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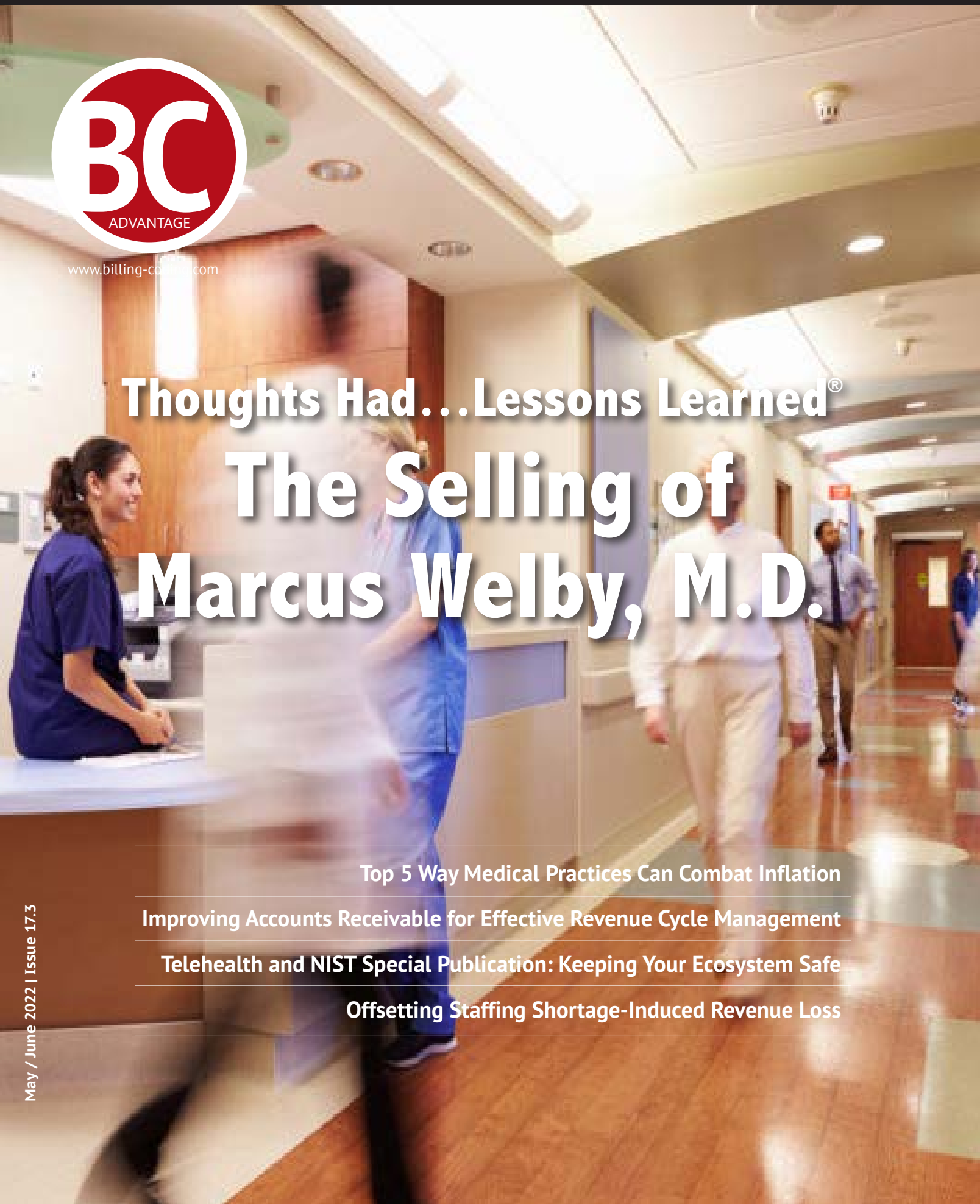

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May / June 2022 | Issue 17.3

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CEO Letter

We are in interesting times. For many, it feels like they're on shifting sand, continually struggling to stand straight and move forward. For others, changes are coming thick and fast, and it's hard to keep up. Prices are on the move (and not in the right direction), making everyday costs more expensive with demand being high for many goods and services. Businesses are having to be creative in how they resolve these issues while trying to stay in business, keep their employees employed, and still provide quality to their customers to keep them happy. It's very challenging and there is no magic wand to make it all go away. Well at least on this level anyway. We are all having to go with the flow right now, with many desiring an end to, what feels like, a bad dream.

But the question on everyone's lips is the big one of: when? When will we wake up, and what will life look like when we do?

We need to be careful about getting bogged down in the negativity and look closer at the small miracles around us every day. They're there, and we just need to keep our eyes and hearts open and recognize them for what they are.

This issue is a little different to what we normally provide to you. Our cover article, written by L.E. Shepherd, gives an amazing amount of information (and opinion) about the changes and challenges we are facing in our physician offices and hospitals. I hope you enjoy it and learn from it as much as I did.

We have other great articles about ways that medical practices can beat inflation, offsetting staffing shortage-induced revenue loss, revenue cycle management, social determinants of health, and leadership abilities. We also have informative articles on prostate surgery, telehealth, and NIST publications.

I'm sure you'll agree with me that there is a wide variety of topics this issue and I know you'll enjoy them.

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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COVER

Thoughts Had... Lessons Learned ®

The Selling of Marcus Welby, M.D.

It was suggested to me that I title this article, "Death of the Independent Practice." I decided not to take that recommendation, because the independent practice didn't die...

FEATURES

OTHERS

CPT (R) CodeBook Guidelines Functionality Enhanced in FindACode.com

Computer-Assisted Coding Toolkit

EXPERT Contributors this issue

Nathaniel Arana is a nationally-recognized healthcare business consultant with experience ranging across many different specialties. He has worked with many practices to negotiate reimbursement rates, market practice, and to help physicians remain autonomous. You can read some tips on how to negotiate your reimbursement rates on his website: www.ngahealthcare.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). www.managedoutsource.com

Betty Hovey, CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I, is the Senior Consultant/Owner of Compliant Health Care Solutions, a medical consulting firm that provides compliant solutions to issues for all types of healthcare entities. Chcs.consulting

Dave Jakielo is an International Speaker, Consultant, Executive Coach, and Author, and is president of Seminars & Consulting. Dave is past president of Healthcare Business 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.

Debbie Jones, CPC, CCA, is the writer and founder of Medical Coding Buff, a blog about medical coding. She helps individuals starting in their medical coding education who are interested in sitting for their CPC credentials. Besides her many articles on medical coding, she strives to make learning fun, engaging, and interactive by providing quizzes, multiple-choice challenges, and crossword puzzles. Receiving an Associate degree from Colorado Technical University (CTU-O) in 2012 in Medical Billing and Coding, Debbie graduated with highest honors. You can reach Debbie at debbie@medicalcoding-buff.com or through her website at medicalcodingbuff.com

Ritesh Ramesh is the Chief Operating Officer at Hayes and leads the customer experience and technology teams, overseeing product management, engineering, customer success, implementation/training, technical support, and security of the MDaudit Enterprise auditing and revenue integrity platform. Ritesh has more than 17 years of technology experience with deep expertise in emerging technologies, Cloud, Digital, and AI.

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

L.E. Shepherd, Jr., BS, MSA, has successfully provided comprehensive business advisory and management services to the healthcare industry and others for over 30 years. With his comprehensive business experiences and extensive speaking engagements, along with his many years of relationship building in the healthcare industry, Mr. Shepherd brings a unique perspective and set of skills to solving the complex business problems facing physicians, businesses, and the healthcare industry today and tomorrow. www.medbizonics.com

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End of vaccination cost reimbursements could limit access for uninsured

Federal COVID relief funds allocated to reimburse medical providers for administering vaccines will soon dry up, potentially jeopardizing providers' ability to offer vaccines to the uninsured.

For patients, the COVID vaccine is completely free. Even though the vaccine itself is free for pharmacies, they still have to pay for the workers who give the shots.

Pharmacies can request reimbursement from patients' health insurance companies.

Congress approved billions of dollars of federal COVID relief funds during the pandemic, some of which was allocated to pay for reimbursements for those without health insurance, generally at Medicaid rates.

The Health Resources and Services Administration's (HRSA) COVID-19 Uninsured Program covers costs for testing, treatment, and vaccination. It has provided about $19 billion in reimbursement since the beginning of the pandemic.

In Pennsylvania, providers have received $254 million in reimbursements, according to CDC data: 52 percent for testing, 21 percent for treatment, and 27 percent for vaccination.

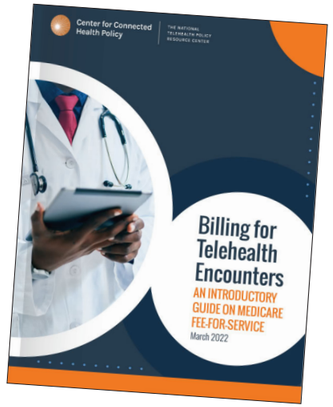
The HRSA program stopped accepting reimbursement claims for testing and treatment on March 22 and will stop paying for vaccination costs on April 6.

The White House asked Congress for $22.5 billion for continued COVID relief efforts in this year's federal budget. That number was later reduced to $15.6 billion and then struck entirely from the budget. No other plans for continued funding for the program have been announced.

Pharmacies will be forced to decide between vaccinating the uninsured and getting paid for their time.

Source: fox43

Free 2022 Billing for Telehealth Encounters Guide



You can now order free COVID-19 rapid tests that will be delivered to your mailbox — but you'll only get a few.

The Center for Connected Health Policy (CCHP) is the national telehealth policy resource center providing free resources to healthcare providers. Due to the COVID-19 public health emergency (PHE), tracking telehealth policy has become complex. The 2022 billing guide seeks to break down permanent post-PHE policies versus temporary PHE policy exceptions, as well as new legislative and administrative requirements relevant to telehealth billing.

The first part of the guide focuses on understanding telehealth billing terminology, including service codes, modifiers, and place of service codes. It also covers:

- service codes for principal care management, chronic care management and transitional care management;
- remote Physiological or Patient Monitoring (RPM);
- remote Therapeutic Monitoring (RTM); and
- eConsult or Interprofessional Consultation Codes

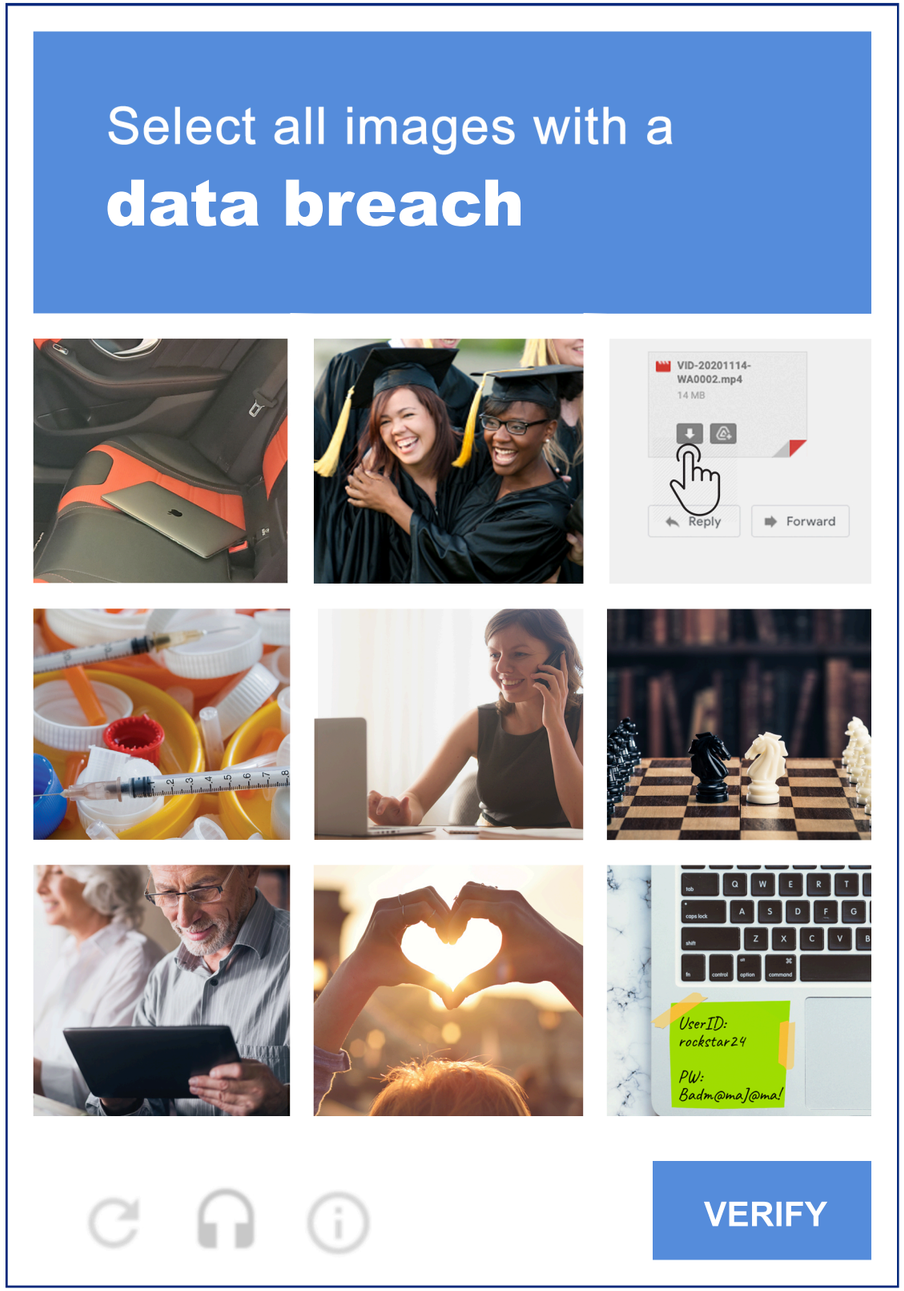
Download: www.billing-coding.com/pdf/telehealth-2022.pdf

ICD-10-CM/PCS Issue of 2022

In light of the continuing COVID-19 pandemic and resultant public health emergency (PHE), we start with the coding changes relating to COVID-19 immunization. There are three new diagnosis codes:

Z28.310 – Unvaccinated for COVID-19;
Z28.311 – Partially vaccinated for COVID-19; and
Z28.39 – Other under-immunization status.

Source: ICD-10 Monitor



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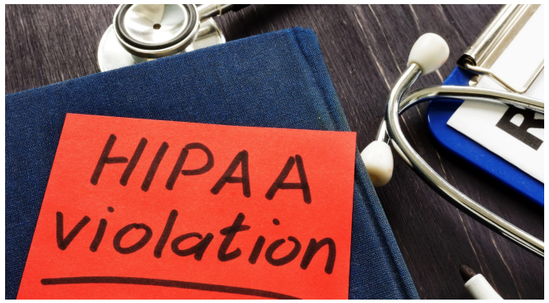
Four HIPAA Enforcement Actions Hold Healthcare Providers Accountable With Compliance



The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) announced the resolution of three investigations and one matter before an Administration Law Judge related to compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

OCR has taken the following enforcement actions that underscore the importance and necessity of compliance with the HIPAA Rules, including the foundational Right of Access provision:

1. Dr. Donald Brockley, D.D.M., a solo dental practitioner in Butler, Pennsylvania, failed to provide a patient with a copy of their medical record. After being issued a Notice of Proposed Determination, Dr. Donald Brockley, D.D.M requested a hearing before an Administrative Law Judge. The litigation was resolved before the court made a determination by a settlement agreement in which Dr. Donald Brockley, D.D.M agreed to pay $30,000 and take corrective actions to comply with the HIPAA Privacy Rule's right of access standard.
2. Dr. U. Phillip Igbinadolor, D.M.D. & Associates, P.A. (UPI), a dental practice with offices in Charlotte and Monroe, North Carolina, impermissibly disclosed a patient's PHI on a webpage in response to a negative online review. UPI did not respond to OCR's data request, did not respond or object to an administrative subpoena, and waived its rights to a hearing by not contesting the findings in OCR's Notice of Proposed Determination. OCR imposed a $50,000 civil money penalty.
3. Jacob and Associates, a psychiatric medical services provider with two office locations in California, agreed to take corrective actions and pay OCR $28,000 to settle potential violations of the HIPAA Privacy Rule, including provisions of the right of access standard;
4. Northcutt Dental-Fairhope, LLC (Northcutt Dental), a dental practice in Fairhope, Alabama, who impermissibly disclosed its patients' PHI to a campaign manager and a third-party marketing company hired to help with a state senate election campaign, agreed to take corrective action and pay $62,500 to settle potential violations of the HIPAA Privacy Rule.

Source: HHS.gov

New ICD-10-PCS Procedure Codes

Starting April 1, we also have the following new ICD-10-PCS procedure codes, which are presented in the new Coding Clinic as well.

XW013V7 – Introduction of COVID-19 vaccine dose 3 into subcutaneous tissue, percutaneous approach, new technology group 7;

XW013W7 – Introduction of COVID-19 booster into subcutaneous tissue, percutaneous approach, new technology group 7;

XW023V7 – Introduction of COVID-19 dose 3 into muscle, percutaneous approach, new technology group 7;

XW023W7 – Introduction of COVID-19 booster into muscle, percutaneous approach, new technology group 7;

XW0DXR7 – Introduction of fostamatinib into upper GI, external approach, new technology group 7;

XW0G7R7 – Introduction of fostamatinib into upper GI, via natural/artificial opening, new technology group 7;

XW0H7R7 – Introduction of fostamatinib into lower GI, via natural/artificial opening, new technology group 7;

XW023X7 – Introduction of tixagevimab and cilgavimab monoclonal antibody into muscle, percutaneous approach, new technology group 7; and

XW023Y7 – Introduction of other new technology monoclonal antibody into muscle, percutaneous approach, new technology group 7.

Source: ICD-10 Monitor

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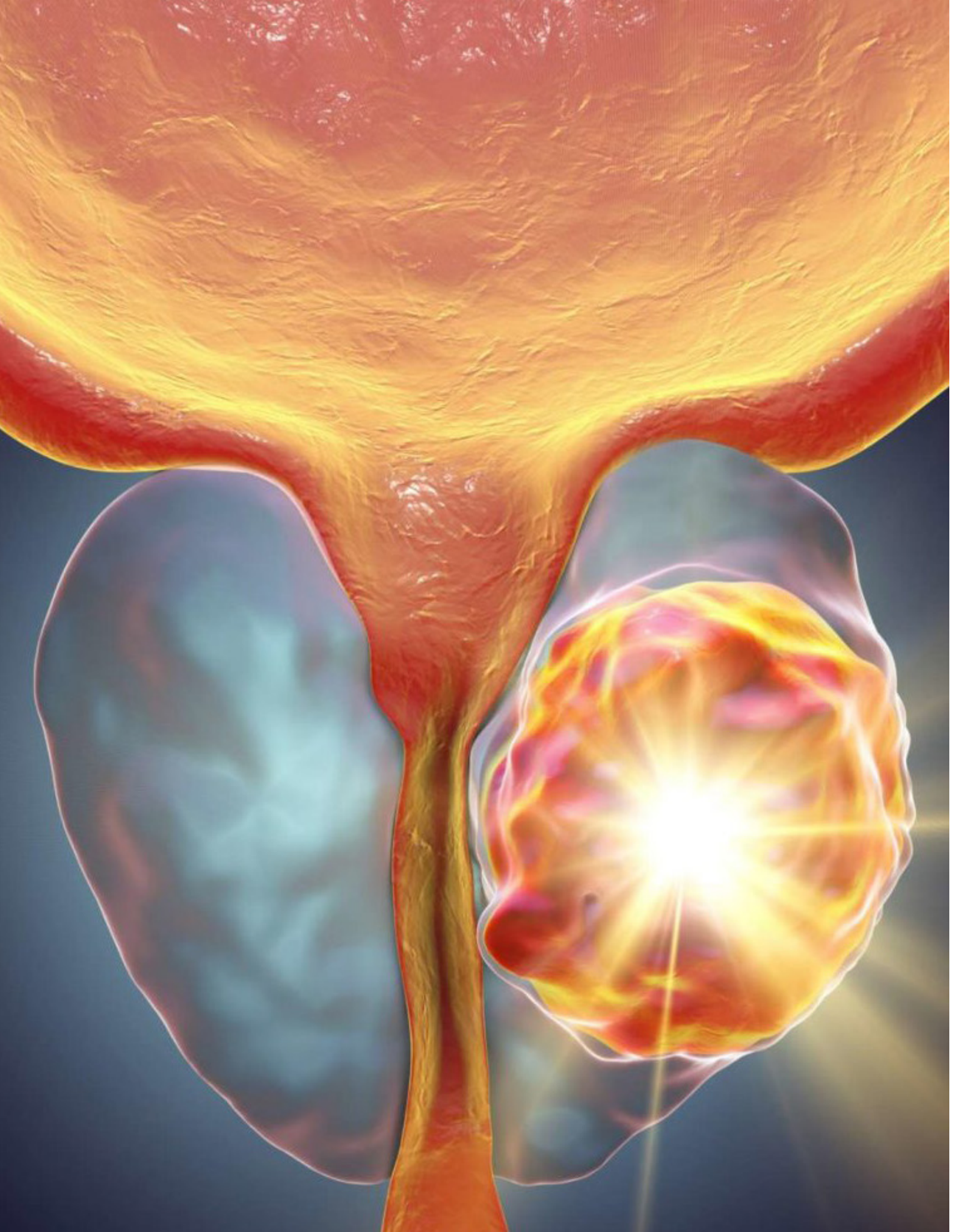


Staying Dry
After Prostate Surgery

When a male patient is diagnosed with prostate cancer and undergoes a radical prostatectomy, he may develop urinary incontinence. This can be a devastating and emotional experience for the patient. The incontinence is caused by the treatment of the prostate and is predictable and possibly preventable.

Generally, the incontinence improves within 12 months following surgery. However, if it persists past that timeframe, treatment may be necessary to help correct or reduce the loss of involuntary urine.

Fast Facts

- Prostate cancer is the most common type of cancer in men, with around 60% of diagnosed cases in men being 65 or older.
- The most common treatment for prostate cancer confined to the prostate is a radical prostatectomy. This procedure involves the removal of the prostate and seminal vesicles.
- Urinary incontinence is one of the major complications of radical prostatectomy, with about 10-15% of men reporting frequent leakage or no control six months after treatment.
- Long-lasting incontinence occurs in about 6 to 8% of men who have had their prostate removed.

How A Prostatectomy Affects Urination

Typically, urine is emptied into the bladder from the kidneys. Two valves called sphincters keep the urine inside the body by remaining closed until the body sends a signal to open them.

When a patient has his prostate completely removed, the surgeon has to remove the prostate gland and one of the sphincters outside the prostate. Having only one sphincter is not usually a problem. Other

times, it can affect the nerves and muscles from the surgery and result in urine leakage.

Risk Factors for Urinary Incontinence

Factors that put a person at risk of incontinence after prostate treatment include advanced patient age, larger prostate size, and a shorter membranous urethral length based on an MRI.

Evaluation of Incontinence

After prostate treatment, the physician should evaluate the patient with incontinence. A history, physical exam, and diagnostic tests are performed to determine the type and severity of incontinence, its progression or resolution, and the degree to which it bothers the patient.

The physician should question the patient as to which activities cause the incontinence. This helps determine if it is stress urinary incontinence due to intrinsic sphincter deficiency (ISD), urge incontinence due to bladder dysfunction, or both. Intrinsic sphincter deficiency (ISD) is the most common cause of incontinence after prostate treatment and is likely a direct result of the surgery.

Before surgical intervention, a physician may perform a urodynamic study to assess the urinary tract function and a 24-hour pad test to determine how many pads are used and the amount of urine leaked. In addition, the physician may perform a cystourethroscopy to assess the patient's urethra and bladder.

Types of Urinary Incontinence After Prostate Treatment

The four main types of urinary incontinence after prostate treatment (IPT) include stress, urge, mixed, and overflow:

- After prostate surgery, stress urinary incontinence (SUI) is the most common type and involves urine leakage when coughing, laughing, sneezing, or exercising. It is not related to mental stress. The cause is usually a problem with the valve that keeps urine in the bladder sphincter.
- Urge urinary incontinence (UUI) is a sudden need to urinate.
- Mixed urinary incontinence is a combination of SUI and UUI.
- Overflow urinary incontinence occurs when there is a problem emptying the bladder.

Treatment of Urinary Incontinence

Before and immediately following a radical prostatectomy, physicians recommend behavioral modification, a practitioner-guided pelvic floor muscle training program or home exercise program, and pads/diapers/penile clamps/condom catheters to enhance continence recovery. A pelvic floor muscle training program or exercises can also be effective at any point postoperatively.

If urinary incontinence is bothersome after prostate treatment and conservative therapy is not successful, surgery may be considered as early as six months later.

Surgical Options

The surgical options for incontinence after prostate treatment (IPT) include an artificial urinary sphincter (AUS) device, male sling, and periurethral balloon. A urologist or urologic oncologist usually performs these procedures. They are done on an outpatient basis or with an overnight hospital stay.

Artificial Urinary Sphincter (AUS) device. This three-part implanted device consists of an inflatable cuff/ring around the urethra, a saline-filled balloon next to the bladder, and a scrotal pump. The procedure is typically performed under general anesthesia, and a catheter is inserted to make sure the bladder remains empty during surgery. A perineal incision is made to place the cuff. An inguinal incision is then made to place the balloon and the scrotal pump. When the scrotal pump is manually compressed, the cuff opens and automatically closes after two to three minutes. The device works much like the patient's own sphincter.

The single cuff perineal approach is the preferred method. There is also a dual/tandem cuff placement using a transverse scrotal incision, but it increases the risk of complications.

The AUS system is the most reliable and predictable treatment for SUI after prostate treatment. It can successfully treat all degrees of urine leakage and lasts for about seven years.

CPT Codes For AUS Device

Insertion, removal and/or replacement, and repair of an artificial urinary sphincter system are reported with CPT codes 53444-53449.

- 53444, Insertion of tandem cuff (dual cuff)
- 53445, Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
- 53446, Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
- 53447, Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff at the same operative session
- 53448, Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session, including irrigation and debridement of infected tissue
- 53449, Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff

CPT code 53445 (Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff) is reported most often.

When a previously inserted AUS system fails, a tandem cuff may need to be inserted to replace the original cuff. When this occurs, 53444 [(Insertion of tandem cuff (dual cuff)] should be assigned.

Coding Example

A 65-year-old male presents with an AUS device for urinary incontinence after a previous radical prostatectomy. The device is 15 years old and is no longer working correctly. The device is removed and replaced with a new system. Assign for CPT.

53447, Removal and replacement of inflatable urethral/blad-

der neck sphincter including pump, reservoir, and cuff at the same operative session

Male Sling. The surgeon uses a synthetic mesh-like tape as a supportive sling. An incision is made through the perineal tissue (area between scrotum and anus) to expose the urethra. The sling is then wrapped around part of the urethral bulb that covers the upper part of the urethra near where it enters the area of the urethral sphincter. The purpose of wrapping the sling around the urethral bulb is to relocate the urethra and increase resistance in this area gently. Once the sling is in place, the perineum is closed with absorbable sutures.

There are three types of male slings available:

- Transobturator sling is a non-compressive sling that relocates the proximal urethra closer to the sphincter complex. It also lengthens the membranous urethra.
- Quadratic sling relocates the proximal urethra and compresses the ventral urethra.
- Adjustable sling is not currently used in the U.S.

However, it can be altered to optimize continence or prevent the retention of urine.

Another type of sling, the bone-anchored sling, has fallen out of favor due to the risk of osteomyelitis.

The male sling has been successful in mild to moderate stress urinary incontinence cases after radical prostatectomy. It is not recommended for individuals who have undergone radiation as part of their prostate treatment.

Since it is not major surgery, the recovery time is short. Complications of the sling procedure are rare. However, the sling may need to be removed or revised when the inability to urinate or another complication develops.

CPT Codes for Sling Procedure

Placement and removal or revision of a sling for male urinary incontinence are reported with CPT codes 53440 and 53442.

- 53440, Sling operation for correction of male urinary incontinence (e.g., fascia or synthetic)
- 53442, Removal or revision of sling for male urinary incontinence (e.g., fascia or synthetic)

Do not confuse these codes with the sling procedure codes for female urinary incontinence (57287, 57288, 51992, and 53500).

Coding Example

A male patient presents to the urologist's office with complaints of stress urinary incontinence. Three years ago, the patient was diagnosed with prostate cancer and had a radical prostatectomy. The physician performs a sling operation using synthetic materials to support the urinary sphincter and to allow it to function properly. Assign for CPT.

53440, Sling operation for correction of male urinary incontinence (e.g., fascia or synthetic)

Adjustable Balloon Device. Periurethral adjustable balloon placement is a minimally invasive procedure performed in patients with stress urinary incontinence. Two silicone balloons are placed near the bladder neck to compress the prostate externally. First, the bladder is filled with contrast to give the bladder and bladder neck an opaque appearance. The balloons are positioned distal to the bladder neck and passed percutaneously through the perineum. This procedure is performed under fluoroscopic guidance or transrectal ultrasound guidance. Ports connected to the balloons are buried superficially. This allows for balloon volume adjustment as needed.

This procedure is performed to treat male intrinsic sphincter deficiency after a radical prostatectomy and may be recommended in cases of mild stress urinary incontinence. There have also been reports to indicate that this procedure is effective in moderate to severe cases of stress urinary incontinence after a radical prostatectomy. Individuals who have undergone radiation are not good candidates for the balloon procedure due to an increased risk of balloon migration and fibrosis.

CPT Codes for Adjustable Balloon Device

Insertion (unilateral and bilateral), removal, and adjustment of periurethral transperineal adjustable balloon continence device (ProACT) is reported with CPT codes 53451-53454. These codes replaced the four Category III codes 0548T, 0549T, 0550T, and O551T on January 1.

- 53451, Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance [ProACT System]
- 53452, Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance [ProACT System]
- 53453, Periurethral transperineal adjustable balloon continence device; removal, each balloon [ProACT System]
- 53454, Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume [ProACT System]

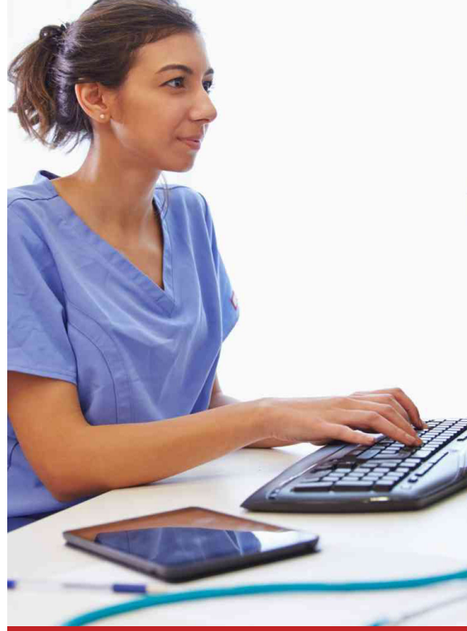
Coding Example

A patient with intrinsic sphincter deficiency and stress incontinence previously had a unilateral ProACT continence device inserted. Today the device is removed due to a mechanical breakdown of the implant. Assign for CPT.

53453, Periurethral transperineal adjustable balloon continence device; removal, each balloon [ProACT System]

As always, be sure to assign the appropriate ICD-10-CM codes to justify the services provided as medically necessary.

Debbie Jones, CPC, CCA, is the writer and founder of Medical Coding Buff, a blog about medical coding. She helps individuals starting in their medical coding education who are interested in sitting for their CPC credentials. Besides her many articles on medical coding, she strives to make learning fun, engaging, and interactive by providing quizzes, multiple-choice challenges, and crossword puzzles. Receiving an Associate degree from Colorado Technical University (CTU-O) in 2012 in Medical Billing and Coding, Debbie graduated with highest honors. From there, she went on to earn her CCA, CPC-A (now CPC), and HCS-D credentials. She is a member of AAPC and AHIMA and a contributing writer for BC Advantage and JustCoding. Her previous healthcare experience includes writing exam questions for CertificationCoachingOrg (CCO) and CodeProU, as well as home health coding for Selman-Holman & Associates. She started her career in healthcare as a hospital admitting clerk before moving on to medical transcription for five years. Before that, she had 20+ years of experience as a secretary/administrative assistant where communications, attention to detail, and implementing and developing office procedures and record systems were part of her daily responsibilities. You can reach Debbie at debbie@medicalcodingbuff.com or through her website at medicalcodingbuff.com



WEBINAR - CEU Approved

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Improving Accounts Receivable for Effective Revenue Cycle Management

Collecting amounts that have been billed or accounts receivable is essential for successful revenue cycle management.

While healthcare is about using the necessary resources to help people maintain their health, it is a business like any other, and patients are the consumers. Practices, hospitals, clinical laboratories, and other facilities need to stay financially viable to serve their communities. That's where healthcare revenue cycle management (RCM) comes in. RCM is about developing, implementing, and managing processes to get paid for patient services and stay financially healthy.

RCM is a complex task that involves several manual and electronic processes, including policies and procedures to collect the amounts owed by patients and insurance companies. RCM covers tasks such as patient scheduling, insurance eligibility verification, patient registration and coding, and billing. But it doesn't end there; there are the tasks associated with claims submission and reimbursement—payment posting, statement processing and handling claims denials, collections, and monitoring accounts receivable or A/R follow-up. Medical accounts receivable is the outstanding amount owed by insurance companies or patients to the healthcare provider for services rendered.

With all its challenges, A/R follow-up has always been a hot topic in medical billing but became a serious concern after COVID-19 broke out. The pandemic exacerbated RCM challenges like never before. The November 2021 MGMA Stat poll, conducted by the Medical Group Management Association, received 587 applicable responses to the question, "How have your days in A/R changed in 2021?" Up to 49% of medical practice leaders reported that days in A/R increased, compared to 15% who reported a decrease, and another 37% who said they remained unchanged.

Collecting amounts that have been billed or accounts receivable is essential for RCM success. That's why healthcare providers need to understand the relevant benchmarks to use for measuring A/R performance.

Measuring Days in AR – A Key Performance Indicator

A/R management involves tracking and measuring accounts receivable performance. Efficiently monitoring and working in AR—what's known as AR follow-up—is essential to recover overdue payer or patient payments.

"Days in A/R," defined as the average number of days it takes a practice to get paid or collect pending payments, is a Key Performance Indicator (KPI). Tracking days in A/R can help practices take actionable steps to get paid faster and avoid mistakes that lead to denials.

Generally, A/R is classified into aging buckets based on 30-day increments of elapsed time, such as 0-30 days, 31-60 days, 61-90 days, 91-120 days, and so on. A/R>120 represents the total amount owed to the practice for services rendered, either by third party insurance or patients, that is 120 days old or older. The lower the number of days in A/R, the more cash a practice has on hand, and vice versa.

The 2 steps in A/R calculation are as follows:

1. Calculate your practice's average daily charges:
- Add up all of the charges posted for a given period (e.g., 3 months, 6 months, 12 months).
- Deduct all credits received from the total number of charges.
- Divide the total charges, less credits received, by the total number of days in the selected period (e.g., 30 days, 60 days, 90 days, 120 days, etc.).

2. Divide the total accounts receivable by the average daily charges. The result is the Days in Accounts Receivable.

Here is a sample Days in A/R calculation:

- (Total Receivables - Credit Balance)/Average Daily Gross Charge Amount (Gross charges/365 days)
- Receivables: $60,000
- Credit balance: $4,000
- Gross charges: $500,000
- [$60,000 – ($4000)] / ($500,000/365 days)
- $56,000/1369 = 40.90 days in A/R

The A/R Aging Report that medical billing companies provide will show how long insurance claims and patient balances have been outstanding, expressed both as a dollar amount and a percentage. The practice average can be compared to the national average for a specialty to see how well the A/R collection process is working.

Management consulting firm, Fox Group, LLC, notes that while Medicare reimburses a claim about 14 days after receiving it, HMOs in some states pay at 45 days after

receiving a claim, as allowed by law.

The days in A/R benchmarks for medical billing and collections are given as:

- 30 days or less for a High Performing Medical Billing Department
- 40-50 days for an Average Performing Medical Billing Department
- 60 days or more for a Below Average Medical Billing Department

According to the AAFP, days in A/R should remain below 50 days at minimum, though 30 to 40 days is desirable. Obviously, the 31-to-60-day aging bucket and the 60-to-90-day aging bucket are the most challenging for medical billing staff. Anything over 120 days is unlikely to ever be collected. The 2021 MGMA Data Dive Cost and Revenue found that the median for total A/R over 120 days in multispecialty practices is 13.54%.

What Causes Increase in A/R Days?

What are the reasons for increase in A/R days? A 2018 MGMA financial conference report listed the indications or possible causes of A/R>120 for insurance A/R and for patient A/R as follows:

Insurance A/R>120
Timely filing risk
Denials are high
Absence of timely insurance follow-up
Insurance denials may not be worked effectively

Patient A/R>120
Co-pays are not collected
Possibility of high eligibility denials
Inadequate focus on patient collections
Deductibles not checked or collected
Patient statements are not effective

Several factors can impact revenue cycle and A/R processes. The following considerations need to be kept in mind when calculating days in A/R:

- Some insurance companies take longer to reimburse claims than overall average number of days in A/R. For example, if your practice's average days in A/R is 40.90, but Medicaid claims average 75 days, this needs to be addressed.
- Ensure that the credit balance is deducted from the receivable to ensure accurate calculation.
- If accounts were sent to a collection agency, take this into consideration; calculate days in A/R with and without the inclusion of collection revenue.
- As payment plans that offer patients extra time to pay can increase days in A/R, consider setting up a separate account that includes these plans and decide whether to include or not include this "payer" in calculation of days in A/R.
- Using the "A/R greater than 120 days" benchmark as good overall days in A/R can also mask elevated amounts in older receivables.

Strategies to Improve A/R and RCM

A practice's financial health is as important as its patients' financial health. Having a top performing revenue cycle means increased cash flow, reduced cost-to-collect, greater point-of-service cash collections, and less denials.

The reason why RCM has become increasingly difficult to handle is that there are many processes involved, such as:

- Completing insurance verification prior to any scheduled procedure or appointment;
- Clinical documentation of care;
- Coding to translate diagnoses and treatments into appropriate codes;
- Billing and generating professional claims;
- Adherence to payers' varying billing and reimbursement guidelines;
- New and complex payment models that have changed how physicians are compensated for care; and
- Keeping up with regulatory changes.

All of this must be done accurately and efficiently prior to claim generation to create and submit the claim, and get paid quickly. As Melissa Scott, the then director of advisory services at the healthcare technology company, Change Healthcare, points out in a 2018 Healthcare Finance article:

"Errors in front-end processes, such as registration, patient demographics, insurance verification, and eligibility can cause all the things done right after that point to be thwarted and result in a denial. Every person that touches data that ends up on a claim, or aids in the care and documentation process that support billing and reimbursement, needs to understand they are part of revenue cycle and how they impact the organization's KPIs."

MGMA reiterates the importance of a comprehensive approach to improving the end-to-end RCM management process. The Association recommends making process and technology improvements at each of the three key revenue cycle phases: pre-service, post-service, and post-adjudication.

- Pre-service: Performing insurance verification before the office visit to obtain the correct benefit information, as well as the patient's payment responsibility for the service. Communicating with patients can help them understand the portion of the bill they are responsible for and other matters. Practices can establish policies such as online payment option for credit card transactions and payment plans for improving patient collections.
- Post-service: Here, the focus should be on making sure claims are clean before they are submitted to the payer. This involves correct coding and billing based on payer-specific criteria. Using a claim scrubbing tool can catch clerical and simple coding errors. Following up on claims can help practices understand why collections are falling short and identify which payers are responsible. They should communicate frequently with patients who have outstanding balances.
- Post-adjudication: After a claim has been paid, remittances should be transferred to the practice management system to create a full historical record of the transaction. Practices should start dealing with denials right away as appeals have deadlines and can also take time. High-dollar claims should be tackled first. This phase also provides practices the opportunity to evaluate performance and find ways to improve.

Other measures that MGMA recommends to improve RCM and A/R include:

- Developing financial policies for handling denials and write-offs.
- Running A/R reports at least once a month, separating out insurance and patient balances due using service date instead of billing date to identify billing schedule issues.
- Benchmarking A/R aging with industry best practice standards.

With all the challenges and rules around coding, billing, and collections, practices need to make sure they're doing everything properly to ensure proper and timely reimbursement.

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).
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Social Determinants of Health (SDOH): What's the Big Deal?

According to Healthy People 2030, Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

In this article, SDOH will be discussed, along with the importance of capturing this data on claims. The ICD-10-CM Z code categories for SDOH will also be given.

The Main Domains

Healthy People 2030 breaks down SDOH into five (5) domains:

1. **Economic Stability:** The U.S. Census indicates that one in ten people live in poverty in the United States. This fact can obviously affect a person's overall health as they may not be able to afford things that they need to be and stay healthy.
2. **Education Access and Quality:** The National Institutes of Health indicate that one factor of inequalities in health and mortality is education. Adults with higher educational levels, on average, are healthier and live longer.
3. **Health Care Access and Quality:** The U.S. Census indicates that approximately one in ten people in the United States still don't have healthcare insurance, and people without insurance are less likely to have a primary care physician. Without insurance, they also may not be able to afford medications or treatments that they need to help control any chronic diseases they may have.
4. **Neighborhood and Built Environment:** Where a person lives and works can have a great influence on their health. Some urban communities are "food deserts," where affordable fresh fruits and vegetables may not be available, and people rely more on fast food or small shops that sell a lot of unhealthy food items. Some neighborhoods don't have sidewalks or bike lanes, which may prevent people from walking or biking places instead of driving or taking public transportation.
5. **Social and Community Context:** People who face social exclusion, rejection, or have family relationship issues can experience negative impacts to their health and well-being.

The examples given in the domains above are just the tip of the iceberg. There are so many things that could be added, but they cannot all be addressed in one article. Government agencies, like the Center for Disease Control (CDC), Office of Disease Prevention and Health Promotion (ODPHP), and the National Institutes of Health (NIH), have formed more than a dozen workgroups, including the Social Determinants of Health Workgroup. You can read more about these and other things being done on the Health People 2030 website: Social Determinants of Health - Healthy People 2030 | health.gov.

Why It's Important to Track the Data

The American Journal of Preventive Medicine, Health Affairs, and the Robert Wood Johnson Foundation, among others, have stated that about 80 percent of the factors that affect a person's overall health are non-medical and due to SDOH. So, how do we know what types of outreach programs are needed most in what areas? How do we account for just how many people are being affected by SDOH? How do we get people into the right programs that they need? By counting them. And, how do we count them? By documentation and ICD-10-CM codes. The AMA recognizes the importance of SDOH also.

When the 2021 E/M Guidelines for Office and Other Outpatient Visits came out, SDOH was added as a factor on the MDM Table in the Risk of Complications and/or Morbidity or Mortality of Patient Management column supporting Moderate risk. If a patient can't get their medication because they can't afford it, their risk of complications/morbidity/mortality rises. If a patient has trouble keeping their wounds clean because they currently live in their car, their risk of complications/morbidity/mortality rises. If a patient has trouble with showing up for their appointments because they do not have transportation or a job… well, I think you get the idea. All of these types of SDOH factors can make what would usually be a straightforward issue to care for riskier and more complex.

To make people count, we must be able to count people. Consider this example: an elderly established patient is taken as a work-in appointment at the clinic with burns to her arm. Upon intake, the patient states that she burned her arm cooking on a camp stove because her electricity had been shut off for nonpayment. Her husband died within the past year, and she is struggling to pay all of her bills as he did not have life insurance and his pension was stopped after his death. She has only been able to work part-time due to her seizures. The physician writes a letter for the patient to the utility company for a medical waiver to get her power restored, has the office staff contact an outside service to enroll the patient in meals on wheels, and gives the patient information on how to enroll in Medicaid services. Gathering the SDOH data made it possible to assist the patient with the right type of connections.

Reporting and tracking SDOH helps practices and clinics provide non-medical services to patients in need. As in the example given above, if the data is captured, patients can be referred to programs that can help them with non-medical issues they are having that affect their "whole-person" health. UnitedHealthcare Medicare Advantage plans reported that in 2017, approximately 560,000 referrals were made for their beneficiaries to transportation, nutrition assistance, and social programs to help reduce isolation.

ICD-10-CM Category Z Codes

The ICD-10-CM Official Guidelines I.C.21.17 states that "Codes describing social determinants of health (SDOH) should be assigned when this information is documented." The guidelines

also allow for any clinician, including social workers, case managers, nurses, and community health workers, the ability to document a patient's social needs, because the information is social information, not medical diagnoses. The patient's self-reported information may also be used if it is signed-off by and incorporated into the medical record by a clinician or provider.

SDOH Z code categories are located from Z55-Z65. Data from the American Hospital Association on the problems or risk factors included in each category are as follows:

Z55: Problems related to education and literacy: This includes illiteracy, schooling unavailable, underachievement in a school, less than a high school diploma, no general equivalence degree (GED), educational maladjustment, and discord with teachers and classmates.

Z56: Problems related to employment and unemployment: Unemployment, change of job, threat of job loss, stressful work schedule, discord with boss and workmates, uncongenial work environment, sexual harassment on the job, and military deployment status.

Z57: Occupational exposure to risk factors: Occupational exposure to noise, radiation, dust, environmental tobacco smoke, toxic agents in agriculture, toxic agents in other industries, extreme temperature, and vibration.

Z58: Problems related to physical environment: Inadequate drinking-water supply, and lack of safe drinking water.

Z59: Problems related to housing and economic circumstances: Sheltered homelessness, unsheltered homelessness, residing in street, inadequate housing, housing instability, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, inadequate food, lack of adequate food, food insecurity, extreme poverty, low income, and insufficient social insurance and welfare support.

Z60: Problems related to social environment: Adjustment to life-cycle transitions, living alone, acculturation difficulty, social exclusion and rejection, target of adverse discrimination and persecution.

Z62: Problems related to upbringing: Inadequate parental supervision and control, parental overprotection, upbringing away from parents, child in welfare custody, institutional upbringing, hostility toward and scapegoating of child, inappropriate excessive parental pressure, personal history of abuse in childhood, personal history of neglect in childhood, personal history of unspecified abuse in childhood, parent-child conflict, and sibling rivalry.

Z63: Other problems related to primary support group, including family circumstances: Absence of family member, disappearance and death of family member, disruption of family by separation and divorce, dependent relative needing care at home, stressful life events affecting family and household, stress on family due to return of family member from military deployment, and alcoholism and drug addiction in family.

Z64: Problems related to certain psychosocial circumstances: Unwanted pregnancy, multiparity, and discord with counselors.

Z65: Problems related to other psychosocial circumstances: Conviction in civil and criminal proceedings without imprisonment, imprisonment and other incarceration, release from prison, other legal circumstances, victim of crime and terrorism, and exposure to disaster, war, and other hostilities.

Conclusion

As payment models continue to expand with alternative payment models, accountable care organizations, patient-centered medical homes, HCCs, Medicare Advantage plans all looking toward payment for outcomes rather than fee-for-service, more attention may be put on SDOH. As stated earlier, these non-medical factors are associated with total health outcomes, so concentrating on them may lead to overall better patient outcomes. Currently, many health plans offer beneficiaries programs on losing weight, tobacco cessation, diabetes prevention, etc., to improve healthy habits and overall quality of life.

Practices, hospitals, and other medical facilities are starting to incorporate gathering SDOH information on their patients. Partnerships are being set up for different departments (community outreach, social services, etc.) to be able to get notification when a patient screening indicates that a SDOH factor may need to be addressed. There is still a lot of work to do, but the addition of SDOH into E/M and ICD-10-CM are beginning to shine a light on these factors that affect so many.

Betty Hovey, CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I, is the Senior Consultant/Owner of Compliant Health Care Solutions, a medical consulting firm that provides compliant solutions to issues for all types of healthcare entities. Chcs.consulting

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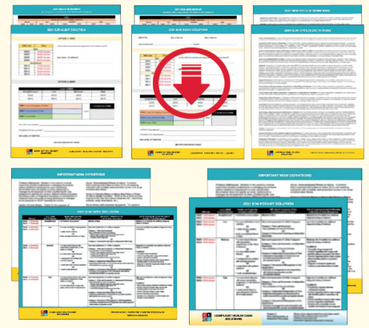

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Betty has educated medical coders, managers, health plans, administrators, physician, and non-physician practitioners all across the country. She has co-written manuals on ICD-10-CM, ICD-10-PCS, and CPT specialty areas.

"...E/M coding has always been a bit of a "gray" area of coding and the changes being made for 2021 will add even more confusion, but Betty has such thorough knowledge and experience that she makes learning and understanding the changes less overwhelming."

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Telehealth and NIST Special Publication: Keeping Your Ecosystem Safe

Telehealth emerged during the COVID-19 pandemic as a means of connecting healthcare providers with patients to mitigate interactions and potential exposure to COVID-19. Its use proliferated. Importantly, telehealth was never appropriate for every clinical diagnosis or treatment.

And, just as with billing and coding in in-person clinical settings, there are parameters and specific codes, which must be utilized to fit a certain set of parameters and be substantiated by medical necessity.

By its very nature, telehealth involves technology. Per the Centers for Medicare and Medicaid Services (CMS), "Medicare telehealth services require that the services occur over real-time audio and visual interactive telecommunications. For purposes of diagnosis, evaluation, or treatment of mental health disorders, if the patient doesn't have the technical capacity or the availability of real-time audio and visual interactive telecommunications, or they don't consent to the use of real-time video technology, we allow audio-only communication for telehealth mental health services to established patients located in their homes." Given the allure and the value of protected health information (PHI) for illicit use by both cybercriminals and criminals, it is not surprising that the healthcare sector and its use of telehealth are prime targets for cybercriminals.

On March 3, 2022, the U.S. Department of Health and Human Services Office of Information Security (HHS-OIS) released Health Sector Cybersecurity: 2021 Retrospective and 2022 Look Ahead, which highlights notable cybersecurity events and government actions across an array of agencies. In this report, several types of attacks, ransomware, and government initiatives are addressed.

These items are what make the National Institute of Standards and Technology's (NIST) Special Publication dedicated to telehealth both timely and important. NIST-SP 1800-30, Securing Telehealth Remote Patient Monitoring Ecosystem is a must read for any person that creates, receives, maintains, and/or transmits PHI, whether they are in the public or private sector. Here is a key take-away: "Without adequate privacy and cybersecurity measures, unauthorized individuals may expose sensitive data or disrupt patient monitoring services." This article highlights some of the key take-aways that healthcare delivery organizations (HDOs) and patients should be aware of in relation to remote patient monitoring (RPM) issues to treat patients at home.

NIST-SP 1800-30A Specifics

It is important to appreciate that multiple actors (e.g., telehealth platform providers, HDOs, and patients) are engaged in RPM solutions in relation to a patient's clinical care.

Here are some key take-aways from the 7 Sections of NIST-SP 1800-30 to help mitigating growing security and privacy risks:

- RPM is different in that monitoring equipment is deployed in the patient's home, which may not offer the same level of cybersecurity or physical security control to prevent misuse or compromise.
- Without privacy or cybersecurity controls in place within the RPM ecosystem, patient data and the ability to communicate with the care providers may be compromised.
- Apply the NIST Privacy Framework to broaden an understanding of risk.
- Educate patients, despite the onus of technology being on the provider or business associate.
- Biometric devices are becoming more prevalent, which means additional risk.
- Risk is "a measure of the extent to which an entity is threatened by a potential circumstance or event…" Identify threats.
- Appreciate the different types of threat taxonomy (i.e., phishing, malicious software, ransomware, command and control, credential escalation, operating system or application disruption, data exfiltration, denial of service attack (DoS and DDoS), and transmitted data manipulation.
- Assess vulnerabilities and employ a prevention, detection, and correction framework.

In sum, this NIST publication references different NIST publications—many of which align with the HIPAA Security Rule.

Conclusion

It is important for providers to educate patients as to the risk of disclosing PHI by failing to implement basic safeguards, such as privacy settings or encryption. A disclaimer is a prudent course of action for providers to have patients acknowledge. Providers should also be aware of selling a patient's data to a third party, which carries significant potential civil and criminal liability without advance and specific written consent of the patient. NIST-SP 1800-30 is a comprehensive guide, which should not be overlooked by any person participating in the telehealth and/or remote monitoring ecosystem.

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

Thoughts Had…Lessons Learned®

The Selling of Marcus Welby, M.D.

Part One

Introduction

The first article I ever wrote for BC Advantage (BCA) Magazine was for the March/April 2017 issue. It was wishfully titled, "An Alternative to Private Practice Extinction." It is hard to believe how much the healthcare industry has changed in those five years—and continues to rapidly change. My observation of the responses by the Independent Physician Owned Practice (IPOP) to these changes and challenges is that the majority of IPOP physicians chose to travel one of the other paths I mentioned in my article instead of remaining on the path as an IPOP like I had recommended. COVID and the responses by our U.S. leaders, the American people, and others in the world in general have definitely had an unprecedented, in my lifetime, dynamic effect on the way medicine is currently practiced in the U.S., as well as everywhere else in the world, and the way medicine will be practiced in the future. These events in the past two plus years certainly affected the small IPOP in the U.S., and probably accelerated the decision for many U.S. IPOP physicians to not continue down the IPOP path. It also probably made many U.S. physicians decide to retire early if they could afford to do so. No matter what your political affiliation or persuasion is, or who you think was responsible for COVID, or what you think about the responses of our leaders and the other world leaders, any rational person will agree that the COVID pandemic has changed our country and the U.S. healthcare delivery system, as well as has changed the world and our lives now and forever.

It was suggested to me that I title this article, "Death of the Independent Practice." I decided not to take that recommendation, because the independent practice didn't die; many physicians gave up and sold out. And in many cases, the physicians just gave their practices away and did not even try to sell them. Physicians lost the IPOP because the physicians refused to accept the reality of corporate medicine, continued to deny the coming healthcare delivery system changes, and tried to hang on to the Marcus Welby, M.D. model. Physicians have been engaged in this self-destructive denial behavior for several decades. This did not happen overnight. The loss of the IPOP could have been prevented. Most of you reading this article are probably too young to remember the television drama series from 1969-1976 about the kindly old family practitioner (Robert Young) and the "practice style" conflicts he had with his younger new colleague (James Brolin) in the Marcus Welby, M.D. series. Both physicians were well-meaning physicians, as most physicians are, but they could not find a common ground on how to structure operations of the practice for patient care and to manage their medical practice from a business perspective. Sound familiar? Before I started working with physicians, I did not realize how on point and prophetic this physician series was in identifying the medical practice business and management issues and predicting the future of the IPOP—and the causes for its demise. Perhaps the IPOP could have been saved if the physicians had been able to overcome their innate (wired) personalities that physicians have that allows them to be physicians. Well-meaning, but in most cases with physicians, they are inflexible in their decision-making and opposed to any change of any type at any time. And, also opposed to doing anything that is not their idea, or not their way. My research and observations tell me that you cannot change a person's innate (wired) personality traits but only find specific triggers for each specific individual that allows you to temporarily change the individual's behavior based on their individual wiring traits and the triggers that affects that individual. This trigger pulling does not change the person's permanently wired personality traits. To quote a medical researcher who studied the effects of genetics on individual behavior (nurture versus nature), "Genetics load the gun, but the environment pulls the trigger" (Dr. Judith Stern). My interpretation of individual behavior based on this theory is that if you pull the environmental trigger and the gun isn't genetically loaded, nothing happens. If you don't pull the environmental trigger and the gun is genetically loaded, still nothing happens. The corollaries also apply to this observation. A discussion of what is motivating versus what is manipulating that wiring is a discussion for another article. See the chart that follows for the differences in the characteristics of the physician versus the manager. Unfortunately, there are too many of "they" out there who understood this behavior game and wanted the physicians to continue in their practice conflicts with each other, and to continue their practice self-destructive behavior because they wanted to take over control of the business of medicine and the IPOP—and they did. We are going to discuss the "they."

Follow the Dollar

I wrote an article for BCA Magazine, for the January/February 2018 issue, titled, "Follow the Dollar." Most physicians I know have always wanted to pursue the dollar for themselves, but not follow the dollar and understand how the dollar flowed into and out of their practices that determined what was left for the physician to have as compensation for physician labor. The physicians certainly didn't have, and most still do not have, any concept of or understanding of practice profit or practice EBITDA. I also wrote an article for BCA, titled, "Do You Have An EBITDA?" Most physicians I know also do not want to share with anyone what they perceive as their dollars. In practices with multiple physicians, whether owner physicians or employee physicians, this is always an issue—many times contentious about who is entitled to what part of the practice dollars. Yes, they are practice dollars and not physician dollars. I have done hundreds of physician compensation plans in my career over the years. The owner physicians just want the maximum dollars to be left in the practice checkbook so the owner physicians can have those dollars that he/she thinks they deserve. Of course, each physician's concept of what he/she deserves is different. The real problem is that most physicians do not make a distinction between physician labor value and the practice organizational value of a practice, which allows all the physicians a place and structure to practice and to use physician labor to earn a living. Therein lies the physician/practice conflict and the opening for us businesspeople to come in and take over. I will not go into any details about that here. Just to say that from a business perspective, where there is conflict, there is opportunity—regardless of the type of business. Also, just because a physician owns a practice does not make the physician a businessperson. The physician assumes that because he/she has the academic aptitude to go through all the training necessary to become a physician, that once they own a practice, the business part is simple, and the physician can become a good businessperson through osmosis. Sorry, it does not work that way—at least not anymore. I recommend you read my two-part article, "Eat What You Kill" in the May/June 2017 and July/August 2017 BCA issues if you want to go more into the "Whose money is it?" debate.

While the owner physicians were following their checkbook balance in their practices, focusing on how much money they could take home instead of focusing on the business of medicine, we businesspeople were following the National Healthcare Expenditure (NHE), i.e., the total healthcare dollar. The U.S. NHE for 2020 was $4.1 trillion. Yes, that is with a "T." That "T" was 19.7% of the U.S. Gross Domestic Product (GDP). For comparison, defense spending in 2020 was only 3.2% of GDP. NHE is projected to grow at 5.4% a year now through 2028. Medicare is 20% of the NHE and Medicaid is 16% of the NHE. In 2020, 62.6 million people were enrolled in the Medicare program, which equates to 18.4 percent of all people in the United States. In 2021, 84.8 million people were enrolled in Medicaid and CHIP in the U.S. This equates to 25% of the people in the Unites States. That is over 43% of the total U.S. population already on Medicare or Medicaid. Some people are on both. Since people are living longer and the number of low-income individuals is increasing, the number of enrolled is going to continue to be explosive in these single-payer healthcare insurance plans. The government regulates and controls these plans and the spending, but

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private insurers get paid a lot of money to administer these plans without any risks to the private payer for patient healthcare claims. The government (taxpayer) pays the bills. The 907,426 businesses in the Health Care and Social Assistance sector topped all other businesses with 20 million employees and over $1 trillion in annual payroll in 2018. Significantly higher now. Employment in healthcare occupations is projected to grow 16 percent from 2020 to 2030, much faster than the average for all occupations, adding about 2.6 million new jobs. While healthcare occupations are projected to add more jobs than any of the other occupational groups, there is already a shortage of healthcare workers—the shortage is projected to grow rapidly. So, that massive number of new workers in healthcare will not make up for the current and future shortages. More specifically, the physician shortage is projected to be over 70,000 by 2025 and double to 140,000 by 2030. That is probably optimistically low. It will likely be higher because academically capable individuals will seek other, more personally rewarding, lucrative, and less stressful careers rather than becoming physicians. According to reports, the average debt of a physician getting out of residency is $250,000. The shortest medical school plus residency program is seven years. Law school is three years. That physician shortage is having, and is going to continue having, a direct disastrous effect on access to care and the quality of care provided to patients. Studies also show that the physicians graduating now are not as skilled at being physicians as the previously graduating physicians were. And it is still trending downward with regards to new graduating physicians in both the numbers and in their skill levels.

Private Health Insurance is 28% of the NHE—and falling. That is because Medicare and Medicaid participants are rising, and employers are providing fewer healthcare benefits to employees. Employers are doing this by changing employees from W-2 employees to 1099 independent contractors. This allows the employer to not have to pay any benefits. The employer is also reducing the number of employees by outsourcing business services to foreign countries. India is a very large resource country for many outsourced healthcare business support services, and other U.S. businesses, as well. Even the U.S. government and U.S. state governments outsource jobs to India. I have been doing business with companies in India for a couple of decades. China and Japan are trying to catch up with India. I am sure many readers and practice patients have experienced this outsourcing experience first-hand. And many have not had positive experiences.

If the employer does not provide private health insurance coverage for its employees, the individual is not going to be able to afford private health insurance for themselves—period. Most Americans cannot afford private health insurance now. Many employers are already requiring the employee to pay a larger portion of the employee's health insurance premium. Many employees cannot afford this additional reduction in their paychecks and simply drop out of the employer's plan and go without health insurance.

Private health insurance has previously paid physicians higher reimbursement rates than Medicare. Most state Medicaid rates pay significantly below Medicare rates, and most are so low in many states that many physicians refuse to see Medicaid patients. Some private insurance companies also pay physicians less than the Medicare rates. There is no question that reimbursement for physician services will continue to drop while overhead to operate a medical practice will continue to rise. That means physician compensation will continue to fall at a steep decline, no matter who owns the medical practice. Physicians forget that they are "overhead" to the healthcare system. Physicians are just very specialized, skilled, high-priced labor in the healthcare system. If a health insurance company or the government pays a physician $75 for a service instead of $100, then the health insurance company just made an additional $25 in profit, and the government reduced its costs by $25. However, the physician just lost $25 in profit, i.e., compensation. The health insurance company and the government get to decide what they pay the physicians for physician services. Given the recent high inflation that is projected to continue upward for everyone in the U.S., the patient is certainly not going to be able to make up the difference to pay the physician for the reduced reimbursement to the physician by third-party payers. One of the major influences on the demise of the IPOP was health insurance, because it became the feeding trough for physicians. The physician no longer had to think business in order to get paid. Getting paid for physician services required no effort on the physician's part, except to fill out an insurance form and send it to the insurance company. If there is an intermediary responsible for paying the bill and that intermediary is between the customer and the seller, regardless of the business, this is always going to create additional business issues and higher costs. The physician feeding trough system was not as large and as available to the Marcus Welby, M.D. model. If gas, food, housing, transportation, and other crucial living expenses continue to rapidly increase in costs as projected, patients are going to have to decide whether to go see the physician at all when they are sick, or instead, feed their families and do self-care. Almost no one is going to go for well check-ups. The healthcare delivery system is going to drastically change. Limited access due to provider shortages and higher costs to the patient are going to be the main causes. There will be more U.S. healthcare rationing. All countries ration healthcare to its people in some way, because there are a limited number of resources and dollars available for healthcare.

How Did They Do It?

According to a study from the Physician Advocacy Institute (PAI), only 30 percent of U.S. physicians were independently practicing medicine at the beginning of 2021, while 70 percent reported being employed by hospital systems or corporate entities. Twenty years ago, I predicted that at least 50%, and probably 80%, of the independent physicians practicing then would be employed by someone else by 2020. I was close. I emphasize corporate entities because that is the IPOP's main enemy/competitor in the IPOP practice survival game. Hospitals hiring physicians were not going to be able to bring down the IPOP. Most physicians are fully aware of hospital systems employing physicians. Many became employed by hospitals and then left to go back into private practice or to work for corporate entities. There are different economic factors at play in those hospital/physician hiring dynamics. The new physician/hospital model is the Physician Services Agreement (PSA). That is a different economic incentive model and a discussion for another article.

Very few physicians I have met have any concept of corporate entities and investors owning medical practices, especially the ownership of U.S. medical practices by foreign corporate entities and foreign investment firms. These foreign investment firms often use money from the foreign government where the foreign investment firm is located, in order to buy the U.S. healthcare companies. I will discuss this and foreign ownership of the U.S. healthcare system later in this article. The growing foreign ownership of U.S. healthcare was my impetus for writing this article and the key takeaway point I want you to get from this article. Before discussing foreign ownership of the U.S. healthcare system, it is critical that you have an understanding of the history of corporate medicine and what got us to where we are now.

It was inevitable and easy to predict that physicians were going to eventually fail to be able to continue as an IPOP because of the increasing business complexity of successfully operating a medical practice. Remember, physicians are not businesspeople; they are doctors. Most of the healthcare system is run by trained businesspeople and not by medically trained people—or doctors. Only physicians and other Advanced Practice Providers (APP) are licensed to independently provide medical care directly to patients and to direct the other healthcare services a patient needs and receives. Prescription writing is a good example. The balance of the healthcare system and the people in it just provides labor, facilities, equipment, supplies, and other support services to the providers so that the providers can provide direct medical care to the patients. Just like the railroad thought it was in the train business when it is actually in the transportation business and the train is only its tool, the physician thinks he/she is in the doctoring business when he/she is actually in the healthcare delivery services business and the doctoring is his/her tool. Both the railroad and the physicians had it wrong and both the railroad and the IPOP failed in "independent" business because doing business became more complex and more competitors entered their businesses. I have been trying to explain this concept to physicians for over four decades. Based on the 70% employed physician statistic, obviously I nor anyone else have been successful at convincing physicians to do what is necessary to survive as an IPOP. Maybe most physicians just really did not want to be businesspeople after all.

As previously stated, I have been preaching the IPOP

gospel for over four decades. The sermon has been modified and given in many different formats, and slightly updated over the years, but my physician business Bible has been the same because the business Bible is the same. I was rummaging through some of my old materials and found a presentation I gave in 2007. Two of my slides (I used to present with real slides) are a good summary of what is driving the inevitable change in the IPOP, as well as in the entire healthcare industry. I decided it was worth the space to include the contents below.

Where Are We Going?

1. There is a finite amount of dollars in the healthcare system.
2. Physicians are not going to get what they want.
3. Some physicians are going to do better than other physicians.
4. Some physicians are going to go out of business.
5. Different specialties will be competing for the same medical services.
6. Old business strategies will not work.
7. It is never going to be the way it used to be.

Stakeholder Viewpoints

1. **Patient -** I am entitled to the best healthcare money can buy and someone else should pay for it.
2. **Physician -** I should be able to decide what care patients receive and how much I get paid for the care I provide, and I do not want to have to collect payment from the patients.
3. **Government -** The government has the right to control the costs of healthcare and decide who receives healthcare and what care is delivered.
4. **Employer -** My employees demand that I pay for their health insurance, but the rising healthcare benefit costs reduce my profits, and I need to increase my profits.
5. **Insurance Company -** I am in the business to make a profit; paying out patient claims increases my overhead and reduces my profits.

As mentioned earlier, physicians are "wired" differently than businesspeople. I have included the slide information below, which was created by an M.D. to explain the differences in thinking of a physician versus a manager when it comes to thinking about business and operating a medical practice. I have my own modified version of this chart but wanted you to see the original and how a physician sees the differences between physicians and businesspeople. As Myers & Briggs will explain to you in their sixteen personality type profiles, different personalities pursue and are skilled at different jobs. This is not to say that physicians cannot learn the academics of being a businessperson. Most physicians just do not have the interest or the personality characteristics to be a businessperson. As the majority of physicians I have known over the years have told me, they just want to be a doctor, care for their patients, and then go home and do other things they enjoy doing—and have the money to do those things. They definitely do not want to spend their time and energy running the business side of their medical practice. I have been able to make a good living because of that physician business philosophy. I take care of the practice business and the physician takes care of the practice patients. I have tried to teach physicians how to be business owner decision-makers and not practice administrators/managers. Many physicians (70%) have decided that they do not want to be a business owner at all, just a doctor. I agree with them, as long as while being the doctor, the physician goes back to establishing that old time doctor/patient relationship to become a patient advocate and liaison in this complex healthcare maze.

Physician vs. Manager Characteristics

Physician	Manager
Is autonomous; makes decisions alone	Uses teamwork; is probably involved in line reporting
Works one-to-one	Works primarily in groups
Is patient-oriented	Is organization-oriented
Is crisis-oriented	Is a long-range planner
Is quality-oriented	Is cost-oriented
Enjoys immediate tangible results	Must often delay gratification and enjoy process
Is accustomed to controlled chaos	Has a planned schedule with inherent flexibility
Sees people as material or objects	Sees people as resources to manage
Is a doer	Is a delegator; gets things done through others
Reacts	Proacts
Is authoritarian in practice style	Delegated authority participative style
Has specialist orientation	Has a generalist orientation
Is a classical scientist	Is a social scientist
Is discipline-oriented	Is socially oriented

Source: David B. Nash, M.D., Director of Health Policy and Clinical Outcomes, Thomas Jefferson University Hospital & John B. Combs, M.D., VP of Medical Affairs, MultiCare, Tacoma, WA

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The Selling of Marcus Welby, M.D.

Below are a couple of additional PowerPoint slides I created for a separate presentation that I gave in 2007. It was given to a large IPOP of family physicians that I helped start and they were my clients for over 20 years. That IPOP is now owned by a management company (corporate medicine). The original IPOP physicians had the right model, at the right time, and were willing to engage the necessary businesspeople to guide them and do the practice trench-work for the practice while the doctors did the doctoring and the owner decision-making. So what happened? The young physicians coming out of residency and joining the practice only wanted large salaries, no call, and nothing to do with the business of medicine. All of those young replacement physicians got their wishes, except the large salary part. They are now just hired help for a large business firm. They are part of the 70% that is still growing.

Who Will Own Medical Practices?

- Health Systems
- Institutions (Hospitals, etc.)
- Retail Chains
- Private Investors
- Physicians

Conclusion

- The future ain't what it used to be and never will be.
- The quality of healthcare providers is declining.
- Healthcare is a $3 trillion a year "industry."
- Healthcare is 14% of the GNP (GDP).
- Everyone wants a piece of the action.
- No one is going to give it to you; fight for it.
- If you don't have a "fighter's heart," become "hired help."
- It is doable!

I told physicians many times over the years that physicians were so worried about socialized medicine that they did not see corporate medicine coming, which would run them over—and it did.

How Does the Investor Make Money?

What are the investors really buying? They are not buying the actual medical practice, the actual treating of patients' part of the practice, or the medical practice legal entity. Some states allow the corporate practice of medicine, but many don't. That's a different discussion. The short version is that in many states, anyone who is not a physician cannot own the patient treatment part of a medical practice. To avoid this issue, the investors (businesspeople) had to create a new business model to accomplish their objectives. In my first article in BCA Magazine that I referenced in the introduction, I explained this separation of the patient care services part of a medical practice from the business support services part of a medical practice. This was and is the business model I have been using and recommending to IPOP physicians as a survival technique since businesspeople started buying medical practices. There is nothing that prevents a physician from using the same business model to survive as an IPOP that the businesspeople are using to take over medical practices. Most physicians (including some of my clients) told me I was crazy and did not know what I was talking about and simply ignored me or terminated my services. I am still an independent businessperson while most of those physicians are not independent physicians anymore. They didn't know how to think like their business competitors.

When I quote, "buying a medical practice," there are actually two separate legal entities created to accomplish this. The patient care services part of the medical practice remains in place while a new legal entity is created to be the new business support services entity. The physicians still own the patient care services part of the medical practice, but there are no assets remaining in the medical practice. The revenue flow from the medical practice patient care services and the patient accounts receivable created by the physicians in the medical practice are processed through the patient care services part of the medical practice but are owned and controlled by the business support services new entity. For brevity going forward, I will use the acronyms, PCS for the patient care services entity, and BSS for the business support services entity. The physicians simply remain employed by the PCS entity and continue to provide and control (mostly) patient care as they had always done. However, the physician compensation within the PCS entity is controlled by the BSS entity. This is either as a fixed salary, "Eat What You Kill" formula, or some combination of both. This is what most physicians said they wanted, and why 70% of physicians are not in an IPOP anymore. There is an old Chinese proverb that says, "Be careful what you wish for; you might get it." All the multi-state physician mega groups I am aware of are structured this way. Many not-for-profit hospitals are also structured this way with a separate legal entity set up to run and own the business part of the hospital operations. Just because the hospital is "not-for-profit" under the IRS tax code does not mean there is not profit being made off the hospital services by an outside for-profit entity. The for-profit entity, if operated effectively, is making a lot of money for someone off the not-for-profit hospital business. Just because a hospital is not-for-profit does not mean it is cheaper for patients or better care for patients. There are for-profit hospitals that provide patients cheaper and better care than some not-for-profit hospitals.

I get asked all the time by physicians, "How can investors make money off my practice, when I am making less money all the time?" I tell them, "You are not a businessperson and you do not understand the business dynamics of your medical practice. You just see money coming into the practice and make no distinction between the monetary value of the practice versus the monetary value of the physician labor." I also ask the owner physicians why they do not pay their employed physicians the same amount that they pay themselves when the employed physician is doing as much or more patient care than the owner physician. Their answer is usually, "Because I own the practice." Their explanation goes no further than that because the owner physician doesn't understand why, from a business perspective, he/she does this. As the owner physicians see it, they simply deserve more money without any specific business reason.

The basic economic business model as presented by Adam Smith in his book on capitalism, The Wealth of Nations, is shown below. Adam Smith was a Scottish social philosopher and political economist who wrote a major influential book on capitalism in the 1700s. You just never know where and from whom you are going to find your answers.

Business Entity Stakeholders

Investor (Capital) - Investment/Risk-Return
Company (Product/Services) - Provide/Sell
Worker (Labor) - Time/Compensation
Customer (Buyer) - Pay For Goods/Services

In the model we are discussing here, separate from the "original company" (medical practice), a "new company" (NewCO) is created to be a "vendor" and provide contracted, controlled business support services to the "original company" (medical practice), which then makes the "original company" a captive "customer" of the NewCO. Thus, the new investors in the NewCO do not invest in, buy, or become liable for the original company legal entity, but buy the assets of the original company. This arrangement is legally structured and called an asset purchase agreement by the NewCO and is not a purchase of the original company, the legal medical practice.

The best example to explain this structure is the original PhyCor model. PhyCor was one of the pioneers of this new business model and the "buying" of medical practices. PhyCor focused on medium to large primary care practices. The physician payment systems at the time were changing to be driven through primary care to control healthcare costs by paying monthly capitation to the primary care physician for controlling and limiting the referrals to specialists, laboratories, diagnostic services, and hospital admissions. That is why PhyCor focused on primary care. The primary care physician got paid for the number of patients for which they were the PCP for and not based on the amount of care they delivered. Therefore, the fewer patients the PCP saw, the lower the PCP overhead but the PCP revenue remained the same. Thus, more profit for seeing fewer patients and providing less patient care. This "capitation" model did not work for several different economic incentive reasons other than what I just described. The physician payment systems went back to mainly "fee for service" and "open access" to physicians for patients because the capitation system was becoming more expensive than the open access, fee for service model, and providing worse patient care.

Under the PhyCor model, PhyCor (investors) purchased all of the assets of the medical practice, which included equipment, accounts receivables, and even sometimes real estate. PhyCor then entered into a 40-year management agreement to run the medical practice. PhyCor did not own the medical practice but did have absolute control over how the medical practice was operated on a business level. The physicians were given an opportunity to own some minority shares in PhyCor. The founder investors of PhyCor owned the majority of, and the controlling interest in, the stock of PhyCor. Eventually, PhyCor did an IPO and was traded on the NASDAQ. You can go on the internet and read about the trials and tribulations of PhyCor. The IPO gave the founder investors, who were four executives who previously worked for HCA, an opportunity to cash in their equity value, regardless of what happened to PhyCor or its physicians in the future. The basic model, without going into details, was that PhyCor charged 15% of the medical practice receipts after operating expenses, but before physician compensation, as its management fee. PhyCor got to control and decide what was in "operating expenses," which provided PhyCor security for their management fees. Some of the operating expenses were support services, such as billing, that PhyCor was providing to the medical practice and thus PhyCor BSS was making a profit from selling billing services and other business services to the medical practice. PhyCor was going to make money from its man-

agement fees and selling support services to the medical practice, whether the physician got paid (depending on each physician's compensation agreement) or the physicians and PhyCor made a profit from the medical practice. There was some "sharing of profits" of the medical practice between the medical practice physician owners and PhyCor, if there were any profits generated in the medical practice. Remember, the medical practice for patient care was still owned by some of the medical practice physicians. The catch was, the only control the medical practice physicians had over the medical practice was the direct treatment and care that the physicians provided to the patients. This arrangement protected PhyCor from malpractice lawsuits but did not protect the physicians. Everything else, and I do mean everything, was controlled by PhyCor. This information is not anecdotal or hearsay, because in the past, I have been involved in deals with PhyCor on behalf of some of my physician clients. I have taken them into and out of PhyCor deals. It was both educational and challenging. Many physicians were financially devastated in their business dealings with PhyCor because of the Physician's business approach to the deal and not because of anything illegal or deceptive that Phycor did. I know one group of physicians personally who told me that they lost $10 million in their dealings with PhyCor. Again, it was not because Phycor did anything illegal or deceptive. That's back when $10 million was worth a lot more than it is now, though still no small amount today. Fortunately, my physician clients may have had a challenging and stressful experience going in and out of PhyCor but did not financially suffer and were able to reestablish and go back into their IPOP. This is not to imply that all deals that physicians did with PhyCor were bad for the physicians, but that physicians making the transition from the Marcus Welby, M.D. model to the corporate medicine model needed to understand the challenges and pitfalls; which many did not. Business deals are about risks and reward; not labor. Just like good doctors know how to do good "doctoring", good businesspeople know how to do good "businessing". If the physician is doing a deal with corporate medicine by himself or herself without the proper business team, it is not going to be a fair fight, and the physician will lose every time. Business people don't doctor.

Hopefully, the above provided some insight into when the corporate medicine model started and how in general it works. The model has changed very little from a business perspective. As I shared, I first saw this model in 1991 in my dealings with PhyCor, which was started in Nashville in 1988. At that time, the NewCO BSS was called a Physician Practice Management Company (PPMC). There are now many different names given to these business companies that own the business part of a medical practice. No matter what you call it, PPMC, MSO, BPO, etc., the basic business model, business structure, and business principles are the same. The key thing to remember about corporate medicine is that there are two separate legal entities: the medical practice that provides direct patient care services, and the NewCO that provides all business support services and management to the medical practice. The NewCO does not control the physician medical care decision making provided to the patient by the provider, nor is NewCO liable for the patient care provided by the medical practice and the physicians/providers.

"The Rest of the Story"

The title of this section is from Paul Harvey who had a segment on his radio show under that name and wrote books using that title. As I said, when businesspeople decide to do serious big business with physicians, it is not a fair fight. To be fair to physicians, they were specifically targeted by certain people in our government who wanted to control healthcare spending both in the public and private sectors. The main driving force for this was increased spending for U.S. healthcare, but this was not the amount being paid to physicians; it was the amount paid for the new and growing science of medicine and medical technology. This growth had been having exponential increases since 1950 due to the advancements in the microchip, which went from an 8-bit microcontroller to a 32-bit microprocessor. The healthcare technology game was afoot. The computer technology allowed for new and complex diagnostic machines, lab testing, and robotic medicines. The science of medical knowledge and new procedures were also increasing because of the advanced technology. This technology also allowed for the development of everything more quickly, which included pharmaceuticals and therapeutics for patients. The COVID vaccine is an example. The "doctor's bag" had given way to the "medical computer bag." More medical tools, processes, and procedures were being developed daily to provide more and diverse treatment options for patients. Hopefully, it was better treatment options for providing more successful care to more patients. This expansion was going to be very expensive and increase healthcare costs exponentially. Here lies the business opportunities. Our government realized that physicians were the only people in the healthcare system that decided what patient care services a patient received and what healthcare technology, processes, and procedures were ordered for patients. Our government decided this was too much power and control over healthcare spending for physicians to have. Our government decided to regulate and control how physicians could care for patients (how to practice) and still get paid for it. Thus began what later became known as the government "death panel" rationing of healthcare. Remember, all countries ration healthcare services to their population in some way. Most socialist governments, because the government pays for most of the population's healthcare, do it through measuring the costs of the care for an individual against the individual's potential economic value to society during the individual's remaining life expectancy. I am sure you have read stories about other countries denying or delaying care to a patient because of the costs of the care or the age of the patient. The U.S. healthcare system did it primarily through letting the insurance companies decide what they would pay for healthcare services method. The U.S. government wanted to control physician ordering of new expensive treatment options, and the costs of those treatment options, as well as the physician's ability to make money from anything in healthcare aside of the physician's direct labor care of the patient. It was never about "managed care"; it was always about "managed dollars." The U.S. government did it to physicians—and is still doing it.

The Government's Toolbox

I am not going to go into details about how this was done by our government or all the specific impacts that these new government-controlled regulations had on physicians treating patients, the costs to the physician practice to comply with these regulations, or the revenue physicians lost due to these regulations. That's not an article but a book. I do want to briefly mention a few key regulations and the general business disadvantage they created for physicians because the regulations were targeted at the physicians and not at others in the healthcare industry.

Stark Law

Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn), also known as the physician self-referral law and commonly referred to as the "Stark Law": Prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies.

RBRVS

The resource-based relative value scale (RBRVS) is the physician payment system used by the Centers for Medicare & Medicaid Services (CMS) and most other payers. In 1992, Medicare significantly changed the way it pays for physician services. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on RBRVS.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. HIPAA covers both individuals and organizations. Those who must comply with HIPAA are called HIPAA-covered entities. A "Business Associate" is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity.

The above descriptions are listed as a reminder, so that physicians understand what each law/regulation is, how it really works, and who must comply. Most physicians I know do not like the laws/regulations as they have reduced practice revenue, increased practice overhead, and reduced physician compensation. I will make some brief comments about the three above laws/regulations to provide a general overview of how these gave the physician a business disadvantage relative to non-physicians in the healthcare industry.

L.E. Shepherd, Jr., BS, MSA, has successfully provided comprehensive business advisory and management services to the healthcare industry and others for over 30 years. With his comprehensive business experiences and extensive speaking engagements, along with his many years of relationship building in the healthcare industry, Mr. Shepherd brings a unique perspective and set of skills to solving the complex business problems facing physicians, businesses, and the healthcare industry today and tomorrow. www.medbizonics.com

Note: These comments and further discussion will be attended in Part Two of "The Selling of Marcus Welby, M.D." in the upcoming July/August 2022 issue. Part Two will discuss foreign takeover of U.S. healthcare, unveiled secrets, and prompts for additional research and reflection, in order to survive in the new globalist U.S. healthcare system. Stay tuned.

Offsetting

Staffing Shortage-Induced Revenue Loss

Exacerbated by pandemic-induced burnout, the Great Resignation, vaccine mandate-driven terminations, and rising retirement rates, the chronic shortage of billing, coding, and audit professionals will continue to worsen over the near future.

And it comes at a time when demand for these positions is skyrocketing, with the American Hospital Association (AHA) projecting a 13% growth in medical records, billing, and compliance positions – the fastest growing healthcare white-collar administrative professions – by 2026.

As a result, healthcare organizations struggle to keep revenues flowing with too few qualified professionals to manage critical billing and compliance processes. The impacts are already being felt. For example, the AMA projects hospital revenue losses between $53 billion to $122 billion in inpatient revenue and another $64 billion in outpatient revenues in 2021.

These devastating figures put health systems under more significant pressure to optimize their billing, compliance, revenue cycle, and revenue integrity capabilities to improve revenue flow while outpacing reduced staffing levels that increase the risk of compliance issues and errors that cause an increase in delayed or denied claims.

An analysis by Hayes of more than $100 billion worth of denials and $2.5 billion in audited claims found that throughout the first 10 months of 2021, 40% of COVID-19-related charges were denied, and 40% of professional outpatient audits for COVID-19 and 20% of hospital inpatient audits failed.
The review of more than 50,000 providers and 900 health systems also identified bundling errors as the top culprit behind 34% of inpatient hospital charge denials, each with an average value of $5,300. Internal auditors also identified a significant number of concerns centered around disagreements between procedure codes and diagnoses, contributing to 33% of all internal audits containing "disagree" findings.

The numbers are staggering. But they can be turned around.

By examining the efforts of auditing, billing compliance, and revenue cycle teams, healthcare organizations can mitigate billing compliance risk, reduce revenue leakage, and improve cash flow, even with fewer billing and coding professionals on staff – particularly with some help from technology.

The Power of Automation

Mining and analyzing retrospective claims data can help coding teams identify and resolve compliance and revenue risks. For example, one of the organizations we work with has more than 50 facilities leveraging risk-based analytics tools to find a widespread systemic risk with modifiers being missed from its professional outpatient claims because of a lack of system edits in the billing system rules. This led to it recovering millions of dollars in lost revenue and educating the provider ecosystem beyond the ones they audited.

In contrast, prospective claims analysis can ensure correction of errors before claims leave the facility to mitigate the risk of denials and delays. Both also help identify critical risk areas and allow revenue cycle teams to identify and benchmark provider patterns without adding to the burden of billers and coders who are already stretched to their limits.

Leveraging Advanced Analytics Tools

Denials are a leading indicator of systemic billing and coding issues among many health systems. Hence, listening to the denial signals and acting upon the root causes can save millions of dollars for a health system. However, manually mining thousands upon thousands of claims lines across denials to identify problematic trends and detect anomalies in at-risk claims to accelerate the revenue cycle and improve association processes is a non-starter for resource-strapped coding, billing, and compliance departments. Thankfully, advances in automation, augmented intelligence (AI), and natural language search (NLS) make it feasible to put the power of retrospective and prospective audits to work, boosting revenues without overwhelming teams.

Specifically, advanced analytic discovery tools exist that can comb through denials within minutes and deliver actionable insights in near real-time, enabling a unified revenue integrity-based approach that uses claims data to help focus auditing efforts and reduce denials. This, in turn, allows healthcare organizations to increase the impact of existing compliance programs by more rapidly identifying and addressing risk, resulting in improved revenue flow and reduced risk of takebacks.

When these tools are integrated into a single auditing and revenue integrity platform that incorporates a robust analytics dashboard, the process is further streamlined, enhancing improve-

ment efforts and providing an at-a-glance understanding of performance by enabling efficient prospective and retrospective audits. Further, by protecting the organization from compliance risk, optimizing reimbursements, and improving revenue retention, a solid business case exists for the required investment – a business case that can override budget constraint arguments by converting what is a cost center into a source of recovered revenues.

Health leaders can get out in front of these potential issues, even with understaffed coding and billing departments. The best of these approaches draws on the power of technology-enabled processes to address front and back-end auditing and contain risk associated with upcoding, bundling, and eligibility issues. See graphic below.

Closing Thoughts
Technology and automation are not silver bullets, but can be powerful tools in driving change, solving labor shortages, and accelerating outcomes when embedded with people and processes within healthcare organizations for revenue integrity programs.

Organizations can take the below outlined steps in driving successful revenue integrity outcomes:

1. Define core objectives, metrics, and outcomes as part of a series of focused pilots that can be executed in an agile manner.
2. Assess how effectively you are leveraging billing and payments data to identify targeted risks in the areas of compliance, coding, and denials. For example, ask yourself, "Are we closing the loop between our auditing processes and denial outcomes?"
3. Train your teams in advanced analytics tools that can be successfully integrated within your defined revenue integrity processes to identify compliance and revenue risks.
4. Set up a cross-disciplinary steering committee of compliance, revenue cycle, coding leaders who can learn from the data and insights and scale remediation across their functional groups.
5. Scale the pilots to multiple areas of your organizations – e.g., facilities, physician groups, specific procedure and diagnosis areas, coder groups, etc.

Ritesh Ramesh is the Chief Operating Officer at Hayes and leads the customer experience and technology teams, overseeing product management, engineering, customer success, implementation/training, technical support, and security of the MDaudit Enterprise auditing and revenue integrity platform. Ritesh has more than 17 years of technology experience with deep expertise in emerging technologies, Cloud, Digital, and AI.

Before joining Hayes, Ritesh had a successful track record in the professional consulting industry, working with several business and technology leaders across multiple industries in driving next generation digital, analytics, and technology initiatives enabling customer experience improvements, revenue growth, and operational excellence in their respective businesses. Ritesh has an MBA from MIT Sloan School of Management and a Master's in Computer Science from the Illinois Institute of Technology.
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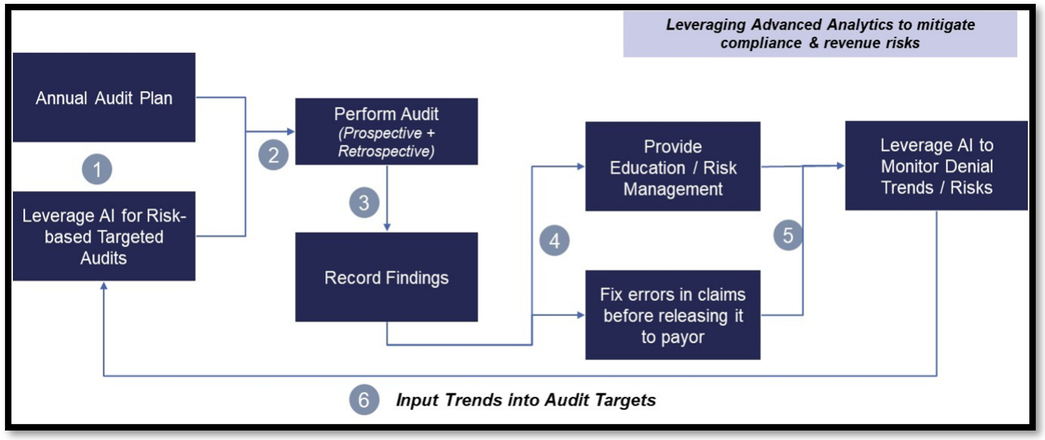

A holistic data-driven approach to closing the feedback loop between your compliance and revenue risks.

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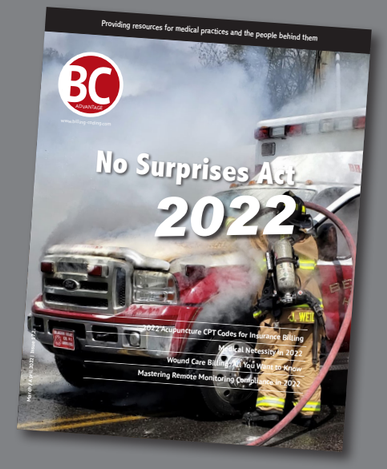

Top 5 Way Medical Practices Can Combat

Inflation

Inflation is affecting many businesses, but medical practices tend to see the brunt of its effects because of the way payment structures are dictated by insurance payers. Even more worrisome, practices have had to increase wages significantly and the current job market tends to favor employees.

In some instances, employees are asking for wages 20-30% higher than previous, and understandably can command these wages as there is fierce competition for skilled employees. While these issues are affecting many businesses, there are things medical practices can do to help ease the squeezing margins.

Outsource Business Functions

You might have a few administrative staff who have left, or you have positions you are trying to fill. Instead of competing in the fierce job market, you could look at outsourcing some job functions either temporarily or perhaps permanently. Often, you can find vendors that provide administrative services less expensively and provide a return on investment rather than having an equivalent full-time employee provide the service. This includes medical billing, credentialing, prior authorizations, and recruiting.

Credentialing is a great example as it generally doesn't take a full-time employee (depending on your practice size) and the needs of this function often increase or decrease depending on the time of year. Also, many reputable credentialing companies can complete credentialing more quickly or may have connections at the health plans if something goes wrong. One word of caution: also vet your vendors and ask them for references from current clients. It's always a good idea to ensure you are working with a reputable partner.

Review your Payer Mix

Many practices are often unaware of how poorly some insurance payers are paying the practice. Payers have notoriously reduced rates and often without any notice. The payer strategy to combat inflation is to lower rates, often at the expense of physicians in their network.

The best thing to do is to put together an analysis of all your top payers and add the allowable rates.

- Take your allowable rates and multiply by each CPT code.
- Take the number of evaluation and management visits and divide the total payer revenue by the number of encounters. This will give you the revenue by patient.
- Compare this between your different payers.
- Compare this figure to your costs.

You may find that you are accepting payers that don't cover your costs. It's time to negotiate those contracts or perhaps even stop accepting that payer altogether. This will improve your margins and profit.

Negotiate your Reimbursement Rates

Negotiating your reimbursement rates is one of the most important and fundamental aspects of running a successful practice. Rates tend to not change; therefore, if you wait three years before negotiating your rates, you are losing a significant margin. For example, if inflation is conservatively at 5%, after three years, you are making 15% less!

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The best scenario is to negotiate your contracts from the onset when you obtain them, and then every year, ask for Cost of Living Adjustments (COLA) - and account for inflation every year. If you already have contracts in place, it is wise to understand your rates, compare them to other payers, and negotiate to what you think is a fair market price. Thereafter, you can ask for COLA adjustments every year. In this situation, you want to ensure that your practice administrator has negotiated rates in the past. We have seen circumstances where payers actually try to lower your rates when you negotiate them, thinking that you do not understand the contract offer. You must ensure that you have modeled any contract offer to your current services and understand the financial impact.

Review Accounts Receivables and Collections

Because medical practices can't simply raise their prices, the alternative is to get better at collecting the money owed to you. Examples include reviewing your accounts receivable and understanding the percentage of money you are collecting. The industry standard is a 96% collection rate. If your collection rate is below that amount, you are likely leaving money on the table. Payers certainly don't make medical billing easy, but your medical billers should be focused on understanding why you are collecting anything below 96%. Run reports on denial trends so you can identify if certain operational procedures are affecting your collection rate.

Many practices also leave money on the table by having an inefficient patient collection system. Many patients still maintain the mindset that medical care is free or not paid by them, but in reality, we know most patients have an increased deductible that most don't meet. Therefore, your front office staff should review patients' deductibles and require the patient to pay upfront. If you have done a good job benchmarking your allowable rates, you should have no problem coming up with an accurate estimate of services and the cost-share that the patient should be paying upfront.

Improve Margins

The above items all improve your margins, but cutting costs where necessary is vital to any business. We live in an era where we tend to put everything on autopay and forget to even review what we are being charged for the many services we require as a business. This is where it is key to have financial reports every month that list all your business services. A monthly financial report will allow you to recognize when a cost or service has gone up and thus you can address that service or perhaps find another service provider. A few examples include your internet service providers, email hosting providers, clinical and administrative supplies, etc. When inflation is high, this is the fastest way to cut costs.

Conclusion

Running a medical practice is difficult - and not just when inflation hits. Payers have made the game very difficult for practices to remain independent. We are seeing a lot of consolidation, but many physicians prefer to remain independent or in smaller groups. The fundamentals of these points can help you avoid consolidation and take your practice to the next level. Understanding the nuances of your payments and how your payers are reimbursing you can set the foundation for the rest of your practice and future growth. Ensuring proper collections can help increase revenue. Being intelligent about what processes you can outsource and putting them in the hands of experts can help you focus on patient care.

Nathaniel Arana is a nationally-recognized healthcare business consultant with experience ranging across many different specialties. He has worked with many practices to negotiate reimbursement rates, market practice, and to help physicians remain autonomous. You can read some tips on how to negotiate your reimbursement rates on his website: www.ngahealthcare.com.

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Coronavirus & Telehealth Cheatsheet

Medicare-Approved Telehealth Services

Evaluation & Management | Other

Service Type	Codes
Evaluation & Management	99202-99205; 99211-99215; G2211-G2212
Prolonged E/M Services	99354-99357; G0513-G0514
Telephone E/M Services	99441-99443
Hospital (inpatient)	99221-99223; 99231-99233; 99234-99236; 99238; 99239; G0425-G0427 G0406-G0408; G0459
Observation Services	99217-99220; 99224-99226; 99234-99236
Intensive Care Unit (ICU)	99477-99480
Nursing Facility	99304-99310; 99315-99316; G9685
Critical Care	99291-99292; G0508-G0509; 99468-99469; 99471-99472; 99475-99476
Home Visits	99341-99345; 99347-99350
Domiciliary, Rest Home, Custodial	99324-99328; 99334-99337
Advanced Care Planning	99497-99498
Annual Wellness Visit	G0438-G0439
Assessment/Care Planning, Cognitive	99483; G0506
Transitional Care (TCM)	99495-99496
Ophthalmology	92002; 92004; 92012; 92014
Otorhinolaryngologic Services/Procedures	92526; 92550; 92552; 92553; 92555-92557; 92563; 92565-92568; 92570; 92587; 92607-92610; 92625-92627
Psychiatry	90785; 90791; 90792; 90832-90834; 90836-90840; 90845-90847; 90853; 90875; G0410
Psych/Neuropsych Testing	96105; 96110-96113; 96125, 96127; 96130-96133; 96136-96139
Cardiovascular Services	93797; 93798; 93750; G0422; G0423
Respiratory Care Services	94002-94005; 94664; G0424
Neurology Services	95970-95972; 95983; 95984
Substance Interventions	G0396-G0397; G0442-G0447; G2086-G2088
Emergency Visits	99281-99285; G0425-G0427
Behavioral Assessments, Counseling, & Education	96156; 96158-96159; 96160-96161; 96164-96165; 96167-96168; 99406-99407; G0108-G0109; G0420-G0421; G0296
Physical, Speech, Occupational, and Adaptive Behavior Therapy	92507; 92508; 92521-92524; 92601-92604; 96116; 96130-96133; 96136-96139; 96156-96171; 97110; 97112; 97116; 97129; 97130; 97150; 97151-97158; 97161-97168; 97530; 97535; 97542; 97750; 97755; 97760-97761; 0362T; 0373T; S9152
Nutrition Services/Therapy	97802-97804; G0270
ESRD Services	90951-90970
Radiation Treatment Management	77427

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Telecommunication Services

Codes	Service Notes
	Virtual/E-visits
G2010, G2012	Virtual Check-ins • New patient OR Established patient • Physician or NPP/QHP • Special rules apply
G2251	Virtual Check-ins • Established patient • QHP provider who cannot report E/M services • Special rules apply
G2061-G2063* 99421-99423	E-Visits • G-Codes are reported by NPPs/QHPs • CPT codes reported by physicians • Established patients only • Time-based codes *Clinicians unable to bill independently (PT, OT, SLP, clinical psychologist) report these codes
G0074	RHC/FQHC virtual communication or remote evaluation of recorded video/image
	Telephone
98966-98968	Telephone Assessment & Management • Nonphysician practitioners/QHP only • Established patient, parent
99441-99443	Telephone E/M service • Established patient • MD/QHP/NPP • Special rules apply
	Remote Services
99457-99458	Remote physiologic monitoring • Clinical staff, physician, QHP • Time based-per month • Primary and add-on codes
G2250	Remote assessment of recorded video and/or images • Established patient • Special rules apply
99473	Remote monitoring BP device • Calibration, education & training • Data collection & physician/QHP report
99493-99494	Remote psychiatric collaborative care management monitoring • Timed based-per month
G2066	Remote evaluation cardiovascular device, technician review
G0453	Continuous intraoperative neurophysiology monitoring
G9978-G9986	BPCI model (Medicare-approved); remote E/M in-home E/M visit
G9868-G9870	CMMI model (Medicare-approved); analysis of remote, asynchronous images, dermatologic/ophthalmologic
G9481-G9489	CMS innovation center demonstration project (Medicare-approved); remote in-home E/M visit

COVID-19 ICD-10-CM Codes

POSITIVE/CONFIRMED
- Confirmed case (symptomatic, asymptomatic, or presumptive positive) (U07.1)
- Personal history of COVID-19 (Z86.16)
- Follow-up visit, post-COVID (Z09 and Z86.16)

NEGATIVE/UNCONFIRMED
- Exposure to, actual or suspected:
  - asymptomatic (Z20.822)
  - symptomatic, test results inconclusive/unknown (Z20.822)
- Exposure (possible) ruled out (Z03.818)
- Asymptomatic (none or unsure of exposure), ruled out (Z11.59)
- Symptomatic, not confirmed (e.g., rule out, suspected, possible [code symptoms, e.g.,R05 Cough])
- Negative COVID-19 but confirmed other condition or illness (report codes for other condition or illness)
- Antibody testing encounter (non confirmatory) (Z01.84)

SCREENING (Do **NOT** use during pandemic; report exposure code(s) including for preoperative testing)
- Screening asymptomatic individuals (Z11.52)**

MEDICAL CONDITIONS (due to/with COVID):
(Sequence U07.1 first ONLY with confirmed cases)
- Acute bronchitis due to COVID-19 (U07.1 and J20.8)
- Acute respiratory distress syndrome (ARDS) (U07.1 and J80)*
- Acute respiratory failure (U07.1 and J96.0-)*
- Lower respiratory infection associated with COVID-19 (J07.1 and [J22 or J98.8, as applicable])
- Multisystem inflammatory syndrome (MIS-C) with (plus other associated complications if applicable):
  - Current COVID infection (U07.1 and M35.81)
  - Previous COVID infection (M35.81 and B94.8)
  - COVID history, but unknown if COVID is the cause (M35.81 and Z86.16)
  - Known/suspected exposure but not current COVID infection or history of (M35.81 and Z20.822)
- Pneumonia due to COVID-19 (U07.1 and J12.82)
- Nonrespiratory manifestations (sequence U07.1 + manifestation codes)

INPATIENT HOSPITAL EXCEPTION: Hospital inpatient guideline change for COVID-only. Code only provider document or positive test results as U07.1. All "rule out, possible, probable, suspected, or inconclusive" results report as symptoms NOT U07.1.
- COVID infection
  - Progressing to sepsis (see Section I.C.1.d. guidelines); In pregnancy (see Section 1.C.15.s.); In newborn (see Section I.C.16.h); In lung transplant patient (see Section I.C.19.g.3.a.)

Post-COVID Condition

Do **NOT** report code U09.9 with an active COVID infection. When reporting this condition, first First code the COVID-related condition followed by U09.9.

Examples:
- Chronic respiratory failure with hypoxia due to COVID (J96.11 and U09.9)
- Loss of taste due to COVID (R43.8 and U09.9)

Other Charges

Some payers allow the use of the following charges billed with telehealth services. Do **NOT** use these codes if the patient is in their home at the time of service.

G2025 Distant site service furnished by RHC or FQHC only
Q3014 Telehealth originating site facility fee
T1014 Telehealth transmission fee

Place of Service (POS)

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

COVID-19 codes and guidelines can change rapidly. This coding cheat sheet is current as of March 7th, 2022. Visit our Resource Page and verify codes at FindACode.com for continued current information.

COVID-19 SARS-CoV2 Specimen Collection & Testing

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

*Report with codes G2023 or G2024

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

Laboratory Prorated Travel Fees	
P9603	miles traveled
P9604	trip charge

Testing | Other
- U0001 CDC test (real-time RT-PCR panel)
- U0002 Non-CDC (any technique, multiple subtypes)
- U0003 Nucleic-Acid (high-throughput technologies)
- U0004 Any method (high-throughput technologies)
- U0005 Add-on for U0003, U0004 when done within 2 days of specimen collection

Testing | Testing labs require CLIA certification

Antibody;
- 86769 multi-step
- 86408 neutralizing, screen
- 86409 neutralizing, titer
- 86328 single step (reagent strip)
- 86413 quantitative

Infection agent antigen detection;
- 87426 immunoassay
- 87428 immunoassay; w/flu A&B
- 87811 immunoassay w/visual observation
- 87635 nucleic acid (swab)
- 87636 DNA/RNA; w/flu A&B and RSV
- 87637 DNA/RNA; w/flu A&B

Testing | Proprietary Laboratory Analyses (PLA)
- 0202U BioFire® Respiratory Panel 2.1
- 0223U QIAstat-Dx Respiratory SARS CoV-2 Panel
- 0224U COVID-19 Antibody Test
- 0225U ePlex® Respiratory Pathogen Panel 2
- 0226U Tru-Immune™
- 0240U Xpert® Xpress SARS-CoV-2/Flu/RSV (w/o RSV)
- 0241U Xpert® Xpress SARS-CoV-2/Flu/RSV (all)

Modifiers

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

Vaccination Codes

Manufacturer	Code	Administration
AstraZeneca	91302	0021A, 0022A
Janssen	91303	0031A, 0034A
Moderna (100 mcg/0.5 mL)	91301	0011A, 0012A, 0013A
50 mcg/0.25 mL	91306	0064A
50 mcg/0.5 mL	91309	0094A
Novavax	91304	0041A, 0042A
Pfizer (12+ yrs)	91300	0001A, 0002A, 0003A, 0004A
Tris-sucrose (12+yrs)	91305	0051A, 0052A, 0053A, 0054A
Tris-sucrose (5-11 yrs)	91307	0071A, 0072A, 0073A
Tris-sucrose (6 mo-4 yrs)	91308	0081A, 0082A

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Your Leadership Abilities Are Directly Tied to Your Success

There are many variables that contribute to the success of a company, but one of the most important is the leadership of the management team. People at the top of any organization must realize that management's key responsibility is the accomplishment of the company's goals.

However, the definition of a successful leader isn't based on the individual efforts and accomplishments; rather, it is determined by the contributions and accomplishments of the entire team. If, as a top-level manager, you find yourself performing the lion's share of the workload, or if the company's tasks could not be accomplished without your direct involvement, then your leadership skills have room for improvement. A poor performing team can exist because of lack of talent on the team or due to the lack of talent of their leader.

We could go on and on about leadership styles, but it boils down to two principles: Today's leaders need to be both caring and demanding. They must realize that these two leadership traits need to be effectively combined to maximize the team's potential.

While a leader needs to show concern about the employees' welfare, that should not be mistaken for a need to always be "Mr. Nice Guy." When a leader is overly concerned about being well liked, productivity will suffer. Employees may seem happy to work under a manager who is always nice, but a happy employee does not always guarantee a productive employee. In fact, such behavior can backfire when other, more hardworking employees take notice of the fact that they are treated with the same reverence and appreciation as the company slackers. Naturally, the ambitious and productive members of the team will become resentful and may end up leaving to join organizations that express greater appreciation for their hard work. That will ultimately leave your organization with the underperformers.

When I mention demanding, I don't mean it to have a negative connotation. Another way of stating the same principle is to have employee expectations and hold people accountable. If you don't hold employees accountable, you won't have much success attracting and retaining good team members.

Without a climate of accountability and excellence, the following could occur:

- Good employees may become unmotivated and join the ranks of the mediocre employees.
- Good employees may leave to find a work environment where they feel appreciated.
- There will be unused capacity if everyone is permitted to work below expectations.

Inevitably, when I'm conducting a leadership seminar, someone will always ask me for advice on how to motivate employees. I always tell them, "You can't motivate anyone unless they want to be motivated."

It is important to keep in mind that motivation must come from within an individual. As a leader, you are responsible to create an environment where people will want to motivate themselves.

Here are some tips as to how to create a caring/motivating environment:

- Be a continuous teacher. Share your knowledge with others.
- Delegate to help others grow in experience and to add variety to their workday.
- Give feedback and praise daily.

It is a very important concept to keep in mind that you can't change anyone unless they want to change. If you have a bad employee on your team, it may not be worth your effort to try over and over again to motivate them. Leaders have more important things to do than to try to change a person's attitude and it always seems that we spend more time working with the marginal employees than we do with our excellent employees. Never take your good employees for granted. You should spend most of your time with your good employees. Often managers waste too much time trying to save or turn around employees that really don't want to improve.

A quick way to determine if you should continue to invest time in a marginal employee is to ask yourself the following question: "Knowing what I now know about this person, would I hire this employee again?" If the answer is no, then I recommend freeing them up for other opportunities ASAP.

It's incumbent upon everyone who has management responsibilities to continue to enhance their leadership skills. The excuse, "My employer doesn't pay for training resources," doesn't fly. There is no excuse for being a poor leader with all the available resources. Seminars, books, webinars, podcasts, etc. are among the many inexpensive venues to further your leadership abilities. There's also a multitude of free resources at your local public library or on YouTube. If you find yourself struggling to be an effective team leader, start working on enhancing your leadership skills, or you may find that you are the star of a new reality TV show, The Lousy Boss. Or worse yet, you may find yourself freed up to seek other opportunities.

Dave Jakielo, CHBME, is an International Speaker, Consultant, Executive Coach, and Author, and is President of Seminars & Consulting. Dave is past President of Healthcare Business 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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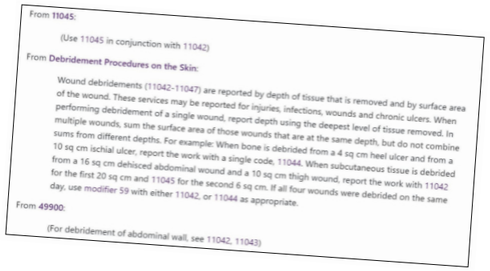
From **11045**:

(Use 11045 in conjunction with 11042)

From **Debridement Procedures on the Skin**:

Wound debridements (11042-11047) are reported by depth of tissue that is removed and by surface area of the wound. These services may be reported for injuries, infections, wounds and chronic ulcers. When performing debridement of a single wound, report depth using the deepest level of tissue removed. In multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths. For example: When bone is debrided from a 4 sq cm heel ulcer and from a 10 sq cm ischial ulcer, report the work with a single code, 11044. When subcutaneous tissue is debrided from a 16 sq cm dehisced abdominal wound and a 10 sq cm thigh wound, report the work with 11042 for the first 20 sq cm and 11045 for the second 6 sq cm. If all four wounds were debrided on the same day, use modifier 59 with either 11042, or 11044 as appropriate.

From **49900**:

(For debridement of abdominal wall, see 11042, 11043)

innoviHealth is pleased to announce that we have expanded the functionality for reviewing the guidelines found in the CPT codebook within FindA-Code. Sometimes it takes a little work using a standard book to find all the guidelines that apply to a particular code. This new feature, available to all subscribers, simplifies this process.

Expansion of Code-Level Guidelines

All guidelines applicable to a code now appear when viewing that individual code. For example, if you look at code 11042 in a printed book, there is a single guideline that states "For debridement of skin [i.e, epidermis and/or dermis only], see 97597, 97598." However, if you look after code 11047, there is a guideline that states "Do not report 11042-11047 in conjunction with 97597-97602 for the same wound." FindACode.com now lists both guidelines below code 11042, so you don't have to go looking for this important information.

New [CPT CodeBook Reverse Guideline Lookup] Function

In addition to making it easier to find the guidelines that apply at the code level, we have also added the ability to view other references to that code that are found elsewhere in the CPT codebook. Using code 11042 again as an example, scroll down to the [CPT CodeBook Reverse Guideline Lookup] bar and click it to view this information. For example, the screenshot shown here is just a few of the places where this code is referenced in other guidelines.

Title: Computer-Assisted Coding Toolkit
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