25 Principles for Adult Behavior in Healthcare

This month **John Perry Barlow** died.

Described by **Stephen Levy of Wired** as a "cowboy, poet, romantic, family man, philosopher, and ultimately, the bard of the digital revolution", Barlow penned a list he called the "25 Principles of Adult Behavior," as a series of instructions for life.

I see it as a series of turn signals and it inspired me to create the "25 Principles of Adult Behavior in Healthcare."

I stole 9 of his principles (those in italics) and added a bunch of my own.

1. Don’t assume you know what a patient is going through.
2. Don’t think the patient owes you respect for caring for them.
3. Don’t think anyone owes you respect because you’re in charge.
4. Be patient with every patient. Be patient with everyone. *Be patient. No matter what.*
5. *Don’t badmouth: Assign responsibility, not blame.*
6. *Say nothing of another you wouldn’t say to him.*
7. Put nothing in writing that you are not willing to repeat in a court of law or have printed on the front of the local newspaper.
8. *Laugh at yourself frequently. Just laugh, but not at others.*
9. *Concern yourself with what is right rather than who is right.*
10. *Expect no more of anyone than you can deliver yourself.*
11. *Never forget that, no matter how certain, you might be wrong.*
12. *Praise at least as often as you disparage.*
13. *Admit your errors freely and soon.*
14. Knock before entering.
15. All people deserve dignity. Offer it.
16. Everyone is frightened in healthcare, even if they don’t act like it – patients and admins alike.
17. Leave it at the office.
18. Address patients and others by their formal titles until they give you permission to do otherwise.
19. Keep your hands away from your eyes, your nose and your mouth regardless of what your job is.
20. Wash your hands frequently, regardless of what your job is.
21. Listen more than you talk. Especially listen to patients even if you are sure you know what they are going to say.
22. Let people finish their sentences and pause before answering.

23. Start conversations with questions. You might be surprised at what you learn.
24. If you're the boss: sit at every workstation in the office once every three months and observe.
25. Bring cookies to work once in awhile.

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Credit Card Signatures: Bye Bye

What follows is an article adapted from one published in the Infintech News January 30, 2018. Infintech is my **Credit Card on File** gateway and credit card processor for my consulting business. It is also a company I recommend to clients. I've been working with my rep, **Michael Gutlove** for 6 years implementing Credit Card on File in medical and dental

practices, and can honestly say his customer service is unparalleled.

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The rise of mobile payments such as Apple Pay and Google Wallet have set the stage for consumers to have an improved shopping experience when purchasing goods or services. With the influx of convenient payment methods, credit cards companies are continually taken to task on improving overall purchasing practices.

The major credit card brands – MasterCard, Visa, American Express and Discover – have found a way to do just that. These brands recently announced that as of April 2018, **they will no longer require a signature on debit or credit card purchases**, so buyers can have a faster and more convenient shopping experience. This will also help reduce merchants' operating expenses associated with retaining these signatures.

Here is a quick recap of the statements from the card networks according to creditcards.com:

- **Mastercard**, which announced in October that it would make signatures optional in April, says more than 80 percent of the in-store transactions it processes now don't need a signature.
- **Discover** said on Dec. 6, that it, too, would abandon the signature requirement. "With the rise in new payment security capabilities, like chip technology and tokenization, the time is right to remove this step from the checkout experience," Discover's Jasma Ghai, vice president of global products innovation, says.
- **American Express** announced Dec. 11 that it will drop the signature requirement globally in April. "The payments landscape has evolved to the point where we can now eliminate this pain point for our merchants," said Jaromir Divilek, Executive Vice President, Global

Network Business, American Express.

- **Visa** said in a blog post that it will make “the signature requirement optional for all EMV contact or contactless chip-enabled merchants in North America, beginning April 2018.”

Credit Card Signatures No Longer Fight Fraud

In the past, signatures were perceived as an added layer of protection to prevent customers and merchants from fraudulent transactions. Initially, retail stores could use the signature on the receipt and match it to the signature on the back of the customer’s card, but merchants rarely do this making the need for a signature less impactful. Although it isn’t mandatory to collect a signature from a customer, merchants can still do so if they wish.

The need for signatures has also declined around the world due to many advancements in the payments industry such as contactless payment options, the global adoption of EMV chip technology and the ever-growing world of online commerce. According to pymnts.com, in the two years since EMV chip cards launched in the United States, fraud at the physical point of sale has declined by 66 percent. This is attributed to the deployment of EMV technology at the in-store point of sale and consumers’ use of chip cards. Signatures as an added measure of authentication is unlikely to create risk for chip card transactions.

Credit Card Security Isn’t Compromised

According to macrumors.com, credit card companies eliminating signatures for in-store transactions will not have any impact on customer security. In fact, security is better than ever

due to the move towards a more digital payment world.

“Our secure network and state-of-the art systems combined with new digital payment methods that include chip, tokenization, biometrics, and specialized digital platforms use newer and more secure methods to prove identity,” said Linda Kirkpatrick, an Executive Vice President at Mastercard.

Both Merchants and Customers Are Okay with this Change

According to usatoday.com, Kirkpatrick says that “eliminating the need for signature is another step in the digital evolution of payments and payment security.”

Since security is not an issue, both merchants and customers are looking forward to saying goodbye to signatures. Payments will become easier and more convenient, checkout lines will move faster and merchants will be able to push more customers through lines in a timely manner. It’s a win-win for everyone.

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So You Want to Be a Practice Management Consultant?

I recently was asked how to start consulting in the medical practice management space. I love consulting, but it’s not nearly as glamorous and freewheeling as it might look.

Don’t Quit Your Day Job

Unless you have an amazing referral stream or money to put into marketing, you cannot expect to be able to support yourself initially. I consulted informally on the side for years before starting my actual consulting practice, and after 6 years of pure consulting, I’ve gone back to having a day job managing a practice and consulting on the side.

Write Every Day

Consultants write reports. Every day. It’s our product. If you don’t write well or have trouble with spelling or grammar, get help. If you’re not sure if you can write well, get help.

Consultants Have to Market Themselves

As an independent consultant you have to wear every hat. You have to:

- Market yourself.
- Get consulting agreements.
- Collect deposits.
- Consult and write a report on your findings and recommendations.
- Bill and collect your fee.

I started my blog in 2008 with the idea that I might someday leverage it into an income stream. I was told then, and believe it holds true today that producing good-quality content is the best form of advertisement for consultants. I get 90% of my business through my blog which ranks well because I've been writing faithfully for 10 years.

Independent Consultant Advice

- **Start or continue consulting** if opportunities are available and give more than you get in service and value to help build word-of-mouth. Get testimonials and clients willing to act as referrals.
- **Get a website.** Everyone who considers hiring you wants to see that you are "real" and a website is one measure of real. If you teach yourself how to create a website, you will save money and not have to rely on anyone else to correct mistakes or publish a post when you want it published.
- **Develop your voice** by producing content for your website – don't be afraid that by writing content you are giving away your secrets. Your secret sauce is who you are and the skill you bring to the table.
- **Troll listservs** for problems practices are talking

about. Don’t be afraid to answer questions on listservs (your state MGMA listserv, for instance) and build your reputation as a go-to consultant.

- Make sure to **offer email subscriptions** to your website so you are pushing content to your audience.
- **Pay attention to what content does well** (Google Analytics is free) and adjust your writing appropriately.
- **Make one article or blog post work three times** – where else can you publish it? LinkedIn? Facebook? A practice management newsletter? Expand it into a white paper or eBook? A webinar?
- **Consider offering something for free** – a free 30-minute consultation is a great way to introduce potential clients to you.

Be a Consultant With a Firm

Many consultants “pay their dues” by joining an established consulting company for two or more years. This gives you great experience and can be great money, but you don’t get paid if there’s no work and the traveling is tough after awhile. You have to be a real road warrior to travel every Monday and Thursday and only be home on the weekends.

I am at the point in my consulting career that I don’t travel. Clients prefer the face-to-face, but once I point out how much money I save them by not traveling to their location, they are fine with it. Put a recording or a video on your website to introduce yourself so potential clients can see and hear you and get a feel for who you are.

Blog Monetization

I’ve tried every possible way to monetize my blog (ads, products, sponsored content and campaigns, affiliate marketing) and once you have eyeballs on your site they will

produce small income streams but not significant ones unless your website is drawing thousands of visitors per day. I even considered a paywall at one time, but after market research decided that practice managers and practices would not be willing to pay even a small amount per month for exclusive content.

Create a Product

Because medical practices – especially small and non-surgical/procedural practices – are really hurting financially you may want to develop products to sell as well as your time and expertise. One of my niches is implementing Credit Card on File. Practices may have the resources to implement the program themselves, so I also sell an Action Pack of templates and worksheets so they can DIY.

Develop Your Specialty

Think about your experience and skills, and research who is filling a niche that you'd like to develop. Do your homework and see if you can either emulate what they're doing, or provide something different or better. Think about how you can distinguish yourself in that niche and write, write, write about it so you can be found.

How to See Patients When the Physician Isn't Credentialed

Yet

Credentialing new physicians is the definition of Catch-22.

You can’t start the process too early as payers won’t accept the application (especially if the physician doesn’t have their malpractice in place), and by the time payers will accept the application to begin credentialing, the provider is already onboard and ready to see patients.

Credentialing typically takes 3 to 6 months and sometimes longer as insurance plans are not motivated to put more physicians on their networks and increase their payment exposure.

One of the strategies many practices employ is to bill for the new physician’s services as if an existing physician provided

them, but you don’t want to do that. Ever.

You might get away with it, but the risk is too great.

First, if you are billing under an enrolled physician’s NPI as rendering and supervising, the enrolled physician’s utilization is going to spike – that’s a red flag.

Second, if a patient sees the enrolled physician’s name on their EOB, they might call the insurance plan and say “I never saw that doctor.” Another red flag. Don’t forget that patients are increasingly attuned to the possibility of fraud, and they should be!

Third, a payer might request your appointment schedule, which will tell the tale of who actually saw the patient.

These red flags can trigger an audit – something to avoid at all costs.

What can you do while waiting for credentialing to be complete?

Ask for a Statement of Supervision

Some plans will officially let you bill under a supervising physician once the credentialing of the new physician is underway. Ask every plan if they will accept a Statement of Supervision from a physician enrolled in the plan, so the new physician can start seeing patients.

Divert Self-Pay and Medicare Patients to the New Physician

Physicians can see Medicare patients right away. Medicare will

let physicians retro-bill back 30 days from the date their Medicare application was received at the Medicare Administrative Contractor's (MAC's) office. This is why I prefer to enroll physicians in Medicare the old fashioned way – on paper – because I can always prove the delivery with a Return Receipt Requested response. You won't be able to bill until you get the "Welcome to Medicare" letter with the physician's PTAN, but you will get paid.

Check With Medicaid

If you are enrolling the new physician in Medicaid, check on your state's rules (each state is different). They are usually so hungry for physicians taking Medicaid that they will allow retro-billing as well.

Schedule Patient Meet and Greets

Offer complimentary Meet and Greets (no medical care provided) to potential patients who might want to see the new physician when credentialing is complete. This is not appropriate for every specialty, but works well for many.

Put the New Physician on the Speaking Circuit

If you can't fill the physician's schedule due to credentialing, get the physician out to meet other physicians and the community. Marketing a new physician is never a waste a time – make a plan long before the physician arrives to have speaking engagements set up – so many organizations are looking for free speakers! Contact TV, radio stations, newspapers and local magazines to see if they'd like to interview the new physician. Also connect the new physician with other new physicians starting around the same time – they'll often start to refer.

Work With Your Web Team

Have the physician write for your blog, or have your social media folks work with the physician to produce articles.

See Some Patients for Free

Sometimes it’s worth it to see a patient for free to get the new practice moving along and to spread the good word!

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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 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 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.