Solo and Small Medical Practices Benefit from New Manage My Practice and The Billing Department Partnership

Durham, North Carolina and Falmouth, Maine: Today, Manage My Practice, LLC, a full-service consulting firm specializing in services to solo and small medical practices and The Billing Department, Inc., a company that provides revenue cycle management services to healthcare providers, announced a partnership to offer practice consulting, coding, medical billing and a range of other services to physicians and other healthcare providers nationally.

Of the decision to form a partnership to jointly provide high-quality coding and billing services, Mary Pat Whaley, founder and president of Manage My Practice said “I’ve been recommending The Billing Department to my clients for several years and they report back to me that The Billing Department’s services are always exceptional. It seemed a natural step that The Billing Department and Manage My Practice collaborate to offer a wider range of services together.”

Vanessa Higgins, founder and president of The Billing Department stated “Manage My Practice is well-established as the premier consulting company specializing in solo and small medical practices in the United States today. It is a thrill to be able to partner with such a well-respected company to serve an often-overlooked market such as solo physicians and other small practice healthcare providers.”

Among the services the new partnership will offer are:
- New Practice Start-up
- End-to-end Revenue Cycle Management including Credit Card on File implementation
- Consulting on medical practice organizational and operational issues
- Professional Coding and Clinical Documentation Improvement for primary care and other specialties

About Manage My Practice: Mary Pat Whaley, FACMPE, CPC, founder and president of Manage My Practice, LLC, has 30+ years managing physician practices of all sizes and specialties in the private and public sectors. In addition to her Board Certification in Medical Practice Management, she is also a Certified Professional Coder and a Fellow in the American College of Medical Practice Executives. Her company, Manage My Practice, LLC, a full-service practice management consulting firm, has assisted practices nationally and internationally since 2008.

About the Billing Department: Established in 1999, The Billing Department, Inc. has steadily grown. Providing practice and revenue cycle management services for healthcare providers nationwide, The Billing Department offers a fully-integrated, end-to-end solution which simplifies every step of the revenue cycle management process — from the initial scheduling of an appointment to the cumbersome billing process following each patient visit. The company’s ultimate goal is to reduce the expenses and increase the income of their clients.

Mary Pat Whaley, FACMPE, CPC

Manage My Practice

www.managemypractice.com
Vanessa Higgins
The Billing Department
www.billingdepartment.com
(877) 270-7191

Photo Credit: inabstractive via Compfight cc

Advance Beneficiary Notice FAQs
The advance beneficiary notice (ABN) is a powerful tool for practices to educate patients about their benefits and responsibilities for Medicare non-covered services. Many of our readers still write us to ask questions about the form and the correct way to use it in the office, so we developed this Frequently Asked Questions list for the ABN to clear up some of the confusion.

We always tell the physicians we work with: “If you are going to accept insurance, you need to be the expert on insurance.” In practice this means knowing your patient’s benefits and working with them to communicate with them about what, if anything, they will owe before or after payer adjudication. No one enjoys being surprised about money!

The ABN is also a tremendous opportunity to talk about financial responsibilities with a patient. If you don’t have a credit card on file program in your practice, it’s important to be proactive about patient financial responsibilities and how they will be handled. Having a patient sign that they
understand they will be financially responsible for payment for a non-covered service is a natural way to start that process.

Here are some of your most frequently asked ABN questions.

**What is the ABN? What does it do?**

The ABN was originally developed by the Centers for Medicare and Medicaid Services (CMS) to make sure Medicare patients were aware that if they received services that were not covered by Medicare, payment for these services would be their responsibility. By signing the ABN, the patient agrees that if Medicare (or other payer) does not pay the physician then the patient will have to pay for it. The document affirms that the patient knows they could be required to pay out of pocket. Once the ABN is signed, if you are sure Medicare won’t pay you can (and probably should) collect the patient portion listed on the form immediately. You can charge in full for the services if the ABN is signed, however the service is self-pay at that point, so I always suggest you charge your self-pay rate.

**What won’t Medicare pay for?**

The classic example is an annual physical, which many people assume is part of their Medicare coverage. Medicare will pay for an initial “Welcome to Medicare” visit, as well as an “Annual Wellness” visit, but the key word to hear is “visit”. These are not physical examinations. If a patient wants a physical, they will need to sign an ABN before the service saying they understand that Medicare will not pay for it. Other things that Medicare will not pay for include services without specific medical need, like labs or imaging diagnostics without diagnoses that are accepted as medically necessary. Medicare will also only pay for certain services at regular intervals, for example women who are considered “low risk” for cervical cancer can only receive a pap smear every
24 months. Note that you are not required by Medicare to get an ABN signed for services that are never covered, such as the annual physical, however, it pays to be absolutely clear when discussing payments, so I suggest you get an ABN signed by the patient regardless.

**Should we just have everybody sign an ABN?**

No. The ABN is to be used in specific instances for a specific service. You cannot require a patient to sign a “blanket” ABN for the year, just in case. If Mr. Smith wants a service that Medicare is unlikely to, or definitely will not pay for and the physician is comfortable ordering or performing the service, a staff member should present an ABN to Mr. Smith for that specific day’s procedure, before it is performed. If the patient is a having a series of recurring services that will not be covered, you can have one ABN signed for up to twelve months of the specific service. An example of this might be a series of physical therapy sessions. The ABN is not a catch-all to protect from denial, however, and persistent misuse will not only be denied, but could open the door to an audit.

**We are a small, busy practice; that sounds like a lot of work!**

It is a lot of work for a practice! Many practices choose to not use the ABN rather then work out a protocol to implement it. The practice has to have a system in place so that the physician or staff member can explain the situation, fill out the form, answer the patient’s questions and file the ABN for posterity (they have to be kept seven years, like other records). It can be the physician in a micropractice, or a dedicated billing or customer service employee in a larger setting. Also, a note has to be made of the ABN signing in the patient’s chart so that modifiers can be added to the CPT codes for billing.
Are ABNs for Medicare only?

No. You can also have a patient sign an ABN for a private payer. This helps the patient to understand that if their insurance doesn’t cover the service specified, the patient will have to pay for it. Medicare requires an ABN be signed in order to bill the patient, but for patients with private insurance it’s still a great opportunity to talk about non-covered services, deductibles, copays, coinsurance or any past balances if you haven’t already. A few private payers actually require a waiver/ABN to bill patients for non-covered services – check your contract to be sure.

Mary Pat has created a generic non-Medicare ABN; if you’d like a copy, just email Mary Pat and she can send you one.

Should You Outsource Your Chronic Care Management Program? An Interview With Flow Health

We recently caught up with Robert Rowley, MD, Co-Founder and Chief Medical Officer of Flow Health, The Operating System for Value-Based CareSM, to discuss
practices outsourcing chronic care management services as well as the services that Flow Health offers to physician practices. Some of our readers may know Bob as the former Chief Medical Officer of Practice Fusion, the cloud-based electronic health record company.

Mary Pat: What is the Medicare Chronic Care Management (CCM) program?

Bob: In 2015, Medicare began a new program called Chronic Care Management (CCM) and established a new billing code for it – 99490. This is an initial step away from in-office, traditional care, and starts to promote (i.e., pay for) regular contact with patients in between office visits. A Medicare patient must first enroll in the service, since there is a charge for it – payable by Medicare just like any other service. Then, once a month, a CCM nurse will reach out to the patient, usually by phone, and review the patient’s treatment plan with them. Once 20 minutes each month has been spent addressing the patient’s case, a bill is generated. This service is unlike Case Management, or Home Health, which are intended for the 5% or so of Medicare enrollees who are very ill and need intensive support. Instead, the CCM service is intended for all Medicare enrollees with 2 or more chronic conditions – estimated to be about 80% of all Medicare members.

Mary Pat: Why have few physicians implemented CCM in their practices?

Bob: After a year of implementation, Medicare is discouraged at the low uptake of this new code by clinicians. According to CMS, CCM services have only been billed for 100,000 patients, out of 35 million enrollees – 0.029% of the potential. Why is
that? There are a number of barriers:

- The code is new, and physicians are just starting to become aware of it.
- The service is burdensome, especially for smaller practices. It may involve hiring extra staff to do the CCM nurse calling. It involves extra billing—an extra bill for every enrolled Medicare member every month. The reimbursement from Medicare (about $40-44 per patient each month) may not cover the overhead of CCM nursing staff and billing.
- Medicare wants a connected health platform, so that everyone taking care of the patient can see what is going on, and a consolidated care plan can be developed, understood by all. This is hard to achieve in a disaggregated, siloed environment.

**Mary Pat:** What are the benefits of CCM to a small practice?

**Bob:** Medicare’s CCM service is like a non-physician health coach that reaches out from the practice to the patient and makes sure the care plan is understood, and “checks up” on the patient. If a patient does not want the service, after initially signing up for it, he or she can disenroll from the service at any time. In our experience, very few patients disenroll; most appreciate the extra outreach. The practice gets improved patient engagement and satisfaction, with fewer patients “falling through the cracks.”

**Mary Pat:** Tell me about Flow Health.

**Bob:** Flow Health is a universal patient-centered data platform that can draw from all separate sources of information and put it all in one place, unifying the data into a standard form. It can organize a patient’s data, and make it immediately and universally useful. Flow Health also has a suite of apps that sit on this data platform, and allow direct access to this data—a patient-facing app (called Guide), a provider-facing
app, and a point-of-care app (Patient Check-In). Flow Health interfaces in the background with connected EHRs in physician offices, so that the data appears “native” to each EHR, and is updated whenever an event occurs in any connected care team member’s systems.

**Mary Pat:** How does Flow Health address CCM for practices?

**Bob:** Flow Health offers a full-service outsourced CCM service to medical practices. Flow Health hires the CCM nurses, who present themselves to patients as members of the medical practice, and have all the collected information about the patient and the care plans at their fingertips. Then, when the interaction has reached 20 minutes cumulatively over the month, a bill is sent on behalf of the practice for the CCM service. This allows smaller practices to participate in CCM without having to encumber the overhead required (staff, billing, connected platform).

Flow Health charges a portion of the bill as a fee to cover the cost of administering the service (CCM nurses, billing and platform), and the practice enjoys new revenue from Medicare without the down-side of out-of-pocket expenses to set up and run the new service.

**Mary Pat:** How much of the monthly Medicare reimbursement does the practice get?

The practice nets about $10-$15 per patient per month or approximately 25% of the Medicare allowable.

**Mary Pat:** What is the process for outsourcing CCM to FlowHealth?

A practice interested in participating in CCM and wanting the Flow Health outsourced solution simply contacts Flow Health, and an implementation process begins. Integration with the practice’s EHR is set up, which will vary depending on the EHR the practice uses. The Check-In app, deployed on iPads that
Flow Health provides for office-lobby use, captures patient consent and on-boards patients into the system so that they can effectively use the patient-facing Guide app subsequently. The mechanism for billing Medicare for the service is set up.

Mary Pat: How does the Check-In app work?

Bob: Using the Check-In app facilitates enrollment in CCM for candidate patients. The authorization forms are embedded in the app, and appear when the patient is a Medicare enrollee with 2 or more chronic conditions. The Check-In app also collects numerous other data (pre-populated as much as possible), including the history of present illness, past medical history, and all the other things generally included on a paper check-in clipboard. It can be used for all of the practice’s patients, not just CCM patients, since its information is linked with the practice’s EHR.

Mary Pat: Who supervises the CCM nurses?

Flow Health sets up teams of CCM nurses comprised of a mixture of Medical Assistants trained in CCM and supervising RNs. The notes from the CCM encounters are posted on the Flow Health platform, which the physician office staff can see using the provider-facing app. If there are suggestions and improvements that the clinician feels are important, these can be communicated using the provider app, or by phone. Every attempt is made to assign the same CCM nurse to the same patients, so that longitudinal relationships and trust can be built.

For more information about Flow Health’s CCM program, Contact Flow Health.

Full Disclosure: I receive no compensation from Flow Health for this published interview, or for any business that Flow Health may garner due to this interview.
12 Medical Practice Models for 2016

In 2012, we wrote “Yes, You Can and Should Start a New Practice in 2013” and more than 13,000 people have viewed it since then. Despite what you may read on the internet, private medical practice is not dead, and physicians are starting new medical practices using new practice models every single day.

What kind of practice is right for you? Here are 12 common and not-so-common medical practice models for independent physicians and other practitioners.

12 Practice Models for 2016 from Manage My Practice

Read more about our new practice start-up services here. For more information, contact us here or call (919) 370.0504.
I recently helped a physician start a new practice and we began applying for enrollment with the Big Five insurance companies. The physician was stunned to find:

- Insurance companies regularly “lost” her applications and we had to submit the same information numerous times. Some companies require an online application which provides no ability to track. They will not accept paper applications which can be tracked by the delivery service.
- She was offered contracts with no fee schedule attached. When we asked for the fee schedule, we were told it was available in the physician portal. When we went to the physician portal, we were told that only enrolled physicians have access to the portal.
- Contracts she received made reference to the physician adhering to the rules of the Provider Manual. When we asked for a copy of the Provider Manual, we were told it was available in the physician portal. You guessed it – only enrolled physicians have access to the portal.
- Some insurance companies routinely took 90-120 days or more to complete the application process, then another 60-90 days to enter the contract into the system so physician claims would be paid. This means that a physician may not be able to get paid by one or more payers for 6-7 months after opening a practice.

The physician ultimately decided to walk away from the most egregious of the payers.

After having numerous potential new patients call the practice
to find out if she was contracted with this payer, she had to tell them that she would not be contracting with this payer.

Here’s the letter she wrote to the Insurance Company Representative:

Good Afternoon:

Thank you for your follow-up note. I am uncertain why, but the information you provided, once again, is in direct conflict with the data provided by our local physician’s organization as well as the objective data of looking at pricing vs reimbursement for the ___ vaccination.

I have included for your review comments made by an 18-year veteran of contract negotiations, Ron Howrigon. It appears being evasive and obtuse in how you negotiate with physicians is an intentional cultural value.

The tenets of our practice require honesty, good-faith and integrity from all of our partners in healthcare. This article and our experience with you suggests a different and unacceptable organizational value displayed by your company.

At this time, given the disorganized credentialing process, the poor interactions with your company and the vexatious conversation with you, we will not be partnering with you. We have notified all of our patients insured by your company that we will not be accepting your plans in our practice. This is a values and ethics-based decision. We regret you and your company have chosen to conduct yourselves with such hostility and disregard for physicians and the important work we do on behalf of our patients.

Sincerely,

Physician in a New Practice
Why You Should Not Reward Your Billing Staff for Collections

Do not incentivize and reward your billing staff for reduced days in accounts receivable, increased collections or decreased non-contractual (bad debt) write-offs!

I bet you thought I was going to say that billers are paid to do a job and they should not be incentivized for doing the job you hired them to do.

Not true – I am not against incentivizing employees to do a job at all; most people enjoy a challenge and feel great when they reach a goal.

However, when a subset of employees in your practice is incentivized for increasing revenue, you can be sure it will create resentment and low morale for the rest of your employees. Do you think word won’t get around that you’re rewarding the billers? If so, you’re completely wrong. There are no secrets in a medical office. People know what others make, and regardless of what your Employee Handbook might say, it is not grounds for termination for employees to share what they make with others.

What I do encourage you to do is to incentivize your ENTIRE
staff to reduce days in accounts receivable, increased collections and decrease non-contractual (bad debt) write-offs. Ultimately, your entire staff is responsible in one way or another for collections.

Consider how each person in your practice must contribute to the overall effort to make sure collections are at goal:

**Front Desk:** entering/verifying demographics and picking the right insurance plan for each patient; collecting the correct amount at time of service, whether it is an exact amount or an estimate of the patient’s responsibility.

**Phones/Scheduling:** making new patients aware of financial policies and what will be expected at time of service (“Please remember to bring the credit card you’d like us to keep on file for you”); making sure that Medicare patients know the difference between an Annual Wellness Visit and a Complete Physical.*

**All clinical staff including Physicians/PAs/NPs:** making sure that the patient signs an Advance Beneficiary Notice (ABN) for any services that insurance will not pay for, regardless of whether the patient is Medicare or non-Medicare**, before the service is rendered.

**Manager:** addressing patient complaints that escalate to you quickly and efficiently, not giving a patient any reason not to pay; making sure you have an easy-to-read-and-understand Financial Policy*** explaining your collection at time of service policy.

**Everyone:** embracing a culture of Customer Service, making sure that patients are satisfied with their experience; sending a consistent message to patients that you are interested in bringing them **value for their dollars** and reinforcing your desire to have an ongoing relationship with them.
Wearables Will Soon Be Part of Major Shift In Medical Practice

For a long time the idea of wearable health tracking devices seemed like an idea out of science fiction, but these days the technology is real and cost effective, and wearables will have a big effect on how your practice operates. Here with more insight on the nascent wearable industry is Guest Author Anne Zieger, CEO of Zieger Healthcare. – Abe

For most doctors in private practice, the astonishing growth of health wearables has all but passed them by.

According to a leading health IT group, the use of health and fitness apps is growing 87% faster than the entire mobile industry. That’s pretty astonishing for a product category most of us hadn’t even heard of five years ago.

But to date, this hasn’t changed medical practice much. While physicians may review readings gathered by consumer-grade measurement devices such as home glucose meters, blood pressure cuffs and pulse oximeters, few are integrating data
from wearables into their consult, much less integrating that data into their EMR.

The reasons for this are many. For one thing, doctors are creatures of habit, and are unlikely to change their assessment routine unless they are pushed into doing so. What’s more, their EMRs are not set up to gather fitness data in a routine and streamlined data. Then when you consider that physicians aren’t quite sure what to do with the data — short of a shocking data outlier, what does a physician do with a few weeks of exercise data? — it seems even less likely that they’ll leverage wearables data into their clinical routine.

Over the next few years, however, this state of affairs should change dramatically.

Data analytics systems will begin to including wearables data into their calculations about individual and population health. And physicians will be expected to become adept at using wearables to better track the health status of chronically-ill patients. In short, wearables should fundamentally change the way physicians care for patients, especially those at greater risk.

Here’s some examples of how this will play out.

**Data analytics**

In an effort to improve the health of entire patient populations, organizations such Louisiana-based Ochsner Health System are testing Apple’s HealthKit technology. Through HealthKit, which connects with Ochsner’s Epic Systems EMR, the health system will be able to pull in and integrate a wide range of consumer-generated data, notably input from wearables.

While Ochsner’s first big win came from its test with wireless scales for heart patients—which led to a 40% decrease in admissions—the bigger picture calls for clinicians to use
wearables data too, leveraging it to track the health of its entire patient base.

**Tracking the chronically ill**

Though most wearable health bands are consumer devices, used largely by the already fit to help them stay that way, medical device companies are building a new class of wearable devices designed to help clinicians track serious chronic illnesses in a serious manner.

Phillips, for example, announced a few months ago that it had released a biosensor patch designed to track symptoms of COPD, send the data to a cloud-based central software platform using the patient’s wireless device, then route the results to that patient’s clinician via a pair of related apps. This gives the physician 24-hour access to key indicators of COPD status, including respiratory rate, heart activity and rhythm and physical activity.

**Conclusion: Much more to come**

The bottom line in all of this is that wireless monitoring of remote patients has already arrived, and that new uses for data from health bands and other fitness devices are likely to become a standard part of patient care over the next few years.

While no one is suggesting that the data and practical observations a doctor gathers during a fact-to-face medical visit are becoming less value, medical practice is likely to rely more heavily on monitoring of wearable smart bands, sensors, smart bands, sensor-laden smart clothing and more as time goes by. Now is a good time to prepare for this shift in medical practice, or risk getting left behind.

Anne Zieger is CEO of Zieger Healthcare
Zieger Healthcare’s team of veteran marketing communications pros will help you reach out to key healthcare stakeholders and grab their attention. With decades of experience in the industry, we know exactly how to tell healthcare stories that sell.

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CMS and AMA Make ICD-10 “Family” Clarification

Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities

Question 1:
When will the ICD-10 Ombudsman be in place?

Answer 1:
The Ombudsman will be in place by October 1, 2015.

Question 2:
Does the Guidance mean there is a delay in ICD-10 implementation?

Answer 2:
No. The CMS/AMA Guidance does not mean there is a delay in the
implementation of the ICD-10 code set requirement for Medicare or any other organization. Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015 or accept claims that contain both ICD-9 and ICD-10 codes for any dates of service. Submitters should follow existing procedures for correcting and resubmitting rejected claims.

Question 3:

What is a valid ICD-10 code?

Answer 3:

ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided. To be valid, a code must be coded to the full number of characters required for that code, including the 7th character, if applicable. Many people use the term billable codes to mean valid codes. For example, E10 (Type 1 diabetes mellitus), is a category title that includes a number of specific ICD-10-CM codes for type 1 diabetes. Examples of valid codes within category E10 include E10.21 (Type 1 diabetes mellitus with diabetic nephropathy) which contains five characters and code E10.9 (Type 1 diabetes mellitus without complications) which contains four characters.

A complete list of the 2016 ICD-10-CM valid codes and code titles is posted on the CMS website at http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GE Ms.html. The codes are listed in tabular order (the order found in the ICD-10-CM code book). This list should assist
providers who are unsure as to whether additional characters are needed, such as the addition of a 7th character in order to arrive at a valid code.

Question 4: What should I do if my claim is rejected? Will I know whether it was rejected because it is not a valid code versus denied due to a lack of specificity required for a NCD or LCD or other claim edit?

Answer 4:
Yes, submitters will know that it was rejected because it was not a valid code versus a denial for lack of specificity required for a NCD or LCD or other claim edit. Submitters should follow existing procedures for correcting and resubmitting rejected claims and issues related to denied claims.

Question 5:

What is meant by a family of codes?

Answer 5:
“Family of codes” is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as
well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.

Question 6:

Does the recent Guidance mean that no claims will be denied if they are submitted with an ICD-10 code that is not at the maximum level of specificity?

Answer 6:

In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. (See Question 7 for more information about this). This reflects the fact that current automated claims processing edits are not being modified as a result of the guidance.

In addition, the ICD-10 code on a claim must be a valid ICD-10 code. If the submitted code is not recognized as a valid code, the claim will be rejected. The physician can resubmit the claims with a valid code.

Question 7:
National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) often indicate specific diagnosis codes are required. Does the recent Guidance mean the published NCDs and LCDs will be changed to include families of codes rather than specific codes?

Answer 7:

No. As stated in the CMS’ Guidance, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family of codes. The Medicare review contractors include the Medicare Administrative Contractors, the Recovery Auditors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

As such, the recent Guidance does not change the coding specificity required by the NCDs and LCDs. Coverage policies that currently require a specific diagnosis under ICD-9 will continue to require a specific diagnosis under ICD-10. It is important to note that these policies will require no greater specificity in ICD-10 than was required in ICD-9, with the exception of laterality, which does not exist in ICD-9. LCDs and NCDs that contain ICD-10 codes for right side, left side, or bilateral do not allow for unspecified side. The NCDs and LCDs are publicly available and can be found at http://www.cms.gov/medicare-coverage-database/.

Question 8:

Are technical component (TC) only and global claims included in this same CMS/AMA guidance because they are paid under the Part B physician fee schedule?

Answer 8:
Yes, all services paid under the Medicare Fee-for-Service Part B physician fee schedule are covered by the guidance.

**Question 9:**

Do the ICD-10 audit and quality program flexibilities extend to Medicare fee-for-service prior authorization requests?

**Answer 9:**

No, the audit and quality program flexibilities only pertain to post payment reviews. ICD-10 codes with the correct level of specificity will be required for prepayment reviews and prior authorization requests.

**MEDICAID**

**Question 10:**

If a Medicare paid claim is crossed over to Medicaid for a dual-eligible beneficiary, is Medicaid required to pay the claim?

**Answer 10:**

State Medicaid programs are required to process submitted claims that include ICD-10 codes for services furnished on or after October 1 in a timely manner. Claims processing verifies that the individual is eligible, the claimed service is covered, and that all administrative requirements for a Medicaid claim have been met. If these tests are met, payment can be made, taking into account the amount paid or payable by Medicare. Consistent with those processes, Medicaid can deny claims based on system edits that indicate that a diagnosis code is not valid.

**Question 11:**

Does this added ICD-10 flexibility regarding audits only apply to Medicare?
Answer 11:

The official Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. This Guidance does not apply to claims submitted for beneficiaries with Medicaid coverage, either primary or secondary.

Question 12:

Will CMS permit state Medicaid agencies to issue interim payments to providers unable to submit a claim using valid, billable ICD-10 codes?

Answer 12:

Federal matching funding will not be available for provider payments that are not processed through a compliant MMIS and supported by valid, billable ICD-10 codes.

OTHER PAYERS

Question 13:

Will the commercial payers observe the one-year period of claims payment review leniency for ICD-10 codes that are from the appropriate family of codes?

Answer 13:

The official Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. Each commercial payer will have to determine whether it will offer similar audit flexibilities.

Photo Credit: born1945 via Compfight cc
A Manage My Practice Classic: Five Simple but Powerful Performance Evaluation Questions

This continues to be one of our top ranking posts of all time.

This tells me that people continue to struggle with the process of evaluating employee performance.

The point of the “Five Questions” evaluation is not to focus on the fact that the employee is often tardy or doesn’t complete assignments on time — those things should be initially dealt with outside of this process (remember the old adage “No new news at the performance evaluation.”) They can be added to #3 as goals, but the idea is to dig under those things and see if the employee is dissatisfied, overwhelmed or under-challenged.

I typically use this form at 90 days after hire, then at the one year mark, then every 6 months thereafter.

Yes, evaluating this much is very time-consuming — but it pays BIG dividends.

Invest in your employees by using this form and meeting for at least an hour — you might be surprised that it’s one of the
most in-depth evaluations you’ll ever do!

This is a VERY succinct performance evaluation that I’ve used for years. Called “Five Questions”, the employee completes it, submits it to the manager, then together they discuss, evaluate and add to it during the evaluation interview. Here are the questions:

1. What goals did you accomplish since your last evaluation (or hire)?
2. What goals were you unable to accomplish and what hindered you from achieving them?
3. What goals will you set for the next period?
4. What resources do you need from the organization to achieve these goals?
5. Based on YOUR personal satisfaction with your job (workload, environment, pay, challenge, etc.) how would you rate your satisfaction from 1 (poor) to 10 (excellent.) 1 2 3 4 5 6 7 8 9 10

You do have to stress that question #5 is not how well they think they’re doing their job, but how satisfied they are with the job.

The great thing about this evaluation is that it is one piece of paper and not too intimidating. Staff can use phrases or sentences and write as little or as much as they like. If it’s hard to get a conversation going with the employee, ask them “What was your thought process when you assigned your job satisfaction a number __.” Usually that opens the floodgates!

If you use a goal-oriented evaluation like this one, you will find that employees will grasp that you are asking for their performance to be beyond the day-to-day tasks, and to focus on learning new skills, teaching others, creative thinking and problem-solving and new solutions for efficiency and productivity.
What Tools Will You Need for the ICD-10 Transition? Q & A with Swiftaudit

October 1, 2015 is a date that looms large for everyone involved in the operational and financial functions of any medical practice. At the time of this post’s publishing, practice administrators, managers, billers and coders have less than three months to make sure they have the processes and systems in place to minimize the business disruption from the changeover. As we talked to clients and readers about the challenges they are facing with the ICD-10 upgrade over the past several years, we started looking for tools that could help practices ease the transition.

One tool really stood out more than the others. Swiftaudit Search is a web-based coding conversion and look-up tool for both ICD-9 and ICD-10 code sets that we strongly endorse for its ability to supercharge ICD-10 coding, audits and upgrade preparations. We’ve been using Swiftaudit Search here at Manage My Practice for months now and we are very excited about how it can help our readers and clients.

We sat down with the creators of Swiftaudit Search, Chicago’s SpringSoft to ask them more about how practices can prepare for the upgrade.
Manage My Practice: Tell us about SpringSoft and how you starting working in the healthcare software market.

SpringSoft: We’ve provided software to the healthcare coding and compliance market since 1995. Our first product was E&M Coder™ for evaluation and management coding and audits. It all started when a few forward thinking doctors told us “the auditors are coming.” Given our background in corporate business systems, our research provided a couple of interesting observations at that time. One – physician offices had few easy to use software applications. Two – from a business point of view, physician offices needed help with coding and compliance. So we tackled a challenging little-understood coding issue in 1994 – the introduction of evaluation and management codes.

Manage My Practice: Your product that is designed for medical coding has gone through several iterations since the ICD-10 mandate was first announced – how did your product evolve?

SpringSoft: We started designing what is now Swiftaudit Pro several years ago. As we designed the coding components, we realized that our ICD-10 Search features would benefit physicians during the transition to ICD-10. Again, we took on a daunting challenge. We knew we had to design an intuitive ICD-10 Search Feature. Once you find a group of codes, the next problem was to be present all of the ICD-10 coding information to describe the patient’s health condition. So now, as Swiftaudit evolves, our goal is to present the ICD-10 coding guidelines in a quick and straightforward way.
Manage My Practice: We’ve seen a wide variety of encoder-type products designed for hospitals and large organizations, and some designed for billing companies and consultants. What target market is the best fit for your products and why?

SpringSoft: Currently, we see our market as physician offices. Hospital and large organization coding systems have to address ‘packet’ coding, such as DRG (Diagnosis Related Groups) and HCCs (Hierarchical Condition Categories). Hospitals and large organizations will benefit from our auditing platform – SwiftAudit Pro. Providers who need to code ICD-10s will benefit from Swiftaudit Search. They can use our product to learn how code their common ICD-9 diagnosis in ICD-10 language.

Manage My Practice: What do you hear are the biggest challenges faced by practices in making the transition to I-10?

SpringSoft: We hear that immediacy and time are the biggest challenges. **Immediacy** – it is always easier to learn new methods when you can consistently work in the new method. A baseline understanding helps provide context and what the changes are. We will all learn when everyone starts coding in ICD-10. **Time** – the change to ICD-10 is not trivial. It impacts the office’s income. Everyone will need to spend a little more time – coding in ICD-10, and time in improving their coding as payers respond to codes submitted. A practice can reduce frustration if they understand and prepare for their learning curve. Like all new methods, it takes practice to perfect.
Manage My Practice: For many practices, their ability to utilize ICD-10 will come down to the support the EHR or Practice Management vendor has built into the software, yet many practices have not even seen how their software will work with ICD-10. What do recommend for practices whose software has not yet been updated to I-10, or whose software makes no useful correlation between I-9 and I-10?

SpringSoft: We agree with many consultants and trainers. Transition your top ICD-9 codes to specific ICD-10 codes. Be cautious of depending on published crosswalks. ICD-9s which describe ‘unspecified’ elements often are crosswalked to ‘unspecified’ ICD-10s. Experts in the industry are cautioning that ‘unspecified’ ICD-10s may not be paid. Ask your EMR vendor, will you handle all of the ICD-10 coding guidelines, such as Code First, Code Also, Use Additional Codes? Will you map to ‘unspecified’ ICD-10 codes or warn me of ‘unspecified’ ICD-10 codes? How will you help me find more specific codes? You can use Swiftaudit Search to build your Favorites Lists. We will provide you the ICD-10 coding guidelines, and provide a communication platform for your expert coders to provide you with coding tips and alerts.

Manage My Practice: What are some of the features in Swiftaudit Search that your product has that others you’ve seen do not?

SpringSoft: We feel that our ease of use and screen design makes us stand out from the crowd. The ICD-10 code set is overwhelming. We’ve worked very hard to provide the information you need at a glance.
Manage My Practice: Swiftaudit Pro (as opposed to Swiftaudit Search) is more for the coding and billing side of the practice. How do you see coders and billers using this product in their practices?

SpringSoft: Our background is in coding and compliance. Managers and auditors can use Swiftaudit Pro to improve their coding accuracy and educate their providers. We built Swiftaudit Pro to be a communication platform to aid discovery and process improvement between a practice’s providers and expert coders.

Readers who would like more information or would like to try Swiftaudit Search for free for 30-days can [click here](#).

NOTE: We’ve heard of so many practices that have not started preparations for ICD-10 that that we made the 20-minute webinar “ICD-10 CM: Getting Started Today.” The video addresses strategies for the first step – crosswalking your most used ICD-9 codes into ICD-10.

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