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Ohio Podiatric Medical Association
Journal

OHIO PODIATRIC MEDICAL ASSOCIATION

INSIDE THIS ISSUE

President's Message

A View of The Road Ahead

by David Hintz, DPM, MPH, CPH

2012 OPMA PRESIDENT

Good summer to everyone. I trust it is going well. I want to commend the OPMA staff and all volunteers for a spectacular program for Region IV. Work has already begun on next year's program. I especially commend Larry DiDomenico, DPM; Mark Mendeszoon, DPM; and Jeffery Robbins, DPM for their hard work and service to our program.

I write to you to make a few comments. First, our profession is the best profession to be in of all of the medical professions. And it is the best time to be in it. Demographics are perfect, and the population to be served continues to grow. Virtually every government health agency and private insurance company recognizes and promotes the importance of foot care for diabetics and PAD patients. This momentum is helping create policy for other high-risk groups, including rheumatoid patients (any collagen disorder), patients with neuropathy of any cause, and patients on immune suppressive therapy such as transplant patients, and the list goes on. Our profession has benefited from billions of dollars' worth of free promotion, because our services are that important and that cost effective. It is also noteworthy that there is a statistically significant difference in outcomes when a podiatrist provides the care versus someone from another profession. Thompson Reuters and Duke both confirmed this independently.

Second, the merger of the Ohio College of Podiatric Medicine with Kent State University will form the Kent State College of Podiatric Medicine on July 1, 2012. Opportunities for multi-disciplinary research will be created. Kinesiology and engineering are disciplines that come to mind that have ties with our profession, and the list is endless. Possibilities are limited only by imagination. We have a great future with this merger, but we must work to make it happen.

Several issues, however, will be threats to our profession. We don't know how the Affordable Care Act will fare in the Federal Supreme Court, but no matter the decision parts of the bill will affect both health policy and business regulatory policy. Remember, we are small businesses as well as health care providers. This is always a two-edged sword. I will detail my thoughts on these areas in the next newsletter. As you know, we are waiting for the appeals decision for our fair-pay matter. Once that is done, we can decide how best to proceed. Until then, enjoy the summer, the time with your family and friends; and please remember to support OPPAC. If we don't defend ourselves no one will do it for us.

I say again—it is a great time to be in our profession, and it is the best of all the medical professions. I sincerely believe in our future.

Regards, David

REPRESENTING YOU

Legislative Update

A Sad Good-bye

Regretfully, I must begin by informing OPMA that our number one lobbyist, Charlie Solley, left Capitol Consulting in June to assume a new position as a governmental relations lobbyist at Akron's Children's Hospital. Charlie was proud to represent you and OPMA in all facets of government relations. He will be sorely missed. We wish Charlie the best.

The Legislative Side

A few of the many items we watched were regarding healthcare and insurance contracting.

Senate Bill 294

SB 294 – A surprisingly non-controversial update to laws impacting the Ohio Environmental Protection Agency was finalized by the General Assembly and sent to Governor Kasich. Thankfully the co-mingling of biomedical waste by small generators (under 50 pounds per month) was exempted and remains intact. You may dispose of medical waste with regular waste management services unless special handling is required due to biohazard content. This legislation ends two years of meetings and lobbying to remain exempt as a small generator. The OPMA and Ohio Dental Association were indeed instrumental in keeping providers (i.e., small generators) exempt.

Senate Bill 136

SB 136 – Provider Agreements/Prior Authorization – The legislation would prohibit health insurers from making material changes to existing contracts without those changes being mutually agreed upon and it also prohibits health insurers who have given prior authorization approval for a service from retroactively issuing a denial for that service.

Senate Bill 301

SB 301 – Prescription Drugs – A clean-up bill to HB 93 from last year which dealt with regulating certain prescription drugs (aka *The Pill Mill Bill*).

SB 301 contains language regarding reporting limited drug samples and procedures of the Ohio Dental Board.

Senate Bill 324

SB 324 – Insurance Reimbursement – The Healthcare Provider Coalition was informed about this due to problems encountered by the Ohio Dental Association. This legislation would prohibit a health insurer from reimbursing dental providers based upon a fee schedule if the dental services provided are not covered by any contract or participating provider agreement between the health insurer and the dental provider.

House Bill 259

HB 259 – The Ohio Podiatric Medical Association expressed our opposition to House Bill 259. This legislation would risk patient safety by not having regulatory oversight of individuals who could practice alternative health care without standards, validation of competency or education.

House Bill 487

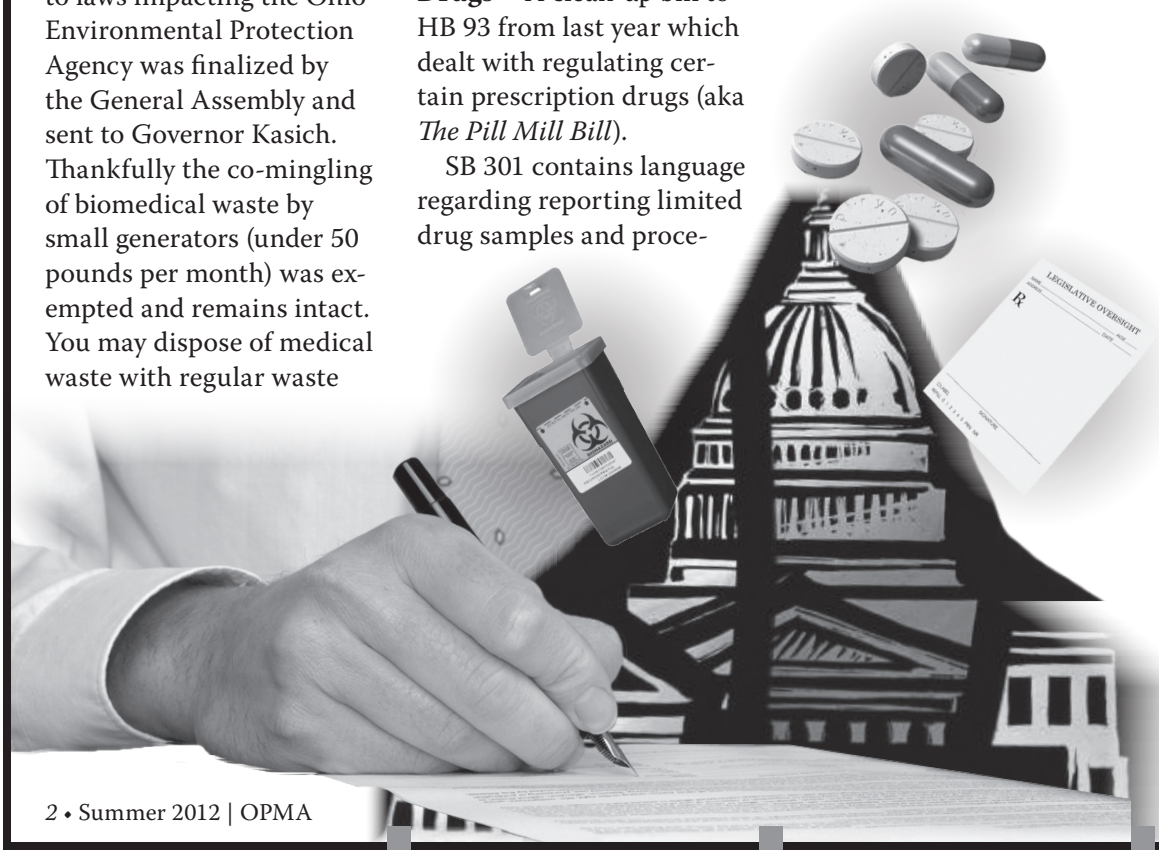
HB 487 – Mid-Budget Review Bill – This legislation passed the House with mainly "general government provisions." Taxation, education, energy and other initiatives will be dealt with in separate bills. The bill contained very few health care issues.

House Bill 412

HB 412 – Health Insurance Exchange – This legislation would establish a health insurance exchange in Ohio as required by the federal health care legislation.

House Bill 479

HB 479 – Ohio Asset Management Modernization Act – OPMA wrote legislators to support this legislation that will create the Ohio Legacy Trust Act to modernize trust laws. It will modify property rights and amend laws regarding the creation and management of trusts.



Duals Demonstration Project

Ohio recently submitted its final proposal to CMS in Washington to establish a three-year "demonstration project" to provide service to 118,000 Ohioans who are covered by both Medicaid and Medicare. The Final plan submitted by Ohio would deliver services to these "duel eligible" in seven service regions.

Prescribing for Self and Family Members

With respect to self-prescribing, a physician is prohibited from self-prescribing or self-administering controlled substances [OAC Rule 4731-11-08].

by Kimberly Anderson, Esquire
Assistant Executive Director, Investigations, Compliance & Enforcement – State Medical Board of Ohio

Every year, the State Medical Board receives complaints involving physicians who prescribe to themselves or to family members. Standard of care requires physicians to be able to use detached professional judgment in treating patients. It is not possible for physicians to exercise detached professional judgment dealing with their own care or close family members' care.

Since 1998, Rule 4731-11-08, Ohio Administrative Code, prohibits prescribing controlled substances by physicians to themselves and to close family members. For this rule, a family member means a spouse, parent, child, sibling or other individual where the physician's personal or emotional involvement may render the physician unable to exercise detached professional judgment.

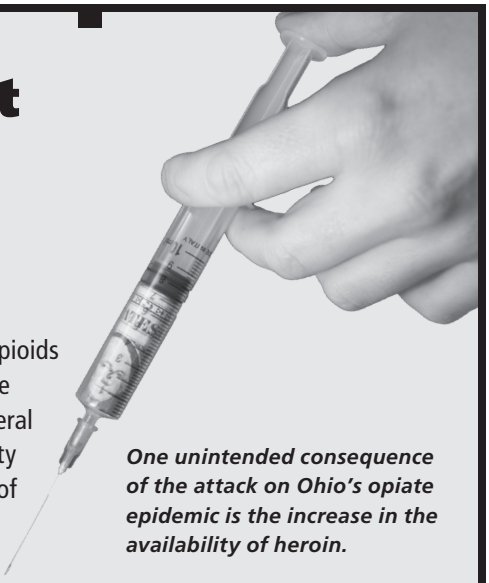
A physician may only use controlled substances to treat one of the above-described family members in an emergency situation. The treatment must be documented in the patient's record. All other prescribing of controlled substances to close family members is not permitted and is a violation of the Medical Board's rule.

With respect to self-prescribing, a physician is prohibited from self-prescribing or self-administering controlled substances. A physician may obtain an over-the-counter schedule V controlled substance for personal use when it is obtained in compliance with state and federal laws, and in the same manner a non-physician would obtain it.

To review the entire rule, please go to: http://codes.ohio.gov/oac/4731-11-08

Thought about Opioids Lately?

Though prescription opioids remain highly available throughout Ohio, general decreases in availability exist in many regions of the state.



One unintended consequence of the attack on Ohio's opiate epidemic is the increase in the availability of heroin.

The Effects of House Bill 93

The decrease in availability has also been attributed to the passage of House Bill 93, which Ohio passed in May 2011. HB93 called for the closing of "pill mills" around the state, increased regulation at pharmacies, and additional regulations for Ohio's physicians, dentists, and pharmacists in dealing with prescriptions for opioid painkillers.

Pharmaceutical companies have also reformulated many prescription painkillers to a tamper resistant formulation.

Unintended Consequences

While much of the work around the bill has been successful to combat prescription painkiller abuse, heroin is now making a comeback. With lower prices and increased availability, Ohio faces a new challenge. One unintended consequence of the attack on Ohio's opiate epidemic is the increase in the availability of heroin. Heroin has become highly available throughout Ohio, with law enforcement identifying heroin trafficking as a primary concern with the increased demand being attributed to the realization that heroin is easier to obtain than prescription opioids, and that it is cheaper.

On average, street cost for prescription painkillers is between 50 cents and $1 per milligram and range in strength from 10mg to 160mg pills. In Dayton, Ohio, the street cost for heroin is approximately $10 per 100mg, or one dose.

| Primary Source: Prescription Painkillers to Heroin: Diversion in Ohio – OACBHA News |

From The Desk of the Executive Director

Time to Gear Up for Summer!

by Jimelle Rumberg, PhD, CAE

Hear ye, Hear ye, Hear ye.

It's now time to enjoy the summer. With the Coding Seminar and Region IV meetings officially behind us, it's time that OPMA begins to work on the OPMA House of Delegates and the 2013 APMA Region IV seminar.

Thank You, Thank You!

Sincere thanks goes to our Region IV co-chairs—Dr. Larry DiDomenico and Dr. Mark Mendeszoon as well as Chair Emeritus, Dr. Jeff Robbins. These physicians undertook a lofty task and developed an absolutely stellar seminar for attendees.

If you missed the seminar, you missed one heck of a great meeting. It is through your attendance at Region IV that we can keep your dues in check (and not raise dues). So next year, when you decide where to spend your CME dollar, consider the APMA Region IV in Columbus and support the association that works for you on a *daily* basis.

Region IV Research and Topics

We realize that our academies host dynamic programs; however, we need your support to continue to grow our meeting successfully. In 2013, Dr. Larry Osher and Dr. Bryan Caldwell will co-chair our Region IV. If you're willing to share your research or a program topic please contact OPMA by September. We will be getting a jump start this year to release our 2013 programming earlier, so don't delay.

By the way, four OPMA members shared their research at the Region IV. They were **Dr. John Roseman, Dr. Gary Unsdorfer, Dr. Angelo Petrolla** and **Dr. Marc Greenberg.** The evaluations were outstanding!

APMA Lecture Series and More

Region IV also had the APMA Lecture Series, two great cadaver labs, the Gerard V. Yu, DPM Memorial Residency Paper Competition plus a great PICA lecture series. The weather was perfect and the exhibit hall was booming with lots of activity.

We officially sold out of exhibit space one month before the meeting and had 10 companies on our waiting list! Thanks to all involved for making our meeting a success. It was a great time—check out the event photos.

More Thanks Needed

We would also like to thank CGS, The State Medical Board, ODJFS and OCPM for their informational booths. Many attendees received one-on-one assistance to their Medicare and Medicaid billing and coding questions, and we were pleased to see so many physicians taking advantage of having these agencies at our seminar.

Looking Forward

As summer wanes in a few months, please remember that your local academies will gear back up for fall CME and meetings.

Get Geared Up This Summer

- Watch your email for constant updates on Federal and State issues.
- Become an active member by giving professional service as a volunteer.
- Donate to OPPAC to keep podiatry strong in Ohio.
- Consider a leadership role in OPMA. It's certainly *not* just someone else's obligation to serve your profession.

I look forward to working with everyone in every academy as we continue to grow a solvent and productive OPMA.

MARK YOUR CALENDAR

September 20-21, 2012
GXMO Didactic Course
OPMA Office I Columbus

September 22, 2012
GXMO Clinical Course
OPMA Office I Columbus

September 22, 2012
6th Annual Quickie Seminar
from 7:30 AM to 5:00 PM
7.5 CMEs (pending)
Wyndam Garden Hotel I Dayton
31 Prestige Place
Miamisburg, Ohio 45342
OPMA Cost: $50
Non-OPMA member: $125

October 25-28, 2012
Super Saver Seminar
Airport Marriott Hotel I Cleveland

November 8-9, 2012
GXMO Didactic Course
OPMA Office I Columbus

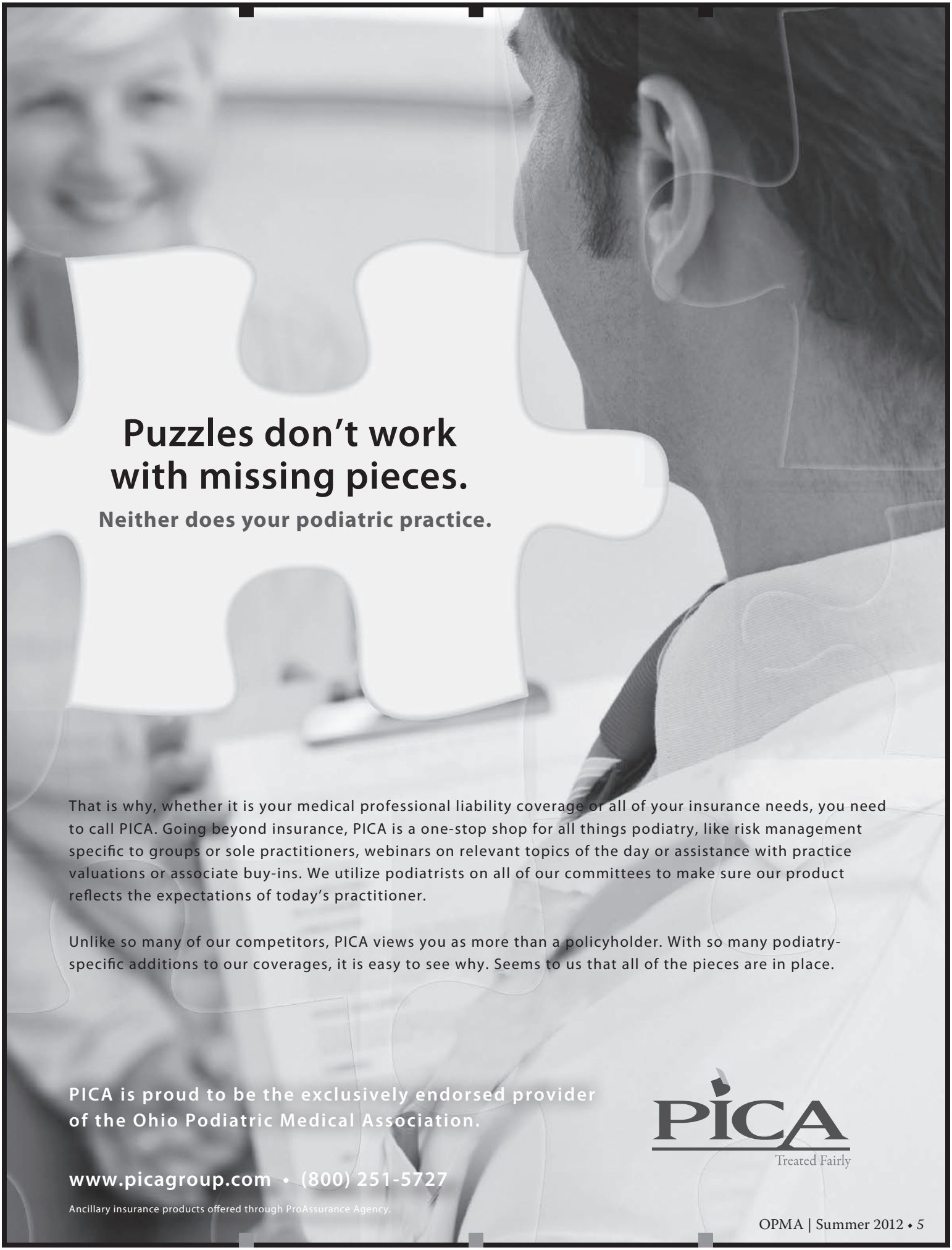
November 10, 2012
GXMO Clinical Course
OPMA Office I Columbus

Nov 30 – Dec 1, 2012
OPMA House of Delegates
Airport Embassy Suites I Columbus

March 7-8, 2013
GXMO Didactic Course
OPMA Office I Columbus

March 9, 2013
GXMO Didactic Course
OPMA Office I Columbus

June 6-8, 2013
APMA Region IV Seminar
Hilton at Easton I Columbus



That is why, whether it is your medical professional liability coverage or all of your insurance needs, you need to call PICA. Going beyond insurance, PICA is a one-stop shop for all things podiatry, like risk management specific to groups or sole practitioners, webinars on relevant topics of the day or assistance with practice valuations or associate buy-ins. We utilize podiatrists on all of our committees to make sure our product reflects the expectations of today's practitioner.

Unlike so many of our competitors, PICA views you as more than a policyholder. With so many podiatry-specific additions to our coverages, it is easy to see why. Seems to us that all of the pieces are in place.

PICA is proud to be the exclusively endorsed provider of the Ohio Podiatric Medical Association.

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Ancillary insurance products offered through ProAssurance Agency.

TEST YOUR SOCIAL MEDIA

You and Your Online Reputation

Today's version of the wild frontier is the World Wide Web. If it's every person for him- or herself, it's now more important than ever to take control of your online reputation.

Google Yourself and See

Have you "googled" yourself recently? You should and without delay. There is no opt-out option, so you need to check both Google and Google Images to see your online persona.

As some of our members have found out the hard way, all your efforts won't prevent patients from talking about you online. Your good reputation can be discredited in one or two bad postings. What can you do if someone posts something negative about you online?

Steps to See You Through It

First, federal privacy laws make it difficult for podiatric physicians to address individual patient complaints in a public forum; however, nothing prevents you from talking generally about your practices and procedures. Ensure that your website features extensive information about your services, policies and staff. If the public is compelled by what they read about you online (good or bad), they will visit your website.

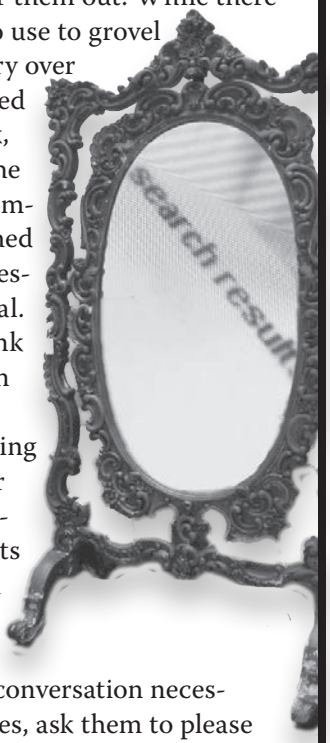
Make sure you include any media, especially your charitable care efforts. Do you volunteer at a "foot check clinic" for seniors? Do you participate any academy projects locally? Post it on your website. Community service and care is always a great item to include on your office website.

Second, you should reach out to patients that have complaints and address their concerns *offline.* If you know who posted the negative comments and they are a patient, call them. Many times disgruntled patients just want to be heard (without interruption).

Last, be proactive—not reactive. Effectively handling crises and negative online comments required a hands-on, positive approach. When you're proactive, you'll develop a policy outlining how your office will handle negative comments on the Web.

A Word to the Wiser

Get busy and develop a policy now while this idea is fresh in your mind. Build a positive reputation for your practice. Reach out to online reviews if you know who they are and open the lines of communication. Hear them out. While there is no use to grovel or cry over spilled milk, be the accomplished professional. Thank them for sharing their comments with you If the conversation necessitates, ask them to please remove the posting. If they refuse, thank them and politely end the conversation. Good luck and don't forget to Google yourself.



PRACTICING CYBERSMARTS

Using Strong Passwords

Good password policies are an important tool in protecting the patient data that you have on your computer network. According to Dr. Michael Brody, a podiatric physician and HIPAA expert, one of the policies you should implement is the use of strong passwords. A strong password has at least 8 characters, at least one lowercase character, at least one uppercase character, at least one number, and at least one special character (&^%$#@!) if allowed.

Additionally, passwords should not be based on dictionary words, your username, birthdays, anniversaries or other dates, or names of friends and family members.

Never share your username and password with anybody else in your office. Protect your passwords. Keep a password log with hints. Never state the full password unless you keep items of this nature in a secure locked location. In case of an emergency, having passwords is vital, especially if you bill pay on-line or need to access email.

OPMA Region IV Conference Highlights in Photos

June 7–9, 2012

BAKO Podiatric Pathology Services—Platinum Sponsor

This was one great seminar!

Region IV had the APMA Lecture Series, two great cadaver labs, the Gerard V. Yu, DPM Memorial Residency Paper Competition plus a great PICA lecture series.

BioMedix—Gold Sponsor

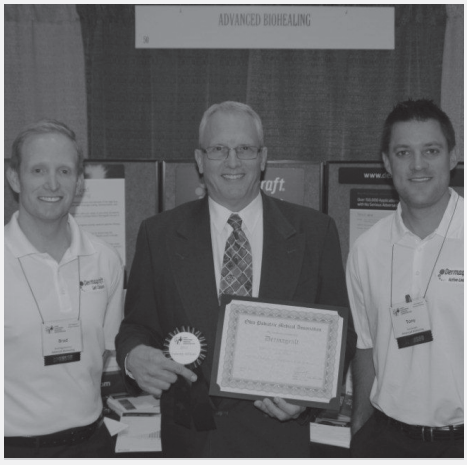
OsteoSolutions—Gold Sponsor

Below: At The Region IV Seminar, OsteoSolutions featured a Cadaver and Sawbones Mobile Operating Van.

Stryker—Gold Sponsor

Merz—Silver Sponsor

PICA—Silver Sponsor



Advanced BioHealing—Industry Affiliate

EIP—Industry Affiliate of OPMA

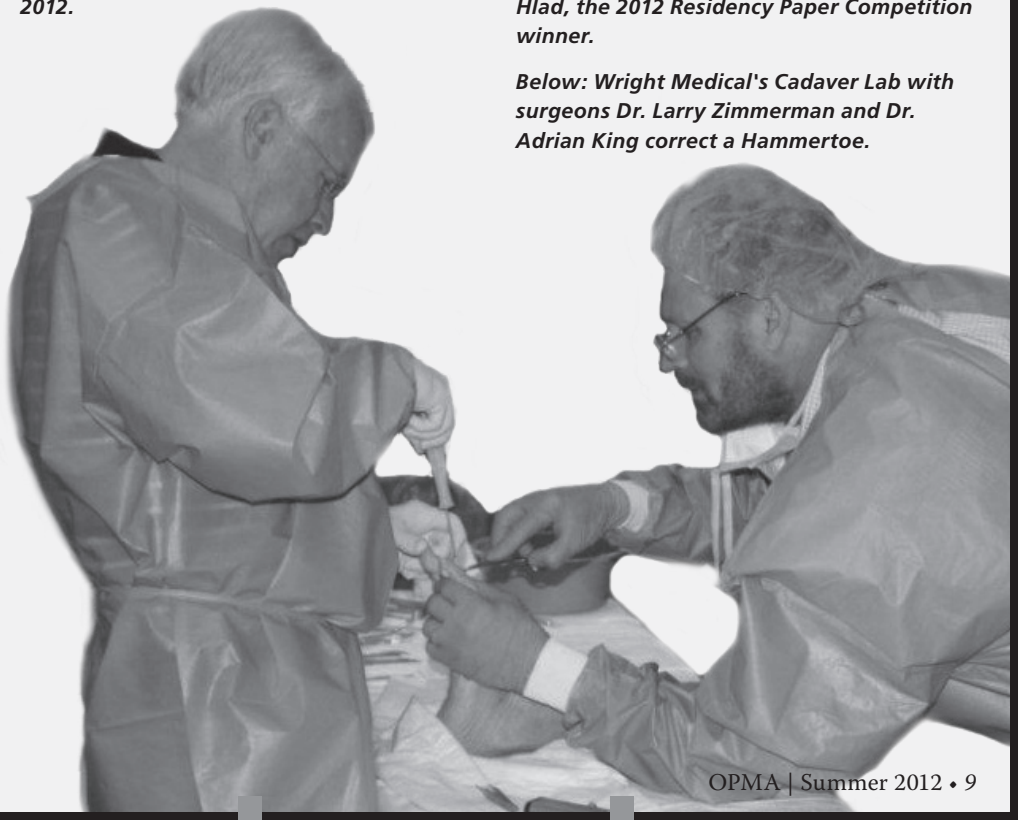
Premier Podiatric Group—Industry Affiliate

Residency Paper Competition Finalists for 2012.

Dr. Rick Weiner, Chair, congratulates Dr. Lee Hlad, the 2012 Residency Paper Competition winner.

Below: Wright Medical's Cadaver Lab with surgeons Dr. Larry Zimmerman and Dr. Adrian King correct a Hammertoe.

Dr. Eric Anderson won the Crocs Door Prize at Friday's Exhibitor Marketplace Luncheon.



YOU PRACTICING SAFELY

Practices Must Be Trained in OSHA's New Labeling Guidelines

Medical practices will soon be mandated to train staff to use revised labels and safety data sheets for potentially hazardous chemicals in products that include cleaning agents such as bleach, disinfectants, and glass cleaners and substances used for local or general anesthesia, as dictated in a new rule for hazard communication issued by the Occupational Safety and Health Administration (OSHA) on March 20.

Training By Date

Training must be provided by December 1, 2013, and can be performed by a staffer using OSHA materials or a specialty consultant. Makers of chemicals have the option of providing labels and safety data sheets in the new or old format, although only the new format can be used as of June 1, 2016.

The Reason for The Rule

The rule's objective is to have the labels of hazardous chemicals and the safety data sheets of manufacturers uniformly display information as to whether a substance is a skin irritant, a carcinogen, a poison, or a narcotic or has some other detrimental effect.

| Source: American Medical News (04/03/12) |

OHIO PODIATRIC MEDICAL ASSOCIATION

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AROUND OHIO
He Taps His Toes for Local Fundraiser

Dr. Jeffrey Schwein joined Neos Dance Theatre onstage on May 4 for the fourth annual Neos Dances with the Stars fundraiser. Dr. Schwein received his Doctor of Podiatric Medicine degree in 1990, graduating as class salutatorian from the Ohio College of Podiatric Medicine. He completed his surgical residency under the direct supervision of foot and ankle surgeon, Dr. Raymond Suppan. He is a core pro-staff member of the popular hunting show, "Blitz TV," airing on the Pursuit Channel.

|*Source: Mansfield News Journal* |

PASSINGS
Dr. Robert Ellis

Dr. Robert Ellis, 86, of Naples died after a brief illness on Monday, April 23, 2012. He was a graduate of Youngstown State University and the Ohio College of Podiatry and worked for 35 years in Boardman and Alliance, Ohio. He was predeceased by his of 45 years, Joan. Robert was an avid sports fan and tennis player. Interment at Forest Lawn Cemetery in Boardman, Ohio.

Medicaid Beneficiaries Can Pick From Managed Care Plans

Ohio has picked managed care organizations for new state Medicaid contracts that will provide health care services for more than 1.5 million poor and disabled individuals.

On April 6, 2012, state officials selected

- Aetna Better Health of Ohio
- CareSource
- Meridian Health Plan
- Paramount Advantage
- United Healthcare Community Plan of Ohio

Medicaid beneficiaries will be offered five managed care plan choices, up from the original two or three. Ohio is also upping performance expectations in the contracts by linking a portion of each Medicaid managed care plan's payment to standards aimed at making people healthier. The plans will also have to develop financial incentives for hospitals, doctors and other providers that are ties to improving quality and patients' health. Enrollment for patients begins in January 2013. The map details the different managed care regions through the state of Ohio.

Managed Care Regions Draft

Effective January 1, 2013

State Medical Board of Ohio Geographical Distribution of DPM Licenses

May 2012: Based on Credential Mail Address County Listing; Total in-state licensees: 824

Out-of-State Licensees

Pennsylvania	26
Michigan	21
West Virginia	11
Kentucky	8
Indiana	8
Other States	67
Other Countries	2
Out-of-State Total	**143**
Ohio Total DPMs	**824**
Total All DPM Licensees	**967**

Key County Total

- More than 100 DPM
- 50-99 DPM
- 10-49 DPM
- Less than 10 DPM
- No DPM

Quick Stat

In 2010, thirty-two new DPM licenses were issued in the state of Ohio; and in 2011, thirty-eight new DPM licenses were issued, according to the State Medical Board of Ohio.

GOING FORWARD

Baby Steps

CMS to Version 5010 Laggards: Get Ready to Borrow Money

Physicians not yet up to speed on new federal standards for electronic claims should be prepared to borrow money to keep their practices afloat come July. That dire counsel comes from the Centers for Medicare and Medicaid Services (CMS). CMS advised physicians who are still trying to comply to either take out a line of credit or expand an existing one at a bank because of payment delays that may occur when the agency begins to enforce the standards on July 1. At stake is the ability of physicians to meet payroll and write rent checks.

The new standards are called Health Insurance Portability and Accountability Act Version 5010 standards. The successor to Version 4010 standards, they are designed to streamline electronic claims and other digital transactions between providers and third-party payers, including Medicare. Physicians, insurers, makers of billing software, and claims clearinghouses are all under the gun to convert to the new standards.

| Source: Robert Lowes, Medscape News [5/22/12] |

New Updates: X-Ray Registration

Computer improvements rolled out on 5/16/12 have improved customer service. Customers can print certificates immediately after changing their facility's address or adding radiation-generating equipment. Certificates can be printed after approval of new applications and after removal of radiation-generating equipment. Public user access and use of the system has been improved by adding online instructions, amendment instruction screens, and an online step-by-step instruction guide. Login assistance from program staff facilitates quicker access to facility records and timely reset of customer passwords.

Bureau of Radiation Protection
Ohio Dept. of Health
246 North High St.
Columbus, OH 43215
614-644-2727
BRadiation@odh.ohio.gov

CMS Drops 48-Hour Signature Deadline, Permits Use of Standing Orders

CMS has ditched its 48-hour deadline for physician signatures and given hospitals a freer hand to shape their own destiny in this and other areas, according to the final update to the Medicare conditions of participation. While hospitals enjoy greater regulatory freedom, they take on the burden of developing new policies and procedures, compliance experts say, and may experience more claims denials if signatures are missing because physicians aren't under Medicare's 48-hour gun. In addition to the physician signature change, CMS now requires a physician on the hospital board, permits the use of standing orders, and allows hospitals to make greater use of non-physician practitioners (NPPs).

The new hospital conditions of participation (COPs) cover a lot of ground. CMS emphasizes it is opening the door to the flexibility rather than requiring it. For example, hospitals can choose to stick with a 48-hour physician signature deadline, but CMS is not enforcing it universally.

| Source: Nina Youngstrom, Report on Medicare Compliance [5/21/12] |

Free Patient Brochures on OPMA Website

OPMA has patient brochures on its website to satisfy EHR compliance. Please refer to the *Members Only* section and look under *OPMA Exclusive Member Benefit* for the brochures. The tab is password protected for members' use only.

PQRS Reporting Codes for Diabetic Foot Exams

Neurological Exam
(Measure 126) – Reporting Code 126=G8404

Evaluation of Footwear
(Measure 127) – Reporting Code 127 = G8410

Diabetic Foot Exam
(Measure 163) – Reporting Code = 2028f

Basic Drug Disposal

Learn how to safely dispose of expired, unwanted and unused prescription drugs, over-the-counter medications, vitamins and supplements.

Community Drug Take-Back Programs

The safest way to dispose of medicines is to take advantage of community drug take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Call your city or county government's household trash and recycling service, or look at your city's or county's Web page to see if a take-back program is available in your community. The Drug Take-Back Network can help you locate a take-back program in your state.

Finding a Disposal Method For You

If no medicine take-back program is available in your area, follow the disposal instructions on the drug label or patient information that came with the medicine. Do not flush any drugs down the toilet unless the information instructs you to do so. When in doubt about proper disposal, talk to your pharmacist or doctor.

If you have additional questions about disposing your medicine, please contact the FDA at (888) INFO-FDA (463-6332). Visit the FDA's Web page "How to dispose of unused medicines" to learn more about safe medicine disposal.

SECRETS OF SUCCESS

Clean Claims Mean More Consistent Cash Flow

by Lynn Homisak, SOS Healthcare Management Solutions LLC

Depending on the insurance company, a clean claim might get paid in 7 days; whereas a denied claim can take anywhere from six to eight weeks (or longer!) and have a harmful impact on your A/R. Do you know why *your* claims are being denied? Below are several common reasons—and *all* of them are fixable, provided you have in place the right billing person and a good billing system.

Errors and missing data in patient registration

Front desk personnel need to be trained in ***consistently*** securing accurate patient data with not only new, but also inactive and existing patients. First time, every time. Insurance information changes all too often. Photocopying the front *and* the back of insurance cards is critical. For those patients who are seen routinely, staff should at least ask to see the card to compare it (again, front and back) with what's in their record. Relying on patients to automatically provide insurance updates results in old, useless data and ultimately—a denial. Since they are not always quick to offer up new information, the responsbility falls on the front desk to ask. When asking, to see the insurance card, replace the wording *"has anything changed with your insurance?"* to *"I would like to see your insurance card to double check that everything is still the same."*

Lack of insurance verification

Yes, this takes time. It's time *well* spent, however, considering the risk of getting no payment for treating someone whose insurance coverage has expired. Insurance verification can easily be done online—but if you really want to get benefits information at the same time, particularly for new patients—a call is usually more effective. Remember, it's wise to delegate such time-consuming tasks to the lowest paid staff person who can get it done right.

Incorrect coding

Staff should not be kept in a bubble when it comes to educating them about coding processes and techniques. In addition to sending them to podiatry-specific coding seminars, give them sufficient tools and resources such as Codingline—www.codingline.com/; APMA Coding Resource Center—www.apmacodingrc.org/; webinars, and up-to-date coding reference manuals. Having an educated billing staff means keeping them in the know with procedure and diagnosis codes, proper modifiers, bundling of services and contractual rules so that they can proactively double check a claim for accuracy and make necessary input or changes *before* claims are submitted.

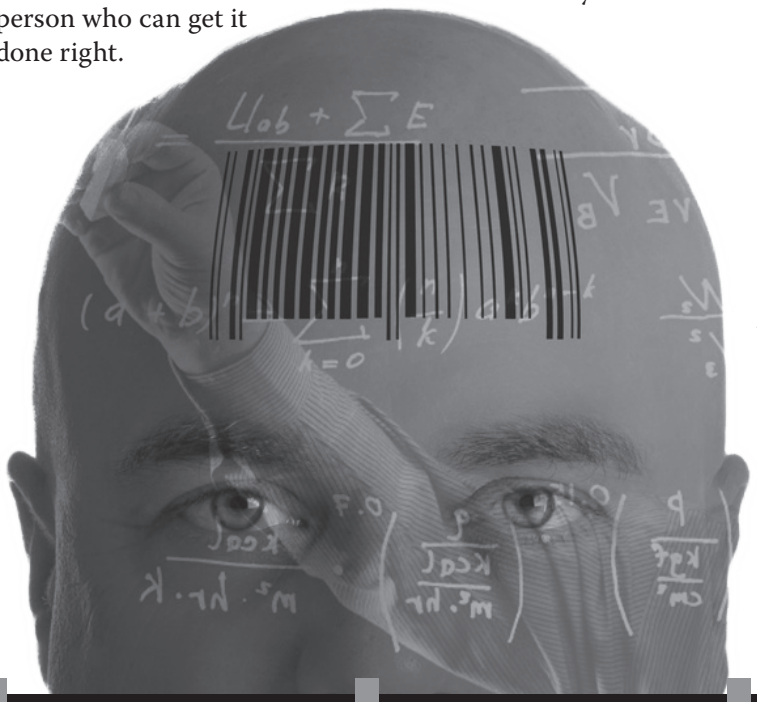
Insufficient documentation to process claim

Whether it's lacking required preauthorization, medical necessity documentation, mandatory referrals or clinical information, a claim, for any one or all of these reasons, an insurance company may hold up or reject payment of your claim. If orthotic claims for example are repeatedly being returned because medical necessity is required—save yourself a step, and another denial, by making a point to always include this documentation with the original claim. Some companies may not allow claims with attachments to be filed electronically. So in these select cases, mailing them would be in your best interest as opposed to waiting for the expected denial.

Taking a closer inspection

Too many doctors remain disconnected from their billing operations, and as a result, I very often see unapproved short cuts, inefficiencies, errors, no reporting or monitoring, lack of follow through and disappointing A/R numbers.

Understandably, doctors should be focused on the clinical, opposed to the billing, aspect of their practice, there is a certain involvement necessary to ensure that proper coding is being submitted, optimum revenue is received for their services. Additionally, insurance companies need to be kept in check and responsible for agreed-upon and contracted payments. Last, all monies passing through the practice must be documented and accounted.



SECRETS OF SUCCESS

Diminish "Patient-Staff-Doctor" Generated Delays

by Lynn Homisak, SOS Healthcare Management Solutions, LLC
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Do you sometimes or constantly run behind schedule? The ability to manage, or *not* manage, our time during the day directly affects the flow, efficiency and productivity of our practices. So it is worthwhile to not only identify things that slow us down, but also make an effort to avoid them whenever possible. Here are some proactive tips to minimize delays

Reduce Patient-generated Delays

Have patients complete their registration forms at home by downloading them from your website before presenting to the office. If internet access is unavailable to them, insist they arrive 20 minutes earlier than their scheduled appointment.

Help patients understand (then be consistent in enforcing) your scheduling policies to reduce early or late arrivals, arriving without their paperwork, etc. Help them with their shoes and socks upon arrival and discharge.

Make sure they are ready and sitting in the treatment chair when the doctor enters their room.

Remind patients of their appointments one to two days ahead of their scheduled appointment, preferably by an automated system to free staff to do other less time consuming tasks.

Reduce Staff-generated Delays

Transfer patients in a full reception room to an empty treatment room and ready them for the doctor.

Unless an emergency, MAs should avoid taking calls during patient hours—staff should provide patients with a time that the MA will get back to them.

Avoid tying up a treatment room chair by letting the patient sit there while scheduling surgeries, special tests, etc. It's better to send them home and call them or have them wait in the reception room, if preferred, until all arrangements have been made. Additionally, check on obtaining patient benefits and insurance authorization before or after clinic hours.

Schedule patient appointments according to the amount of time it takes to see each condition. Preview patient's charts *daily;* anticipate and prepare for each patient's needs and make sure it is ready.

Practice how to end a phone conversation with an overly talkative patient by using closed questions (Did, Have, Can, Will, Shall, etc.) provoking only yes or no responses and speaking in the past tense. e.g., "It's been nice speaking with you Mrs. Jones."

Re-direct all patients calling for prescription refills to their pharmacy, who will fax over a "refill request form." This method provides easy follow-through, reduces interruption, and serves as documentation to scan or file in patient's chart.

Schedule only one "complicated" patient/doctor/hour and effectively double book around them according to each patient's anticipated treatment needs.

Ask patients *before they leave* if they have any questions to avoid potential/interruptive call-backs for more information.

Reduce Doctor-generated Delays

Except on rare occasions —emergencies and time allowances, treat only what the patient is scheduled to be seen for and reschedule them for additional services/conditions. Staff should triage calls better to determine if patients have more than one complaint, so they can be scheduled appropriately, time-wise.

Doctors should avoid taking patient calls during patient hours—staff should provide patient with a time that the DPM will get back to them.

In non-EMR offices, delayed dictation leads to a waste of staff time trying to locate chart. Consider using a scribe to free up doctor dictation time.

Refrain from walking patients to the front of the office at the completion of their visit. Explain what needs to be said to them in the treatment room, say goodbye and move along to dictation or to the next patient. Have the staff walk them up or consider that they know their own way.

Take the time up front to train staff properly; then appropriately delegate some trainable tasks to those who prove to be proficient, qualified and skilled to handle them. By failing to train staff up front, you only wind up spending twice the amount of time on the back end to correct their mistakes and *re-train* them!

Make sure all drawers in treatment rooms are fully stocked, injections for the day are pre-drawn, and anticipated DME items are in the room, according to written treatment protocol, so that the doctor does not have to summon a staff person.

Have staff review with patient all necessary instructions following treatment.

Develop a professional transition "code" to help the doctor get out of the room with a talkative patient by having staff come in and ask, "Is there anything I can help you with, Dr.?"

Ms. Homisak is President of SOS Healthcare Management Solutions. She is the 2010 recipient of Podiatry Management's Lifetime Achievement Award and was recently inducted into the PM Hall of Fame. She is a nationally recognized speaker, writer, and staff and human resource management expert.

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