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.

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 impactfull. 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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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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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@manageyourpractice.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
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-denier 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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Advance Beneficiary Notice FAQs

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

We always tell the physicians we work with: “If you are going to accept insurance, you need to be the expert on insurance.” In practice this means knowing your patient’s benefits and working with them to communicate with them about what, if anything, they will owe before or after payer adjudication. No one enjoys being surprised about money!
The ABN is also a tremendous opportunity to talk about financial responsibilities with a patient. If you don’t have a credit card on file program in your practice, it’s important to be proactive about patient financial responsibilities and how they will be handled. Having a patient sign that they understand they will be financially responsible for payment for a non-covered service is a natural way to start that process.

Here are some of your most frequently asked ABN questions.

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

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

**What won’t Medicare pay for?**

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

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

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

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

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

Are ABNs for Medicare only?

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

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

2016 CPT Code Changes

The 300 new, deleted, revised, and converted CPT codes for 2016 are here and you will need to make sure they are loaded in your billing and EMR system(s) on or before January 1, 2016. This is also a great time to upload the 2016 Medicare allowables for your locality and for any payer contracts that apply a multiplier to the current Medicare fee schedule for
their own allowables (for instance, XYZ payer pays 125% of 2016 Medicare).

Only a few areas do not have any changes this year – there are no deleted or changed modifiers and there are no changes to the anesthesia chapter of CPT. As for everything else, grab your 2016 CPT code book or digital version and follow along. *Note that this is not an all-inclusive list; review your CPT book for complete description of all codes.*

Don’t forget to scroll down to the bottom of this post to see the new category three (temporary) codes that may apply to your specialty.

**Evaluation and Management Codes (E/M)**

- Add-on codes for Prolonged Services +99354 and +99355 now apply to prolonged face-to-face outpatient psychotherapy as well as to prolonged face-to-face E/M codes. Use a primary E/M or psychotherapy code, one 99354 (30-74 minutes in addition to the time spent on the initial/primary service) per day and as many units of 99355 as needed to match the time spent. *NOTE:* check the table in your CPT book to report the correct codes by time. OUTPATIENT ONLY.

- Two new add-on Prolonged Services codes have been created. +99415 and +99416 are to be used to report prolonged face-to-face clinical staff service with physician, NP OR PA supervision. Same rules as above. Prolonged codes start at >45 minutes. *NOTE:* Document what you did and how long you did it. If you are reporting additional procedures, document the time and
note that they are excluded from the prolonged service so no one thinks you’re double-dipping. OUTPATIENT ONLY.

- Any code with a “+” prefix must be reported with a primary code. These add-on codes can never appear on a claim by itself.

**Integumentary System**

- **New**: 10035, placement of soft tissue locations devices such as clips, markers, etc., first lesion
- **New add-on**: +10036, placement of soft tissue locations devices such as clips, markers, etc., additional lesions (Not be used for breast, use existing breast codes 19081-19086), w/biopsy (19281-19288)

**Musculoskeletal System**

- **Deleted**: 21805 – open treatment w/o fixation for rib fracture (Closed treatment or uncomplicated to use E/M code, Open treatment with fixation, use 21811- 21813)

**Respiratory System**

- **Revised**: 31632 and 31633 bronchoscopy codes now include moderate sedation
- **Deleted**: 31620
- **New**: Bronchoscopy codes with EBUS 31652 (one or two node stations or structures), 31653, (three or more node stations or structures), +31654 (peripheral lesions – look in the CPT book for primary codes this add-on code can be used with)

**Cardiovascular System**

- **New**: Category III code 0262T has been replaced with 33477, Transcatheter pulmonary valve implantation, includes procedure, angioplasty and imaging guidance,
supervision and interpretation when performed

- **Revised:** 37184, 37185, and 37186 were revised to include description “non-intracranial vessels”. Fluoroscopy is included.
- **New:** 37211 is for intracranial vessels
- **Deleted:** +37250 and +37251
- **New add-on:** +37252 (intravascular ultrasound, initial noncoronary vessel) and +37253 (intravascular ultrasound, each additional noncoronary vessel. Look in the CPT book for primary codes this add-on code can be used with.)
- **Deleted:** 39400
- **New:** 39401 (Mediastinoscopy with biopsy of mediastinal mass, when performed) and 39402 (Mediastinoscopy with lymph node biopsy, when performed)

**Digestive System**

- **New:** 43210 transoral approach using endoscope, not open, partial or complete

**Biliary**

- **Deleted:** 47560 and 47561 (see 47579, 47531, or 47532 for percutaneous cholangiography)
- **Deleted:** 47630 (see 47544)
- **Deleted:** 47500, 47505, 47510, 47511, 47525, 47530, 74305, 74320, 74327
- **New:** 47531 Injection procedure for cholangiography, includes RSI – radiologic supervision and interpretation, existing access and 47532 Injection procedure for cholangiography, includes RSI – radiologic supervision and interpretation, new access.
- **New:** 47533 Placement of biliary drainage catheter, includes cholangiography, includes RSI – radiologic supervision and interpretation, external and 47534 Placement of biliary drainage
catheter, includes RSI – radiologic supervision and interpretation, internal-external.

- **New: 47535** Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, includes cholangiography, includes RSI – radiologic supervision and interpretation

- **New: 47536** Exchange of biliary drainage catheter, all types, includes cholangiography, includes RSI – radiologic supervision and interpretation

- **New: 47537** Removal of biliary drainage catheter, includes cholangiography, includes RSI – radiologic supervision and interpretation

- **New: 47538** Placement of stent into bile duct, includes cholangiography, includes balloon dilation and catheter exchange(s) and removal(s), includes RSI – radiologic supervision and interpretation, each stent, existing access

- **New: 47539** Placement of stent into bile duct, includes cholangiography, includes balloon dilation and catheter exchange(s) and removal(s), includes RSI – radiologic supervision and interpretation, each stent, new access, without placement of separate biliary drainage catheter

  *(Handy table for reference in CPT book before this code!)*

- **New: 47540** Placement of stent into bile duct, includes cholangiography, includes balloon dilation and catheter exchange(s) and removal(s), includes RSI – radiologic supervision and interpretation, each stent, new access, with placement of separate biliary drainage catheter

- **New: 47541** Rendezvous Procedure, new access, includes RSI – radiologic supervision and interpretation

- **New add-on: +47542** Balloon dilation of biliary duct, each duct *(look for primary codes this can be used with and use modifier -59 if a second unit/duct is treated)*

- **New add-on: +47543** Endoluminal biopsy of biliary tree, single or multiple, includes RSI – radiologic supervision and interpretation, report this code once
New add-on: +47544 Removal of calculi or debris from biliary ducts or gallbladder, includes RSI – radiologic supervision and interpretation (look for primary codes this can be used with)

Digestive System: Sclerotherapy

New: 49815 – one unit per lesion treated, report subsequent lesion(s) with modifier -59

Urinary System: Kidney

Revised: 50387 deleted transnephric ureteral stent and added “nephroureteral catheter”, see 50688 for removal and replacement of externally accessible ureteral stent (removal of stent without a replacement falls under E/M)

Kidney: New Heading Called Injection, Change or Removal

Deleted: 50392, 50393, 50394, 50398

New: 50430 (new access) and 50431 (existing access) both include RSI – radiologic supervision and interpretation

New: 50432 and 50433 (new access) both include RSI – radiologic supervision and interpretation, report one unit of 50432 for each renal collecting system or ureter accessed

New: 50434 (pre-existing nephrostomy tract) and 50435 (exchange catheter), both include RSI – radiologic supervision and interpretation, report one unit of 50435 for each renal collecting system or ureter accessed

New add-on: +50606 non-endoscopic endoluminal biopsy, once per ureter per day, includes RSI – radiologic supervision and interpretation (look in the CPT book for primary codes this add-on code can be used with)
• New: **50693** (placement of ureteral stent, existing access) **50694** (new access separate nephrostomy catheter) and **50695** (new access with separate nephrostomy catheter), all include RSI – radiologic supervision and interpretation

• **New add-on: +50705** (ureteral embolization or occlusion) includes RSI – radiologic supervision and interpretation, once per ureter treated per day (look in the CPT book for primary codes this add-on code can be used with)

• **New add-on: +50706** (balloon dilation) includes RSI – radiologic supervision and interpretation (look in the CPT book for primary codes this add-on code can be used with)

**Male Genital**

• **New: 54437** Penis Repair (repair of urethra may be reported separately)

• **New: 54438** Penis Replantation, complete amputation (for partially amputated see 54437, for urethra repair see 54310 and 54315)

**Nervous System**

• **New: 61645** Mechanical thrombectomy, intracranial

• **New: 61650** Endovascular intracranial prolonged administration of pharmacologic agents not for thrombolysis, arterial, initial vascular territory

• **New add-on: +61651** Endovascular intracranial prolonged administration of pharmacologic agents, arterial, not for thrombolysis, each additional vascular territory

• **Deleted: 64412**, use **64999**

• **New: 64461** Paravertebral Block (PVB), thoracic, single injection, includes imaging guidance when performed

• **New add-on: +64462** Second and any additional injection sites, can only be reported once per day, includes
- **New: 64463** Continuous infusion by catheter, includes imaging guidance when performed

**Eye**

- **New: 65785** Implantation of intrastomal corneal ring segments, revised to state “one session” (Category III code 0099T was replaced by this code)
- **Revision: 67101** Trabeculoplasty by laser surgery, revised to state “including drainage when performed” and revised to replace “with or without” with “including when performed”
- **Revision: 67105** Trabeculoplasty, photocoagulation, repair of retinal detachment, revised to state “including drainage when performed” and revised to replace “with or without” with “including when performed”
- **Deleted: 67112** Retinal detachment, use 67107, 67108, 67110 or 67113 as appropriate
- **Revised: 67107** Repair of retinal detachment, scleral buckling, revised to replace “with or without” with “including when performed”
- **Revised: 67108** Repair of retinal detachment with vitrectomy, revised to replace “with or without” with “including when performed”
- **Revised: 67113** Repair of complex retinal detachment, revised to replace “with or without” with “including when performed”
- **Revision: 67227** Destruction of extensive or progressive retinopathy, revised to remove “one or more sessions”
- **Revision: 67228** Treatment of extensive or progressive retinopathy, photocoagulation, revised to remove “one or more sessions”
Auditory System

- **New: 69209** Removal of impacted cerumen using irrigation/lavage, unilateral
- **New: 69210** Removal of impacted cerumen requiring instrumentation, unilateral, **NOTE:** For removal of non-impacted cerumen, use E/M code, append modifier -50 for bilateral (both ears), do not report 69209 and 69210 for the same ear!

Diagnostic Radiology

- **Deleted: 70373** (see unlisted code 76499 for contrast laryngography)
- **Revised: 72080** Spine, thoracolumbar junction, minimum of two views
- **Deleted: 72069 and 72090**
- **New: Scoliosis Evaluation Codes 72081** (one view), 72082 (two or three views), 72083 (four or five views) and 72084 (minimum six views)
- **Deleted: 73500, 73510, 73520, 73530 and 73540**
- **New: Hip With Pelvis** (when performed) Unilateral 73501 (one view), 73502 (two or three views), 73503 (minimum four views)
- **New: Hip With Pelvis** (when performed) Bilateral 73521 (two views), 73522 (three or four views), 73523 (minimum five views)
- **Deleted: 73550**
- **New: 73551** Femur (one view) and 73552 (two or more views)
- The word “film” has been replaced by “image” in 74240, 74241, 74245, 74246, 74247, 74250 and 74340
- **New: MRI of Fetus 74712** (single gestation) and +74713 (each additional gestation) only if fetus is imaged
Radiology: Brachytherapy

- **New**: 77767 and 77768 (multiple lesions or channels)
- **Deleted**: 77785 and 77786
- **New**: 77770 (one channel), 77771 (two to twelve channels), 77772 (more than twelve channels)
- **Deleted**: 77776 and 77777 (see 77799 for intermediate service)
- **Revised**: 77778 to include “supervision, loading and handling of the radiation source”

Radiology: Nuclear Medicine

- **Revised**: 78624 to include “imaging study” and “(solid food, liquid food or both)”
- **New**: 78265 (small bowel transit) and 78266 (small bowel and colon transit)

Pathology and Laboratory

- **New**: 80081 addition of HIV testing the standard OB panel (must have all elements of the panel performed to use 80085 or 80081, otherwise must code each test separately)
- **NOTE**: Refer to the CPT book for many additional changes

Medicine: Vaccines

- **Deleted**: 13 outdated codes deleted
- **Revised**: 40+ codes reworded to improve clarity
- **New**: 90625 Cholera Vaccine
- **New**: 90697 DTap-IPV-Hib-HepB
- **New**: 90620 Meningococcal, 2 dose schedule
- **New**: 90621 Meningococcal, 3 dose schedule

Otolaryngology

- **Deleted**: 92543
- **New**: 92537 (bilateral, bithermal, 4 irrigations) and
92538 (bilateral, monothermal, two irrigations)

**Cardiovascular and Pulmonary**

- **New:** 93050 Arterial pressure waveform analysis (Category III code 0311T deleted)
- **Revised:** 94640 “for therapeutic purposes” and includes “sputum induction”

**Neurology and Neuromuscular**

- **Deleted:** 95973
- **Revised:** 95972 revised to remove the time element

**Dermatology**

- **New primary and add-on codes:** RCM Codes 96931 (image acquisition, interpretation and report, first lesion), 96932 (image acquisition only, first lesion), and 96933 (interpretation and report only, first lesion), +96934 (image acquisition, interpretation and report, each additional lesion), +96935 (image acquisition only, each additional lesion), and +96936 (interpretation and report only, each additional lesion) **NOTE:** Technical is image acquisition, Professional is interpretation and report. Both components are included in 96931 and 96934.

**Medicine: Other**

- **Revised:** Ocular Screening 99174 to include “remote analysis and report”
- **New:** Ocular Screening 99177 onsite analysis

**Category III Codes**

- **Sunset Codes:** 0103T, 1223T, 0123T, 0223T, 0224T, 0225T, 0233T, 0240T, 0241T, 0243T, 0244T (codes not replaced by a Category I code)
- **Replaced Codes**: 0099T see 65785, 0182T see 0394T and 0395T, 0262T see 33477, 0311T see 93050

- **New**: 0381T (Epilepsy seizure recording up to 14 days with review and report), 0382T (14-day with review and report only), 0383T (Epilepsy seizure recording for 15 to 30 days with review and report), 0384T (15 to 30 days with review and report only), 0385T (Epilepsy seizure recording for more than 30 days with review and report), and 0386T (>30 days with review and report only)

- **New**: Permanent Leadless Pacemaker 0387T (insertion/replacement), 0388T (removal), 0389T (programming), 0390T (evaluation) and 0391T (interrogation)

- **New**: Esophageal Sphincter Augmentation Device 0392T (placement), and 0393T (removal)

- **New**: Electronic Brachytherapy 0394T (skin surface) and 0395T (interstitial or intracavitary)

- **New add-on**: +0396T Implant stability testing during knee replacement

- **New add-on**: +0397T Optical endomicroscopy during ERCP

- **New**: 0398T MRI-guided ultrasound for intracranial lesion ablation

- **New**: +0399T Myocardial strain imaging

- **New**: 0400T (Digital skin lesion analysis, one to five lesions) and 0401T (digital skin lesion analysis, six or more lesions)

- **New**: 0402T Collagen cross-linking of cornea

- **New**: 0403T Behavior change in high-risk patients for diabetes prevention, group setting, 60 minutes per day

- **New**: 0404T Uterine fibroid ablation with ultrasound guidance, radiofrequency, reported once regardless of number of fibroids treated

- **New**: 0405T Thirty minutes or more per month non-face-to-face liver assist care oversight

- **New**: 0406T Nasal endoscopy, placement of drug-eluding implant and 0407T endoscopy with biopsy, polypectomy or debridement
EMV: How Your Practice Will Be Affected By Credit Card Changes in October 2015

At Manage My Practice, we are big proponents of using a Credit Card on File (CCOF) system in medical practices to reduce expenses and improve cash flow. Knowing how your processing vendor’s pricing plan and security features work are critical to implementing this system. You have to be able to understand and negotiate your costs, and stay current on best practices and technology that keep your patients’ data safe.

Big changes are coming to the technology end of your credit card system in October of this year (as if you won’t be busy enough with ICD-10!) and you need to make sure now that you have all the details handled for your employees and your patients. The new technology is called EMV, or “Euro Mastercard Visa” and has been used in most of the rest of the world for awhile now.

Whenever we have questions about anything credit card related, we go straight to Michael Gutlove, Director of Merchant Services at IDT. Michael has been our own vendor, as well as our top recommendation to clients for almost three years now. We asked him to help us sort out the changes.
Mary Pat: Michael, what’s your background?

Michael: I’ve been helping business owners improve their bottom lines since 1997. Reducing costs are critical – now more than ever – for all business owners, and I’ve been able to repeatedly reduce operating costs by clearing away the traditional smoke and mirrors of credit card processing.

Mary Pat: Are people in general and patients specifically using credit cards more than they used to? Do you foresee a time when people will only use credit cards, no cash or checks?

Michael: While electronic payment volume has steadily increased year after year it’s highly unlikely that cash or checks will ever be completely eliminated. Cash payments serve the “underbanked” population and checks remain a highly effective method of payment for high ticket (luxury) items.

Mary Pat: What about payment via a smartphone or watch — do you see that becoming a predominant part of the American payment experience?

Michael: Apple Pay is the first mobile wallet solution that’s made any traction into the payment space. It’s opened the door for cell phone manufacturers, wireless carriers, and any/every technology company under the moon to think about getting involved. The problem with suggesting that mobile technology will replace the way we pay (or become the primary way we pay) is that it’s not fixing an existing problem. Mobile payments are generally viewed as a convenience as opposed to a necessity and we’ve become accustomed to carrying a wallet or purse with actual credit cards.
Mary Pat: The new acronym in credit cards is EMV. What is EMV?

Michael: EMV stands for Europay MasterCard Visa. It’s an acronym for the Global standard of chip card technology facilitating electronic payment transactions. The United States is the last major country to adopt this method.

Mary Pat: Why do readers need to know about EMV?

Michael: October 2015 marks the deadline for business owners, accepting credit or debit cards, to upgrade their terminals for chip card acceptance. While it is not legally necessary to upgrade, doing so reduces the liability for fraudulent or counterfeit duplicate transactions.

Mary Pat: What does accepting chip cards have to do with liability?

Michael: EMV prevents “card present” duplicate fraud as the customer always maintains possession of their card. Instead of swiping the mag-stripe on the back, merchants will instruct customers to insert cards into the EMV ready terminal and enter a PIN or signature when prompted. Businesses that do not have the ability to accept EMV cards will be held liable for fraudulent “swiped” transactions.

Mary Pat: Does EMV eliminate fraud?

Michael: EMV is not a cure all for all types of fraud. The programs put in place will help with duplicate card fraud charge-backs, but will not impact others. Visa, MasterCard, Discover, and American Express have different liability shift requirements.

Mary Pat: What about “Card Not Present” transactions?

Michael: EMV only applies to face-to-face transactions. When it was released in Europe increased levels of fraud showed up via ecommerce and MOTO (mail order/telephone order). A similar scenario is expected once the US adopts EMV making PCI-DSS
compliance even more important.

**Mary Pat: What is PCI?**

**Michael:** PCI–DSS stands for the Payment Card Industry Data Security Standard. Most processors offer comprehensive programs to ensure PCI compliance and validation.

**Mary Pat: What should I do now?**

**Michael:** Reach out to your processor and determine your risk level for EMV. Accepting EMV can only help your business but it isn’t necessary to do anything prior to October. The majority of POS (point of sale) manufacturers haven’t released EMV readers and new hardware might not be necessary depending on your existing terminal make & model.

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Making sure you are getting the most you can from your credit card vendor is a critical part of protecting your data and your bottom line in today’s healthcare industry. You need to know the steps you and your vendors are taking to safeguard patient data as well as being able to relay those steps back to patients and employees. That’s why it’s important for managers to understand EMV – and their credit card setup in general. Successful implementation of a credit card on file program or any credit card processing system will always require buy-in and communication.

**NOTE:** *Credit Card on File* clients of Manage My Practice should know that Michael Gutlove will be swapping out your current swipers for EMV terminals for chip and non-chip cards at a considerable discount.

For additional information, questions, or anything else credit card related feel free to reach out to Michael Gutlove at 201.281.1621.
ICD-10: Practices Should Focus on Just 3 Things

There is a lot of advice out there on making the transition to ICD-10. Your medical practice may already have taken some of this advice and you are well on the way to readiness for I-10. But if you’ve not done anything yet for the transition, this article is for you. I’ve distilled all the blah-blah-blah down into three easy steps that any practice can follow to embrace the change.

1. Do You Need More Software Support?

There is no question that most everything hinges on your EMR and billing system’s management of ICD-10. Your vendor may say the system is I-10 ready, but what does that really mean?

Ask your vendor these questions:
1. Are ICD-10 codes available in the system now? If not now, when?

2. Can the providers and staff rehearse using I-10 inside the system by dual coding and assigning both an ICD-9 and an ICD-10 to services without having the I-10 drop to the claim?

3. What support, if any, does the system give for choosing the right ICD-10? Is there any type of translator or crosswalk between I-9 and I-10?

4. After October 1, 2015, will the software have the ability to use an I-10 or crosswalk from 10 to 9 if the payer does not accept 10? It should! Physicians and coders/billers should not have to look at the patient’s payer of record to decided which one to use, nor should they require you to change the I-10 to I-9 on the back end. It is very doable for software to crosswalk from 10 to 9 for you.

If the software supports getting to the most specific ICD-10 possible, not just picking the first one that vaguely matches, choosing the I-10 should be straightforward. If your software does nothing more than save the I-10 codes you choose to a favorites or a pick list, then you will need a standalone piece of software called an “encoder.” Hospitals and mega practices have been using encoders for years to help navigate the maze of Medicare local and national rules.

Practices without sufficient support from their EMR/Billing software will need an encoder that can not only suggest possibilities for ICD-10 codes, but can also assist in finding the right code from a series of words algorithmically ordered. (If you want to know which encoder is my particular favorite, send me an email at marypat@managemypractice.com.) Encoders also usually have additional benefits that your billing software or claims scrubber may not have such as CCI edits, modifier rules, global period and wRVU information.

Example of the drilling down to the correct I-10 diagnosis
Fracture:

- Cause?
- Which bone? Which part of the bone? Laterality?
- Type of fracture? Open, closed, displaced, non-displaced?
- Encounter? Initial, Subsequent, Sequela?
- External cause?
- Associates diagnoses, conditions?

2. Could Documentation Be Brushed Up?

In hospitals, entire teams of people (Clinical Documentation Improvement staff, usually nurses) are dedicated to making sure that the documentation can support the specificity of the I-10 code chosen. This is especially important for the hospital side of reimbursement.

In the hospitals there are often silos between the service providers and the coding review and billing staff. In practices, we have the good fortune to be able to reflect on the documentation once the I-10 code is chosen, and clarify the documentation on the spot if needed.

Some easy ways to make sure your documentation is as complete as possible to support the I-10 code are:

- Think of MEAT when you document. Every condition in your documentation should be described as Monitored, Evaluated, Assessed and/or Treated. If the patient has an existing diagnosis that you did not address during the visit, don’t put it in the documentation or on the claim.
- Use “due to” or “manifested by” for each problem that you describe, if you know that information.
• Change/improve your EMR templates (or paper progress note format) to accommodate the points above.

3. Are You Ready for Cash Flow Interruption?

You’ve heard this for years and it remains a legitimate concern. If there is any problem with claims processing OR if you are not using ICD-10 properly causing denials, there is a good chance your money from insurance companies will slow down or even dry up for awhile. I suspect that insurance companies may use ICD-10 as a handy excuse to delay payment regardless of the plethora of other excuses they have to choose from.

Predictions on the cost of ICD-10 fluctuate wildly, but here are the places you are most likely to feel the financial pain:

• If your EMR/Billing system wants you to pay for an upgrade to your software to compensate them for the money they’ve spent upgrading their software. Since the delay, I’ve heard of fewer companies requiring a special payment for the upgrade.

• Reduction of productivity based on time spent to choose an I-10 code:
  • Any manual form in your practice that uses ICD-9 will need an ICD-10. How will you find those codes?
  • Physicians who choose codes through their EHR will need software support to find those codes. Because there are so many more codes due to the specificity of each code, it will take a while to get the hang of it if you are not using an encoder.

• Inability of your clearinghouse to send claims. Unless you are directly submitting claims to any payers, your clearinghouse has probably tested (end-to-end, please) with payers. Ask your clearinghouse who they’ve tested
end-to-end with and what the results were. If things really bog down with CMS, they may grant advance Medicare payments to physicians that are not receiving payments due to the ICD-10 transition.

- Delay in payment from any payer due to ICD-10 general chaos.

Keep in mind that a lot of the hoopla over ICD-10 has been on the hospital side. Physician practices are very lucky in that we use CPTs for reimbursement (at this point), not diagnoses. This is a huge change for the hospital/facility side, but much less of a transition for medical practices. We are hoping that physician practices will have less impact to their bottom line, but you should be ready with a line of credit or some extra funds in the bank for this possible rainy day. Starting today, practices that make distributions to owners quarterly may want to scale this back until the smoke clears.

**Resources to Help You:**

AHIMA (American Health Information Management Association (AHIMA) has an a nice set of tools relating to the adoption of ICD-10 [here](#). Not all tools are available for non-members.

**CMS Road to 10: The Small Physician Practice’s Route to ICD-10** compiles resources from the AAPC (American Association of Professional Coders) AHIMA, the AMA (requires AMA login) and CMS/PAHCOM (Professional Association of Healthcare Office Managers) produced resources.

The AAPC has lots of high-quality offerings [here](#), most for members or for purchase by nonmembers. Although it was written for the original 2014 transition, here’s a [good article](#) to review for the creation of an ICD-10 superbill, or just to review your top I-9s and translate them to I-10s.

Your software vendor, claims clearinghouse and specialty society should also have ICD-10 tools.
New “One Patient” MU Rule Brings Relief

Last week, CMS published a new proposed rule for Meaningful Use (MU). This rule strives to “…align Meaningful Use (MU) Stage 1 and Stage 2 objectives and measures with the long-term proposals for Stage 3…”. In other words, make the program simpler and make it easier to achieve.

The proposed rule would simplify MU by:

- Reducing the overall number of objectives;
- Removing measures that have become redundant,
duplicative or have reached wide-spread adoption;

- **Allowing a 90 day reporting period in 2015** to accommodate the implementation of these proposed changes in 2015, and possibly of the greatest interest to medical practice,
- Remove the 5 percent threshold for Measure 2 from the EP Stage 2 Patient Electronic Access objective, **requiring that at least (only) 1 patient seen by the provider during the EHR reporting period views, downloads, or transmits his or her health information** to a third party.

This last one is extremely important as practices have spent much time and money trying to encourage patients to use their portals to fulfill the view/download/transmit requirement. As a patient, I understand this. I only use my PCP’s portal a couple of times a year, so I invariably forget my user ID and password (yes, I do know there are programs to store and retrieve these for me, but that’s a conversation for a totally different post) and it all ends up just being a big pain. My health is important to me, but I don’t have reason to get on the portal on a regular basis, and practices are finding out that many patients just don’t care to use the portal or don’t have a need.

More light reading on the proposed rule is available [here](#) in the Federal Register.

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Are Patients Lost in Translation? An Interview
With Dr. Charles Lee of Polyglot

Sometimes you find the most amazing things in your own backyard. In Research Triangle Park, NC, I found the wonderful Dr. Chuck Lee, President and Founder of Polyglot. I was bemoaning the lack of good translation software for healthcare and Sims Preston, CEO of Polyglot, contacted me on LinkedIn and invited me to see their product Meducation. I was fascinated by Dr. Lee’s story and I think you will be too.

Mary Pat: Dr. Lee, you had a very personal reason for starting a healthcare company that focuses on communication in different languages, didn’t you?

Dr. Lee: First, as a clinician, I’ve always believed that we need to help all our patients understand their health information so that they can make better health decisions. To me, it’s just common sense that better health outcomes starts with better informed patients. The challenge is that much health information is not usually written with the patient in mind. It’s often written in high grade reading levels using medical jargon, and often only available in English. If it is available in another language, it’s usually only in Spanish.

About one of every three US adults has some difficulty understanding health information and almost 30 million struggle with the English language — almost 10 percent. Because I am a first generation Korean immigrant — I came to the US when I was 7 years old — I saw how my grandmother struggled to understand how to take her medications. This is one of the reasons I became interested in this issue.

Mary Pat: How did your own experiences drive your vision for your company ‘Polyglot’?
Dr. Lee: It became very apparent that other HIT companies had little interest in serving the needs of minority populations – they said that there’s not much money in it. They said it was too difficult, too costly, and that the market wasn’t big enough. If you look just at the numbers, yes it may not make sense – but how do we continue to ignore almost 10 percent of the population – thirty percent if you count low health literacy! That’s when I decided to form Polyglot Systems to show that creating technology to support language and cultural needs of underserved populations doesn’t have to be hard or costly. If our small company can do it, the big guys will have no excuse.

Mary Pat: Can you talk about the state of healthcare communication for non-English speakers in the United States today?

Dr. Lee: Just think about what it would be like for you if you were in another country and they didn’t speak English. If you got sick and needed medical care, would you know how to read the signs? Know where to go? Know what forms you are signing? Know what the doctors were saying? What your treatment choices are? Or how to take your medicine if the bottle didn’t have English instructions? That gives you a glimpse into what it’s like for non-English speakers in the US.

After I saw my grandmother’s pill bottles with instructions written in English that she couldn’t read, I became aware that this was not an isolated incident. So I asked myself this: How many medication errors are caused by language barriers? Last year there were about 4 billion prescription written – that’s not including over-the-counter medications. Just based on statistics, that would mean about 400 million prescription were given to patients who are limited English proficient. The need was obvious. If you include English-speaking patients who have difficulty understanding health information, this number approaches 1.5 billion prescriptions. Have you seen some of instruction they give you at pharmacies? Even I
can’t understand what much of it says. Also, a lot of the instructions are printed in such small print that I had a hard time reading them. So one of the features we built into Meducation was larger font support for elderly and visually impaired patients.

Mary Pat: It seems that the timing for Meducation is perfect based on the recent emphasis on patient engagement, eliminating waste in healthcare, and increasing medication compliance. How does Meducation address these?

Dr. Lee: For me, it all comes down to common sense. We submitted our first grant proposal to the NIH for Meducation almost 10 years ago – when all those issues you mentioned should still have been issues back then, they just weren’t popular things to talk about then.

Healthcare statistics usually say that a minority of the population utilizes the majority of our healthcare resources. This includes those with heart disease, diabetes, CHF, etc. Do we ignore them because they are the minority? Of course not. I bet you that a significant portion of the patients with heart disease, diabetes, CHF have low health literacy and/or language barriers. If we can make even a few percent improvements in these populations, wouldn’t it be worth doing? This just made sense to me.

I sometimes like to compare our healthcare system to the cable industry. The cable companies spend tremendous amount on research and expense for laying fiber-optic cables in streets in front our homes. But unless we can connect the home to the corner – what they call “the last mile” – it means nothing. It’s the same in healthcare. Unless patients understand and act to self-manage their own condition, all our advances in healthcare will have little effect. Patient engagement is the last mile.

Mary Pat: How does Meducation interface with EMRs?
Dr. Lee: This is our biggest challenge now. We’ve developed APIs to make it easy for EMRs to request and download our multi-language patient information. The difficulty has been getting many of the EMR vendor’s attention. They are so preoccupied with Meaningful Use and certifications that they have paid little attention to patient education and engagement. But I predict that this will start to turn around as reimbursements will force them to do so.

Mary Pat: Meducation also has videos with demonstrations on medication techniques. What types of videos are available and how can patients view them at home?

Dr. Lee: The videos focus on techniques for taking complex medicines such as inhalers, eye drops, etc., so the patients are actually benefiting from the medicine and not wasting it by using it incorrectly. We want to expand these to include other techniques such as wound care, port care, etc. in the future. The demos are free to patients if their healthcare provider or pharmacies use Meducation. Patients receive a card with the website and video ID so they can view it as often as they like at home.

Mary Pat: Meducation uses a universal graphic that shows patients when to take medication which seems like a great idea for communication despite the language the patient speaks – can you talk about this?

Dr. Lee: Yes, this is called the Universal Medication Schedule (UMS). It was developed by a group of health literacy researchers at Northwestern University and Emory University. It breaks up medication times into four times of day: morning, noon, evening, and bedtime. Over 90% of all daily meds can fit into this schedule and make taking medicines much easier to follow. The Institute of Medicine (IOM), the American College of Physicians (ACP), and most recently the National Council
for Prescription Drug Programs (NCPDP) have recommended its use. I really like it because it helps patients remember with pictures if they have difficulty understanding written instructions.

Mary Pat: You use the word “affordable” as part of your mission for Polyglot. I am always seeking solutions that are affordable in healthcare. Can you talk about the cost of Meducation for a solo primary care physician?

Dr. Lee: You know, I wish I could give this away for free to everyone. But we have to make this a sustainable effort. I’ve seen so many good projects die because they didn’t have a plan to keep it funded and going beyond the grant or some other funding source. This is one of the reasons I left academics to start our Polyglot. That being said, our products need to be affordable for front line providers – safety nets and federally qualified health centers (FQHCs) – because they interact most often with underserved patients – and have the least financial resources.

For provider practices, the subscription list price is $50/mo for unlimited use. That’s less than $2 day for the ability to print instructions for all your patients in 16 languages – including elderly English-speaking patients in larger fonts. As a comparison, $2 is about what it cost to use a telephone interpreter for about 1 minute. Mary Pat, we would be happy to provide your readers a discount on Meducation. Just have them contact me at lee@pgsi.com.

Mary Pat: What other projects do you have planned for the future?

Dr. Lee: I think the opportunities to improve communication for patients are only limited by our imagination. There is so much that we can do create quality literacy and language solutions and deliver it inexpensively to a wide audience. We are currently working on a solution to reduce hospital
readmission through simplified multi-language discharge instructions that can be individualized for each patient. We are adapting this for use during home care visits as well.

Dr. Lee: Polyglot Systems was founded in 2001 to help our US medical community care for the 26 million Americans who are unable to communicate effectively in English. Our mission is to deliver solutions that eliminate communication barriers at every stage of the medical encounter – improving the experience of both the patient and health care provider.

For more information about Meducation, Dr. Lee invites you to visit the [Polyglot website](https://www.polyglot.com). He is extending a discount on Meducation to readers of this article – please contact him at [lee@pgsi.com](mailto:lee@pgsi.com).

For another post on communicating with patients, read my post “Can Patient Safety Be Improved By Asking Three Questions?” [here](https://www.polyglot.com/blog/can-patient-safety-be-improved-by-asking-three-questions).

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**Medicare to Providers “Tell Us More”**

Medicare recently started denying an increased number of claims because documentation submitted for diagnostic tests does not include signed test orders or evidence of intent (MD progress notes listing tests needed) and evidence of medical necessity (description of clinical conditions and treatment showing the need for the
Most of us who have gone through the implementation of an EMR realize that electronic medical records (EMRs) do not always “tell the story” of a visit in the way that paper records used to. Encounters are documented without the glue that allows an auditor to understand what went on during the visit. Here are three ways to make sure that your documentation meets requirement for Medicare and other payers.

Establish Medical Necessity: Make sure the test is attached to the right diagnosis

Some providers attach all diagnoses assigned to a visit to any/every test ordered and performed. This is incorrect. All diagnoses can be attached to the Evaluation & Management (E/M) code, since all were addressed during the visit. Don’t list any diagnoses from previous visits that were not addressed at the current visit unless you note their impact on your decisions for care at the current visit.

Remember that screening tests and diagnostic tests are two different things. A screening test is ordered when you are looking for something with no provocation. Wikipedia states that a screening test “may be performed to monitor disease prevalence, manage epidemiology, aid in prevention, or strictly for statistical purposes.”

A diagnostic test is ordered when there is a sign or symptom that prompts the provider to look for the cause. Wikipedia defines a diagnostic test as “a procedure performed to confirm, or determine the presence of disease in an individual suspected of having the disease, usually following the report of symptoms, or based on the results of other medical tests.”

According to Medscape, the 5 main reasons for any test are as follows:

- Screening: Screen for disease in
asymptomatic patients. For example, a prostate-specific antigen (PSA) test in men older than 50 years.

- **Screening:** A test may be performed to confirm that a person is free from a disease or condition. For example, a pregnancy test to exclude the diagnosis of ectopic pregnancy.

- **Diagnostic:** Establish a diagnosis in symptomatic patients. For example, an ECG to diagnose ST-elevation myocardial infarction (STEMI) in patients with chest pain.

- **Diagnostic:** Provide prognostic information in patients with established disease. For example, a CD4 count in patients with HIV.

- **Diagnostic:** Monitor therapy by either benefits or side effects. For example, measuring the international normalized ratio (INR) in patients taking warfarin.

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**Reveal your decision making in the record**

- Need add’l tests to est. xxxxxx. Plan to...
- Return in 3 wks and repeat test to establish...
- DM worsening – will...
- Consider d/c xxxxxx medication if fatigue persists.
- Hypothyroidism vs. anemia?
- Fatigue most likely sec. to HTN meds – r/o electrolyte abn.
- DM stable, continue current regimen, recheck in 3 months.
Don’t forget the signatures!

A signature log can be as simple as entries on a document such as:

Provider Name (printed): __________________________

Full signature (written by provider): ________________

Initials (written by provider): _______________________

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