MEDICAL SYSTEMS
HELPING DOCTORS BE DOCTORS

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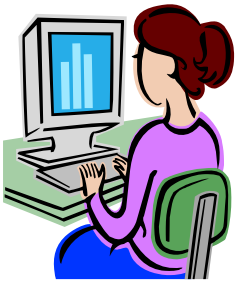
THE BILLING BULLETIN

Coming Soon….Patient Portal Will Make Collecting Patient Balances Easier

CRT Medical Systems will roll out the new **Patient Portal** in the next few months, making it easier for our client practices to not only create send electronic patient statements, but allow patients to make payments through the portal, in a safe, **HIPAA** secure environment. This addition to the **EBC** program will be offered at **no cost** to our clients, and will afford a tremendous cost savings just from no longer having to produce paper statements for mailing.

To get ready for this portal, we encourage you to start entering your **patients' email addresses** into the demographics screen in **EBC**. There are two fields for email addresses, and you can enter two different email addresses in those fields. Once deployed through the portal, a patient would receive notification that their statement is available. They would need to log into the portal, using an ID and password that they create, and view their statement. They will be given the opportunity then to make a payment on their account.



More information will be available in the coming weeks, and we will keep you informed of this new cost-saving option for **CRT** clients.

AMA Urges Scrutiny of EHR Program Requirements

The **AMA** submitted formal comments recently to the Office of the National Coordinator for Health Information Technology (ONC) regarding the committee's proposal for Stage 3 of the meaningful use **HER** meaningful use requirements.

"The **AMA** shares the administration's goal of widespread **EHR** adoption and use, but we again stress our continuing concern that the meaningful use program is moving forward without a comprehensive evaluation of previous stages to resolve existing problems," said **Steven J. Stack, MD** and chair of the AMA Board of Trustees. "A full evaluation of past stages and more flexible program requirements will help physicians in different specialties and practice arrangements successfully adopt and use **EHR's**."

Details Really Do Make A Difference

The addition of one or just a few words to a procedure report can make a major difference in the coding and reimbursement of a service, and increase the accuracy of documentation that may be evaluated in an audit.

Practitioners who perform tissue-related procedures, for example, may want to audit a sample of their reports to make certain that they are consistently commenting on crucial aspects of their services.

- If I performed a debridement of tissue, or destruction, excision, or shaving of a lesion, or repaired a wound, did I describe the exact location?
- Did I mention the size of each area?
- Did I identify the deepest level of the procedure using terms such as subcutaneous, subfascial, or bone?
- If I performed a closure, did I specify whether it was layered?
- Did I classify any lesion as being benign, malignant (primary, secondary, or cancer in situ), of uncertain behavior, or unspecified?

It is important to realize that when these details are absent, the lowest level of code must be used as a default. This can result in substantial loss of revenue or, in an audit, assessment of an overpayment.

Now is the perfect time to fine-tune documentation for other reasons as well. ICD-10-CM will require far more specificity than has been the case with ICD-9-CM, and October 1, 2014 is looming on the horizon. And let's don't forget about the increased emphasis on documentation associated with successful participation in various quality initiatives.