Practice Management Reference Guide

A comprehensive resource to ensure compliant operations and revenue cycle management success

SECOND EDITION
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Medicare Disclaimer

This publication provides situational examples and explanations, of which many are taken from the Medicare perspective. The individual, however, should understand that while private payers typically take their lead regarding reimbursement rates from Medicare, it is not the only set of rules to follow.

While federal and private payers have different objectives (such as the age of the population covered) and use different contracting practices (such as fee schedules and coverage policies), the plans and providers set similar elements of the quality in common for all patients. Nevertheless, it is important to consult with individual private payers if you have questions regarding coverage.

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Payer fee schedule rates compared to Medicare rates

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Practice Fee Medicare</th>
<th>United %Medicare</th>
<th>Cigna %Medicare</th>
<th>Humana %Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202 -- Office or other outpatient visit for</td>
<td>$150.00 $59.00</td>
<td>$65.00 110.17%</td>
<td>$70.00 118.64%</td>
<td>$90.00 152.54%</td>
</tr>
<tr>
<td>99203 -- Office or other outpatient visit for</td>
<td>$225.00 $88.00</td>
<td>$95.00 107.95%</td>
<td>$97.00 110.23%</td>
<td>$140.00 159.09%</td>
</tr>
<tr>
<td>99204 -- Office or other outpatient visit for</td>
<td>$300.00 $115.00</td>
<td>$117.00 101.74%</td>
<td>$125.00 108.70%</td>
<td>$170.00 147.83%</td>
</tr>
<tr>
<td>99212 -- Office or other outpatient visit for</td>
<td>$100.00 $40.00</td>
<td>$45.00 112.50%</td>
<td>$48.00 120.00%</td>
<td>$60.00 150.00%</td>
</tr>
<tr>
<td>99213 -- Office or other outpatient visit for</td>
<td>$150.00 $71.00</td>
<td>$76.00 107.04%</td>
<td>$75.00 105.63%</td>
<td>$85.00 119.72%</td>
</tr>
<tr>
<td>99214 -- Office or other outpatient visit for</td>
<td>$250.00 $95.00</td>
<td>$99.00 104.21%</td>
<td>$98.00 103.16%</td>
<td>$120.00 126.32%</td>
</tr>
<tr>
<td>99354 - Prolonged physician service</td>
<td>$200.00 $115.00</td>
<td>$135.00 117.39%</td>
<td>$130.00 113.04%</td>
<td>$180.00 156.52%</td>
</tr>
<tr>
<td>99355 - Prolonged physician service</td>
<td>$300.00 $165.00</td>
<td>$185.00 112.12%</td>
<td>$180.00 109.09%</td>
<td>$275.00 166.67%</td>
</tr>
<tr>
<td>99356 - Prolonged physician service</td>
<td>$450.00 $250.00</td>
<td>$280.00 112.00%</td>
<td>$270.00 108.00%</td>
<td>$350.00 140.00%</td>
</tr>
</tbody>
</table>

This report is helpful when negotiating contracts with payers.

Read and understand all contracts with payers, including contracted rates, timelines for filing claims, and other requirements for proper payment. The ability to negotiate better contracted rates will depend on the strength of the payer, how bad the payer needs your specialty in its network, and persistence of the negotiator.

A software program is the most efficient way to verify that each insurance payer is paying you the correct, contracted rates. A more time intensive process is to perform periodic audits of Remittance Advice (RAs) and compare contracted rates for the payer. Either of these two methods requires keeping up-to-date fee schedules of the contracted rates for each payer.

**Types of Reimbursement**

The most common reimbursement methods from insurance payers are prospective fee schedules, discounted charges, capitation, and resource-based relative value scale (RBRVS) systems.

- Prospective fee schedules are the most common for commercial payers. Payments are based on physician fee schedules negotiated with the payer. These can either be unique contracted rates or can be tied to a percent of Medicare (based on the RBRVS method).
Ancillary Staff

Although the physician is ultimately responsible for documentation of medical services, basic billing and coding training for ancillary staff is critical. All services provided must be documented, not just the interaction with the patient in the exam room. Medical assistants and other ancillary staff perform billable services such as venipuncture, injections, X-rays, lab services, etc. For this reason, all staff involved in providing services should be educated on proper documentation and coding to assist in making sure all services are captured. For example, when a nurse or medical assistant administers a vaccination, they must document the type of vaccine given, the dose, and the route of administration. Medical assistants, lab personnel, and others play an important role in making sure that when ancillary services are ordered and performed, they are also properly captured and documented in the medical record and reported accurately to the insurance carrier.

The staff member assigned to obtain the appropriate pre-certification for procedures and services performed also needs to have basic coding knowledge and a working knowledge of current insurance contracts. Without this knowledge, it’s difficult to provide the correct codes when contacting the insurance company. If the practice fails to obtain proper authorization, services may be denied, which will result in a loss of revenue.

Because such a large percentage of services are office visits, having a general understanding of regulations surrounding the coding of evaluation and management (E/M) and other services provided in an office setting is imperative. Practice managers may have multiple roles in the practice. If coding or auditing is the responsibility of the practice manager, they must have extensive education/training in coding. If the practice manager supervises certified coders, knowledge of coding is required — but not at the same level as if they were coding. The practice manager is responsible for making sure the ancillary staff (e.g., medical assistants, nurses, etc.) is trained to document services appropriately for coding and billing.

Coding and Billing Departments

The primary responsibility of a medical coder is to review clinical documentation, ensuring the appropriate CPT®, ICD-10-CM, and HCPCS Level II classification codes are assigned to all billable services performed. Medical billers are responsible for creating claims based on the codes provided, submitting claims to the insurance company, and following up on the claims to make sure the practice receives the highest and most appropriate reimbursement possible. It’s imperative that medical billers and coders understand the difference in submission and processing guidelines between respective insurance companies (i.e., commercial payers versus government payers). Coding and billing departments should be adequately cross-trained. A biller cannot effectively work denials without knowledge of coding guidelines. Coders should be aware of the carrier’s contracts and carrier-specific guidelines for circumstances; understanding bundling issues and knowledge of proper documentation requirements are essential to ensure
The internet consists of masses of computers connected together to exchange information. To send information to the right place, each computer has a unique address called an Internet Protocol (IP) address. IP addresses are 32-bit numbers, normally expressed as four octets in a dotted decimal number. A typical IP address looks like this: 218.162.125.141. A LAN may be broken down into smaller sub-networks (subnet), which is a range of IP addresses. All computers that belong to a subnet are addressed with an identical bit-group in their IP address.

A router is a device located where two or more networks connect, such as the WAN (internet) to a LAN (small business). It examines data packets and determines the best path for forwarding.

A firewall is a program or hardware device that filters the information coming through the internet. If the filters flag an incoming packet of information, it is not allowed through. A firewall, working closely with a router program, examines each network packet to determine whether to forward it toward its destination. A firewall may also work with a proxy server that makes network requests on behalf of workstation users. Firewalls may allow or deny users based on several criteria including the following examples:

- IP addresses
- Domain names
- Protocols
- Ports
- Specific words and phrases

A network switch is a small hardware device that joins multiple computers together within one local area network.

Bridges are network appliances that route information between two different networks in an organization. They connect a local area network to another local area network that uses the same protocol, for example via Ethernet. If one department is on one subnet IP address range and another department is on another subnet, a bridge can connect them and provide appropriate communication between the departments.
The principle responsibilities of human resource (HR) management include recruiting and retaining an effective work force that has the abilities, skills, and knowledge to carry out the mission and goals of the organization. The human resource manager should understand the legal environment in which the clinic must function and maintain compliance with applicable employment laws.

**Hiring and Firing**

Hiring and firing employees is an important part of the HR management role. Identifying employees who have the right skill set and personality that fit in with the culture of the company are very important to create successful relationships that result in high production, low turnover, and greater overall job satisfaction. Hiring diverse groups of individuals may prove to be challenging; however, mixing skill sets, personalities, and cultures, often makes an organization stronger. Below are several effective tactics for finding the right employee that will thrive and contribute to your organization’s success.

**Job description:** To identify the right person for the right job, start by identifying the responsibilities and the skills required to perform the job. Writing a job description for the position that details the specifics of what is expected is beneficial in hiring the right person. A good job description is the first step in identifying the requirements of the position so you can find a good match. Job descriptions should be as detailed as possible to provide a clear picture of what is expected in the position. This proves valuable in matching the skill sets of applicants, as well as holding new hires accountable.

**Recruiting for the position:** Recruiting for a position happens from both inside and outside an organization. Many organizations will post a position internally before posting it externally. When a position is posted internally it is only open for current employees to apply. Typically, the job is posted for a period of time before opening up to external candidates. This type of effort shows value to internal candidates and can add to a positive culture for current employees. Outside postings include placing the job in forums such as:

- Organization’s website
- Job posting websites such as Monster, CareerBuilders, Indeed, LinkedIn, etc.
- Social Media sites of credentialing associations, such as AAPC.
- Association websites and publications such as MGMA, ACHE, and many others
- Temporary Employment Agencies
- Search firms that will aggressively look for candidates meeting identified requirements

Each of these options will vary in cost and effectiveness. An organization should consider the cost of each option, the quality of applicants that will result from the posting, and what conveniences such as the delivery method of applications, resumes, cover letters, that the source can provide for you in your recruitment process.
4. “What can we do to prevent this from happening?”
   
   You know that working fire alarms help warn everyone of fire or smoke. What other preventive measures can you enact now to prevent the worst from happening later?

5. “What can we do to make this less catastrophic?”
   
   Incorporating contingencies and Plan Bs (and Cs and Ds and so on) into your policies and protocols can go a long way in simplifying and hastening your response when one of these scenarios inevitably arises.

6. “Who is responsible for what?”
   
   Assign specific responsibilities to specific employees or roles — for “everyday” bad scenarios as well as full-on disasters. Make sure everyone knows their responsibilities beforehand, so the crisis isn’t heightened by confusion or apathy.

---

**Question:** I’m a clinician considering moving to a different state. What are the basics I need to know about whether my current malpractice coverage follows or whether I need a new policy?

**Answer:** Definitely check with your insurance broker for specifics pertaining to your exact policy and situation.

When you leave a state, you need to make sure that you are covered not only in the new state moving forward, but also for your prior acts exposure in the state you are leaving.

Covering your prior acts exposure from the prior state, as well as those from the new state can be accomplished by carrying out one of these strategies:

1. Notifying your current carrier that you are moving and getting them to include prior acts for the previous state as well as your new state exposure moving forward. *(Note: This is not acceptable in Pennsylvania.)*

2. Purchasing a claims-made policy from another carrier — one that includes prior acts for the previous state as well as your new state exposure moving forward. *(Note: This is not acceptable in Pennsylvania.)*

3. Buying a tail from your current carrier. Starting retro date inception (RDI) on a new claims-made policy or occurrence.

4. Purchasing standalone tail from another carrier. Starting retro date inception (RDI) on a new claims-made policy or occurrence.

**Remember:** Don’t leave your malpractice coverage on the bottom of your to-do list when moving, as forgetting to cross any t’s or dot any i’s could mean a bumpy and complicated move.
Example: Risk Level Assessment

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Virtually Certain/High</th>
<th>Moderate</th>
<th>High</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probable/Moderate</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Remote/Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>Insignificant/Low</td>
<td>Significant/Moderate</td>
<td>Material/High</td>
<td></td>
</tr>
</tbody>
</table>

Impact

Example:

<table>
<thead>
<tr>
<th>Vulnerability: Risk Identification</th>
<th>Likelihood/Impact</th>
<th>Risk Level</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water sprinkler system in Data Center = Fire would activate sprinkler system causing water damage to hardware.</td>
<td>Likelihood: Low Impact: High</td>
<td>Moderate</td>
<td>None. Replacing the sprinkler system in the Data Center has been determined to be cost-prohibitive. Executive management accepts risk.</td>
</tr>
<tr>
<td>Passwords are not set to expire = Unchanged passwords could result in compromise of confidentiality of data.</td>
<td>Likelihood: Moderate Impact: Moderate</td>
<td>Moderate</td>
<td>IT will set Oracle to expire passwords and require changes.</td>
</tr>
<tr>
<td>USB drives used by nurses = Loss or theft could result in compromise of confidentiality of data.</td>
<td>Likelihood: High Impact: Moderate</td>
<td>High</td>
<td>New policy that clearly prohibits storing PHI data on removable media. Acceptable Use policy, under development for use in the Security Awareness and Training program.</td>
</tr>
<tr>
<td>Office is located over a fault line. An earthquake is possible.</td>
<td>Likelihood: Moderate Impact: High</td>
<td>High</td>
<td>New policy that clearly outlines office staff procedures for their safety and patient safety in the event of an earthquake during business office hours.</td>
</tr>
</tbody>
</table>

Corrective Measures

Actions to Take After a Disaster

Below is a list of issues to consider in the event a practice is severely damaged or destroyed. The list is not all-encompassing but may provide an overall guide in the event a catastrophic disaster occurs. You may want to add, modify, or take out some of these items depending on your practice and the extent of the disaster. Whatever checklist you formulate, you may want to keep it off-site where it would not be damaged and could be easily accessed. The sample policies contained in this model disaster plan may also provide steps regarding action taken in the event of a particular kind of disaster.

Post-Disaster Checklist

1. **Physicians and/or office manager must contact employees** regarding the extent of the disaster and what action employees should take in the short-term. The physicians within the practice and/or the office manager should notify all employees regarding whether the practice will open, and to ensure employees can be notified about future actions.
(iii) Requirement to provide continued coverage pending the outcome of an appeal. An issuer subject to the requirements of this paragraph (b)(3) is required to provide continued coverage pending the outcome of an appeal. For this purpose, the issuer must comply with the requirements of 29 CFR 2560.503-1(f)(2)(ii) as if the issuer were a group health plan, so that the issuer cannot reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review.

(c) State standards for external review -

(1) In general.

(i) If a State external review process that applies to and is binding on a health insurance issuer offering group or individual health insurance coverage includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the issuer must comply with the applicable State external review process and is not required to comply with the Federal external review process of paragraph (d) of this section. In such a case, to the extent that benefits under a group health plan are provided through health insurance coverage, the group health plan is not required to comply with either this paragraph (c) or the Federal external review process of paragraph (d) of this section.

(ii) To the extent that a group health plan provides benefits other than through health insurance coverage (that is, the plan is self-insured) and is subject to a State external review process that applies to and is binding on the plan (for example, is not preempted by ERISA) and the State external review process includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan must comply with the applicable State external review process and is not required to comply with the Federal external review process of paragraph (d) of this section. Where a self-insured plan is not subject to an applicable State external review process, but the State has chosen to expand access to its process for plans that are not subject to the applicable State laws, the plan may choose to comply with either the applicable State external review process or the Federal external review process of paragraph (d) of this section.

(iii) If a plan or issuer is not required under paragraph (c)(1)(i) or (c)(1)(ii) of this section to comply with the requirements of this paragraph (c), then the plan or issuer must comply with the Federal external review process of paragraph (d) of this section, except to the extent, in the case of a plan, the plan is not required under paragraph (c)(1)(i) of this section to comply with paragraph (d) of this section.

(2) Minimum standards for State external review processes. An applicable State external review process must meet all the minimum consumer protections in this paragraph (c)(2). The Department of Health and Human Services will determine whether State external review processes meet these requirements.

(i) The State process must provide for the external review of adverse benefit determinations (including final internal adverse benefit determinations) by issuers (or, if applicable, plans) that are based on the issuer’s (or plan’s) requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(ii) The State process must require issuers (or, if applicable, plans) to provide effective written notice to claimants of their rights in connection with an external review for an adverse benefit determination.

(iii) To the extent the State process requires exhaustion of an internal claims and appeals process, exhaustion must be unnecessary where the issuer (or, if applicable, the plan) has waived the requirement; the issuer (or the plan) is considered to have exhausted the internal claims and appeals process under applicable law (including by failing to comply with any of the requirements for the internal appeal process, as outlined in paragraph (b)(2) of this section); or the claimant has applied for expedited external review at the same time as applying for an expedited internal appeal.

(iv) The State process provides that the issuer (or, if applicable, the plan) against which a request for external review is filed must pay the cost of the IRO for conducting the external review. Notwithstanding this requirement, a State external review process that expressly authorizes, as of November 18, 2015, a nominal filing fee may continue to permit such fees. For this purpose, to be considered nominal, a filing fee must not exceed $25, it must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review, it must be waived if payment of the fee would impose an undue financial hardship, and the annual limit on filing fees for any claimant within a single plan year must not exceed $75.
<table>
<thead>
<tr>
<th>Place of Service Code(s)</th>
<th>Place of Service Name</th>
<th>Place of Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Temporary Lodging</td>
<td>A short-term accommodation such as a hotel, camp ground, hostel, cruise ship, or resort where the patient receives care, and which is not identified by any other POS code. (Effective January 1, 2008)</td>
</tr>
<tr>
<td>17</td>
<td>Walk-in Retail Health Clinic</td>
<td>A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (This code is available for use immediately with a final effective date of May 1, 2010)</td>
</tr>
<tr>
<td>18</td>
<td>Place of Employment-Worksite</td>
<td>A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013 but no later than May 1, 2013)</td>
</tr>
<tr>
<td>19</td>
<td>Off Campus-Outpatient Hospital</td>
<td>A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
<td>Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. (Effective January 1, 2003)</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
<td>A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.</td>
</tr>
<tr>
<td>22</td>
<td>On Campus-Outpatient Hospital</td>
<td>A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room – Hospital</td>
<td>A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
<td>A freestanding facility, other than a physician’s office, where surgical and diagnostic services are provided on an ambulatory basis.</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
<td>A facility, other than a hospital’s maternity facilities or a physician’s office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
<td>A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).</td>
</tr>
<tr>
<td>27-30</td>
<td>Unassigned</td>
<td>N/A</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
<td>A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
<td>A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
<td>A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.</td>
</tr>
</tbody>
</table>
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