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Practice Focus

Practice Focus is published four times per year by the Michigan Medical Group Management Association (MiMGMA).

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Michigan MGMA has a career center on our website WWW.MIMGMA.ORG

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MiMGMA welcomes the submission of articles for publication in Practice Focus. Submit article proposals to Debra O'Shea at INFO@MIMGMA.ORG

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President's Message

By Patty Kerrins, FACMPE

Reflecting on the Spring Conference, I thought about how many speakers we had and how much quality information I received from them. There are always many pearls of wisdom gleaned from these conferences, and it reminds me that I'm never too old to learn.

For example, I pulled out a book I was given from a keynote speaker from a MiMGMA conference long ago and skimmed this book that I haven't put my hands on for years. An "AHA" moment occurred that I would like to share with you: "11 Tips to Delight in the Little Things" that you may be able to achieve in the near future.

1. Make it a point to carve out some time to watch a full sunrise or sunset
2. Take a friend to your favorite restaurant
3. Go to the nearest zoo
4. Visit a state park and find a secluded area
5. Observe a child under the age of seven
6. If you have a family, take a long weekend somewhere
7. Make a mental list of three people you know who are worse off than you
8. Volunteer some time to help out a charitable organization, like Habitat For Humanity, The Make-A-Wish Foundation, or Big Brothers Big Sisters
9. Watch a "Feel Good Movie." Oprah has a list of "34 Feel-Good Movies to Watch When You're Feeling Down" – Google it!
10. Go for a walk in nature
11. Consider resurrecting a tradition that has unfortunately gone out of fashion in our busy culture: Sending Thank You notes, playing Charades, sitting down to a family dinner or playing a record

Reflecting on this list, I see many activities that I have done recently and others I will strive to do. I also immediately wanted to share the list with everyone involved in the Michigan MGMA. Most of you are not only the glue, but also the glue gun (that with which warms the glue [caring and compassion] and moved the glue through [that with which strives to make your team the best at what they do]). Our glue holds the organization together, but our glue can get watered down with the minutia of our jobs, and, as we all know, watered down glue tends not to hold things together. So my advice to you this summer is to take this list, or any other list that takes YOU into consideration, and spend some time treating yourself to things that make you feel good.

Also, with that in mind, think about Fall Conference. Registration is now open and I am excited about the agenda that is planned. Maybe think about catching a sunset over Lake Michigan while you're up there visiting Traverse City. MiMGMA is a fantastic organization, because it has YOU in mind.

Have a great summer EVERYONE!

Executive Director Update

By Debra O'Shea, FACMPE

Happy summer, MiMGMA members! This season tends to be particularly eventful as we balance work, vacations, and family schedules. I hope you find time to relax and recharge while enjoying Michigan's outstanding summer scenery and activities.

Here at Michigan MGMA, our eyes are on autumn as we make plans for the Fall Conference and Third Party Payer Day. Our Fall Conference agenda is almost finalized, and we can't wait to share it with you. Sessions include a Malpractice & Risk Management Panel, "What's Your Problem?" Round Table, Improving Your Revenue Cycle with Coding Audits, Creating a Culture of Employee Success, How to Survive a Merger or Acquisition, How to Build a Story, State of Michigan Legislative Panel, and more. We are excited to welcome our highly rated keynote speaker, Erik Dominguez, who will be sharing an interactive presentation, The Three T's of Confidence for Leaders. We are also planning a fun and unique networking event for Thursday evening with the help of our Networking Event Sponsors, The Rybar Group and Rehmann. Please make plans to join us at the **Fall Conference** on September 28th & 29th at the Hotel Indigo in Traverse City.

Looking further ahead, **Third Party Payer Day** will be held on Friday, November 3rd at the Soaring Eagle Casino & Resort. We have secured a number of organizations who are eager to participate this year, including Aetna, Availity, Blue Cross Blue Shield of Michigan, DIFS, HAP, Humana, McLaren Health Plan, MDHHS, Medicare Administrative Contractor (MAC), Meridian, Molina, Physicians Health Plan, Priority Health, Saginaw VA, and Workers' Disability Compensation Agency. Rivet Health Law will be sponsoring our first ever TPPD Welcome Reception on Thursday evening from 4-6 PM, so join us there as we enjoy a nice evening of drinks, hors d'oeuvres, and networking.

I also want to encourage you to submit your Administrator of the Year nominations, which will be accepted through August 11th. More information about the award and nomination process can be found on page 5.

I look forward to seeing you at our events later this year. If you have any questions about our conferences or would just like to connect, don't hesitate to contact me at 800-314-7602 or DOSHEA@EPOXYHEALTH.COM. Have a great summer!

Business Partner Update

By Julie Hardy, MSA, RHIA, CCS, CCS-P
Affiliated Business Partner Committee Chair

Even though summer is just getting started, the MiMGMA Business Partners are looking forward to the Fall Conference! For us, this is what it's all about! We're passionate about spending time with you, the members, in person and getting to know you and your organizations. We're constantly trying to come up with new, fun, and interesting ways to network. As we meet monthly, we discuss what we can do better to connect with you, and if you ever have suggestions or feedback, we'd love to hear it. Just shoot an email to **INFO@MIMGMA.ORG.**

I'd also like to take a moment to thank those who participate on the Business Partner Committee:

- Matt Barczak, Rehmann
- Brandon Button, Hylant
- Teresa Datema, CARR Inc.
- Michael Glass, TSI – Transworld Systems Inc.
- Chris Harper, Revenue Integrity Solutions
- Heather Turcany, Merchants' Credit Guide
- Renae Tyler, PSIC

They show up each month ready to discuss how we can continue to meaningfully contribute to MiMGMA as Business Partners, and ultimately be of service to the membership.

The Rybar Group and Rehmann are looking forward to hosting a very cool networking event at the Fall Conference. Stay tuned for details, and we'll see you there!

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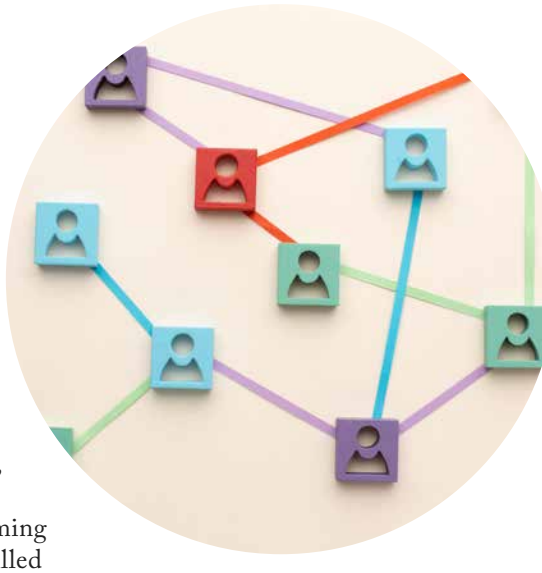
- Transworld Systems - TSI
- USC Cyber
- Veradigm
- Whittaker Group Healthcare Search Consultants
- Wolgast Corporation

Membership Committee Update

By Samona Owens, Membership Committee Chair



Happy Summer to all our readers! The hustle and bustle of the season is here with vacations, family reunions, and simply spending quality time with family and friends. This is such a healthy time of the year for long walks, bike riding and enjoying the fresh air. I am so excited to present this update to you about the MiMGMA membership committee.

I am eager to report that our membership numbers remain consistent. We are working diligently to reorganize our membership committee. The membership committee remains dedicated to ensuring that our members find value in our professional organization. We will continue with the vision of the previous chairperson, which included our quarterly new membership orientation and pop-up networking events.

Our Fall Conference will be here before we know it, and we are looking forward to coming together for an excellent conference. Trust me, you do not want to miss this great event filled with networking opportunities.

If you are interested in an opportunity to get more engaged with MiMGMA, I encourage you to consider joining the membership committee. Also, if you know someone that can benefit from networking and education, invite them to join MiMGMA.

Enjoy your Summer and I look forward to meeting you at the Fall Conference in Traverse City. ■

MGMA® MICHIGAN

Organizational Membership

We recently redesigned our MiMGMA Organizational Membership program to be more affordable and provide further value to practices and systems. If your practice has five or more managers who would benefit from being part of Michigan MGMA, an organizational membership is a great opportunity to provide them with additional education and resources. Our new pricing has multiple levels based on the number of administrators, so we have options for almost any practice. You can view the pricing structure below.

Ready to learn more or begin the process of setting your practice up with an organizational membership? CLICK HERE to fill out our contact form.

Please note that dual members and affiliate business partner members are not eligible for MiMGMA Organizational Memberships.

# MEMBERSHIPS	ANNUAL CORPORATE COST	COST PER MEMBER RANGE
5 members	$500	$100
6-9 members	$750	$125 - $83.33
10-15 members	$1,000	$100 - $66.66
16-24 members	$1,500	$93.75 - $62.50
25 or more members	$2,500	$100 max *(unlimited savings!)*

2023 Administrator of the Year Award

Know a Practice Administrator who excels at their job?

Nominate them for Administrator of the Year!

Our annual Administrator of the Year award recognizes a medical group practice administrator affiliated with the Michigan Medical Group Management Association (MiMGMA) who has exhibited exceptional leadership and management proficiency. This individual has also enhanced the effectiveness of the delivery of healthcare in their practice and the community through a recent, noteworthy achievement.

Nominations must be submitted by Friday, August 11.

The 2023 Administrator of the Year recipient will be announced at our Fall Conference at the Hotel Indigo in Traverse City on September 28th & 29th. The recipient will be honored with a plaque and a $500 check.

Thank you to Dean Schink of Alera Group's Healthcare Liability Team for sponsoring this award!

SUBMIT A NOMINATION

Upcoming Webinar

Minors and Risk: Immunizations, Pregnancy, STI, Addition, Mental Health, Custody Battles and More!

August 8 at 1 p.m EST

Register Here!

2023 Conferences

FALL CONFERENCE

September 28-29

Hotel Indigo, Traverse City

REGISTER NOW!

THIRD PARTY PAYER DAY

November 3

Soaring Eagle Casino & Resort, Mount Pleasant

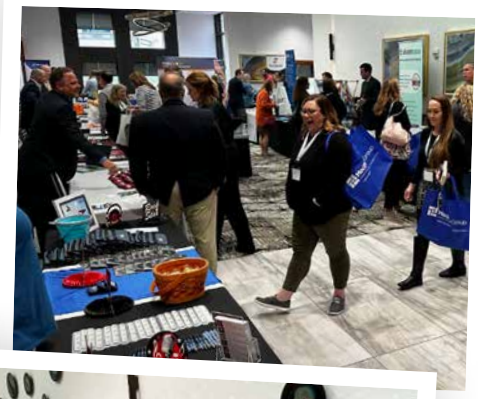
REGISTER NOW!

Did you know?

National MGMA provides an easy way for you to let your representatives know how you feel regarding issues impacting the medical practice community. With the click of a few buttons, you can find your elected officials and send them a pre-written message about important legislative issues. Click "Contact Congress" below to learn more about MGMA's current legislative initiatives and contact your representatives today!

CONTACT CONGRESS

Thanks to all who attended our Spring Conference!



Programming Committee Update

by Christine Hosmer, CMPE, Program Committee Chair

The April Spring Conference in Lansing was a hit (Check out the photos on p. 7)! The Afternoon at the Capitol session was an excellent opportunity to meet with state legislators and express concerns of medical practices statewide. I am looking forward to having more conversations with legislators, and I am even hopeful that we see some of them at MiMGMA events in the future.

Kicking off the summer educational program is the monthly webinar on July 13th, Lessons Learned from Extended EHR Downtime. Join us as Joy Putney, RN-BC, MSN, relays lessons learned during an extended EHR downtime, and gives attendees tools to prepare for the unexpected. Michigan MGMA members can register for free here.

The Programming Committee has been working on the Fall Conference, and we hope you'll come sail away with us in Traverse City September 28-29 at Hotel Indigo. As always, the Fall Conference will offer educational sessions and opportunities to meet new peers, including an evening of lively networking.

REGISTER HERE

MiMGMA strives to make the member experience positive and worthwhile. If you have suggestions for how we can improve, or to suggest educational content and topics, please contact us at INFO@MIMGMA.ORG. ■

Meet the Fall Conference Keynote Speaker

Erik Dominguez is a communication and confidence expert with over 25 years of experience teaching thousands of individuals from all walks of life how to speak up for themselves. As an immigrant who grew up between two cultures and mixed messages, his familiarity with communication fears fueled him to learn and share the mindsets and tools to be seen and heard. His team-oriented approach has centered around a philosophy that everyone has a unique story and believes that everyone can share their minds and hearts with confidence, power, and - yes - a LOT of fun! ■

ABOUT THE KEYNOTE

The Three T's of Confidence for Leaders

Building Lasting Self-Trust to Achieve Your Dreams

Unexpected change is the new norm, and the pressure to navigate it falls on leaders. As a result, we've seen increased anxiety, burnout, turnover, and poor decision-making. Our leaders lack (and leak!) the confidence needed to keep up with the ever-changing workplace.

But what if we could train leaders to lead well in any situation simply by improving confidence? What if we could learn the tools to build confidence that lasts and levels up our entire team?

During this session, Erik will use the Three T's of Confidence to equip new and seasoned leaders to help them build authentic confidence, navigate change, and find balance in an unbalanced world.

His high-energy delivery and science-backed content will leave you feeling more confident and better equipped to lead at new levels... immediately!

Fall Conference Venue

Hotel Indigo Traverse City
263 W Grandview Pkwy
Traverse City, MI 49684

CLICK HERE FOR ROOM BLOCK DETAILS

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Body of Knowledge

Assess and develop your expertise in medical practice management

By Sandy Sprague, FACMPE

Group practice management is unique, and the profession's nuances make it unlike any other. That's why the Body of Knowledge (BOK) for Medical Practice Management is so essential to success. It serves as a repository of industry knowledge, a guide to practice management, an assessment of competency and a learning tool.

The BOK also serves as the exam blueprint for MGMA members who are pursuing **certification and Fellowship through the American College of Medical Practice Executives (ACMPE), the certification and standard-setting entity of MGMA.**

Domain exam percentages

- Operations Management.....25%
- Financial Management.....25%
- Human Resource Management.....15%
- Risk and Compliance Management.....12%
- Transformative Healthcare Delivery.....13%
- Organizational Governance.....10%

We will take a closer look at the Financial Management domain in this edition of the MiMGMA Newsletter; do you feel additional knowledge would be beneficial to you and your organization? Please continue reading…

Financial Management

Maintaining financial systems to ensure a profitable practice.

Financial management in a medical practice involves the development and maintenance of financial systems to ensure a profitable practice. Skills in accounting, budgeting, revenue cycle management and financial analysis support effective financial management.

Financial management performance objectives include:

- Coding and billing concepts, payer reimbursement policies and revenue cycles
- Explain how the various functions of front-end operations are performed, including scheduling, insurance verification, authorizations, and copayment and deductibles collection.
- Identify inaccuracies in medical record documentation, charge capture and coding.
- Conduct a charge audit.
- Submit a claim.
- Resolve an edit to a claim.

Cash flow management performance objectives include:

- Manage a non-patient accounts receivable.
- Analyze and design a cash flow projection.

Accounts payable management performance objectives include:

- Describe the basics of bookkeeping.
- Identify and give an example of the use of accounting software.
- Discuss vendor payment terms.
- Define lease agreements.
- Explain segregation of duties.

Payroll systems management performance objectives include:

- Explain the payroll process.
- Illustrate a policy and procedure that ensures that the organization is paying employees the correct amount for the exact hours worked.
- Identify employment and payroll regulatory requirements.

Budget management performance objectives include:

- Discuss the various types of budgets and their application for a medical group practice.

Audit processes performance objectives include:

- Describe the different types of audits and explain what an audit report should include.
- Discuss the generally accepted auditing standards (GAAS).

If you are not currently a Certified Medical Practice Executive, CMPE, there are several paths available to you to embark on this journey! Please contact Sandy Sprague, ACMPE Forum Rep, for additional information at SSPRAGUE@GREATLAKESEYEINST.COM. We can discuss your specific details to determine the best course for you! ■

Summer Reimbursement Updates

By Joe Rivet, Esq., CCS-P, CHC, CEMC, CPC, CPMA, CICA, CHRC, CHPC, CCEP, CAC, CACO, Reimbursement Committee Chair

AMBULATORY SURGICAL CENTERS

Update to the MCS for Ambulatory Surgical Center (ASC) Code Pairs

On April 21, CMS published One-Time Notification Transmittal 11990 regarding the creation of a MCS maintained audit to reject claims with a pass-through device code without an appropriate paired procedure code from the ASC code pair file and apply the appropriate reduction rate for the ASC code pair. The current design of the MCS does not allow users to assign multiple reduction rates to ASC code pairs under a single audit and given the quarterly updates to ASC code pair files, the number of audits available are being exhausted. This change will fix that issue. The production of this edit is being split into two quarterly updates in October 2023 and January 2024.

Effective date: October 1, 2023, for October 2023 release (coding, testing and implementation) – BRs 13163.1 – 13163.4.1.3 and 13163.7 – 13163.10; January 1, 2024, for January 2024 release (coding, testing, and implementation) – BRs 13163.5, 13163.6, and 13163.11-13163.11.3

Implementation date: October 2, 2023, for October 2023 release (coding, testing, and implementation) - BRs 13163.1 - 13163.4.1.3 and 13163.7 – 13163.10; January 2, 2024, for January 2024 release (coding, testing, and implementation) – BRs 13163.5, 13163.6, and 13163.11-13163.11.3

COMPLIANCE

Renewal of Advanced Beneficiary Notice of Noncoverage (ABN) Form

On April 4, CMS published the new version of the ABN form, which the OMB approved for renewal. The nondiscrimination language was updated, and the form expires on January 31, 2026. Providers may start using the form now, and it must be used beginning June 30, 2023.

FAQ: CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency

On April 26, CMS published an FAQ regarding the end of CMS waivers and flexibilities as the COVID-19 PHE expires on May 11. The FAQ addresses the exact ending of the PHE, how CMS will handle payments for COVID-19 vaccines, when enforcement discretion for certain billing policies will end, and more.

CMS also published a Document regarding coverage for COVID-19 tests after the end of the COVID-19 PHE.

MEDICARE SECONDARY PAYER

Manual Updates Regarding Common Working File (CWF) Medicare Secondary Payer (MSP) Processes

On April 27, CMS published *Medicare Secondary Payer Transmittal 11996* regarding updates to chapter 6 of the manual related to MSP CWF processes. The update adds current terminology and acronyms and removes outdated policies and procedures. There are no MSP policy or operational changes being made to this chapter in this update.

Effective date: May 29, 2023; *Implementation date:* May 29, 2023

CODING/DOCUMENTATION

HCPCS Application Summaries and Coding Recommendations

On April 27, CMS published the First Quarter 2023 HCPCS Application Summaries & Coding Recommendations.
The document contains a summary of each HCPCS code application and CMS' coding decisions for each of the processed applications. All new coding actions will be effective by July 1, 2023, unless otherwise indicated in the document.

WPS Part B Upcoming Webinars

WPS Part B has a series of webinars scheduled through the end of the year. A few of the Upcoming Webinars:

- Modifier Monday: Using Modifiers with NCCI (7/10); JW and JZ 0 Single Does (8/7)
- Understanding Split/Shared Services (7/11, 7/12)
- Ins and Outs of the Advance Beneficiary Notice of Noncoverage (7/13)

New Claim Modifier Required for Single-Dose Container or Single-Use Package Drugs

On June 2, CMS published *Medicare Claims Processing Transmittal 12067* regarding the requirements of the new JZ modifier beginning July 1, 2023. The MACs are instructed to perform audits of Part B claims beginning July 3, 2023. The new JZ modifier is reported when zero drug amount discarded/not administered to a patient. This modifier applies to separately payable drugs under Medicare Part B that are described as being supplied in a "single-dose." An FAQ has been published covering JW and JZ modifiers.

MEDICARE ADVANTAGE

Final Rule: Contract Year (CY) 2024 Policy and Technical Changes to the Medicare Advantage Program and Medicare Prescription Drug Benefit Programs

On April 5, CMS published a draft copy of a Final Rule regarding the policy and technical changes for CY 2024 Medicare Advantage (MA) plans, Part D plans, and Programs of All-Inclusive Care for the Elderly (PACE). The rule made significant clarifications to the clinical criteria guidelines used by Medicare Advantage (MA) plans to ensure MA plan patients receive the same access to medically necessary care that they would receive under Traditional Medicare Clarifications discussed in the rule include:

- Specifying that MA plans must establish a Utilization Management Committee to review policies annually and ensure MA plans guidelines comply with NCDs and LCDs

as well as general coverage and benefit conditions included in Traditional Medicare.

• Allowing MA plans to create internal coverage criteria when coverage criteria are not fully established through NCDs, LCDs, and other rules. Internal coverage criteria must be based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available to CMS, enrollees, and providers.

• Clarifying that inpatient admission regulations—including the two-midnight rule and inpatient only list, requirements for coverage of Skilled Nursing Facility care and Home Health Services, and coverage criteria for Inpatient Rehabilitation Facilities—are applicable to MA plans.

• Streamlining prior authorization requirements and adding provisions for continuity of care.

• Adding provisions to protect beneficiaries from confusing and misleading marketing by MA plans, including provisions related to television ads and agents and brokers for the plans.

The rule also contains provisions strengthening Quality Star Ratings, advancing health equity, and improving access to behavioral healthcare. It also implements certain required changes under the Consolidated Appropriations Act of 2021, the Inflation Reduction Act of 2022, and the Bipartisan Budget Act of 2018.

CMS published a Press Release and Fact Sheet on the rule on the same date. The rule was published in the *Federal Register* on April 12.

Effective date: June 5, 2023; ***Applicable:*** Coverage beginning January 1, 2024, unless otherwise noted in the rule

MACS

Update to MAC Provider Customer Service Program Information

On April 20, CMS published *Medicare Contractor Beneficiary and Provider Communications Transmittal 11956* regarding revisions to Chapter 6 of the manual to remove duplicate sections, update references, revised language, and add new reporting requirements for MACs, including reporting "non-compliant" callers to a General Services Administration custom network message providing an email address for callers to contact before their calls connect to the Provider Contact Center.

Effective date: May 22, 2023; ***Implementation date:*** May 22, 2023

OIG

Updated OIG Work Plan

On April 17, the OIG updated its Work Plan with the following new items:

- Use of Remote Patient Monitoring Services in Medicare
- Adverse Events Toolkit: Clinical Guidance for Identifying Harm

COVID-19 Healthcare Fraud Enforcement Action

On April 20, the OIG published a variety of Releases regarding actions it has taken alongside the DOJ to crack down on fraudulent behavior during the COVID-19 PHE. In 2023, nationwide enforcement against this type of fraud has resulted in criminal charges against doctors and providers for false billings and Provider Relief Fund fraud, manufacturers for fake COVID-19 vaccination record cards, and individuals for fraudulent charges to Medicare for over-the-counter COVID-19 testing kits.

Compliance Guidance Update

On April 24, the OIG published a Notice regarding its upcoming plans to modernize Compliance Program Guidance (CPG) documents. The OIG has developed a new format for CPGs and will publish them on the OIG website instead of in the *Federal Register*. The agency said it would publish a general CPG by the end of 2023 on federal fraud and abuse laws, compliance program basics, operating effective compliance programs, and OIG processes and resources. It said it will begin publishing industry-specific CPGs in 2024 and expects the first two topics addressed will be Medicare Advantage and nursing facilities.

Toolkit: Analyzing Telehealth Claims to Assess Program Integrity Risks

On April 24, the OIG published a Toolkit which is intended to help public and private sector partners (such as Medicare Advantage plan sponsors, Medicaid fraud control units, and other federal healthcare agencies) analyze telehealth claims to identify program integrity risks associated with telehealth services. The toolkit is based on the OIG's methodology to develop a report on telehealth program integrity risks from the first year of the COVID-19 pandemic. The toolkit includes detailed descriptions of seven data analysis measures which the OIG used to identify indicators of fraud and abuse. It outlines the steps involved in the data analysis, program integrity measures, and examples of how this process works.

Review of Medicare Payments for Services Provided to Individuals with Medicare and Veterans Health Administration Benefits

On April 26, the OIG published a Review of how Medicare paid providers for medical services that were authorized and paid for by the VA's community care programs, as the Veterans Health Administration (VHA) is solely responsible for paying providers for these services. The OIG found that Medicare paid providers in these scenarios up to $128 million in duplicate payments during the audit period of January 2017 through December 2021. These payments occurred because CMS did not establish a data-sharing agreement with the VHA and did not develop an interagency process to include VHA enrollment, claims, and payment data in CMS's data repository as required by federal law. CMS, therefore could not compare VHA claims data with existing Medicare claims data to identify duplicate claims.

The OIG recommends CMS establish a data-sharing agreement with the VHA, establish an interagency process to integrate data into the CMS Integrated Data Repository, establish an internal process to address duplicate payments made by Medicare for medical services authorized and paid for by the VHA, and issue guidance to providers on not billing Medicare for a medical service authorized by the VHA. CMS concurred with the OIG's recommendations.

ENFORCEMENT ACTIONS

SYSTEMS / CLAIM PROCESSING: Modernization of Communications regarding Cross Over Errors

On April 5, CMS published *Medicare Claims Processing Transmittal 11939* regarding improvements to the National Coordination of Benefits Agreement (NOBA) Detailed Error Reporting Notification Process. The change will allow the MACs to inform providers via alternative communication, including the provider portal, rather than only direct mailing of a special notification letter or report that their patients' claims could not be crossed over.

Effective date: July 6, 2023; *Implementation date:* July 6, 2023

AUDIT CONTRACTORS AND APPEALS: March 2023 Livanta Claims Review Advisor

On April 10, Livanta published its March 2023 edition of the Claims Review Advisor. It covered the first year of review findings for short-stay reviews. Livanta found that 86% of short-stay review claims were approved for appropriate Part A reimbursement. Denials were most common amongst CMS region 4 (southeast US), and more than half of the denials were traced back to two major diagnostic categories (MDC): circulatory system and digestive system.

FISS User Enhancement Change Request (UECR) - Modify Additional Development Request (ADR) Letters to Set Response Due Date from the Reason Code File

On April 27, CMS published *One-Time Notification Transmittal 12001* regarding a modification to FISS ADR letter generation to allow MACs to determine the number of calendar days allowed for providers to respond. The FISS is currently hard-coded to always allow for 45 days, and the change is necessary to accommodate Unified Program Integrity Contractor (UPIC) reviews that allow for 35 days for a provider response.

Effective date: Oct. 1, 2023; *Implementation date:* Oct. 2, 2023

CONTRACTORS AND APPEALS: Prior Authorization for Facet Joint Interventions

On April 11, CMS updated items on the Prior Authorization for Certain Hospital Outpatient Department (OPD) Services website. The Operational Guide was updated with information on the addition of facet joint interventions to the list of services requiring prior authorization, documentation requirements and frequency limitations for joint intervention procedures, and additional details about the exemption process for non-exempt providers. The Final List of Outpatient Department Services That Require Prior Authorization was updated with the list of HCPCS codes for facet joint interventions added effective July 1, 2023. Providers can start submitting the prior authorization requests on June 15 for dates of service on or after July 1. ■

Process Improvement and Customization

By The Rybar Group

As a valued member of your organization's compliance team, the compliance auditors view process improvement as an integral part of developing an efficient audit program. Whether your organization is starting a system from scratch, or seeking to refine the structures already in place, the opportunity exists to evaluate current tools and make an informed decision about how they can better serve the everyday needs of the folks utilizing them.

There are many considerations to keep in mind when developing an internal audit process specific to each organization. There are of course elements that must remain fixed, as they are dictated by outside entities (e.g., coding and payor guidelines). Keep in mind all the elements that make each organization unique, and consider the following:

- Who will be utilizing these forms/processes?
- What roles does the compliance/audit team fill in different situations?
- How can this work inform other departments of related processes?
- What does accountability look like in the current process, and can it be enhanced?

For example, one of the many important tasks that the compliance department participates in is the implementation of new services. Let's say one of the practice leaders attends a conference and hears of a service they would like to offer at your organization. Service implementation is a unique opportunity to coordinate with multiple departments and involves so much more than providing a new service to patients. Your team has the chance here to show their additional value beyond risk reduction through regular audits.

By outlining a start to end methodology for service implementation, organizations would have a paper trail which would serve as a valuable reference should there be a guideline or personnel change. Additionally, this can help reduce duplicative work, which saves both time and money. This process could include, at a minimum, the following:

- Identifying stakeholders
- Performing and reporting on payor research (e.g., reimbursement, documentation requirements, any NCD or LCD, etc.)
- Creating timelines for implementation
- Coordinating EMR builds and clinical workflows
- Envisioning how clinical workflows can complement back-end processes
- Providing education to clinical staff
- Providing education to non-clinical staff
- Integration of these services to the audit process

Often, the biggest barrier to accomplishing a process refresh is the time it takes to sit down and make the revisions. However, making regularly scheduled space for improving processes will add efficiency, value, and time back into your regular work. ■

In Healthcare Real Estate, Losing Time Equates to Losing Profitability

"TIME IS MONEY." The basic idea behind the phrase is that we have a limited amount of both, and we should spend them efficiently—wasted time can mean wasted money. But for healthcare professionals wearing multiple hats, it also means a minute spent doing one thing is a minute that's not spent doing something else. It's why you guard your own time for your best work. It's why you hire experts—an expert landscaper, accountant, lawyer, and when negotiating the second-highest expense in your practice, a real estate agent.

Healthcare professionals are becoming increasingly more aware of the importance of a real estate strategy to increase profitability and save time. Commercial real estate agent's services are free for tenants and buyers (typically paid for by the landlord or seller), and they're vital to maximizing profitability, efficiently.

Here's a look into the value of time during commercial real estate transactions—and how agents can save you both precious minutes and money.

Timing discussions with landlords

For every negotiation and transaction, there's an ideal timeframe to follow. Identifying top lease and purchase options or negotiating a mutually agreeable deal can take several months. Add on a few more months for legal reviews of contracts, finalizing important details with architects, contractors, lenders and equipment providers. Then follow that up with any necessary build-out processes or renovations— space design, permitting, engineering plans, construction and more. All that to say: the real estate process takes time, and beginning it too late can set into motion costly issues, including holdover penalties if you're not able to vacate your previous space or losing the opportunity to negotiate multiple spaces at once.

If negotiations—and their timing—are not handled properly, the results can mean decreased profitability. That's where healthcare real estate agents come in. While the timing may vary whether you're renewing a lease, purchasing your first space, looking to relocate or expanding your office, our rule of thumb is to begin the process 18-24 months in advance.

Negotiating multiple spaces at one time

A great real estate agent will not only help you avoid costly delays, they'll also save you dozens of hours of valuable time during the market evaluation process.

Each transaction begins with a detailed game plan aimed at maximizing opportunity, time and spending. If timing the real estate process is step number one, then step number two is creating a strong posture. By leveraging a local real estate professional's expertise and then dictating favorable terms to a landlord, tenants and buyers yield consistently more favorable terms.

That's because the foundation of a successful negotiation starts with understanding market availability and area comps. Whether you're planning to renew your lease, looking to buy or considering relocation, you must understand the viable options available in your area. How do they compare to each other? How can you leverage those spaces at the negotiation table?

Healthcare real estate agents analyze all available properties that suit your healthcare business's needs. They tour a significant number of them to determine which ones are best-suited for your workforce and patients. And they negotiate no fewer than four spaces simultaneously. Why? So they don't have to start at the beginning if a property falls through. So they

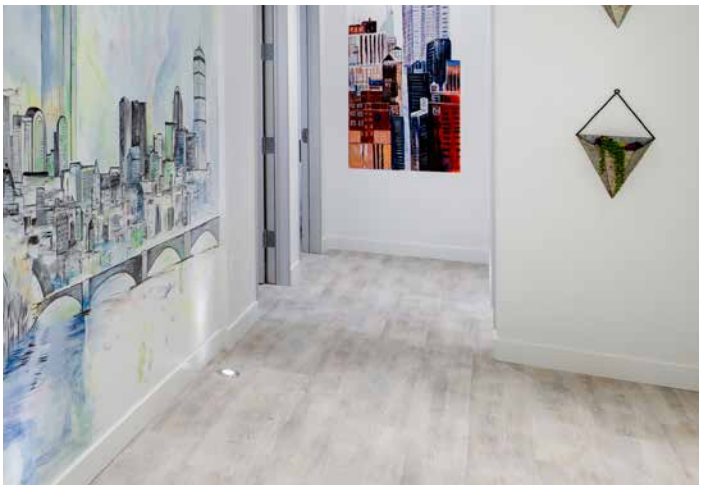
can pick up with the next best option without losing a beat. And because calling and touring one property at a time is never efficient. Just like you wouldn't cook Thanksgiving dinner one dish at a time, expert agents aren't negotiating one property at a time—it'll all come out cold.

Doing this allows agents to efficiently deliver multiple, legitimate options and build a better posture. Having a credible willingness for buyers and tenants to choose another property creates an environment where landlords and sellers compete to attract and retain quality tenants and buyers. It also ensures they get the most competitive terms.

Time is money, let an expert take care of the real estate

As a healthcare professional or manager, your practice's success is dependent on time management. Spending unnecessary hours completing market analysis, analyzing properties, leases and offers to make sure your deal is competitive and handled properly is not the best use of your time.

Because while getting the best possible deal or lease terms is vital, so is ensuring you don't waste your own time—time that could have been spent on your business. Hiring commercial real estate professionals who specialize in healthcare will not only protect your valuable time, it'll also allow you to identify the very top options, negotiate the most favorable terms and save you a substantial amount of money in the long run. ■



CARR is the nation's leading provider of commercial real estate services for healthcare tenants and buyers. Every year, thousands of healthcare practices trust CARR to achieve the most favorable terms on their lease and purchase negotiations. CARR's team of experts assist with start-ups, lease renewals, expansions, relocations, additional offices, purchases, and practice transitions. Healthcare practices choose CARR to save them a substantial amount of time and money; while ensuring their interests are always first.

Visit **CARR.US** *to learn more about our expert representation services.*

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