Coding: Opportunities to Improve Your Bottom Line

By Elizabeth Woodcock, MBA, FACMPE, CPC

My daughter recently had out-of-network medical services, so I requested a copy of the superbill. Without so much as glancing at it, I submitted it to my health insurance company for processing towards our deductible. A few weeks later, I received a letter denying the services. Confused, I looked through the paperwork and quickly realized that the CPT codes were incorrect on the superbill. I connected with the practice's biller, noting the mistake. She apologized, not for the mistake, but for the failure to *understand* the codes. I educated her about the codes that should have been recorded – and thought about the challenge – and importance - of maintaining currency in the ever-evolving field of coding and reimbursement.

A recent article in the popular peer-reviewed journal, *Annals of Internal Medicine*, pointed out that primary care physicians were leaving more than $200,000 on the table in unbilled services each year – to be exact, "$124,435 (interquartile range [IQR], $30,654 to $226,813) for prevention services and $86,082 (IQR, $18,011 to $154,152) for

coordination services." Most, if not all, physicians, would agree that this revenue boost would be a welcome addition to their practice's bottom line. Coding opportunities are particularly appealing because there are rarely any *costs* associated with the revenue bump – the space, staff, computer systems, etc., have already been paid. Therefore, financial earnings because of improvements in coding fall directly to the bottom line as profits.

Before we unpack the opportunities, let's determine the reason behind the problem. Just like the biller with whom I interacted, medical practices typically rely on one or two people as subject matter experts. That person is normally overworked and underappreciated. Unless prompted, seeking information about coding opportunities is typically not a priority due to their workload, and they don't make an incremental dime for correcting a past mistake or discovering a new coding opportunity. Coding conferences for billers ceased during the pandemic and are just now resuming. And, perhaps most importantly, coding is not easy. There are thousands of CPT® codes. Understanding how they are matched or paired with other codes is a massive undertaking, let alone the reimbursement rules that govern getting paid. Did I mention that the typical practice participates with dozens of health plans, if not hundreds? Each one has different rules for getting paid. Frankly, it's a hot mess.

It's not possible to escape the chaos of the reimbursement landscape in healthcare. However, there are opportunities to effectively navigate the challenges. Invest in good people – and have them attend formal training at least once a year. Ask them to prepare a presentation upon their return, with a minimum of three recommendations. Make sure they connect with at least one other practice of your specialty to exchange ideas once or twice a year. Engage with an online coding advice service to maintain currency; CodingIntel is a good resource. Consider adding an automated code scrubber package to your electronic health record system.

To determine the opportunities, take a multi-pronged approach. First, ask the person who codes and bills for you to shadow you for a half-day. Without showing the coder/biller what you do, the employee may never know the "real" opportunity. The employee can experience what you do firsthand, thereby identifying potential gaps in documentation. Take, for example, the moderate "risk" column in the medical-decision making (MDM) table . It includes: "Diagnosis or treatment significantly limited by social determinants of health (SDOHs)." Moderate risk is one of two components (in addition to data and problems) needed to code an office or hospital encounter as a level 4, yet many physicians don't realize that patients' inadequate housing, unemployment, divorce, low income, or other SDOHs can lead to a higher level of code. Therefore, it is not documented. Shadowing the physician allows the employee to identify the opportunities firsthand – thereby encouraging documentation that can lead to improved coding opportunities.

Next, know the basics yourself. **Physicians and practice executives should spend at least one hour per month perusing the coding section of their specialty society website.** Whether you're a pediatrician – or an interventional radiologist – there is a

coding resource section for your association. Read it.

Finally, contemplate the situation. What services did you perform today – or last week? How did you code them? Perhaps you're confident in the codes you submitted; however, are you sure the auxiliary services you ordered in your practice – or performed yourself – were coded and billed appropriately? Prior to computers, these were all captured on forms; since the visibility is gone, make sure your practice has replicated the workflow in your computer. One way to do this is to take a single clinic day from last fall and ask an employee to pull all the codes submitted and payments received. Are there any surprises? Without going overboard, gather evidence about the coding and billing protocols for your practice so that you can make changes for the better.

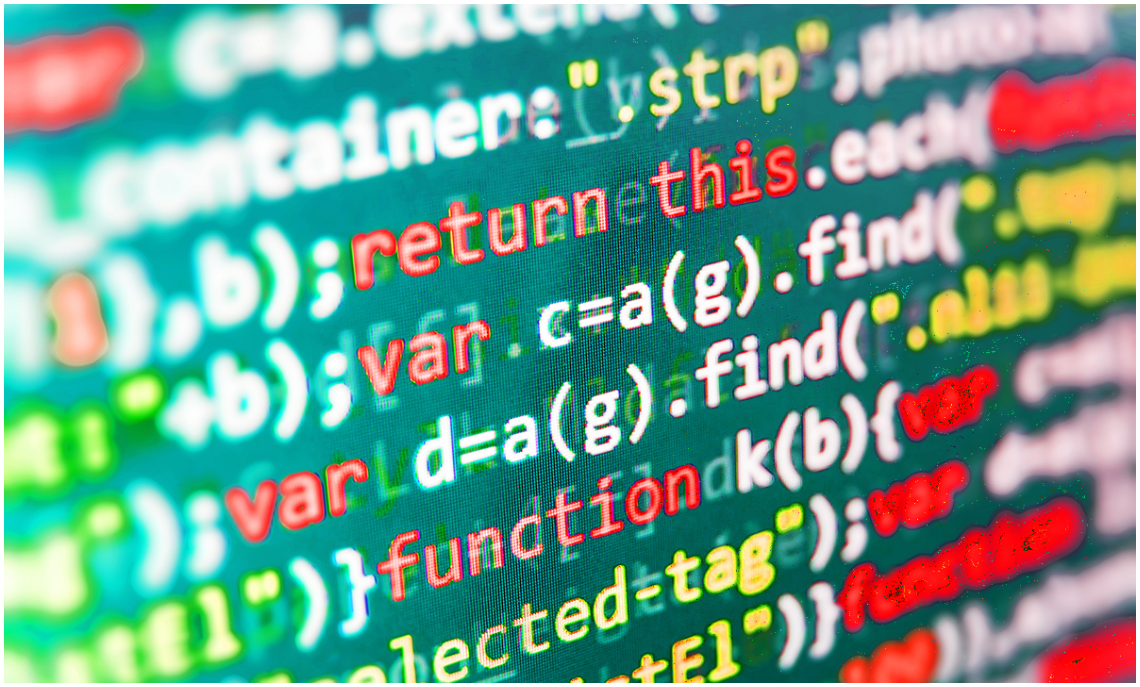
Coding opportunities take some effort, but the payoff is certainly worth your time.

PREVENTIVE CARE PROVIDERS

For primary care physicians – as well as specialists engaged in preventive care – query the government's "Medicare Preventive Services" reference chart to ensure you're billing appropriately for services rendered.
https://www.cms.gov/medicare/prevention/prevntiongeninfo/medicare-preventive-services/mps-quickreferencechart-1.html

In addition to being a value-add to patients' care, many services can be provided at no cost to Medicare beneficiaries, thus eliminating the administrative burden of collecting from the patient.

The Dangers of Meta Pixel on Your Websites



By TMHCC Cyber Risk Team Shortened by Judy Musgrove

We are seeing hundreds of healthcare providers and other businesses targeted by class action lawsuits across the country, alleging the unauthorized disclosure of personally identifiable information (PII) and personal health information (PHI), and seeking civil damages for each disclosure. PII and PHI was gathered using a tracker called Meta Pixel. In addition to the exposure organizations may face from class action lawsuits, breach notifications and regulatory enforcement may also cause significant expense.

What is Meta Pixel?

As a business owner, you need to know if your ads are reaching your customers. To do this, several companies (including Facebook's parent company, Meta) offer tools like Meta Pixel to track website user interactions using JavaScript code. Trackers run a script when a user visits a website in a browser which can collect information in HTTP headers, button click data, form field names, and other user-specified data. Meta Pixel is added to a

business website either manually by a developer or through a partner integration.

Businesses are not always aware of the data that these tracker tools are collecting. If trackers are not configured correctly, they may collect sensitive user data. Federal law, state law, and HIPAA require patient consent and a business associate agreement to share PHI between companies.

Recommendations

We strongly encourage you to identify any specific forms or pages on your company websites containing Meta Pixel and removing it using the following information:

1. Use a tool to assess whether your website uses Meta Pixel: https://themarkup.org/blacklight.
2. Remove Meta Pixel by following the instructions on the following links:

If hardcoded on your website:
https://www.facebook.com/business/help/4224030857607474

If plugin, direct website or partner integration, Google Tag Manager implementation:
https://back2marketingschool.com/delete-facebook-pixel/

For Additional Information

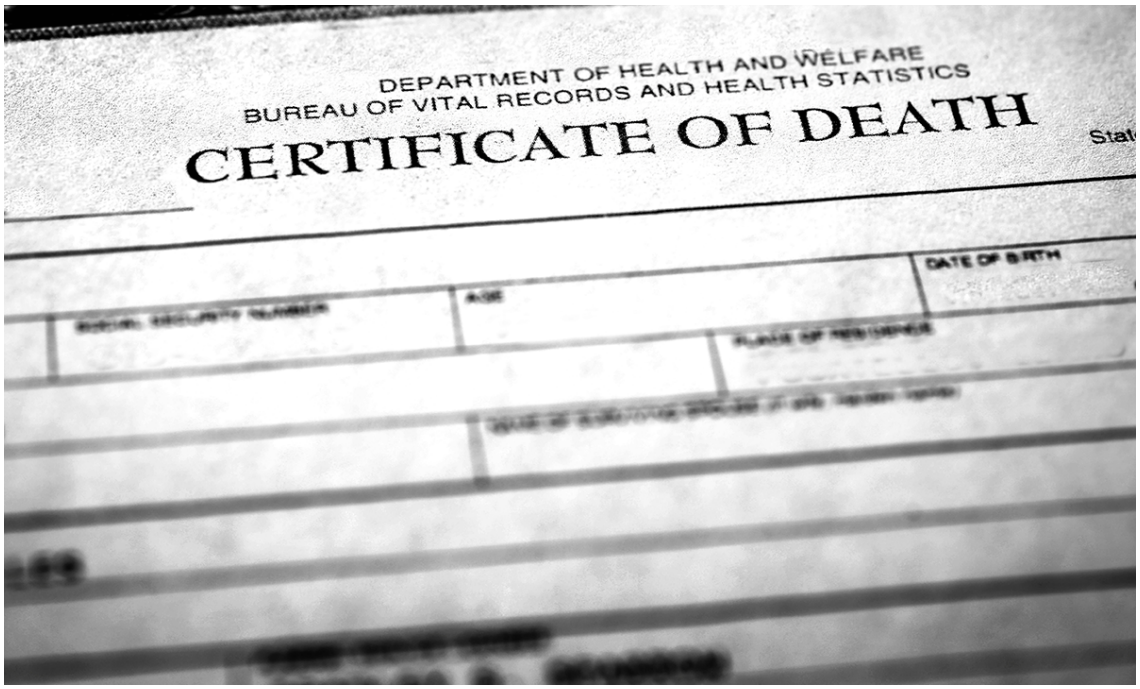
https://www.digitaltrends.com/social-media/what-is-a-facebook-pixel/

https://www.spectroomz.com/how-to-delete-facebook-pixel

https://www.hipaajournal.com/meta-facing-further-class-action-lawsuit-over-use-of-meta-pixel-code-on-hospital-websites/

If you need further assistance or have questions, we suggest contacting your IS resource, website/social media support service, or SVMIC at ContactSVMIC@svmic.com or 800.342.2239.

Immunity of a Different Type



By Matthew Bauer, JD

No doubt physicians are familiar with the concept of immunity in the medical context. However, there is another type of immunity with which physicians may not be familiar. Namely, immunity from legal liability. State legislatures have passed statutes granting immunity for a variety of activities that are deemed beneficial to society and promote the public good provided specific requirements are met. The reason for these immunity statutes is that legislatures want to encourage individuals to engage in certain types of activities by removing the disincentive of potential liability exposure flowing from such activities. For instance, many states have passed legislation granting immunity to physicians for the treatment of COVID during the pandemic. If this sounds too good to be true, you may be right as COVID immunity laws have not been tested in the courts yet. It is unknown how the courts will apply such statutes, and what their efficacy in protecting physicians will be. However, as demonstrated by the closed claim below, SVMIC has had cases where immunity statutes have been used to defend insured physicians in lawsuits.

The sixty-year-old male patient presented to the emergency room due to chest pain and heart failure. During hospitalization, the patient was treated by insured cardiologist Dr.

Smith. Unfortunately, the patient suffered myocardial infarction and coded at the hospital. Resuscitation efforts were unsuccessful, and the patient expired. Pursuant to the Tennessee death certificate statute (T.C.A. § 68-3-502), "[t]he medical certification shall be completed, signed and returned… by the physician in charge of the patent's care for the illness or condition that resulted in death within forty-eight (48) hours after death". Additionally, the Tennessee Office of Vital Records has instituted a web-based, electronic system for the completion and registration of vital records called the Vital Records Information System Management (VRISM). Due to a systems issue, the death certificate for the patient was not available in the VRISM for Dr. Smith to review and complete the medical section of the death certificate for several days. Consequently, the patient's death certificate was not certified within the 48-hour statutory time frame through no fault of Dr. Smith. However, once the systems issue was resolved and the patient's death certificate became available for review in the VRISM, Dr. Smith reviewed, completed, and certified the relevant medical section within a few hours of its availability.

A lawsuit was subsequently filed against Dr. Smith alleging he negligently filled out the death certificate with undue delay causing economic injury and emotional distress to the patient's surviving spouse. SVMIC hired defense counsel for Dr. Smith, and defense counsel filed a Motion to Dismiss (MTD) based upon the immunity statute found at T.C.A. § 68-3-513, which states "[a]ny physician who in good faith complies with [the requirements of the Tennessee death certificate statute] shall be immune from civil suit for damages."

The MTD argued that the plaintiff failed to state a claim upon which relief could be granted because the plaintiff did not plead any facts in the Complaint that would establish Dr. Smith acted in bad faith or failed to act in good faith in the certification of the death record, and therefore, T.C.A. §68-3-513 applied to Dr. Smith making him immune from civil suit for damages. After a hearing, the Court granted Dr. Smith's MTD and dismissed the lawsuit with prejudice.

In addition to the death certificate immunity statute discussed above, state legislatures have passed statutes granting legal immunity to physicians in a variety of other contexts to encourage certain health care activities. For instance, many states have immunity statutes covering volunteer and good Samaritan scenarios as well as quality review committees provided specific requirements are met. If only immunity from COVID infection could also be addressed by passing a statute!

Risk Matters: M.E.D.I.C.

By Jeffrey A. Woods, JD

A few years ago, nationally recognized trial consultant, Dr. Jill Huntley Taylor, was a contributor to our live seminar program and wrote an article for our newsletter outlining juror expectations in a medical malpractice trial. To identify these expectations, she uses the acronym “MEDIC” which stands for:

Medicine - whether or not the standard of care was met will be in dispute;

Education - education is really about communication - communication to the patient about their medical condition and treatment plan, and communication within a medical practice;

Documentation - jurors look for evidence of both communication and medical care in the medical documentation and tend to rely heavily on what was documented contemporaneously;

Informed consent - one specific aspect of communication to which jurors pay very close attention is the informed consent process and they want the patient to be informed about what the medical treatment entails and what to expect, including potential side effects and

complications - an informed patient is an empowered patient, and;

Caring - jurors take all the information that they can gather about that professional and determine, “is this someone I would want caring for me?"

For a more in-depth discussion, read Dr. Huntley Taylor’s Sentinel article: Addressing Juror Expectations in Everyday Practice: MEDIC.
