

FIT and New Allergist Learning Track

Penny Phillips, Esq.

Richard Wasserman, MD, PhD, FAAAAI

Amanda Reed

Teresa Thompson, CPC, CMSCS, CCC

Revitalize, Refresh, Reimagine Your Practice



2019 Practice Management Workshop
July 12-14, 2019 Cincinnati, OH

Agenda

- 2:00 – 2:45 pm – Negotiating Employment Contracts
- 2:45 – 3:30 pm – Business Management Basics
- 3:30 – 4:00 pm – Refreshment break (Rookwood)
- 4:00 – 4:45 pm – Marketing Your Practice
- 4:45 – 5:30 pm – Coding and Billing Basics

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The Basic Anatomy and Negotiation of Employment Contracts for Physicians

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Penelope (Penny) J. Phillips

(612) 373-8428
pphillips@felhaber.com

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Background

- Similar to other employment contracts for other highly-compensated professionals
- But . . .
 - Licensing and standards of care
 - Significant malpractice liability exposure
 - Additional federal and state healthcare-specific laws apply
 - *e.g.*, HIPPA, Stark, federal anti-kickback, etc.
 - More common for an employer to be a non-profit
 - Potential for partnership / buying into the practice

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Basic Anatomy of Physician Employment Contracts

- Identification of the parties, recitals, definitions
- Term, termination, renewal
- Duties and responsibilities
- Compensation, fringe benefits, expenses
- Malpractice insurance
- Restrictive covenants & confidentiality
- Indemnification, dispute resolution, remedies, etc.
- Miscellaneous provisions (*e.g.*, governing law, forum selection, notice, zipper clause, etc.)
- Signature page, exhibits, schedules, addenda



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Common Contract Pitfalls (1/2)



- Vague, missing, undefined, inconsistent, inaccurate, one-sided material terms
- Independent contractor classification (vs. employee)
- Only incentive-based compensation (vs. guaranteed)
- No outside compensation permitted
- Bonuses & advances structured as forgivable loans
- Limited or poor fringe benefits
- Limited or no expense reimbursement
- Overbroad restrictive covenants
- Physician pays for malpractice insurance
- Physician pays tail coverage for malpractice insurance

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Common Contract Pitfalls (2/2)



- Overbroad indemnification by physician
- Shifting excessive risk / liability to the physician
- No physician termination / broad employer termination
- Giving away intellectual property rights to employer
- Binding arbitration and waiver of jury trial
- Out-of-state governing law / forum selection
- Allowing employer to freely assign contract
- Contract provisions that survive termination
- Documents referenced in agreement are not provided or attached (e.g., employee handbook, code of conduct, standards of care, etc.)

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Common Physician Mistakes



- Relying on prior oral terms or agreements
- Failing to read all or portions of the employment contract
- Agreeing to terms they do not understand
- Taking on excessive risk or liability
- Not negotiating and/or ineffective negotiation of the terms of the employment contract
- Not hiring an attorney to review (and negotiate) the employment contract
- Relying on recruiters to assist with negotiation of the employment contract

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Basic Contract Provisions



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Employee vs. Independent Contractor (1/3)

- Contract must provide whether the physician will be employed by the practice as either an **employee** or an **independent contractor**
 - Note: label placed on relationship in the contract is not always conclusive
- Significant practical differences in being classified as an employee versus an independent contractor
- For physicians in their first years of practice, classification as an **independent contractor** is, in most circumstances, a pitfall to **avoid**

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Employee vs. Independent Contractor (2/3)

- **Employee**
- Pros: employer withholds payroll taxes; employer-provided benefits; mitigated liability risk; covered by federal & state employment laws
- Cons: less flexibility, employer controls terms and conditions of employment and benefits, fewer tax advantages
- In **most** circumstances, it is better for a physician – at least during their first years of practice – to be classified as an **employee**

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Employee vs. Independent Contractor (3/3)

Independent Contractor

- Pros: greater flexibility; choose schedule, who to work for, etc.; additional tax deductions; easier to work for multiple practices
- Cons: must withhold and pay taxes; no employer-provided benefits; greater risk of liability; added overhead expenses; no employment law protections
- If any physician will be classified as an **independent contractor**, hiring legal counsel to set up a **professional entity** (e.g., PLLC, PA) is **highly recommended**
 - Mitigates risk of personal liability (except for malpractice)

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Physician Schedule

- The contract should specify whether the employee will be employed full time or part time
 - How many hours is full time? Part time?
- The contract should clearly define and delineate the specific hours the physician will be required to work
 - What days is the physician required to work? Are there any set days they are not required to work?
 - What hours is the physician required to work?
 - When and how many days is the physician required to be "on-call"?
- **Expectations must be SPECIFIC**

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Duties and Responsibilities (1/2)

- The contract should specifically identify what the physician's responsibilities will be. For example:
 - What specialty? What procedures?
 - What clinic(s) and location(s)?
 - Is the physician required to see a set number of patients per hour/day/week?
 - Who does the physician report to?
 - Record-keeping and billing requirements?
 - Are there specific standards of care or protocols?
 - Does the physician hire/control support staff?
 - Can the physician provide services to other clinics, organizations, etc.?

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Duties and Responsibilities (2/2)

- Pitfalls to Avoid:
- Taking on additional responsibilities beyond providing care to patients
 - *e.g.*, supervision of other employees, teaching, marketing, administrative tasks, etc.
- Language permitting employer to unilaterally change and/or add responsibilities
- Where applicable, language preventing physician from engaging in other work or activities (*e.g.*, teaching)
 - Usually more important in part-time positions

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Term, Termination, and Renewal (1/2)

- Term: When does the contract start and end?
- Termination: under what circumstances can the contract be terminated?
 - For-cause termination? (*e.g.*, license revocation)
 - At-will: termination for any (legal) or no reason?
 - Termination upon notice or mutual agreement?
- Renewal: what happens to the contract when it ends?
 - Automatic renewal?
 - Renegotiation of terms?

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Term, Termination, and Renewal (2/2)

- **Pitfalls to Avoid**
- Term: a longer term is not always better, especially where termination is difficult or has bad consequences
- Termination:
 - Contract gives the employer unilateral or broad power to terminate
 - Employee is unable to terminate or can only terminate with significant notice (*e.g.*, 90 days)
- Renewal:
 - Contract does not provide for renewal
 - Contract does not provide for re-negotiation of terms, automatic increase of compensation, etc. upon renewal

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COMPENSATION



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Salary vs. Incentive Pay (1/2)

Possible Pay Structures

1. Guaranteed salary
 2. Incentive-based pay (RVUs, charges, net/gross collections)
 3. Combination of guaranteed salary and incentive-based pay
 - #1 is more common in a physician's first year(s) of practice
 - #3 is usually the most common pay structure
- **Relative Value Units (RVUs)**
- Common measurement for incentive-based pay
 - Represents the amount of work a physician must do to treat a patient (based on skill, expertise, effort, etc.)
 - For example, different RVUs for a surgical procedure versus a well-patient checkup



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Salary vs. Incentive Pay (2/2)

➤ Best Practices

- Contract accurately describes the compensation structure
- Ensure guaranteed pay is sufficient to cover expenses
- Use objective criteria to negotiate pay (*i.e.*, what do other physicians in similar practices, in similar locals make?)
 - Important to do your homework!

➤ Pitfalls to Avoid

- For physicians in their first years of practice, agreeing to a strictly incentive-based pay is not recommended
- No automatic increase or renegotiation of compensation in multi-year contract (*e.g.*, 3+ years)
- Agreeing to complex compensation formulas the physicians does not understand

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Signing Bonuses / Recruitment Loans

- Significant signing bonuses are very common in physician employment contracts
- Usually structured as a forgivable loan over “x” time period
 - Usually forgivable on a set basis – *e.g.*, monthly, annually, etc.
 - Encourages physicians to stay at a practice
 - Will usually require the physician to sign a promissory note in favor of the employer
- **CAUTION:** leaving prior to complete forgiveness will result in the physician having to repay all or a portion of the signing bonus to the employer



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Ownership/Equity Opportunities

- If equity will be paid to the physician, or if there is the opportunity for ownership in the future, the contract should provide these terms. For example:
 - When/after how long is a physician eligible?
 - What conditions must a physician meet to be eligible?
 - How much is the buy in?
 - What is the compensation structure?
- While an employment agreement may outline basic ownership/partnership terms, full agreement will likely be in a separate partnership or buy-sell agreement.
- Pitfall to Avoid: relying on oral promises of future ownership opportunities without outlining such terms in the contract.

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Outside Activities & Compensation

- Common for employment agreements to provide that the physician must devote their “full time and best efforts” to the employer’s practice
 - May also prohibit income from other sources
- Best Practice: If the physician practices elsewhere, or derives income from other sources (or plans to in the future), the contract should expressly provide such activity is permitted
 - For example: outside research, teaching, consulting, expert witness, work for another practice, etc.
 - Alternative: permitted “upon mutual written agreement”

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FRINGE BENEFITS



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Liability and Malpractice Insurance

- Physician must ensure a provision(s) addressing professional liability and malpractice insurance is included in the employment agreement.
 - Who pays for the policy premiums?
 - What are the policy premiums?
 - When will coverage be effective?
 - What are the limits of coverage?
- Claims-made Policy vs. Occurrence Policy
 - Claims-made = cover losses reported within the active policy period
 - Occurrence = covers losses that take place within a specific coverage period, no matter the reporting date

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Gap/Tail Insurance Coverage (1/2)

- Applies for claims-made policies
- Contract should provide details of professional liability insurance coverage for claims made after the physician leaves the practice – *i.e.*, gap/tail coverage
 - Pitfall to Avoid: Common that the employment contract will provide employee must pay for all of this cost, which can be expensive
 - Commonly negotiated provision
 - It is in the physician's best interest to get employer to agree to pay as much of the tail coverage as feasible

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Gap/Tail Insurance Coverage (2/2)

Two possible compromises:

- (1) Premium for the tail insurance is paid by (a) the **physician** if they resign voluntarily or are terminated for cause; or (b) the **employer** if the physician is terminated involuntarily and without cause
- (2) Phase Out – Employer pays more of the premium for tail insurance based on number of years physician was employed

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“Tangible” Benefits

- Physician should ensure contract clearly outlines what the employer will and will not provide to the physician. For example:
 - What support staff will be provided?
 - *e.g.*, Scribe, physician’s assistance, etc.
 - Will the physician have an office or other workspace?
 - What medical equipment and supplies will be made available for the physician’s use?

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Expense Reimbursement

- Employment contracts commonly provide for the reimbursement of expenses the physician will incur.
- Expenses that employers commonly reimburse include:
 - Relocation and travel expenses
 - Automobile expenses
 - Cell phone, pagers, etc.
 - Licensing and board recertification fees
 - Continuing Medical Education (CME) fees
- Pitfall to Avoid: Employment contract provides for limited or no expense reimbursement

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Paid / Unpaid Time Off (1/2)

- The employment contract should also clearly outline what types of time off from work a physician will be provided, and whether such leave is paid or unpaid:
 - Vacation / Paid Time Off
 - Holidays
 - Time for CME and/or professional development
 - Sick leave
 - Parental leave
 - Partial disability



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Paid / Unpaid Time Off (2/2)

- Even if it not provided in the employment contract, the Family and Medical Leave Act ("FMLA") provides for 12 weeks of unpaid family and medical leave for qualifying reasons
 - But, only applies to employers with 50 or more employees working within a 75 mile radius
- There are also state and local family and medial leave laws which may provide for additional paid or unpaid leave

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Student Loan Assistance

- Physician employment contracts may also provide the physician with assistance for repayment of student loans
- Similar to signing/retention bonuses, there are usually conditions imposed on receiving such assistance from the employer. For example:
 - Completing residency, continued licensure, working for the practice for “x” number of years, etc.
- Pitfall to Avoid: If physician fails to satisfy the requirements for the student loan assistance, it is likely the physician will be required to repay any amount advanced to the employer

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Other Benefits

Other fringe benefits that physicians should ensure the employment contract provides for and outlines their eligibility for include:

- Retirement plan – 401K / pension / 403(b)
- Health insurance
- Disability insurance – short-term & long-term
- Life Insurance
- Dental and vision coverage

Best Practice: Obtain copies of and read all policies from the employer to ensure the fringe benefits being provided are satisfactory

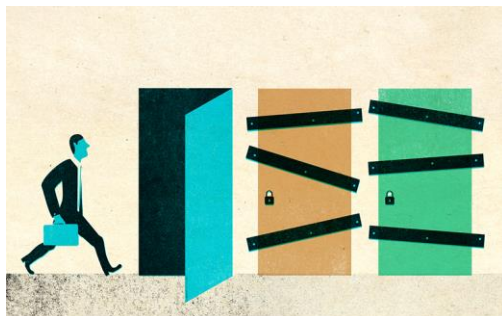
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Restrictive Covenants



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Restrictive Covenants Generally

The three most common types of restrictive covenants that will almost always be found in a physician employment agreement include:

- (1) **Confidentiality** – must keep certain defined information confidential both during and after employment
- (2) **Non-Compete** – cannot work for certain competitors of the employer for “x” time after employment ends and within “x” geographic area
- (3) **Non-Solicitation** – cannot attempt to solicit or hire away other employees of the employer for “x” time after employment ends

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Non-Competition (1/3)

- Usually, to be enforceable, non-competes must be reasonable both in (i) duration, and (ii) geographic scope
 - Some non-competes, however, will provide for a restriction for working for certain competitors or customers, rather than providing a geographic scope
- Whether a non-compete is enforceable will be determined by state law
 - Some states do not allow non-competition agreements altogether
- When in doubt – talk to an attorney!

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Non-Competition (2/3)

Duration

- Two Standards:
 1. Length of time necessary so that employer's customers no longer identify former employee as working for employer; or
 2. Length of time necessary for employer to hire and train replacement employee
- Two years is typically reasonable in Minnesota

Geographic Scope

- Usually limited by "x" distance from employer's location(s)
- Fact specific depending on business and customers
- Best Practice: try to have geographic scope limited to a narrow area where physician actually worked

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Non-Competition (3/3)

Pitfalls to Avoid:

Duration

- Agreeing to an amount of time greater than that which is reasonable and necessary
- Non-compete that fails to provide for a duration

Geographic Scope

- Agreeing to a geographic scope greater than that which is reasonable and necessary
 - For example, in a metropolitan area a “20 mile” radius will likely prohibit a physician from working for a significant number of employer
 - But, a “100 mile” radius in a more rural area could be reasonable

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Non-Solicitation

- More common for more senior physicians – *i.e.*, physicians that would leave and open their own practice
- No geographic limitation
- Similar to non-compete, whether duration is reasonable depends on the specific situation
 - Length of time necessary so that employer’s customers no longer identify former employee as working for employer

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Employment Contract Best Practices

- Everything in the contract is negotiable
- Terms must be in writing and set forth in the contract
- Terms must be specific and accurate
- Get copies of every document referenced in the employment agreement
- Read everything!
- Avoid taking on unnecessary costs, liability, and risk
- Watch out for provisions that provide the employer with the “sole discretion” to make a decision
- Hire an attorney to review the contract
- Do not start working until both you and the employer have signed the contract

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Negotiating the Employment Agreement

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Negotiating Tips

Before beginning negotiations....

1. Read the contract and all attachments
 - Identify problem spots, missing terms, etc.
2. Do your homework and research
3. Determine your goals
4. Determine your leverage
5. Determine where and how the negotiations will take place (via phone, e-mail, in person, etc.)

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Negotiating Tips

When negotiating

1. Do not start at your desired outcome
 - For example, if you want to end up with a salary of \$200,000, you need to start higher
2. Start with small concessions, moving to larger concession when appropriate
3. Provide reasons for each position you take, supported by objective criteria if possible
4. Determine what areas are important to the other party – *i.e.*, the areas that will be hotly negotiated – and vice versa
5. Do not make the negotiation personal

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Negotiating Tips

After negotiations have ended

1. Coordinate who will make the changes to the agreement
 - Professional assistance recommended
 - Redlines are important!
2. Make sure the final contract accurately reflects the agreements reached during negotiations
 - Do not sign anything until you are confident everything is correct

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Other Negotiating Best Practices

- Use comparative information whenever possible – *i.e.*, objective criteria
 - For example, what are other physicians in similar practice areas and in similar locales earning?
- Determine what aspects are most important to obtain and which aspects you are willing to concede
- Determine at what point you are willing to walk away
- Don't have recruiters negotiate for you – they do not have your long-term interests in mind
- If you want a third-party to negotiate on your behalf, hire an attorney
 - The short-term cost can pay off handsomely in the long run

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QUESTIONS?

Thank you.

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Business Management Basics New Allergist Track

Richard L. Wasserman, MD, PhD
Managing Partner
Allergy Partners of North Texas

Medical Director
Pediatric Allergy and Immunology
Medical City Children's Hospital

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Disclosures

- Employee of Allergy Partners, a large, multi-site, single specialty practice

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Acknowledgement

Marshall Grodofsky, MD, the guru of allergy practice business management generously shared slides used for this talk in previous workshops.

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Learning Objectives

Attendees will be able to

- Describe the elements of operating an allergy/immunology practice
- Outline the factors that impact physician compensation
- Plan the kind of allergy/immunology office in which they would like to practice

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The Patient Comes First!

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New to Practice: Starting vs Joining

Needs	Opening an Office	Joining a Practice
Lawyer	Incorporation, real estate, contracts	Advice and final review of employment agreement
Consultant	Help in developing a business plan	Help in evaluating employment opportunities
Banker	Crucial	Can be helpful in a minor role
Debt increase	Immediate	? At buy in

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Getting Started

- Office space
- Information systems
 - Telephone system -VOIP
 - EMR
 - Patient communication
 - Practice management software
 - Appointment reminders
- Equipment
- Front office staff
- Back office staff
- After hours calls

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Your medical training can be helpful in the business of running an A/I practice.

Be Analytical !!

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Stop Running and Understand What You Are Doing

- Most doctors are so pressured to see more patients that they have not invested in efficiency
- Most new allergists will have unscheduled time as they build their appointment book
 - Examine workflow
 - Learn your EMR
 - Create/assemble patient education material
 - Review practice SOP's

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What Kinds of Patients Do You Want?

- It is okay to do everything, don't restrict practice
- Decide on a niche and market the niche
 - Depends on the established competition
- Scope of practice niches
 - Biologic therapy
 - Cough
 - Eczema
 - Food allergy
 - Immunodeficiency
 - Sinusitis

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Audience Response Question #1

Which New Patient Yields the Highest Net Revenue?

- A. 2 yo boy with recurrent pneumonia and an IgG=24mg/dL
- B. 7 yo girl with anaphylaxis to peanut and elevated sIgE to cashew, hazelnut and walnut
- C. 19 yo patient with severe eosinophilic asthma
- D. 35 yo female with chronic sinusitis
- E. 40 yo male with allergic rhinitis

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Getting the Patients You Want to See

- Biologic therapies – allergists, ENT, other
 - Asthma, eczema, nasal polyps, autoimmune disease
 - Financials – significant risk, moderate reward
- Cough – allergists, ENT, pulmonology
 - Some will be asthma, some won't
 - Some patients will be complex and time consuming
- Eczema – primary care and dermatology
- Food allergy – allergists, pcp's
- Immunodeficiency – allergists, heme/onc, etc.
 - Significant risk, significant reward

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Front Office Responsibilities

- Customer service is the priority
- Registration
- Filling the schedules 110%
- Collecting co-pay, deductibles?
- Charge entry
- Daily closing batches – reconciling
- Financial reporting



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Back Office Responsibilities

- Managing patient flow
 - Check in, medication reconciliation, vital signs
 - Rooming the patient
 - Initial history
 - Post-provider discharge instructions
- Procedures
 - SPT, patch testing, PFT, FeNO
 - Shots
 - Infusions
- Provider support

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Staffing and Delegation

- Only providers generate revenue
 - E&M visits
 - Tests, procedures, treatments ordered
- Providers should spend all of their time generating revenue
- Delegate as much as you can
 - Consider the impact of delegation on labor costs
 - Everything you can delegate to the patient is free
 - Provider functions can be facilitated by IT

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Building Bridges - Communication

- Among the front office staff
 - Registration and scheduling
 - Check in/check out
 - Collection, posting, payment analysis
- Among the back office staff
 - Coordinate patient care for efficient operation
- Between the front office and the back office



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Business Operations Made Simple

Profit (physician compensation) = Income - Expenses

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Keys to Financial Management

- Make sure you have cash to operate your business
- Have loans or lines of credit to allow you to finance your business while building up a practice
- Know how to track and maximize revenue production
- Know how to track and minimize expenses
- Plan, Plan, Plan
- Don't spend extravagantly if you can't afford it

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Your Practice's Financial Management

- Understanding revenue generation – money in
- Understanding expenses – money out
- Accounting:
 - Analysis
 - Budgeting
 - Quality Measure
- Revenue Cycle Management
- Coding
- Leadership – Engagement

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Audience Response Question #2

The Primary Revenue Source During the First Year of A/I Practice is

- A. Allergy testing
- B. Biologics for asthma, urticaria and eczema
- C. E&M (office) visits
- D. Pulmonary function testing/FeNO
- E. SCIT

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Sources of A/I Practice Income I

- Patient office visits
- Procedures (PFT's, FeNO, stress tests, SPT, patch testing, food/drug challenges)
- Services (SCIT shots, acute asthma treatment, OIT)
- Drug sales (SCIT, SLIT, IgG, biologics)
- Durable medical equipment sales
- Nutraceutical/dermaceutical sales
- Clinical research participation

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Sources of A/I Practice Income II

- Maximize billing
- Accurate coding
- Quality metrics “bonuses”
- Invest cash reserves
- Sublet unused space

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Initially, Seeing Patients Will Be Your Primary Revenue Source

- Volume drives revenue
- Initial scheduling template
 - New patient visits – 1 hour
 - Established patient visits – 15 minutes
- Experienced physician NP visit – 30 minutes
 - Some may need more time for complex problems
- Experienced F/U visit – 15 minutes
 - Briefer visits allow for catch up
 - Limit problems per visit

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True A/I Profit Centers

- High volume – High margin – Low risk
 - Allergen immunotherapy (SCIT or SLIT)
- High volume – Moderate margin – Low risk
 - Skin prick testing
 - Procedures (PFT, FeNO, etc.)
- High volume – Low margin – Low risk
 - E&M visits are day labor
- Low volume – High margin potential – high risk
 - IgG treatment
 - Biologic therapies

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Analyzing Practice Performance?

- Create “benchmarks” to allow for comparisons
 - The most important comparison should always be internal – always check against yourself
 - Comparison against industry norms can help identify your own strengths and weaknesses
- Budgeting creates the financial benchmarks for your projected revenue sources and your expenses
 - Exploit the available information management tools for financial analysis

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Why Bother Budgeting?

- Budgeting is the bedrock of planning
- Imposes expense discipline
- Clarifies revenue streams informing decisions on practice focus
- Allows you to compare and analyze how you're doing weekly, monthly or annually
- Compares current performance with past performance, or from expected performance
- Allows you instant knowledge of "where you stand!"

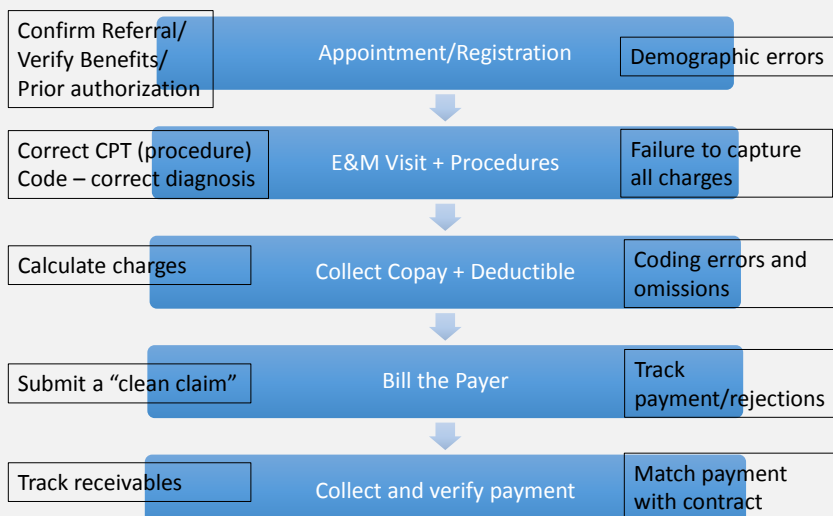
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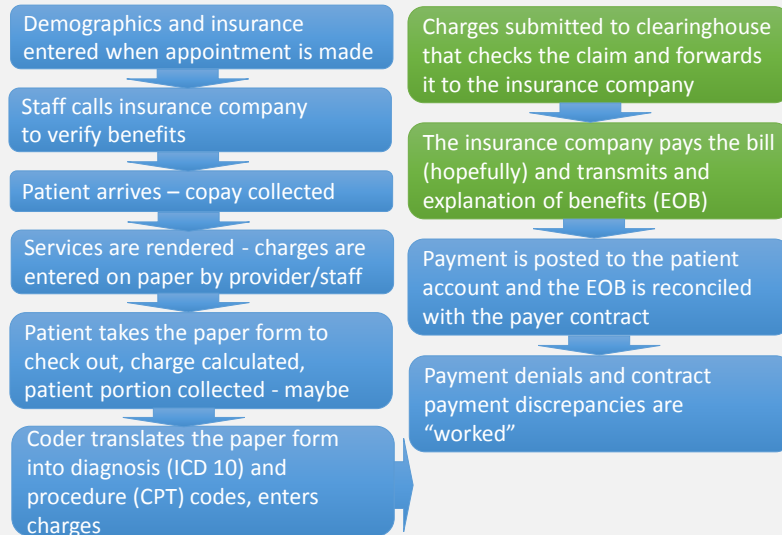
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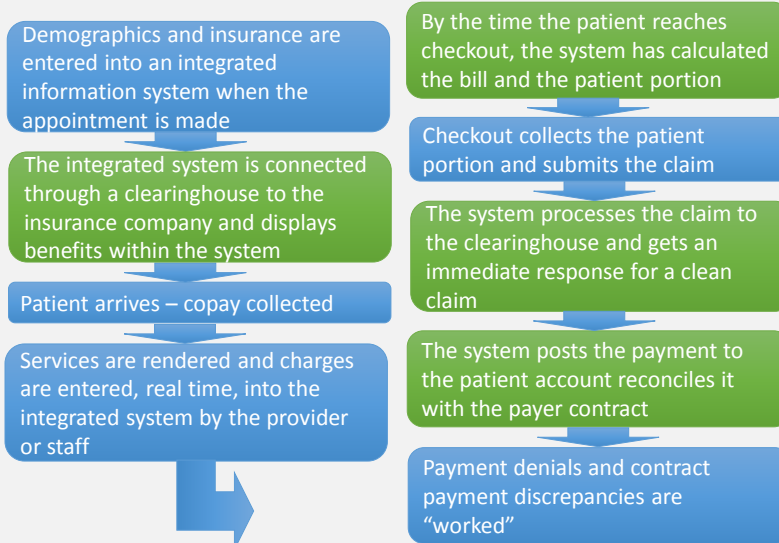
Revenue Cycle Management



Traditional Billing



Modern Billing



Software Can Minimize Denials

- Can't ID / Incorrect ID
- Insurance information wrong
- No coverage
- Lifetime benefit max has been met
- No prior authorization
- Diagnosis code incorrect
- Duplicate claim/services
- Timely limit for filing has expired



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Proper Coding Requires Proper Documentation

- If it wasn't documented, it wasn't done
- The person who performs the service should code its charge
 - Office visits – doctors or mid-levels
 - Procedures – staff performing the procedure

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Patient Registration

- Pre-Registration –
 - Immediately after they schedule appointment
- Online Registration
 - Increases new patient show rate
 - Expedites established patient intake
- On site Registration
 - Prolongs time in the office
 - Reduces the opportunity for error checking



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Audience Response Question #3

The payment method that should be avoided is

- A. Cash
- B. Charity
- C. Credit cards
- D. Commercial credit companies
- E. Payment plans



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Getting Paid

- Insurance
- Collect co-pays and deductibles at the time of service
- Credit cards
- Care Credit®
- Avoid payment plans
- Charity
 - Don't assume that self pay = needy

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Giving Away Free Care

- You can **choose** to provide free care in the office
 - Marketing tool
 - Morale booster
 - Personal altruism
- You shouldn't give free care by accident
 - Collect all money due at the time of service
 - Patients with an outstanding balance don't get out of the waiting room
 - To prevent inadvertent give-aways the staff must know the status of the account, the copay and deductible

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Charge Adjustments



Waiving co-payments routinely is a contract violation and may be subject to criminal penalties

Waiving co-payments on a case by case basis for financially needy with documentation

Providing free or discounted services to uninsured with documentation

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Avoid Embezzlement By Segregating Tasks

- Analyze your front office workflow
- Follow the money
- Ideally, a different person should be responsible for each step of billing and collections
 - Collecting at the time of service
 - Posting charges
 - Posting payments
 - Depositing cash
 - Reconciling EOB's
 - Generating financial reports

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Insurance Plans

The Good Old Days – as recently as 10 years ago

- Avoid M'care/caid
- Limit HMO's
- Assess payments annually and leave the poorest paying 10% of plans

Third Party Payers in 2019 – who knows what's coming

- M'care/caid
 - Published rules
 - Pay promptly
 - Not much worse than managed care
- Payer consolidation
- Limited physician choices

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Managed Care Plans

Where do you start?

- What is your **Payer Mix**?
- What is your **Product Mix**
 - HMO/POS/PPO/M'care/M'caid/Workers Compensation
- How are your **participation agreements** held?
 - Individually, Group, IPA
- How is your **reimbursement terms** determined?
 - % of RBRVS, conversion factors, discount off billed

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Getting Your Money

- Accounts receivable aging
 - 80% should be under 30 days
 - Over 120 should be less than 10%
- Number of days in A/R
- Calculate by dividing the A/R Balance by daily average charges (YTD charges/365 days)
- Goal should be under 30 days



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A/R Controls – Sample Benchmarks

- Posting should be complete and the patient portion collected at the time of service
- Traditional claims processing
 - Claims that haven't passed the clearinghouse – Fatal error rate <2%
 - Claims have been rejected by the insurance company – Denial rate <2%
- Modern claims processing
 - Claims that haven't passed the clearinghouse – Fatal error rate <<<1%
 - Claims have been rejected by the insurance company – Denial rate <<<1%
- A/R ≤38 – high dollar claims will take longer



Understanding Revenue

- CPT coding analysis for E&M codes (i.e., visits)
 - Is the provider billing the appropriate level of service?
 - What is the mix of new versus established patients
 - New patients generate much more revenue
- CPT analysis of orders (e.g., SPT, SCIT, PFT, FeNO, biologics)
 - Is testing and treatment appropriate?
 - Is the provider failing to convert opportunities?

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Audience Response Question #4

Provider CPT code analysis

- A. Allows comparisons over time – trending
- B. Can benchmark within a practice
- C. Motivates providers
- D. Tells you how you compare with other allergists
- E. All of the above

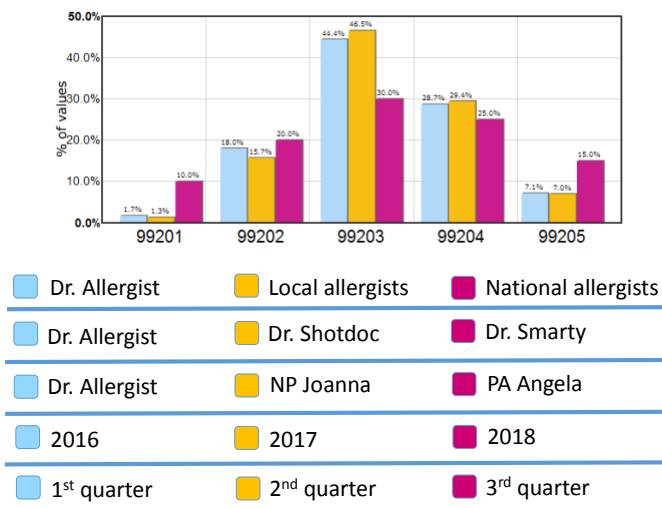
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CPT Provider Code Analysis



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Understanding Expenses

Of every dollar that comes in...
how much goes out for expenses?

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Understanding Expenses

- Overhead ratio – the Holy Grail, not
 - General and administrative expenses (not including physician salary and perks) divided by gross collections
 - Traditional A/I practices – 55-60%
- Distortions to the overhead ratio
 - Use of mid-level providers
 - High cost, high yield therapies
 - IgG replacement
 - Biologics

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Annually Evaluate Fixed Expenses

- Expenses that do not increase with increased operating hours
 - Rent
 - Information systems (EMR, practice manager)
 - Malpractice insurance premiums
 - Salaried employees
- Increasing volume per hour or hours of operation will not impact fixed expenses

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Monthly Evaluate Variable Expenses

- Expenses that are dependent on the hours of operation and the intensity of operation
 - Hourly staff payroll
 - Allergen extracts
 - Drugs
 - Office and medical supplies
- Increasing the amount of activity per hour and the hours of operation will cost money

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Constantly Evaluate Discretionary Expenses!

- Discretionary expenses may or may not be necessary
- Judgments are subjective
 - Generate more net revenue
 - Improve staff morale
 - Improve provider morale
- Beware cost creep!
- Budgeting will help

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Payroll is the Biggest Expense

- Very subjective! Depends on needs and wishes of physicians
 - Cost depends on training and experience
 - For equal experience RN is 40% > RT is 60% > MA
 - Paying high for a training level may be more cost effective than paying low for the next level. (I.E., a great MA may be better than a mediocre RT or RN)
 - Beware of “FTE Creep”

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Information Technology

- EMR
- Medical office management
 - Scheduling with appointment reminders
 - Billing
 - Financial reporting and analysis
- Phone systems – VOIP
- Interoffice communication
- Spirometer
- Can decrease staff costs

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Physician Compensation

- Revenue minus expenses
- Increasing revenue is more likely to result in increased compensation than cutting expenses
- Take the global long view
 - Invest in yourself and your practice
 - Don't shortchange infrastructure

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Business Management Basics New Allergist Track

Richard L. Wasserman, MD, PhD
Managing Partner
Allergy Partners of North Texas

Medical Director
Pediatric Allergy and Immunology
Medical City Children's Hospital

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Practice Marketing: Role of the Allergist

Presented by:
Amanda Reed
Marketing Consultant

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Reputation

60% of a company's value is attributable to its reputation

4 most trusted sources:

- #1- people you know (word of mouth)
- #2- online reviews
- #3- branded sites (Yelp, Facebook, Twitter, Instagram)
- #4- editorial sites (news articles and blogs)

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#1- People You Know

Imperative for physicians to establish and grow relationships with all potential referral sources, community partners and local consumers.

- | | | |
|---------------------|--------------------|-----------------|
| -PCPs | -Chamber | -Health Fairs |
| -Peds | -Non Profits | -Sponsorships |
| -Specialists | -Employers | -Coach/Mentor |
| -Pharmacists | -Education Systems | -Ask the Expert |
| -Healthcare Systems | -Media | |

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#2- Online Reviews

Medical Expertise is Key but Patient Experience is Vital

-Consumers are avid researchers

- 6 out of 7 go online when experiencing a new symptom
- 92% read online reviews prior to making an appointment
- 67% are influenced to select a provider based on online reviews

-Communication and feelings are most important to patients

- | | |
|-------------|----------------|
| -Engaged | -Concerned |
| -Interested | -Understanding |

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#3- Branded Sites

A Google search yields a variety of links to provider and practice profiles resulting in multiple points of engagement.

- Facebook
- Yelp
- Twitter
- Instagram
- HealthGrades
- Vitals
- ZocDoc

77% of consumers will search and review online profiles before booking an appointment

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#4- Editorial Sites

Be a thought leader.

- Blogs
- Mommy/Parent sites
- Email marketing
- Backlinks
- YouTube channel
- Practice website

Content should be human interest (emotion evoking) or research/clinically based.

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Questions?

Contact:
Amanda Reed
AmandaReed.HealthcareMarketing@gmail.com

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Introduction to Coding and Billing

Presented by
Teresa Thompson, CPC, CMSCS, CCC
TM Consulting, Inc.
Carlsborg, WA

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- I have nothing to disclose

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Coding through 2019

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Background

- The desire to develop a consistent “language” to describe standard physician/patient interactions led to the current coding system we now have
- Two types of codes: HCPC Codes (procedure codes) & ICD codes (diagnostic codes)

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Coding Systems

- Purpose: To provide a uniform language that will accurately describe the medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients and third parties
- Use for gathering population statistics and used for reports, outcome studies and cost analysis for covering patient populations in US and rest of the world

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Background – HCPCS Codes

- AMA has standing committee that evaluates and adjusts the existence of the codes (Dr. Gary Gross and Dr. James Sublett are the allergy representative)
- Just because a code exists and is used properly does not mean the involved third party payer accepts the code. (We are required to diligently monitor “explanation of benefits” or “EOBs”)

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Procedure Coding Systems

- Health care provided to patients
- Health care services paid for by third party payers – Medicare, BC, UHC, Aetna, etc.
- Computer systems
- Communication between parties

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Procedure Coding Systems

- Health Care Procedural Coding System (HCPCS):
 - First used in 1966
 - Definition: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians

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Procedure and Diagnosis Coding Systems

- In 2000, the Department of Health and Human Services was designated as the national coding standard for physician and other health care professional services and procedures under the Health Insurance Portability and Accountability Act (HIPAA)

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Healthcare Common Procedure Coding System (HCPCS)

- Codes that describe the patient interactions, from visits to testing procedures or treatment procedures. Fees are set for each “current procedural terminology” (CPT) code for your practice. Reimbursements are based on contract.
- Recent reviews now have established a relative value unit (RVU) for each code to try to create consistency based on work, malpractice, and overhead expense for each procedure

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CPT Code Book

- Modifiers
- Place of service codes
- Evaluation and management services
- Anesthesia
- Surgical procedures
- Radiology procedures
- Lab and pathology procedures
- Medicine guidelines
- Category II guidelines
- Category III guidelines
- Appendix – A-P

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CPT Code Book

Symbols –

^ - Revised code

■ – New code

◆ - New or revised text

+ - Add on code

- Out of numerical sequence code

*Telemedicine

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CPT Code Book

Modifiers

- 22 – Increased procedural services
- 25 – Significant, separately identifiable E/M by the same physician or qualified health care professional on the same day of the procedure or other service
- 26 – Professional component
- 32 – Mandated service
- 52 - Reduced services
- 76 – Repeat procedure or service by same physician or other qualified health care professional
- 95 – Telehealth services

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CPT Code Book

Place of Services

- 02 – Telehealth
- 03 – School
- 11 – Office
- 12 – Home
- 19 – Off campus outpatient hospital
- 20 – Urgent care
- 21 – Hospital
- 22 – On campus outpatient hospital
- 23 – Emergency room – hospital
- 31 - Skilled nursing facility

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HCPCS Level II Book

- Services not covered with a HCPCS Level I code
 - Example – cosmetic procedure
- Ambulance procedures
- Dental procedures
- Supplies and durable medical goods
- Medications
- Medicare specific codes – services, supplies, MIPS, MACRA codes
- Blue Cross specific codes

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Diagnosis Coding (The medical necessity for the encounter)

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Diagnosis Codes

- Created by the Centers for Disease Control and Center for Medicare and Medicaid services
- HIPAA requires we use ICD-10CM codes for claims
- Revised yearly –
- Committees meet during the year and take recommendations from societies regarding changes, additions and deletions should be made to the code
- ICD-11 is currently in review from the WHO for use
- Purposed change from ICD-10 to ICD-11 – 2019???

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Diagnosis Coding

- Various publications available – in hard back
- EHR – should be updated yearly with new codes
- “Favorites” list should be reviewed yearly to edit for deletions, corrections and additions
- One hard bound copy should be in each office

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Diagnosis Coding

- Coding from a book –
 - Code from the tabular section
 - Read the subsection heading guidelines
- Coding from an electronic device
 - Read subsection guidelines for code
 - Code to the specificity known at the time of coding

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Diagnosis Codes

- All active diagnoses should be used in any patient interaction. Level of importance for that diagnosis should be documented. (Important to support complexity of visits later on and link each diagnosis to procedure!)

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Diagnosis Codes

- Must link the diagnosis code with each procedure code used for billing purposes
- With ICD-10 CM codes, you may use up to 12 diagnosis codes for each claim

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Basics of Diagnosis Coding

- Select the code which corresponds to a diagnosis or reason for visit documented in the medical record
- Diagnosis codes are reported at the highest level of specificity documented
- Codes that describe symptoms and signs as opposed to diagnoses are acceptable for reporting purposes when a related definitive diagnosis has not been established by the provider
- Signs and symptoms that may not be associated routinely with a disease process should be coded separately
- Acute and chronic may be reported if separate subentries exist. The acute code is sequenced first.

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Basics of Diagnosis Coding

- Chapter J guidelines
 - When a respiratory condition is described as occurring in more than one site and is not specifically indexed, it should be classified to the lower anatomical site
 - Use additional code, where applicable to identify:
 - Exposure to environmental tobacco smoke (Z77.22)
 - Exposure to tobacco smoke in the perinatal period (P96.81)
 - History of tobacco use (Z87.891)
 - Tobacco dependence (F17.-)
 - Tobacco use (Z72.0)

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Basics of Diagnosis Coding

- Excludes 1 – two codes may not be coded together on the same claim
- Excludes 2 – Two codes are usually not coded together but in some circumstances may be allowed

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Basics of Diagnosis Coding

- Use additional codes to identify infectious agents for tonsillitis, sinusitis, etc – if you know
- Excludes 1 examples
- J30 – subsection
 - Excludes J45.909 - unspecified asthma
 - Excludes – rhinitis NOS (J31.I0)
- L50 – Urticaria
 - Excludes angioneurotic edema (T78.3)
 - Excludes contact dermatitis (L23.-)

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Basics of Diagnosis Coding

Chapter 19 – Injuries, poisoning and certain other consequences of external causes requires the 7th character

- A – Initial encounter while the patient is receiving active treatment for the condition. Examples of active treatment – emergency department encounter and evaluation and continuing treatment by the same or a different physician
- D – Subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.
- S – The residual effect (condition produced) after the acute phase of an illness has terminated. There is no time limit. Sequela coding generally requires two codes sequenced in the following order: the condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

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Basics of Diagnosis Coding

- Chapter 19 - Subsection guidelines for Poisoning by, adverse effects of and under-dosing of drugs, medicaments and biological substances (T36-T50)
 - Includes adverse effect of correct substance properly administered
 - Poisoning by wrong substance given or taken in error
 - Poisoning by overdose of substance
 - Under-dosing by (inadvertently)(deliberately) taking less substance than prescribed or instructed
- Code first, for adverse effects, the nature of the adverse
 - Dermatitis due to substances taken internally
 - Urticaria
 - Pruritus
 - Erythema
- Codes from the T36-T50 will be sequenced second

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Basics of Diagnosis Coding

- Status - Indicates that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition.
 - The status code is informative, because the status may affect the course of treatment and its outcome.
- History – Indicates that the patient no longer has the condition

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Basics of Diagnosis Coding

- Do not use the status code with a diagnosis code from one of the body system chapters if the diagnosis code includes the information provided by the status code
- Alphabetical index list food and bee Z codes under “history – personal – allergy

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Basics of Diagnosis Coding

Z codes

- Z codes may be listed as the primary diagnosis code
- Z23 is for encounters for vaccinations. The procedure code required will identify the actual administration of the injection and the type(s) of immunizations given.
- Z01.82 – “Encounter for allergy testing without complaint, suspected or reported diagnosis”
- Z88 - Allergy status to drugs, medications and biological substances

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Diagnosis Coding Guidelines

- Code for why the patient sought medical advise
- Do not code probable, possible, or rule out diagnosis
- Code to the highest level of ICD-10CM code that is available

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Diagnosis Coding Guidelines

- When other conditions exist, these conditions should be coded additionally
- The co-morbidities must be addressed in the note as to the impact on the allergy/asthma diagnoses
- Chronic diseases may be coded as often as necessary

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Documentation

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Documentation – the beginning for all coding

Document, Document, Document!!!!

- If it's not recorded, it did not happen!
- If it is illegible – it did not happen!
- If it is not specific, it may not be reimbursed
- If it is “cloned” it doesn't count

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Documentation

HIPAA:

- Documentation had to reflect the codes submitted for payment
- Law created for Health Care Fraud & Abuse Control through the HHS & OIG
- Covers Medicare, Medicaid and private health care industry

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Documentation

HIPAA - Penalties

- \$2,000-\$10,000 per incident & limit increased to not more than three times the amount
- Presenting a claim for an item or service based on a code that a person knows or should know will result in greater payment than appropriate
- Third party payers are doing a percentage error rate and then multiplying it times the universe of payments

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Documentation

• Penalties

- A person submits a claim that they know or should know is for a medical item or service not medically necessary
- Criminal penalties for “knowingly and willingly” attempting to defraud

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Coding for Evaluation and Management Services

CPT 99201-99215

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Codes Based on Complexity of Visit

Three key components:

- History
- Examination
- Medical decision making
- Time - only if 50% or more of the encounter is counseling and coordination of care

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General Principles of Documentation

- Complete & legible
- Each encounter should include:
 - Chief complaint
 - Relevant history
 - Physical exam findings
 - Prior diagnostic tests
 - Assess/impression/diagnosis
 - Plan for care
 - Date & verifiable legible identity of the provider

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Chief Complaint

- Chief complaint can be part of the HPI or separate
 - Chief complaint is to be in the patient's own words or summary of the reason why the patient is seeking medical care
 - If chief complaint is for a "procedure or diagnostic test" third party payers will consider the E/M "incidental" to the procedure or diagnostic test and will not reimburse for the E/M

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Relevant History

- The billing provider is responsible for obtaining and documenting the history of present illness
2019 – staff may document but provider must indicate a review of information
- The review of systems, past, family and social history may be obtained by the staff, but it needs to be reviewed by the provider

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History Levels

- Patient history taking can range from brief (chief complaint only) to very detailed and extensive including complete review of systems, past history & social history
- **MUST DOCUMENT IF CLAIMING TO BE DONE!!!**

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HPI: History of Present Illness

- Location – specific to area of the body
- Quality – describe the pain – dull, sharp; wound jagged, dirty or clean
- Severity – measure on a scale
- Duration- how long, since when, etc.

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HPI: History of Present Illness

- Context - how complaint occurred
- Modifying factor - what has alleviated symptoms
- Signs and symptoms – additional information from patient
- **HPI elements need to be verified by provider if documented by staff**

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Review of Systems

- **Ten** are required for a complete ROS
- Pertinent positives and negatives must be documented
- A notation of negative for the remaining review of systems may be documented for the remaining systems

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Review of Systems

- Can be documented by staff patient
- Must be reviewed by physician
- Can be separate or part of the HPI
- Cannot use one statement in both categories

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Past, Family and Social History

- Past – events in the patient's past medical/surgery history
- Family – diseases that impact patient's health
- Social - factors which are age appropriate that impact from an environmental and social pattern

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Physical Exam

- Pertinent positives and negatives need to be documented to count toward the appropriate level of E/M
- Document what you find and what you exam even if it is negative
- Remember if it isn't documented

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Exam

- The 1995 guidelines or the 1997 guidelines can be used for documentation
- Allergy has a specific exam for the specialty in 1997
- Abnormal findings must be described
- Normal findings can be indicated by negative

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Physical Examination

- **Problem focused** – one body area or organ system;
Level 1
- **Expanded problem focused** – 2-4 body areas or organ systems; **Level 2-3 – established pt.**
- **Detailed** – 5-7 body areas or organ systems; **Level 4 – established pt**
- **Comprehensive** – 8 or more body areas or organ systems; **Level 5 – established pt**

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Diagnostic Tests

- The medical decision to order tests, review tests or perform diagnostic testing needs to be indicated in the body of the E/M
- CMS indicated several years ago the lack of medical necessity in allergy for performing allergy testing and desensitization was found in many cases reviewed

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Assessment, Impression

- If diagnoses are documented as “rule out possible, probable, I think it is consistent with, etc” the correct diagnoses to code on the billing are the presenting signs and symptoms for the patient
- If a definitive diagnosis is documented, the definitive diagnosis is the appropriate diagnosis to use on the billing

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Documentation Principles

- If not specifically documented, the rationale for ordering diagnostic test and other ancillary services should be able to be easily inferred
- Past & present diagnosis and conditions should be accessible to the treating and/or consulting provider, but not coded unless they are addressed today

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Allergy Testing and Immunotherapy Documentation

- Document the medical necessity of testing based on hx, ex for the patient
- Document the results of the allergy testing together with the actual test
- Document the need for immunotherapy versus other pharmaceutical options
- Document the recipe
- Document the number of anticipated doses the patient will receive when preparing the doses
- Document review and orders for reviews for immunotherapy

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Documentation Principles

- Appropriate risk factors should be identified
- Progress, response, changes in treatment, planned follow-up care and instructions, and diagnosis
- CPT & ICD10-CM codes should be the same on the billing form as in the chart

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Plan/Recommendation

- This information is necessary to indicate how the patient is going to be cared for currently and for future services
- Signature of the provider indicates that the provider is attesting to the validity of the encounter and the encounter supports the charges presented to either the patient or the insurance carrier
- Attesting provider is accountable for any other person's documentation in the patients' chart

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New Patients Versus Consults

- Consultation requires a request from another provider for your opinion and advise
- Your opinion must be rendered back to the requesting provider
- There cannot be a transfer of care prior to seeing the patient
- Many payers are not covering consultation codes since CMS has stopped recognizing the 99241-99245 as payable codes

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Additional Documentation Requirements for Consultations

- Note must state that the patient was sent for consultation and state the requesting physician's name as well as the reason for the consult
- Note must state the findings
- Note must indicate that a report was sent to the requesting physician
- Assumption is that patient's follow up care may be provided by requesting physician

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Follow up visits – 99211-99215

- Follow up office visit codes require a less stringent criteria to establish “complexity” levels
- A patient seen by any provider in your office within the last 3 years is a follow up visit patient
- If the physician changes practices, patient is considered established
- More than 3 years between visits makes the interaction a “new” patient visit

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Medical Decision Making

- Number of diagnosis and treatment options
- Amount of data and complexity of data
- Risk

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Number of Diagnosis and Treatment Options

- Established problem stable
- Established problem worsening
- Established problem, improved
- New problem, no workup planned
- New problem, workup planned

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Amount and Complexity of Data

- Review/order lab tests
- Review/order routine x-rays
- Review/order medicine tests
- Discussion of tests results with performing physician

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Amount and Complexity of Data

- Decision to obtain old records and document
- Direct visualization and independent interpretation documented

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Risk

- Presenting problem
- Diagnostic procedure
- Management options

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Presenting Problem

- Minimal:
 - One self limited or minor problem
- Low:
 - Two or more self-limited or minor problems
 - One stable chronic illness
 - Acute uncomplicated illness/injury

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Presenting Problem

- Moderate:
 - One or more chronic illness with mild exacerbation
 - Two or more stable chronic illnesses
 - Undiagnosed new problem with uncertain prognosis
 - Acute illness with systemic symptoms
 - Acute complicated injury

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Presenting Problem

- High:
 - Chronic illness with severe exacerbation
 - Acute or chronic illness/injury that may pose a threat to life or bodily function

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Diagnostic Procedures Ordered

- Minimal:
 - Lab tests requiring venipuncture
 - X-rays
 - Ultrasounds
- Low:
 - Superficial needle biopsies
 - Skin biopsies
 - Pulmonary function tests

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Management Options

Minimal:

- Rest
- Gargles
- Elastic/superficial dressings

Low:

- Over the counter drugs – saline washes
- Minor surgery – ear piercing
- Physical therapy

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Management Options

Moderate:

- Minor surgery with risk
- Elective major surgery
- **PRESCRIPTION DRUG MANAGEMENT**
- Closed treatment of fracture w/o manipulation

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Management Options

High:

- Elective major surgery with risk
- Emergency major surgery
- Decision not to resuscitate or de-escalate care because of poor prognosis
- Drug therapy requiring intensive monitoring for toxicity
- High morbidity mortality without treatment

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Key Components: Medical Decision Making

- Straightforward Level 1 & 2
- Low Level 3
- Moderate Level 4
- High Level 5
- Medical decision making remains the same for new patients, established patients, inpatient and outpatient consultations

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Calculation of Level of Complexity

- For new patients the level is based on the lowest level of the three key components
- For established patients based on the lowest level of 2 out of 3 components
- Medical decision making must always be one of the two components for an established patient encounter
- Medical necessity is the over arching criteria

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CONSULT-HOSPITAL	99251	99252	99253	99254	99255
CONSULT-3 of 3	99241	99242	99243	99244	99245
NEW PT- 3 of 3	99201	99202	99203	99204	99205
HISTORY					
CHIEF COMPLAINT	Required	Required	Required	Required	Required
HX of PRESENT ILL	Brief(1-3)	Brief(2-3)	Extended(4+)	Extended(4+)	Extended(4+)
REVIEW OF		Problem	Extended	Complete	Complete
SYSTEMS		Pertinent (1)	(2-9 System)	(10 + system)	(10+ system)
PAST HX			Pertinent-1	Complete-1ea	Complete-1ea
FAMILY HX			Pertinent-1	Complete-1ea	Complete-1ea
SOCIAL HX			Pertinent-1	Complete-1ea	Complete-1ea
EXAM					
	Perform/ document	Perform/ document	Perform/ document	Perform/ document	Perform document
	1 organ sys	2-4 organ sys	5-7 organ sys.	8 organ systems	8 organ systems
MED. DEC MAKING					
	(2 of the 3 must be met or exceeded)				
MGMT OPT. & DX.	Minimal (1)	Minimal (1)	Limited (2)	Multiple (3)	Extensive(4)
AMT DATA & COMPLEX	Minimal(1)	Minimal (1)	Limited (2)	Moderate (3)	Extensive(4)
RISK OF COMPLICAT.	Minimal	Minimal	Low	Moderate	High

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ESTABLISH PT	Level 1	Level 2	Level 3	Level 4	Level 5
2 OF 3	99211	99212	99213	99214	99215
HISTORY					
CHIEF COMPLAINT	Required	Required	Required	Required	Required
HX PRESENT ILL.		Brief	Brief	Extended	Extended
SYSTEM REVIEW			Prob. Pertinent	Extended	Complete
PAST HISTORY				Pertinent-1	Complete:
FAMILY HISTORY				Pertinent-1	Choice of 2
SOCIAL HISTORY				Pertinent-1	ele PFS Hx.
		Perform/	Perform/	Perform/	Perform/
EXAM		document	document	document	document
		1-3 systems	4-6 systems	5-7 systems	8 systems
MED. DEC MAKING					
MGMT/OPTION DX		Minimal (1)	Limited (2)	Multiple (3)	Extensive(4)
AMT DATA/COMPLEX		Minimal(1)	Limited(2)	Moderate(3)	Extensive(4)
RISK OF COMPLICAT.		Minimal	Low	Moderate	High

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Time Based Coding

- When counseling and coordination of care are greater than 50% of the service, code by time
- Must have total face to face time
- Total time spent in counseling or coordination
- Details of the discussion

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Time vs. Coding by Key Components

- Code either by **time** or **key component** – you do not code by both
- Time is not a consideration when coding by key component

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Time Tables – New Patient

99201	10 minutes
99202	15 minutes
99203	30 minutes
99204	45 minutes
99205	60 minutes

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Time Tables – Established Patient

99211	5 minutes
99212	10 minutes
99213	15 minutes
99214	25 minutes
99215	40 minutes

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Basic Allergy Procedures

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Pulmonary Codes

PFTs:

- 94010 – spirometry
- 94060 – Bronchodilation responsiveness, spirometry as in 94010, pre and post bronchodilator administration
- 94070 – Bronchospasm provocation evaluation, multiple spirometric determinations with administered agents
- 95070 – Inhalation bronchial challenge testing

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Allergy Testing Codes

Skin testing codes:

- 95004 - Scratch testing
- 95024 - Intradermal

- Precutaneous/Intradermal:
 - 95017 – venoms
 - 95018 – drugs or biologicals

- 95044 - Patch tests:
- Remember you need to document the results of the tests as part of the testing code

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Allergy Codes

Immunotherapy codes:

- 95165 - Professional services for the supervision or preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specific number of doses)
- 95145-8 for venoms
- 95170 – Fire ant extract or other biting insect
- 95115 or 95117 - Extract administration

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Billing

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Payment Methodology

Usual and customary terms:

- RVU – Relative value units
- ACO – Accountable Care Organizations
- MH – Medical home models
- Value based payments for containing cost
- MACRA's, MIPS

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CMS - RVU

- Values for RVUs are modified on a yearly basis
- Three components – work RVU, overhead RVU, malpractice RVU
- Conversion factor is determined by Congress and CMS based on economic index factor

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Medicare Part A vs. Part B – Private Payers

- Part A – hospitals are reimbursed with DRG's
- Part B – physician and non-physician provider reimbursement for fee for service
- Medicare Advantage programs – adopts some of third party payer guidelines but must follow Medicare guidelines for medical necessity
- Other payers may use RVU values and a conversion factor determined by their actuary

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Payment Methodology

- Usual and customary was used until 1992 for reimbursement of services provided by physicians and other health care entities
- RVU – Relative value units
 - Based on a scientific basis to determine values of codes: work, practice expense, malpractice
 - Non facility or facility
 - GPCI (Geographic Price Cost Index)

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The Value of CPT Codes by CMS

$$\text{Payment} = (\text{work} \times \text{GPCI} + \text{PE} \times \text{GPCI} + \text{MP} \times \text{GPCI}) \times \text{CF}$$

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RVUs CMS Fee Schedule

- Headings
- Columns
- Values
- (Let's look at some codes)
- www.cms.gov/PhysicianFeeSched/PFSRVF/

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RVU quick look

- Code – 95004
- Description – Percut allergy skin test
- Status code – A – Active
- Work RVU – 0.1
- Non-fac PE – 0.10 – 2018 .13
- Fac PE – 0.10 – 2017 .13
- Mal Prac – 0.01
- Total non Fac – 0.12
- Total Fac – 0.12
- Conversion factor - \$36.04
- GPCI for local area for MAC to apply
- Physician supervision - 02 (direct)

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CPT/HCPCS	Mod	Status	Not Used for Medicare Payment	Description	2018 Work RVUs ²	2018 Non-Facility PE RVUs ²	2019 Non-Facility PE RVUs ²	2019 Facility PE RVUs ²	2019 Mal-Practice RVUs ²	Total Non-Facility RVUs ²	2019 total Non-Facility RVUs ²	Total Facility RVUs ²	2019 Total Facility RVUs ²
95004		A		Percut allergy skin tests	0.01	0.13	0.10	NA	NA	0.01	0.15	0.12	NA
95012		A		Exhaled nitric oxide meas	0.00	0.56	0.56	NA	NA	0.01	0.57	0.57	NA
95017		A		Perq & icut allg test venoms	0.07	0.14	0.15	0.03	0.03	0.01	0.22	0.23	0.11
95018		A		Perq&ic allg test drugs/biol	0.14	0.45	0.46	0.05	0.06	0.01	0.60	0.61	0.20
95024		A		Icut allergy test drug/bug	0.01	0.21	0.21	0.01	0.01	0.01	0.23	0.23	0.03
95027		A		Icut allergy strate-airborn	0.01	0.11	0.11	NA	NA	0.01	0.13	0.13	NA
95028		A		Icut allergy test-delayed	0.00	0.36	0.36	NA	NA	0.01	0.37	0.37	NA
95044		A		Allergy patch tests	0.00	0.15	0.15	NA	NA	0.01	0.16	0.16	NA
95052		A		Photo patch test	0.00	0.18	0.18	NA	NA	0.01	0.19	0.19	NA
95056		A		Photosensitivity tests	0.00	1.28	1.29	NA	NA	0.02	1.30	1.31	NA
95060		A		Eye allergy tests	0.00	0.99	0.98	NA	NA	0.01	1.00	0.99	NA
95065		A		Nose allergy test	0.00	0.70	0.73	NA	NA	0.01	0.71	0.74	NA
95070		A		Bronchial allergy tests	0.00	0.86	0.88	NA	NA	0.02	0.88	0.90	NA
95071		A		Bronchial allergy tests	0.00	0.99	1.04	NA	NA	0.01	1.00	1.05	NA
95076		A		Ingest challenge ini 120 min	1.50	1.83	1.87	0.55	0.59	0.06	3.39	3.43	2.11
95079		A		Ingest challenge addl 60 min	1.38	0.95	0.99	0.50	0.54	0.05	2.38	2.42	1.93
95115		A		Immunotherapy one injection	0.00	0.24	0.25	NA	NA	0.01	0.25	0.26	NA
95117		A		Immunotherapy injections	0.00	0.28	0.29	NA	NA	0.01	0.29	0.30	NA
95120		I		Immunotherapy one injection	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
95125		I		Immunotherapy 2/> injections	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
95130		I		Immnix 1 sting insect	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
95131		I		Immnix 2 sting insects	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
95132		I		Immnix 3 sting insects	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
95133		I		Immnix 4 sting insects	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
95134		I		Immnix 5 sting insects	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
95144		A		Antigen therapy services	0.06	0.31	0.34	0.02	0.02	0.01	0.38	0.41	0.09
95145		A		Antigen therapy services	0.06	0.66	0.74	0.02	0.02	0.01	0.73	0.81	0.09
95146		A		Antigen therapy services	0.06	1.27	1.43	0.02	0.02	0.01	1.34	1.50	0.09
95147		A		Antigen therapy services	0.06	1.36	1.48	0.02	0.02	0.01	1.43	1.55	0.09
95148		A		Antigen therapy services	0.06	1.97	2.16	0.02	0.02	0.01	2.04	2.23	0.09
95149		A		Antigen therapy services	0.06	2.61	2.90	0.02	0.02	0.01	2.68	2.97	0.09
95165		A		Antigen therapy services	0.06	0.30	0.33	0.02	0.02	0.01	0.37	0.40	0.09
95170		A		Antigen therapy services	0.06	0.21	0.23	0.02	0.02	0.01	0.28	0.30	0.09
95180		A		Rapid desensitization	2.01	1.77	1.83	0.82	0.87	0.08	3.66	3.92	2.91
95199		C		Allergy immunology services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Billing

- Credentials with payers
- Contracts with payers
 - Allowed amounts known and keyed into practice management system
 - Denials are identified and worked prior to any write offs
- Timeliness for payment

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Questions???

- Thank you for attending.

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