

Bad Online Reviews and How to Respond to Them



It is important to address **every** online review – good or bad – publicly so that others reading the review will know you are responsive to patient communication and concerns.

Here's How to Respond

Here are some simple steps to addressing a bad review, potentially resolving the patient's complaint and showing possible future patients how you deal with patient concerns.

Don't get bent out of shape.

As much as we want to think that we do the best we can for

every patient, we do make mistakes. I spoke with a patient recently and told her the practice had failed to send her prescription in and she was dumbfounded. "You mean you are actually admitting you made a mistake?" she said "That's so refreshing." We will all make mistakes, and we all must own them.

Read it. Go away. Come back and read it again.

First blush reads can be deceiving because we are instantly on the defensive. All healthcare is under the microscope and we are all peddling so hard to keep up that it's easy to feel that we are doing everything we can and resent anyone who thinks we could do better. If you let it go for 24 hours, when you come back and read it a again, it could read differently and may be not as harsh as we originally perceived it to be.

Address the online review and include:

- An **apology** acknowledging that the patient was dissatisfied – regardless of the specifics or what you cautioned them about, you want patients to know you do not want them to be dissatisfied. This is not necessarily to admit that you did something "wrong", but that if the patient feels something went wrong, you want to acknowledge their feelings and address them. This is not the forum to say "we told you this might happen..."
- **Reassurance** that patient care is the top priority in your practice.
- An **invitation** to contact the practice administrator to discuss the issue in more detail and review if anything could have been done differently. Include a phone number and email.
- **Edit, edit, edit.** Write it, let it sit for awhile, and come back and see if it reads the way you want it to. Have others read it and give their opinions. Less is often more when responding to a bad review.

Keep a copy of the online review and your response

Share with employees at a staff meeting. Make it a customer service teaching moment.

Contact the Patient

If you know who wrote the online review, contact the patient with an offer to discuss over the phone or face-to-face.

Keep in mind that the most important thing is to take the public sting out of the review by responding in an open, calm and compassionate way.

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Getting Paid: Master the ABN Advance Beneficiary Notice



One of the most popular topics I've written about over the past 10 years, and the one I get the most email on, is the ins and outs of using the Medicare Advance Beneficiary Notice of Noncoverage – the ABN – also known as form CMS-R-131.

Why is getting an ABN so important?

The answer to this question is simple. If you supply a service to a Medicare patient and Medicare does not pay for it, you can only collect payment from the patient if you've communicated to the patient what the cost is and that the cost will be their responsibility AND the patient has agreed. If you routinely supply services to patients that Medicare does not cover and do not use the ABN, your practice will be missing income that is rightfully yours. Read on for more information on the appropriate times to issue ABNs for Medicare (and non-Medicare patients).

Why do practices find it difficult to use ABNs?

The ABN is a collection tool that many medical practices do not know how to implement. It is particularly difficult to determine who has ownership of this process, because the form must be completed and signed by the patient before the service is provided. The patient is in the exam room or the lab, ready for the service or test, and a knowledgeable staff person must step in, explain the rules and pricing and obtain the patient's signature.

Which insurance plans require the ABN?

Although you can use the ABN for Medicare Advantage Plans (commercial insurance plans that offer Medicare replacement coverage) only original/traditional Medicare (sometimes referred to as the "red, white and blue card" Medicare) **REQUIRES** the ABN.

Commercial non-Medicare plans have also started asking physicians to issue ABNs when a service will not be covered by the plan and the patient will be paying for the service out-of-pocket. I've developed a non-Medicare ABN that you are welcome to have a copy of – just drop me an email (marypat@managemypractice.com) and request it. I think ABNs are not a bad idea at all to give to non-Medicare patients as it formalizes the process and drives home to the patient what the cost for something they ask for will be and that they've agreed to pay for it.

The ABN is not a replacement for a good financial policy

Please don't use a blanket ABN in place of a solid financial policy. Your financial policy should state that patients agree to be responsible for payments for services their plans don't

cover. The ABN is meant for specific individual services or series of services that the insurance plan is not going to cover, not as a catch-all for whatever insurance does not pay for. **Note that the ABN is not meant to cover any dollars for which you are contractually obligated to write-off.**

What version of the ABN is current?

As of last summer (6/21/2017), there is an updated ABN. You should be using the one that has the date of 03/2020 in the lower left-hand corner. In accordance with Section 504 of the Rehabilitation Act of 1973 (Section 504), the form has been revised to include language informing beneficiaries of their rights to CMS nondiscrimination practices and how to request the ABN in an alternative format if needed.

Copies of the current ABN are available in English and Spanish [here](#).

Who uses the ABN?

The ABN is to be used by all providers, practitioners, and suppliers paid under **Medicare Part B**, as well as hospice providers and religious non-medical healthcare institutions (RNHCIs) paid exclusively under **Medicare Part A**. Since 2013, home health agencies (HHAs) providing care under Part A or Part B issue the ABN instead of the Home Health Advance Beneficiary Notice (HHABN) Option Box 1 to inform beneficiaries of potential liability. The HHABN has been discontinued.

When should the ABN be used?

The ABN's purpose is to allow the physician practice to collect from the patient for services that the patient wants but are not covered by Medicare. Practices are not expected to give ABNs to patients to cover services that are never covered (called statutory exclusions), however, many practices find

that supplying this form to patients helps patients understand why they are responsible for the paying for the service. Practices may collect in full at time of service for services that are never covered by Medicare, but if you are not sure if Medicare will or will not pay, you may want to wait for Medicare to adjudicate the claim before collecting from the patient.

Note that the ABN must be completed and signed **BEFORE** providing the items or services that are the subject of the notice.

Also note when the ABN is used as a voluntary notice (i.e. for statutory services), the beneficiary is not required to choose an option box or sign the notice.

The four broad categories of items and services not covered under Medicare are:

1. Services and supplies that are not medically reasonable and necessary
2. Non-covered items and services (statutory exclusions)
3. Services and supplies denied as bundled or included in the basic allowance of another service
4. Items and services reimbursable by other organizations or furnished without charge

The brochure that describes in-depth of what Medicare does not cover is available [here](#).

Can you give an example of when to use an ABN?

A Medicare patient wants an EKG even though she does not have any symptoms or diagnoses that would point to an EKG being medically necessary. She is not in her first 12 months of Medicare coverage, therefore she does not qualify for an EKG as a part of her Welcome to Medicare Visit (not an exam.) She

believes there may be something wrong with her heart, even though she cannot name any symptoms that would warrant a diagnostic EKG. In this case, without a diagnosis to support the EKG, an ABN would be appropriate. You would advise the patient that Medicare may not pay for the EKG, in fact probably won't pay for the EKG, and you complete the ABN, showing the patient what she will be paying out of pocket for the test. In the case of Medicare not covering the test, you may charge the patient your full rate for an EKG and are not restricted by the Medicare allowable. If the patient agrees to have the test and signs the ABN stating she understands she will be responsible for the cost of the test if Medicare does not pay, you will provide the patient with a copy of the signed form and will attach the completed form to the patient's encounter form or somehow note in the EMR that an ABN has been obtained so the EKG will be billed with the modifier "GA" which indicates an ABN was executed for a service that might not be covered by Medicare. In the case where a service is never covered (i.e. statutory exclusions) you may append a modifier "GY" to the service to indicate an ABN is on file.

The ABN can be scanned with the encounter form or any other financial paperwork from the visit so it can be retrieved if requested by Medicare during an audit. If you do not archive your paperwork electronically, you can file the ABNs alphabetically by patient name by month. You can also scan the ABN into your EMR if you choose.

What are statutory exclusions (services that are never covered) under Part B?

- Oral drugs and medicines from either a physician or a pharmacy. **Exceptions: oral cancer drugs, oral antiemetic cancer drugs and inhalation solutions.**
- Routine eyeglasses, eye examinations, and refractions for prescribing, fitting, or changing eye glasses.

Exceptions: post cataract surgery. Refer to benefits under DME prosthetic category.

- Hearing aids and hearing evaluations for prescribing, fitting, or changing hearing aids.
- Routine dental services, including dentures.
- Routine foot care without evidence of a systemic condition.
- Injections which can be self-administered. **Exceptions: EPO, and clotting factors.**
- Naturopath's services.
- Nursing care on a full-time basis in the home and private duty nursing. (Refer to benefits under Medicare Part A).
- Services performed by immediate relatives or members of the household. Services payable under another government program.
- Services for which neither the patient nor another party on his or her behalf has a legal obligation to pay.
- Immunizations. **Exceptions: Influenza, Pneumovax and Hepatitis B.**
- Wheelchair van ambulance services.
- Cosmetic surgery.
- "Annual Physicals" best described by codes 99387 or 99397. This is a long discussion for another post, but note that Medicare does not pay for annual preventive EXAMINATIONS, although they pay for annual wellness visits, which are not physical examinations. They do, however, pay for screening pelvic and breast exams and pap test collection at specific intervals.

How do you complete the "Estimated Cost" Section F of the ABN?

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D). CMS expects that the estimate should be within \$100 or 25% of the actual costs, whichever is greater; however, an

estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Thus, examples of acceptable estimates would include, but not be limited to, the following:

For a service that costs \$250:

- Any dollar estimate equal to or greater than \$150
- "Between \$150-300"
- "No more than \$500"

For a service that costs \$500:

- Any dollar estimate equal to or greater than \$375
- "Between \$400-600"
- "No more than \$700"

What about estimating the costs for a series of services?

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in the column under Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in laboratory reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is

available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

How do I use modifiers to indicate the ABN is present?

The modifiers can be confusing! Focus on using the GA and GX modifiers as best practice.

GA Modifier – Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case – ABN Needed and Obtained

Use this modifier to report that an advance written notice was provided to the beneficiary of the likelihood of denial of service as being not reasonable and necessary under Medicare guidelines.

- Report when you issue a mandatory ABN for service as required and is on file.
- You do not need to submit a copy of the ABN but it must be available upon request.
- The most common example of these situations would be services adjudicated under a Local Coverage Decision (LCD).
- The presence or absence of this modifier does not influence Medicare's determination for payment.
- Line item is submitted as covered and Medicare will make the determination for payment.
- If it's determined that the service is not payable, the claim denial is under "medical necessity denial."
- It is inappropriate to use the GA modifier when the provider/supplier has no expectation that an item or

service will be denied.

- Do not use on a routine basis for all services performed by a provider/supplier.

GX Modifier – Notice of Liability Issued, Voluntary Under Payer Policy – No ABN Needed But Was Issued Nonetheless

Use this modifier to report when you issue a voluntary ABN for a service that Medicare never covers because it is statutorily excluded or is not a Medicare benefit.

- Line items submitted as non-covered will be denied as beneficiary liable.
- You may use this modifier in combination with the GY modifier.

GY Modifier – Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit – No ABN Needed and None Issued

Use this modifier to report that Medicare statutorily excludes the item or service or the item or service does not meet the definition of any Medicare benefit. Use this modifier to notify Medicare that you know this service is excluded.

- Services provided under statutory exclusion from the Medicare Program; the claim would deny whether or not the modifier is present on the claim.
- It is not necessary to provide the patient with an ABN for these situations.
- Situations excluded based on a section of the Social Security Act.
- Modifier GY will cause the claim to deny with the patient liable for the charges.

- Do not use on bundled procedure or on add-on codes.
- Line items submitted as non-covered and will be denied as Patient Responsibility
- You may use this modifier in combination with the GX modifier.

GZ Modifier – Item or Service Expected to Be Denied as Not Reasonable and Necessary – ABN Needed But Not Obtained

Use this modifier to report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued.

- This modifier is an informational modifier only.
- Medicare will adjudicate the service just like any other claim.
- If Medicare determines that the service is not payable, denial is under “medical necessity.” The denial message will indicate that the patient is not responsible for payment.
- If either the beneficiary or provider requests a review, the modifier tells us an ABN was not given, and this could help in completing the review quickly.
- Medicare will auto-deny services submitted with a GZ modifier. The denial message indicates that the patient is not responsible for payment; deny provider liable.
- If either beneficiary or provider requests a review, the modifier tells us that an ABN was not given.

For in-depth instruction from Medicare on completing the ABN, click [here](#).

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Excel is the Skill You Need or Need to Improve



It's Time to Improve Your Excel Skills

Excel (or any spreadsheet program, try [OpenOffice](#) if you don't have Excel) should be the go-to tool for any medical practice manager who is tasked with data analysis.

Examples of some of the data you should be analyzing in your practice:

- What are my net collection percentages by payer?
- Am I receiving reimbursement at cost plus for any vaccines and injectables I am supplying to patients?

- Do I know the potential value of a contract offered by a payer or an Independent Physician Association?
- What is the cost of adding a new physician, NP, PA or service line to my practice?

Your practice management system may already crunch numbers for you, but:

1. Is it exactly the information you need?
2. Is it in the format in which you need it?
3. Is all the data I need to analyze found inside the practice management system?

What if you don't trust the information coming from your practice management system? Many managers don't. One of the first rules to data analysis is "Know What You Are Looking At". Are you confident that the data you received is the data you asked for? You may need a conversation with your practice management system support team to be sure you understand where the system is pulling data from and if it is the date you want.

A clear understanding of how your practice management system filters and reports your data is critical to producing INFORMATION. Data only has the potential to become information when it is accurate and actionable.

How to learn Excel or improve your Excel skills:

If you know only enough Excel to get by, Nate Moore's series on Excel is a great place to start. Because he is in the healthcare field, his examples make sense. His videos (new ones regularly) are free [here](#).

I first wrote about Massive Open Online Courses (MOOCs) back in 2013 [here](#) and the list of offerings just keeps growing. Coursera offers buckets of **free** courses, including courses on

Excel like these:

- Microsoft: [Microsoft office Fundamentals: Outlook, Word and Excel](#)
- PricewaterhouseCoopers Accounting Firm: [Problem Solving With Excel](#)
- Rice University: [Introduction to Data Analysis Using Excel](#)

For those of you that have the basics of Excel under your belt, proceed to learning about **Pivot Tables**. They will become your new best friend.

Big list of all kinds of free courses [here](#).

Flu Shot Coding for 2017-2018



What's new this flu season?

- The recommendation to **not** use the nasal spray flu vaccine (LAIV) was renewed for the 2017-2018 season. Only injectable flu shots are recommended for use again this season. CDC recommends use of the flu shot (inactivated influenza vaccine or IIV) or the recombinant influenza vaccine (RIV).
- Flu vaccines have been updated to better match circulating viruses (the influenza A(H1N1) component was updated).
- Pregnant women may receive any licensed, recommended, and age-appropriate flu vaccine. (NOTE: there is some concern about administration of the flu shot during the first trimester – [NPR news story today 9/25/17](#))
- Two new quadrivalent (four-component) flu vaccines have been licensed: one inactivated influenza vaccine (“Afluria Quadrivalent” IIV) and one recombinant

- influenza vaccine (“Flublok Quadrivalent” RIV).
- The age recommendation for “Flulaval Quadrivalent” has been changed from 3 years old and older to 6 months and older to be consistent with FDA-approved labeling.
 - The trivalent formulation of Afluria is recommended for people 5 years and older (from 9 years and older) in order to match the Food and Drug Administration package insert.

Cell-based Flu Vaccines

A candidate vaccine virus (CVV) is an influenza (flu) virus that has been prepared by CDC or its public health partners for use by vaccine manufacturers to mass produce a flu vaccine. During the 2017-2018 season, for the first time, a true cell-based CVV has been approved for use in flu vaccine production for the Northern Hemisphere. Traditionally, CVVs have been produced using fertilized chicken eggs. The cell-based CVV has been used to produce the influenza A (H3N2) component of cell-based flu vaccines for the Northern Hemisphere in 2017-2018. Recombinant flu vaccines also are based on genetic sequences of recommended vaccine viruses that have not been propagated in eggs. Cell-based flu vaccines that use cell-based CVVs or genetic sequences have the potential to offer better protection than traditional, egg-based flu vaccines as a result of being more similar to flu viruses in circulation. For more information, see CDC’s [Cell-Based Flu Vaccines](#) webpage.

Options this season include:

- Standard dose flu shots. Most are given into the muscle (usually with a needle, but one can be given to some people with a jet injector). One is given into the skin.
- High-dose shots for older people.
- Shots made with adjuvant for older people.
- Shots made with virus grown in cell culture.

- Shots made using a vaccine production technology (recombinant vaccine) that does not require the use of flu virus.

Medicare Reimbursement for the Flu Shot

The Part B deductible and coinsurance amounts do not apply to influenza vaccines or vaccine administration. All physicians, nonphysician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination **must take assignment** on the claim for the vaccine.

The following Medicare Part B payment allowances for HCPCS and CPT codes apply to 8/1/2017-7/31/2018:

- 90630 \$20.343
- 90653 \$50.217
- 90654 Pending
- 90655 Pending
- 90656 \$19.247
- 90657 Pending
- 90661 Pending
- 90662 \$49.025
- 90672 Pending
- 90673 \$40.613
- 90674 \$24.047
- 90682 \$46.313
- **(New code) 90685 \$21.198**
- 90686 \$19.032
- 90687 \$9.403
- 90688 \$17.835
- Q2035 \$17.685
- Q2036 Pending
- Q2037 \$17.685
- Q2038 Pending
- Q2039/90756 \$22.793 **Until CPT code 90756 is implemented**

on 1/1/2018, Q2039 will be used for products described by the following language: influenza virus vaccine, quadrivalent (ccllv4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use. Providers and MACs will use HCPCS Q2039 for dates of service from 8/1/2017- 12/31/2017. HCPCS Q2039 Flu Vaccine Adult – Not Otherwise Classified.

Flu Shot Administration Codes

Don't forget to code the vaccine administration as well as the vaccine itself!

Administered by a Physician, NP, PA, RN, LPN, Medical Assistant (etc) WITHOUT COUNSELING:

- **90471** –percutaneous, intradermal, subcutaneous, or intramuscular injections: one vaccine (single or combination vaccine/toxoid)
- **90473** – intranasal or oral: one vaccine (single or combination vaccine/toxoid)

Administered by a Physician, NP, PA (etc) WITH COUNSELING:

- **90460** – Immunization administration through 18 years of age via any route of administration, w/ counseling by physician or other qualified healthcare professional; first vaccine/toxoid component

Here's that [invaluable flu shot chart](#) from the Immunization Action Coalition with flu vaccine manufacturer, trade name, how supplied, age group, and CPT/HCPCS codes for Medicare and non-Medicare plans.

2017 Medicare Deductibles and Premiums



2017 Medicare Parts A & B

Premiums and Deductibles Announced

The Centers for Medicare & Medicaid Services (CMS) announced the 2017 premiums for the Medicare inpatient hospital (Part A) and physician and outpatient hospital services (Part B) programs.

Medicare Part B Premiums/Deductibles

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and other items.

On October 18, 2016, the Social Security Administration announced that the cost-of-living adjustment (COLA) for Social Security benefits will be 0.3 percent for 2017. Because of the low Social Security COLA, a statutory “hold harmless” provision designed to protect seniors, will largely prevent Part B premiums from increasing for about 70 percent of beneficiaries. Among this group, the average 2017 premium will be about **\$109.00**, compared to \$104.90 for the past four years.

For the remaining roughly 30 percent of beneficiaries, the standard monthly premium for Medicare Part B will be **\$134.00** for 2017, a 10 percent increase from the 2016 premium of \$121.80. Because of the “hold harmless” provision covering the other 70 percent of beneficiaries, premiums for the remaining 30 percent must cover most of the increase in Medicare costs for 2017 for all beneficiaries. This year, as in the past, the Secretary has exercised her statutory authority to mitigate projected premium increases for these beneficiaries, while continuing to maintain a prudent level of reserves to protect against unexpected costs. The Department of Health and Human Services (HHS) will work with Congress as it explores budget-neutral solutions to challenges created by the “hold harmless” provision.

“Medicare’s top priority is to ensure that beneficiaries have affordable access to the care they need,” said CMS Acting Administrator Andy Slavitt. “We will continue our efforts to improve affordability, access, and quality in Medicare.”

Medicare Part B beneficiaries not subject to the “hold harmless” provision include beneficiaries who do not receive Social Security benefits, those who enroll in Part B for the first time in 2017, those who are directly billed for their Part B premium, those who are dually eligible for Medicaid and have their premium paid by state Medicaid agencies, and those who pay an income-related premium. These groups represent approximately 30 percent of total Part B beneficiaries.

CMS also announced that the annual deductible for all Medicare Part B beneficiaries will be \$183 in 2017 (compared to \$166 in 2016).

Medicare Part A Premiums/Deductibles

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. **About 99 percent of Medicare beneficiaries do not have a Part A premium** since they have at least 40 quarters of Medicare-covered employment.

The Medicare Part A **inpatient hospital deductible that beneficiaries pay when admitted to the hospital will be \$1,316 per benefit period in 2017**, an increase of \$28 from \$1,288 in 2016. The Part A deductible covers beneficiaries' share of costs for the first 60 days of Medicare-covered inpatient hospital care in a benefit period. Beneficiaries must pay a coinsurance amount of \$329 per day for the 61st through 90th day of hospitalization (\$322 in 2016) in a benefit period and \$658 per day for lifetime reserve days (\$644 in 2016). For beneficiaries in skilled nursing facilities, the daily coinsurance for days 21 through 100 of extended care services in a benefit period will be \$164.50 in 2017 (\$161 in 2016).

Enrollees age 65 and over who have fewer than 40 quarters of coverage and certain persons with disabilities pay a monthly premium in order to receive coverage under Medicare Part A. Individuals who had at least 30 quarters of coverage or were married to someone with at least 30 quarters of coverage may buy into Part A at a reduced monthly premium rate, which will be **\$227** in 2017, a \$1 increase from 2016. Uninsured aged and certain individuals with disabilities who have exhausted other entitlement and who have less than 30 quarters of coverage will pay the full premium, which will be **\$413** a month, a \$2 increase from 2016.

It's Not Too Late to Launch CCOF on January 1st



High Deductible Plans and CCOF Are Becoming Mainstream

When we first starting teaching practices how to implement credit card on file (CCOF) in their practices in 2010, only a few practices had ever heard of it. Today, we get calls weekly from practices who need help collecting patient balances, especially from patients with high-deductible plans, many whom do not understand how their plan works. Note that almost 25% of persons covered by employer health plans are enrolled in

high-deductible plans, and almost 90% of enrollees in the healthcare exchange (Affordable Care Act Marketplaces) have a high-deductible plan!

The time-honored tradition of sending patients monthly statements and allowing them to pay on their own timetable has increasingly become untenable for medical practices, especially small practices that have limited financial resources to wait out patient payments. Physicians are paying their staff, medical supplies, utilities and rent monthly while waiting for insurance plans to pay in 30 to 45 days and patients to pay anywhere from 60 to 120 days or more past the date of service.

Having the Talk With Patients

Credit card on file opens the patient payment dialogue by changing the conversation from ***“We’ll send you a bill when insurance pays their portion”*** to ***“Once we receive the insurance Explanation of Benefits (EOB), we’ll charge your card for the patient-responsible balance. If the balance is over \$____, we’ll call you to discuss your payment.”***

On January 1st, the deductible starts afresh for most plans, and any practice not using credit card on file to collect those deductibles is in for a particularly tough quarter – what I’ve always called “The Black Months”. With the size of deductibles however, many practices are in for another tough year. Contrary to plans of the past that applied the deductibles only to very high-priced services or hospital events, many deductibles apply to office visits, medications, labs – essentially every healthcare service one can have. Some patients will never meet their deductible and will be paying your practice out of their pocket for every service all year long.

Is 2017 the year you streamline and improve patient collections?

It's not too late to get it together to launch your program now to be ready for the new year. Here are the steps:

1. **Integrate software** that allows you to keep patient credit cards on file on an offsite, secure, third-party server as an add-on to your current merchant services (credit card processing). Call your current credit card processor to see if they have CCOF, but be careful – there is a lot of confusing language around the CCOF part and CC processing charges. My recommendation for [CCOF software is here.](#)
2. **Educate patients** on the change. Inform and educate patients about your new policy between now and when you launch.
3. **Rewrite your financial policy** to include CCOF. If no one ever reads your financial policy, now is the time to make it simpler and clearer.
4. **Educate the staff.** Explain why you're making the change, how it works and how to communicate with patients that might have questions.
5. **Change your patient scripts** to include CCOF language when you schedule and confirm appointments.
6. **Get rid of patient statements.** Decide how you will handle current patient statements to clear those balances. You eliminate statements when you implement CCOF.
7. **Determine your philosophy.** How are going to deal with patients who say they don't have a credit or debit card, or refuse to give you their card to place on file? Most practices will lose a few patients, but it is always less than you expect. Most patients who refuse are patients who never intended to pay you anyway!

I ask physicians this question:

If you collected the same amount of money each month whether you saw 500 patients who paid you part of what they owed, or 350 patients who paid you everything they owed, which would you prefer?

Of course, every physician would love to see less patients, having more quality time with each patient! What's wrong with having a practice full of patients who agree to pay you what they owe? FYI, CCOF does not mean you cannot also serve patients who need help with medical expenses – that's a different conversation!

For more information and help, see our [CCOF page here](#), or watch this 30-minute [YouTube video here](#).

NOTE: I use the term “credit card” in this article, but you can accept, if you so choose, debit cards, health savings account cards, flexible spending account cards – even gift cards.

Flu Shot Information: 2016 – 2017



CDC Updates Flu Shot Recommendations for 2016-2017 Flu Season

A few things are new this season:

- Only injectable flu shots are recommended for use this season.
- Flu vaccines have been updated to better match circulating viruses.
- There will be some new vaccines on the market this season.
- Live attenuated influenza vaccine (LAIV) – or the nasal

spray vaccine – is **not** recommended for use during the 2016-2017 season because of concerns about its effectiveness.

- CPT code 90674 is a new code for 2017, and some code descriptions are revised for 2017 to indicate dosage as opposed to age.
- The recommendations for vaccination of people with egg allergies have changed.

The recommendations for people with egg allergies have been updated for this season:

- People who have experienced only hives after exposure to egg can get any licensed flu vaccine that is otherwise appropriate for their age and health.
- People who have symptoms other than hives after exposure to eggs, such as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who have needed epinephrine or another emergency medical intervention, also can get any licensed flu vaccine that is otherwise appropriate for their age and health, but the vaccine should be given in a medical setting and be supervised by a health care provider who is able to recognize and manage severe allergic conditions. (Settings include hospitals, clinics, health departments, and physician offices). People with egg allergies no longer have to wait 30 minutes after receiving their vaccine.

Options this season include:

- Standard dose flu shots. Most are given into the muscle (usually with a needle, but one can be given to some people with a jet injector). One is given into the skin.
- A high-dose shot for older people.
- A shot made with adjuvant for older people.
- A shot made with virus grown in cell culture.
- A shot made using a vaccine production technology

(recombinant vaccine) that does not require the use of flu virus.

Medicare and the Flu Shot

The Medicare Part B payment allowance limits for seasonal influenza and pneumococcal vaccines are 95% of the Average Wholesale Price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. When the vaccine is furnished in the hospital outpatient department, payment for the vaccine is based on reasonable cost.

Providers should note that:

- All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- The annual Part B deductible and coinsurance amounts do not apply.

Medicare Payment Allowances and Effective Dates for the 2016-2017 Flu Season

Effective Dates 8/1/2016 – 7/31/2017

- CPT 90630 Payment allowance is \$20.343.
- CPT 90653 Payment allowance is \$37.383.
- CPT 90656 Payment allowance is \$17.717.
- CPT 90657 Payment allowance is pending.
- CPT 90661 Payment allowance is pending.
- CPT 90662 Payment allowance is \$42.722.
- CPT 90672 Payment allowance is \$26.876.

- CPT 90673 Payment allowance is \$40.613.
- CPT 90674 Payment allowance is \$22.936.
- CPT 90685 Payment allowance is \$26.268.
- CPT 90686 Payment allowance is \$19.032.
- CPT 90687 Payment allowance is \$9.403.
- CPT 90688 Payment allowance is \$17.835.
- HCPCS Q2035 Payment allowance is \$16.284.
- HCPCS Q2037 Payment allowance is \$16.284.
- HCPCS Q2039 Flu Vaccine Adult – Not Otherwise Classified payment allowance is to be determined by the local claims processing contractor with effective dates of 8/1/2016-7/31/2017.

[Click here](#) for a handy flu shot chart with CPT codes and manufacturers.

Creating Facebook and Blog Content for Your Medical Practice – Free Webinar!

Ever wish you felt more



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ident about social media,
particularly Facebook and blogs?

If you are ready to start using Facebook and posting blog content for marketing, you've come to the right place.

If you're not 100% sold on the time and effort you and your staff have been putting into social media, **you are not alone.**

Managers, physicians and other healthcare providers tell me they are stressed out over what they should be doing for social media and blog content. They have questions like:

- How much time I should focus on Facebook?
- Why is no one engaging with my Facebook posts?
- I have no followers/fans – what am I doing wrong?
- Are Facebook Ads really worth it?
- Should our practice have a blog?
- How do we get started?
- How do we create a doable plan for posting?
- What on earth should we be blogging about, anyway?

Because I think this is so important to medical practices, I've asked my good friends, Janet Kennedy and Carol Bush with Get Social Health if they would introduce this topic to my readers and they've agreed to share their best social media secrets for healthcare practices – for free!

Janet and Carol will be addressing the questions above and answering your specific questions in the web clinic: “Creating Engaging Content for Your Blog and Facebook”. Click [here](#) to reserve your spot for “Creating Engaging Content for Your Blog and Facebook”

They will be sharing with you (and me) the latest information on how to create engaging Facebook and Blog posts.

Can't wait to see you there!

Mary Pat

P.S. The web clinic will last about an hour because I asked Janet and Carol to devote at least 10-minutes to full-on Q&A. That means you can ASK THEM ANYTHING about your business, their business, social media, or whatever you can think of. So start jotting down your questions now, and [don't forget to sign up by clicking here](#).

P.S.S. They'll be giving away some freebies – but you can only get them if you're on the Web Clinic LIVE! So register now and mark your calendar for **Thursday, August 25th at 12:00pm EST**.

What's Driving Your Medical Practice to Change?



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Why small independent practices of their desire to evaluate/change their practice model due to:

- Ongoing Medicare quality program and commercial insurance fee reductions.
- Increasing administrative expense related to pre-authorizations, denials, and patient collections due to high-deductible health plans.
- Desire for more time with patients without sacrificing income.

Now you can weigh in on the discussion by participating in [Kareo's](#) and the [American Academy of Private Physicians' \(AAPP\)](#) annual survey which asks independent physicians for their perceptions of different practice models such as traditional fee-for-service, cash fee-for-service,

concierge/retainer plans, telemedicine and more.

This description of the survey is posted on [Kareo's blog](#):

“Industry research has shown that many independent physicians are concerned about whether or not they can be adequately prepared from the growing shift to value-based reimbursement. As a result, they are testing or fully transitioning to other options like concierge, direct-pay, and virtual models. For the second year, Kareo has partnered with AAPP to investigate this trend more broadly, seeking to understand the challenges and benefits of each payment structure. Furthermore, this survey seeks to determine if a hybrid practice model, which takes into account various payment models, could solve issues of contention that physicians have with their current practice model.”

Healthcare providers and those who manage their practices can access the survey for a chance to win an Apple Watch, an iPad, or a one year AAPP membership. The survey is here: [Private Practice Model Perspective 2016](#).

Want to learn more about different practice models. See my slide deck below “Twelve Practice Models for 2016”

[12 Practice Models for 2016](#) from [Manage My Practice](#)

Heart Failure Patient

Innovation Leads to New Service Line



Setting up new practices and healthcare businesses gives me the opportunity to meet some very creative and dedicated people. An exceptional case in point – Elizabeth Blanchard-Hills, the founder of CareConnex. She and I met several years ago while she was piloting a Transitional Care Management program for Heart Failure patients and she wanted a business model to match the care model.

Fast forward several years, and Elizabeth has taken her experience and her success and made it available to organizations who are looking for a proven way to improve care to patients, reduce healthcare costs by preventing hospital readmissions, and improve patient satisfaction.

Elizabeth agreed to an interview to update me on CareConnex.

Mary Pat: What is CareConnex?

Elizabeth: CareConnex is a care transition service giving heart failure patients renewed hope and a sense of personal control over their emotional well-being and physical health. Patients meet weekly for one month in a small group; they are coached by a multidisciplinary team and encouraged by their peers.

Mary Pat: Why would CareConnex be of interest to hospitals, physician practices or home health agencies?

Elizabeth:Hospitals interested in lowering their heart failure readmissions and improving their HCAHPS scores would benefit from CareConnex. Nurse practitioners and doctors who want to increase revenue by saving time would also benefit from CareConnex, as Medicare and private insurers will pay for this model of care. Home health agencies tell us CareConnex offers them a unique marketing edge over their competitors.

Mary Pat: What is the science behind CareConnex?

Elizabeth: CareConnex is the result of a randomized clinical trial (then called SMAC-HF) which followed more than 200 patients for five years. The results were recently published in *Circulation*, an American Heart Association journal for cardiologists.

Mary Pat: What is the business rationale for CareConnex?

Elizabeth: My company currently has the privilege of “transitioning” the results of the randomized clinical trial into practice. We have been conducting an on-going pilot project with The University of Kansas Hospital since November

2013, and our results are corroborating the results of the randomized clinical trial. Happily, we also discovered that Medicare and private insurers are willing to pay us for the work we do. This is an important benefit when attempting to persuade executive leadership to implement CareConnex.

There are dozens of very good interventions for heart failure, such as software solutions or post-discharge case management tools. Very few are able to pay for themselves; fewer still have the rigor of a randomized clinical trial behind their results.

Mary Pat: What are the main findings of the study?

Elizabeth: That we could, in fact, significantly lower hospital readmissions among heart failure patients.

Mary Pat: What was most surprising about the results?

Elizabeth: We have found several surprises:

- The importance of **managing emotions** when managing a chronic disease such as heart failure;
- The randomized clinical trial showed **depression puts heart failure patients at risk for readmission**; this mirrors what we are now finding in the literature; helping patients feel emotionally and spiritually better is now a signature piece of CareConnex. We screen for depression using the PHQ9, and watch our patients rebuild hope by regaining a sense of control. We do so by talking frankly and directly about sensitive issues that are often time-consuming to address: end-of-life planning, the loss of independence, or asking family members to participate in a change of diet.
- The **value of peer-to-peer coaching**; because of the time

constraints we as health care professionals face, we too often resort to “lecturing” our patients, leaving us little time to validate our patients’ understanding, or their ability to take positive action. For example, it is easy to “tell” someone to limit their sodium intake to 2 grams a day. But does the patient even understand how to read a food label? If not, would he or she feel comfortable revealing that? CareConnex provides a safe environment for patients to recognize and overcome knowledge gaps, as they rely on one another for real-life strategies and emotional support. Our providers are mostly on “standby,” available to address specific questions or misconceptions that specifically require the expertise of an advanced practice nurse or physician.

- Our **data holds across varying patient populations;** patients who struggle with literacy or language benefit from our intervention as do patients who are affluent, well-educated and compliant. Only the “sickest of the sick” (Heart Failure Class III and IV) were included in the randomized clinical trial.
- Our **physicians and nurse practitioners enjoy the CareConnex model,** too. Our team is quite talented, and therefore much in demand at The University of Kansas Hospital. They are often recruited for interesting projects always in play at a large academic medical center. They tell us CareConnex is professionally rewarding, and a welcome change from the standard, one-on- one office visit.

Mary Pat: What should clinicians and patients take away from your report?

Elizabeth: This particular patient population will remain engaged if they find something of value. Being “noncompliant” is a convenient label we often misuse with our patients. Heart Failure patients have logical reasons for being

skeptical of what they perceive as “yet another doctor’s appointment,” such as a lack of energy.

We have been quite strategic in attempting to meet our patients’ emotional needs. The “clinical stuff” (monitoring fluid volume, especially overload) we offer as part of CareConnex is the ‘greens fees’ we pay so we can address and change patient behavior. By making patients feel emotionally and spiritually empowered, we help them change the feelings they have and the choices they make.

Mary Pat: How does a reader get more information?

Elizabeth: Many organizations have approached us over the past couple of years about implementing CareConnex within their own institutions, using their own staff. We now have the experience, “lessons learned” and tools to help them be successful. Readers can email me directly to start the conversation at ehills@careconnex.org and can also visit our website: www.careconnex.org

Mary Pat: Anything else you’d like to say about CareConnex?

Elizabeth: Yes, I’d like to give you a special shout-out, Mary Pat. I first approached you with what I saw as an insurmountable problem several years ago: We had a unique care model that delivered outstanding outcomes for patients with Heart Failure, but no way to get paid for it. Using both common sense and a “roll up your shirt sleeves” approach, you helped us figure it out. Now I am excited to help others do the same, and I am grateful for your belief in me, my team and CareConnex.

Mary Pat: Thank you for the kind words, Elizabeth!



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