigning the task to someone in your organization, or outsourcing to a reputable negotiator.

Negotiating your rates can be a lengthy and complicated process, so it is better to not be reactionary and have a long-term solution in place. It's understandable that most practices are busy places and don't have the time or energy to start renegotiating their reimbursement rates. They have so much on their plate. With that in mind, utilizing an experienced negotiator can pay for itself, as long as you find someone that charges based on performance. Ensure that the negotiator's incentives are aligned with your rate increase needs, and like credentialing, experience and professional references should be key determinants in choosing your negotiation team.

Cameron Wood is head of client services at NGA Healthcare, a physician advocate who works with small and mid-sized physician practices to negotiate their reimbursement rates. Cameron is an expert at forging business relationships, branding, and working with these groups to help discover their leverage against insurance payers.

Clinical Documentation Integrity:

Stop the Insanity

As inpatient programs mature and there is less need for consulting in the CDI space, CDI consulting companies have set their eyes upon promoting and developing outpatient CDI programs to current and potential clients to replace the revenue spicket that is drying up associated with peddling inpatient CDI consulting projects. Outpatient CDI is a relatively new concept and entity that has yet to be fully flushed out and defined.

Despite this fact, consulting companies and CDI associations are hanging their hats upon HCC capture as the hallmark of outpatient CDI, repeating the same mistake as inpatient CDI of chasing revenue through diagnoses capture while overlooking the real opportunity to improve the quality and completeness of the physician's documentation. Where should outpatient CDI be focusing its efforts and energies to set the tone and foundation for attainment of accurate and complete physician documentation?

Defining the Mission of Outpatient CDI

Defining the mission of outpatient CDI determines in part where outpatient CDI efforts and energies should be focused. Let us look first at the title "Outpatient CDI Specialists" as a Segway to creating and developing a rational well-thought-out mission. The notion that clinical documentation improvement specialists can improve the quality and completeness of physician documentation is a misnomer and fallacy. The physician or provider is the only individual who can achieve real improvement in documentation and communication of patient care. Rather than refer to the name Outpatient CDI Specialists, individuals in this role should be referred to as a "Patient Advocates-Facilitators in Patient Care Communication." The name Patient Advocate puts the patient in the center of the role that the individual is expected and charged with playing in the chart review process. The medical record serves as a primary communication tool versus a reimbursement tool; the latter detracts from achievement of any meaningful sustainable improvement in the quality of physician documentation. Efforts to improve HCC capture neglect the critical role of reviewing and approaching the

record holistically. Reference is made to the American College of Physicians Position Statement from January 2015, titled Clinical Documentation in the 21st Century: Executive Summary of a Policy Position Paper (ACP Position Statement). The following points must drive a sound mission for outpatient CDI:

- The primary goal of EHR-generated documentation should be concise, history-rich notes that reflect the information gathered and are used to develop an impression, a diagnostic and/or treatment plan, and recommended follow-up.
- The clinical record should include the patient's story in as much detail as is required to retell the story.
- The primary purpose of clinical documentation should be to support patient care and improve clinical outcomes through enhanced communication.

The prime mission of Outpatient CDI should be to facilitate complete and accurate physician documentation serving to represent the right care at the right time for the right reason with the right clinical judgment and medical decision making with the right documentation. Right documentation incorporates the concept of the provider adequately and sufficiently telling and describing the patient story, depicting the patient's specific clinical needs, reporting the physician work performed, and outlining how the physician work performed addressed and met the patient's specific clinical needs. Clearly, outpatient CDI processes must incorporate a 360 holistic approach to chart review with consistent identification of true documentation improvement opportunities beyond just HCC reporting. I submit to you the following as the mission for CDI.

Mission of CDI

The unwavering mission of CDI can be defined as the following:

- The new paradigm of CDI incorporates completeness, consistency, organization, and accuracy of the medical record, reflecting the physician's clinical judgment and medical decision making. CDI supports positive outcomes in patient care, quality, cost, resource consumption, fee for value, reimbursement, and revenue cycle processes. This new paradigm requires a wholesale shift in the mission, goals, and objectives of any CDI program. The unwavering mission of CDI should be to improve actual processes of clinical documentation, striving to achieve meaningful and lasting changes in physician behavioral patterns of clinical documentation that optimally reflect communication of patient care, regardless of stakeholders, including third-party payers. By focusing on primary outcomes of reimbursement, we are overlooking the vitally important component of true documentation improvement. Enhanced reimbursement should be thought of and treated as a "byproduct" of solid documentation reflective of medical necessity for outpatient care, appropriate resource consumption, and appropriate financial responsibility of the patient for physician services provided and ordered.

An encompassing mission must be supported by adequately seated goals that serve as the basis for accomplishment of a stated mission.

Reasonable goals for outpatient CDI are as follows:

- To achieve the highest order of specific, accurate, detailed medical documentation whereby to ensure the most precise final coding, so that the institution receives the optimal and appropriate reimbursement to which it is entitled based upon care provided and resources consumed
- To produce a medical record, which is the most efficacious communication tool for all healthcare providers rendering care in each case
- To provide accurate, specific, detailed medical documentation whereby to effect enhanced patient safety, as well as efficiency-effectiveness of care efforts
- To provide a medical record, for external reviewers of all types, free of ambiguity, inconsistency, or clinical incompleteness
- To provide a medical record which is defensible relative to external audits

Designing and Operationalizing an Effective CDI Program

Designing and operationalizing an effective CDI program starts with identifying the service lines ripe for improvement from a physician documentation and financial perspective. One must answer the question attending where the medical necessity denials are coming from; what departments and physicians are generating these costly medical necessity denials? Most medical necessity denials are caused by insufficient documentation and/or use of a diagnosis or symptom that is not considered a covered benefit by the payer. Another area of medical necessity denials that is often overlooked and not addressed by outpatient CDI programs is medical necessity denials associated with physician office encounters. Once again, the root cause of these costly denials, or at a minimum, office E & M level downgrade by the payer, is poor documentation on the part of the physician.

My personal experiences over the years working with physicians in their offices has consistently demonstrated ample opportunity for documentation improvement, including documentation of the medical necessity for physician services ordered and/or provided, including services referred to the hospital for performance. It is shocking how hospitals and health systems allow medical necessity denials to come from physician practices owned by them. A well-thought-out outpatient CDI program will position itself to address documentation inefficiencies through CDI processes intended and designed to consistently achieve clinical documentation excellence. Outpatient CDI is simply much more than chasing HCCs day in and day out with the goal of increasing risk adjustment factor scores and "hopefully" increasing reimbursement next calendar year.

In short, there are a myriad of opportunities and areas of focus for outpatient CDI programs that will drive sorely needed net patient revenue with achievement of a high performing revenue cycle. There are endless areas where outpatient CDI can avail itself and really make a tremendous difference in the financial health of our hospitals and health systems. Do not let yourself get caught in the frenzy of CDI consulting companies promoting outpatient CDI as all about HCCs and the need to acquire their expensive software that purports to streamline HCC capture. What really matters today is hospitals and health systems being able to address significant financial shortfalls caused by the COVID-19 pandemic by improving actual processes of physician documentation that include but extend well beyond HCC diagnosis capture. Capturing HCCs for next year is a reasonable goal if the facility survives to collect the reimbursement. Outpatient CDI can be a real financial savior if structured and deigned properly. I encourage all CDI professionals to expand their vision and view of outpatient CDI as a matter of principle and necessity.

Glenn Krauss, RHIA, BBA, CCS, CCS-P, CPUR, CCDS, C-CDI, PCS, FCS, C-CDAM, is the president and CEO of Core-CDI.com and a nationally cognized CDI/revenue cycle expert and speaker.

CDC - Handwashing

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

How can washing your hands keep you healthy?

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

Handwashing helps prevent infections for these reasons:

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

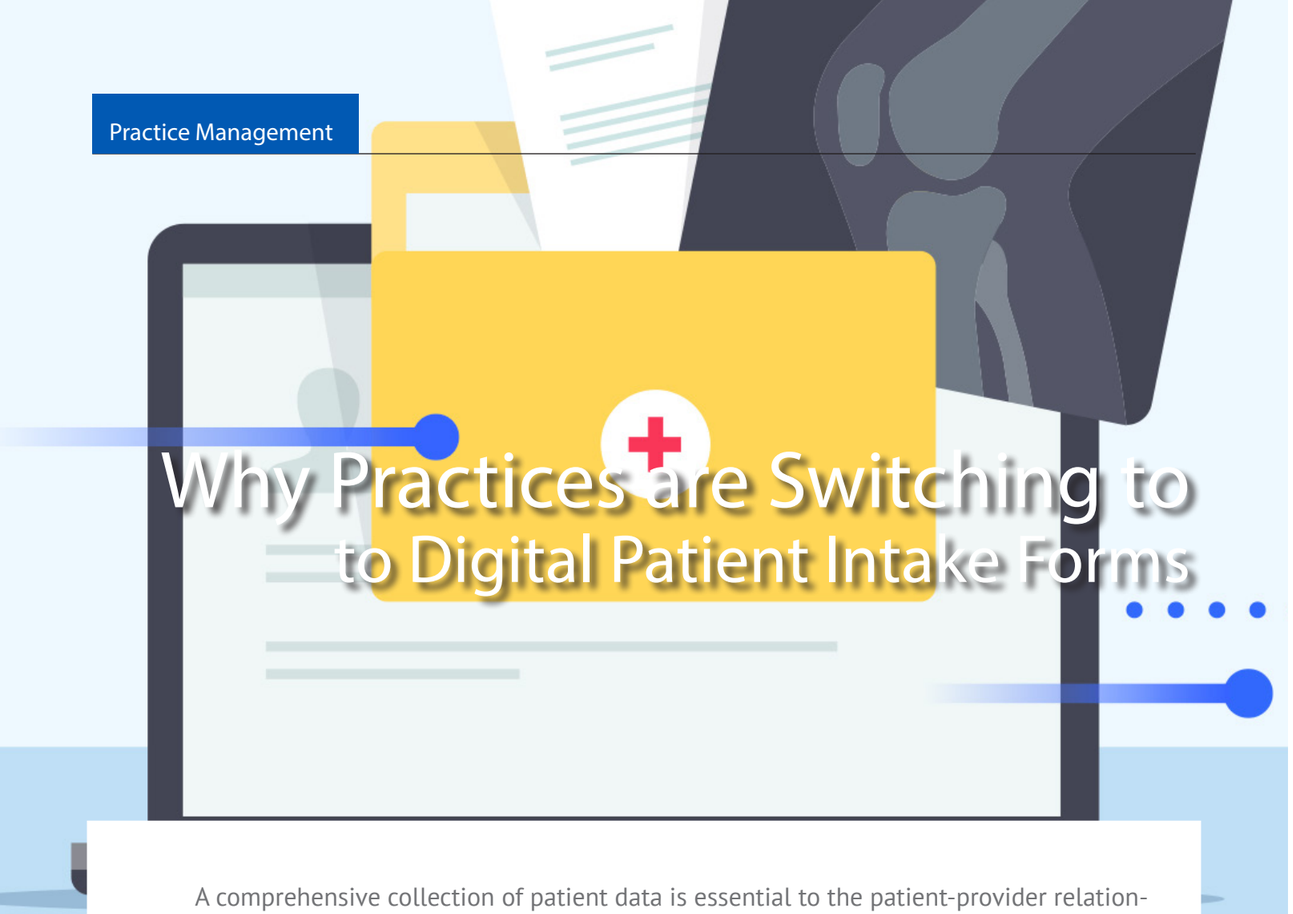
Germs from unwashed hands may get into foods and drinks when people prepare or consume them. Germs can grow in some types of foods or drinks and make people sick.

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

What is the right way to wash your hands?

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

CS 280522A



Why Practices are Switching to to Digital Patient Intake Forms

A comprehensive collection of patient data is essential to the patient-provider relationship. The collection of patient health information helps providers get an idea of who their patient is and how to treat them. Without a complete set of information, providers are forced to make dangerous assumptions regarding the patient's health or rely on the patient to quickly answer a question during a visit. With a full set of data, providers can make decisions more accurately and efficiently, resulting in better patient outcomes, involvement, and experiences.

Where traditional intake processes involve collecting patient health information on paper forms and transcribing those documents into their chart, digital patient intake forms are a much better alternative. With digital patient intake forms, your practice will see an improvement in efficiency, accuracy, and usability throughout each chart and process.

See Results with a Digital Patient Intake Form

Efficient Collection of Data

Traditional intake processes have patients filling out a stack of forms that then need to be transcribed into their digital chart. This approach to collecting patient data has your patients rushing to complete documentation before the start of their visit and has your staff spending hours of their time on transcription. Digital intake eliminates the transcription processes and offers a way for patients to complete these documents before they ever enter the office. This increases efficiency in your intake processes, decreasing wait times, and improving the patient experience while also empowering your team to get other important work completed.

Easy to Understand

Intake forms are often extremely difficult to read, sometimes leaving patients frustrated and confused about which parts of the form they are supposed to complete and why certain details are even relevant to their care. With a quality digital patient intake form, your patients can avoid the frustrations and difficulties associated with traditional forms. Digital patient intake forms from the right vendor make the intake processes simpler for your patients, making it easier to navigate and improving their experience.

Avoid Transcription Errors

The transcription processes can lead to dangerous gaps or mistypes in a patient's chart, having a huge negative impact on the clinical decision-making process. These errors can happen for a number of reasons, such as poor patient handwriting, staff rushing through their work to get it done, or a patient not understanding the form. The digital patient intake form eliminates these issues and makes entering patient data much simpler by taking what the patient enters and putting it directly into their chart. By completing these forms prior to the visit, the patient does not have to rush trying to fill out every detail and can ask questions, eliminating bad handwriting and misinformation.

Flexible Patient Use

Flexibility is key to improving the patient experience and improving the accuracy of a patient's chart. By giving your patients the time and flexibility they need with a digital intake, they are able to avoid the cumbersome and non-interactive paper intake process. The digital patient intake form offers patients the opportunity to take their time completing their forms and complete them at a time that works best for their schedule.

More and more patients are expecting their providers to offer digital solutions for things like scheduling and intake processes.

Kimberly Von Feldt writes for iSalushealthcare.com. To learn more about a quality digital patient intake form solution for your organization, visit their website at iSalushealthcare.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; 99238; 99239; G0425; G0427 G0406-G0408; G0459
Observation Services	99217-99220; 99224-99226; 99234-99236
Intensive Care Unit (ICU)	99477-99480
Nursing Facility	99304-99310; 99315-99316; G9685
Critical Care	99291-99292; G0508-G0509; 99468-99469; 99471-99472; 99475-99476
Home Visits	99341-99345; 99347-99350
Domiciliary, Rest Home, Custodial	99324-99328; 99334-99337
Advanced Care Planning	99497-99498
Annual Wellness Visit	G0438-G0439
Assessment/Care Planning, Cognitive	99483; G0506
Transitional Care (TCM)	99495-99496
Ophthalmology	92002; 92004; 92012; 92014
Psychiatry	90785; 90791; 90792; 90832-90834; 90836-90840; 90845-90847; 90853; 90875; G0410
Psych/Neuropsych Testing	96110-96127; 96130-96133; 96136-96139
Respiratory Care Services	94002-94005; 94664
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, and Adaptive Behavior Therapy	92507; 92508; 92521-92524; 92601-92604; 96116; 96130-96133; 96136-96139; 96156-96171; 97110; 97112; 97116; 97150; 97151-97158; 97161-97168; 97530; 97535; 97542; 97750; 97755; 97760-97761; 0362T; 0373T; S9152
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	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, 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

Laboratory Prorated Travel Fees

- P9603 miles traveled
- P9604 trip charge
- *Report with codes G2023 or G2024

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)
- 87426 Infectious agent antigen detection by immunoassay
- 87635 Nucleic-Acid (swab)
- 86328 Antibody: Single step (reagent strip)
- 86769 Antibody: Multi-step

Testing | Proprietary Laboratory Analyses (PLA)

- 0202U BioFire® Respiratory Panel 2.1
- 0223U QIAstat-Dx Respiratory SARS CoV-2 Panel
- 0224U COVID-19 Antibody Test

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 June 25th, 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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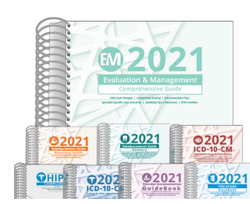

September is
Rheumatic Disease
Awareness Month

Rheumatic diseases are considered the leading cause of disability in the United States. September is designated as Rheumatic Disease Awareness Month by the American College of Rheumatology (ACR) to draw attention to these painful autoimmune and inflammatory diseases that affect about 54 million or 1 in 4 American adults. Awareness about symptoms and risk factors, early diagnosis, and specialized treatment can help people better manage their condition and improve their quality of life.

Rheumatic Disorders – Common Types and Prevalence

Rheumatic diseases cause the immune system to attack the joints, bones, cartilage, tendons, ligaments, and muscles. They can also damage the vital organs, including the lungs, heart, nervous system, kidneys, skin, and eyes. There are hundreds of different rheumatic diseases. The most commonly known types are rheumatoid arthritis, osteoarthritis, lupus, psoriatic arthritis, Sjogren's syndrome, gout, and scleroderma.

While the risk of gout, osteoarthritis, and rheumatoid arthritis increase with age, these conditions can also affect people age 20-40. Pediatric rheumatic diseases affect nearly 300,000 children in the United States, and for many, symptoms may persist even in adulthood. Affordability is a major concern for individuals with rheumatic disease, according to the 2019 Rheumatic Disease Patient Survey conducted by Simple Tasks, a public awareness campaign from the American College of Rheumatology. Sadly, nearly 60 percent of patients being treated for a rheumatic disease reported that they had difficulty affording their medication(s) or treatment(s) in the past year.

Importance of Early Diagnosis and Treatment
Lack of awareness about rheumatic disease increases the risk of longer-term pain and damage of not only the joints but also various organs and body systems. Rheumatic diseases are painful conditions that affect the joints, tendons, ligaments, bones, and muscles. Autoimmune rheumatic diseases cause the immune system to attack the body's healthy tissues. However, autoimmune rheumatic diseases, such as rheumatoid arthritis (RA), systemic lupus erythematosus (SLE), Sjogren's syndrome, polymyositis, and systemic sclerosis also affect the tendons, ligaments, bones, and muscles, as well as many organs. They can even affect the eyes and skin.

It is crucial that people learn to recognize the symptoms of rheumatic diseases and get timely treatment. Recent studies suggest that patients with autoimmune rheumatic diseases may be at higher risk for severe COVID-19 disease than the general population.

The Rheumatic Disease Awareness Month is a national campaign dedicated to drawing attention to the more than 100 conditions that come within the sphere of rheumatic disease. Rheumatic disease symptoms can be difficult to recognize and may be just considered as aches and pains usually associated with aging. Unfortunately, many people live with their condition for years before they get a correct diagnosis and treatment.

The goal of Rheumatic Disease Awareness Month is to educate people about the risk factors, treatment options, economic impact, and lifestyle or healthcare challenges associated with rheumatic diseases, and importantly, what symptoms to look for and when to consult a rheumatology specialist.

Causes and Symptoms of Rheumatic Conditions
Rheumatic diseases are believed to be triggered by a combination of hereditary and environmental factors, though it is difficult to determine the cause of the condition in a particular individual. Many of these conditions occur when the immune system gets "confused" and attacks your own joints, muscles, bones, and organs. Examples of autoimmune (self-immune) diseases include rheumatoid arthritis (inflammation of the joints), lupus (an inflammatory disease of connective tissue), and vasculitis (inflammation of the blood vessels of the body).

Factors that increase risk of developing rheumatic disease include:

- Your sex. Women are more likely than men to develop rheumatic diseases such as Rheumatoid Arthritis, Scleroderma, Fibromyalgia, and Lupus.
- Age. Rheumatic diseases can occur at any age, but it most commonly begins in middle age.
- Family history. If a member of your family has rheumatic disease, you may have an increased risk of the disease.
- Smoking. Cigarette smoking increases your risk of developing rheumatoid arthritis, particularly if you have a genetic predisposition for developing the disease. Smoking also appears to be associated with greater disease severity.
- Environmental exposures. Although poorly understood, some exposures, such as asbestos or silica, may increase the risk of developing rheumatoid arthritis. Emergency workers exposed to dust from the collapse of the World Trade Center are at higher risk of autoimmune diseases such as rheumatoid arthritis.
- Hormones. High levels of estrogen may contribute to the development of the disease.
- Stress. High levels of stress may cause symptoms to flare up.

Signs and Symptoms
Rheumatic disorders are generally chronic, and symptoms can worsen over time and lead to severe complications. Common signs and symptoms of rheumatic diseases include:

- Chronic and debilitating joint pain
- Inflammation indicated by joint swelling, tenderness, warmth, and redness
- Morning stiffness
- Muscle pain
- Pain in the neck, spine, or back
- Numbness and tingling in the hands and feet
- Swelling
- Difficulty moving the joints
- Joint deformity
- Fatigue
- Eye inflammation, infections, or dryness
- Rashes and sores

Timely diagnosis can prevent the condition from becoming more serious or causing more severe symptoms. Also, having one rheumatic disease can put a person at a risk of developing others. Initiating treatment early can slow the progression of rheumatic disorders, prevent irreversible joint or organ damage, and improve chances of remission. This, in turn, depends on early diagnosis.

"The sooner a person is diagnosed and referred to the correct specialist to receive proper treatment for rheumatic disease, the better a patient's chances are of managing their disease and

We Want You!

*** PLEASE READ ***

With so much going on in the healthcare industry, with COVID-19, code changes, policy updates, and more, those in the industry have many questions. We encourage all our members to either join an association or make sure you are frequently checking up with your association's news and updates.

You can never gain enough education and information. Each association offers their own unique knowledge and experiences for their members.

BC Advantage is proud to work closely with the associations listed below. Take a few minutes and visit some or all of the associations' websites. Check out their news, certifications, products, and services to learn more about them. Tell them you are a BC Advantage member for any additional discounts they can provide you.

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

enjoying a fuller, healthier life," said Paula Marchetta, MD, MBA, president of the ACR in an official September 2019 press release.

Types of Rheumatic Disease
Here is a list of different types of rheumatic disease with varied symptoms that can affect different parts of the body.

Ankylosing Spondylitis: This chronic inflammatory disease can cause some small bones of the spine to fuse, affecting movement and leading to stiffness, pain, and hunching. Other complications include breathing difficulties, eye inflammation, compression fractures, and heart problems. Men are at greater risk of developing ankylosing spondylitis than women.

Bursitis: This painful condition affects the bursae, the small fluid-filled sacs that serve as a cushion for the bones, tendons, and muscles near the joints. The bursa become inflamed when there is too much friction. The most common areas where inflammation occurs are the shoulder, elbow, hip, and knee. In addition to pain, symptoms include stiffness of the affected joint, swelling, warmth and redness at the site, tenderness, and fever.

Crohn's Disease: Crohn's disease is a chronic, inflammatory bowel disease that appears early in life, typically age 15. Different people experience inflammation caused by Crohn's disease in different areas of the digestive tract, and the disease can progress deep into the layers of affected tissue. Symptoms include pain, abdominal cramps, diarrhea, mouth sores, delayed growth (in younger children), fever, weight loss, and anemia. Crohn's disease can also lead to complications such as colitic arthritis, inflammation of the tissues around the bile ducts (pericholangitis), kidney stones, fistulas, and urinary tract problems.

Gout: Gout is a form of inflammatory arthritis that results in painful, swollen joints. It is caused by monosodium urate crystal deposits in the joints which result from excessive uric acid in the body. Gout most commonly affects the joint at the base of the big toe. Common symptoms include severe sudden pain, chills, fever, and general malaise.

Juvenile Idiopathic Arthritis (JIA): Juvenile idiopathic arthritis is a group of conditions that causes joint inflammation in children. Though children often outgrow this autoimmune disorder, it can stunt bone development in the growth stage. There are different types of JIA, distinguished by the number of joints affected, their signs and symptoms, the results of laboratory tests, and family history. Symptoms include swollen, stiff, and painful joints, usually in the morning, eye inflammation, fatigue, and appetite loss. Systemic JIA can cause high fever and rash and swollen lymph nodes.

Osteoarthritis (OA): OA is the most common type of arthritis. OA is actually not considered a rheumatic disease as it is caused by the natural wearing down of the joint's cartilage over time, as opposed to causing inflammation. OA causing stiffness, pain, and loss of movement in the joint. Though the condition can damage any joint, OA usually affects the joints in the hands, knees, hips, and spine. Staying active, maintaining a healthy weight, and some treatments can help manage the OA symptoms, slow disease progression, and help improve pain and joint function.

Osteoporosis: Osteoporosis causes bones to become weak and brittle due to a decrease in bone mass and density. Bone is constantly broken down and replenished. Osteoporosis occurs when the body stops creating new bone to replace the loss of old bone. The condition affects more than 10 million Americans. Up to 1 in 2 women will break a bone due to osteoporosis, according to the Johns Hopkins University School of Medicine.

Polymyalgia Rheumatica (PMR): This inflammatory disorder usually affects people over 65, causing muscle pain and stiffness in the shoulders, neck, hips, and lower back. PMR can occur along with giant cell arteritis, another inflammatory disease of the arteries that causes headaches, vision difficulties, jaw pain, and scalp tenderness.

Polymyositis: This inflammatory rheumatic disease can affect the whole body. Signs and symptoms usually develop gradually over time, causing muscle weakness and ultimately, disability.

Psoriatic Arthritis: Psoriatic arthritis is a chronic disease that usually occurs in people with skin psoriasis. It can affect just one joint, several joints, or multiple joints. It typically affects the joints at the end of the toes and fingers and the back and sacroiliac joints of the pelvis. Early accurate diagnosis is crucial as research suggests that persistent inflammation from psoriatic arthritis can ultimately damage the joints.

Rheumatoid Arthritis (RA): This is the most common type of autoimmune arthritis. It is estimated that about 1.3 million people in the United States are living with RA. This chronic condition is characterized by pain and swelling in the wrist and small joints of the hand and feet. It can cause long-term joint damage, with chronic pain, loss of function, and disability. Fortunately, early treatment for RA can improve symptoms and help people lead an active life.
Scleroderma: This is a rare condition caused by overproduction of collagen in the skin. Scleroderma is characterized by thickening and tightening of the skin and inflammation and scarring in many areas of the body. Systemic scleroderma, the most serious form of the disease, can also affect the lungs, kidneys, heart,

intestinal system, and other areas.

Sjogren's Syndrome: This autoimmune disease causes dry eyes and a dry mouth.

It typically affects older women. Many patients develop Sjogren's syndrome as a complication of rheumatoid arthritis or lupus. In some patients, the disease may cause lung problems, abnormal liver and kidney function, skin rashes, and neurologic problems.

Spondyloarthropathies: Spondyloarthropathies (spondyloarthritis) are a group of rheumatic diseases that cause arthritis. They mainly cause pain and inflammation in the spine. Some forms also affect the arms and legs, hands and feet, hips, shoulders, and knees. Axial spondyloarthritis can progress into ankylosing spondylitis. Spondyloarthropathies may be associated with eye problems, skin rashes, and mouth sores.

Systemic Lupus Erythematosus: Lupus causes widespread inflammation in the body and affects the joints, muscles, skin, blood vessels, and even kidneys. It is believed to be caused by a combination of genetics, hormones, and environmental factors. Lupus is more common among women and about 20 percent of people with lupus develop the disease before age 20.

Tendinitis: Tendinitis or bursitis involves inflammation of the tendons in the shoulder, elbow, wrist, hip, knee, and ankle. It is usually the result of overuse or repetitive stress but can also occur as a result of a sudden intense injury or a pre-existing rheumatic condition. Tendinitis symptoms include pain, tenderness, and restricted mobility.

Diagnosing Rheumatic Disease

Diagnosing rheumatic disease begins with a physical examination, discussion of symptoms, and questions about present and past health. The rheumatologist will examine the patient's range of motion and reflexes and check for conditions like swollen glands and eye inflammation. Laboratory tests may be recommended to detect various signs of inflammation and test for inflammatory markers. Imaging tests can show progression of the disease in the joints.

Early and rapid diagnosis is an important prerequisite for managing rheumatic disease. However, while some conditions like gout are usually easy to diagnose, some autoimmune rheumatic diseases are challenging to detect during the early stages. A 2019 report published by the American Association of Family Physicians (AAFP) noted that the initial symptoms of autoimmune diseases can be similar, may flare and remit, and overlap with those of other conditions, including other autoimmune rheumatic disorders.

Another thing that makes diagnosis difficult is that in the early phases, rheumatic illnesses will not present in the way that they're described in textbooks, notes Sergio Schwartzman, MD in an article published on the HCP LiveNetwork. For example, in patients who have rheumatoid arthritis, the early symptoms may be just a little morning stiffness and arthralgias, and the typical exam may not reveal much. The same patient may present with red swollen joints a year later, says Dr. Schwartzman.

The elements that go into diagnosing a rheumatic disease, according to Dr. Schwartzman, include: a careful detailed history and a very good detailed physical, supported by both laboratory studies and imaging studies. The AAFP report says that utilizing antibody panels, which involves testing for a number of autoantibodies at the same time, can help earlier diagnosis.

Treatment

As rheumatic diseases are chronic conditions, the focus of treatment is to ease symptoms, reduce inflammation, slow progression, and/or achieve remission. Treatment would depend on the patient's condition. Medications for musculoskeletal disorders include oral and topical analgesics, corticosteroids to address inflammation, disease-modifying anti-rheumatic drugs (DMARDs) including Janus kinase inhibitors, injections into a joint or the soft tissues, physical therapy, chiropractic treatment, and surgical options. Individual response to treatments for arthritis may vary.

Billing and Coding Rheumatic Disease

To get paid, physicians should report a valid ICD-10 code that informs payers of the reason for services. Medical necessity generally determines the payment.

Here are 50 top rheumatology ICD-10 codes as listed by the ACR:

1. Ankylosing spondylitis - M45.
2. Arthralgia (joint pain) - M25.5
3. Arthopathy - M12.8
4. Baker's Cyst - M71.2
5. Bechet's syndrome - M35.2
6. Bursitis knee - M70.5
7. Bursitis olecranon - M70.2
8. Carpal tunnel syndrome - G56.0
9. Chronic pain - G89.29
10. Costochondritis - M94.0
11. Cushing syndrome, other - E24.8

12. De Qervain's tenosynovitis - M65.4
13. Effusion - M25.4
14. Elevated CRP - R79.82
15. Elevated SED rate - R70.0
16. Enteropathic arthropathies, multiple sites - M07.69
17. Fibromyalgia - M79.7
18. Gout, acute idiopathic - M10.0
19. Gout, chronic, idiopathic - M1A,0
20. Juvenile rheumatoid arthritis, Still's disease NOS - M08.20
21. Lupus erythematous NOS - L93.0
22. Lupus SLE, NOS - M32.9
23. Myalgia - M79.1
24. Osteoarthritis primary - MlS.0
25. Osteoarthritis bilateral, hip - M16.0
26. Osteoarthritis unilateral, hip - M16.1
27. Osteoarthritis bilateral, knee - M17.0
28. Osteoarthritis unilateral, knee - M17.1
29. Osteoarthritis bilateral, first carpometacarpal joint - M19.0
30. Osteoarthritis unilateral, first carpometacarpal joint - M19.1
31. Osteopenia - M85.89
32. Osteoporosis w/pathological fracture, age related - M80.0l
33. Osteoporosis w/o pathological fracture, age related - M81.0
34. Polymyalgia rheumatica - M35.3
35. Pseudo gout - Mll.29
36. Psoriatic arthritis - L40.50
37. Psoriatic spondylitis - L40.53
38. Raynaud's syndrome w/o gangrene - 173.00
39. Reactive arthritis (Reiter's) - M02.3
40. R/ Aw/rheumatoid factor w/o organ or systems involvement - M05.7
41. R/A w/o rheumatoid factor - M06.0
42. Sjogren's disease - M35.0
43. Spondylosis with myelopathy - M47.1
44. Stills disease, adult onset - M06.1
45. Trigger finger - M65.3
46. Wegener's granulomatosis - M31.3
47. Drug monitoring long term use - 279.899
48. Drug monitoring - current (NSAIDS) - Z79.1
49. Drug monitoring - current (steroids) - 279.52
50. Pregnant state - Z33.1

Along with choosing the correct ICD-10 code, physicians should ensure relevant documentation in the medical chart to support the level of the ICD-10 code.

Based on the diagnosis, documentation should specify:

- if the condition is chronic or acute
- the etiology of the disease
- the anatomical site that is affected
- the side of the body that is affected

If the provider has not established a related, definitive diagnosis, codes that describe signs and symptoms can be reported. The patient's signs and symptoms should be clearly recorded in the medical record documentation. This will allow medical coding service providers to code to the highest level of certainty based on the known signs and symptoms.

Correct Diagnosis and Appropriate Treatment by a Rheumatologist

Rheumatologists specialize in diagnosing and treating musculoskeletal diseases and autoimmune rheumatic disease. People who experience joint pain usually first consult their primary care physician (PCP). As inflammatory arthritic diseases can progress quickly, the PCP may initiate early tests prior to referral to a rheumatologist. Some rheumatologists may provide consultations without requiring a referral from another physician. Rheumatologists will do a thorough patient evaluation, assess the results of prior tests, and may order additional lab tests and/or imaging tests to identify musculoskeletal abnormalities. They will then develop a personalized treatment plan to reverse or slow the progression of rheumatic disease and its complications with ongoing assessment and evaluation. Rheumatologists work closely with physical therapists, primary care physicians, orthopedic surgeons, neurosurgeons, and other specialists to provide the best care for their patients.

Rheumatic Disease Awareness Month is dedicated to increasing the public's understanding and awareness about the prevalence or severity of rheumatic diseases. The ACR's Simple Tasks platform encourages patients to educate their close family members, friends, and even children about their disease. This can go a long way in addressing any potential confusion and anxiety on their end as well as helping them understand how the disease impacts the patient's day to day life.

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Getting More Control Over Your Communications

Remember when we picked up the phone, sent a memo (on paper!), or just met face to face? Me neither! Ha! I wish I was that young. Today, we're immersed in a world of omni-directional communication – coming at us in every form for our private, social, and business lives. Let me share a few ideas to help you swim in the big sea of business communication.

The challenge is to focus on the information we need to be successful, including providing high quality patient care, staying up-to-date on regulation changes, and being financially sound. We know Google isn't a great doctor, and it's not a great business consultant either. For example, a recent CMS proposed rule is 785 pages long. The rule refers and links to a host of other documents, some in excess of 1,000 pages. The information in these documents determines how physicians get paid, new laws to follow, and guidelines to stay out of all sorts of trouble. Whether you are a solo provider, small group practice, or frankly, a group of any size, knowing what's important and knowing it fast are the keys to success.

How can you get the answers you need when everything changes so quickly and you don't have a team of lawyers at your service? Here are a few suggestions particularly important for solo providers and small group physician practices (but also applicable to all practices):

1. **Join a professional network!**
   Professional networks understand what you mean when you ask questions. If you're utilizing an association forum, you're likely to not only find a good solution, but also learn a lot more from the conversation and build your professional network.

2. **Use webinar services**
   Most providers have used webinars about once a month in the past, but now we're finding that online meetings are the norm beyond the physical practice. The best professional networks provide free webinar services for audiences *and* presenters! Friendly and frequent webinar use is the "new normal" for successful practices.

3. **Use the network's online services**
   The best professional networks allow you to easily access peers by geography and/or medical specialty, etc. For example, if you have a challenge in your pediatrics practice in Pennsylvania, you can easily contact a peer from the other side of the state or the other side of the country (our experience is that people love to *share* their experience in a non-competitive environment).

4. **Participate in the network**
   The more you give, the more you get. In a strong professional organization, there are online tools and a wide range of networking opportunities that not only build relationships, but also build knowledge. When questions arise, you can quickly use their system to retrieve the information you need, and you also have an opportunity to share your experience and expertise when the need arises.

Physicians who employ professional office managers have an advantage, and access to current information and answers is now largely transferring to webinars. Getting more control over your communications means working seamlessly with others in your professional circle who are doing the same. Communicate, share, and learn.

Join a professional association! If you're already a member, ask about access to free webinar services, and take control of this crazy world of communications!

Karen Blanchette, MBA, is the Executive Director for the Professional Association of Health Care Office Management. PAHCOM leads the way in professional networking, nationally accredited certification, and embracing technology solutions within medical practice management. Webinar services are currently available FREE to our member community for purpose of sharing knowledge across the industry to ultimately help fellow practices excel during these extraordinary times. Visit www.pahcom.com or call 800-451-9311.

Billing / Coding

Office of Inspector General Says

Medicare Advantage Organizations are Denying Services Inappropriately

We attended the recent virtual RISE National Conference and had the opportunity to listen to presenters share their knowledge about risk adjustment and HCC reporting and data validation. Among the presenters were representatives from the Office of Inspector General (OIG), who presented findings from encounter data from 2012-2016.

They began by stating their desired outcomes, which include healthier beneficiaries, lower costs, better care, and a more efficient system and that the three main areas for concern include:

- Quality services (network adequacy, denials, and appeals)
- Federal funding (fraud, risk adjustment validation audits (RADV), and rates)
- Data integrity (security, adequacy, and compliance)

The OIG is the federal policing agency which identifies criminals committing fraud in an effort to reduce beneficiary harm and fraudulent behavior that leads to increased tax burden on the population. According to them, although only 1% of denials by Medicare Advantage Organizations (MAOs) were appealed, 75% of those were overturned on appeal. This begs the question, why are providers and beneficiaries not appealing more denied requests for covered services?

Asking the following questions may shed some light:

1. Does the MAO provide a benefits coordinator that can interact with the beneficiary to ensure they understand their medical benefits?

   Providing the beneficiary with an explanation of their benefits in a manner they can understand (layman's terms) helps not only the beneficiary by ensuring they obtain the care and education that may help them improve their risk scores, but will also assist the payer in helping the beneficiary see the value behind wellness checks to ensure they are receiving the best available care and information about their health.

2. Does the MAO provide beneficiary representation to the provider organization?

   Providers caring for the beneficiaries will verify benefits when they are needed for the services being rendered; however, they may not be aware of additional benefits that promote prevention, wellness, and patient education. Providers want their patients to be healthy, and when they are empowered with knowledge about the benefits available to them for wellness visits, vaccines, and more, they can encourage patients to invest in their own health and identify the tools the MAO offers to assist them in accomplishing that goal.

3. Does your MAO encourage provider groups to appeal service and claim denials? Is the process straightforward or is it cumbersome to discourage appeals?

   If MAO benefits are being wrongfully denied, and the process of appeals is cumbersome and difficult, the welfare and health of the beneficiary are not being put first.

As a result of the study, the OIG recommended MAOs take the following actions:

- Implement enhanced oversight of MAO contracts to ensure denials are valid
- Address inappropriate denials
- Provide beneficiaries with clear information

As an MAO, now is the time to begin looking into how you can facilitate education on the benefits available to beneficiaries and the options available to appeal a denial for services. The information available through the OIG is an excellent place to begin.

Aimee Wilcox writes for Find-A-Code. www.findacode.com

Proper Phone Etiquette
Can Be a Rude Awakening

The Problem
The dreaded horrible phone call experience.

It happens to all of us. We call a business and hope to get something done. Instead, the result is annoying, frustrating, and a time sap. Let's face it. Sometimes you just want to throw your phone against the wall.

For doctors, the phone experience for patients is even more critical. A phone call is usually the first contact with your medical practice. It is also one way for your existing patients to ask questions or convey essential information. On a busy day, your telephone may not stop ringing. That means a drain on staff time and energy. But answering calls is also one of the easiest things to get right in order to maintain a calm and professional relationship with your patients.

Our staff's behavior can positively or negatively impact your practice when patients call the physician's office. As you know, patients expect a lot. Here are a few tips:

Answer Quickly When the Phone Rings
This sounds easy, but it's not always possible. Nevertheless, it's best to answer inbound calls as quickly as possible. Too many rings can irritate waiting patients and affect their perception of your practice. You can lose patients. And don't forget how all those extra rings can add noise to your office. It can even create patient attrition and negative word-of-mouth. No practice would want that.

Be Friendly and Professional
Cheerful = Good business. Greet callers in a friendly and professional manner. Make sure to state your name and the name of your medical practice. Ask the caller's name to refer back to it if needed. Make sure to ask the caller how you can be of assistance to them. Here's a trick. Try smiling as you answer the phone. It naturally improves your voice to make it sound lively, energetic, and approachable. Avoid answering a phone call while eating or chewing gum, as this is like showing disrespect to the caller.

Use the Right Volume and Speed When Speaking
Speak in a low tone, moderate volume, and right speed when talking to patients. This way, you'll be able to convey your words clearly and understandably. You should only raise the volume of your voice when you need to clarify a statement. For example, if a patient is elderly and has a hard time understanding what you're saying, you can speak louder. However, make sure you aren't shouting at a patient when clarifying statements.

Before Putting Patients on Hold, Ask for Their Permission First, and Wait for Their Reply
It can make the patient feel unimportant if they are quickly shuttled to hold before getting their okay. Let the caller know if the person they are looking for is available. If not, inform them that the call will be transferred to voicemail. The caller may have no idea how long they will be on hold. Always check back with patients and reassure them that they haven't been forgotten. If the caller is put on hold for a little longer, apologize for the inconvenience. Thank them for their patience.

Listen Attentively to the Caller
This is a big one: Listen carefully on a call to determine how you can best assist. If the caller is explaining something complex, show interest and concern. It is best to take notes while listening to the patient so that you won't miss any relevant information. Wait for the caller to finish before you ask questions. Before you end the call, repeat the key points, or clarify confusing statements to get the right information.

When Taking a Message, Tell the Caller When There Will Be a Response
Always try to manage patient expectations. Don't make promises you can't keep. If you know that the patient will not get a response from you until the end of the week, inform them. You don't want them to call the office continuously. If the patient has not yet received an update during the promised time frame, explain the delay, and tell him that you will immediately get back to them when you have the answer.

End Calls Politely
When you need to end the call, it can sometimes get awkward. So prepare a closing statement to end calls properly. It should be in a friendly and courteous manner. You must always ask the caller if there's anything else you can help them with. Don't forget to thank your caller at the end of the conversation. Wait for the caller to end the call before hanging up.

The Bottom Line
You want to avoid broken phones thrown by frustrated patients. It's not just about answering properly, but the way you sound. Practice your answering skills. And practice that smile.

Aprillice Valdez writes for DrCatalyst. www.drcatalyst.com
If you're looking for a healthcare company to help you deal with phone calls, scheduling, voicemail transcription, and appointment reminders, DrCatalyst can help you. We offer medical billing, clinical & administrative, medical transcription, and medical marketing services to help healthcare providers and medical practices.

COVID-19 and Patient Visits

At least once a year, I have healthcare appointments. I usually have lab tests done as part of those visits, and another doctor visit for the results. Prior to COVID-19, my primary care physician (PCP) would give me paperwork to go to my local lab to have these tests done. I wouldn't need an appointment, so I could simply walk in and be seen.

Since COVID-19 hit, all lab visits are to be made by appointment. As a result, I saw that former walk-in patients overwhelmed the required online appointment system, so I decided to chance it and do a walk in anyway. The place was deserted with social distancing signs everywhere. Chairs were labeled where you were not permitted to sit, to comply with social distancing guidelines.

I was required to wear a face mask before I walked into the building. As I sat there to have my blood drawn, the lab technician was also wearing a face mask, and gloves, as well as a face protector and a paper gown. I was in and out in less than 5 minutes and was told that my doctor would be receiving the test results before my next doctor visit. I provided all of my insurance cards like I usually do and verified that the lab took my primary and secondary insurance and that these lab tests were covered so that I should not have any problems with the lab processing the tests. As a patient, and as a coder and biller, I want to ensure that absolutely no problems will occur, because if I do have any problems, I won't return to this lab.

My only complaint was that the lab wanted me to be tested to determine if I had coronavirus, at a cost of $150. I had already done my homework on this and found that my primary insurance would pay $120. My secondary insurance would cover the remaining $30, but it required preapproval by my doctor, which I didn't have, so I declined the test. When I went to my doctor and asked him, he said I didn't need to have the test done, and because I trust him, I didn't go back to have the test done, and I was not pressured by the lab to do so.

My doctor is in a small strip mall close to the hospital. The building owner assigns my doctor a number of parking spots for patients. Prior to the virus, anyone could park in one of the physician's assigned parking spots, walk into the building, sign in, and have a seat in the waiting room. Once the doctor has a patient room open, we would be taken to the room, have our vital signs taken, have any prescription refills ordered, and ask any questions we need answering. Any copays or coinsurances were due at the time of service—like most physician offices.

Post COVID-19, things with my visit changed. My doctor's receptionist escorted me to a designated parking spot next to the front door. While in my car, she had me sign in, and his nursing assistant took my weight and vital signs, and asked me if I needed any prescription refills. In compliance with the current pandemic guidelines, all of this was done requiring the wearing of a face mask. I was asked to have a seat in my car until the doctor was available. His receptionist and nurse also wore face masks, gloves, a paper gown, and a face shield.

Just as I was texted that it was my time and I was preparing to walk to the front door of the office, a man decided to park his car in one of the designated parking spots. He wasn't wearing a face mask and he started smoking a cigarette, despite signs that the campus was in a no-smoking zone. Had the non-mask wearing smoker decided to cause a problem, the staff had the police on speed dial. Pre COVID-19, patients waited to be seen in the waiting room. Post COVID-19, our car is the waiting room.

Building security escorted the non-mask wearing smoker away from the building. Security was not taking any chances with this virus. The smoker was free to find a non-emergent doctor somewhere else who probably didn't have a problem with someone who doesn't want to wear a face mask. My doctor has never had a problem with a lack of patients; he maintains responsibility for himself, his staff, and us, his patients. He is a single-provider practice and has been my and my wife's doctor for 10 years now.

The difference between the pre and post COVID-19 visit was noticeable, but I still felt safe and secure during my "office" visit, and both my doctor and his staff were a well-oiled machine. COVID-19 has made a lot of changes in our world, but what it has not changed or eliminated was the requirement to pay my coinsurance. When I checked out, the receptionist asked me how I would like to pay for my mandatory out-of-pocket expenses. My doctor's staff isn't embarrassed by asking me to pay, by check, cash, or credit card. Just like with my lab visit, I had my stimulus check in the bank and paid for that in full.

A couple of days ago, I received an email from my insurance company. The lab visit was now processed, and I was pleased to see that the coding and billing of both my lab and doctor visits were accurate. As a patient, I appreciate the communication of everyone involved, from the lab technician, to the receptionist, the nurse, and my doctor.

After my well-oiled visit, I received word that unlike Elvis, COVID-19 has entered my apartment building. Due to a technicality by my State leadership, we are not able to have someone in our building investigate to see how far it has spread in the building. If one person in our building has the virus, I am sure many now have it. Now, the maintenance staff must make an appointment to come to our building and they must wear masks and gloves. My apartment is its own quarantine, because both my wife and I have no immunities. We do not allow anyone in our apartment, not even Amazon, FEDEX, UPS, or the USPS. When a package is delivered, we receive a message that it is outside of our front door. Technology is a fantastic thing, and for most, a sanity lifesaver.

If my wife and I do need to go out (and we do go out for medical visits, groceries, and take-out food so we aren't hermits!), we correctly wear face masks and surgical gloves, wash our hands, use hand sanitizer, and take our clothes to the laundry upon arriving home. I insist that no one walks into the laundry room until I am done, and I know that doesn't make the anti-maskers happy, but I'm not here to please them, I'm here to keep my family safe. The coronavirus is not something to be trifled with, but in my opinion, you don't need to fear it as long as you follow the CDC guidelines and you wear a face mask correctly. I don't plan on getting sick from this virus.

Ladies and gentlemen, our world is in a pandemic. However, medical visits still need to go on, their claims still need to be coded and billed correctly, our insurance companies still need to pay our doctors for the medical care they provide, and we still need to pay our mandatory out-of-pocket expenses.

Until this is over, stay safe, and above all: Never Give Up and Never Surrender.

Steve Verno

Source: CDC

Wear a Mask to Protect Others

- **Wear a mask that covers your nose and mouth to help protect others in case you're infected with COVID-19 but don't have symptoms**
- **Wear a mask in public settings when around people who don't live in your household, especially when it may be difficult for you to stay six feet apart**
- **Wear a mask correctly for maximum protection**
- **Don't put the mask around your neck or up on your forehead**
- **Don't touch the mask, and, if you do, wash your hands or use hand sanitizer to disinfect**

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Coding Injections for Pain Management

Coding for pain management can get confusing. How many injections, the location, and when to use a modifier are all common questions. This article will cover some of the most common injections used in pain management.

Use the Correct Diagnosis Codes and Revenue Codes to Get Paid for PAD Rehab

The initial treatment in rehabilitation for patients suffering from Intermittent Claudication (IC) is Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD). Rehabilitation using SET involves the use of intermittent walking exercise, which alternates periods of walking to moderate-to-maximum claudication, with rest.

Maximizing Resources for ICD-10 Coding Audits

From internal reviews to external inpatient coding audits, healthcare organizations nationwide are revisiting tried-and-true audit practices with ICD-10 coding quality in mind. MS-DRG validation audits under ICD-10 have also become more strategic to realize a hospital's revenue cycle success.

Online Webinars

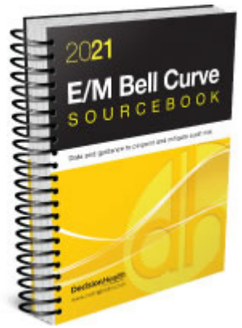
Appropriate Use Criteria: What you Need to Know (1 CEU)
Objective: 2020 is the official CMS testing year for AUC/CDS implementation. As organizations continue to bridge the gap with imaging facilities, it is important that everyone be on the same page throughout the CMS implementation and testing period.

COVID 19: Testing, Reimbursement, and Provider Relief Funds (1 CEU)
Objective: This timely webinar is a discussion of laboratory testing for COVID-19, including the types of tests available, requirements for testing, operational and business considerations for offering testing, employer-mandated testing, and reimbursement for testing. Additionally, this program will discuss the Provider Relief Funds issued pursuant to the CARES Act and enforcement of the terms and conditions of that program.

View more information at https://www.billing-coding.com.

New product discounts and Reviews

Title: 2021 E/M Bell Curve & Auditing Sourcebook



Price: $409.45
From: www.codingbooks.com
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Available for pre-order!

The 2021 E/M Bell Curve & Auditing Sourcebook is the most comprehensive tool you'll find to help you test and assess your E/M billing and utilization patterns to spot red flags of under or over-coding and correct your behaviors to drive down audit risk.

With the 60-day overpayment rule in effect, which imposes stiffer than ever penalties for common coding mistakes, this resource is a must-have to protect your practice!

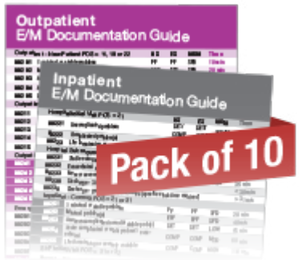
This data-driven analysis workbook allows you plot your own E/M billing utilization numbers against national averages to see how your coding matches up in a matter of seconds. But it doesn't stop there – you also get official E/M coding guidelines and guidance to help you adjust your coding up or down. In addition, you get E/M case scenarios and audit tool templates to practice and self-test for correct E/M auditing.

Features include:

- E/M utilization data—for 48 E/M codes for 59 different specialties, including recently-added specialties Interventional Cardiology, Cardiac Electrophysiology, Hospitalist, Hospice, and Palliative Care
- Access to easy bell-curve generation—You'll be given access to pre-populated spreadsheets, organized by specialty, to help you save time and zero in on unique E/M billing patterns
- Expanded bell curve templates—quickly chart billing patterns against national norms

Title: 2021 E/M Documentation Quick Reference Card Set (10 pack)

Price: $69.00
From: www.codingbooks.com
Product Code: DHMPLEMCAR21



Avoid E/M coding guesswork and gain the confidence you need to code accurately and efficiently with DecisionHealth's 2021 E/M Documentation Quick Reference Card Set.

Provider uncertainty surrounding the proper selection of E/M service codes is the most common cause of up coding and down coding—exposing physicians and the practice/facility to greater audit risk and OIG scrutiny. And come Jan. 1, 2021, there will be even less room for errors as the 2021 E/M documentation guidelines will create a sea change in how medical practices select a level of E/M service. The revised reporting requirements mark the first significant update in more than 20 years since the release of the 1995 and 1997 documentation guidelines.

Keep these cards handy for at-a-glance guidance and reinforcement to ensure the most appropriate level of service is selected and coded correctly with emphasis on the patient's presenting problem.