ADAM
Executive Decisions in DERMATOLOGY
July/August 2013

You Asked, We Listened!

ADAM webinars are now just $99! That's right. You said you loved our online learning opportunities, but you needed the price to drop in order to make them affordable. Well, we heard you. Education is one of the most important values of your membership, and we want everyone to have the opportunity to take advantage of it.

ADAM members can now register for any live webinar for just $99. But wait, there's more! We've also added the **ADAM Access Pass**. For just $149 you can get access to ALL of our recorded webinars anytime, anywhere. Take advantage of this fantastic training opportunity for you and your staff! You can purchase the ADAM Access Pass in the Online Store on ADAM's website.

Register today for these upcoming webinars!

Wednesday, July 10 3:00-4:00pm ET

Preparing Your Practice for the Federal Sunshine Act

- ◊ Learn about Sunshine Act background and purposes.
- ◊ Understand manufacturer reporting requirements and exceptions.
- ◊ Understand the interplay between Sunshine Act and state laws.
- ◊ Learn practical compliance measures.

Wednesday, August 21 3:00-4:00pm ET

HIPAA, Electronic Risk and the New Omnibus Rule

- ◊ Learn about the Omnibus Rule and what it will mean for your practice.
- ◊ Get ready to rewrite all Business Associate Agreements by September.
- ◊ Learn strategies for compliance for the HIPAA and HITECH Act. Practices will need to have a Security Risk Analysis conducted.

In this issue

President's Corner

A series about the state of the Association and what's new with ADAM. Do you have a question for Jayne? Email us at ADAMinfo@shcare.net

It's the dog days of summer, and I don't know about you but sometimes it's hard to find the time or the motivation to keep up with all of the little things we need to worry about! I'm talking about ICD-10, business associate agreements, reviewing practice efficiency, and the list just goes on. Luckily, our committees have been hard at work developing educational webinars and beneficial articles so you can have everything you need right at your fingertips. Enjoy your summer and don't forget the sunscreen!

Sincerely,

Member Spotlight

Would you like to nominate someone for the Member Spotlight? Email us at ADAMinfo@shcare.net

ADAM: What is your name and where do you work?
Christine: Christine Foley, Chief Operating Officer at SkinCare Physicians, Inc. We are located just outside Boston, MA and provide General Dermatology, Cosmetic, Laser and Mohs Surgery to over 50,000 patients per year.

ADAM: When did you join ADAM?
Christine: I am a Charter Member and joined back in 1994. Wow, that is a long time! Clearly I was 20 when I joined.

ADAM: How long have you been a practice manager?
Christine: I started out as the Administrative Director of Dermatology at the Beth Israel Deaconess Medical Center in 1989. We opened SkinCare Physicians in 2000, where I assumed the role of COO. Since then we have grown from 18 to 87 employees and utilize 20,000 square feet in one location.

ADAM: As a practice manager what do you find to be the most challenging part of your job?
Christine: Over the years my role has morphed into one more focused on network development and strategic planning. Continuing to look for solid revenue enhancement opportunities is one of our biggest challenges. We have found year over year that growing revenue contributes to the largest margins, and cutting expenses and trimming staff often have minimal effect on the bottom line. Every month our Executive Committee discusses, reviews, and modifies our revenue enhancement strategic plan.

ADAM: What would you recommend to a member who is looking to be more involved?
Christine: I absolutely love the ADAM Linkedin discussion groups. I think participating in those on a regular basis, as well as attending an annual meeting every few years keeps you involved enough to experience real value as a member.

Featured Member Benefit!

Access all of the previous newsletter articles easily through the Resource Library! Just login to My ADAM and select the Resource Library tab. Here you can search articles by topic such as Human Resources, Marketing, and ICD-10. Each article is a simple pdf that you can print out and share with your staff!

Call Centers…the Evaluation, Investment and Benefits

By Angela Short, MHA

You are a manager for a small to medium size dermatology practice where the front office and billing office staff still manage the bulk of the inbound telephone calls. It seems that no matter how hard these individuals try to pick up the telephone in a timely manner, you still get complaints regarding hold time and patient service issues. If this is your practice, now may be the time to evaluate if a call center function is right for your office. Before you tell yourself that your practice is too small for a call center, consider the benefits including:

- A dedicated team of professionals focused on the patient's needs on the telephone. Often the first impression with the patient or the referring physician is the telephone operator. If your staff is juggling three different tasks, this will come across as disorganized on the telephone.
- Decompress the front office function that allows staff to present in a professional and patient friendly etiquette. Ask for feedback from your patients about their experience dealing with the front office. Furthermore, removing the telephone function from the front desk generally enhances employee satisfaction and provides time for staff to focus on collecting outstanding balances and/or co-payments. In my current organization, we collect approximately 98% of all co-payments at time of service.
- Allows the practice to offer appointments to patients based on the next available appointment regardless of the provider. This helps enhance revenues to the practice and increases patient satisfaction by reducing wait times for appointments. This is a dynamic tool to help fill new provider's schedules. (This function may not be feasible in all practices.)

When evaluating if a call center is right for your practice, the most important piece of information that you need is current call volume. If you have a reports module with your current telephone system, this should be a simple report that will empower you with daily volumes. If your telephone system does not provide you with call statistics, you will need to obtain this information manually. The easiest place to start is by providing all staff that answers the telephone with number counters. Instruct staff to provide the total count of calls managed each day. **Note of caution**, you need to reassure staff that the practice is evaluating a better system to manage telephone calls and not using the information to evaluate individual performance. If staff is concern that their performance is being monitored, then the validity of the information provided could be questionable. You need at least two to three weeks worth of call volumes and it is highly desirable to have this information at different points in time (January, April, December) to understand the variations of call volumes due to seasonality.

Evaluating the numbers

Based on your call volume evaluation, does the practice routinely receive more than 250 calls per day? If your answer is yes, it is time to start centralizing the call function and moving towards a call center environment. While 250 calls may seem like a low call volume, keep in mind that a dedicated telephone operator can successfully manage between 85 and 100 calls in an eight hour day; with 250 calls, the function supports 2.5 full time employees (FTEs).

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Furthermore, if your office calls patients to remind them of appointments, you should add this function to the call center. Before you panic about adding staff, if you remove the call function from the front office, you may be overstaffed in the front and can shift resources to the call function. A word of caution about shifting resources is that you may want to move the right people, those individuals that have the telephone etiquette to represent the company well on the telephone.

Technology – Telephone systems

To most effectively manage a call center, the practice should have a telephone system in place that tracks number of calls, wait times, call volumes by operator and total telephone time. Data is powerful and provides the administrator a tool to track performance, provides timely feedback to physician partners, and allows the function to be evaluated for improvement opportunities. There are many systems on the market that provide the reports as mentioned, and just like electronic health records, they all range in price. I have worked with a number of vendors and currently work with Avaya which provides a good solution for our practice. Telephone systems are expensive, so you want to do your homework to make sure that you are investing in not only the system that works today but also one that will grow as the practice grows. Good news about financing the telephone system, is that most companies offer a lease option, which helps reduce the challenge of the initial capital outlay.

Matrix for staffing the department

What is the right number of calls that each call center professional should be able to manage in a patient friendly manner? It depends. You have to look at your practice to determine how much information your practice requires on the front end prior to booking the appointment. The more information requested over the telephone, the longer the call will take and the fewer calls the professional will be able to manage each day. How complex are your physician's appointment schedule templates? The more standard the template, the more productive the call center representative can be. Often physicians have the philosophy that another provider in the practice should not see their patient, and while there are legitimate clinical reasons where this may be the case, if your practice is a group practice with a shared record, the patient should be able to been seen by any physician in the group. Very important, no matter how simple or complex your scheduling protocols are, make sure they are in writing and the call center staff understands them. You do not want staff to be in a situation where they have made an error scheduling for a physician because they did not understand the physician's scheduling preferences. Again, the more standard the scheduling, the fewer errors that will be made.

So, what is the magic number that your practice should look for in recruiting call center staff based on our call volume? To answer this question, we will dive into service performance by starting with wait times. When your patient waits on the telephone, a minute can seem like eternity. So what is the longest acceptable wait time that your patient should hold before speaking with a representative?

Most statistics published for large call centers reflect at least 80% of calls picked up within 30 seconds

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Keep in mind that call volumes vary throughout the day, so your department should be staffed to manage the average call volumes by hour. Additionally, extra time needs to be considered for staff breaks and lunches. Let's walk through an example:

Inbound call volume

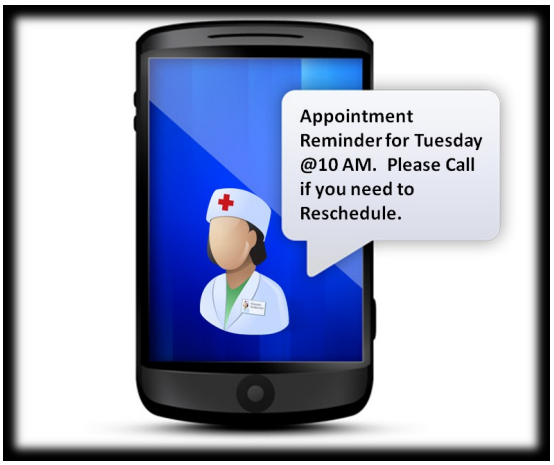
Average **500** calls per day where average call time is 3 minutes plus 30 second wrap-up between call. This means, *75 calls in an hour* – 210 seconds per call on average (3 minutes plus 30 second wrap up) 15,750 seconds of operator time or 262.5 minutes. You will need 4.5 FTEs to manage the call volume. (262.5 minutes divided by 60 for the number of minutes for each operator equals 4.375 FTEs).

Call Center Supervisor

Now that you have your call center in place, at what point should the practice explore adding a dedicated supervisor to the function? While I have been unable to find statistics behind an FTE ratio, I would suggest if your department grows to three that you have a leader among the call center professionals; and once the department has five FTE, you need to explore a call center supervisor. The supervisor does more than just watch call volumes; this individual is in control of patient satisfaction. The call center supervisor often listens to live calls and evaluates the call center professional's performance in managing the call. The supervisor provides timely feedback to staff regarding call answer ratios and individual performance. Since formalizing the call center function in our practice, it is surprising to see how competitive our staff has become with handling the greatest volume of calls. The call center supervisor can be a real cheerleader to motivate the staff during unusually high call periods.

Maximizing electronic tools

The computer can be your best friend, especially in increasing patient satisfaction and removing call volume from the call center. If your practice calls patients to remind them of their appointments, there are electronic solutions on the market that can provide this service for you. (Just a note, if you do not call your patients to remind them of their appointments, you probably want to take a look at your no show ratio. This could be a golden revenue opportunity for your practice). In the past, my practice deployed telephone technology where a recorded message was sent to patients and routinely left on a voicemail. These systems provide a good service and are generally easy to deploy. However, last year, my practice was looking for a more creative way to reach our patient since we discovered that many patients failed to listen to the recorded message all the way through. We identified a system that sends email reminders or text messages to our patients. If you have been to a conference lately, you may have likely found a vendor that offers this service. The system that we deployed provides:



- Email or text message to patients reminding patients of their appointments. You are in control of the message being provided to the patient. The greatest enhancement about the email function is that you have a snapshot of whether or not the patient has opened the email. Just a note on text messaging, some patients will complain that they are charged a fee for the text message, apologize and deactivate the feature for that unique patient. It really is that simple. Since launching this function, our patient satisfaction has increased and our no show rate has decreased by over 18%!
- Patient friendly tools: We have the birthday card set up with the system.

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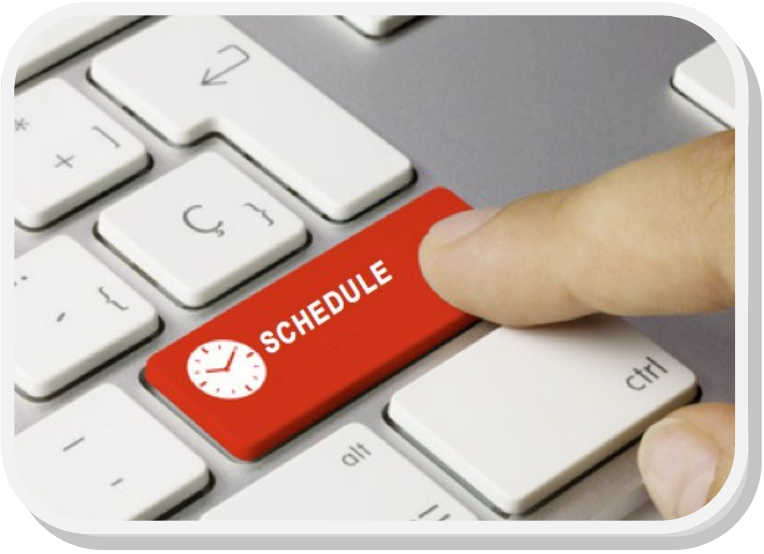
When the system recognizes a birthday, the patient receives either an email birthday card or a text messaging wishing them a happy birthday from the practice.



- Patient satisfaction survey: for patients with email, we send patients a survey asking for their feedback on every aspect of the practice. We have built alerts into the survey so if a patient outlines that the call center representative or front desk was rude then an email to the administrator is generated. We take these alerts seriously and routinely call the patient within hours of the patient completing the survey. It is a powerful situation to be able to close the loop on a patient's complaint in a real time environment. Plus it communicates to the patient that their time to complete the survey was taken seriously. Even if the patient truly had a bad experience, this is one way to keep the patient's loyalty to the practice. We have the survey set up so patients only receive once every six months, so a regular patient visiting weekly or monthly is not inundated with emails.

Expanding appointment scheduling online

We hear the comments all the time that grandma or seniors are not wired to the internet. While ten years or even five years ago, this may be true, statistics show that more and more families have internet availability at home. This opens the door to providing a successful application of online appointments. Two years ago, our practice partnered with a third party vendor, which provides the online function for our patients. When the functionality was launched, we had approximately 20 to 30 appointments scheduled online in a month. With aggressive marketing to our patients (simple business cards advertising services) handed out when the patient came to the office, we now schedule approximately 25% of our appointments online. It is our goal by the end of 2014, that 50% of all appointments scheduled will be online. We have expanded our online function to include more than appointments; patients can pay their bills online or request a prescription refill.

A call center is a dynamic function within the medical office, but not the right solution for every practice. A careful evaluation of the practice in terms of call volume, patient and physician expectation is crucial before launching the function. In those practices that maximize their call centers, the center operates almost as a quasi-revenue center as it allows the practice to ensure open appointments are filled. Good luck in your evaluation and implementation of a call center. The information provided in this article is based on tried and proven protocols but not an all-inclusive list of the operation.

Angela Short, MHA is the Revenue Management and Corporate Compliance for The Dermatology Group.

Her practice has seven locations in New Jersey. Angela is a Certified Medical Practice Executive, Certified Professional Coder, and Certified in Healthcare Compliance. She is an active ADAM member and serves on the Communications and Networking & Mentoring Committees.

New Member Pricing

Do you have a friend, coworker, or colleague who would love to join the only association for dermatology practice managers? You're in luck! Beginning August 1, new members can join ADAM for $425 and be covered through December 31, **2014**! This prorated membership offer will continue through the fall.

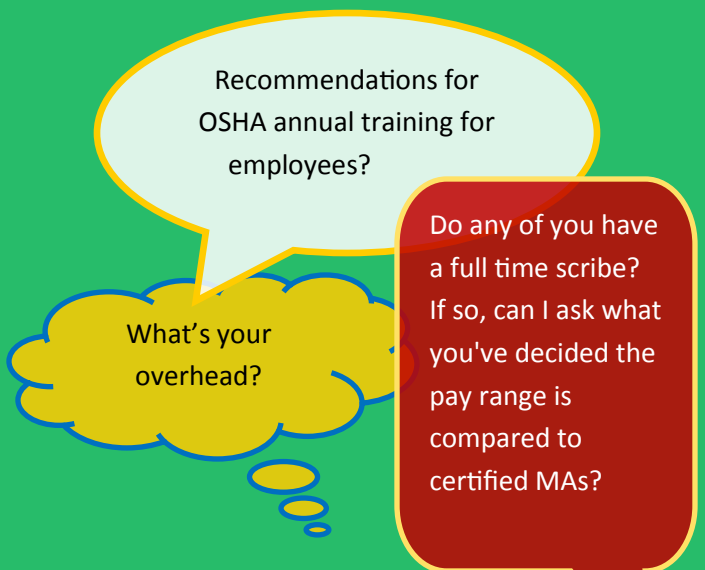
Month	Price
August	$425
September	$400
October	$375
November	$350
December	$325

Remember, this is for new members only. Their dues will pay for the rest of 2013 *and* all of 2014!

Tell your colleagues to join the nation's resource for dermatology practice managers this summer!

Don't miss out on member pricing for webinars, the Annual Meeting, and more. Members can also take advantage of the members-only Linkedin group, My ADAM, and ADAM-Edge. For more information email ADAMinfo@shcare.net today!

Linkedin Hot Topics



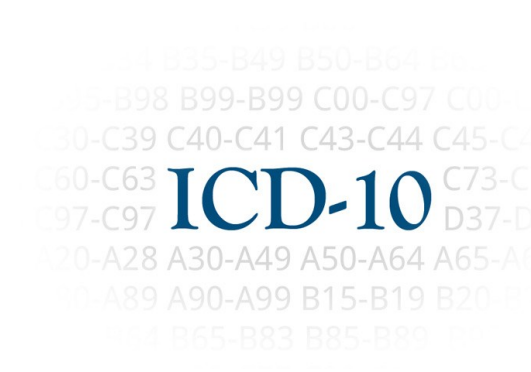
Want to get in on the conversation? Go to Linkedin.com and search Association of Dermatology Administrators and Managers. Request to join and start chatting! Click here for an easy to use guide!

ICD-10: Do We Really Need to Get Ready Now?
AAPC

Healthcare is much more than just patient care, it's an evolving field. As recovery audits (RAC) increase, facilities and practices need more certified medical coders. Documentation has become even more important for providers in every specialty. We have undergone changes from privacy to security with HIPAA, which included National Provider Identifiers (NPI) and, more recently, 5010 transactions upgrades. Will the changes ever stop? Let's hope not. No change means no progression in treating diseases such as diabetes, heart disease, and cancer. If our physicians are constantly changing with the incredible advances in medicine then we can reason that the business of healthcare must change too.

On March 21st, 2013, Marilyn Tavenner, administrator of the Centers for Medicare & Medicaid Services (CMS), announced there will be no more delays with the implementation of ICD-10-PCS and ICD-10-CM; ICD-10 is scheduled to go live on October 1, 2014. CMS and the larger health plan carriers have already started to get ready for the implementation: money has been spent to review their new codes, review the individual payer guidelines, and initiate code mapping. There are very few one-to-one code changes in moving from ICD-9 to ICD-10. The specificity is at a much greater level, so much so that many carriers will NOT accept unspecified codes, especially when laterality is a part of the code. Now is the time to start your own implementation plan to be ready for October 1, 2014.

It is time to get on board the ICD-10 train and evaluate your practice to see where you stand. There are several stops that need to be made, so let's take a ride and get our practices ready.



- Insurance Verification/Authorization: Though healthcare reform states there will be no more pre-existing clauses, what changes to the coverage has the plan made?
- Back Office: Who is responsible for the Advanced Beneficiary Notice? Who is responsible for the ordering of lab work? Both of these require an understanding of diagnostic codes.
- Practitioners: Does your documentation indicate the specificity that is necessary to select the correct code (laterality, granularity, morbidity, and mortality)?
- Coding and Billing: What happens if the documentation is not enough to choose the now required specified code? What changes have the payers made to their policies and procedures? How do we approach denials?

Documentation is now, and has always been, one of the most important components for any medical provider. Proper documentation can allow another provider to understand what is happening with the patient. It can also assist and protect a provider in audits and malpractice situations. ICD-10-CM brings specificity to an unprecedented level. Take a look at some of the new codes:

ICD-9-CM 173.11 Basal Cell Carcinoma of skin, eyelid

ICD-10-CM C44.111 Basal Cell Carcinoma of skin of unspecified eyelid, including canthus
C44.112 Basal Cell Carcinoma of skin of right eyelid, including canthus
C44.119 Basal Cell Carcinoma of skin of left eyelid, including canthus

Note: Many payers will deny claims when billed with "unspecified," especially with laterality.

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ICD-9-CM	682.2	Cellulitis of trunk
ICD-10-CM	L02.211	Cutaneous abscess of abdominal wall
	L02.212	Cutaneous abscess of back (any part, except buttock)
	L02.213	Cutaneous abscess of chest wall
	L02.214	Cutaneous abscess of groin
	L02.215	Cutaneous abscess of perineum
	L02.216	Cutaneous abscess of umbilicus
	L02.219	Cutaneous abscess of trunk, unspecified

With just these two examples of where ICD-10-CM is leading us, it is imperative that you start getting ready now. Involve the key players in your practice (e.g., Administrator, Physician, Coder, Biller) during the implementation efforts.

To get started with documentation training for your physicians, you need to be able to show them there's a problem to fix. Run a frequency report of diagnosis codes used and sort it to find your top ten most common diagnosis codes. Create a second report that lists patients who had those diagnoses appended to them. Starting with the most commonly used diagnosis code, pull 10-20 charts and review the ICD-10-CM guidelines looking in the chapter that covers the diagnosis code. Next, review the chart notes just for the diagnosis. Read the history and the assessment and code it under ICD-10-CM. Do this for each of the charts you pulled and create a report based on the specific diagnosis code. How many notes could be coded fully in ICD-10-CM? How many required more specific information to code accurately? How many notes had to be coded to an unspecified code? Make sure to associate the individual providers with the specific results.

Congratulations, you've just completed your first documentation readiness assessment! Take the results to senior management and the providers, especially those who demonstrated the greatest need for documentation improvement. Explain what was missing from the documentation to support the diagnosis. Answer the providers' questions. Give them examples from the charts you pulled. Some providers will need a focused ICD-10 documentation training.

Move on to the next most common diagnosis code but setup a plan to perform regular documentation assessments on the previous one. How often these assessments occur will depend on how many providers are at your facility, the number of different specialties, the type of specialties, and how each provider performs. Your facility should have a target percentage for all providers for each assessment (i.e., 90% of all documentation is sufficient for ICD-10 coding). Repeat this process until each physician is meeting or exceeding documentation expectations. Consider future assessments to confirm continued documentation specificity.

Everyone and every aspect of our practices will be touched in some way or another by ICD-10-CM. Look to your societies and organizations (e.g., AAPC, ADAM, AAD) to help your office prepare for ICD-10-CM and minimize potential revenue loss. Be proactive and start preparing NOW!

You can take advantage of all of the AAPC's ICD-10 offerings on their ICD-10 Training page

For more information on ICD-10 Documentation Assessments. Visit the My ADAM page for ADAM member discounts through VEI Consultants!

Am I at Risk?

An interview with attorney Mike Sacopulos

ADAM: Does a security risk analysis need to be performed by an outside consultant or can a member of internal staff perform this?
Mike: There is no formal requirement that analyses be prepared by an independent party. However, many experts feel that independent analyses are more complete and carry greater weight with the Office of Civil Rights. I recommend independent analyses simply because, "You don't know what you don't know."

ADAM: What documentation is necessary or suggested to support that a security risk analysis was performed?
Mike: Each analysis should conclude with a written report. This documents that the analysis was done. It also provides a list of areas of risk to be addressed in the future. If a level of security is not feasible due to the size of the practice, it should be noted in the report. For example, certain levels of encryption are not cost effective for smaller practices.

ADAM: What are the top three security risks that most practices need to be most concerned about?
Mike: The Office of Civil Rights has reviewed and classified thousands of reported data breaches over a multi-year period. The #1 category for breaches came from "theft." In fact, this category was larger than all the others combined. The next two largest categories were "unauthorized access" and "loss." This tells us to focus upon access to the data.

ADAM: How do the HIPAA, electronic risk and new Omnibus rule affect the day-to-day operations of a practice in terms of communication with patients?
Mike: The Omnibus rule is sweeping in its scope. While many parts of it focus on Business Associates or specific topics of limited applicability, some do apply to your patients. First, there are additional rights that all patients now have. This means that the privacy notices that your practice distributes must be revised. One new right is the right to prohibit treatment information from being provided to an insurance carrier. If a patient pays in full directly for professional services/care, then they can request that the information related to that care **not** be sent to their insurance carrier.

ADAM: If a patient asks that their claim not be submitted to their insurance, should they sign a separate format that visit?
Mike: I think it is a good idea to have the patient specifically instruct your practice not to send some portion of his/her records to the third party payer. The patient should acknowledge full responsibility for the costs associated with the care he/she does not want revealed to the insurance company.

ADAM: Do you anticipate further changes or corrections to HIPAA and the HITECH Act with the onset of ICD-10?
Mike: The Omnibus Rule is massive (approximately 570 pages). I don't see anything like that hitting again in the near future. However, I do expect further clarification of the rule and additional emphasis by Office of Civil Rights in our near term future.

ADAM: Does the current HIPAA release form for patients need to be rewritten to specifically include the patient consent management provision?
Mike: The record release form used by most practices should continue to be useable. These forms are used to get the patient's explicit permission to release some or all of the patient's medical records to a person or entity of the patient's choice. As long as the form is clear and the patient has recently signed it, it will be valid.

ADAM: When do all of these changes go into effect?
Mike: There are various start dates for different provisions found throughout the Omnibus Rule. Some kicked in this past March and other start in September. I think the timing message is "start now."

If you want to learn more, join Mike on August 21 at 3:00pm ET for his HIPAA, Electronic Risk and New Omnibus Rule webinar. Click here to register today!

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