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March is Multiple Sclerosis

Education and Awareness Month

CDI From a Different Perspective

Relaxing of the PHI Protections Introduced for Public Comment

Chasing Patient Payments? Learn How to Reduce Your Costs

The Role of NIST Standards in the HITECH Act Amendments Included in the
21st Century Cures Act



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CEO Letter

Well, here we are. I don't know about you, but I for one am happy to be heading out of the dormancy of winter into the vibrancy of spring. I'm aware that this is an early thought, but I'm in serious need of something fresh and bright to fill my soul. It has been over a year that we've been dealing with the biggest public health issue of most of our lifetimes, and looking back, we've seen some hits and misses with how it's been handled. For those of us who have lost someone we love or care about, I extend my sincerest condolences. This has been hard on everyone all over the globe, but it is especially hard to look past our own experiences when they are so fresh and raw. I thank the front-line medical staff who are working tirelessly to provide the assistance that so many patients need right now, and I share their pain, in the small way I can, when they lose a battle. I cannot imagine the heaviness that they carry in their hearts every day. There is not enough gratitude in the world to take that feeling away.

I encourage all of us to take a step back from our preconceived thoughts on how others are doing in this country and allow ourselves to truly see each other for who we are, not what we think we are. We are mothers, fathers, sisters, brothers, sons, daughters, aunts, uncles, grandparents, friends, colleagues, and so much more. We cannot allow ourselves to get lost in an "us and them" mentality; otherwise, we will lose so much of ourselves, and in turn, lose the very thing that makes us who we are: our humanity. I get that so much has been said and that it is hard to forget, let alone forgive, but we run the risk of losing so much if we cannot find common ground. Please make time during this season of new growth to create a fresh start with a relationship with someone. We all need to do better, and we can.

As always, this issue brings you, our readers, a wealth of information to absorb and implement in your workplace. But please, as you are "the people" behind your medical practice, keep in mind the people. And be kind.

Until next time,

Storm Kulhan

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Phone: (864) 228 7310 Fax: (888) 573 7210 email: subscriptions@billing-coding.com / www.billing-coding.com



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



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



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



subscriptions manager
Ashley Knight
ashley@billing-coding.com

advertising
sales@billing-coding.com

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EXPERT

Contributors this issue

Nancy Clements is the Director of Marketing for Practice Management Institute (PMI). www.pimimd.com

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

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

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Don Rodden, CPA (Inactive), CHBME, is a principal at

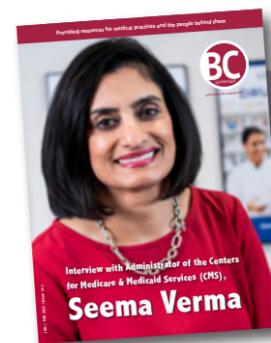
HealthPro Medical Billing, Inc., a leading Revenue Cycle Management and Coding Company. Don is a Past President of the Healthcare Business Management Association (HBMA). He has been a consultant to physicians and medical practices for over 30 years.

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

Jana Weis, BA, DIP COM, CPC, is the principal of Gill Compliance Solutions, a premier Northwest-based compliance support company serving providers within hospitals, healthcare systems, and independent physician offices. www.gillcompliance.com

Aimee Wilcox, CPMA, CCS-P, CST, MA, MT, is the Director of Content for Find-A-Code, an online database of medical billing codes and information. FindACode.com is a quick and easy system that uses a simple search to return accurate information to assist coders in their effort to accurately determine proper codes. Learn more about them at www.findacode.com

Jim Zelem is a former VP of Operations who transitioned to be an effective leader who coached many successful teams. Jim started his career as a simple factory worker who held many positions, such as Industrial and Manufacturing Engineer, as he worked his way up to VP. Jim currently resides in Madison, Wisconsin. He loves sports as he officiated high school football for 18 years. Jim remains active, as he volunteers for the Red Cross and the Senior Center. He enjoys walks in the woods, swimming, and golf.



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Coronavirus & Telehealth Cheatsheet		H innoviHealth	
Medicare-Approved Telehealth Services			
Service Type	Evaluation & Management / Other	Codes	Other (non-telehealth)
Evaluation & Management	99201-99205, 99211-99215	G2010, G2012	Virtual Check-ins
Predefined EM Services	99209-99210, 99213-99214		• New patient (N) established patient (E) • Physician or NPI/CRPA • Special rules apply
Observation Services	99211-99212, 99214-99215, 99218-99219		• Codes are reported by NPI/CRPA • CPT codes reported by physician • Established patients only
Intensive Care Unit (ICU)	99471-99480		• Telehealth services are reported by NPI/CRPA • Established patients only
Nursing Facility	99234-99235, 99237-99238, 99240		• *Patients unable to self-reporting (PT, OT, SLP, clinical psychologist) report these codes.
Outpatient	99201-99205, 99207-99208, 99209-99210, 99213-99214, 99216-99217, 99219-99220, 99222-99223, 99225-99226, 99228-99229, 99231-99232, 99234-99235, 99237-99238, 99240-99241, 99243-99244, 99246-99247, 99249-99250, 99252-99253, 99255-99256, 99258-99259, 99261-99262, 99264-99265, 99267-99268, 99270-99271, 99273-99274, 99276-99277, 99279-99280, 99282-99283, 99285-99286, 99288-99289, 99291-99292, 99294-99295, 99297-99298, 99299-99300, 99302-99303, 99305-99306, 99308-99309, 99311-99312, 99314-99315, 99317-99318, 99320-99321, 99323-99324, 99326-99327, 99329-99330, 99332-99333, 99335-99336, 99338-99339, 99341-99342, 99344-99345, 99347-99348, 99350-99351, 99353-99354, 99356-99357, 99359-99360, 99362-99363, 99365-99366, 99368-99369, 99371-99372, 99374-99375, 99377-99378, 99380-99381, 99383-99384, 99386-99387, 99389-99390, 99392-99393, 99395-99396, 99398-99399, 99401-99402, 99404-99405, 99407-99408, 99410-99411, 99413-99414, 99416-99417, 99419-99420, 99422-99423, 99425-99426, 99428-99429, 99431-99432, 99434-99435, 99437-99438, 99440-99441, 99443-99444, 99446-99447, 99449-99450, 99452-99453, 99455-99456, 99458-99459, 99461-99462, 99464-99465, 99467-99468, 99470-99471, 99473-99474, 99476-99477, 99479-99480, 99482-99483, 99485-99486, 99488-99489, 99491-99492, 99494-99495, 99497-99498, 99499-99500, 99502-99503, 99505-99506, 99508-99509, 99511-99512, 99514-99515, 99517-99518, 99520-99521, 99523-99524, 99526-99527, 99529-99530, 99532-99533, 99535-99536, 99538-99539, 99541-99542, 99544-99545, 99547-99548, 99550-99551, 99553-99554, 99556-99557, 99559-99560, 99562-99563, 99565-99566, 99568-99569, 99571-99572, 99574-99575, 99577-99578, 99580-99581, 99583-99584, 99586-99587, 99589-99590, 99592-99593, 99595-99596, 99598-99599, 99601-99602, 99604-99605, 99607-99608, 99610-99611, 99613-99614, 99616-99617, 99619-99620, 99622-99623, 99625-99626, 99628-99629, 99631-99632, 99634-99635, 99637-99638, 99640-99641, 99643-99644, 99646-99647, 99649-99650, 99652-99653, 99655-99656, 99658-99659, 99661-99662, 99664-99665, 99667-99668, 99670-99671, 99673-99674, 99676-99677, 99679-99680, 99682-99683, 99685-99686, 99688-99689, 99691-99692, 99694-99695, 99697-99698, 99699-99700, 99702-99703, 99705-99706, 99708-99709, 99711-99712, 99714-99715, 99717-99718, 99720-99721, 99723-99724, 99726-99727, 99729-99730, 99732-99733, 99735-99736, 99738-99739, 99741-99742, 99744-99745, 99747-99748, 99750-99751, 99753-99754, 99756-99757, 99759-99760, 99762-99763, 99765-99766, 99768-99769, 99771-99772, 99774-99775, 99777-99778, 99780-99781, 99783-99784, 99786-99787, 99789-99790, 99792-99793, 99795-99796, 99798-99799, 99801-99802, 99804-99805, 99807-99808, 99810-99811, 99813-99814, 99816-99817, 99819-99820, 99822-99823, 99825-99826, 99828-99829, 99831-99832, 99834-99835, 99837-99838, 99840-99841, 99843-99844, 99846-99847, 99849-99850, 99852-99853, 99855-99856, 99858-99859, 99861-99862, 99864-99865, 99867-99868, 99870-99871, 99873-99874, 99876-99877, 99879-99880, 99882-99883, 99885-99886, 99888-99889, 99891-99892, 99894-99895, 99897-99898, 99899-99900, 99902-99903, 99905-99906, 99908-99909, 99911-99912, 99914-99915, 99917-99918, 99920-99921, 99923-99924, 99926-99927, 99929-99930, 99932-99933, 99935-99936, 99938-99939, 99941-99942, 99944-99945, 99947-99948, 99950-99951, 99953-99954, 99956-99957, 99959-99960, 99962-99963, 99965-99966, 99968-99969, 99971-99972, 99974-99975, 99977-99978, 99980-99981, 99983-99984, 99986-99987, 99989-99990, 99992-99993, 99995-99996, 99998-99999		
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New COVID-19-Related ICD-10-CM Codes Take Effect

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) broke from the usual release schedule and implemented the following six new codes related to COVID-19 on Jan. 1 and issued accompanying guidelines.

Z20.822 Contact with and (suspected) exposure to COVID-19

- For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.822. For symptomatic individuals with actual or suspected exposure to COVID-19 and the infection has been ruled out, or test results are inconclusive or unknown, assign code Z20.822.
- If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to COVID-19, assign Z20.822 as an additional code.

Z11.52 Encounter for screening for COVID-19

During the COVID-19 pandemic, a screening code generally is not appropriate. Do not assign code Z11.52. For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19. Coding guidance will be updated as new information concerning changes in the pandemic status becomes available.

Z86.16 Personal history of COVID-19

For patients with a history of COVID-19, assign code Z86.16.

M35.81 Multisystem inflammatory syndrome (MIS)

- For individuals with MIS and COVID-19, assign code U07.1,

COVID-19, as the principal/first-listed diagnosis and assign code M35.81 as an additional diagnosis.

- If MIS develops as a result of a previous COVID-19 infection, assign codes M35.81 and B94.8, Sequelae of other specified infectious and parasitic diseases.
- If an individual with a history of COVID-19 develops MIS and the provider does not indicate that MIS is due to the previous COVID-19 infection, assign codes M35.81 and Z86.16.
- If an individual with a known or suspected exposure to COVID-19 and no current COVID-19 infection or history of COVID-19 develops MIS, assign codes M35.81 and Z20.822.
- Assign additional codes for any associated complications of MIS.

M35.89 Other specified systemic involvement of connective tissue

No guidance was created as this code had to be developed to stay within the coding conventions of an "other" code under M35.8-

J12.82 Pneumonia due to coronavirus disease 2019

For a patient with pneumonia confirmed as due to COVID-19, assign codes U07.1 and J12.82.

Be sure to update your ICD-10-CM codes and guidance for use of the new codes.

Source: *aapplications*

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The documentation of detailed clinical information should result in the assignment of accurate and hopefully reimbursable diagnosis codes. As practices look to streamline documentation and coding processes, it is critical to practice continual quality improvement.

The Role of NIST Standards in the HITECH Act Amendments Included in the 21st Century Cures Act



Signed into law on January 5, 2021, H.R. 7898, which was introduced by Rep. Michael Burgess of Texas, addresses the recognition of security practices and amends the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Additionally, a technical correction Section 3022(b) of the Public Health Service Act (PHSA) was added. The technical correction of the PHSA “shall take effect as if included in the enactment of the 21st Century Cures Act, [Pub. L. 114-255 (Dec. 13, 2016)].”

The security practices under the HITECH Act, which relate to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), are now expressly refined to include National Institute of Standards and Technology (NIST) security standards. Founded in 1901, NIST is now under the umbrella of the U.S. Department of Commerce. What are NIST security standards? “NIST standards are based on the best practices from several security documents, organizations, and publications, and are designed as a framework for federal agencies and programs requiring stringent security measures.” NIST has long applied to government contractors through FedRAMP and FISMA—now, its application is broader in terms of the private sector.

The purpose of this article is to relay the changes to the HITECH Act, as well as provide some of the basic security requirements required by NIST and HIPAA.

Changes to the HITECH Act

H.R. 7898 amended the HITECH Act (42 U.S.C. §17931, et seq. by adding Section 13412:

(a) In General.—Consistent with the authority of the Secretary under sections 1176 and 1177 of the Social Security Act, when making determinations relating to fines under such section 1176 (as amended by section 13410) or such section 1177, decreasing the length and extent of an audit under section 13411, or

remedies otherwise agreed to by the Secretary, the Secretary shall consider whether the covered entity or business associate has adequately demonstrated that it had, for not less than the previous 12 months, recognized security practices in place that may—

(1) mitigate fines under section 1176 of the Social Security Act (as amended by section 13410);

(2) result in the early, favorable termination of an audit under section 13411; and

(3) mitigate the remedies that would otherwise be agreed to in any agreement with respect to resolving potential violations of the HIPAA Security rule (part 160 of title 45 Code of Federal Regulations and subparts A and C of part 164 of such title) between the covered entity or business associate and the Department of Health and Human Services.

(b) Definition And Miscellaneous Provisions.—

“(1) RECOGNIZED SECURITY PRACTICES.—The term ‘recognized security practices’ means the standards, guidelines, best practices, methodologies, procedures, and processes developed under section 2(c)(15) of the National Institute of Standards and Technology Act, the approaches promulgated under section 405(d) of the Cybersecurity Act of 2015, and other programs and processes that address cybersecurity and that are developed, recognized, or promulgated through regulations under other statutory authorities. Such practices shall be determined by the covered entity or business associate, consistent with the HIPAA Security rule (part 160 of title 45 Code of Federal Regulations and subparts A and C of part 164 of such title).

“(2) LIMITATION.—Nothing in this section shall be construed as providing the Secretary authority to increase fines under section 1176 of the Social Security Act (as amended by section 13410), or the length, extent or quantity of audits under section 13411, due to a lack of compliance with the recognized security practices.

“(3) NO LIABILITY FOR NONPARTICIPATION.—Subject to paragraph (4), nothing in this section shall be construed to subject a covered entity or business associate to liability for electing not to engage in the recognized security practices defined by this section.

“(4) RULE OF CONSTRUCTION.—Nothing in this section

shall be construed to limit the Secretary’s authority to enforce the HIPAA Security rule (part 160 of title 45 Code of Federal Regulations and subparts A and C of part 164 of such title), or to supersede or conflict with an entity or business associate’s obligations under the HIPAA Security rule.

The express language of the amendments clearly sets forth the interplay between the recognized security practices, NIST, and HIPAA.

NIST and HIPAA Security Requirements

Rather than “reinvent the wheel,” an article that Patrick Ouellette, Esq., CIPP/US and I co-authored is instructive of the security practices found in the NIST standards, as well as the HIPAA Security Rule’s technical, administrative, and physical safeguard requirements.

According to HHS’s website, “The HIPAA Security Rule establishes national standards to protect individuals’ electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.” Examples of technical, administrative, and physical safeguards, all of which should be addressed in an annual comprehensive risk analysis, include: access controls (i.e., unique user ID and password, access logs); adequate encryption (minimum 256 bit) both at rest and in transit; adequate annual training; and comprehensive policies and procedures.

Related information appears in various NIST publications and frameworks. When approaching any cybersecurity/HIPAA compliance initiative, the following framework should be central to a risk analysis, as well as the related policies and procedures in order to cultivate a culture of compliance.



By approaching security from a prevention, detection, and correction vantage point, risk is mitigated. For example (and especially in light of the telehealth and teleworking initiatives), Wi-Fi security is one area (a technical safeguard) that is worth evaluating.

Typically, when a person logs into his/her Wi-Fi, there are four options of Wi-Fi security protocols: Wired Equivalent Privacy (WEP), Wi-Fi Protected Access (WPA), Wi-Fi Protected Access version 2 (WPA2), and Wi-Fi Protected Access version 3 (WPA3). What does all of this mean? First, WEP was the very first Wi-Fi security protocol, which stems back to 1999. Simply stated, avoid this outdated protocol. In 2003, WPA was the first version to add 256-bit encryption, which is the level stated by NIST and required under HIPAA. A year later, WPA2 implemented Advanced Encryption Standard (AES). Although it provides both greater security and performance, there is still a vulnerability that can be exploited by a hacker and the “keys to the kingdom” (i.e., keys) that enable the cybercriminal to attack other devices on the same network. This is usually an issue for enterprise networks.

The latest version, WPA3, offers increased protection against the gaps in WPA2, including the ability of a cybercriminal to perpetrate a dictionary attack. “A dictionary attack is a method of breaking into a password-protected computer or server by systematically entering every word in a dictionary as a password. A dictionary attack can also be used in an attempt to find the key necessary to decrypt an encrypted message or document.”

WPA3’s features include automatic encryption of the connection. The chart below illustrates the different features of the four (4) types of Wi-Fi protocols...

In order to reduce securities flaws, persons should not overlook Wi-Fi security. It is a key area to address in order to prevent a cyberattack and comply with both NIST and HIPAA requirements.

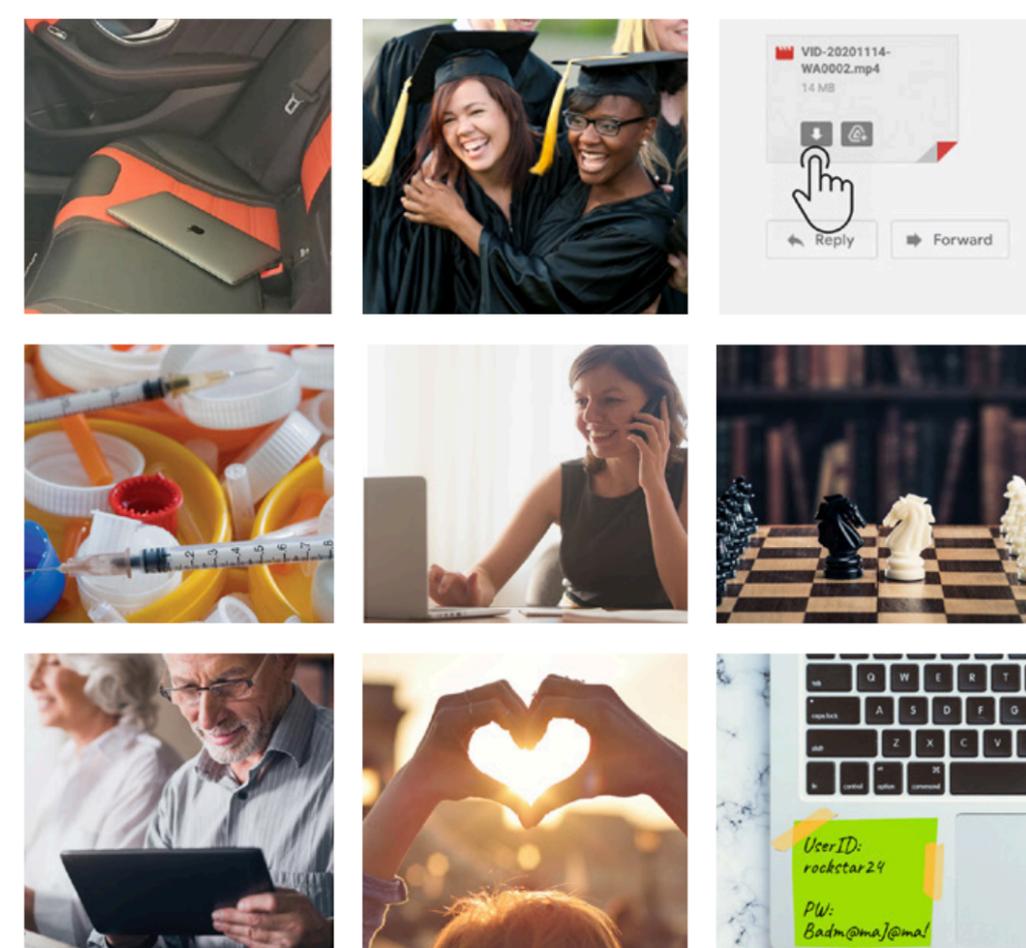
Conclusion

These changes to the HITECH Act should be on every healthcare industry participant’s radar. I’ve always included NIST in HIPAA risk analyses, as do many reputable entities that also perform a risk analysis. The stakes are even greater now, as there are more OCR actions resulting in payments, an increased number of cyberattacks, and a barrage of class action lawsuits. Therefore, it is incumbent upon healthcare industry participants to continually evaluate their technology and compliance programs.

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

	WEP	WPA	WPA2	WPA3
Release Year	1999	2003	2004	2018
Encryption Method	Rivest Cipher 4 (RC4)	Temporal Key Integrity Protocol (TKIP) with RC4	CCMP and Advanced Encryption Standard (AES)	Advanced Encryption Standard (AES)
Session Key Size	40-bit	128-bit	128-bit	128-bit (WPA3-Personal) 192-bit (WPA-Enterprise)
Cipher Type	Stream	Stream	Block	Block
Data Integrity	CRC-32	Message Integrity Code	CBC-MAC	Secure Hash Algorithm
Key Management	Not provided	4-way handshaking mechanism	4-way handshaking mechanism	Simultaneous Authentication of Equals handshake
Authentication	WPE-Open WPE-Shared	Pre-Shared Key (PSK) & 802.1x with EAP variant	Pre-Shared Key (PSK) & 802.1x with EAP variant	Simultaneous Authentication of Equals (SAE) & 802.1x with EAP variant

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Relaxing of the PHI Protections Introduced for Public Comment

In early January, the Department of Health and Human Services (HHS) submitted a 357-page proposal for publication to the Federal Register detailing proposed changes to the Privacy Rule under the HIPAA & HITECH Act standards.

The modifications address standards that may impede the transition to value-based health-care by limiting or discouraging care coordination and case management communications among individuals and covered entities (hospitals, physicians, and other healthcare providers, payors, and insurers) or posing other unnecessary burdens. Once posted in the Federal Register, a 60-day comment period

commenced. (A link to the full pre-Federal Register posted document and online comments portal is provided at the end of this article.)

At its core, the proposals seek to amend provisions of the Privacy Rule that could present barriers to coordinated care and case management—or impose other regulatory burdens without sufficiently compensating for, or offset-

ting, such burdens through privacy protections. “These regulatory barriers may impede the transformation of the health care system from a system that pays for procedures and services to a system of value-based health care that pays for quality care,” the document states.

In the summary of major provisions, the Department proposes to modify the Privacy Rule to increase permissible disclosures of PHI and improve care coordination and case management by:

1. Strengthening individuals’ rights to inspect their PHI in person, shortening covered entities’ required response time to no later than 15 calendar days;
2. Reducing the identity verification burden on individuals exercising their access rights;
3. Creating a pathway for individuals to direct the sharing of

- PHI in an EHR among covered healthcare providers and health plans, by requiring covered healthcare providers and health plans to submit an individual’s access request to another healthcare provider and to receive back the requested electronic copies of the individual’s PHI in an EHR;
4. Requiring covered healthcare providers and health plans to respond to certain records requests received from other covered healthcare providers and health plans when directed by individuals pursuant to the right of access; and
5. Amending some definitions and exceptions to the “minimum necessary” standard for individual-level care coordination and case management use and disclosures.

These modifications come as part of the HHS response to the “Enforcing Regulatory Reform Agenda,” the Presidential Executive Order on Reducing Regulation and Controlling Regulatory Costs,

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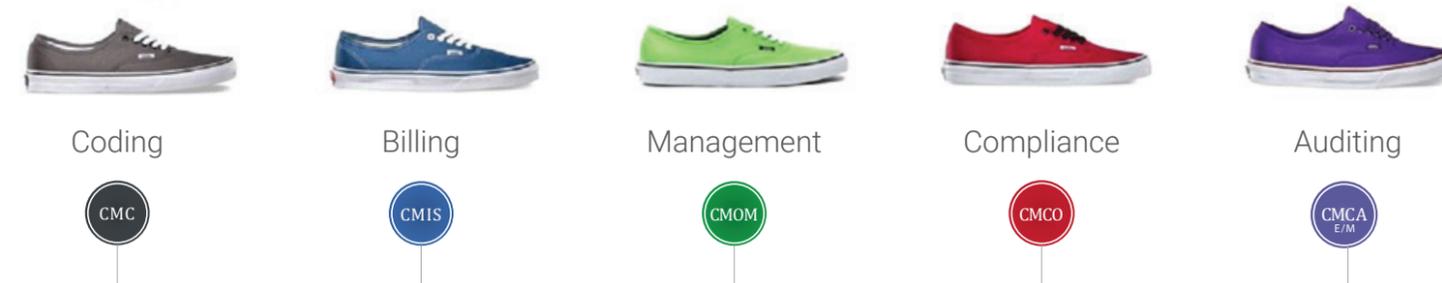
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Jane Rehberg White, President
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and the value-based transformation of the Nation's healthcare system and how it relates to a reduction of regulatory burden.

In 2018, Secretary of Health and Human Services, Alex M. Azar II, said in a speech to the Federation of American Hospitals that he was committed to addressing "government burdens that may be getting in the way of integrated, collaborative, and holistic care for the patient, and of structures that may create new value more generally." In remarks to the Better Medicare Alliance, Azar said, "the barriers to effective coordination among providers are much steeper than just excessive paperwork. . . Addressing these regulations that impede care coordination are part of a much broader regulatory reform effort at HHS."

In support of this priority, HHS Deputy Secretary Eric D. Hargan explained, before the Joint Commission on May 29, 2019, that care coordination is a necessary component of achieving value-based care:

"It's about coordination, above all—we're focused on understanding how regulations are impeding coordination among providers that can provide better, lower cost patient care, and then reforming these regulations consistent with the laws and their intents. And, finally, it's about care. Regulating health care means regulating some of the most intimate decisions and relationships in our lives—deciding where and when to seek health care, how to make decisions with our doctors and family members, and more."

More recently, the Secretary praised the advancement of coordinated care with the publication of final rules on interoperability, access to health information, and certification of electronic health record technology.

"These rules are the start of a new chapter in how patients experience American healthcare, opening up countless new opportunities for them to improve their own health, find the providers that meet their needs, and drive quality through greater coordination."

And, when announcing the publication of a final rule modifying regulations on the confidentiality of substance use disorder treatment records, the Secretary stated, "This reform will help make it easier for Americans to discuss substance use disorders with their doctors, seek treatment, and find the road to recovery."

Care coordination is a key aspect of systems that deliver value and may include a range of activities that link individuals to services and improve communication flow.

The guidance states that the various definitions of this term share three key concepts:

1. Comprehensive coordination (involving coordination of all services, including those delivered by systems other than the health system);
2. Patient-centered coordination (designed to meet the needs of the patient); and
3. Access and follow-up (described as ensuring the delivery of appropriate services and information flow among providers and back to the primary care provider).

Once published in the Federal Register, there will be a 60-day comment period. The Department seeks comment on all issues raised by the proposed regulation, including any unintended adverse consequences. Comment will be accepted by mail or via the Federal eRulemaking Portal: Federal eRulemaking Portal. You may submit electronic comments at <http://www.regulations.gov> by searching for the Docket ID number HHS-OCR0945-AA00. Follow the online instructions for submitting comments through this method.

Review the full document here: <https://www.hhs.gov/sites/default/files/hhs-ocr-hipaa-nprm.pdf>

Nancy Clements is the Director of Marketing for Practice Management Institute (PMI). www.pmi.com

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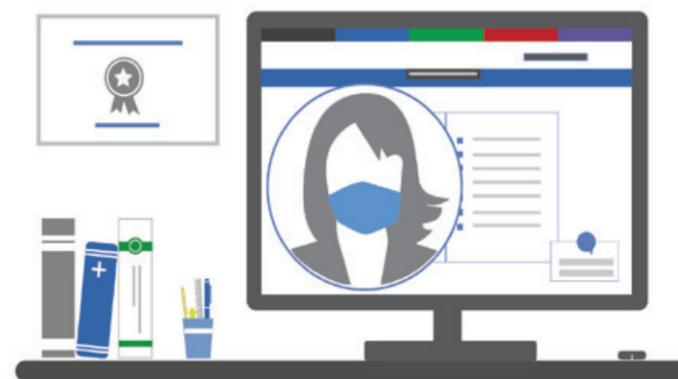
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Consolidated Appropriations Act Brings New Relief for Providers

Medicare Physician Fee Schedule 2021

After the release of the Final Rule December 2, 2020, physicians across the country were feeling the pinch of a 10% reduction in the MPFS. The Consolidated Appropriations Act, finally signed into law on December 27th, modified the Final Rule terms by revising the conversion factor to \$34.8931, reflecting a 3.75% increase across the board for CY 2021.

The legislation also suspended the 2% payment sequestration through March 21, 2021 and reinstated the 1.0 floor work geographic price cost index through 2023. The AMA lobbied against the implementation of the complexity code (G2211) due to its ambiguous and controversial definition; the Act will delay its use now to 2024. You can find the AMA specialty analysis here: <https://www.ama-assn.org/system/files/2021-01/2020-combined-impact-table.pdf>.

Highlights of the Final Rule

IPPE and AWE Changes

As part of Medicare's commitment to identify, prevent, and treat some of the 10.3 million people across the U.S. who are currently part of the opioid epidemic, the IPPE and AWE visits will contain new language to help identify these at-risk patients. The revision to Section 2002 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act Requirements

enforced this change for 2021.

The IPPE and AWE reimbursement will increase along with the opioid screening being added to the documentation criteria. Note that some of the other language will also be revised to better define the purpose of the screening area. For 2021, CMS will be adding a new section to screen for potential substance abuse disorder (SUD) within the criteria.

Providers will need to:

- Review any current opioid prescriptions
- Evaluate the potential risk factors for a SUD disorder
- Evaluate the individual's severity of pain and current treatment plan
- Discuss through counseling non-opioid prescription options
- Create referral to a specialist if appropriate

Although we are waiting for the MLN guidance to publish, it is recommended that this area of screening be included with the 2021 IPPE and AWE initial visit documentation to comply with the MPFS final rule.

Longer Virtual Check-ins

Public comment, as part of the CMS draft rule, was very favorable to the G2012, quick check-in, lasting 5-10 minutes, as it provided a means for the provider to quickly resolve a new complaint or determine if the patient needed a more time-intensive visit. Providers felt this was a valuable service, but often, assessments surpassed the maximum time. CMS created HCPCS code G2252, also defined as a brief communication technology-based service, but with an extended time requirement of 11-20 minutes of medical discussion. The work value of the code is .97 and has the same requirements of the patient not being seen the past 7 days or the next 24 hours. This code is temporary through 2021. Note, when the health emergency (PHE) ends and the telephone codes expire for Medicare payment (codes 99441-99443), providers will use G2012 and G2252 as the replacements.

New Virtual Check-ins for LCSWs, PTs, OTs, SLPs, and Clinical Psychologists

Due to many non-physician qualified healthcare professionals

being restricted to providing most of their services via telehealth, CMS developed two new HCPCS codes to address similar circumstances as the G2012 (virtual check-in) and G2010 (store and forward) available to physicians. The two new G codes can be used by licensed clinical social workers, clinical psychologists, and occupational, speech, and physical therapists (note that the final rule excluded both audiologists and medical nutritionists from billing these services):

- G2250 (Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment)
- G2251 (Brief communication technology-based service, (e.g., virtual check-in), by a qualified healthcare professional who cannot report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)

Direct Supervision

As part of the PHE coverage, CMS implemented a rule to allow physicians to provide direct supervision via telehealth for required visual supervision using real time audio-video. This rule will expire at the end of the year following the COVID-19 pandemic.

PHE Supplies

It is not a surprise that office and hospital resources have increased significantly between PPE and testing supplies. The AMA lobbied to create RVUs for an add-on code to be used with regular E/M services. Code 99072, defined as additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a PHE as defined by law, due to respiratory-transmitted infectious disease, was shot down with CMS

stating, we believe that use of these additional forms of PPE would be inherent to the furnishing of separately paid services under these practitioner/patient interactions, and therefore will not be adding payment for 2021.

Skilled Nursing Telehealth

The final rule making for skilled nursing visits was a huge disappointment for seniors needing regular access to providers via telehealth. During the PHE, limitations are removed from the use of subsequent codes 99307-99310, and provided a new layer of access to prevent our most vulnerable from being sent to the emergency room. The draft rule comment fell short of articulating the need for these codes to be more available for providers to oversee acute problems that oftentimes increase the overall cost of care. CMS ruled that a 14-day visit was enough for oversight of these patients. Several pieces of legislation, house and senate sponsored, could change or modify this rule. These bills likewise address the originating site rules currently waived during the PHE. GCS is watching these events closely and will update if provisions make it through Congress.

Telehealth Services Added

As part of an ongoing effort for CMS to add similar face-to-face services to the approved telehealth list, they expanded the category 1&2 lists and added a category 3 for services through the PHE.

Category 1&2 will include the following permanent codes:

- Group Psychotherapy (CPT 90853)
- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99334-99335)
- Home Visits, Established Patient (CPT 99347- 99348)
- Cognitive Assessment and Care Planning Services (CPT 99483)
- Prolonged Services (HCPCS G2212)
- Psychological and Neuropsychological Testing (CPT 96121)

Category 3 codes have expanded from the original proposed rule list.

These codes will expire at the end of the year following the COVID-19 pandemic.

- Domiciliary, Rest Home, or Custodial Care Services, Established Patients (CPT 99336, 99337)
- Home Visits, Established Patient (CPT 99349, 99350)

- Emergency Department Visits, Levels 1-5 (CPT 99281-99385)
- Nursing Facilities Discharge Day Management (CPT 99315, 99316)
- Psychological and Neuropsychological Testing (CPT 96130-96133, 96136-96139)
- Psychological and Neuropsychological Testing (CPT 96130-96133; CPT 96136-96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Hospital Discharge Day Management (CPT 99238-99239)
- Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT 99469, 99472, 99476)
- Continuing Neonatal Intensive Care Services (CPT 99478-99480)
- Critical Care Services (CPT 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, 90962)
- Subsequent Observation and Observation Discharge Day Management (CPT 99217, 99224-99226)

2021 Evaluation & Management Webinars

The much-anticipated rule change is currently in effect for CPT codes 99202-99205 and 99211-99215. Although the medical decision-making tables mirror several of the 1995 guidelines, there are an abundance of changes that will impact the requirement of documentation and coding.

GCS has prepared education and if you are interested in scheduling a live webinar to review these changes, you can email us at info@gillcompliance.com. Group rates available and all sessions include an on-demand link and a 15-minute post webinar Q&A. Our most popular sessions include:

- Navigating the 2021 E/M Guidelines
- Understanding the 2021 CMS Final Rule for Physician Services
- Telehealth Services for Clinic & Hospital Settings

Jana Weis, BA, DIP COM, CPC, is the principal of Gill Compliance Solutions, a premier Northwest-based compliance support company serving providers within hospitals, healthcare systems, and independent physician offices. You can learn more at www.gillcompliance.com or contact Jana at jana.gill@gillcompliance.com



How to Properly Report Prolonged Services Using 99417 or G2212

Prolonged Evaluation & Management codes underwent big changes in 2021, including the creation of a new prolonged code (99417), reportable only with codes 99205 or 99215.

While Medicare has agreed to accept the AMA's CPT E/M coding changes, they have formulated an opinion contrary to how CPT calculates time specific to reporting this prolonged service code, and have created a separate HCPCS code (G2212) for reporting prolonged services specific to 99205 and 99215. This warrants a quick review of the guidelines and criteria required for reporting this prolonged E/M service, as follows:

Prolonged Codes Specific to 99205 and 99215:
For private payers who do not follow the Medicare guidelines, the appropriate code for reporting prolonged E/M services for office or other outpatient E/M services is 99417. However, for Medicare beneficiaries or payers that publish a policy stating they follow Medicare's guidelines for

prolonged services reporting, the code to report would be G2212. Remember that these codes may only be reported with 99205 or 99215.

Medical Necessity

For Medicare, medical necessity is the overarching criteria, in addition to component scoring, used to determine the level of E/M service. If the patient's condition does not warrant a 99205 or 99215 level of care, then it does not matter how long the provider spent caring for the patient, G2212 technically should not be reported. If, however, the patient's condition and the documentation supports a level five (99205 or 99215) level of service, and exceeds the upper limit of the time range, then HCPCS code G2212 would be reported.

CODES	MINUTES	PAYER
99205	60-74	All
99205 + 99417	75-89	Non-Medicare Payers
99205 + G2212	89-103	Medicare & Payers Adopting Medicare Guidelines
99215	40-54	All
99215 + 99417	55-69	Non-Medicare Payers
99215 + G2212	69-83	Medicare & Payers Adopting Medicare Guidelines

Some Medicare Administrative Contractors (MACs) and commercial plans may require start and stop times (e.g., Novitas) while others may allow the total time to be documented.

A few important rules to remember:

- Time is calculated only for time spent on the day of the E/M encounter (not the day before or days following, even if additional services are provided on those days. According to the AMA, the E/M work expense value already takes into consideration time spent caring for the patient (e.g., phone calls, prescriptions, questions, calling patient with test results) for the three days prior to and seven days following the actual E/M service, so if time spent performing these services was counted in addition to the time spent on the actual date of the encounter, this would be considered double dipping.
- Once the total time has been calculated, and the service level has been determined to be high risk, then subtract either the 74 minutes (99205) or 54 minutes (99215) from the total time and the time remaining is used to determine the number of units reportable for either 99417 or G2212.
 - Example: An established patient, high risk E/M service took a total of 68 minutes. The provider documented the service, including the severity of the patient's condition and decision to admit to the hospital based on EKG and chest x-ray findings positive for pneumonia.
 - Subtract the upper end of the time range for an established patient E/M (99215 - 54 minutes) from the total time (68-54 = 14 minutes). The remaining 14 minutes can then be applied towards a prolonged service code.
 - If this is a Medicare patient, the 15-minute threshold has not been met, therefore it does not qualify for G2212 and would simply be reported as 99215.
 - If this was a private payer who does not follow

Medicare guidelines, then the 14 minutes of prolonged time would qualify for one unit of 99417 and the service would be reported as 99215 (1 unit) and 99417 (1 unit).

Document How Physician/QHP Time Was Spent

The following are a few reasons why instituting a best practice compliance policy of documenting what the physician/QHP spent their time doing with the patient is important:

- Legal issues: If the provider had to defend themselves in a court case, it would be very important for them to be able to easily identify the services, education, advice, or recommendations that were discussed during the encounter.
- Transfer of Care: If the patient's care was being transferred to another provider, the information contained within this record describing the services, recommendations, treatments, or other issues would be of great value.
- Internal/External Audits: When trying to determine whether or not the level of service qualified as a level five (5) service (high risk), an auditor would be looking for key words such as complicated, severe, risk of death, organ failure, or dysfunction. Without documentation to support the level as high risk, a prolonged code may not even be applicable, as the level of service must, first and foremost, be a high-level (level 5) service represented by 99205 or 99215.

For more tips, coding scenarios, and resources for your E/M reporting, consider purchasing the 2021 E&M Book Bundle. This bundle includes the E/M quick reference card, a great tool for quickly identifying the different criteria and time ranges associated with the new E&M coding changes.

Aimee Wilcox, CPMA, CCS-P, CST, MA, MT, Director of Content for FindaCode. Findacode.com.



Chasing Patient Payments? Learn How to Reduce Your Costs

Patients today, struggling to afford expensive high deductible health plans, rising co-pays, and in-network fees, sure do miss the glory days of \$10 co-pays and well covered, affordable health insurance.

But no one misses those glory days more than physicians.

As high deductible health plans proliferate, physicians now depend on patient payments for approximately 30 percent of their revenue stream. Income that used to be collected via payers is now collected by way of deductibles, co-pays, and self-pay patients. The problem is, collecting revenue from patients isn't

nearly as easy or affordable as collecting from payers—and practices are paying the price.

Elizabeth Woodcock, principal of consultancy at Fredericksburg, Virginia-based Woodcock & Associates, gave her advice on collecting patient payments in a Fiercepracticemanagement.com article. Woodcock, who estimates the cost of collecting from patients is as much as double the cost of collecting from payers, insists that prac-

tices need to first understand the “payment-personalities.”

According to her, there are three: (source: Fierce Practice Management)

“Happys”—These patients, for the most part, pay you what you ask for when you ask for it, with little extra effort on your part, provided you are clear about their financial responsibilities and expectations.

“Nudgers”—These patients are likely to pay their medical bills with some additional prodding and incentive.

“Refusers”—These patients have absolutely no intention of paying you, either because they can't or they won't.

And to get the most bang for your buck, Woodcock recommends concentrating most of your collection efforts on the “Nudgers.”

But what is the most cost-effective way to collect money from patients? Should patient billing be outsourced? Or is it just a matter of transition in the culture of practice administration and employing new in-house strategies to collect in a more cost-effective way?

For practices looking to collect payments more efficiently, there are definitely strategies to help avoid using a third-party billing company, collection agency, or other outsourced methods of collecting:

Set Precedent for Payment from Day One

Many physicians are now including a document with new patient disclosure forms that explain the patient's payment responsibility up front. These forms kindly inform the patient that it is their responsibility to understand their deductibles and co-pays and that all fees are due at the time of service. Patients are required to sign and date these forms to acknowledge they have been given this information.

Educate Patients

As part of these “payment disclosure forms,” offices may offer to help patients with any questions they may have about their health plan and payment responsibility. An informed member of the staff can take a few minutes to explain the plan basics and provide them with resources to reach out to insurance companies for more information. Educated patients feel more comfortable with their responsibilities and, as a result, are more willing to pay.

Give Staff the Tools to Accept Payments

Traditionally, many practices were reluctant to accept credit or debit card payments because of credit card fees. This is an outdated, foolish mentality. By not accepting credit card payments, practices are literally turning down money. Equip staff with robust payment systems that accept all forms of credit, debit, and FSA/SA/HRA cards. Find a system with the ability to save credit cards on file securely and automate payment plans. This gives staff ultimate flexibility in working with patients to get them paid up in a comfortable manner.

Let Patients Pay Online

70% of consumers pay their bills online. It's simple, quick, and more cost effective for the consumer, as well as the payee. There is no reason why healthcare should be different. Technology will now allow your practice to integrate (often for free) a patient portal which allows your patients to log on and pay. This feature alone will drastically improve the likelihood of collecting money from patients.

Write Short Scripts

As menial as this may seem, it sometimes helps front desk staff to consider short scripts or phrases that may help them at the time of collections. The language used to ask a patient for money can often make or break their willingness to pay. For example, “How will you be paying today,” may be more effective than “You owe \$35.”

There is nothing new about these strategies, only that they are new to healthcare. Businesses outside of the healthcare industry wouldn't last a month without following some of these principles. As consumer-driven healthcare kicks in, practices will need to learn how to manage the cost of collections like any other business in any other industry.

NTC Healthcare empowers healthcare facilities to effectively manage their revenue cycles and collect more from patients, faster. Our suite of revenue cycle management solutions reduces receivables across all stages of the revenue cycle and allows physicians to focus on what matters most: providing quality patient care. We take a people-first approach to business and aim to build strong relationships, providing expert customer service and going above and beyond to help you succeed. The end result is an enhanced patient experience, optimized revenue cycle, more efficient office, and an overall more successful practice. www.ntchealthcare.com



March is

Multiple Sclerosis

Education and Awareness Month

March is observed as Multiple Sclerosis Education and Awareness Month to spread awareness about multiple sclerosis and to support people living with the condition.

Multiple sclerosis (MS) is a chronic inflammatory disease of the central nervous system. MS is believed to be an autoimmune disease in which the body's immune system attacks the healthy tissue. The disease damages the protective coverings of nerve cells and affects the brain, spinal cord, and optic nerve. The nerve cells lose their ability to transmit information, causing balance problems, weakened vision, fatigue, and other symptoms throughout the body.

Each year, March is observed as Multiple Sclerosis Education and Awareness Month to spread awareness about MS, to support the people living with this progressive and potentially disabling disease, and help them make informed decisions about their treatment and overall health.



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- Mischelle Pittman Henry, MBA, COC, CPC-I, CCS-P

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MS Prevalence

More than 2.8 million people worldwide are estimated to be living with MS, including about 1 million in the United States, according to the recently updated Atlas of MS. The National Multiple Sclerosis Society explains that this means that someone in the world is being newly diagnosed with the disease every five minutes.

Signs and Symptoms

MS has many signs and symptoms, which may differ significantly from person to person. Typical initial signs of MS include:

- Vision problems
- Tingling, numbness, and pain
- Pains and spasms
- Fatigue
- Slurred speech
- Dizziness
- Bowel and bladder issues
- Sexual dysfunction
- Cognitive problems

MS symptoms vary widely among patients. Moreover, in some people, symptoms tend to worsen in a matter of weeks or months, while in others, symptoms do not progress for months or years.

Risk Factors

It is not quite clear as to what causes MS, but the condition is believed to be caused by a combination of genetic and environmental factors:

Sex: MS is more common in women than men. Women are affected 3 times as often as men.

Age: A person can develop MS at any age and symptoms usually make their first appearance between the ages of 20 and 50.

Genetic factors: According to the National MS Society, a person who has a close relative with MS has a higher risk of

developing the disease.

Smoking: MS is more likely to occur in people who smoke. Smoking is linked to increased volume of lesions and higher risk of brain shrinkage.

Infections: Exposure to certain viruses can trigger MS. Viruses associated with MS include Epstein-Barr virus (EBV), or mononucleosis, herpes virus type 6 (HHV6), and mycoplasma pneumonia.

Vitamin deficiency: MS is more common among people with deficiency in vitamin D, vitamin B, and Vitamin B12.

Emotional stress: Mental stress may increase the symptoms of MS.

Types of MS

There are four types of MS:

- **Clinically isolated syndrome (CIS):** This is the first episode of neurologic symptoms, which typically lasts at least 24 hours. However, a diagnosis of MS cannot be made as a CIS may or may not develop into MS.
- **Relapse-remitting MS (RRMS):** Around 85% of people with MS are diagnosed with RRMS, which is characterized by episodes of new or increasing symptoms called relapses or exacerbations. These attacks are followed by periods of remission, during which symptoms disappear partially or completely.
- **Secondary progressive MS (SPMS):** After the initial episodes of relapse and remission, the disease will start to progress steadily.
- **Primary progressive MS (PPMS):** About 15% of people with MS have PPMS. In PPMS, symptoms worsen progressively without early relapses or remissions and neurologic function deteriorates. There may be periods of stability and times when symptoms worsen and then get better.

Diagnosing MS

Like any other disease, early and accurate diagnosis of MS is crucial. As many other disorders have symptoms similar to MS, a neurologist diagnosing MS would also be ruling out other conditions. There is no single diagnostic test for



BETTY A. HOVEY

CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I

Over 30 Years' Experience in Health Care

Betty is a nationally recognized health care consultant and speaker with over thirty years of health care experience. She has spent years on the "front lines," managing practices, and directing health care system departments. Betty has educated medical coders, managers, health plans, administrators, physician, and non-physician practitioners all across the country. She has co-written manuals on ICD-10-CM, ICD-10-PCS, and CPT specialty areas.

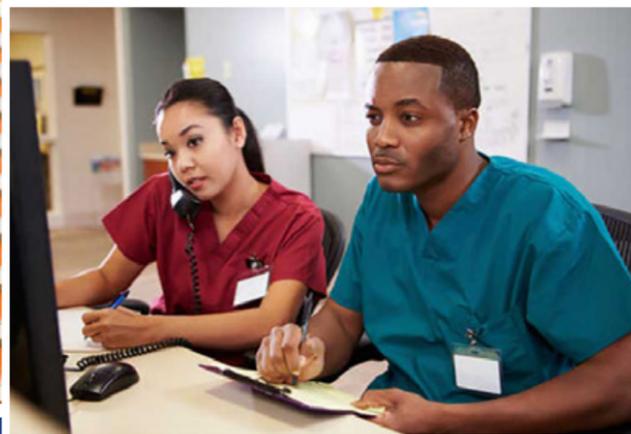
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MS. Diagnosis is based on clinical findings, including medical history and examination, magnetic resonance imaging (MRI) evaluation, and blood and cerebral spinal fluid (CSF) analyses.

Relapsing-remitting MS can be diagnosed based on disease symptoms and MRI. However, MS can be challenging to diagnose, especially in people with uncommon symptoms or progressive disease. In such cases, spinal fluid analysis, evoked potentials, and additional imaging may be used.

- **Blood tests:** Blood work may not be able to diagnose MS, but can help rule out other conditions, such as Lyme disease, syphilis, HIV/AIDS, and rare hereditary disorders.
- **MRI:** MRI provides detailed and sensitive images of the brain and spinal cord and reveals areas of lesions. MRI can confirm diagnosis and helps in identifying other diseases with clinical presentations similar to MS. MRI also assists in monitoring disease progression in the central nervous system.
- **Evoked potentials:** Evoked potential tests use visual or electrical stimuli to measure the activity of the brain, spinal cord, or nerves, and identify changes, such as impaired transmission of information along the nerve pathways. Results are not specific for MS.
- **Lumbar puncture:** Lumbar puncture or spinal tap involves collecting a small sample of cerebral fluid from the spinal canal and analyzing it. The test can reveal abnormalities in antibodies that are associated with MS. Other tests may need to be performed to confirm diagnosis of MS.

All of these tests or a combination of them may be used to confirm diagnosis of MS. In some cases, diagnosis may take several years after symptoms show up, even when all the tests are done.

Treatment

Treatments for MS are aimed at slowing down the progression of the disease and managing relapses and symptoms. Treatment of the symptoms of MS involves

both pharmacologic and nonpharmacologic measures. Food and Drug Administration (FDA) approved disease-modifying medications include injectables, infusions, and oral treatments.

Disease-modifying medications can:

- reduce the frequency and severity of MS episodes or relapses
- control the damage to nerve fibers or growth of lesions
- reduce symptoms

Plasma exchange (plasmapheresis) may temporarily help for severe attacks if steroids are contraindicated or ineffective.

Multiple Sclerosis Coding and Billing

Accurate billing and coding are crucial for the financial health of medical practices. In neurology, billing and coding can be quite challenging, due to specific, complex documentation requirements. The neurologic examination is often time-consuming and patient encounters can be difficult.

The ICD-10 code for MS is:

- G35 – Multiple sclerosis

Other related codes include:

- G36.0 Neuromyelitis optica [Devic]
 - G36.1 Acute and subacute hemorrhagic leukoencephalitis [Hurst]
 - G36.8 Other specified acute disseminated demyelination
 - G36.9 Acute disseminated demyelination, unspecified
- G37 Other demyelinating diseases of central nervous system
 - G37.0 Diffuse sclerosis of central nervous system
 - G37.1 Central demyelination of corpus callosum
 - G37.2 Central pontine myelinolysis
 - G37.3 Acute transverse myelitis in demyelinating disease of central nervous system

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- ▶ Explain what "time" has to do with it in 2021

More Information

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- G37.4 – Sub-acute necrotizing myelitis of central nervous system
- G37.5 – Concentric sclerosis [Balo] of central nervous system
- G37.8 – Other specified demyelinating diseases of central nervous system
- G37.9 – Demyelinating disease of central nervous system, unspecified

New or recurring symptoms that were addressed during the visit can be reported using additional codes. This could help indicate medical necessity for certain treatments. Reporting Conditions such as paraparesis, ataxia, visual field defects, and cognitive disturbance using the right ICD-10 codes would provide evidence of disability and support greater severity of illness. Codes to report other conditions occurring along with MS include:

- R 30.0 Dysuria
- R53.83 Other fatigue
- R.20 Anesthesia of skin
- G82 Paraplegia (paraparesis) and quadriplegia (quadriparesis) Re
 - G82.20 Paraplegia, unspecified
 - G82.21 Paraplegia, complete
 - G82.22 Paraplegia, incomplete
- R27.0 Ataxia, unspecified
- H53.40 Unspecified visual field deficits
- F06.8 Other specified mental disorders due to known physiological condition
- A81.2 Progressive multifocal leukoencephalopathy
- T45.IX5A Adverse effect of antineoplastic and immunosuppressive drugs (initial encounter)

Documentation by the provider needs to be definitive and correctly reflect what actions were performed in order to ensure accurate billing and coding. Services should be reported based on the latest CPT Evaluation and Management (E&M) guidelines. As of January 1, 2021, significant changes to the office and outpatient E&M services (CPT codes 99202-99215) have come into effect for both new and established patients. History and examination are no longer the key components for selecting the level of E&M service. E&M code selection is now based on either: 1) The level of medical decision making (MDM) or 2) The time performing the service on

the day of the encounter. Instead of the typical face-to-face time, the time associated with CPT codes 99202-99215 has been changed to total time spent on the day of the encounter.

The medical decision-making elements associated with codes 99202-99215 now comprise three components: 1) The number and complexity of problems addressed; 2) Amount and/or complexity of data to be reviewed and analyzed; and 3) Risk of complications and or morbidity or mortality of patient management. In order to select a level of E&M service, two of the three elements must be met or exceeded.

While visits with MS patients can take time, proper documentation following these guidelines can result in better reimbursement for services provided.

Patient Education Key to Improving Quality of Life

A key goal of Multiple Sclerosis Education and Awareness Month is to educate patients and others on appropriate management of MS. While there is no cure for MS or a method to assess progression of the disease in a person, severe disability is rare. Life expectancy is near normal and the disease is rarely fatal. Patients with MS can benefit from treatment to manage symptoms and learning how to improve strength, flexibility, and gait problems with physical therapy and exercise. Early recognition of the neurodegenerative process is crucial for early treatment to impede the progression of MS. Patient education is the key to maintaining health and improving quality of life.

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



The Pain of an Unfaithful Billing Partner

In the vast majority of business and industry, the entity itself takes full responsibility for invoicing (billing) its customers or clients. Hospital-based physician practices are uniquely different.

- While you “produce” the work product that generates income, you are heavily reliant on someone outside your practice for:**
- Capturing and processing the entirety of your work product
 - Accurate and appropriate procedure identification
 - Accurate and appropriate diagnosis coding
 - Creation and filing of timely clean claims
 - Follow-up of denied or ignored claims
 - Timely filing of secondary claims
 - Balance billing of remaining amounts to patients
 - Interaction with insurers and patients to clarify or resolve concerns
 - Detailed performance results of the underlying accounting

You’re not just outsourcing your billing; you are delegating the entire responsibility of assuring:

- All interpretations are captured by the billing entity
- All CPT and ICD-10 procedures are compliant with government and industry standards (the failure of which can lead to substantial fines, penalties, and lost revenue)
- Each invoice (claim/patient bill) is followed up on to assure maximum financial receipts
- Every dollar received is received directly into your bank account
- Refunds are issued in compliance with CMS regulations and State Escheat laws

You also want and need accurate and timely reporting to manage your practice, make practice-based decisions, review and assess payor contracts, and perhaps most importantly, be able to easily evaluate your billing company’s performance.

That’s a lot to ask of a “vendor relationship.” In fact, the trust required is more like a healthy marriage than a subcontracted relationship.

In strong relationships, feedback and trust are paramount. Fidelity is confirmed daily in a marriage. Trust is built and maintained through good communication and constant feedback to confirm that each partner is fully living up to his or her commitments. Trust is a wonderful, reassuring, peaceful reality.

Except... when there is doubt. What happens when questions are dodged? When feedback is delayed or missing? When you are just not sure the other party is being faithful to their commitments?

Trust isn’t blind faith in another. It may begin on a small foundation of unknowns, but for it to grow and develop, it needs the food and drink of reassurance and fidelity.

Many physician practices intuitively know when they can’t fully trust their billing business partner. There’s an underlying, gnawing feeling that things just aren’t quite right. So why does it sometimes take so long to bring about change in this area of business activity?

Here are just three of several reasons that may cause you to pause:

1. Practice demands my full attention to clinical performance. Billing just isn’t my highest, most “urgent” priority.
2. Our group is embarrassed to admit we are losing money. It’s easier to just

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The New AKS and Stark Laws Final Rules - Key Take-Aways

Objective: The Centers for Medicare and Medicaid Services (CMS) issued a Final Rule related to the Medicare Physician Self-Referral Law (Stark Law). Nearly simultaneously, the Office of the Inspector General, Department of Health and Human Services (HHS-OIG), released a Final Rule, which amends various safe harbors to the Federal Anti-Kickback Statute (AKS). The changes appear to be based, in large part, on value-based healthcare delivery and payment systems. The purpose of this webinar is to highlight the key changes, along with the similarities and differences in the language between the two Final Rules.

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By: Rachel V. Rose, JD, MBA, principal

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The NAMAS team of experts have put together a series of webinar trainings to help demystify the upcoming 2021 E/M changes and clear some of the confusion.

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keep going than find out we've left \$350,000 on the table each year.

- I don't like confrontation. The idea of having to hold my billing partner accountable sounds incredibly painful.

It often takes an egregious act or many failures over a long time to aggravate someone to a point they are willing and able to finally respond assertively. That is both very understandable and very unfortunate. Because you and your partners deserve to receive all the money you are legitimately due for the professional services you provided your patients.

So what is the next step if your group is in such a situation?

Every responsible and professional billing company is receptive to being held accountable. In fact, they value it, because it offers continuing confirmation that they have solid practices and are performing in accordance with their commitments.

“Putting confidence in an unreliable person in times of trouble is like chewing with a broken tooth or walking on a lame foot.” – Proverbs 25:19

As such, the very first step is to evaluate your billing process every few years. This should be a normal and regu-

lar business activity, but should be employed especially when you have that gnawing feeling (or known facts) that your billing process isn't performing as expected.

On a factual basis, you can begin by examining your practice metrics and compare them to reliable third-party metrics. But, you may already know that you need to move on, and in that case, you can move directly to a due diligence process and evaluate other billing providers.

The major issue is “taking ownership” of the process that generates your revenue (“Revenue Cycle Management” aka billing). There's simply too much at stake. You're running a multi-million-dollar business, and just beyond your clinical performance, the process of billing and collecting your revenue is the most important aspect of your practice.

Take ownership. Take charge. Be decisive. You and your partners will be incredibly thankful you did.

Not sure what your metrics should be? Contact Sara Nofziger-Drew at 800-892-3436 or sara@healthpromedical.com and we can discuss industry standard benchmarks.

Don Rodden, CPA (Inactive), CHBME, is a principal at HealthPro Medical Billing, Inc., a leading Revenue Cycle Management and Coding Company. Don is a Past President of the Healthcare Business Management Association (HBMA). He has been a consultant to physicians and medical practices for over 30 years.

HEY YOU!

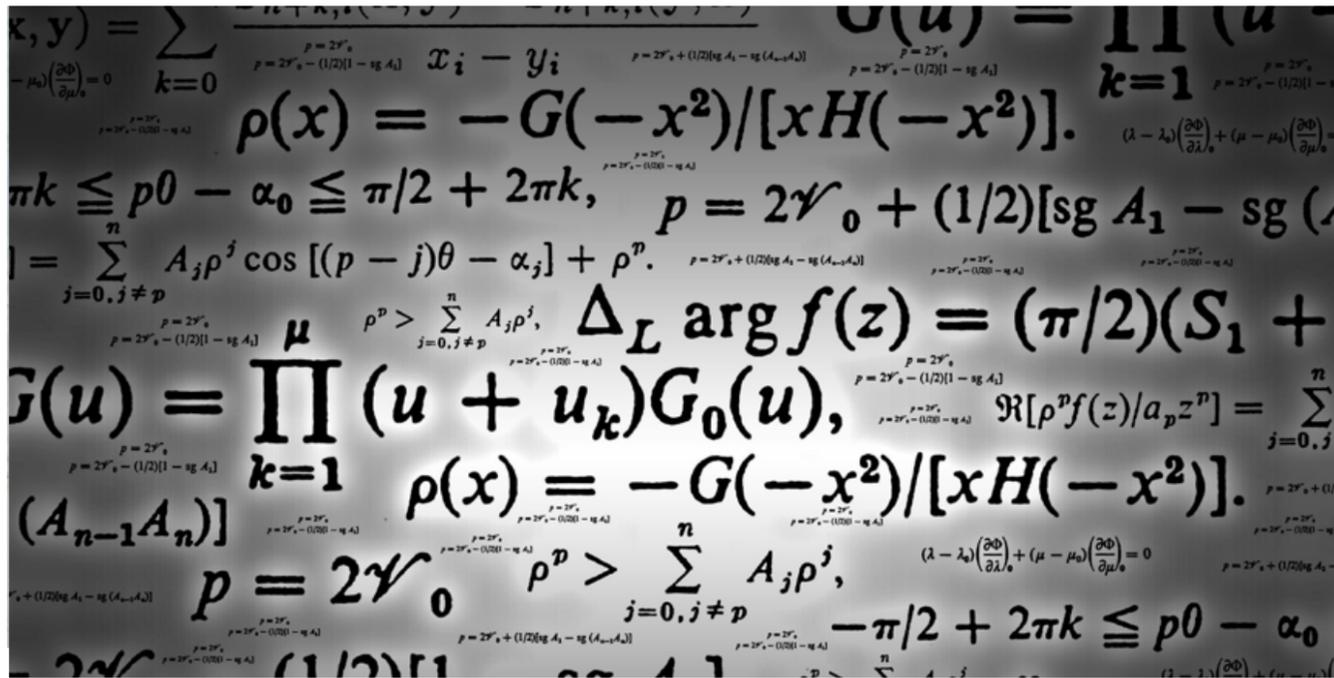
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Why Reporting E/M Based on Time May Not Be Beneficial

Just like math teachers who require students to show their work so they can see how the student reached their answer, providers are also required to “show their work” through the documentation process in the medical record. By the time a provider has reviewed the patient’s subjective complaints (i.e., patient’s medical history), performed an examination, and reviewed any test results, they have already formulated a working diagnosis and understand the associated risks of treatment or failure to treat that the patient will face.

In this process, the provider is sorting through subjective and objective data to determine not only the diagnosis, or whether there is even enough information to do so without additional testing, but also the level of severity associated with it.

Questions providers may be asking include:

- Can the patient wait for additional testing and results before receiving treatment?
- What kind of treatment is required?
- Are more conservative measures appropriate (e.g., rest,

over-the-counter medications) or do they require a prescription medication to recover?

- If a prescription is required, what are the risks associated with it and is it contraindicated with any other prescription medications or supplements the patient is already taking to treat another condition?
- What are the other conditions (chronic or co-morbid) the patient has and how might the recommended treatment for the current problem exacerbate them?
- Will the patient require a minor, major, or emergency surgical procedure and if so, what risks, if any, are associated with the recommended procedure?

- Is there a risk to an organ system, bodily function, or even the patient’s life if they go without treatment (e.g., DNR, palliative care) or if they choose to complete the treatment?

A provider who is adept at documenting the required criteria to support medical decisions and medical necessity and to support the level of E/M service reported is a coveted asset. We have all seen providers who can quickly evaluate, assess, diagnose, and determine treatment for a patient with a problem of moderate complexity, even at times a high complexity problem. So why would you report based on time when MDM may be a better outcome? Although time, when documented correctly, can easily support a level of service, improper or incomplete documentation can result in attempted recoupment of reimbursement.

Payers may be looking at issues such as:

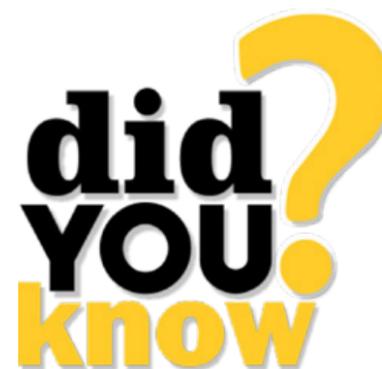
- Whether the provider documented in a Start/Stop or Total Time fashion (and whether that method meets the payer’s rules)
- Whether documented time is supported with a detailed enough description of “qualifying activities”
- Whether the time is specific to only the physician/QHP or if clinical staff time is also included
- Whether any lab or imaging results the provider discussed with the patient were correctly excluded when the provider

was billing for those services separately

Consider documenting the time for all your patient interactions reported with 99202-99215. Remember, these, and only these, services allow you to count both face-to-face and non-face-to-face time spent by the physician/QHP, while all other E/M services do not. Do not mix up your guidelines. When tracking time but documenting to support MDM, you will quickly be able to determine which types of conditions, injuries, or problems are best reported with time and which are best suited to reporting by MDM.

Whichever way you choose to document to support the E/M level reported, at innoviHealth we have created an E/M Quick Reference Card to help you meet the specific requirements for each code reported. This card is a great tool to teach physicians/QHPs how to document to support the various levels of MDM or time, and is extremely useful in explaining audit findings when evaluating claims and supporting documentation, especially related to E/M services (99202-99215).

Aimee Wilcox, CPMA, CCS-P, CST, MA, MT, Director of Content for FindaCode.
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CDI From a Different Perspective

Let's take a look at CDI from an outside and engineering perspective. I am not a CDI expert. In fact, let's say I'm dangerously knowledgeable of CDI. However, that doesn't disqualify me to evaluate the system and make recommendations.

Remember the saying, "You can't see the forest through the trees." Sometimes you are so deep into something (woods), you need a fresh perspective from a person who sees the whole thing (forest). That's why companies hire consultants.

I know it works, because I took a position in a company that I knew nothing about. However, in developing both an effective and efficient process, along with the appropriate coaching in creating a winning team, it was possible to surpass expectations. Actually, it was the process of working

with the people in an effort to understand the existing process, plus helping them eliminate their issues, that resulted in how the team came together. Sharing a common goal by utilizing a dashboard solidified cooperation and created buy-in. It didn't happen overnight; it was a journey. However, there is one caveat. It does work best from the top down.

CDI is a specific process within a hospital setting. As with any process, regardless of the industry, I have found that a successful process must have the following criteria, which I call PDT.

P – Purpose D - Dashboard T – Teamwork

Purpose

In this instance, what is the purpose of CDI? According to the American Health Information Management Association (AHIMA), "Successful clinical documentation improvement programs facilitate the accurate representation of a patient's clinical status that translates into coded data. Coded data is then translated into quality reporting, physician report cards, reimbursement, public health records, disease tracking, and trending."

Does your CDI meet that criteria? Has your CDI improved public records? Has it translated into quality and meaningful reporting? Has it improved reimbursement as it was designed to do? Actually, the ultimate question is, does your CDI process effectively and efficiently translate the patient's clinical status into accurate coded data? And to what degree? Because if it did, all the other questions would be answered.

Dashboard

A dashboard monitors the important aspects of a given process to ensure it is running properly. The dashboard of the CDI is just as important as the dashboard in your car. The car dashboard is taken for granted because every car has one. But try driving your car with your dashboard covered up. How fast are you going? Will you know when to get gas? How about getting your next oil change? How will you know if your car is overheating? Probably when the smoke comes out of it, which is too late.

The dashboard of the CDI process needs to monitor the important aspects of the process to ensure it is delivering the outcomes stated in the purpose. I believe the purpose of CDI is well defined. So, let's take a closer look at what is being monitored.

The typical Key Performance Indicators (KPI) that most programs utilize to demonstrate how effective CDI is in meeting key business objectives are task-based. They are:

- Number of charts reviewed daily (average of 25)

- Number of queries issued (30% query rate)
- Physician response rate (70 to 75%)
- Physician agreement rate (75 to 80%)
- CC/MCC capture rate (70 to 80%)
- Coder CDI DRG agreement rate (75 to 85%)

How do these KPIs ensure compliance with the purpose? How do any of these KPIs guarantee accurate representation of the patient's clinical status that translate into reliable coded data? First and foremost, these stated KPIs are not meaningful in ensuring compliance to the objective. However, before we get into that, let's take a closer look at the percentages they consider acceptable. They range from 70 to 85%. Accurate coding is the primary purpose, so why do they only have a "coder CDI DRG agreement rate of 75 to 85%"? Basically, that is a poor-quality acceptance rate.

Realize, quality is just a mindset. It all comes down to what you or the company are willing to accept as an outcome. For example, would you go to a hospital where the acceptance rate of successful surgeries was 75 to 85%? Of course not. And I love when people tell me, "Well that's different!" No, it's not. The only difference is the consequences. One affects life and the other doesn't. I get it. But why are people willing to accept 75 to 85% coder CDI DRG agreement rates? The agreement rate should be in the 90 percentiles. In essence, there could be 15 to 25% of inaccurate data being used for research data and reimbursement. There are many different Key Performance Indicators that CDI should monitor. It simply comes down to accurate coding. Effective coding would produce better reports, increase revenue, reduce denials, reduce appeals, and reduce DNFB. The dashboard needs to include one or two of these items. The idea of the dashboard is to highlight key items for the process to run successfully.

The initial dashboard should monitor something in denials. I understand that dollars in denial are important. However, one large dollar amount being denied can skew the data and make the data meaningless. It is better to monitor the number of denials. If denials are monitored and minimized, many of the other issues listed could be minimized, as well. And if that isn't the case, once denials are considered to be under control and

acceptable, add another element to the dashboard.

I do not advocate for capturing negative data, such as the number of denials, because it emphasizes the negative. I would prefer to capture the amount accepted. 90% acceptance sounds much better than 10% rejected. Negative thinking generates negative attitudes, which generates negative actions. The same holds true with positive thinking. A football team doesn't want to lose fewer games. They want to win more games. However, I would need to further discuss this with others in the process to see if this is even possible.

The dashboard must be visible to everyone working on the project. Not just CDI. Everyone and anyone working on improving the denial rate needs to be aware of the dashboard and know that is what the hospital as a whole is monitoring. Proper coding is not just CDI's responsibility. It is the responsibility of everyone involved in the coding process. From the doctor to billing. This is where teamwork and cross-functional teams play a major role.

The dashboard should be in some form where quantity doesn't skew the data. For example, monitor the percent of denials with respect to bills submitted. The dashboard needs to be updated on a daily basis. I prefer that it be updated every morning with the data from the previous day. Another requirement is that the dashboard needs to be displayed where the trend can be viewed. My preference is a line graph. Monitoring the trend is going to be important because there will be some bad days and some good days. Only when you monitor trends will you understand the overall trend when these days occur. You can have a bad day, but once you look at the graph, it could just be viewed as a bad day because the graph shows a positive trend. You don't want a bad day to take away the momentum of the team.

Teamwork

Next, an effective process requires teamwork. It's the power of the team that will make things happen. Teamwork is emphasized for two reasons. First and most important, it is the people doing the work who know the most about what is going on. Managers live with the effects of the problems, but the staff actually

doing the work truly live with the problems. In fact, many of them have probably incorporated their own workarounds when certain problems come up. People in general are very innovative to make their life easier.

However, there is synergy in teamwork, which is people with different complimentary skills cooperating. No one is more important than another when working together for a common goal. In fact, a definition of synergy is the interaction or cooperation giving rise to a whole that is greater than the simple sum of its parts.

Sports is an excellent example of synergy. We can use baseball, basketball, or football. Consider the coaches to be either leaders or managers. Unfortunately, they're stuck on the sidelines and can't participate in the game. The players play the game, and based on their talent and teamwork, they either win or lose the game. The coach's responsibility is to put the players in the best position to win. He helps them by coaching their weaknesses.

No player is everything. Yes, some players are elite, but they must understand they can't do it by themselves. Take any Hall of Fame player. None of them did it by themselves. Michael Jordan knew he needed to help his teammates if he wanted to win a championship.

Everything I described in sports also exists in an effective CDI winning team. There are egos that must be massaged. Every position on the roster must do their part. The managers should transition to becoming leaders. Their role is to support the team and help them eliminate problems. The emphasis needs to be on preventing problems from re-occurring, not just fixing them as they pop up. Otherwise, you don't get any better.

The team I am proposing is not a department team. I am referring to cross departmental teams. The team should comprise of the people who can actually work the goal. Each department has their responsibility to ensure everything comes together as a whole. For example, there are many different trades when building a new house. Yet, they must work together to build the house. You can't put up the sheetrock before the electricians wire the house. However, there is only one general



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Additionally, it is important to recognize the personalities that compose the team. You need a mixture of all four types. The inspirational person is needed to celebrate the victories. The cautious and steady person is needed to ensure the quality. They are good at analyzing the data. The driven person is needed to ensure the process runs properly and meets the daily requirements.

The problems of CDI are not just CDI's problems. It is the cooperation of all departments with the help of CDI in providing the proper documentation to ensure compliance. It is the responsibility of everyone in the process that will fulfill the purpose of why CDI was established in the first place. As an example, it is not the responsibility of the FDA to make the medicine. However, it is the responsibility of the FDA to ensure compliance. And I'm sure you won't accept a 75 to 85% compliance.

In summary, we already know the purpose of CDI. It's time to rethink what meaningful data needs to be captured and shared with others to meet that purpose. I can think of a few, but I prefer to give that responsibility to the team. Because it's the power of the team. They're the ones that are going to make it happen.

Jim Zelem is a former VP of Operations who transitioned to be an effective leader who coached many successful teams. Jim started his career as a simple factory worker who held many positions, such as Industrial and Manufacturing Engineer, as he worked his way up to VP.

Jim currently resides in Madison, Wisconsin. He loves sports as he officiated high school football for 18 years. Jim remains active, as he volunteers for the Red Cross and the Senior Center. He enjoys walks in the woods, swimming, and golf.

Jim strongly believes that experience is a great teacher, as it helped him throughout his career. He believes his experience in leadership and teamwork can help others. Jim created a blog site "urjustanumber.com" to share these experiences and has opened the blog site for others to tell their story, as well.

Additionally, Jim has written a book, "Stepping Stones of Leadership," that lists some essential steps that he believes will guide you on becoming an effective leader. Every step is supported by stories of his own personal experiences. He is presently working on his next leadership book with more stepping stones.



Medical Billing Companies: We Are Not a Commodity

Have you ever wondered why sometimes it seems that the relationship between medical practices and their billing companies is not on a level playing field? I have and it leaves me confused as to why relationships deteriorate even when the billing company is producing excellent results.

Problems seem to arise when the practice sits back and looks at the checks they are writing to their billing company each month. After all, their monthly check to the billing company is usually their second largest expense, and they seem determined to try to reduce the percent they pay, even though, logically, the bigger the check they write, the more money they have in their bank. I also recommend you bill your client twice a month. It improves your cash flow and makes their checks seem smaller.

I wonder how a physician would react if after they have examined a patient and before the patient left their office, the patient would say, "You know, you have been providing me excellent care, but I would like a discount on today's visit," or "You know doctor, I've been seeing you for over a year and I really appreciate you saving my life after my heart attack, but you are just too expensive; do you think you could charge me less this year?"

I am sure they would be hurt—or furious. However, this is exactly what some physicians do to billing companies. I

have heard countless stories of how after a billing company has saved a practice that was on the verge of bankruptcy or had an accounts receivable larger than the national debt, they have actually requested a fee reduction from the billing company.

Another amazing phenomenon is once the Revenue Cycle process is corrected and running smoothly, thanks to the efforts of the professional billing company, the practice thinks they can take the billing back in-house and do it at a lower cost themselves. How could they be so quick to forget what a mess they had created previously when they were trying to do their own billing?

Do these same physicians sit down with their accountants and attorneys and ask for periodic decreases in the hourly rates they charge? Of course they wouldn't think of confronting these professionals in that manner, so why do they consider a professional billing company a commodity?

If a practice is utilizing a billing company that is providing excellent service, why would they want to jeopardize the relationship by trying to nickel and dime them on various issues?

Here are some common issues that surface occasionally that can lead to an antagonistic relationship between a practice and the billing company:

- The practice wants the billing company to send an unlimited number of statements to deadbeat patients or accept any monthly payment amount. The reality is, if a patient doesn't pay after 2 or 3 statements, they are never going to pay. That is why collection agencies exist.
- The practice thinks that a billing company shouldn't take a fee on monies collected at the time of service. This doesn't make sense, because there is still the expense of entering the encounter and payment into the system, reporting, recording, balancing, etc. If the practice insists that a fee not be taken, then offer them the alternative of a higher management fee on the monies you do collect.

- Because you are collecting more money than their office staff was ever able to collect, they think they are paying you too much and want a rate reduction. Inform them that you'd be happy to give them a rate reduction, but you will have to cut out some services (to maintain your profitability) and their collections will probably decline. I like giving the client a list of the services that I have been providing and asking them which ones they would like me to eliminate. Let it be their choice.

I am not inferring that you should have an obnoxious attitude when a discussion about fees arises; I'm just trying to point out why you need to hold your ground. Keep in mind that there is always someone out there who will promise (with their fingers crossed) a lower fee and imply that collections will remain the same or improve.

Keep in mind also, when you know you are providing excellent service and you are offering a competitive and fair management fee, there is no reason to cave in and lower your price. It is okay to make a reasonable profit; after all, I don't think you decided to open a billing company as a hobby.

You will lose clients over pricing; it is inevitable. However, do not get angry or become belligerent, treat a client on the way out the way you treated them on the way in. Because if they fail trying RCM internally or have a bad experience with their new billing company, you want to keep the door open for them to return to you.

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

5

Minutes with...



Sean M. Weiss

Partner, Vice President of Compliance
CHC, CEMA, CMCO, CPMA, CPC-P, CMPE, CPC

BC Advantage (BCA): Tell us about yourself, your training, and how you became an expert in healthcare regulatory compliance and auditing.

SW: I have truly been blessed in both my personal and professional life. I have been married to my beautiful wife Jill Ann for longer than I thought she would stay with me and we have raised three amazing kids (McKenzie, McCord, and McKayla... better known as the McKids!) and have now been blessed with five outstanding grandbabies (Hadley Rae, Phinley Ann, Emerie Rose, Fischer Thomas, and Clyde Patrick). I am a good ol' southern boy as many who know me will attest, but don't let my southern drawl, good manners, looks, and charms fool you! I have been so fortunate to be surrounded by and mentored by some true giants in the industry that have allowed me to take bits and pieces of each of them and apply those pieces to myself to make me as well rounded as possible. The truth is my career which has spanned 25+ years has not always been a yellow-brick road! I have had some stumbles along the way, but as I learned early on in life, the fall is not what defines you, it's how quickly you get up and your ability not to fall again over the same bump!

I got into healthcare truly by accident. I was working toward my commercial pilot license in 1993 and due to vision problems (became colorblind), I was forced to figure out something else to do. In my junior and senior years in high school, I was in a program called Health Occupation Students of America (HOSA) and loved working in the various settings they put us in. When I got to college, I focused on life sciences and thought I wanted to go pre-med, but after taking my first business class, I was hooked and transitioned to business. I was one of those kids with severe ADD before ADD was a mainstream diagnosis, which is why I jumped around so much—until I landed on what I do for a career. Even since I began working, I have transitioned my focus several times, until I landed on Regulatory Compliance and Health Law, which was at the 5-year mark in my career.

BCA: Can you describe a typical workday for you?

SW: Every day is different because of the type of cases I get to work on, the clients I support, and the healthcare professionals I get to work with. Over the past 20 years, I have really focused on strategic defense litigation services and audit appeal representation. With the help of what I would say is one of the best professional auditing teams, hands-down, we work with more than 25 law firms across the country preparing cases for arbitration, litigation, and appeal. Beyond that, we do a lot of forensic audits, revenue cycle management reviews, serving as Independent Review Organizations, Facilitators of Settlement or Resolution Agreements with Office of Inspector General, Department of Justice and the Office of Civil Rights for medical practices and health systems.

When I am not working on cases, I provide solution-based services for providers across the country, which include audits and education, development of corporate compliance programs, and serving as Chief Compliance Officer for some of the nation's largest medical groups. I am also very fortunate that I get to present a lot of education sessions throughout the course of the year and author quite a few papers and articles.

BCA: How do you stay on top of the ever-changing rules, regulations, and news that our industry faces?

SW: This industry is ever-changing and growing more complex by the day, it seems. Outside of collaborating with my teammates and other partners within DoctorsManagement, I often engage with healthcare professionals who are members of NSCHBC, AHLA, HCCA, AAPC, AHIMA, and other specialty societies. I work hard to maintain

relationships with folks on Capitol Hill that I have engaged with throughout my career, as well as those at OIG, DOJ, and OCR, and some amazing and hard-working folks at CMS and various private payors. Mostly though, I do a lot of independent research and spend my time reading documents that most folks would never want to simply because they are really boring. My very first job in healthcare was in 1995 with The Medical Management Institute in Alpharetta, Georgia. The CEO was Bob Keene, a retired Major (Air Force). Every day, he was in the office before anyone else reading the Federal Register and Part B Newsletters from the various Medicare Administrative Contractors (MACs) around the country so that he could provide guidance to all of the consultants to ensure we were well armed with information before going out to clients. As Bob got older, several of us stepped up and took over reading all of those documents and more, and I guess it just stuck with me throughout the years. My guess is that I spend somewhere in the neighborhood of 20+ hours per week reading and researching.

BCA: What has been the most recurring question from your clients in 2020?

SW: "Am I a government target for audit or investigation?" The reason is, 2020 was such a crazy year with rule and policy changes from CMS, and honestly, all the payers trying to figure out how to cope with COVID-19.

BCA: What do you believe to be the most challenging topic facing the industry in 2021?

SW: I am a regulatory and health law guy, so: payor audits and government investigations will be the biggest challenge/risk in 2021 to healthcare organizations. The risks beyond the normal ones all stem from the changes in 2020 due to the public health emergency (PHE) and those especially tied to the 1135 Waivers (Telehealth, Incident-To, etc.) since many of the guidelines that were relaxed as a result of the waiver(s) are 180 degrees from the normal requirements. Again, the interesting thing will be, once we are out of the PHE, is what CMS will do with the changes made during the PHE, because some of the changes were great for providers and patients alike; and telehealth, while problematic for a number of reasons, has proven to be a sustainable service that should remain in effect after the PHE—in my humble opinion.

BCA: What topic do you feel many practices do not spend enough time or resources on, and how would you direct your clients moving forward?

SW: There is one thing that I tell all clients and those I am fortunate to lecture in front of and write for: your corporate compliance program! Your efforts with how you build, implement, monitor, and revise your compliance program will have the most impact if and when your organization or provider(s) are targeted by the Office of Inspector General or Department of Justice and will play a huge role in a prosecutor's charging decision or whether or not they seek a plea agreement or some other type of resolution to a perceived violation whether it be civil or criminal. A compliance program cannot be a "paper" program; it has to be a living, breathing document and you have to demonstrate a culture of compliance within your organization. That means compliance starts at the top and trickles down to all employees regardless of title or role within the organization. Compliance does not have to be this 3-headed monster that is so complex and overwhelming that no one will comply with it. The truth is that the compliance plan itself is static for the most part; once your build it, unless there is a dramatic change to your organization, it is what it is. The driver of any sound compliance program are the policies and standard operating procedures (SOPs) as those need to remain fluid and written in a way that allows maximum flexibility in keeping with the requirements of published guidance documents. That is why when I draft policies or SOPs for clients or I am advising them how to draft them, I use the KISS principal!

BCA: Do you have 2 or 3 questions you always like to ask a new practice that can really give you quick insight into their potential needs? And why those questions?

SW: Anyone who knows me knows I can't just ask 2 questions, but if I could only ask 2, they would be: First, do you have a corporate compliance program? Second, is it an effective one? (Please see my answer above for why I ask these two.)

BCA: With COVID-19 restrictions in 2020, how has it changed the

way you deal with clients for the good and bad?

SW: When the pandemic hit, I thought, oh boy, we are in for it now. I travel 36-42 weeks annually, between speaking at live events to being on site with clients, and in court rooms. The fact that we were able to pivot as an industry so quickly with the help of technology is what saved our industry from the devastation suffered by so many others. The ability to use Zoom or Go-To-Meetings allowed us to maintain that face-to-face relationship with our clients. I think it also allowed us to see clients in their true state and they got to see us in ours. When the PHE first hit, my inbox and my phones were completely blown up, and that lasted for several months as clients were seeking guidance, insights, solutions/work-arounds, and help with drafting policies and SOPs to navigating the PPP and other funding created by Congress and what it could and could not be used for and the terms for repayment and ensuring compliance with all of the information that was thrown at us in such a short period of time.

The bad part to this PHE was the constant changes we were subjected to by the payors and how fast they changed their policies. I do not begrudge them in anyway since this was all new to them and they were trying to figure it out. I think the biggest lesson that I along with all of our clients and most likely the vast majority of healthcare organizations learned from what we went through is that we have to be better prepared. We have to have a contingency plan. We have to have PPE stockpiled, and we have to know where and to whom we turn to internally when we experience something like this in the future. Simply put, we have to have a plan!

BCA: Moving forward into 2021, what's the one thing you would like to see practices concentrate on the most?

SW: I want to see practices get back to normal, but that does not mean being lax. We have to keep our guard up and we have to look at every day like today could be the day we're hit

with another crisis, and as healthcare professionals, we have to be prepared. Our frontline workers have been and continue to be the beacon on the hill for all of us. They give selflessly and put themselves into harm's way when others are running in the other direction. Clinicians have to be given a seat at the boardroom table, because things cannot be just about profits. That mentality is what put so many health systems at risk of financial ruin and an inability to properly care for patients. Clinicians, for the most part, do not care about the business of medicine; they care about humanity and how to best care for and heal the sick. I can assure you that many executives at health systems who got sick or had one of their family members get ill with COVID-19 and experienced shortages in supplies were gasping for air and desperately trying to figure out how to rectify their bad business decisions putting profit over care. Let's hope they learned their lesson and have reversed some of their bad policies to prevent the same mistakes in the future.

BCA: Outside of the office, what do you enjoy in your free time to relax and take the stress off work?

SW: Those who know me know I'm a good ol' boy from South Georgia. I spend my time with family and working on our 84-acre farm to get away from all the stress of the 60-hour workweek. There is nothing better than getting on the tractor for 6-hours and bush-hogging or plowing the fields since it is mindless work and it allows me to reflect on what really matters and that is my family and how I can make their lives as great as possible. When I am not doing work on the farm, I am an avid weightlifter. I have been lifting weights since I was 13 and it has always been something that makes me feel healthy, physically and mentally, and without a doubt helps with the physical demands of working our land. Other than that, I love vegging in front of the TV watching the Food Network (Guy's Grocery Games, Chopped, etc.), The History Channel (American Pickers, Pawn Stars, etc.), and Major League Baseball (die-hard Red Sox Fan).

BCA: Before we go, did you want to give our readers any tips or personal thoughts for moving into 2021?

SW: Once we are out of this PHE and life begins to return to a sense of normalcy (whatever that is), don't forget what 2020 was, in the sense it tested us to our limits in many cases. Don't forget those who sacrificed so much and all those who made the ultimate sacrifice to care for the sick. Be grateful for each and every day and don't take for granted any of the little things. Strive to be better today than what you were yesterday and do something for someone randomly, anonymously. I am all about paying it forward, but without getting any of the recognition. I have been blessed with so much in this life (family, friends, co-workers, clients, and even random strangers who brought a smile to my face) that for me not to give back would be shameful. Take time to give thanks for what you have, no matter how little it is, because at the end of the day, there is always someone a lot worse off than you—whether you want to believe it or not! We will get out of this nightmare by the fall of 2021 or once we achieve "herd immunity" (60-70% of the U.S. population will have to be vaccinated), which at some point, we will. Until then, be good to yourself and others!

Contact Sean M. Weiss at sweiss@drsmgmt.com or visit <https://www.doctors-management.com/>

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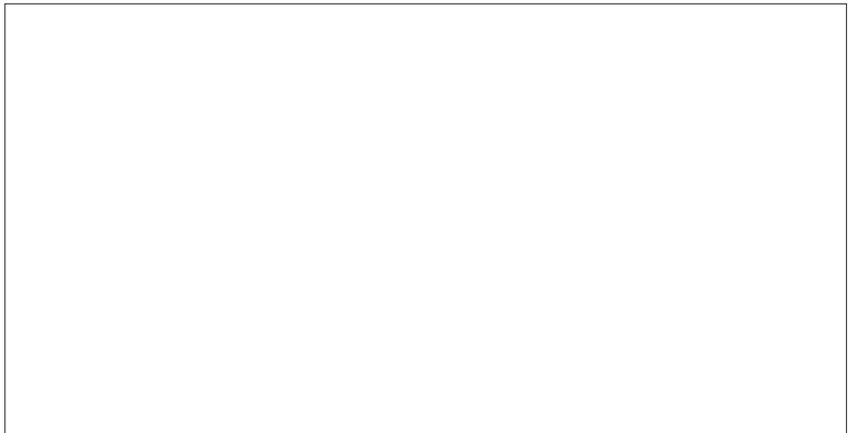
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