the newsletter for physician office administrators

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Need more money? Don't let a single copay slip by

losses can run as high as $120,000 per physician

Want more revenue?

Collect the copayments.

Copays represent a tremendous amount of income, yet they get neglected for two reasons. One is that offices don't appreciate how much money is involved; the other is that staff neither want nor know how to ask patients for money.

Offices that aren't collecting every payment possible need to add up what they're missing, says **PEGGY E. DELANY, CHBC**, head of DR Management, a health care consulting practice in Fort Wayne, IN. Bare minimum: suppose the average copay is $10 and the doctor sees only 10 patients a day who have copays. That's $100 a day. Now suppose that doctor likes to take it easy and works just four days a week and takes 12 weeks of vacation every year. That's still $16,000 a year.

More realistic is a $20 copay with the physician seeing 25 patients a day, five days a week, 48 weeks a year. That's $120,000 the office is losing – per physician.

The picture is equally scary for specialists. If the copay is $35 and the doctor sees no more than 10 patients a day and is in the office only three days a week for 48 weeks, loss potential reaches $50,400.

get the money up front

The key to getting the copays in is to do the collecting at the front desk before the patient sees the doctor. With a good front-end system, the office can expect a collection rate as high as 95%.

Why not collect at check-out?

Because often there are payment problems. A patient might think the insurance covers everything and doesn't realize a copay is owing, a parent may be trying to get several children in at the same time and thinks there's only one copay, or somebody may simply be trying to dodge payment. Whatever the issue,

(please turn to page 3)

– Medicare fax scam –

Be aware of a Medicare fax scam now going on.

The fax carries a questionnaire – which asks for Medicare account information – and tells the office it must respond within 48 hours or experience a gap in Medicare payments.

The sender claims to be the Medicare carrier or the Medicare Administrative Contractor, and some of the faxes even carry Medicare logos.

The fax is a scam to get Medicare information and possibly use it for fraudulent billing.

Medicare says not to submit any information without first checking with the contractor. It also says that information should be sent to a contractor only through one of two web addresses. They are *http://www.cms.hhs.gov/MLNGenInfo/* and *http://www.cms.hhs.gov/MedicareProviderSupEnroll*. Both are part of the CMS website. ❑

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this month's idea

Staff set goals to benefit the office and to change what they don't like

To give staff "an opportunity to contribute in their own way" and also to have ownership in the practice, one manager requires that everybody set three goals each year. And each goal has to be something that will improve not "the" practice but "our" practice, says **LINDA D. MYERS**, administrator for Comprehensive Vascular and Endovascular Care in Southfield, MI.

The goals, which are set at review time, are for changes the staffer believes the office needs. Mostly, they are changes in how things are done, perhaps a new way to greet patients or a different way to put the charts together.

Myers tells staff "this is your opportunity to make things the way you want them to be – to change what you don't like and make things work better."

The improvements have been significant.

One staffer, for example, set up an organization system for the inactive records. She labeled the boxes by number and by year and alphabetized the files in each one. Then she developed a spread sheet that identifies the box where each chart is located.

Another staffer set up a front-desk procedure to reduce the self-pay receivables. As each chart is pulled, staff highlight the encounter sheet if there is a balance. The chart then goes to the biller who attaches a form listing the amount due and the reason – an unpaid copayment or a rejected claim or whatever. Then when the patient comes in, the front desk asks for payment and can tell the patient the amount, the date of service, and what the balance covers. That explanation is especially important for elderly patients who see several doctors and get confused about what they owe.

Each goal has to be measurable in that the staffer has to demonstrate a benefit – such as the organized file closet or the improved self-pay collections. It also has to be doable, which means it can't rely on other people. Getting Dr. A to document something, for example, is out of the staffer's control.

As they complete their goals, staff have to present them to the other staff and tell how the office has benefited.

Myers also points out that when a goal such as the collection procedure involves other staff, those staffers get credit for it. In each employee file, she keeps an ongoing list of positives such as compliments from patients and outstanding work. She also notes the project participation. Then at review time, the staffer gets credit.

If your office has set up a system that makes managing easier, MOM *would like to write about it. Contact the Editor,* Medical Office Manager*, P.O. Box 52843, Atlanta, GA 30355. Telephone 404/367-1991 and fax 404/367-1995. We pay $100 for every idea we write about in this column.* ❑

(continued from page 1)
a patient is more of a mind to address it while the service is pending than afterwards when the money suddenly becomes the office's problem.

Why not just bill the no-pays?

Because the billing process itself cancels out the profit, Delany says.

Even if the system can send out the bills automatically, the expense will run at least $3.50, and for most offices, it will be higher; on average, it costs $20 to get in any type of payment.

Without the pre-visit payments, copays either slip through the cracks or don't get paid to the point that "it's reasonable" to estimate a $50,000 to $75,000 loss per physician each year.

a policy with positive spin

How to start the up-front collecting if the office isn't doing it now?

Start with a policy that the office requires payment at check-in.

Post a notice of it at the front desk. Do the same in the patient brochure. Include it in the financial agreement patients sign. Put a notice slip in the bills.

There's an art to saying it, however.

First, state the requirement: "we're going to collect copays up front."

But don't put a period there. Instead, finish the sentence with something positive for the patient: "so you will no longer need to stop for check-out" or "so you will not have to worry about getting a bill from us later."

Then go further and cite one more positive customer service element such as "we now accept not only Visa and MasterCard but also American Express and Discover."

plus an enforcement provision

The policy also needs teeth, so follow it with a statement that the copayment is part of the patient's contract with the payer, that the office is required to collect it, and that if a patient comes in after two missed copayments and still doesn't pay, "we will have to reschedule you."

Two skipped payments "is plenty," Delaney says. At that point, it's time to enforce the rule.

But do it only after giving the patient every opportunity to pay. Tell the patient about the overdue amount at the appointment reminder call and phrase it as "we want to remind you that you have missed two copayments and we do require that you pay that before you can be seen tomorrow."

Then if the patient comes in without the money, the response is "I see you haven't paid for the last two visits. We really do require this. But what I can do is fit you in this afternoon, which should give you time to get it and come back."

The office is seeing the patient that very day but is making its point – nicely – that two misses is enough and three strikes is an out.

how to train staff to ask for copays

Staff education is next.

Most staffers are hesitant to ask patients for money, Delaney says, so present it to them not as collections work but as a necessary element for the office to stay open.

Explain the purpose of copays, which is that insurance companies require them because paying for a portion of the care discourages patients from seeking care unnecessarily.

Tell them that asking for and collecting money in a medical office is part of doing business just as it is in a grocery store.

Explain too that the office has a legal obligation to collect the copays. Waiving them can violate anti-kickback laws, because it can be seen as a financial inducement to bring patients in.

What's more, a waiver violates the contract with the payer, and the office could lose its contract as a result. Show that if the payer agrees to pay, say, 80% of the amount due and if the fee is $100, the office gets $80 – $60 from the payer and $20 from the patient. But if the office waives the patient's part, that in essence says the fee is only $80, and the payer is obligated to pay only 80% of that, or $64.

now here's what to do

Past the background education, show staff how to ask for payment in a way that's "conversational and helpful" but also gets the money.

The wrong way: "Do you want to pay now?" That invites a resounding no.

The right way: "Your copay is $X. Do you want to pay by cash, check, or credit card?" What that translates to is "we know you are going to pay. Just tell us how."

Show staff how to explain copays: "We bill $70 for this visit, but the insurance only covers $50 of that and requires that you pay the other $20."

Have them role play, with one person being the front desk staffer and the other "the grumpiest of all patients" who doesn't want to part with the money.

Along with all that, emphasize "that they should never feel alone" in the job and that if they get uncomfortable dealing with a patient they should call in the manager. Give them a script: "I'm sorry. I'm not doing a good job of explaining this to you. Can I

have you talk with our manager who can give you a better understanding?"

Then the manager can take the patient to a private area and say "I'm sorry you're upset. How can I help? Can I call the insurance company for you?"

prepare for the problems

Staff also need to be prepared to respond to the no-checkbook-no-credit-card excuse.

A good solution, Delany says, is to hand the patient a stamped addressed envelope and say "That's no problem. Just drop us a check in the mail when you get home this afternoon." Many offices see good results with that, because the patient can only agree to take the envelope.

Another solution is to get a copy of a credit card for each patient and keep it on file. Tell patients the office is doing it "as a courtesy to you" so the patient doesn't have to stop and make a payment at each visit. Then use the card automatically or use it only when the patient comes in without the payment.

"All hotels do that." They tell guests that any extra charges will be put on the card so there's no need to stop at checkout to pay for them.

an incentive with no money

Finally, to encourage collections, have staff keep track of who brings in what. Then give an incentive.

Delany's advice, however, is not to make it a dollar incentive but an actual prize such as movie tickets or a day off. When there's money in the picture, "people can get carried away with the dollars" and lose sight of patient service.

In addition, she says, put controls on the cash.

Don't intermingle the copay money with the petty cash. Keep it in a separate box.

Start the day with $100 in cash, keep a cover sheet of what comes in, and at the end of the day balance everything out against the superbills. Leave the $100 in the box, lock up the rest, and start the next day with the same $100. ❑

by john chase

A little checklist of what should be included in the office's handbook

No new office should open its doors without an employee handbook. And no long-standing office should let the years go by without reviewing it.

The handbook is never an office's main concern, says **ROB WILSON**, president of Employco, a Westmont, IL, professional employer organization that provides human resources and benefits administration services. Doctors aren't in practice "because they love HR work." And even when they have handbooks, something almost always is omitted.

Here's checklist of the key items the handbook needs to cover. They fall into the categories of documents, policies, and pay.

first come the documents

The documents are the employment forms and general information the manager needs to keep on file. There are five main items here.

- An employee information page. This is the staffer's personal information – full name, address, phone number, race, gender, date of birth, Social Security number, driver's license number, and emergency contact information.

Along with that, Wilson says, outline the information about the job – the title, whether it's full- or part-time, the starting pay, and whether the pay is hourly or annual.

- New employee certification. This is a signed acknowledgement that the employee has been offered a job and understands the office's policies. It also says that
  - the employee will abide by the office's policies, procedures, and other rules,
  - the office can require drug and alcohol testing, and
  - the employee will honor the office's decisions on job duties, scheduling, evaluations, promotions, and salary changes.
- The W-4 Form plus whatever forms are required for state tax withholding.
- An at-will employment statement. This says the employment can be terminated at any time by either side without notice and without cause.
- The Employment Eligibility Verification, or I-9 form. This shows the office isn't hiring illegal aliens, and it's a requirement for any business, even if there is just one employee. Fail to have it or fill it out incorrectly, and the office can be fined up to $1,000 per employee.

This is one of the first things his company looks for

in an office, Wilson says, because small business often don't have it. "Some don't even know the form exists."

The need for that form becomes more than evident when the office files its payroll taxes and the government sends a notice that somebody's Social Security number isn't valid. At that point, the office has to produce the I-9 form.

Be sure the office is using the revised form that came out April 1, he says. It has different requirements for identity documents. (The form can be found at *http://www.uscis.gov/files/form/i-9.pdf*.)

second are the policies

For the policies, the required ones are these. And with them, there needs to be a signed acknowledgement that that staffer has read and understands them.

- An equal employment opportunity statement, which says the office does not discriminate based on race, color, gender, national origin, veteran status, age, religion, disability, or sexual orientation.
- An anti-discrimination and harassment policy. This should be extensive, covering all type of discrimination, examples of prohibited behavior, and the procedure for reporting a complaint.
- A drug-free policy that prohibits drug and alcohol use in the workplace. Here outline whatever testing procedures the office will employ and what discipline it will take if there is a violation.
- An outline of the Family and Medical Leave Act. This applies to offices with 50 or more employees.
- The Consolidated Omnibus Budget Reconciliation Act or COBRA provisions for continuing group health coverage after leaving the job.
- Worker's Compensation provisions.
- Safety guidelines, if any.

Along with those are the individual policies the office wants to set. Those mostly cover

- The vacation and sick leave, including when the staffer becomes eligible for either and the procedure for requesting time off.
- The dress code.
- A patient confidentiality statement.

and then the payroll and benefits

Finally, the handbook needs to explain the salary and benefits.

Outline the pay period, and if the office provides direct deposit, include the bank form.

Also, Wilson says, if the office does its payroll in-house, it has to send a new-hire report to the state within 15 days of the hire. States have stepped up their people-tracking capabilities for purposes of tax garnishments and child support. ❑

reader question

When can one doctor bill for another's services?

Question: A general practitioner wants to have one of our specialists come to his office to see his patients.

The general practitioner wants to bill the services himself and then pay the specialist for the time spent at his office.

Is there any Medicare violation with that type of arrangement?

Submitted by **CONNIE PRUITT**, office manager, River Cities Cardiology, Jeffersonville, IN.

Answer: There is no fraud issue with that type of arrangement, says **L. LAMAR BLOUNT, CPA, FHFMA**, of Health Law Network in Atlanta.

There is a caution, however, and it is that the claim must carry the specialist's NPI to identify the specialist as the one providing the service. The billing can then be done under the general practitioner's name or the name of the practice.

In addition, to avoid any question later about the billing arrangement, the two doctors need to have a written contract outlining how the specialist will be paid.

To use the wrong doctor's NPI on a claim is fraud, because that doctor did not provide the service, Blount say. Yet it happens often.

Sometimes the violation is innocent, as when a nurse performs a service and the office inadvertently puts the physician's NPI on the claim.

Other times, it's not so innocent. He cites one case where a doctor's NPI appeared on claims when that doctor was out of the country on vacation. A nurse practitioner was providing the services.

An employee brought the error to the office's attention, but the billing continued. The employee then blew the whistle, and the office came under the gun.

When an office is notified of an error and does nothing about it, the payer can extrapolate or count cases, and penalties can be enormous.

watch for fraud on the superbill

Blount adds that the fraud risk offices most need to guard against is wrong codes on the superbill. Those

can creep in quietly year after year when the office redoes its superbill to reflect the annual CPT and ICD-9-CM updates.

Every office needs to have an experienced coder review the superbill each year to make sure the codes are correct.

Many times the updates are made by the manager or by a staffer who is not a certified coder, and mistakes happen for misunderstanding the medical terminology or what a procedure entails.

The office then ends up billing for a wrong code – or several wrong codes – and may not discover the error until months down the road when Medicare or a commercial payer starts denying the claims.

By then the office could have submitted a large number of incorrect claims, and in comes the money damage.

Medicare's penalty is three times the overpayment – plus $11,000 for each incorrect claim submitted. So if the office has submitted 100 claims, it's looking at triple payback plus a $1.1 million fine. "That's serious money."

Worse, there's no requirement that the government prove intent to commit fraud. All it has to do "is show the office should have known better," and that's easy to do, because the carrier sends notices about the code updates, "and the office is expected to know what they say."

No matter how innocent the office is, "the government can be heavy-handed," he says.

It may reduce the fine in exchange for an agreement to implement extensive assessment activities, but if the office doesn't comply, it can kick the doctors out of Medicare and go after the full $1.1 million.

"That's a costly mistake to make." It's also an unnecessary one, because it can be avoided entirely by having a qualified coder review the superbill every year.

watch too for fee-reduction fraud

Be aware too of the fraud risk in fee reductions and waivers, both of which are becoming more prevalent in the current economy.

Don't reduce the patient-pay portion of any bill "unless there is a legitimate credit reason" to do so, Blount says. And that includes professional discounts. The danger is that Medicare will say the office held out a financial inducement to get patients.

Set up a basic written policy outlining the circumstances under which the office will grant fee relief. There's no legal requirement to do that, but it's a good safety net to have.

The policy can be as simple as a notice to patients that "we require information about your income if you believe you cannot afford medically necessary services." Or it might say the office will consider waiving copays for patients whose family income is less than, say, three times the poverty level for the family size.

Keep the policy somewhat open. "The more specific it gets, the more the office has to prove" if a discount is challenged. ❑

ICD-9-CM and CPT coding update

ICD-9's updates for 2010: neoplasms to circulation

BY THERESE M. JORWIC, MPH, RHIA, CCS, CCS-P

The 2010 updates to ICD-9-CM are lengthy, with 141 new codes, 16 deleted codes, and 14 codes with revised descriptions.

This month, we are looking at the updates from the chapter on neoplasms through the circulatory diseases chapter. Next month we will continue, starting with the chapter on the digestive system.

The updates take effect October 1 for all payers.

– *neoplasms* –

Last year's updates brought new codes for neuroendocrine tumors, or tumors that originate from the hormone-producing cells of the neuroendocrine system. Now this year's updates bring new codes for specific types of neuroendocrine tumors.

They begin with 209.31-209.36 for Merkel cell carcinoma, with the fifth digit showing the anatomical site of the cancer.

Merkel cell is a very aggressive and very lethal nonmelanoma skin cancer. It's relatively rare, but incidence has more than tripled in the last 20 years, and in the U.S., about 1,200 new cases are diagnosed each year. The mortality rate is 33%, which is higher than that of melanoma.

Next are codes 209.70-209.74 for secondary neuroendocrine tumors, again with the fifth digits showing the site. Last year's neuroendocrine tumor codes covered only the primary tumors. The new additions are for the secondary tumors, or tumors resulting from metastasis.

Following those are 209.75 for secondary Merkel

cell carcinoma and 209.79 for secondary neuroendocrine tumors of other sites.

And related to all those is a new V code (V10.91) for personal history of malignant neuroendocrine tumor. It covers history of malignant carcinoid tumors as well as any type of tumor that's coded in the 209 area.

The last two new neoplasm codes are 239.81 and 239.89. The first is for unspecified neoplasms of the retina and choroid, and the second is for the same in other sites.

Retinal and choroidal neoplasms are also known as retinal freckles. They are black areas or spots within the eye, and they need to be followed, because they can turn into melanoma. Unfortunately, because they are located within the eye, it is not possible to biopsy them.

– endocrine, immunity disorders –

The new codes here begin with gout, which, because of its association with rich foods and alcohol, has been called the Disease of Kings.

Gout (or podagra) is a form of arthritis where uric acid crystals get deposited into the joints and soft tissues and cause inflammation. It's the most common form of inflammatory joint disease in men age 40 and older.

It has four stages.

The first is asymptomatic where the urocemia is occurring and uric acid is accumulating in the blood but there are no symptoms.

The second is acute gout where the uric acid crystals are being deposited in the joints and are causing swelling and pain.

The third stage is intracritical gout, or the periods of relief between the acute attacks when there are no symptoms.

And the fourth stage is chronic gout, where tophi or crystal deposits have developed in the joint and have caused permanent damage.

The new codes (274.00-274.03) show those four stages. There are now new drugs for each stage, so the codes were needed to show which stage is being treated.

After the gout codes is 277.88 for tumor lysis syndrome, which is a serious and sometimes fatal complication of cancer. Usually is it caused by chemotherapy, most often in treating leukemia or lymphoma, but it can also occur without drug treatment. What happens is that the dying cancer cells upset the calcium and phosphate levels. Eventually that can cause acute renal failure.

When it is drug induced, use an E code to identify the drugs.

There are two final newcomer codes in this chapter.

The first is 279.41 for autoimmune lymphoproliferative syndrome, which is a rare genetic disease where the lymph cells don't die off as they should but instead build up in the tissues. Lymphoproliferative syndrome usually responds well to steroid therapy.

The second is code 297.49 for other autoimmune diseases.

– blood and blood-forming organs –

There is just one new code in this chapter, and it is 285.3 for chemotherapy-induced anemia.

It applies only to simple anemia. If the anemia is aplastic where all the blood cell types have lower counts, the code is 284.89.

Anemia is the most common side effect of chemotherapy, and it occurs because the drugs inhibit the production of bone marrow.

– nervous system, sense organs –

The new codes begin with 348.81 for temporal sclerosis, or epilepsy, and 348.89 for other localization-related epilepsy.

Temporal epilepsy, which is also known as mesial temporal lobe epilepsy, can be acquired, as when the lobe is injured by trauma or by a shortage of oxygen that causes the tissue to harden. The condition can sometimes be treated by removal of the hardened part of the lobe.

Next is code 359.71 for inclusion body myositis followed by 359.79 for other myopathies.

Myositis is chronic muscle inflammation with muscle weakness. Its onset can take months or even years. Often it affects just one side of the body, and the first symptoms can be tripping and falling, or there can be weakness in the wrist and fingers and the inability to pinch the fingers.

About half of the patients also have difficulty swallowing.

The disease usually begins after age 50 and affects men more than women. It has no cure and is unresponsive to steroids, which leaves physical therapy the only course of treatment.

The last new code here is 372.06 for acute chemical conjunctivitis, or pink eye that's caused by some chemical getting into the eye such as a household cleaner or chlorine or even smoke and smog.

– circulatory system –

There are lots of new codes here for thrombosis and embolism.

First is 416.2 for chronic pulmonary embolism or blood clot. A note says to use V58.61 with it if there has been long-term use of anticoagulants.

Then come two new codes for late effects of cere-

brovascular disease, specifically dysarthria (438.13) and fluency disorder (438.14).

Dysarthria is slurred speech that results from a stroke or injury. The muscles of the face, mouth, and respiratory system get weak, and the outcome is very slow or slurred speech. Sometimes the patient can barely whisper; other times the patient can't speak at all.

Fluency disorder is stuttering. While stuttering is usually associated with children, it can also result from stroke or brain injury, and that is what the new code covers.

For dysarthria and stuttering that are not the result of stroke, there are two new codes in the symptoms chapter. They are 784.51 and 784.59.

The remainder of the new circulatory codes are for venous embolisms. There are 20 of them, all in the 453 category.

The current codes have been revised to say that the embolism is acute (453.4x), and the new codes (453.5x) say the embolism is chronic.

There are also new codes for embolisms in other vessels, and they too distinguish chronic (453.7x) from acute (453.8x).

Therese M. Jorwic, MPH, RHIA, CCS, CCS-P, is assistant professor of health information management at the University of Illinois at Chicago and senior consultant for MC Strategies in Atlanta. ❑

Swine flu gets its own code: 488.1 takes effect October 1

Yes, swine flu will get its own code this fall.

The current flu codes are 487.0 for flu with pneumonia, 487.1 for flu with other respiratory manifestations, 487.8 for flu with other manifestations such as encephalopathy or gastrointestinal distress, and 488 for avian or bird flu.

In October, the 488 subcategory will be expanded to cover influenza due to certain identified flu viruses. Code 488.0 will be for bird flu, and code 488.1 will be for influenza due to H1N1 virus, a/k/a the swine flu.

The ICD-9-CM updates appear in the *Federal Register* (May 22 issue) as part of the regulations proposing changes to hospitals' Medicare payments. (They are outlined in last month's issue of *MOM*.)

Why does the new swine flu code not appear there?

Because the regulations are only proposed. The government is reviewing comments on them and will publish a final version in August.

Thus, there will be a few last-minute additions to the code updates, and one of them will be the new swine flu code.

MOM will cover all the additions as soon as they appear. ❑

Little bits of useful information

Still time to code quality and get half a bonus, maybe more

There's still time to start quality coding and get a bonus for this year.

Latecomer offices can do the coding one of two ways.

The first way is through a registery. (*To find a registry, see below.*) Code three individual measures for at least 80% of the patients to whom they apply for services given from July 1 to December 31. Some registries may also accept data from the start of 2009 and thereby make it possible for the office to get a full-year bonus.

The second way is to code a measures group, and that can be done either through a registery or through individual claims.

Get a half-year bonus by reporting the group on 80% of the patients to whom it applies, and again, that is for services given between July 1 and December 1.

Even better, get a full-year bonus by reporting the group on 30 consecutive patients.

There's no sign-up or registration. Just start using the quality codes through a registry or start coding the measures group through a registry or on individual claims. That tells Medicare the office is participating.

For the late birds, there is a tip sheet titled "Satisfactorily Reporting 2009 PQRI Measures" that tells how to get started. Go to *http://www.cms.hhs.gov/PQRI/Downloads/pqri_satisfactorily508.pdf.*

There's also a good, clear (and short! only three pages) outline of how to crank up both quality coding and e-prescribing.

To get to the document, go to *http://www.medicarepatientmanagement.com/issue_04-3.php*. Look under "feature articles" and click on "Implementation Advice for 2009 PQRI and E-Prescribing."

■ ■ ■

A guide to qualified registries; but there are no guarantees!

Want to report quality codes via a registry?

A list of the qualified registries is available at *http://www.cms.hhs.gov/PQRI*. Click on "reporting" on the left side and then scroll down to the downloads

and click on "qualified registries for 2009 PQRI."

Offices that want to submit their quality data through a registry must contact the registry directly.

And there is a caveat. While Medicare has vetted all the registries listed and says it's "highly likely" they will submit the office's data correctly, nobody is making any promises. If the registry makes a mistake, the only place to turn is to the registry itself.

■■■

Here's what got missed most in quality coding during 2007

For the stout of heart, Medicare has a long and laborious chart showing the mistakes offices made last year on each of the quality measures. It can be found at *http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp#TopOfPage*. Scroll to the downloads and click on "January 1, 2008-September 30, 2008 Quality Data Code Submission Error Report."

For the not-so-stout-of-heart, here's a summary. (The codes in italics were deleted for 2009.)

invalid quality code

#40 management following fracture – only the quality code appeared on the claim
#82 ESRD: plan of care for inadequate peritoneal dialysis – incorrect diagnosis
#123 CKD: plan of care for elevated hemoglobin for patients receiving ESAs – incorrect diagnosis; only quality code on claim
#53 asthma: pharmacologic therapy
#64 asthma assessment

patient did not meet the age requirement

#65 appropriate treatment for children
#66 appropriate testing for children
#94-#98 otitis media (*#96-#98 deleted for 2009*)
#53 asthma: pharmacologic therapy
#64 asthma assessment
#116 inappropriate antibiotic treatment for adults
#119 urine screening for microalbumin or medical attention for nephropathy, diabetic patients

patient did not meet the gender requirement

#71 hormonal therapy for stage IC-III ER/PR positive breast cancer
#48 assessment of presence or absence of urinary incontinence in women
#39 osteoporosis screening or therapy for women
#74 RT recommended for invasive breast cancer patients with breast-conserving surgery

incorrect CPT code for the measure

#20 timing of antibiotic prophylaxis – ordering physician
#46 medication reconciliation
#130 documentation of current medications
#74 RT recommended for invasive breast cancer patients with breast-conserving surgery
#45 discontinuation of prophylactic antibiotics

incorrect ICD-9-CM code for the measure

#97 OME: systemic antimicrobials – avoidance of inappropriate use
#40 management following fracture
#94 OME: diagnostic evaluation – assessment of tympanic membrane mobility
#66 appropriate testing for children
#65 appropriate treatment for children

incorrect ICD-9-CM and quality code

#82 plan of care for inadequate peritoneal dialysis
#133 screening for cognitive impairment
#128 universal weight screening and follow-up
#110 vaccination for patients age ≥ 50

(For an overall explanation of the mistakes to avoid, see last month's issue of MOM*: "Why e-scripting doesn't fit the global package, and what offices miss on PQRI.")*

■■■

Eight more curious questions on the art of e-prescribing

Here are some new questions on e-prescribing.

• If the office refills a prescription or provides a new prescription without seeing the patient, does that count toward e-prescribing?

No. To qualify for e-prescribing, the claim has to carry a visit code.

• *If the e-prescribing system doesn't recognize the medication being prescribed, what G-code should the office use?*

Use code G8446 (e-prescribing system available but not used due to patient/system reasons).

• *Some providers such as doctors of optometry can prescribe only certain medications. When a different prescription is needed, they must consult an MD who then prescribes the medication. How should the first provider code that?*

Use code G8445 (office has a qualified system but no prescriptions were generated during the encounter).

• *If a pharmacy cannot accept electronic prescriptions, can the doctor still get credit for e-prescribing?*

Yes. Send the prescription electronically and report it. If the pharmacy converts it into a fax, that's the pharmacy's issue. It still counts as e-prescribing.

A note of caution: offices in rural areas need to

make sure their systems are in fact capable of two-way transmissions. It makes no difference if the local pharamacy can't receive electronic transmissions and turns them into faxes. To qualify for e-prescribing, the office's system still has to have two-way capability.

• *With e-prescribing, what is meant by 10% of allowed charges for covered services?*

To count toward the e-prescribing bonus, at least 10% of the doctor's total Medicare charges have to come from the e-prescribing encounter codes (CPT or HCPCS). In addition, the doctor has to report e-prescribing on at least 50% of all patient encounters.

• *If a doctor works in several clinics and not all of them have e-prescribing capabilities, will that affect the 50% threshold required?*

It depends.

E-prescribing credit is determined by the Tax Identification Number.

If a doctor bills under the same TIN at several clinics, some of which don't have e-prescribing capability, that will hurt the doctor's ability to get the bonus.

However, if each of the clinics has a separate TIN, the doctor's bonus ability will not be affected

• *How should the office code e-prescribing if its system goes down?*

If the system isn't used because the pharmacy can't accept the transmittal, use code G8446.

However, if the system isn't used because it can't transmit prescriptions, the office is out of luck. It can't code e-prescribing because it didn't e-prescribe.

• *Can a doctor get quality and e-prescribing bonuses for care given to Medicare Advantage patients?*

Yes. Medicare Advantage payments are governed by the terms of the contract. If the doctor is eligible for either the PQRI or the e-prescribing program, that organization must pay the incentive.

Doctors who treat MA patients but have not contracted with an MA organization are also eligible for PQRI and e-prescribing payments from those organizations. The MA payment amounts are calculated the same as for traditional Medicare.

■■■

Don't forget HIPAA 5010; all payers will be following it

It's a long way off, but don't lose sight of HIPAA's new 5010 standards version for submitting electronic claims. It will require changes in offices' billing software, systems, and possibly in their billing procedures.

Beginning January 2012, all offices have to be ready to use the X12 Version 5010 and NCPDP Version D.0 standards. That will be a requirement for all payers, both Medicare and commercial.

In addition, the 5010 version will be necessary for using ICD-10 when it takes effect.

Medicare says it will start transitioning to the new formats in January 2011 and then will require them beginning January 2012.

Offices should right now contact their billing and software vendors or clearinghouses to find out what to do to prepare for the changeover. ❑

How to keep a good staff and high productivity when the money is tight

No raises to give out this year?

Worried productivity is going to suffer?

Most people don't leave a job because of money. Neither do they stop being productive because of it, says practice management consultant **LYNN HOMISAK** of SOS Healthcare Management Solutions in Seattle.

What most encourages productivity is something that carries no dollar sign at all – appreciation and respect from the employer. That's what makes people anxious to come to work each morning.

Conversely, without appreciation and respect, no amount of money is going to keep people on board – or spur them to productivity.

Here are 10 ways to keep a good staff even when the raises are not there to give out.

recognize staff's little extras

One element managers tend to forget about is the need to be aware of and recognize all the work each staffer is doing.

Many times a staffer takes a job a step further "and nobody notices," Homisak says. There's no appreciation for it, so the staffer slowly becomes dissatisfied.

The best way to find out what's going on is the tell staff to be prepared to toot their own horns at review.

An easy way for them to do that is to keep their daily or weekly to-do lists in folders and right before the review make notes of all the things they have done. That way, each person can come into the review saying "this is what I have done for our practice."

A staffer might say, for example, "I drew up this form and it brought in X more patients" or "I analyzed our patient satisfaction surveys and found out where we need to change our hours."

Or it could be something as simple as "I'm the one who's been changing the paper towel rolls in the break

room." No matter how small the contribution, let an unsolicited task go unnoticed and the staffer feels unappreciated.

Appreciation is a tremendous productivity builder. She cites one client office where a staffer told her "I would clean the toilets if I knew the doctor appreciated it."

cite the specifics

Make the expressions of appreciation believable by telling the staffer exactly what it is that's being appreciated.

Homisak gives the example of telling a staffer "I really appreciate what you do." The staffer says "what do I do that you like?" and the manager's response is "I don't know."

People want more than a slap on the back. They want to know specifically what's appreciated, and that in turn tells them what to continue doing.

four times a day, every day

Be generous with the appreciation. Give it out "every single day."

Managers "are quick to tell staff what they're doing wrong" but not so quick "to stop to say thank you."

Homisak tells her own clients to start off each day with four quarters in the left pocket and move one to the right pocket every time they compliment a staffer.

At the end of the day, all four should be in the other pocket.

give a rundown of the money

Show staff all the compensation they are actually getting.

People calculate their salaries by their paychecks, Homisak says. They don't take into consideration all the other things they are getting – from insurance to free lunches – and they don't realize "that their employers have quite an investment in them."

Draw up a compensation worksheet and lay out what the office pays for. (*See sample form below.*)

Homisak recommends including a disclaimer on the form that the numbers are estimates and are subject to change and that there is no guarantee any benefit will continue.

a little token plus a note

Tokens of the manager's appreciation also go a long way toward keeping staff productive.

There are two caveats to that, however.

The first is to include with the token a hand-written note telling the staffer what the reward is for and what the manager appreciated about it.

The second is match the token to what the staffer

Sample statement of compensation and benefits

I. BASE PAY

hourly wage _____
monthly base pay _____

ANNUAL BASE PAY = $_____

II. OFFICE'S CONTRIBUTIONS

government-required payments

Social Security _____
Medicare _____
FICA _____
unemployment ins. _____
Worker's Comp _____

TOTAL = $_____

insurance and retirement

health insurance _____
short-term disability _____
long-term disability _____
life insurance _____
health savings acct. _____
retirement _____
401(k) contribution _____

TOTAL = $_____

paid time off

sick (___ days)
value _____
vacation (___ days)
value _____
holidays (___ days)
value _____
personal (___ days)
value _____

TOTAL = $_____

other benefits

education/seminars _____
uniforms _____

TOTAL = $_____

TOTAL OFFICE CONTRIBUTIONS = $_____

III. TOTAL COMPENSATION

(*base pay + office's contributions*)

$_____

likes. A Starbucks coupon is a nice treat – if the staffer like coffee. And opera tickets are good – for somebody who doesn't prefer baseball.

Finding out each staffer's likes and interests, she says, is part of being a good manager.

a public compliment

Another good moneyless motivator is a compliment given in front of a patient such as "Patient A, you're in good hands with Staffer B here." That serves the office two ways. It encourages the staffer, and it gives the patient confidence in the office.

Compare that to "Oh, Staffer B can't to do that. I'll have to take over." That immediately destroys both the staffer's ego and the patient's confidence.

lend a good ear

Yet another motivator: a good ear.

When a staffer is talking, listen. "That's a huge thing to do," Homisak says. It tells people they are appreciated.

On the other hand, not paying attention or cutting somebody short says the manager has no respect for what that staffer has to say.

let staff do some marketing

Get staff involved in the marketing. Brainstorm with them, and let them participate in the activities.

Volunteer to speak at schools and at PTA meetings. The physician might talk about a clinical topic, then the manager might talk about the services the practice provides, and then a staffer might talk about insurance coverage.

Choose the audience to suit the practice. If it's a pediatrics office, offer to talk with children about what vaccines do for them and have the nurse there "to lower the level of fear" children have about going to a doctor.

That's effective marketing because it gives people several faces to connect with and several levels of information.

get staff involved with collections

Involve staff in getting the money in. Show them how to collect it.

Many staffers, for example, don't know what to say to patients about copayments.

Show them what not to say: "Your balance is $X. Do you want to pay that now?" (The patient can say no and walk out the door.)

Then show them what they should say: "Your balance is $X, and we accept checks as well as credit cards. Which do you prefer?" (A no answer is not an option.)

Also tell them when to say it: when the patient comes in. Wait till the end of the visit and the patient is apt to say "I'll call you about that."

give some hope with the bad news

Then there's the question of how to announce a no-raise year and still maintain a motivated staff. And the answer is to balance the bad news with some good.

Announce that there will be no raises but in the same breath give some type of nonmonetary compensation that tells staff the office appreciates their work. Time off is a good option, perhaps a full day off or an option to leave early on Fridays.

Be honest about what's happening, that like other businesses, the office is going through a rough time.

Then emphasize the positive side of the picture – that at least everybody can be thankful for still having a job.

And then give staff something to look forward to: "if you can hang on and help us bring in more patients, we will hopefully be able to give everybody a raise down the road." ❑

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