Insights

OCTOBER 2024

WCH® Service Bureau

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Editor's Note

Welcome back, providers!

Our mission remains steadfast: to support you in delivering the best patient care while ensuring your practice thrives financially. Our October issue is packed with essential insights and strategies to help you navigate the billing complexities, optimize your practice, and deliver exceptional patient care.

Automate Payments: A Strategic Necessity
In our previous issue, we explored the recent CFPB (Consumer Financial Protection Bureau) rule, which aims to alleviate the burden of medical debt on patients' credit reports. The shift necessitates providers to adapt their billing practices to encourage timely payments while fostering a patient-centered approach. It can be an effective tool to streamline collections, whether initiated in-office during a patient visit or sent out after billing statements. With automation, not only can you enhance your financial efficiency, but you can also offer patients the convenience they seek.

The Complexities of Billing and Medical Debt Legislation
Understanding the intricacies of in-network and out-of-network billing can be daunting. As healthcare providers, you face many challenges, especially with the recent shifts in medical debt legislation. Our article breaks down these complexities, providing you with essential insights to navigate the billing landscape more effectively. We emphasize the importance of efficient collections to safeguard your practice's financial health and viability.

Debt in the Healthcare Workforce: A Growing Concern
The financial strain on healthcare professionals is more pronounced than ever. A recent study highlighted the staggering medical and educational debt collectively owed by healthcare workers—over $150 billion! This issue transcends individual experiences, influencing career choices and exacerbating stress in an already demanding profession. We delve into practical solutions for managing this debt, empowering you to thrive professionally while mitigating financial burdens.

Maximizing Productivity in Medicare Part B
For those looking to enhance efficiency while providing exceptional care, we discuss the invaluable "incident to" billing under Medicare Part B. This strategy allows providers to leverage auxiliary personnel for reimbursement, maximizing productivity without compromising care quality. Our insights aim to help you optimize your billing practices, allowing you to focus on what you do best—providing outstanding patient care.

Unlocking Financial Benefits through Technology
We emphasize the role of technology in enhancing patient adherence and improving outcomes. However, did you know that adopting these technologies can also lead to significant financial benefits for primary care practices? By integrating solutions like telehealth consultations and remote monitoring, practices can unlock new revenue opportunities, particularly with Medicare and other insurers.

Understanding Personality Types in Medical Practice
Communication is key. We explore the dynamics between introverted and extroverted doctors and how these personality traits impact patient interactions and care delivery. Understanding your personality type can lead to a more fulfilling practice and enhance patient relationships, allowing you to remain true to yourself while offering the best care possible.

Learning from Experience: Successful Audit Resolutions
In our ongoing commitment to learning and improvement, we share a compelling case study detailing our team's experience with a challenging audit request. This journey taught us invaluable lessons about accuracy and thoroughness in documentation—insights we are eager to pass on to you as we all strive for excellence.

Celebrating Excellence: Olga Khabinskay Honored with Thomas N. Hackett Memorial Award
We are thrilled to announce that our Director of Operations, Olga Khabinskay, has been recognized for her outstanding contributions to the healthcare billing industry with the prestigious Thomas N. Hackett Memorial Award. Her dedication and expertise are a valuable asset to our team and the industry as a whole.

We packed October's issue with vital insights and strategies designed to support your practice amid ongoing changes in the healthcare landscape. We hope you find these articles engaging and informative.

Thank you for your dedication to healthcare, and as always, we are here to support you!

Warm regards
Iryna Tetera

MEDFINANCE

Maximizing productivity while maintaining high-quality care is one of the main crucial goals for providers. One way Medicare Part B allows physicians and certain Non-Physician Practitioners (NPPs) to enhance their efficiency is by billing for services provided by auxiliary personnel on an incident to basis. Let's understand how you can navigate this valuable option for reimbursement.

MAXIMIZING PRODUCTIVITY IN MEDICARE PART B THROUGH INCIDENT TO BILLING

Understanding Incident To Billing

At its core, incident to billing refers to services performed by auxiliary personnel under the supervision of a physician that are considered an integral part of the physician's professional service. When these requirements are met, the services provided by auxiliary personnel—like nurse practitioners (NPs), physician assistants (PAs), and clinical social workers—can be billed under the physician's National Provider Identifier (NPI), ensuring full reimbursement (100% of the Physician Fee Schedule rate). Otherwise, when NPPs bill independently, they are reimbursed at 85% of the Physician Fee Schedule rate.

Who Can Provide Incident To Services?

Auxiliary personnel eligible for incident to services include various healthcare professionals such as:

- **Physician Assistants (PAs)**
- **Nurse Practitioners (NPs)**
- **Clinical Nurse Specialists**
- **Certified Nurse Midwives**
- **Clinical Psychologists**
- **Clinical Social Workers**
- **Physical Therapists**
- **Occupational Therapists**

These professionals, collectively referred to as Non-Physician Practitioners (NPPs), have their own Medicare coverage categories and can provide services independently, subject to state laws. However, when working as auxiliary personnel under a physician's supervision and meeting incident to requirements, their services can be reimbursed at the physician's rate.

Key Incident To Requirements

For a service to qualify as incident to a physician's services under Medicare Part B, certain conditions must be met:

- **Part of an Established Treatment Plan:** The services must be part of the physician's ongoing treatment plan for an established patient. New patients or patients being treated for a new illness or injury do not qualify for incident to billing.

- **Integral, Yet Incidental to Physician Services:** The services provided must be an essential, yet incidental part of the physician's professional service. For example, NPPs may perform follow-up care or administer treatments as part of the physician's established plan, but the physician remains responsible for the patient's overall care.

- **Commonly Performed in a Physician's Office or Clinic:** Incident to services should be those that are typically provided in a physician's office setting, such as non-self-administerable medications, rehabilitation services, or wound care.

- **Supervision Requirements:** The supervising physician must be present in the office suite and immediately available to assist if needed (known as "direct supervision"). However, recent changes in Medicare regulations now allow for "general supervision"—where the physician is available but not physically present—for certain behavioral health services, which is an important development for telehealth.

- **Consistent Physician Involvement:** The supervising physician must remain actively involved in the course of treatment. It's not sufficient for the physician to initiate care and then leave the auxiliary personnel to manage the patient independently.

- **Compliance with State Laws:** Any incident to services provided must be within the scope of the auxiliary personnel's licensure as defined by state law. It means that certain procedures or services may be restricted based on the state's scope of practice for the NPP involved.

Billing Incident To in Telehealth Settings

With the rise of telehealth, the application of "incident to" billing has expanded to remote care. Here's how telehealth services provided by NPPs can meet incident to billing requirements:

- **Remote Chronic Care Management:** A physician creates a care plan for a patient with chronic conditions like diabetes. Regular follow-up visits are conducted via telehealth by an NP. As long as these visits are part of the physician's established treatment plan and the physician is available for supervision remotely, the NP's telehealth services can be billed as "incident to," ensuring full reimbursement.

- **Post-Operative Telehealth Visits:** After surgery, a physician establishes a post-operative care plan for a patient. Telehealth follow-up visits with a PA monitor wound healing and recovery. These visits, part of the established care plan, can also be billed as incident to the physician's services.

- **Mental Health Services:** A psychiatrist formulates a treatment plan for a patient with anxiety. A clinical social worker conducts telehealth therapy sessions as part of this plan. As long as the psychiatrist remains available for supervision, these sessions can be billed under the psychiatrist's NPI as incident to services.

Case Example: Optimizing Incident To Billing for a Small Practice

Dr. X runs a small private practice with the assistance of an NP and a clinical social worker. By utilizing incident to billing, Dr. X can maximize the practice's revenue without sacrificing patient care. Here's how:

- NP sees patients for routine follow-ups and chronic disease management, operating under Dr. X's established treatment plans. These visits are billed under Dr. X's NPI, allowing the practice to receive full reimbursement.
- The social worker provides therapy to patients diagnosed by Dr. X, again following the physician's care plan. These sessions are billed under Dr. X's NPI, maximizing revenue while allowing the social worker to handle the bulk of mental health care in the practice.

Through proper supervision and careful adherence to Medicare's incident to requirements, Dr. X's practice increases patient capacity and profitability.

Pitfalls to Avoid in Incident To Billing

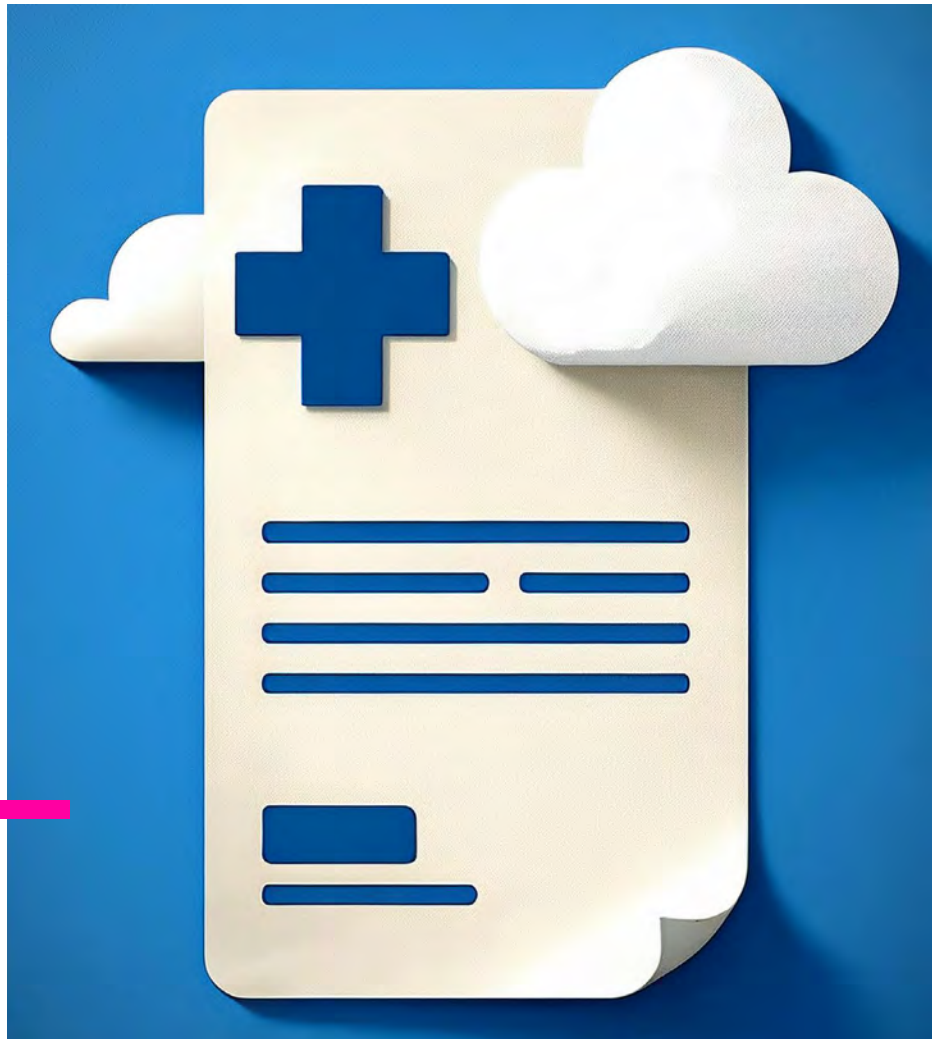
While incident to billing is a valuable tool for providers, it's essential to avoid common pitfalls:

- **Improper Supervision:** Failing to provide the required level of supervision—whether direct or general—can result in denials of reimbursement or even penalties if audited. Ensure that the supervising physician is either physically present in the office or available remotely as required.
- **Billing for New Patients or Conditions:** Incident to services only apply to established patients or ongoing care plans. Attempting to bill incident to for new patients or new conditions can lead to claim denials.
- **State Scope of Practice Violations:** Even if Medicare allows for incident to billing, providers must ensure that the services rendered by NPPs are within the scope of practice defined by state law. Violating these regulations can lead to legal and financial repercussions.

Evolving Trends in Incident To Billing

Incident to billing remains a powerful tool for maximizing practice efficiency while maintaining high-quality care. By leveraging this Medicare provision, practices can increase patient throughput, reduce physician workload, and enhance financial sustainability. However, navigating the complexities of incident to billing requires careful attention to regulations, supervision requirements, and state laws.

For practices seeking to optimize their operations, understanding and effectively implementing incident to billing can be the key to thriving in a competitive healthcare environment.



EXPERT COMMENT FROM WCH BILLING SPECIALIST ELEN POGHOSYAN

When used effectively, incident to billing can greatly enhance both the financial health and operational efficiency of a medical practice. For healthcare providers looking to make the most out of their resources, here are a few practical insights to consider:

1. **Maximizing Reimbursement:** One of the clearest benefits of "incident to" billing is the potential for full Medicare reimbursement at 100%, compared to the 85% rate that applies when non-physician practitioners (NPPs) bill under their own NPI. This higher reimbursement rate is a game changer for practices aiming to increase their revenue while maintaining high-quality patient care. Delegating tasks to nurse practitioners (NPs) or physician assistants (PAs) under "incident to" rules are particularly useful for routine visits and follow-ups, allowing physicians to focus on more complex cases.

2. **Optimizing Physician Time:** By delegating routine tasks to NPPs, physicians can expand their capacity and handle a larger patient load without compromising care quality. For example, in practices dealing with chronic disease management, NPPs can handle routine check-ups, ensuring consistent care while allowing the physician to focus on critical issues. This efficient division of labor makes your practice run smoother and ensures all patients receive timely attention.

3. **Expanding Access to Care:** In areas where physician availability is limited, especially in rural and underserved regions, "incident to" billing offers a powerful solution. NPPs can handle a significant portion of patient care, helping to increase the number of patients seen and improving access to services. This setup allows practices to grow and better serve communities without overburdening the physicians.

4. **Promoting Team-Based Care:** This billing method fosters a collaborative environment where physicians and NPPs work closely together. NPPs manage ongoing patient needs, while physicians provide overall supervision and handle more complex cases. This team-based approach ensures that patients receive well-rounded care, which can improve both outcomes and patient satisfaction.

5. **Streamlining Workflow:** Incorporating "incident to" billing into your practice can streamline your workflow. With NPPs managing much of the routine care, the practice can maintain high productivity levels without overwhelming any one provider. This balance improves overall operational efficiency and reduces bottlenecks, helping your practice run more smoothly.

As you can see adopting incident to billing offers both financial and operational benefits, allowing practices to increase revenue while maintaining or even improving care standards. It's particularly advantageous for practices with robust internal processes that can fully leverage the skills of their NPPs to optimize care delivery.

MEDICAL AND EDUCATIONAL INDEBTEDNESS AMONG U.S. HEALTHCARE WORKERS:

CHALLENGES AND PRACTICAL SOLUTIONS FOR PHYSICIANS

A Growing Crisis of Debt in the Healthcare Workforce

The U.S. healthcare system is one of the most expensive in the world, and the financial burden of becoming and working as a healthcare professional is staggering. A recent study published in JAMA Health Forum on July 26, 2024, by Dr. Kathryn E. W. Himmelstein and Dr. Alexander C. Tsai shines a light on the substantial medical and educational indebtedness of U.S. healthcare workers. The study found that health professionals—ranging from physicians to nursing aides—are more likely than other workers to carry debt, collectively owing over $150 billion.

The implications of these debts are far-reaching. Educational loans can influence career choices, while medical debt can lead to financial instability, further aggravating stress levels in a high-pressure profession. We decided to delve into the study's findings and discuss practical steps physicians can take to alleviate the burden of debt.

Understanding the Extent of Medical and Educational Debt in Healthcare

The study, which analyzed data from the 2018-2021 Survey of Income and Program Participation (SIPP), revealed several alarming trends:

- **Medical Debt:** Healthcare workers, on average, held more medical debt than other professions—13.9% of healthcare workers had medical debt compared to 11.1% of the general workforce. The average medical debt was $1,567 per individual, totaling $19.8 billion across the country.
- **Educational Debt:** A significant proportion of healthcare workers (26.7%) were burdened with student loans, with an average educational debt of $10,642. This educational debt was especially prevalent among younger healthcare workers and those with higher levels of education, such as physicians.
- **Disparities in Debt:** The study found that medical and educational debt disproportionately affects certain groups:
  - **Women** were more likely to carry medical debt (15.3%) compared to men (9.3%).
  - **Black healthcare workers** had higher medical and educational debt levels than their white counterparts. Nearly 20% of Black healthcare workers had medical debt, compared to 13% of White workers.
  - **Workers in lower-paying sectors like home health and nursing home care, those lacking insurance, and those recently hospitalized** were also more likely to face medical debt.

The Impact of Debt on Physicians

Physicians often face significant financial challenges due to the high cost of medical education and the operational demands of running a practice. The average medical school graduate owes more than $200,000 in student loans, and this debt can linger for decades. Medical debt, meanwhile, is exacerbated by rising healthcare costs, leaving even high-income professionals vulnerable.

Physicians burdened by debt may face:

- **Limited Career Choices:** Educational debt often steers physicians toward higher-paying specialties rather than primary care or public health roles, which may offer lower salaries but are crucial for addressing healthcare gaps in underserved communities.
- **Burnout and Stress:** Financial stress contributes significantly to physician burnout, which is already a widespread issue. Worrying about loan repayments or unexpected medical expenses can compound the mental and emotional strain of practicing medicine.
- **Professional Mobility:** Physicians with substantial debt may feel trapped in their current positions, limiting their ability to transition to other roles, invest in further education, or even take necessary breaks from clinical practice.

Practical Solutions for Physicians Facing Debt

Addressing debt as a healthcare worker—particularly as a physician—requires a multifaceted approach. Here are practical strategies for managing both medical and educational debt:

Student Loan Repayment Options

- **Income-Driven Repayment Plans:** Many physicians can benefit from income-driven repayment (IDR) plans, which calculate monthly payments based on income and family size. These plans help lower the monthly payment burden, especially in the early years of practice when salaries are typically lower.
- **Public Service Loan Forgiveness (PSLF):** Physicians working in qualifying public or nonprofit settings may be eligible for PSLF after 10 years of service and consistent loan repayments. Many primary care roles, hospital-based positions, and teaching hospitals qualify, making this a valuable option for reducing educational debt.
- **Refinancing:** Physicians with private loans or those ineligible for PSLF may consider refinancing their student loans to secure a lower interest rate, potentially saving thousands of dollars in interest over time. Be cautious, though—refinancing federal loans will make you ineligible for PSLF and IDR plans.

Debt Relief Programs

- **State and Federal Loan Repayment Programs:** Many states offer loan repayment programs for physicians who commit to working in

underserved areas. These programs can reduce educational debt significantly and offer a pathway to lower overall financial burden.

- **National Health Service Corps (NHSC):** Physicians who serve in high-need areas can receive loan repayment assistance through the NHSC. In exchange for a service commitment, NHSC provides substantial loan repayment for primary care physicians and other healthcare workers.

Financial Planning and Debt Management

- **Seek Professional Financial Advice:** Physicians facing large amounts of debt may benefit from consulting with a financial advisor who specializes in working with medical professionals. An advisor can help create a comprehensive debt repayment strategy that balances immediate financial obligations with long-term wealth-building goals.

- **Automated Savings Plans:** Even while paying down debt, it's essential to build an emergency savings fund. Setting up an automated savings plan can help physicians grow a financial cushion for unexpected medical or personal expenses without adding to their debt.

Advocate for Policy Changes

Physicians and healthcare workers can also push for systemic changes that address the root causes of educational and medical debt:

- **Support Legislative Reform:** Advocating for legislation that expands access to PSLF, reduces the cost of medical education, or provides more robust health insurance coverage for healthcare workers can have a significant long-term impact.

- **Encourage Employer-Sponsored Debt Relief:** Hospitals and healthcare organizations can play a role in alleviating debt by offering loan repayment assistance as part of compensation packages. Healthcare workers can advocate for debt relief as a retention and recruitment strategy within their organizations.

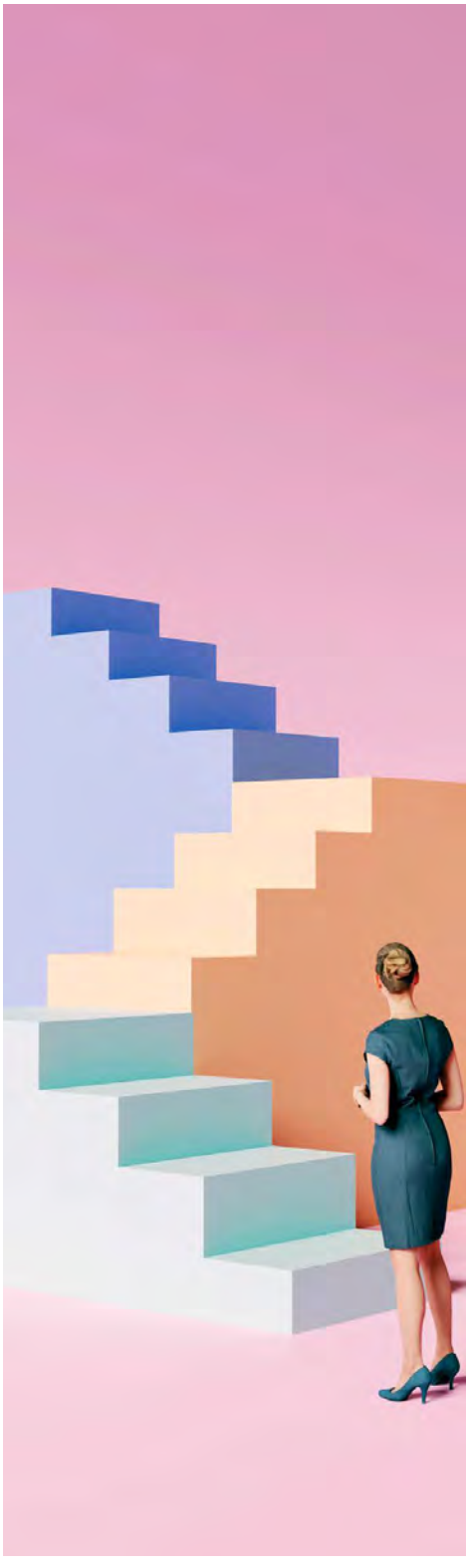
Addressing Medical Debt Directly

- **Negotiate with Providers:** Physicians, like any other patients, should actively engage with healthcare providers to negotiate medical bills. Many hospitals offer payment plans, financial assistance programs, or reduced fees for employees.

- **Use Medical Debt Relief Resources:** Nonprofits such as RIP Medical Debt and Patient Advocate Foundation offer resources to help individuals reduce or eliminate medical debt. These organizations work to buy and forgive medical debt or provide direct assistance with navigating medical bills.

Debt's Impact on Healthcare Quality

The debt burden on healthcare workers, particularly physicians, has broader implications for the healthcare system. High debt may deter talented individuals from pursuing medical careers or entering lower-paying specialties, leading to shortages in critical fields like primary care. Additionally, financial stress can impact the quality of care, with indebted healthcare workers potentially less willing to advocate for patient safety or challenge harmful work conditions out of fear of losing their income.



AUTOMATE PAYMENTS:

A STRATEGY FOR MODERN MEDICAL PRACTICES

In our last issue, we discussed how the new CFPB (Consumer Financial Protection Bureau) rule, which seeks to eliminate medical debt from credit reports, will significantly impact healthcare providers and their billing practices. With fewer patients at risk of having medical debt negatively affect their credit scores, providers must find alternative ways to encourage timely payments while maintaining a patient-centered approach. Today, we delve into one such solution: automating payments.

The financial landscape in healthcare is evolving, and practices are faced with the challenge of improving their collections processes while maintaining patient satisfaction. One of the most effective tools in this regard is payment automation. Whether initiated in-office during a patient's visit or following a billing statement, automating payments can help practices improve their financial efficiency while making payments more convenient for patients.

Let's explore the benefits of payment automation, discuss practical steps for implementing it in your practice, and address how it can help reduce the risk of bad debt collections.

The Case for Automating Payments

Streamlining Operations for Patients and Staff
Automating payments simplifies the billing process for both patients and medical staff. Instead of manually processing payments and chasing down overdue bills, practices can set up systems that securely store patient payment information and automatically process payments on the due date. It creates a seamless experience for patients who no longer need to remember to log in or send checks. For staff, it significantly reduces administrative workloads, freeing up time to focus on more critical issues.

Mitigating Bad Debt Risk
One of the primary challenges in healthcare billing is the risk of accounts ending up in bad debt collections. Patients who delay payments or cannot meet their financial obligations often end up with debts sent to collections agencies, which can damage patient-provider relationships and reduce the likelihood of recovering the full amount owed. By automating payments, practices can reduce the chances of missed payments, ensuring that funds are transferred automatically according to the patient's pre-approved plan. This proactive approach minimizes the potential for bad debt and increases the likelihood of full payment collection.

Enhancing the Patient Experience
Offering automated payment options is a way to improve patient satisfaction. Patients today expect convenience and efficiency, especially when it comes to managing their healthcare expenses. Automating payments provides them with a predictable, transparent, and hassle-free way to handle their bills. It can also reduce the confusion and anxiety that often accompanies healthcare billing, as patients won't need to worry about missing a payment or facing unexpected charges.

Improving Cash Flow Predictability
For healthcare providers, maintaining a steady and predictable cash flow is essential for operational stability. Automated payments help ensure that payments are made on time, reducing the unpredictability that can come with manual billing and follow-ups. This allows practices to forecast revenues more accurately and make informed decisions about budgeting, staffing, and resource allocation.

Steps to Implement Payment Automation in Your Practice

Choose the Right Payment Platform
The first step in automating payments is selecting a secure and reliable payment platform that integrates seamlessly with your existing electronic health records (EHR) and billing systems. Ensure the platform complies with healthcare regulations such as HIPAA (Health Insurance Portability and Accountability Act) and PCI DSS (Payment Card Industry Data Security Standard). A compliant payment platform will protect patient data and provide encrypted, secure transactions.

Pre-Authorize Payment Information
When patients come into the office for a visit, your front desk staff can securely collect and store their payment information with their consent. By pre-authorizing a payment method, patients agree to have their accounts charged automatically on the due date. This step is crucial in ensuring that payments are collected promptly without the need for follow-up or manual intervention.

Offering patients the option to pre-authorize payments during their visit helps ensure a seamless billing process. Practices can give patients peace of mind by providing transparency about how and when their accounts will be charged.

Set Up Customizable Payment Plans
Patients with large bills or high deductibles may find it difficult to pay their balances in full immediately. To accommodate their financial needs, offer flexible payment plans that break down the total amount owed into manageable monthly payments. Automated payment plans can be customized according to the patient's preferences and financial situation, allowing them to meet their obligations without undue stress.

Payment plans should be interest-free or come with low fees

to encourage patients to stay current on their bills. Practices can also work with third-party financing companies that specialize in medical expenses to offer additional payment solutions. These companies often provide zero-interest or low-interest options for patients, ensuring that they can pay off their balances over time while the practice receives full payment upfront.

Provide Transparent Billing and Communication
Although automating payments reduces the need for manual intervention, clear and transparent communication is still essential. Patients should receive notifications and reminders about upcoming payments or any changes to their payment schedules. By keeping patients informed, you can foster trust and prevent confusion, which in turn helps reduce billing disputes and misunderstandings.

Ensure that your payment automation system can send automated emails or text messages to remind patients of upcoming payments and provide them with detailed billing statements. Offering patients easy access to their billing history and payment schedule through a patient portal can further enhance their experience.

Monitor and Evaluate Payment Data
Payment automation systems typically offer robust reporting features that allow practices to monitor payment trends and assess the overall success of their billing strategy. Use these reports to identify any bottlenecks or areas where patients may be struggling to meet their payment obligations. By analyzing this data, you can make informed decisions about adjusting payment plan terms or offering additional financial assistance to certain patient groups.

Regularly reviewing payment data also helps practices identify any gaps in their billing process, allowing them to refine their strategies and improve overall efficiency.

Addressing Common Concerns with Payment Automation

Data Security and Patient Privacy
One of the most significant concerns patients may have about automated payments is the security of their financial information. It's essential to reassure them that their data is protected by industry-standard encryption and security protocols. Make sure your payment platform complies with HIPAA and PCI DSS standards and educate patients about the steps you take to safeguard their information.

Patient Resistance to Automation
Some patients may be hesitant to enroll in automated payment plans, especially if they are uncomfortable with pre-authorizing charges. To address this concern, offer flexible options and provide clear explanations of the benefits of automation. For example, you can highlight how automation reduces the risk of missed payments and collections while offering patients greater control over their finances through customizable payment plans.

Additionally, for patients who prefer not to automate, ensure that you have alternative payment options, such as manual payment plans or one-time online payments, so they can choose the method that best suits their needs.

What to Wait?

Automated payments can become an increasingly essential tool for managing revenue cycles efficiently. By embracing payment automation, practices can reduce administrative burdens, improve cash flow predictability, and enhance patient satisfaction.

At the same time, automated payments align with the broader trend toward consumer-driven healthcare, where patients expect convenience, transparency, and flexibility. As more patients become accustomed to digital solutions in other aspects of their lives, they will increasingly expect the same level of service from their healthcare providers.

For practices looking to stay ahead of the curve, now is the time to invest in payment automation and create a more efficient, patient-centered billing process that ensures financial stability for your practice while reducing the likelihood of bad debt collections.

THE COMPLEXITIES OF IN-NETWORK, OUT-OF-NETWORK, AND MEDICAL DEBT LEGISLATION

Efficient billing and collections are essential to maintaining financial health and ensuring that practices remain viable. However, providers face numerous challenges in managing these processes, particularly when dealing with the complexities of in-network insurance, out-of-network insurance, and evolving state regulations on medical debt.

Out-of-Network Providers: Simplified Billing with Higher Patient Responsibility

For out-of-network providers, the billing process is relatively straightforward. Payment is typically required upfront, shortly after the visit, eliminating the need to wait for insurance claim reimbursement.

From a practice's perspective, this approach ensures immediate payment, reducing the risk of unpaid balances. By collecting fees directly from the patient, providers eliminate the administrative burden of filing insurance claims and reduce the likelihood of disputes.

However, it's crucial to recognize that this model places a significant financial burden on patients, which may discourage them from seeking care. High out-of-pocket costs can be a deterrent, so clear communication about payment expectations and any available options, such as payment plans, is essential to maintaining a positive patient-provider relationship.

In-Network Providers: Managing Insurance Complexities for Efficient Collections

In-network billing, while beneficial for patients, is often much more complex for providers. It involves managing insurance co-pays, deductibles, and co-insurance, which can delay collections and create confusion for the patient and the provider. Implementing a systematic approach to these processes is critical for timely collections.

Insurance Verification and Coordination of Benefits (COB)

Before each patient visits, providers must verify insurance coverage and determine if there are multiple insurance plans involved through Coordination of Benefits (COB). This step ensures that all primary and secondary payers are accounted for, minimizing the risk of claim denials. However, this process can be time-consuming, especially when certain insurers require direct phone verification rather than offering information through online portals.

To streamline this process, it's beneficial to maintain a list of insurers that require manual verification and ensure your team is trained to handle these verifications efficiently.

Co-Pays, Deductibles, and Gaps in Coverage

Once insurance coverage is verified, providers must carefully calculate the patient's out-of-pocket costs, including co-pays, deductibles, and co-insurance. Collecting these amounts at the point of service can be challenging, as insurance plans can change unexpectedly. For example, a patient may pay a deductible upfront, only to find that gaps in coverage later require a refund.

Managing Deductibles

Deductibles present a particular challenge for in-network providers. Patients may be asked to pay toward their deductible at the time of service, but if the deductible isn't fully met or the insurance claim is denied, the provider may need to issue a refund. Clear communication with patients about their deductible responsibilities and a system for managing potential refunds are essential to avoid confusion and maintain patient trust.

Best Practices for Point-of-Service Collections

Collecting payment at the point of service is one of the most effective ways to prevent unpaid balances. Whether it's collecting a co-pay, a deposit for a deductible, or storing a patient's credit card information for future payments, having a streamlined system in place ensures that your practice maintains healthy cash flow.

However, when storing credit card information, it's important to obtain the patient's written consent, ensuring compliance with both legal requirements and patient data security standards. Some patients may be hesitant to provide this information, so it's vital to communicate the security measures in place and how this process benefits both parties by reducing future administrative burdens.

State-Specific Medical Debt Laws: What Providers Need to Know

In recent years, state-specific legislation regarding medical debt has become increasingly important for providers to understand. Laws governing medical debt, credit reporting, and collection practices vary widely, and compliance with these regulations is essential to avoid penalties and maintain positive relationships with patients.

Medical Debt and Credit Reporting Laws

The Consumer Financial Protection Bureau (CFPB) has affirmed that states have the right to enact their own laws regarding medical debt, despite federal regulations like the Fair Credit Reporting Act (FCRA). This has led to various states passing laws aimed at protecting patients from long-term financial harm caused by medical debt.

For example, several states—such as Colorado, Connecticut, Illinois, Minnesota, New Jersey, New York, Rhode Island, and Virginia—have completely removed medical debt from credit reports. Providers in these states must adjust their billing and collections processes to align with these regulations, avoiding potential disputes and ensuring compliance.

Changes to Billing Statements and Communication

States such as Nevada, Washington, New Mexico, and Delaware now mandate that healthcare providers send more detailed billing statements to patients before initiating any collection activities. Providers must clearly outline the amount due, the service date, and the steps for making a payment. This transparency helps to reduce disputes and allows patients to address billing errors more easily.

Statutes of Limitations on Medical Debt Collection

For providers operating in Florida, South Carolina, and Virginia, the statute of limitations on collecting medical debt has been reduced to three years. This means that providers have a limited window to pursue collections, emphasizing the importance of timely and accurate billing.

Caps on Interest and Collection Fees

To protect patients from excessive financial strain, some states have introduced caps on the interest and fees associated with medical debt collections. For example:

- Maine prohibits any interest or collection service fees on medical debt.
- New Jersey imposes a 3% cap on interest rates.
- Nevada limits interest rates on medical debt to 5%.

Providers in these states should ensure their billing systems are updated to reflect these limits and avoid overcharging patients.

Financial Assistance Requirements and Payment Plans

Many states now require healthcare providers to offer financial assistance programs to patients who are unable to pay their medical bills in full. Illinois, Minnesota, New Mexico, and New York are just a few examples where state laws mandate that providers screen patients for financial assistance eligibility before pursuing collections.

Additionally, Colorado limits payment plans to a maximum of 4% of the patient's monthly household income (2% for healthcare professionals), and any remaining debt is forgiven after 36 payments. Providers must ensure that their payment plan offerings comply with these regulations and are effectively communicated to patients.

Building a Robust Billing and Collections System

For healthcare providers, mastering the nuances of both in-network and out-of-network billing is crucial to maintaining financial stability and reducing administrative burdens. While out-of-network billing may be more straightforward, in-network providers face a web of insurance complexities that must be managed with diligence and precision. At the same time, state-specific medical debt legislation continues to evolve, requiring providers to stay up-to-date on laws that impact billing practices and patient collections.

To optimize your practice's billing and collections, consider the following best practices:

- **Verify Insurance Coverage and COB Early:** Ensure accurate verification of insurance coverage before the patient's visit to minimize claim denials.
- **Collect at the Point of Service:** Whenever possible, collect co-pays or deposits at the point of service to reduce unpaid balances.
- **Obtain Consent for Payment Storage:** Secure consent for storing patient payment information, ensuring compliance with security standards and legal requirements.
- **Stay Compliant with State Laws:** Familiarize yourself with state-specific medical debt laws, including statutes of limitations, interest caps, and financial assistance requirements.

EXPANDING HORIZONS:

CONSIDER THE MEDICAL HEBREW ULPAN COURSE

Healthcare is becoming more globalized. The ability to speak multiple languages is no longer just a bonus—it is becoming a necessity. For healthcare professionals, effective communication is key to providing high-quality care, and when language barriers arise, it can lead to misunderstandings that negatively affect patient outcomes.

Recognizing the importance of language in healthcare, the World Zionist Organization's Department for the Promotion of Aliyah, in collaboration with the Ofek Israeli, has launched a Medical Hebrew Ulpan course aimed specifically at healthcare professionals. This online course is designed to help doctors, nurses, and other healthcare staff build proficiency in Hebrew, particularly regarding medical terminology. If you have ever worked with Hebrew-speaking patients, are considering expanding your practice to include Hebrew speakers, or are considering working as a medical professional in Israel, this course is worth considering.

Why Hebrew Matters for Healthcare Professionals

Healthcare professionals frequently encounter patients from diverse backgrounds, and the ability to communicate in the patient's native language can make a world of difference. For Hebrew-speaking patients, the lack of understanding between provider and patient can be especially challenging, as medical discussions often involve complex terminology that is difficult to convey even in one's own language.

For those considering Aliyah and working in Israel's healthcare sector or serving Hebrew-speaking patients in their current practice, learning medical Hebrew can dramatically improve the quality of care. Israel's medical field, in particular, is known for its high standards and innovation, and there are numerous opportunities for healthcare professionals who can speak Hebrew. By learning Hebrew medical terminology, professionals can provide better care, enhance patient relationships, and improve diagnostic accuracy.

What the Medical Hebrew Ulpan Course Offers

The Medical Hebrew Ulpan course provides a structured, focused approach to mastering Hebrew medical terminology. The course offers more than just conversational language skills; it teaches the specific vocabulary needed for use in healthcare settings.

Participants will learn:

- **Key medical terminology in Hebrew:** Words and phrases necessary for patient care, diagnosis, and treatment.
- **Communication skills for consultations:** Interacting confidently with Hebrew-speaking patients in routine and emergency scenarios.
- **Practical phrases for clinical settings:** The language needed to explain symptoms, discuss treatment options, and provide patient instructions in Hebrew.

This course is perfect for doctors, nurses, and healthcare providers who want to improve their communication with Hebrew-speaking patients, or those looking to expand their practice to include patients from Israel's thriving healthcare system or provide medical services in Israel.

Who Should Consider This Course?

The Medical Hebrew Ulpan is particularly relevant for:

- Doctors, nurses, and other healthcare providers who want to enhance their Hebrew for professional use.
- Healthcare professionals working with Hebrew-speaking patients in any part of the world.
- Medical providers interested in working in Israel or collaborating with Israeli medical institutions.

Whether you are planning to work in Israel or simply aiming to serve Hebrew-speaking patients in your community better, this course is designed to meet your professional needs.

Why You Should Consider Enrolling

There are several compelling reasons for healthcare professionals to consider joining the Medical Hebrew Ulpan:

- **Israel's Growing Healthcare Opportunities:** Israel is a world leader in medical research and healthcare innovation. The country's healthcare system is considered one of the best globally, and for professionals interested in working there, being proficient in Hebrew is often essential. Learning medical Hebrew through this course can help healthcare providers transition into Israel's medical field, which continues to offer new opportunities, particularly for those with specialized language skills.

- **Enhance Patient Care and Communication:** Even if you don't plan to work in Israel, learning Hebrew medical terminology can greatly benefit your practice if you regularly encounter Hebrew-speaking patients. Misunderstandings in healthcare can lead to errors in treatment, delayed diagnoses, and poor patient satisfaction. By learning to communicate in Hebrew, you will ensure that your patients feel understood and supported, improving their overall experience and quality of care.

- **Professional Growth and Cultural Competency:** In an increasingly globalized world, multilingual healthcare professionals are in demand. Being able to communicate in Hebrew will not only benefit your patients but also expand your professional network and opportunities for collaboration with Hebrew-speaking colleagues. In addition, learning Hebrew can improve your cultural competency, helping you to understand and empathize with the backgrounds and perspectives of your patients.

Course Structure and Flexibility

The Medical Hebrew Ulpan is designed with healthcare professionals' busy schedules in mind. The course is held online on Sunday mornings (Eastern Standard Time) via Zoom, making it accessible no matter where you are located. All sessions are recorded, so if you are unable to attend live, you can still keep up with the course material at your convenience.

Additionally, the course offers extensive materials for continued study, ensuring that participants have the resources they need to practice their new language skills beyond class hours. The course fee is $600, which includes all learning materials.

DEPARTMENT FOR THE PROMOTION OF ALIYAH

NORTH AMERICAN DIVISION

אופק ישראלי

OFEK ISRAELI

How to Get Started

To enroll in the Medical Hebrew participants are required to take a brief placement test to assess their current Hebrew language level. While the course is primarily focused on medical terminology, basic Hebrew knowledge is a prerequisite for enrollment. The placement test ensures that participants are grouped according to their language abilities, optimizing the learning experience for everyone.

If you want to enhance your medical Hebrew skills, contact Ilana Kozak at ilanakozakwzo@gmail.com for further details or to register for the course.

Whether you are aiming to improve patient interactions, enhance your professional qualifications, or consider Aliyah and new career possibilities in Israel's healthcare sector, this course is a significant step in the right direction. Don't miss out on this opportunity to expand your skills and improve the care you provide to Hebrew-speaking patients.

Take the placement test now! Start Here

MEDICARE REVALIDATION: A CRITICAL UPDATE FOR ORGANIZATIONAL PROVIDERS

Are You Prepared?

As an organizational provider, it's essential to stay informed about the latest Medicare regulations to ensure your continued participation in the program. One crucial requirement is revalidation, a process that helps to verify the accuracy and completeness of your enrollment information.

Check Your Revalidation Status

To determine whether you need to revalidate your enrollment record, consult the Medicare Revalidation List. CMS typically posts revalidation due dates 6-7 months in advance, giving you ample time to prepare. However, if your due date is listed as "TBD," it means that your due date has not been set yet.

Important Notice: No New Revalidation Due Dates for November 2024 - April 2025

Please note that there will be no new revalidation due dates issued for the period from November 2024 to April 2025. Revalidation will resume in May 2025.

Why Revalidate?

Revalidating your enrollment is crucial for several reasons:

- **Accuracy of Provider Information:** It ensures that your provider information is up-to-date and accurate.
- **Continuity of Participation:** Timely revalidation helps to prevent disruptions in your Medicare participation.
- **Patient Access to Care:** Accurate enrollment information is essential for patients to receive the care they need.

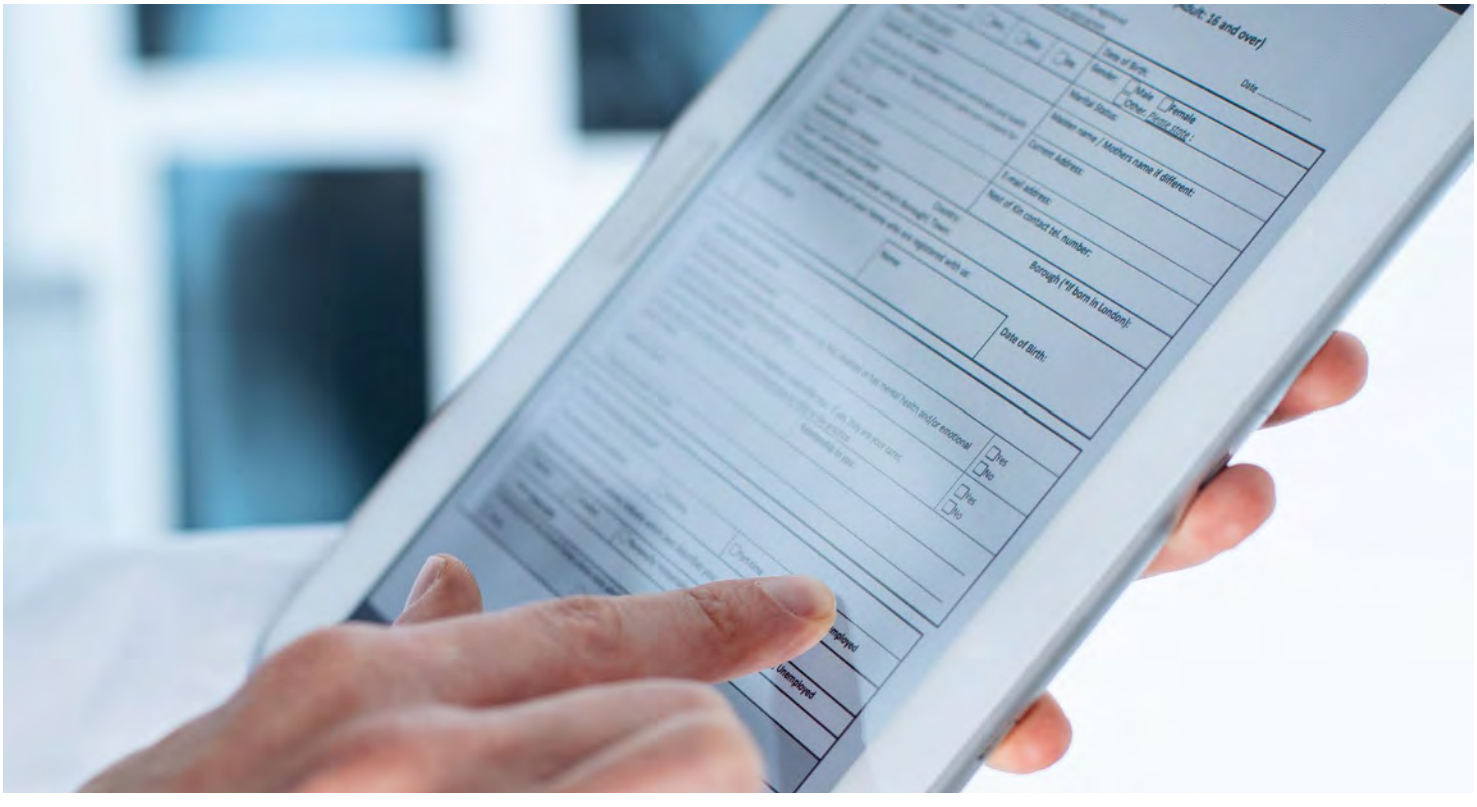
For More Information

To learn more about revalidations and the process of renewing your enrollment, please visit the Revalidations page on the CMS website.

Take Action Today

Don't delay. By staying informed about your revalidation status and taking prompt action when necessary, you can help ensure the continuity of your Medicare participation and continue providing quality care to your patients.

Source: https://www.cms.gov



DON'T MISS OUT: REQUEST A TARGETED REVIEW OF YOUR 2023 MIPS PERFORMANCE

The time to review your 2023 Merit-based Incentive Payment System (MIPS) performance feedback is here! Head to the Quality Payment Program (QPP) website to check your final score and payment adjustment factor(s).

What is a Targeted Review?

Good news! If you believe there's an error in your MIPS payment adjustment calculations, you can request a targeted review from the Centers for Medicare & Medicaid Services (CMS). This allows CMS to re-evaluate your score based on specific circumstances.

Who Can Request a Targeted Review?

The option to request a targeted review is available to various healthcare providers including individual clinicians, groups, subgroups, virtual groups, Accountable Care Organizations (ACOs), designated support staff, and authorized intermediaries.

Deadline to Act: Oct. 11, 2024

Don't delay! You have until **Oct. 11, 2024, at 8:00 p.m. ET** to request a targeted review. This timeframe applies if you believe your calculations were impacted by situations like:

- Data submitted under the wrong Taxpayer Identification Number (TIN) or National Provider Identifier (NPI).
- Unintentional qualification for a MIPS payment adjustment despite having Qualifying APM Participant (QP) status.
- Performance category weights are not automatically adjusted due to extreme and uncontrollable circumstances.

Note: This list is not exhaustive. If you are unsure whether your situation warrants a targeted review, contact the QPP Service Center at 1-866-288-8292 (TTY: 711) or by email at QPP@cms.hhs.gov.

How to Request a Targeted Review

1. Log in to the QPP website using your Healthcare Administrative Routines Program (HARP) credentials (ACO-MS credentials for Shared Savings Program ACOs).
2. Once logged in, navigate to "Targeted Review" on the left-hand menu.
3. Follow the on-screen instructions to submit your request.

Documentation may be required to support your targeted review request. The specific documents needed will vary depending on your situation. A CMS representative will contact you if additional information is necessary.

What Happens After a Review?

If your targeted review is approved and leads to a score change, your final score and/or associated payment adjustment will be updated as soon as possible. However, it's important to remember that targeted review decisions are final and cannot be appealed.

Additional Resources:

- 2023 Targeted Review User Guide (PDF). This guide provides a more detailed overview of the targeted review process and includes examples of situations where you would or wouldn't request a review.
- 2025 MIPS Payment Year Payment Adjustment User Guide (PDF). This guide explains how MIPS payment adjustments are calculated and applied, along with answers to frequently asked questions.

Don't wait! Ensure you receive a fair assessment of your MIPS performance by requesting a targeted review if you believe an error has occurred.

2024 QPP EXCEPTION APPLICATIONS: A LIFELINE FOR HEALTHCARE PROVIDERS

Are You Struggling to Meet MIPS Requirements?

The 2024 Quality Payment Program (QPP) presents unique challenges for healthcare providers. If you're facing difficulties meeting the requirements for one or more Merit-based Incentive Payment System (MIPS) performance categories, a QPP exception may be the solution.

Two Types of Exception Applications Available

1. MIPS Promoting Interoperability Performance Category Hardship Exception Application:

This application is designed for providers who have encountered obstacles in meeting the Promoting Interoperability performance category requirements. Eligible reasons include:

- **Decertification of EHR technology:** If your EHR technology has been decertified by the ONC Health IT Certification Program.
- **Insufficient internet connectivity:** If you lack reliable internet access.
- **Extreme and uncontrollable circumstances:** Events beyond your control, such as disasters, practice closures, severe financial distress, or vendor issues.
- **Lack of control over CEHRT availability:** If you don't have access to certified EHR technology.

If approved, this exception will exempt you from reporting data for the MIPS Promoting Interoperability performance category.

2. MIPS Extreme and Uncontrollable Circumstances (EUC) Exception Application:

This application is available for providers who have faced extreme and uncontrollable circumstances that have significantly impacted their ability to collect or submit data for one or more MIPS performance categories. These circumstances must be rare events entirely outside of your control and the control of your practice.

Examples of qualifying circumstances include:

- **Inability to collect necessary information:** If you were unable to gather the data required for a MIPS performance category.
- **Inability to submit information:** If you were unable to submit data for a MIPS performance category for an extended period.
- **Impact on normal processes:** If the circumstances disrupted your usual processes, affecting your performance on cost measures or other administrative claims measures.

If approved, you won't be required to report data for the specified performance category or categories. However, please note that any data you submit will still be scored.

How to Apply

To submit an exception application, follow these steps:

1. Log in to the QPP website using your HARP account.
2. Navigate to "Exceptions Application."
3. Click "Add New QPP Exception."
4. Choose the appropriate exception type.

Important Note: Data submission overrides approved reweighting on a category-by-category basis. If you submit data for a performance category, it will contribute to your final score, even if you have an approved exception for that category.

For More Information

- Quality Payment Program Access User Guide
- Exception Applications
- 2024 MIPS Promoting Interoperability Hardship Exception Application Guide
- 2024 MIPS Extreme and Uncontrollable Circumstances Exception Application Guide

Submit your application before the Dec. 31, 2024, deadline.

UNDERSTANDING UNITEDHEALTHCARE'S NATIONAL GOLD CARD PROGRAM: WHAT PROVIDERS NEED TO KNOW

UnitedHealthcare has introduced its National Gold Card program to streamline prior authorizations for eligible providers, making the administrative process smoother while improving patient care delivery. Providers who meet specific eligibility requirements are granted a "Gold Card" status, which allows them to bypass prior authorization on designated codes.

What is the UnitedHealthcare National Gold Card Program?

The UnitedHealthcare National Gold Card program is designed to simplify the prior authorization process for qualifying providers. By meeting the program's eligibility requirements, providers are awarded Gold Card status, allowing them to skip the prior authorization process for certain services. This status is available for providers participating in several UnitedHealthcare plans, including UnitedHealthcare commercial, UnitedHealthcare Medicare Advantage, and UnitedHealthcare Community plans.

Eligibility Requirements for Gold Card Status

Providers don't need to apply for the Gold Card program. However, specific criteria must be met to qualify. The requirements are as follows:

In-network status: The provider's care group tax ID number (TIN) must be in-network with at least one UnitedHealthcare health plan, such as UnitedHealthcare commercial, UnitedHealthcare Individual Exchange, Medicare Advantage, or UnitedHealthcare Community plans.

Minimum annual volume: The provider must have at least 10 eligible prior authorizations per year across Gold Card-eligible codes for two consecutive years.

High approval rate: The provider must maintain a prior authorization approval rate of 92% or higher across all Gold Card-eligible codes for each review year.

How to Find Out if You Qualify

Checking your eligibility for the Gold Card program is a straightforward process. Providers can log into the UnitedHealthcare Provider Portal and follow these steps:

1. Select "Prior Authorizations & Notifications" from the main menu.
2. Use the Gold Card status lookup tool located in the Quick Links & Tools section.
3. View the Gold Card status of all TINs associated with your account by selecting the desired TIN.

Additionally, UnitedHealthcare Insights offers detailed reporting on the healthcare professionals linked to each TIN. Providers already using the UnitedHealthcare Provider Portal may have access to this tool, which provides insights to help you track your eligibility.

Gold Card Benefits and Coverage

Once a TIN qualifies for the National Gold Card program, the status covers all providers associated with that TIN. It means that any provider linked to a qualified TIN will not need to obtain prior authorization for Gold Card-designated codes. However, an advance notification is still required for these services.

What to Do if Your TIN Doesn't Qualify

If your TIN did not qualify for the Gold Card program but you believe it met the criteria, you can request a one-time review. Your TIN administrator can initiate this process by chatting with a live advocate on the UnitedHealthcare Provider Portal. To submit the review, you'll need:

- Your tax ID
- At least one NPI from your group
- The state where services are performed
- Specific Gold Card codes in question.

The deadline for review submissions is Oct. 1, 2024, so be sure to act quickly if you wish to have your TIN re-evaluated.

Source: https://www.uhcprovider.com

IMPORTANT UPDATE: CHANGES TO SLEEP STUDY AUTHORIZATIONS FOR WELLCARE MEMBERS

Starting Oct. 1, there will be significant changes to the authorization process for sleep studies for Wellcare members.

Key Changes

- **Direct Submission:** From Oct. 1, all sleep study authorizations must be submitted directly to Wellcare. The previous process involving EviCore for managing authorizations will no longer apply.

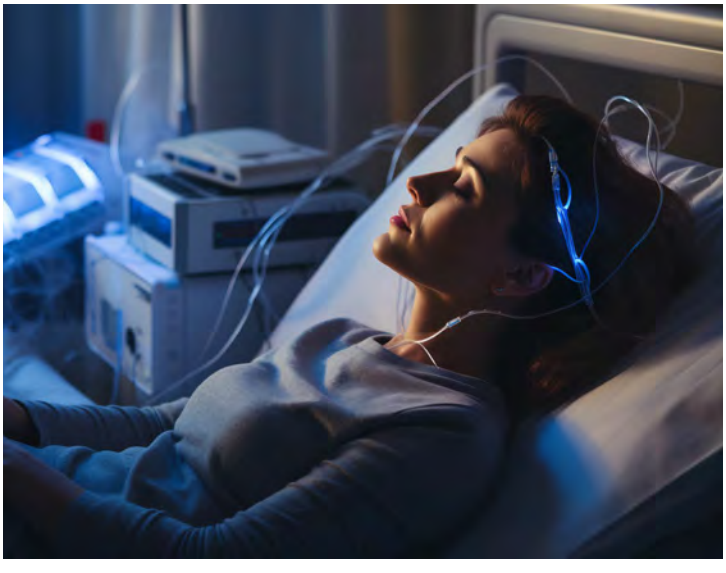
- **Authorization Requirements:**
  - **No Prior Authorization Required:** Certain sleep study procedures will not require prior authorization.
  - **Prior Authorization Required:** Facility-based sleep study procedures will require prior authorization.

These changes aim to streamline the authorization process and ensure timely access to necessary care for Wellcare members.

What This Means for Providers

- **Submit Requests Directly:** Ensure that all future sleep study authorization requests are submitted directly to Wellcare rather than through EviCore.
- **Check Requirements:** Be aware of which procedures require prior authorization and which do not to avoid any delays in patient care.

Source: https://www.wellcare.com



NEW GA MODIFIER REQUIREMENT FOR UNITEDHEALTHCARE COMMERCIAL PLANS

Starting Feb. 1, 2025, UnitedHealthcare will implement a new GA modifier requirement for their commercial plans. This update is part of the company's ongoing effort to enhance transparency in healthcare costs and improve the billing process for non-covered services.

What You Need to Know

Under the new requirement, providers must use the GA modifier on claims when they suspect or know that a service is not covered by a patient's benefits. This modifier will document that the necessary consent was obtained from the patient, as outlined in UnitedHealthcare's Charging Members for Non-Covered Services protocol.

The GA modifier serves to confirm that patients were made aware of their potential cost-sharing liabilities before any services were rendered or billed. This addition aims to ensure that patients are fully informed about their financial responsibilities in advance, promoting greater transparency in the billing process.

What Providers Should Do

- **Obtain Written Consent:** Before proceeding with services that are suspected to be non-covered, secure written consent from the member to ensure that all protocol requirements are met.

- **Include GA Modifier:** If the consent is properly obtained and documented, include the GA modifier on the claim for the non-covered service to indicate that the member was informed about their potential financial liability.

- **Check the 2025 Administrative Guide:** The new GA modifier requirement will be detailed in the 2025 Administrative Guide for Commercial Plans. Be sure to review this guide to ensure compliance with the updated billing procedures.

For any questions or further information, providers should consult the UnitedHealthcare Provider Services or refer to the updated administrative guidelines.

Source: https://www.uhcprovider.com

NEW JERSEY: UPCOMING RANDOM MEDICAL RECORD REVIEWS FOR UNITEDHEALTHCARE COMMUNITY PLAN PROVIDERS

UnitedHealthcare Community Plan of New Jersey is set to conduct annual medical record reviews for its network care providers. These reviews are a contractual obligation designed to uphold the quality of member care and ensure compliance with industry standards.

The UnitedHealthcare clinical quality team will be undertaking these audits to assess adherence to the guidelines specified in Chapter 12 of the care provider manual. Providers should be prepared for random reviews of selected member records.

Key Documentation Requirements

To help facilitate a smooth review process, ensure that the following frequently missed items are included in your medical records:

- **Primary Language Documentation:** For all ages.
- **Advance Directive Records:** For adults and emancipated minors.
- **Dental Education/Referral Documentation:** For adults and children aged 1 and older.
- **Alcohol/Substance Abuse Screening:** For individuals aged 11 and up.
- **Tobacco/Nicotine Screening:** For individuals aged 11 and up.
- **Sexual Activity/Family Planning Screening:** For individuals aged 11 and up.
- **Immunization Documentation:** For all ages.
- **Prenatal Care, Birth, and Childhood Operations:** For children from birth to age 18.
- **Verbal Lead Risk Assessment:** For children aged 6 months to 6 years.

What to Wait

If selected for a review, your medical records must be complete, well-organized, and legible. Upon completion of the review, you will receive the results by mail within a few weeks.

Note: Consistent non-compliance may lead to the implementation of a corrective action plan.

Ensuring that your documentation meets these requirements will help maintain high standards of care and avoid potential issues during the review process.

Source: https://www.uhcprovider.com

MEMBER COST SHARE REINSTATEMENT FOR 1199SEIU BENEFIT FUNDS STARTING JANUARY 2024

Beginning **Jan. 1, 2024**, the 1199SEIU Benefit Funds will reinstate **member cost-sharing** for certain services, which means that members will once again be responsible for co-pays on select healthcare services. Providers are encouraged to be aware of these changes and to review patients' Health Benefits ID cards for accurate co-pay information.

Key Cost Share Changes:

- **Home Care Benefit Fund Plan B Network Members:**
  - $5 co-pay for office visits to primary care providers (PCPs)
  - $10 co-pay for office visits to specialists
  - $25 co-pay for inpatient visits
- **Greater New York Benefit Fund Members:**
  - $75 co-pay for emergency room visits

These co-pays will be deducted from the **Benefit Funds' reimbursement** for the listed services, so providers must verify the applicable co-pays when billing for services rendered to ensure accurate claims submission.

What This Means for Providers:

To avoid any billing issues, providers should ensure that they are verifying co-pays during the patient intake process by reviewing the **Health Benefits ID cards** of their 1199SEIU members. It's important to note that these changes will impact reimbursements starting Jan. 1, 2024, so timely adjustments to your billing practices may be necessary.

If you have any questions regarding these changes or how they may affect your practice, please contact the 1199SEIU Benefit Funds directly for further information.

Source: https://www.1199seiubenefits.org

ESSENTIAL UPDATES FROM 1199SEIU BENEFIT FUNDS: NEW EFT PARTNERSHIP AND PHARMACY MANAGER TRANSITION

The 1199SEIU Benefit Funds have recently announced significant changes impacting providers and members. Here is a breakdown of the latest updates:

Zelis Partnership for EFT Enrollment

In a move to streamline the **electronic fund transfer** (**EFT**) **process**, the 1199SEIU Benefit Funds have partnered with **Zelis**. Providers who are not yet enrolled in Zelis' EFT system can begin the enrollment process right away. To enroll, providers are directed to visit the **1199SEIU ePayment Center**. If there are any questions or concerns during the enrollment, Zelis customer service can be reached at **(833) 306-0337** for support.

This partnership aims to make the payment process more efficient for healthcare providers, ensuring smoother transactions and faster processing times. Providers who rely on the Benefit Funds' EFT services are encouraged to act promptly to ensure no disruption in their payment process.

Cyber-Security Incident at Change Healthcare

A recent cyber-security breach affecting Change Healthcare — the vendor that handles the Benefit Funds' EDI, EFT, and ERA processes — has impacted business operations for multiple healthcare organizations, including the 1199SEIU Benefit Funds. The security incident may cause delays or disruptions in these services as Change Healthcare works to restore operations.

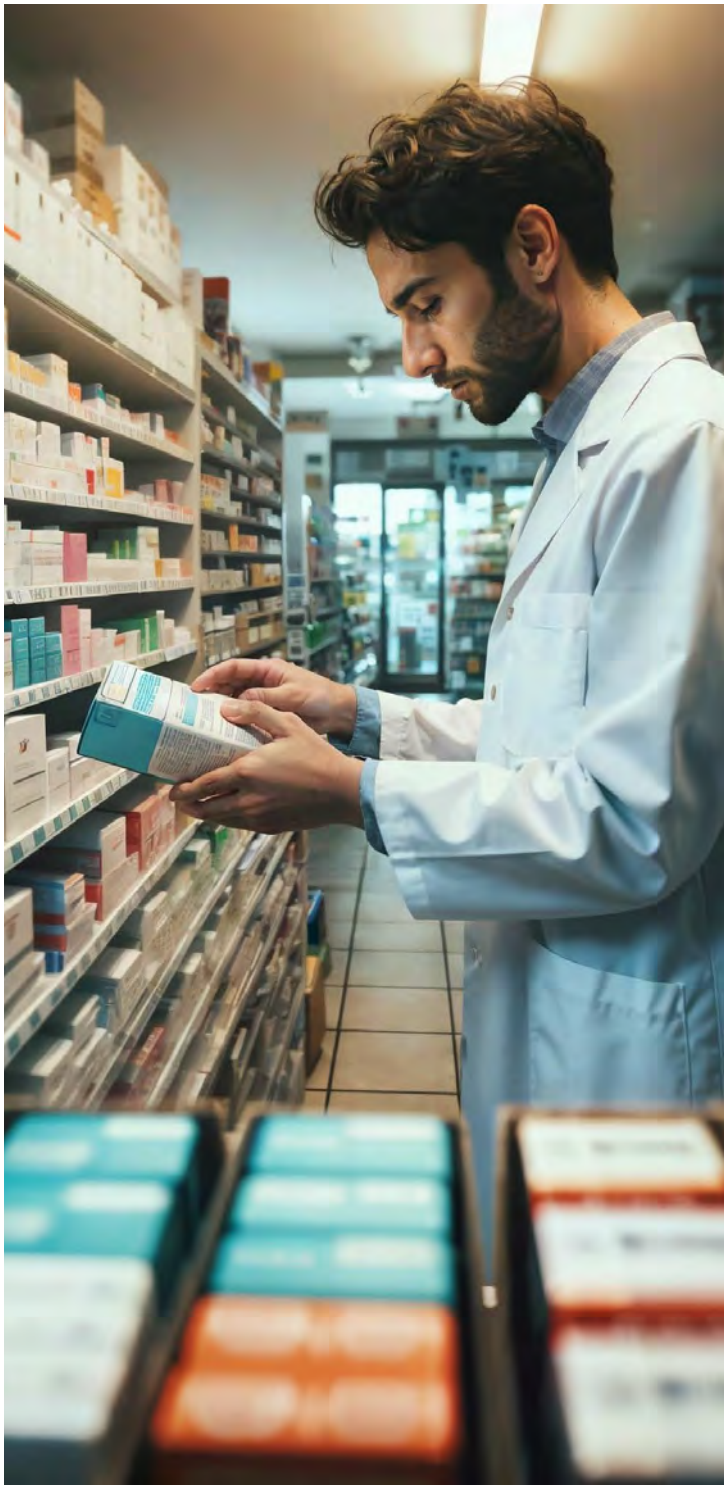
While the full scope of the incident is still being assessed, the 1199SEIU Benefit Funds are actively monitoring the situation and will provide updates to keep providers and members informed as more information becomes available. In the meantime, we recognize that this situation may pose challenges and appreciate everyone's patience as this matter is addressed.

Pharmacy Benefit Manager Transition to CVS Caremark

In another important development, the **1199SEIU Benefit Funds** have transitioned their pharmacy benefit manager from **Express Scripts** to **CVS Caremark**, effective **July 1, 2024**. This change will impact how members access prescription services as CVS Caremark takes over managing pharmacy benefits for the fund.

The decision to switch to CVS Caremark aims to enhance the pharmacy services provided to members, offering broader access to medications and an improved member experience. Members are advised to stay updated with any new information regarding prescription fulfillment processes under the new provider.

Source: https://www.1199seiubenefits.org



2024 PROVIDER QUALITY INCENTIVE PROGRAM: EARN INCENTIVES FOR PREVENTIVE AND CHRONIC CARE SERVICES

The Federal Employee Program (FEP) has launched the 2024 Provider Quality Incentive Program, encouraging healthcare providers to close care gaps by delivering key preventive and chronic care services to eligible FEP members. The program runs from Sept. 19, 2024, to Dec. 31, 2024, with incentives for practices that meet program criteria.

How to Earn Your Incentive

To participate, review your monthly gap list—available through the HorizonDocs portal—which identifies patients who need specific services. Schedule appointments or referrals for these patients before Dec. 31, 2024. After providing the care, submit the appropriate documentation by Jan. 31, 2025, using one of the following methods:

- **Preferred Method:** Claim Submission
  Submit a claim with **measure-specific compliant codes** and the correct **CPT® II codes**, when applicable.

- **Secondary Method:** Supplemental Data Submission
  For services like **BCS-E** (**Breast Cancer Screening**) and **COL-E** (**Colorectal Cancer Screening**), use **ECDS file submission** via **HorizonDocs Secure File Transfer Protocol**. Submit under the appropriate "Quality" subcategory.

Key Dates and Payments

- **Service Period:** Sept. 19, 2024 - Dec. 31, 2024
- **Documentation Deadline:** Jan. 31, 2025
- **Incentive Payments:** Separate from other compensation, based on care gaps closed and distributed at the **Tax Identification Number** (**TIN**) level. Payments are expected by **Apr. 30, 2025**.

Why Participate?

By participating in this program, providers not only improve patient outcomes but also earn financial incentives. It's a great opportunity to gain additional compensation.

For questions or assistance, contact **Provider Services** at **1-800-624-5078**

Source: https://www.horizonblue.com

NEW ABA VISIT ATTESTATION FORM FOR FIDELIS CARE PROVIDERS

Fidelis Care has introduced a new Applied Behavioral Analysis (ABA) Visit Attestation Form, designed to streamline the authorization review process for ABA services. This new form is a key part of ABA authorization submissions and is now required for all future requests.

What You Need to Know

If your practice provides Applied Behavioral Analysis services, it is essential to have the Fidelis Care Visit Attestation Form on file. This form must be included in any ABA authorization requests submitted to Fidelis Care moving forward.

The form is available for download on the Fidelis Care website here, ensuring you have easy access to it for all applicable patient cases.

Why This Matters

Accurate and complete submission of the ABA Visit Attestation Form helps facilitate a smoother authorization process, allowing for timely approvals and continuity of care for patients undergoing behavioral therapy. Ensuring all required documentation is submitted will help avoid delays and ensure that services can be provided without interruption.

Need Assistance?

For any questions or additional support regarding the new form or the authorization process, you can contact your Fidelis Care Provider Engagement Account Manager. If you're unsure who your designated representative is, visit the Contact Your Designated Provider Relations Specialist section on the Fidelis Care website for more information.

Source: Fidelis Care

MEDICAL RECORD REVIEW (MRR) REQUESTS: WHAT YOU NEED TO KNOW

Healthcare providers in Horizon's network are periodically required to respond to Medical Record Review (MRR) requests as part of federal, state, and NCQA compliance. These reviews are crucial for Healthcare Effectiveness Data and Information Set (HEDIS®) data collection and other audits, ensuring quality care across all lines of business. MRR is a standard practice, and responding to these requests is part of every provider's contractual obligation.

Timelines for Medical Record Submission

Providers must adhere to strict timelines when responding to MRR requests, depending on the nature of the audit:

- **HEDIS Audits:** Documentation must be submitted within **5 days** of the request.
- **CMS or New Jersey State Audits:** Submission is required within **10 days**.
- **Other Requests:** Providers have **30 days** to respond.

Prompt submission is essential to ensure compliance, avoid delays in audits, and help improve the overall quality of healthcare data.

No Reimbursement for Associated Costs

It's important to note that Horizon's policy does not cover costs associated with responding to MR Healthcare. Providers in Horizon's network are periodically required to respond to Medical Record Review (MRR) requests as part of federal, state, and NCQA c R requests. Copying, postage, and miscellaneous costs are the responsibility of the provider. This is outlined in the Provider Agreement and Horizon's policies and procedures.

Options for Submitting Medical Records

Horizon offers multiple ways to submit medical records, making the process as streamlined as possible. Below are the available options, categorized for **Risk Adjustment** and **HEDIS** data collection:

Risk Adjustment Record Retrieval	Quality/HEDIS Record Retrieval
Remote EMR Access: Providers can offer Horizon **remote access** to their electronic medical records (EMR) by coordinating with their EMR vendor.	**Remote EMR Access:** Similar to Risk Adjustment, remote access can be set up via your EMR vendor.
Onsite Chart Collection: Coordinated directly with Horizon when they reach out.	**Onsite Chart Collection:** Facilitated upon Horizon outreach.
Manual File Transfer (MFT): Email VBPSupport@HorizonBlue.com for login setup or password resets.	**Manual File Transfer (MFT):** Email VBPSupport@HorizonBlue.com for MFT access.
HorizonDocs via Availity Essentials™: Submit documents securely.	**HorizonDocs via Availity Essentials™:** Use this platform for easy submission.
Secure Email: Send to ChartFax-RetrievalTeam_@HorizonBlue.com.	**Secure Email:** Use the email address listed on the request document.
Mail: Address to **Horizon BCBSNJ, Risk Adjustment, PP15Q, 3 Penn Plaza, Newark, NJ 07105-2200.**	**Mail:** Address to **Horizon BCBSNJ, HEDIS, PP12X, 3 Penn Plaza, Newark, NJ 07105-2200.**

Coordinated Collection Options

For Risk Adjustment collections, Horizon may coordinate directly through the Chart Retrieval Team or the Provider Engagement Team, depending on the needs and outreach.

For any questions or additional support in submitting your medical records, contact VBPSupport@HorizonBlue.com or refer to the instructions provided in your MRR request.

Source: https://www.horizonblue.com

SIMPLIFY MEDICAL RECORD SUBMISSIONS WITH HORIZONDOCS

Healthcare providers can now simplify the process of submitting medical records and post-service appeals using **HorizonDocs**, a web-based, secure platform designed by Horizon. This centralized document repository allows for the safe exchange of protected health information (PHI), making it easier for providers to manage documentation requests and appeals efficiently while ensuring data security.

Why Use HorizonDocs?

HorizonDocs offers several key advantages that can help medical practices streamline their administrative tasks:

- **Organized Document Management:** Easily manage documents by category and subcategory, such as Post-Service Medical Records or Appeals for Commercial or Braven Health. This organization makes it simple to keep track of what's been sent and received.
- **Track Submissions by Tax ID:** View all submitted documents, including medical records and appeals, based on your practice's Tax ID Number, ensuring that all data is centralized and accessible.
- **Control User Access:** Assign permission levels within your organization to control access to sensitive documents, ensuring that the right people handle specific tasks while maintaining privacy and security.
- **Automated Notifications:** Receive automated email alerts whenever documents are requested, sent, or received, keeping your team updated and on top of deadlines without manual follow-ups.

What Documents Can Be Submitted Through HorizonDocs?

- **Lists of Members Requiring Screenings**
- **Performance and Incentive Reports**
- **HEDIS Chart Requests**
- **Electronic Health Record (EHR) Data Submission Templates**

This allows providers to ensure that necessary screenings, data submissions, and audits are efficiently handled through a single, secure platform.

How to Get Started with HorizonDocs:

1. Log in to Availity Essentials
2. In the navigation bar, select **Payer Spaces**, then choose Horizon.
3. Click on **HorizonDocs** under the Applications tab.

For more detailed guidance and resources, visit the **HorizonDocs** webpage.

Source: https://www.horizonblue.com

ENCOURAGE YOUR PATIENTS TO GET THIS YEAR'S SEASONAL VACCINES

With the fall season fast approaching, now is the ideal time to start discussing the importance of flu, COVID-19, and RSV vaccines with your patients. Early vaccination can provide timely protection against the seasonal rise in illnesses, and as a healthcare provider, you play a critical role in ensuring your patients are informed and prepared.

Why Vaccination Timing Matters

Flu Vaccine:

It takes about two weeks for the flu vaccine to offer full protection after administration. By encouraging patients to get their flu shots in early fall, they can build immunity before flu season typically begins in October and peaks between December and February. Early vaccination is key to ensuring protection as flu activity starts to increase.

COVID-19 Booster:

For the 2024-2025 season, all individuals aged 6 months and older are recommended to receive the new COVID-19 vaccine, regardless of their previous vaccination history. This updated vaccine has been tailored to protect against the most recent circulating strains, offering better protection throughout the colder months when respiratory illnesses tend to spike.

RSV Vaccine:

For patients aged 60 to 74 who are at risk, and those over 75, the RSV (Respiratory Syncytial Virus) vaccine is highly recommended. Pregnant people between 32-36 weeks of pregnancy are also encouraged to receive the RSV vaccine to protect themselves and their babies. As with the flu and COVID-19, the RSV vaccine can be administered during the same appointment, making it convenient for patients to get all the protection they need at once.

How You Can Help

As a healthcare provider, your role in discussing seasonal vaccines is vital. Now is the time to reach out to your patients and help them understand the importance of getting vaccinated early. Here's how you can make a difference:

- **Educate Patients:** Provide clear, concise information about the benefits of the flu, COVID-19, and RSV vaccines. Many patients may have questions or concerns, and your expertise can help address these issues.
- **Emphasize Safety and Efficacy:** Assure patients that all three vaccines have been thoroughly tested and are proven to be both safe and effective.
- **Encourage Early Action:** Patients may need time to schedule their vaccinations, especially if they are planning to receive all three shots. By starting the conversation now, you can help them plan ahead.

Source: https://www.horizonblue.com

JOIN FIDELIS CARE'S QUALITY PROVIDER OFFICE HOURS: SEPT. 24, 2024

Fidelis Care is inviting healthcare providers to attend its upcoming **Quality Provider Office Hours** on **Sept. 24, 2024**. This session offers a great opportunity to engage directly with Fidelis Care staff, who will be available to share valuable information, provide resources, and answer questions related to quality programs.

Event Details:

- **Date:** Tuesday, Sept. 24, 2024
- **Time:** 2:00 p.m. – 3:00 p.m. EST
- **Topic:** Fidelis Care and Wellcare Quality Programs
- **Registration:** Click here to register
  (*Please note: Attendance is limited to the first 300 registrants*)

What Will Be Covered:

The session will focus on Fidelis Care and Wellcare's various quality programs, offering insights into initiatives that can improve provider performance and patient outcomes. Topics include:

- **Annual Preventative Visit (APV) / Member Without Visit (MWOV):** Strategies to ensure patients receive necessary preventive care.
- **2024 Peak Performance Program:** Fidelis Care's performance improvement initiative.
- **2024 Quality Boost Program:** A program aimed at helping providers enhance care quality and patient satisfaction.
- **Medicare Focus – Triple-Weighted Measures:** An overview of Medicare measures that carry significant impact on provider ratings.
- **RxEffect:** A tool that helps manage prescription adherence and patient medication therapy.
- **SuDS (Substance Use Disorder Services):** Information about resources and support for managing substance use disorders.

Why Attend?

This webinar is an important opportunity to gain a deeper understanding of Fidelis Care's quality programs, learn how to maximize incentives and stay up to date with best practices. Providers will also have the chance to ask specific questions and clarify details directly with Fidelis Care experts.

HEALTHFIRST TRANSITIONS TO AVAILITY ESSENTIALS FOR PROVIDER TOOLS ACCESS

Healthfirst is making significant updates to how healthcare providers access their tools, with the transition to the Availity Essentials™ platform. This new secure provider portal will host many of the tools that providers have previously accessed on the HFproviderportal.org website, improving efficiency and security in managing patient data.

What's Changing?

As part of a phased approach, Healthfirst's Eligibility Search tool will no longer be available on the HFproviderportal.org platform starting September 30, 2024. Providers should begin using Availity Essentials for eligibility searches and other important functions. This phased transition ensures minimal disruption, as some tools will still be available on both platforms for a short time to help ease the shift to the new system.

Why Availity Essentials?

Availity Essentials offers a range of functionalities that simplify administrative tasks for healthcare providers. The platform enhances efficiency by offering secure access to various tools all in one place. Key features include:

- **Claim Submission:** Simplify how you file claims and track them through the system.
- **Eligibility Search:** Quickly check patient eligibility and benefits in real time.
- **Remittance Viewer:** Easily view remittance advice for submitted claims.
- **Claim Status:** Track the status of claims efficiently to stay informed.

Upcoming Features

Healthfirst will continue adding new functionalities to Availity Essentials throughout the year, with several important updates on the way:

- **Eligibility Search and Inquiry Enhancements:** Set to release in September 2024, these enhancements will streamline the search process, making it easier to find patient eligibility information.
- **Claim Status Enhancements:** Expected in October 2024, these updates will allow for faster claim status inquiries and improved claim tracking.
- **Online Authorization Tool:** A Single Sign-On (SSO) feature is coming in Q4 2024, simplifying the authorization process for providers.

What to Do Now?

Providers should prepare for the full transition to Availity Essentials by familiarizing themselves with the platform and its features. To stay informed and ensure a smooth switch, check for updates on the Healthfirst provider portal and explore the Availity FAQ section for detailed guidance.

Healthfirst is committed to making this transition as seamless as possible, ensuring that providers have the tools they need to deliver top-quality care with ease.

Source: Healthfirst

UPCOMING CHANGES TO NEW YORK STATE CONSENT LAW: SEPARATE TREATMENT AND PAYMENT CONSENTS REQUIRED BY OCTOBER 20, 2024

A significant change in New York State's public health law will take effect on October 20, 2024, requiring healthcare providers to collect separate consents for treatment and payment. This change, introduced as part of the 2024 New York State budget, is designed to ensure that patients give explicit consent for both treatment and payment independently, rather than combining them into a single authorization.

This new regulation means healthcare providers must adjust their administrative processes to comply with these legal requirements, or they could face hefty fines.

What the New Law Entails

The new public health law mandates that healthcare providers obtain a patient's informed consent for treatment, such as any procedure, examination, or direct care, separately from consent for payment. Key points of the law include:

- **Treatment Consent:** Consent for treatment must be obtained before the patient receives care.
- **Payment Consent:** Payment consent can only be obtained after services have been rendered and after the costs of those services have been discussed with the patient.

In essence, you cannot seek authorization for payment at the time of treatment. Providers will need to ensure that these conversations and consents happen in two distinct steps—treatment first, and payment second.

Penalties for Non-Compliance

Failing to adhere to this new requirement carries substantial financial penalties. Providers who do not comply with the updated consent law could face fines of up to **$10,000 per violation.** Given the potential risks, ensuring your practice's administrative processes are updated and in full compliance with the law is essential.

Implications for Patient Billing and Payment Collection

For many healthcare providers, this change represents a dramatic shift in how patient billing has traditionally been handled. Previously, practices could collect payment information (such as credit card details) in advance, even before services were rendered. Under the new law, this will no longer be permitted.

For example, imagine a scenario where a patient consents to treatment and provides a credit card for payment before receiving care. Under the new law, this would not be allowed. Instead, the provider must first complete the treatment, discuss the costs with the patient, and then obtain the patient's explicit consent to process the payment.

Credit Card Rules and Other Financial Considerations

The new law also introduces changes to **credit card payment rules**, which are linked to these new consent regulations. The specifics of how credit card payments will be regulated and enforced are still unclear, but it appears that upfront collection may be restricted under these rules.

This creates challenges for healthcare providers who rely on pre-payment models or ask for deposits before offering services. For instance, in many industries—such as contracting, dining, or retail—businesses routinely collect payment or deposits before delivering services. But now, healthcare is becoming an exception, with New York State leading the charge in changing how payments are managed.

Steps Providers Should Take to Prepare

To ensure compliance, healthcare providers need to take several proactive steps:

- **Review and Update Consent Forms:** Your practice will need to revise its patient forms to include separate sections for treatment consent and payment consent. These should clearly outline that payment consent will only be requested after services are provided and discussed.
- **Train Staff:** Your staff will need to understand these new processes and how to explain them to patients. Ensuring that staff members are trained to communicate these changes will prevent confusion and facilitate smoother patient interactions.
- **Adjust Billing Systems:** If your practice uses software for billing and consent collection, make sure it is updated to accommodate this new two-step process. Separate digital consent may also need to be implemented for those using electronic health records (EHRs) or other digital tools.
- **Communicate with Patients:** Letting patients know about this change in advance will help manage expectations and prevent confusion during appointments. Consider adding information to your website, appointment reminders, or patient-facing materials to explain the new law.

UNDERSTANDING MEDICAID MANAGED CARE FOOT CARE COVERAGE:

METROPLUS AND HEALTHPLUS PODIATRY SERVICES OVERVIEW

For healthcare providers serving Medicaid Managed Care members, podiatry services are essential, especially for patients with diabetes or other localized foot illnesses. MetroPlus and HealthPlus Medicaid Managed Care plans offer specific coverage guidelines that providers should be aware of to ensure compliance and optimal care delivery. Here's a breakdown of key podiatry coverage details from both plans, focusing on routine foot care, referrals, and prior authorization requirements.

MetroPlus: Foot Care Coverage

MetroPlus Medicaid Managed Care covers foot care services for all age groups when deemed medically necessary, especially for individuals with conditions that pose a risk to foot health. The following are key coverage provisions:

- **Routine Foot Care:** Covered when necessary due to localized illness, injury, or symptoms affecting the foot. It includes services for conditions like diabetes, ulcers, and infections.
- **Podiatry Services for Members Under 21:** These services are covered but must be provided upon referral by a physician, registered physician assistant, certified nurse practitioner, or licensed midwife.
- **Podiatry Services for Adults (21 and Older):** Coverage extends to adults with diabetes mellitus without the need for a referral. For individuals without diabetes, podiatry services must still meet the requirement of being necessary for the treatment of a medical condition to be covered.

In summary, MetroPlus offers comprehensive foot care services to patients with medical conditions like diabetes or foot injuries, but certain age groups or conditions may require referrals.

HealthPlus: Foot Care Services

HealthPlus Medicaid Managed Care also provides coverage for foot care services, with a slightly different approach to referrals and precertification:

- **Routine Foot Care Coverage:** Similar to MetroPlus, HealthPlus covers foot care when the patient's condition poses a hazard due to foot-related illness or injury. This includes treatment for diabetes, ulcers, and infections.
- **Services for Members Under 21 and Adults with Diabetes:** HealthPlus covers podiatry services upon referral from a physician, registered physician assistant, certified nurse practitioner, or licensed midwife. Precertification is not required for evaluation and management (E&M), testing, or procedures, but may be needed for other services depending on the specific treatment.
- **Exclusions:** Routine hygienic care such as the treatment of corns, calluses, and nail trimming are excluded unless they are related to a pathological condition or precertified.

Providers should familiarize themselves with HealthPlus's requirements to ensure seamless delivery of podiatric care, particularly regarding referrals and precertification rules.

Key Considerations for Providers

- **Referral Requirements:** Both plans require referrals for patients under 21 and those with diabetes to access podiatry services. Ensure that referrals come from authorized medical professionals such as physicians, nurse practitioners, physician assistants, or licensed midwives.
- **Precertification:** HealthPlus may require precertification for certain podiatry services, particularly those that are not E&M, testing, or common procedures. Checking specific precertification requirements through HealthPlus's provider portal is recommended before delivering services.
- **Service Exclusions:** Routine foot care services that do not involve a pathological condition, such as corns, calluses, and nail trimming, are generally not covered unless linked to a medical condition or approved through precertification.

MetroPlus and HealthPlus offer coverage for essential foot care services under Medicaid Managed Care plans. Providers must pay close attention to referral requirements and precertification processes to ensure compliance. Whether treating pediatric patients, adults with diabetes, or those with foot-related medical conditions, understanding each plan's specific rules will allow providers to offer efficient and compliant care.

CLOSED PANELS
WE CAN HELP WITH

GET APPROVED BY INSURANCE
YOU CANNOT GET IN

CAIPA
Diagnostic Radiology

FIDELIS CARE
Physical Therapy
Radiology

PALLADIAN
Physical Therapist
Occupational Therapist
Physical Therapy Assistant

EMBLEM HEALTH
Nurse Practitioner
Surgery
Physical Therapy
Neurology

HIP EMBLEM HEALTH
Family Medicine
Diagnostic Radiology

OXFORD HEALTH PLANS
Occupational Therapist
Physical Therapist

AETNA
Diagnostic Radiology
Interventional Radiology
Neurology

CIGNA
Occupational Therapist
Physical Therapist
Diagnostic Radiology
Neurology

WELLCARE OF NEW YORK
Cardiovascular Disease
Diagnostic Radiology
Neurology
Pulmonary Disease

MULTIPLAN
Occupational Therapist
Optometrist
Physical Therapist

1199 SEIU
Cardiovascular Disease
Diagnostic Radiology
Family Medicine
Interventional Radiology
Neurologist
Optometrist
Physical Therapy

VNS HEALTH
Acupuncturist
Cardiovascular Disease
Diagnostic Radiology
Family Medicine
Interventional Cardiology
Interventional Radiology
Neurology
Occupational Therapist
Physical Therapist

HEALTHCARE
Cardiovascular Disease
Diagnostic Radiology
Family Medicine
Internal Medicine
Neurology
Nurse Practitioner
Occupational Therapist
Physical Therapist
Acupuncturist
Surgery

HEALTHPLUS
Cardiovascular Disease
Diagnostic Radiology
Internal Medicine
Neurology
Primary Care
Radiology

UHC
Cardiovascular Disease
Diagnostic Radiology
Nurse Practitioner
Occupational Therapist
Ophthalmology
Optometrist
Pain Medicine
Pediatric Cardiology
Physical Medicine & Rehabilitation
Physical Therapist
Podiatrist
Radiology
Surgery

METRO PLUS HEALTH PLAN
Acupuncturist
Anesthesiology
Cardiovascular Disease
Diagnostic Radiology
Neurologist
Occupational Therapist
Optometrist
Physical Therapy
Physical Therapy Assistant
Podiatrist
Radiology

HEALTH FIRST
Acupuncturist
Cardiovascular Disease
Diagnostic Radiology
Internal Medicine
Neurology
Nurse Practitioner
Occupational Therapist
Physical Therapist
Podiatrist
Psychiatry& Neurology
Psychiatry

EMPIRE BLUE CROSS AND BLUE SHIELD OF NEW YORK
Internal Medicine
Physical Medicine & Rehabilitation
Physical Therapist
Psychologist
Radiology
Cardiovascular decease

IMPORTANT REMINDER FOR ALL DOCTORS: CULTURAL COMPETENCY TRAINING REQUIREMENT BY EMBLEMHEALTH

As part of the annual compliance with the New York State Department of Health regulations, all healthcare providers and their staff who have regular and substantial contact with EmblemHealth Enhanced Care (Medicaid Managed Care) and Enhanced Care Plus (HARP) members must complete Cultural Competency Training. This crucial training ensures that healthcare professionals are equipped to deliver effective communication and language assistance services to diverse patient populations, improving the quality of care and fostering better patient outcomes.

The deadline for submitting certification for this training is **Oct. 31, 2024**. Providers must ensure that both themselves and their staff are certified to meet the state's requirements. Below are **the steps to complete the certification**:

1. Visit the Training Site: Access the e-learning program titled "The Guide to Providing Effective Communication and Language Assistance Services."
2. **Complete the Training:** Review the program materials and ensure all necessary learning modules are completed.
3. **Select Certification Type:**
   - **Individual Certification:** Select this if you are certifying as an individual.
   - **Group Certification:** If certifying as part of a group, make sure to submit separate certifications for each group/organization's tax ID number (TIN).
4. **Complete the Certification Form:** After selecting the appropriate certification type, check the box for the certification statement, fill in the required fields, and submit.
5. **Receive Confirmation:** Once submitted, you will receive an email confirmation to verify that your certification has been recorded.

Why Cultural Competency Training Matters

Cultural competency in healthcare is vital for reducing health disparities, improving patient satisfaction, and providing care that respects the diverse needs of patients. This training helps ensure that providers can effectively communicate with patients from different cultural backgrounds, address potential language barriers, and create a more inclusive healthcare environment. By completing this training, providers are committing to enhancing the patient experience and promoting equitable care for all.

Be sure to complete the certification process by the Oct. 31, 2024 deadline to maintain compliance with EmblemHealth and New York State health regulations.

NORTH CAROLINA STATE HEALTH PLAN OPEN ENROLLMENT STARTED SEPT. 30

The **North Carolina State Health Plan** is gearing up for its annual open enrollment period, which runs from **Sept. 30, 2024**, through **Oct. 25, 2024**. This year's open enrollment is particularly significant as the **NC State Health Plan** will transition to a new third-party administrator, **Aetna®**, starting on **Jan. 1, 2025**.

Key Dates to Remember

- **Open Enrollment Period:** Sept. 30 – Oct. 25, 2024
- **New Plan Administrator:** Aetna® (effective Jan. 1, 2025)

What You Need to Do

During the open enrollment period, members will have the opportunity to review and select their health plan options for the upcoming year. It's essential for all participants to take this time to explore the plan offerings, review benefits, and ensure their selected plan best suits their needs and those of their families.

Stay Informed

For the latest information and updates, visit the **NC State Health Plan** page. This page will be regularly updated with news and important details to help guide you through the enrollment process. Be sure to check back frequently to stay informed about any changes or new resources.

This enrollment period is your chance to ensure you have the best coverage starting in 2025, so mark your calendars and prepare to review your options with Aetna as the new administrator.

OPTUM REMINDER: COMPLETE YOUR REQUIRED ANNUAL CULTURAL COMPETENCE TRAINING BY SEPT. 30

The New York Department of Health (NYDOH) mandates that all network Medicaid providers and agencies complete an annual cultural competency training to improve care delivery and reduce health disparities. Optum Behavioral Health has set **Sept. 30** as the deadline for reporting this year's training completion.

Cultural competency training is crucial for healthcare professionals, helping them better understand and connect with patients from diverse backgrounds, ultimately enhancing the quality of care. Here's how to fulfill this requirement:

Training for Individual Clinicians:

Complete the Training:

- You must take the **Think Cultural Health** online course. This free course, provided by the U.S. Department of Health and Human Services Office of Minority Health, covers key topics such as the role of culture in behavioral health care, how to recognize both your cultural identity and that of your clients, and how to build stronger, more effective therapeutic relationships.

Report Completion:

- After finishing the course, log into the **Provider Express** secure portal. Navigate to **My Practice Info** > **Clinician Information** > **Edit** to update your cultural competency details.
- Review the list of available trainings and select those that align with the course you completed.

Training for Agencies:

Complete the Training:

- Agencies are required to take a course from the **Curriculum for Cultural and Linguistic Competence**, available on the Center for Practice Innovations (CPI) platform. These are state-approved courses tailored to behavioral health providers.

Report Completion:

- After all staff members have completed the training, email nynetworkmanagement@optum.com with the subject line "Cultural Competency." In your email, attest that the staff has completed the training and indicate the completion date.
- Agencies should also maintain certificates of completion for each staff member.

Why Cultural Competence Training Matters

This training helps providers and staff build stronger connections with clients from diverse cultural and linguistic backgrounds, ensuring more equitable and effective behavioral health care. By completing the training, healthcare professionals are better equipped to understand cultural influences on health behaviors and improve therapeutic outcomes for all patients.

Don't miss the **Sept.30** deadline—complete your training and report it to Optum Behavioral Health to stay compliant with NYDOH requirements.

IMPORTANT CHANGES TO DEMOGRAPHIC DATA SUBMISSION PROCESS FOR UNITEDHEALTHCARE PROVIDERS

Starting Oct. 1, 2024, UnitedHealthcare is implementing changes to the way healthcare providers and groups submit their demographic updates. To ensure better data security and accuracy, email will no longer be accepted for maintaining demographic information, and the existing demographic and practice change request form will also be discontinued. However, if your practice manages demographic data through a roster, this change will not affect your current process.

To keep your records up to date, UnitedHealthcare requires you to submit demographic updates using one of the following methods:

Council for Affordable Quality Healthcare (CAQH) Provider Data Portal:
This portal allows healthcare providers to manage directory profiles in real time across multiple payers. By making updates or attestations through CAQH, your information will be accessible to all participating payers you've authorized, ensuring seamless updates across multiple healthcare organizations.

My Practice Profile (UnitedHealthcare Provider Portal):
This tool allows you to verify and attest to the accuracy of demographic information for every healthcare professional associated with your Tax Identification Number (TIN). It provides an easy way to manage your practice's data in one place.

Roster Submission:
If your demographic updates are currently submitted through a roster, you should continue using this process. Roster-managed submissions remain unaffected by the new changes.

Key Points:

- You only need to submit demographic updates through one method. There's no need to submit to multiple platforms.
- Using these methods will help ensure timely and accurate updates and reduce the need for clarifications.

Failure to submit demographic information through one of the approved methods could lead to inaccuracies in UnitedHealthcare's directories, negatively impacting the patient experience and potentially causing delays in claims payment. Keeping your information current is crucial for maintaining smooth operations and ensuring that patients can find you easily, and for claims to be processed without delays.

If you are a Medicaid-contracted healthcare provider, you must continue following your state's specific process for submitting updates. However, you will also need to submit updates through one of the options listed above to ensure your information remains accurate in UnitedHealthcare's systems.

ENROLLMENT FOR COMMERCIAL AND MEDICAID LINES OF BUSINESS IN NEW YORK

If you are a healthcare provider looking to serve commercial and Medicaid patients in New York, there are a few essential steps to keep in mind. Whether you are a physical therapist, audiologist, or acupuncturist, understanding the distinct requirements for enrolling in these lines of business is crucial for a smooth credentialing process.

Two Contracts for Two Lines of Business

When enrolling with both commercial and Medicaid lines of business, it is essential to note that you must sign and return two separate contracts. Commercial and Medicaid programs operate under different regulations and reimbursement structures, meaning each line requires its own agreement. Providers entering the New York market should review these contracts thoroughly to understand the specific obligations and opportunities associated with each program.

Medicaid Enrollment Requirements

For those enrolling with Medicaid, an active Medicaid ID number is required before you can see patients as a participating provider. This ID is essential for billing and receiving reimbursement for services rendered to Medicaid patients. Therefore, it's crucial to ensure that your Medicaid credentialing is complete before accepting Medicaid patients. Without this ID number, any services provided to Medicaid patients cannot be billed under the Medicaid program, potentially resulting in lost revenue and delays.

Specialized Provider Categories

Different provider types have unique pathways for enrollment. For example:

- **Therapy Providers (Physical Therapy, Occupational Therapy, Speech Therapy):** If you belong to one of these professions, or if you're an audiologist, registered dietician, or acupuncturist, you should start your application by selecting "Specialty Care Provider" from the "Provider Type" drop-down menu. It ensures that your application is directed through the appropriate channels for review and approval.
- **Hearing Aid Providers:** Hearing aid providers fall into a separate category and must select "Non-Credentialed Provider" from the "Provider Type" menu. This distinction is essential as hearing aid providers may not require the same credentialing as other specialty providers but still must complete the necessary steps to enroll.

Streamlining the Enrollment Process

To begin your enrollment application, providers must use the appropriate online tools provided by the network or insurance entity. Selecting the right provider type at the start of the application process is essential to avoid delays and ensure the application is routed to the correct department.

Key Takeaways

- **Two Contracts:** Providers enrolling in commercial and Medicaid lines of business will receive two separate contracts. Make sure both are signed and returned to begin the credentialing process.
- **Medicaid ID:** If you are enrolling in Medicaid, an active Medicaid ID is mandatory before you can treat patients under this program. Ensure your credentialing is complete to avoid disruptions in service and billing.
- **Provider Categories:** Therapy providers, audiologists, registered dieticians, acupuncturists, and hearing aid providers each have specific instructions for enrollment. Following the correct steps will help streamline your application process.
- **Accuracy and Compliance:** Double-check all application fields to ensure accuracy and avoid delays. Maintaining compliance with Medicaid and commercial enrollment requirements is essential for long-term success in serving patients in New York.

CASE STUDY: RESOLVING ANTHEM BLUE CROSS BLUE SHIELD AMERIGROUP PRE-PAYMENT REVIEW ON NST STUDIES

In this case our client faced a complex issue with Anthem Blue Cross Blue Shield Amerigroup regarding NST (Nuclear -Stress Test) studies. The insurance company had placed a pre-payment review on all NST claims submitted by the provider, flagging them for additional scrutiny. Here's how our team tackled the problem.

THE CASE WAS LED BY JULIE ABDULLATYPOVA

The Initial Problem

After submitting the necessary documentation for the claims, Anthem Blue Cross Blue Shield Amerigroup denied payment for the A9500 pharmaceutical code, which is essential for conducting the NST test. The denial was based on a seemingly illogical rationale: the insurer claimed that the test itself was missing despite the fact that the procedure had been billed correctly and was even approved after documentation review.

STEP 1: The First Appeal

Our team immediately initiated the appeals process, challenging the denial. The first round of appeals involved submitting a detailed case to the insurer, explaining why the A9500 code should be paid separately from the test. At the same time, we identified a key contact within Anthem who could handle all related cases — over 80 claims — as a dedicated project.

STEP 2: The Second Appeal

Despite our efforts, the individual we found within the insurance company closed the case unilaterally without providing a proper explanation. It forced us to escalate the matter further. We initiated a second round of appeals, emphasizing the validity of the claim and the necessity of payment for the A9500 code.

STEP 3: Involving State Authorities

When the second appeal was dismissed without cause, we escalated the matter to the Department of Finance at the state level. In a detailed submission, we outlined the entire history of the case, including the insurer's improper handling and the lack of transparency in the appeals process.

The Outcome

After three months of consistent effort and appeals, the case was finally resolved in favor of our client. The provider received a payout of over $24,000, along with interest for the outstanding claims. This victory not only ensured appropriate compensation for the provider but also set a precedent for handling similar cases in the future.

This case highlights the importance of persistence, attention to detail, and the strategic use of external resources when dealing with complex insurance disputes. By following a multi-step appeals process and leveraging state authorities, we were able to secure a successful outcome for our client, ensuring that they were paid for their services in full.

MEDICAL AUDIT

Get paid for all your services through a preventive screening of your billing practice

- Be SAFE and SAVE with WCH
- We are not control but ASSIST
- MAXIMIZE your reimbursement
- We are ON YOUR SIDE

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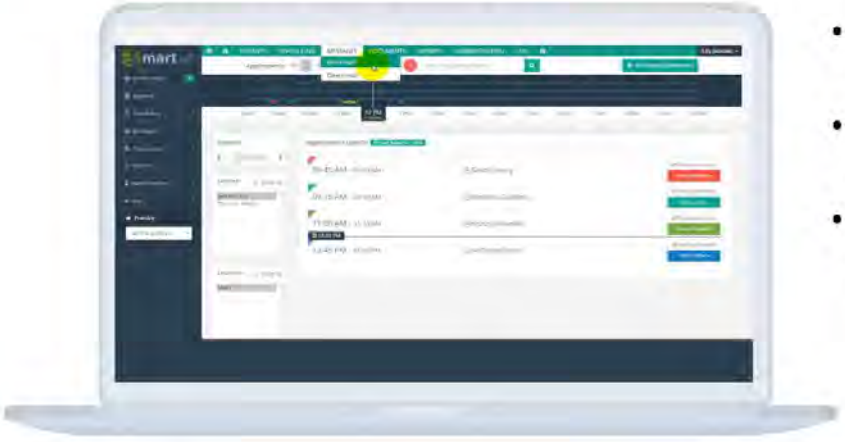
Get access to all your processes 24/7 with fully certified EHR software.



- Maintain patient health care data
- Improve patient care and coordination
- Facilitate the work of the entire practice staff

CONTACT US →

DIRECTOR OF OPERATIONS OLGA KHABINSKAY WINS PRESTIGIOUS THOMAS N. HACKETT MEMORIAL AWARD AT HBMA CONFERENCE 2024

"I am deeply honored to receive the Thomas N. Hackett Memorial Award at the HBMA 2024 Conference. This recognition is not only a testament to my dedication but also to the collective hard work and commitment of the entire HBMA community. I am grateful for the opportunity to serve as a board director and chair of the CPR committee, and I look forward to continuing our shared mission of advancing the healthcare billing industry. Thank you, HBMA, for this incredible honor and for the privilege to contribute to such a meaningful cause.

We are proud to announce that WCH Director of Operations Olga Khabinskay has been awarded the esteemed Thomas N. Hackett Memorial Award for 2024 at the HBMA (Healthcare Business Management Association) annual conference. This prestigious honor recognizes individuals who have made significant contributions to HBMA and have demonstrated leadership, dedication, and an unwavering commitment to advancing the healthcare billing industry.

The Thomas N. Hackett Memorial Award is named after Tom Hackett, a founding member of HBMA and a pivotal figure in the development of the Greater Northeast Chapter. Tom was known for his business acumen, active involvement in the association, and professional demeanor. His sudden passing left a legacy that this award now seeks to honor.

Each year, the HBMA Awards Committee, appointed by the current president at least ninety days before the annual business meeting, selects outstanding individuals who exemplify the spirit of service and leadership within the association.

Olga's selection for this prestigious award recognizes her:

- Leadership in promoting the goals and values of committee.
- Going above and beyond as a volunteer, demonstrating exceptional dedication to achieving the objectives of committe.
- Her influential role in shaping the direction and quality of the healthcare billing industry through her tireless efforts.

Olga's recognition at this year's conference is a testament to her hard work, commitment, and leadership, not only within HBMA but also in the broader healthcare billing community. We congratulate her on this well-deserved honor and are confident that her contributions will continue to positively impact the industry for years to come.

Once again, congratulations to Olga Khabinskay for winning the 2024 Thomas N. Hackett Memorial Award!

SECURING A MIPS WAIVER FOR A LONG-TIME CLIENT AMID COMPLEX CIRCUMSTANCES

In 2024, one of our long-time clients, a physician working in a hospital setting, faced a challenging situation involving the Merit-based Incentive Payment System (MIPS). The doctor, like many hospitalists, was concerned about the time-consuming nature of MIPS reporting. With limited applicable measures and a heavy workload, he sought to avoid the process altogether by applying for a waiver under the Extreme and Uncontrollable Circumstances Application, citing the ongoing impact of COVID-19.

Initial Attempt: Application Denied

At the start of the year, the doctor submitted his waiver application, hoping for relief from the MIPS reporting requirements. However, the application was declined, which left him with no choice but to prepare for full MIPS reporting. The physician gathered the necessary documentation, despite his initial reluctance, and started working on meeting the reporting requirements.

New Opportunity: Cybersecurity Waiver

In the midst of this, Julie Abdyllatypova, WCH account representative, received crucial information that changed the course of the case. Due to a cyberattack, the MIPS waiver for Extreme and Uncontrollable Circumstances was now available for the physician. This presented an opportunity to resubmit the waiver under this new justification.

The Challenge: Duplicate Application

Julie promptly notified the doctor about this update and submitted the waiver application under the new criteria. However, to our surprise, the application was declined as a "duplicate." This setback required immediate intervention. Julie took the initiative to reach out to Quality Payment Program (QPP) representatives on behalf of the doctor, only to learn that she couldn't resolve the issue herself. The doctor had to personally communicate with QPP for this type of case.

Persistence and Collaboration: Securing the Waiver

Together, we prepared a detailed letter for the physician to submit directly. He spoke with the appropriate representatives, and after multiple communications, we finally received approval for the MIPS waiver due to the cybersecurity circumstances.

The Takeaway: Client Success Through Continuous Support

This case demonstrates our commitment to keeping clients informed about relevant updates and supporting them through every step of the process. Despite the initial denial, we continued to work diligently to find a solution, ensuring that our client received the outcome he needed.

The lesson learned? Always stay in touch with your billing team and be proactive in addressing any changes or new opportunities in healthcare regulations.

A SUCCESSFUL AUDIT RESOLUTION

Two years ago, our team was faced with a challenging audit request from SafeGuard, an organization known for its thorough evaluations of medical records. The request, aimed at one of our clients, was for a comprehensive review of submitted documentation. At that time, our client's records were submitted quickly due to time constraints, and unfortunately, the results were far from ideal—receiving a 100% error rate on the submission. SafeGuard clarified that this audit was intended to be educational, providing insights for future improvements. However, the experience served as a crucial learning moment for both our team and our client.

Fast forward to the present, more than two years later, our client found themselves placed under a pre-payment medical record request by SafeGuard. This meant that 100% of their sent claims were subject to review before any payments could be processed. The situation was complex and demanded immediate and precise action.

Recognizing the importance of addressing this issue with diligence, our client sought legal counsel to reduce the volume of record requests. The attorney successfully negotiated the request down to a more manageable number, setting the stage for our clinical staff to step in and demonstrate their expertise. Having learned from the previous audit, our team led by Julie Abdullatypova meticulously reviewed the documentation, proactively correcting any potential errors and ensuring that the submission met all requirements.

The result? After submitting the requested records in a timely and well-organized manner, our client received notification that the pre-payment review had been terminated. This was a significant milestone—both for our client and for our team—demonstrating the value of collaboration, attention to detail, and relentless commitment to achieving the best possible outcomes.

While the review process is not yet fully complete, as the submitted records remain under further evaluation, we remain confident in the quality of the documentation provided. Our team's ability to learn from past experiences and apply those lessons to current challenges has proven invaluable. We await the findings with anticipation, and if any errors are identified, we are ready to use them as learning opportunities for continuous improvement.

This successful termination of the pre-payment review underscores the importance of a comprehensive, collaborative approach to audit preparation and submission. Our team's proactive efforts in reviewing and refining the documentation well in advance played a pivotal role in ensuring this positive outcome. Every step of the way, from working with legal experts to executing precise clinical reviews, our team remained dedicated to delivering excellence.

We are proud of the teamwork and precision that defined this project, and we look forward to continuing to support our clients with the same level of dedication and expertise in the future. Our commitment to high-quality service and thorough documentation ensures that we not only meet audit requirements but exceed expectations, solidifying our reputation as a trusted partner in navigating complex healthcare processes.

KEY INSIGHTS FROM THE HBMA CONFERENCE:

PRACTICAL STEPS FOR PROVIDERS ON DATA SECURITY, AUTOMATION, AND VENDOR MANAGEMENT

Data security, compliance, and automation are becoming increasingly critical for healthcare providers. At the recent HBMA conference, our WCH team gathered valuable insights on how to navigate these challenges effectively. From cybersecurity to vendor management and process automation, we share actionable takeaways to help you implement these practices and protect your healthcare organization.

1. Streamlining Data Breach Notifications and Strengthening Compliance

One of the most important discussions revolved around how healthcare providers should handle data breaches under HIPAA regulations. The requirement is to notify affected individuals within 60 days of discovering a breach, yet delays in notification are still prevalent. For instance, Change Healthcare missed the window after a February breach, notifying patients only in July, which raised legal concerns.

To avoid such risks, ensure breach notification protocols are as streamlined as possible. Automate the notification process across your vendor chain to eliminate bottlenecks and assure timely responses to breaches. This way, you can mitigate regulatory and reputational risks by keeping all parties informed efficiently.

2. Strengthening Vendor Relationships with Tailored Business Associate Agreements (BAAs)

BAAs are essential in managing third-party vendor relationships, especially when they handle patient data. Many providers still rely on generic BAAs, but it is no longer enough. Your BAAs should be customized to define responsibilities clearly, particularly around data breaches and liability.

Take immediate steps to review your current BAAs. Ensure they include detailed clauses on breach notification procedures, vendor accountability, and cybersecurity measures. With cybersecurity insurance costs rising by up to 75%, securing sufficient coverage and addressing these concerns in your BAAs will safeguard you from future financial risks.

3. Managing the Risks of Mergers and Data Centralization

Large healthcare mergers are increasing the volume of data held by organizations, making them more attractive targets for cyberattacks. For example, UnitedHealthcare now controls nearly one-third of all U.S. health data after a recent merger. This centralization increases the risk of large-scale breaches, which could have devastating legal and financial consequences.

As a provider, it's crucial to stay proactive. Implement rigorous cybersecurity protocols and review your breach response strategies. Consolidated data should be regularly audited to identify potential vulnerabilities, ensuring that you are prepared for any cybersecurity challenges that may arise from mergers and acquisitions.

4. Reviewing Indemnification Clauses in BAAs

An often-overlooked detail in BAAs is indemnification. Some agreements leave providers fully liable for breaches, even when the vendor is at fault. This could expose your organization to significant financial and legal liabilities.

Now is the time to review your existing agreements. Ensure that your BAAs include strong indemnification clauses, clearly holding vendors accountable for breaches caused by their negligence. This not only protects your organization but

also ensures a fair distribution of risk between you and your vendors.

5. Proactive Vendor Management and Compliance Monitoring

It's not enough to sign a BAA and move on. Continuous vendor management is essential for maintaining compliance and minimizing risk. Keep an updated list of all third-party vendors with access to sensitive data, and regularly review their compliance with HIPAA and other regulations.

Use technology to track vendor relationships, and conduct periodic audits to ensure that vendors are meeting their obligations. By taking a proactive approach to vendor management, you'll reduce your exposure to data breaches and other compliance risks.

6. Embracing Automation to Streamline Billing and Internal Processes

Automation is revolutionizing billing and coding processes, reducing manual workloads, and increasing accuracy. Although AI adoption is still in its early stages, tools like Clearing House and Trizetta's ARM are already helping to validate claims and streamline operations.

If you haven't done so yet, explore these tools to automate routine tasks and free up your team for more complex work. Automation not only enhances efficiency but also reduces the risk of human errors that can delay payments and impact your bottom line.

7. Leveraging AI to Improve Insurance Communication and Claims Processing

AI is also transforming the insurance industry, offering tools to detect payment discrepancies and speed up claims processing. Effective communication with insurers remains critical, and automation can play a significant role in improving these interactions. By utilizing tools such as insurance company report cards, you can manage complaints more effectively and improve communication with payers.

Consider adopting these AI-driven tools to enhance your claims process, especially for routine tasks. However, for more complex cases, human intervention may still be required, as AI solutions may not yet be advanced enough to handle specific claim details.

8. Optimizing Billing Software to Prevent Claim Denials

Optimizing your billing software is key to reducing manual work and preventing claim denials. By creating rules and automation guides, you can streamline the claims process and improve collections. Predictive denial tools, which flag unusual claim behavior, can help you identify issues before they escalate into denials.

Start by reviewing your current billing software to ensure it's being used to its full potential. Create custom rules tailored to your organization's needs, and consider investing in predictive tools that can preempt denials and ensure smoother processing.

Actionable Steps for Protecting Your Healthcare Organization

The insights we've brought back from the HBMA conference highlight the growing importance of automation, vendor management, and proactive risk mitigation in healthcare. Whether it is refining your BAAs, embracing automation tools, or ensuring compliance with data security regulations, taking these steps will help protect your organization from financial and legal risks. Staying proactive and vigilant is critical in today's healthcare.

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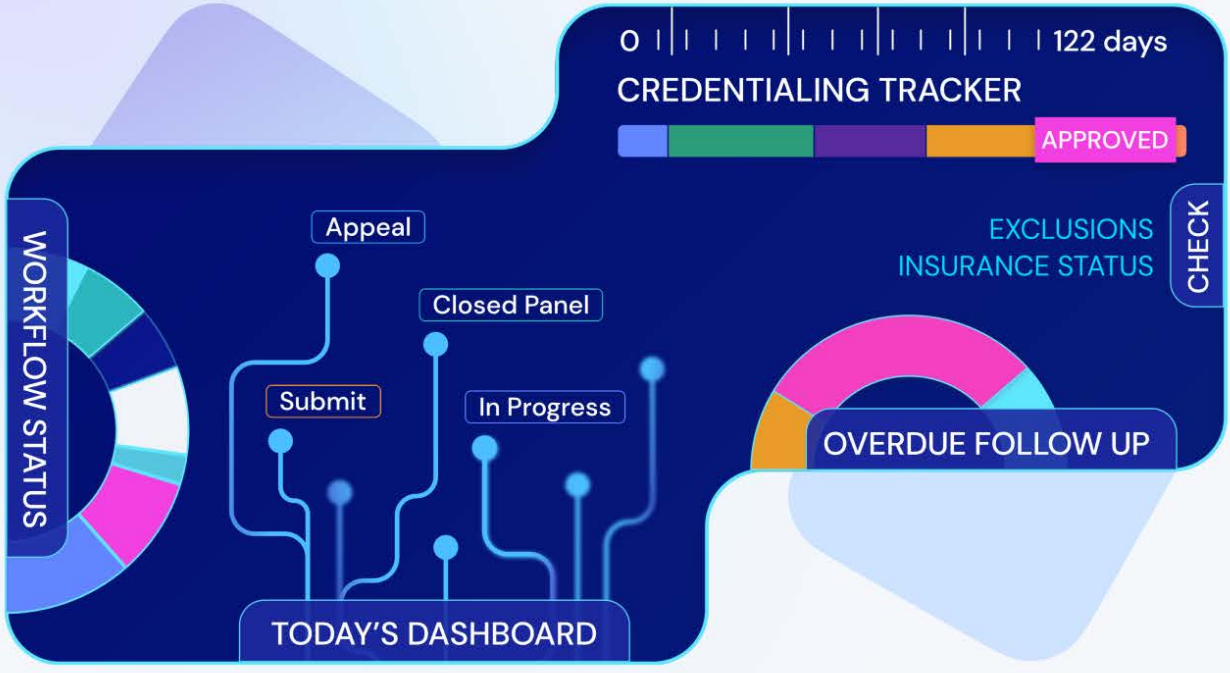

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DR. ITTEERA ON THE BENEFITS OF TMS THERAPY

We are honored to speak with Dr. Annupriya Itteera, a distinguished psychiatrist with an impressive career spanning over two decades. Dr. Itteera is double board certified by the American Board of Psychiatry and Neurology in General Psychiatry and Geriatric Psychiatry. She earned her medical degree from the Kempegowda Institute of Medical Sciences in India and completed her General Psychiatry residency at Creedmoor Psychiatric Center, affiliated with Columbia University Medical Center/New York Presbyterian Hospital.

Following her residency, Dr. Itteera pursued a fellowship in Geriatric Psychiatry at Zucker Hillside Hospital/ Northwell Health System. Her extensive training and experience are complemented by her active involvement with the American Psychiatric Association and the Clinical TMS Society.

Dr. Itteera currently serves as the Medical Director of Hillside TMS, where she leads a team in providing innovative treatment options for patients. In addition, she maintains a thriving private practice, where she has been serving patients for 18 years. Her approach to treatment is both comprehensive and integrative, combining medication management, psychotherapy, and cutting-edge neuromodulation techniques, including Transcranial Magnetic Stimulation (TMS).

Today, we will delve into Dr. Itteera's insights on TMS therapy, its application in treating various psychiatric conditions, and her perspectives on the evolving landscape of mental health treatment.

What inspired you to incorporate TMS into your practice?

After practicing psychiatry for over two decades, I have worked with many patients suffering from treatment-resistant depression (TRD). These individuals have often undergone numerous rounds of different antidepressants, each time hoping for improvement, but without success. As a clinician, it is difficult to see patients endure this cycle of trial and error, especially when their quality of life continues to be compromised. It led me to explore alternatives beyond medication.

TMS caught my attention as a non-invasive, scientifically backed option that targets the brain differently than pharmacological treatments. Its ability to offer relief to patients who have not responded to conventional methods ultimately inspired me to integrate it into my practice. It provides a sense of hope and an additional path for those who feel they have exhausted all other options. In a field where personalized care is key, TMS offers another valuable tool for addressing the complex nature of depression and other mood disorders.

For which mental health conditions is TMS most commonly used, and why?

Repetitive Transcranial Magnetic Stimulation was first approved by the FDA in 2008 for TRD treatment. It is currently the most common condition for which TMS is utilized. The reason TMS is so effective in treating TRD lies in its mechanism of action. By applying electromagnetic pulses, TMS directly stimulates nerve tissue beneath the stimulation coil and indirectly affects other areas of the brain through their anatomical and functional connections.

The pulses generate a transient electromagnetic field, which induces electrical fields in neurons in the brain's superficial cortical layers. This process alters neuronal excitability—either increasing or decreasing activity in specific brain regions—and repeated sessions have been shown to enhance neuroplasticity, which contributes to long-term improvement in mood and cognitive function.

In addition to TRD, TMS is being explored for use in other psychiatric and neurological conditions, such as anxiety disorders, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD). Research in these areas is ongoing, but the ability of TMS to modulate brain circuits involved in mood, anxiety, and executive function makes it a promising treatment for a variety of mental health conditions.

What about generalized anxiety disorder (GAD)? Are there any specific TMS protocols that are particularly effective for anxiety disorders?

While TMS is not yet FDA-approved for the treatment of GAD, ongoing studies suggest it may offer significant benefits for individuals whose anxiety is not adequately managed with medication or therapy alone. In the case of OCD, a version of TMS known as deep brain TMS, which targets deeper brain structures using a specialized coil, has recently been FDA-approved as an adjunct treatment. This approval marks an important step forward in expanding the use of TMS for anxiety-related conditions.

In my practice, I offer TMS to patients with treatment-resistant anxiety disorders, including those who struggle with GAD. We follow a specific anxiety protocol that targets the right dorsolateral prefrontal cortex, a region of the brain linked to emotional regulation and stress response. It is distinct from the protocol used for depression, which focuses on the left dorsolateral prefrontal cortex.

Although TMS for anxiety is still an evolving area of research, many of my patients have experienced marked improvements in their symptoms following treatment. For some, this has led to a significant reduction in their reliance on anxiety medications. The neuroplastic effects of TMS seem to help recalibrate brain circuits involved in anxiety, offering a potential alternative for those who have not responded to traditional therapies.

In which cases do you believe TMS is not the appropriate treatment option, and why?

TMS is a safe and non-invasive treatment option for many individuals. However, there are specific cases where it may not be appropriate due to safety concerns related to certain medical conditions or implanted devices. In our practice, we carefully screen patients for contraindications before starting TMS therapy to ensure the treatment is safe and suitable.

Patients who have metal or electronic implants, especially in or around the head, are typically not eligible for TMS. These contraindications include devices like cochlear implants, implanted electrodes or simulators, aneurysm clips, deep brain stimulators, pacemakers, cardioverter defibrillators (ICD), infusion pumps, and magnetically programmable shunt valves, among others. The electromagnetic pulses used during TMS could interfere with these devices, potentially causing malfunction or other adverse effects.

We also screen for conditions such as ferromagnetic materials in the body (e.g., bullets or shrapnel within 30 cm of the coil), as well as metallic devices implanted in the head or neck, including ocular implants, dental implants activated by magnets, and cervical fixation devices. Patients with facial tattoos containing metallic ink or those who have had certain surgeries involving metallic staples or sutures are also carefully evaluated.

There are also temporary precautions. Patients need to remove portable electronic devices, hearing aids, eyeglasses, and other metal-containing items, such as portable glucose monitors or headphones, before treatment. These steps ensure that the electromagnetic pulses delivered during TMS do not interfere with external electronics or cause unintended effects.

While TMS is a powerful and effective therapy, it is crucial to exclude patients for whom it might pose risks to ensure safety and efficacy.

How do you see TMS evolving in the future?

I believe the future of TMS is incredibly promising, and we are only scratching the surface of its potential. As technology advances, I foresee TMS becoming more precise and personalized, allowing us to deliver even more targeted and effective treatments based on an individual's specific brain activity and condition. This could lead to better outcomes and reduced side effects, making it an even more viable option for a broader range of patients.

In terms of clinical applications, while TMS is currently most commonly used for treatment-resistant depression, ongoing research is exploring its potential for a wide array of mental health conditions. We're seeing promising results in trials for conditions like bipolar disorder, post-traumatic stress disorder (PTSD), chronic pain syndromes, and even movement disorders such as Tourette syndrome. As the evidence base grows, I believe we'll see expanded FDA approvals and increased adoption of TMS as a standard treatment across different specialties.

Furthermore, there's exciting research into combining TMS with other therapies, such as cognitive behavioral therapy (CBT), to enhance its effectiveness. This multimodal approach could become a standard part of treatment protocols, particularly for complex conditions like PTSD or anxiety disorders, where multiple treatment angles are often necessary.

In essence, TMS is at the forefront of a revolution in neuropsychiatric treatments, and I expect its evolution to open up new frontiers in mental health care.

Are there any ethical or social considerations when prescribing TMS, especially for elderly patients?

While there are no unique ethical or social considerations specifically for elderly patients compared to the adult population, there are still some important factors to keep in mind, such as the potential for age-related medical conditions that could increase the risks associated with TMS. For example, elderly patients may have more comorbidities or be on multiple medications, which could interact with TMS or affect the outcome of the treatment. In such cases, it is essential to carefully screen and monitor these patients to ensure TMS is appropriate and safe for their particular health status.

Socially, there may be challenges related to accessibility for elderly patients, such as mobility issues or lack of transportation to regular TMS sessions. We need to assess these logistical barriers and work with the patient and their support system to ensure they can complete the recommended treatment protocol.

Ultimately, while there are no specific ethical guidelines that differ for elderly patients, careful attention to individual circumstances, informed consent, and the potential for medical complexities is essential for this population.

What are the most common questions that patients ask you about TMS?

Patients frequently have several important concerns when considering TMS treatment. Some of the most common questions include:

- **Effectiveness:** Patients often want to know how effective TMS is, particularly if they've struggled with treatment-resistant depression or other mental health conditions. They ask if TMS can help where medications or traditional therapies have failed and what kind of improvement they can expect.
- **Number of Sessions:** Many patients inquire about the duration of the treatment protocol—how many sessions they will need and how long each session will take. They also ask how quickly they might notice improvements.
- **Potential Side Effects:** A key concern for many patients is whether TMS has any side effects. They want to know if the treatment is painful, if there are any long-term effects, and how it compares to the side effects of medications they may have taken in the past.
- **Cost of TMS:** Cost is a significant factor, and patients often ask how much the treatment will cost them, especially if they need multiple sessions. This leads to questions about the overall affordability of the treatment.
- **Insurance Coverage:** Insurance is another common topic, as patients want to know if TMS is covered by their health insurance plan. They inquire whether their specific insurance policy will cover the treatment, and if not, what other payment options might be available.

How does billing work for TMS? Are there challenges with insurance coverage?

Billing for TMS services requires proper alignment with insurance companies, which involves having the correct procedure codes included in the provider's fee schedule. Some insurance providers also require prior authorization before TMS services can be administered. The key CPT procedure codes for TMS include:

- **90867:** This code is used for the initial mapping of the treatment target site and the first treatment session.
- **90868:** This code covers each of the subsequent daily treatment sessions.
- **90869:** This is used for remapping when adjustments are needed to improve the target site due to discomfort, such as excessive twitching or pain, or if sufficient improvement has not yet been achieved.

Each insurance company may allocate a different number of authorized sessions for each of these codes, typically ranging from 36 to 39 daily treatments. These

sessions usually occur over the course of several weeks, with an initial 6-week period where treatments happen 5 days a week, followed by a tapering phase of 3-4 treatments per week.

Navigating insurance coverage can sometimes be challenging due to variations in the number of approved sessions and differences in how insurance companies handle reimbursement for TMS. Ensuring that billing practices are compliant and using appropriate codes is crucial for smooth reimbursement. I've found that working with a specialized billing service like WCH has been invaluable in overcoming these challenges. They've helped streamline the process, making it easier to manage the financial side of offering TMS treatments.

What is involved in the credentialing process for healthcare providers who want to offer TMS? What are the key regulatory and licensing requirements for offering TMS in a clinical setting?

To offer TMS (Transcranial Magnetic Stimulation) in a clinical setting, healthcare providers must navigate a detailed credentialing and regulatory process. First and foremost, the provider needs to be a certified psychiatrist. This certification often involves specialized training, typically conducted by the manufacturer of the TMS machine. Additional training opportunities may be available through universities or specialized institutions, which offer further education on the use of various TMS machines and protocols.

The TMS equipment used must be FDA-cleared for the treatment of TRD. Compliance with FDA regulations is crucial for ensuring the machine meets safety and efficacy standards.

If the psychiatrist plans to employ additional staff to assist with administering TMS treatments, those staff members must also receive TMS certification. It ensures they are properly trained to conduct daily sessions under the psychiatrist's supervision, maintaining the quality and safety of the treatments provided.

HISTORIC MEDICAL BREAKTHROUGH:

FIRST-EVER INTERCONTINENTAL REMOTE SURGERY

In a groundbreaking medical achievement, a Chinese medical team led by Dr. Zhang Xu successfully performed the world's first live broadcast of an intercontinental remote surgery this summer. The operation, which took place between Rome and Beijing, was a testament to the power of modern technology and innovation in healthcare.

Dr. Zhang, an academician of the Chinese Academy of Sciences and director of the Department of Urology at the Third Medical Center of the Chinese PLA General Hospital, operated on a patient in Beijing from over 8,000 kilometers away in Rome. Using a state-of-the-art robot and China's advanced 5G+ internet communication technology, the surgery showcased the potential of remote procedures with almost no latency or delay.

The Power of Technology in Medicine

The robot, developed domestically in China, responded to Dr. Zhang's instructions with precision and stability, making it seem as though he were in the same room as the patient. This remarkable success underscores how 5G technology and cutting-edge robotics are revolutionizing healthcare, eliminating the need for travel and enabling doctors to perform surgeries remotely, regardless of location.

Dr. Zhang emphasized the significance of this advancement, stating, "If experts in cities like Beijing and doctors in other locations collaborate using this system, they can perform surgeries together in real time. This technology brings the best medical expertise to underserved and remote areas, ensuring life-saving care is accessible to all."

The surgery was part of the prestigious "Challenges in Laparoscopy & Robotics" conference in Rome, a global event where medical professionals explore and demonstrate advanced surgical techniques. Zhang's team, invited for the 15th consecutive year, performed the surgery in front of an audience of experts who watched in awe as the operation unfolded seamlessly.

A Milestone for Global Healthcare

Vito Ansadoro, president of the conference, expressed his admiration for the achievement: "For me, it's a historical experience and moment. We were emotional watching it happen." He highlighted that the procedure, a radical prostatectomy, is one of the most complex and risky urological surgeries. The Chinese team overcame the challenges of network latency and data compression, proving the feasibility of remote surgeries on a global scale.

Dr. Zhang's team is no stranger to pioneering work in this field. Over the years, they have completed more than 60 remote surgeries in various medical disciplines, including urology, gynecology, and general surgery, with a 100% success rate. This latest achievement solidifies their reputation as leaders in the development and implementation of remote surgical technology.

A Global Future for Medicine

The implications of this breakthrough are far-reaching. With remote surgery becoming a reality, patients in underdeveloped or remote regions can now access world-class medical care without the need for travel. As Dr. Zhang aptly stated, "We are connecting the world into a village, a hospital, or an operating room." This technology is set to transform global healthcare by ensuring that geography is no longer a barrier to receiving the best possible care.

The success of this surgery marks a significant step forward in the integration of robotics, 5G, and medical expertise. It paves the way for a future where surgeons can operate remotely from anywhere in the world, offering hope and treatment to patients who previously lacked access to specialized care. The possibilities for healthcare are endless, with remote surgery at the forefront of this exciting new frontier.

Source: https://www.chinadaily.com.cn

FINANCIAL BENEFITS FOR PRIMARY CARE PRACTICES THROUGH TECHNOLOGY

We all know that technology is revolutionizing medication adherence and improving patient outcomes. However, today, we will focus on a critical aspect that is often overlooked: the financial benefits for primary care practices that adopt these technologies. You got it right: Incorporating technology to improve medication adherence not only enhances patient care but also presents significant opportunities for revenue growth. Primary care practices can unlock new billing opportunities, particularly with Medicare and other insurers, by offering services such as telehealth consultations, remote monitoring, and personalized digital health solutions.

The Financial Impact of Medication Non-Adherence

Before diving into the financial benefits, it's important to understand the financial strain caused by medication non-adherence. When patients do not take their medications as prescribed, the consequences can be dire, including increased hospital readmissions, avoidable emergency room visits, and worsening of chronic conditions. The numbers are staggering: medication non-adherence costs the healthcare system approximately $300 billion annually, with an additional $25 billion in readmission penalties paid by almost half of all U.S. physicians.

Non-adherence also affects the financial well-being of primary care practices. Providers must frequently spend extra time managing complications caused by missed medications. This time is often non-billable, further straining the financial health of the practice. In contrast, investing in technologies that improve adherence can help mitigate these costs and open new revenue streams.

Revenue Opportunities Through Medicare and Insurers

With the growing emphasis on value-based care, Medicare and many private insurers are offering reimbursements for services that improve patient outcomes, including medication adherence. Here's how primary care providers can benefit financially:

Telehealth Consultations: Telehealth services have become mainstream, especially after the COVID-19 pandemic, and Medicare continues to reimburse providers for virtual visits. These consultations allow providers to discuss medication adherence with patients remotely, ensuring that they are following their treatment plans. For patients with chronic conditions such as diabetes or hypertension, regular telehealth check-ins can help address non-adherence before it becomes a serious issue. These services are billable, providing a steady income stream for practices.

Remote Monitoring Services: Remote patient monitoring (RPM) technologies, such as smart pill bottles or wearable devices, allow providers to track patients' medication adherence in real-time. Medicare reimburses for RPM services, and practices can bill for both the initial setup and ongoing monitoring of these technologies. For patients with complex medication regimens, RPM can offer peace of mind and ensure better health outcomes, while also generating revenue for the practice.

Chronic Care Management (CCM): Medicare offers payments for chronic care management services, which involve ongoing care coordination for patients with two or more chronic conditions. Medication adherence is a key component of CCM, and primary care practices that use technology to track and improve adherence can bill Medicare for these services. CCM provides a monthly recurring revenue opportunity for practices, while also helping to reduce hospital readmissions and improve patient outcomes.

Personalized Digital Health Solutions: As technology continues to evolve, personalized digital health solutions are becoming more widely available. These include mobile apps for medication management, digital reminders, and telehealth platforms that integrate with a practice's electronic health records (EHR). Many of these solutions are billable to Medicare, as they contribute directly to patient care. For example, a digital health platform that provides patients with reminders to take their medications and offers telehealth consultations for follow-up care can be reimbursed under Medicare's telehealth guidelines.

Streamlining Administrative Tasks and Improving Efficiency

Adopting technology for medication adherence does more than just create new revenue streams. It also helps practices streamline their administrative processes, which can lead to long-term cost savings. For instance, medication tracking systems reduce the time that healthcare staff spend managing prescriptions and refills. By automating these tasks, staff can focus on more critical areas of patient care, which in turn improves overall productivity.

Additionally, data from remote monitoring technologies and digital health platforms can be integrated into a practice's EHR, reducing paperwork and manual data entry. The ability to automatically capture and store patient data improves accuracy and efficiency, reducing the potential for errors and the time spent on administrative tasks. In a field where every minute counts, reducing these burdens can translate to more time for billable patient care and fewer administrative costs.

Boosting Patient Retention and Satisfaction

The adoption of technology to improve medication adherence can also positively impact patient satisfaction and retention. Patients are more likely to remain loyal to a practice that offers convenient, tech-driven solutions for their care. Technologies such as mobile apps, telehealth services, and smart devices make it easier for patients to follow their treatment plans, improving their overall health outcomes and experience.

Patients who feel supported in managing their medications are less likely to experience complications that require urgent care or hospitalization. This not only improves their quality of life but also helps providers avoid penalties associated with high readmission rates. In the long run, practices that prioritize patient satisfaction through technology-driven adherence solutions are likely to see higher patient retention rates, which translates to more consistent revenue.

Addressing Barriers to Technology Adoption

While the financial and operational benefits of technology adoption are clear, there are challenges that practices may face. The cost of implementing new technologies can be a significant barrier for smaller practices. However, the long-term financial benefits often outweigh the initial investment, particularly when factoring in the additional revenue from Medicare reimbursements and the reduction in non-billable tasks.

To make the transition easier, practices should start small by adopting one or two technologies that address the most pressing issues in their patient population. For example, if non-adherence among patients with chronic conditions is a significant issue, investing in remote monitoring technologies for that group could be a good starting point. Practices can then gradually expand their use of technology as they become more comfortable with the systems and see positive returns on investment.

Incorporating technology to improve medication adherence offers primary care practices a unique opportunity to enhance patient care while also boosting their financial health. Telehealth consultations, remote monitoring services, and digital health solutions are billable to Medicare and private insurers, creating new revenue streams that can offset the costs of technology adoption. In addition, these technologies help streamline administrative tasks, reduce the burden of non-adherence, and improve patient satisfaction and retention.

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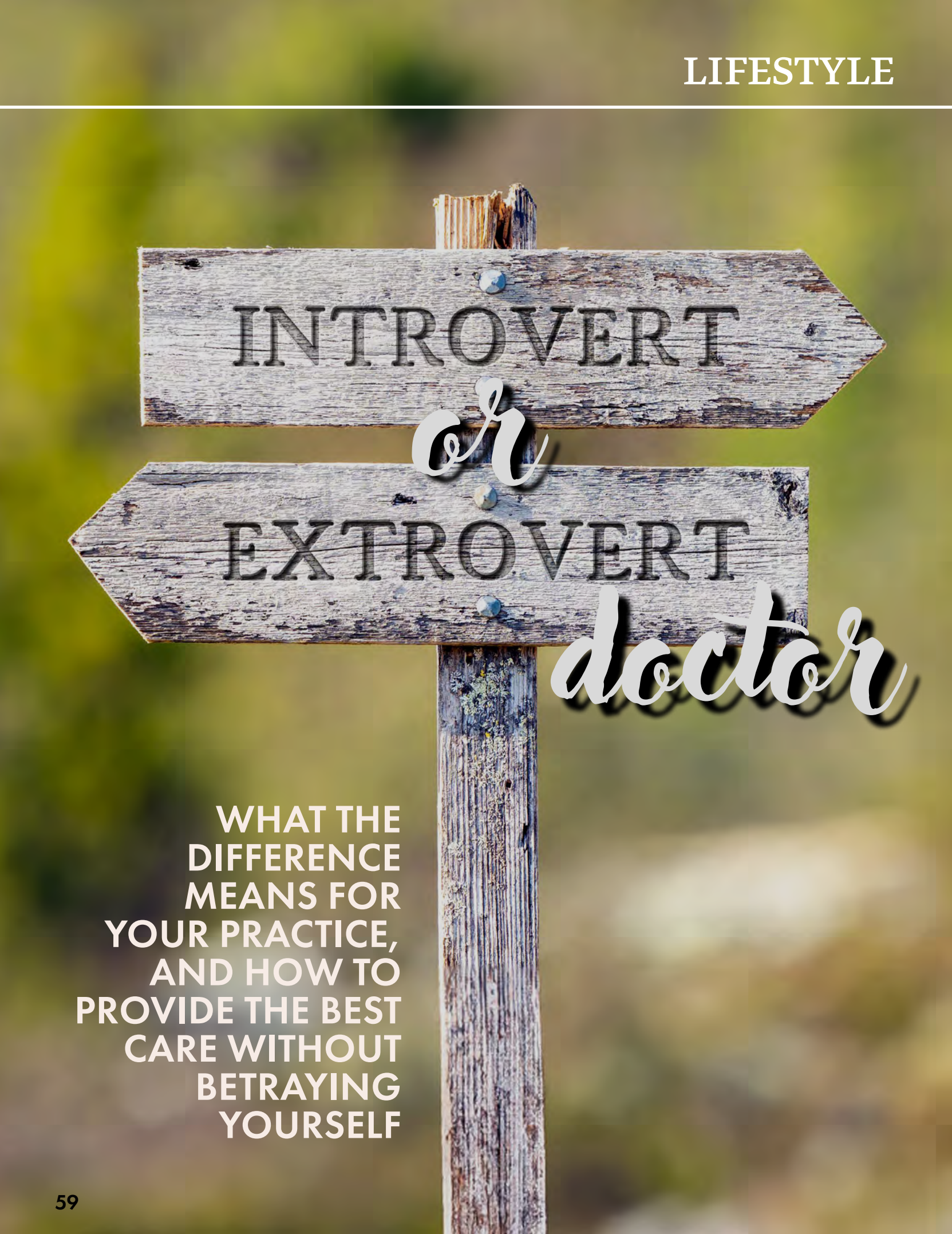

introvert or extrovert doctor

WHAT THE DIFFERENCE MEANS FOR YOUR PRACTICE, AND HOW TO PROVIDE THE BEST CARE WITHOUT BETRAYING YOURSELF

When we think about medical practice, certain traits might come to mind—strong communication skills, confidence, and quick decision-making. These are often associated with extroverted personalities. However, not all doctors fit this mold. Many doctors are introverts, and while this might seem like a disadvantage in such an interpersonal profession, it can actually be a source of strength.

Whether you're an introverted or extroverted doctor, understanding your personality type is essential in shaping how you practice medicine, interact with patients, and navigate your career. More importantly, it's about finding balance—how to offer the best patient care without straying from your authentic self.

Understanding Introversion and Extroversion in Medicine

First, it's important to clarify what we mean by "introvert" and "extrovert." Introverts tend to draw energy from spending time alone, requiring quiet reflection to recharge. Extroverts, on the other hand, feel energized by social interactions and often enjoy being in stimulating environments.

Neither personality type is inherently better for a doctor. Instead, each has unique strengths and challenges when applied to medical practice:

The Introverted Doctor: Strengths and Challenges

Strengths:

- **Deep Listening and Reflection:** Introverts tend to be more reflective, making them exceptional listeners. Their ability to give full attention to a patient's concerns can create a strong sense of trust and rapport, leading to more accurate diagnoses and patient satisfaction.
- **Attention to Detail:** Because introverts often prefer to observe before acting, they tend to catch subtle details that might be overlooked in hurried environments. This can be crucial in patient care, especially for complex or chronic cases.
- **Calm and Thoughtful Approach:** Introverted doctors are often seen as calm, which can be comforting to patients, especially during stressful medical situations. They think carefully before speaking or making decisions, reducing the risk of rash errors.

Challenges:

- **Energy Depletion in High-Interaction Environments:** Medicine often requires long hours of interaction with patients, families, and colleagues. For introverts, this can be mentally exhausting, especially if they don't find time to recharge between appointments.
- **Perceived as Detached:** Introverts may come across as aloof or less approachable to patients who expect more overt enthusiasm or quick responses. Misunderstanding these quieter tendencies can sometimes lead to communication barriers.

The Extroverted Doctor: Strengths and Challenges

Strengths:

- **High Energy in Social Settings:** Extroverts thrive in social environments, which makes them naturally comfortable in patient interactions. They are often seen as approachable, friendly, and easy to connect with, which can help put anxious patients at ease.
- **Quick Decision-Making:** Extroverts tend to be more comfortable making decisions on the fly, which is an asset in fast-paced environments like emergency rooms or during critical situations that demand immediate responses.
- **Team Collaboration:** Extroverts enjoy collaborating with colleagues and are typically more willing to take leadership roles in team-based care, promoting open communication and shared decision-making in clinical settings.

Challenges:

- **Overstimulation and Burnout:** While extroverts love social interactions, the intensity of non-stop engagement, especially in emotionally charged medical settings, can lead to burnout if not managed properly.
- **Less Reflection Time:** Extroverts' quick responses, while often an advantage, can sometimes result in decisions made without enough reflection. This can lead to misjudgments or overlooking important details.

What Does This Mean for Your Practice?

Regardless of whether you're introverted or extroverted, practicing medicine will require a balance of interpersonal skills, decision-making abilities, and self-awareness. Here's how to tailor your practice to your personality type while maintaining quality care:

Leverage Your Strengths

- **For Introverts:** Play to your strength in deep listening and observation. Take advantage of your reflective nature to build strong, meaningful relationships with your patients, and don't hesitate to schedule breaks between patient appointments to recharge. Use your calm demeanor to your advantage, especially in stressful situations, where patients need a doctor who exudes quiet confidence.
- **For Extroverts:** Capitalize on your ability to make quick connections with patients and staff. Use your high energy to lead in fast-paced environments and in situations that require teamwork. However, be mindful of giving yourself reflection time before making significant decisions to ensure that you're not overlooking critical information.

Adapt Your Environment

- **For Introverts:** Create a practice environment that allows for moments of solitude. Whether that means taking short breaks during your shift or structuring your office space to allow for quiet reflection, ensure that you have opportunities to recharge. Working in fields that require deep, focused attention—like pathology or dermatology—may also align with your strengths.
- **For Extroverts:** Surround yourself with colleagues and team members who share your energy and enthusiasm for collaboration. Consider roles that involve high patient interaction and leadership, like family medicine or emergency care, where your ability to work with a variety of patients and make fast decisions will be most appreciated.

Find Balance in Patient Communication

- **For Introverts:** Though small talk may not come naturally, find ways to initiate brief, warm interactions that make your patients feel comfortable. You don't have to change your quiet demeanor, but showing empathy and attentiveness through small gestures can go a long way.
- **For Extroverts:** You may need to dial back your enthusiasm at times, particularly when dealing with anxious or overwhelmed patients. Be mindful of giving them space to share their concerns without feeling rushed.

How to Offer the Best Care Without Betraying Yourself

Finally, the most important part of this journey is authenticity. Whether introverted or extroverted, patients value doctors who are genuine in their approach. Pretending to be someone you're not—whether forcing small talk as an introvert or suppressing your enthusiasm as an extrovert—can lead to dissatisfaction for you and your patients.

Instead, embrace your personality while developing strategies to address any challenges. This might mean extra self-care and intentional scheduling for introverts or structured time for reflection for extroverts. The goal is to create a practice where your personality type enhances patient care, not hinders it.

Being an introverted or extroverted doctor is not about limitations but about how you harness your natural tendencies to provide compassionate and effective care.

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WCH Service Bureau is headquartered in New York with a division in California, Connecticut, and Washington. Our team of specialists is certified by AAPC offering decades of experience and outstanding results for DME providers. To schedule your evaluation, please contact Olga.

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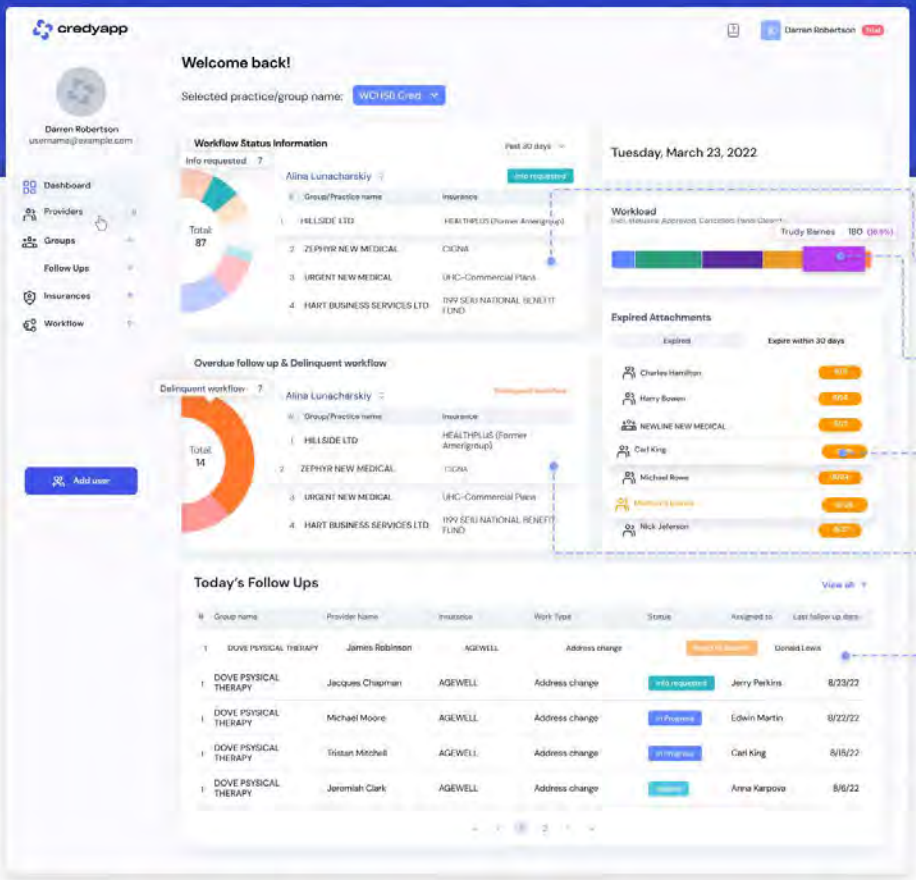

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