The Enlighten Newsletter
March 2015

Free CEUs
See Page 11 for Details
Quick Tips to Remember

Protect Yourself from Data Breaches: Quick Tips to Remember

Data breaches have been a mainstay of news reports lately – and unfortunately, they are not going away anytime soon. With the access our readers have to sensitive and confidential information, it’s more important than ever that you take extra precautions to ensure the security of your data.

As we see more and more data breaches happening, Advize Health would like you to remember some common quick tips that will help stay safe:

1. Lock your computer or laptop when you leave your work area.
2. Redact as much as possible.
3. Password-protect and encrypt as much as you can.
4. Be extra careful when faxing or emailing PHI - one incorrect key could result in PHI going to the wrong recipient.
5. If you must use paper, lock medical records when you are not working with them.
6. Properly shred and destroy paper or other media containing PHI and other sensitive information when disposing of it.
7. Lock your desk when you leave your area if there is any PHI or confidential information.

Data breach protection is your first and best line of defense against fraud. Make it your top priority to protect the confidential information you have access to, as well as your bottom line!

Did You Know? Fraud Waste and Abuse Facts

Here are 12 facts about fraud waste and abuse that you should know about!

1. Every $2 million invested in fighting health-care fraud returns $17.3 million in recoveries, court-ordered judgments, bogus claims that weren’t paid, and other anti-fraud savings.
   Source: National Health Care Anti-Fraud Association, 2008

2. Fraud accounts for 19 percent of the $600 to $800 billion in waste in the U.S. healthcare system annually. Fraud amounts to between $125 and $175 billion annually, including everything from bogus Medicare claims to kickbacks for worthless treatments and other services.
   Source: Thomson Reuters, 2009

3. More than half (57 percent) of insurers expect to see an increase in fraud losses this year on personal insurance lines (mainly auto and home insurance), while only 5 percent of insurers expect to see a decline in dollar fraud losses on personal lines.
   Source: Insurance Information Institute, 2015

4. Each family in the U.S. pays more than an extra $800 in health care costs every year because of health care fraud.
   Source: Blue Cross Blue Shield Assoc., 2013

5. In 2013, the U.S. Department of Health and Human Services estimated that it improperly spent about $65 billion in taxpayer funds through waste, errors and fraud – with $60 billion attributed to overpayments to Medicare and Medicaid.
   Source: U.S. Department of Health and Human Services, 2013

6. The United States Government Accountability Office estimates that $1 out of every $7 spent on Medicare is lost to fraud and abuse.

7. Abuse cannot always be easily identified, because what “abuse” versus “fraud” is depends on specific facts and circumstances, intent and prior knowledge, and available evidence – among other factors.
   Source: AARP, 2009

8. Private-sector payers have less success in combating fraud and abuse because they lack the legal and administrative tools available to the federal government.
   Source: AARP, 2009

   Source: Office of Inspector General

10. The Congressional Budget Office estimates that increased enforcement would save Medicare and Medicaid about $2 billion over 10 years.
    Source: Congressional Budget Office

11. In October 2012, Medicare Strike Force operations in seven cities led to charges against 91 individuals for their alleged participation in Medicare fraud schemes involving approximately $432 million in false billing. These individuals included doctors, nurses and other licensed medical professionals.
    Source: U.S. Department of Health and Human Services, 2013

12. Due to the Affordable Care Act, criminals convicted of fraud now face tougher sentences and more jail time. Criminals will receive 20 to 50 percent longer sentences for crimes that involve more than $1 million in losses.
    Source: U.S. Department of Health and Human Services, 2013
Diagnosing the Future of Healthcare: HCC Coding

The future is now - at least in terms of the HCC coding world.

The Hierarchical Condition Category (HCC) codes assigned to patients today will form the foundation of each patient's Medical Risk Adjusted (MRA) score for next year. There are several factors involved in creating an MRA score for a patient aside from diagnosis codes including age, gender, geographic location, and even social status.

Let's start with a brief overview of how this all works. In basic terms, the HMO insurances are reimbursed by Medicare based on how sick the patient is. In theory, the more chronic conditions and accompanying manifestations a particular patient has, the more it should cost the insurance company to maintain quality of care for the patient. This is reflected by the patient's selected primary care provider attesting to the conditions that the patient is diagnosed by them or any other provider.

Not every code is an HCC code. Qualifying conditions are assigned to an HCC category for purposes of reimbursement. For example, a condition such as depression is not considered to be a chronic condition warranting significant additional cost to treat. Instead, major depression is reimbursable even if it is in remission, because major depression is considered a chronic condition that significantly increases the likelihood of hospital admission, is typically treated with a prescription, and requires routine follow-up care.

In addition to the HCC codes, there are also Rx codes that cover the cost of prescriptions for conditions such as hypertension and hyperlipidemia that are easily controlled. The Rx codes only pay pennies on the dollar since they are designed to cover the costs of prescriptions and the condition alone typically requires no significant additional treatment once controlled. HCC and Rx codes are updated annually and are released by CMS. Much like CPT code updates, they can be taken from HCC status and put into Rx status or even be deleted.

So why does it seem that this trend in healthcare is becoming the norm? If the cost that Medicare deems is necessary for care to the patient is not needed, is it a surplus payment to the insurer and trickles down to providers. Simply put, if a provider does an excellent job of diagnosing the patient, keeps prescription costs low, only utilizes specialists when necessary, and limits hospital admissions, they will likely have money left over that is profit. The trick to all of this is maintaining the delicate balance of quality healthcare while still being cost-efficient.


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Compliance 101

Compliance Corner

Want to test your knowledge before taking our CEU test? Take our compliance corner quiz below!

Answers on page 11.

1. What are five reasons why a covered entity may deny a patient a copy of their PHI without providing the individual the right to having the denial reviewed?

2. Is a pharmaceutical manufacturer considered a covered entity?

3. When a covered entity changes a privacy practice that is stated in the notice described in §164.520 and makes corresponding changes to its policies and procedures, can it make the changes effective for protected health information that it created or received prior to the effective date of the notice revision?

4. How many days after the receipt of the request does a covered entity have to act on a request for PHI under normal circumstances?

5. While at her daughter’s school’s open house, Samantha, a receptionist at Dr. Johnson’s Neurology practice, mentions to a friend that she saw a mutual friend at the office last Friday. Is this a violation of HIPAA?

6. Define the Acronym NPP.

7. What are the three core health activities where a covered entity could disclose a patient's PHI?

8. If a patient is deceased, may a covered entity disclose PHI of the deceased to a family member who was involved in the patient’s care or payment for healthcare prior to the death?

9. Where should patient complaints first be filed?

10. True or False: The Privacy Rule requires the return or destruction of all protected health information (PHI) at the termination of a business associate agreement contract where feasible or permitted by law.

11. When is a covered entity required to disclose PHI?

12. Define the principle of “minimum necessary?”

History of Present Illness: Location

Location is a statement from the physician regarding the anatomical place, position, or site of the chief complaint (examples include left leg, upper chest, head, neck, low back, etc.). It can be defined by a descriptive word that tells the reader if the pain or problem is diffused/localized, bilateral/unilateral, fixed, migratory, or radiating/referred. It is not to be inferred in any way, meaning the site or location must be evidenced in the documentation. Clear documentation of the location or site often helps to avoid medical mistakes, such as wrong site errors. Documenting this HPI element can help to protect the physician from a liability standpoint.

In the following statement, please pull the location HPI:

The patient returned today with a worsening sore throat; complains of fever for two days.

Answer on page 9.
Healthcare Toolbox: Quality Measuring Tools

For Healthcare Providers

Just as healthcare consumers expect quality from their healthcare plan, physicians are expected to provide quality healthcare services as well. Likewise, there are multiple programs in place to help assure this outcome. For example, the National Committee for Quality Assurance (NCQA) manages voluntary accreditation programs for individual physicians, medical groups, and health plans. Health plans seek accreditation and measure performance through the administration and submission of the Healthcare Effectiveness Data and Information Set (HEDIS). NCQA also provides an evidence-based program for case-management accreditation available for use in payer, provider, and community-based organizations.

HEDIS is a widely used set of quality performance measures in the managed care industry. HEDIS is one component of NCQA's accreditation process, although some plans submit HEDIS data without seeking NCQA accreditation. An incentive for many health plans to collect HEDIS data is a Centers for Medicare and Medicaid Services (CMS) requirement. Ninety percent of America's health plans use HEDIS to measure performance on important dimensions of care and service. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts. Some of the HEDIS measures per the NCQA are:

- Asthma Medication Use
- Blood Pressure Control
- Comprehensive Diabetes Care
- Breast Cancer Screening
- Antidepressant Medication Management
- Childhood and Adolescent Immunization Status
- Childhood and Adult Weight/BMI Assessment

Still, the Patient Protection and Affordable Care Act (PPACA) or (ACA) requires that all health plans participating in the new health insurance exchanges be accredited. Per NCQA: "Health plans that maintain NCQA Accreditation report clinical quality and patient experience measures, and allow the results of those measures to be publicly reported. They have a strong record of steady improvement in reported measures. Today, nearly 60 percent of all health plans in the U.S. are accredited by the NCQA. These plans provide coverage for 109 million Americans or 70.5 percent of all people covered by private health plans."

Quality measures from health plans will continue to be a demand of the healthcare consumer. With NCQA and other rating agencies in place, a consumer can compare health plans and determine what is best for an individual or their employees. The impact on a clinical practice is to ensure that the proper methods of reporting on clinical performance but did not elect quality tiering will have a neutral value modifier in 2015. Groups of 100 or more EPs who self nominated/registered for and then participated in any of the above mentioned PQRS group reporting methods available in 2013: (1) the web interface group reporting option, (2) a registry, or (3) request that CMS calculate the group's performance on quality measures from administrative claims.

In 2013, in order to avoid an automatic negative 1 percent value modifier adjustment to 2015 payment under the Medicare Physician Fee Schedule based upon the quality of care furnished compared to cost during a performance period. Per CMS, in 2015, physicians in groups of 100 or more eligible providers who submit claims to Medicare under a single Tax Identification Number (TIN) will be subject to the value modifier, based on their performance in calendar year 2013.

In 2006, CMS established Physician Quality Reporting Initiative (PQRI) which later became known as the Physician Quality Reporting System (PQRS). This "pay for reporting" program provides incentive payments to physicians who report quality data. Also, according to the AMA, physicians who participate in the program transmit data to CMS regarding the quality measures reported on in caring for their Medicare patients. Under the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), the PQRS program was made permanent. MIPPA also required CMS to post on a website the names of those who have participated or not participated under the PQRS. The Patient Protection and Affordable Care Act (PPACA) made participation in PQRS mandatory, beginning in 2015. For clarification, CMS ruled in 2012 that, if a provider is not successfully participating in PQRS during the 2013 reporting period (Jan. 1 – Dec. 31, 2013), their reimbursement will be decreased by 1.5 percent, in 2015. Starting in 2016, reimbursement will be decreased by 2 percent and will be based upon performance two years prior.

CMS lists several clinical quality measures, or CQMs, which are tools that help measure and track the quality of healthcare services provided by eligible professionals. According to CMS, the measures data associated with providers' ability to deliver high-quality care or relate to long-term goals for quality healthcare. CQMs measure many aspects of patient care including:

- Health Outcomes
- Clinical Processes
- Patient Safety
- Efficient Use of Healthcare Resources
- Care Coordination
- Patient Engagement
- Population and Public Health
- Adherence to Clinical Guidelines

Measuring and reporting CQMs helps to ensure that our health care system is delivering effective, safe, efficient, patient centered, equitable, and timely care. Measuring and reporting CQMs helps to ensure that our health care system is delivering effective, safe, efficient, patient centered, equitable, and timely care.

Value based modifier payments (V BMP) provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule based upon the quality of care furnished compared to cost during a performance period. Per CMS, in 2015, physicians in groups of 100 or more eligible providers who submit claims to Medicare under the Medicare Physician Fee Schedule based upon the quality of care furnished compared to cost during a performance period. Per CMS, in 2015, physicians in groups of 100 or more eligible providers who submit claims to Medicare under a single Tax Identification Number (TIN) will be subject to the value modifier, based on their performance in calendar year 2013.
Annual Exam Showdown

What's the difference between annual wellness and physical exams? Distinguishing between these can be challenging unless you know what to look for in the documentation.

Let’s start with preventative medicine services (CPT codes 99381–99397). Commonly referred to as physical exams or well visits, preventative medicine services are comprehensive preventive evaluations which are age and gender-specific, beginning with infancy and ranging through patients age 65 and older for both new and established office patients. These visits do not need a chief complaint noted.

Documentation requirements for preventive physical exams include a gender- and age-appropriate history and physical examination, counseling or anticipatory guidance, and risk factor reduction interventions. CPT codes for immunizations and ancillary studies such as laboratory and radiology are reported separately. The preventive medicine comprehensive examination documentation requirements represent significant work for the physician or other provider, and payer fee schedules appropriately reflect that work.

Does Medicare cover Physical Exams?

Originally, Medicare only provided coverage for the once-in-a-lifetime “welcome to Medicare” visit. The lack of coverage was a source of frustration for many providers who understood the best way to keep their patients healthy, is through regular health maintenance. For many years, the Medicare population did not have coverage for annual exams – until January 2011, when Medicare expanded their preventive services and created the Annual Wellness Visit (AWV). Since its creation, the Annual Wellness visit has been a source of confusion among primary care practices. Many mistook the Medicare AWV to be the same service as a yearly physical exam where the provider performs a comprehensive physical exam, and depending on age and gender, certain screening tests would be employed (such as cholesterol levels, Pap smear, mammogram, bone density, and/or PSA screen, among others).

Annual Wellness Visit vs. Preventive Exams

Preventive Medicine Exams (99381–99397) and Annual Wellness Visits (G0438-G0439) are not one in the same, so how do you tell the difference? It boils down to the documentation. If all of the CMS criteria is captured and documented in the first AWV, and updated each year following, then it supports a Medicare AWV. If an age-appropriate exam with risk factor screening/ counseling is documented, then a preventive exam was performed.

The AWV (G0438-G0439) is not synonymous to the annual physical exam (99381–99397). The AWV was created for Medicare part B patients to create a personalized prevention plan and discuss health concerns with their primary care provider; whereas physical exams (not payable by Medicare Part B) are an extensive visit focusing more on the comprehensive examination of the patient.

Both AWV and Physical Exams contain elements of risk reduction, anticipatory counseling, and screening. Providers have discretion when it comes to the components used to document a Physical Exam. This is not the case with an AWV, 100 percent compliance is required by CMS as outlined in The ABCs of Providing the Annual Wellness Visit (AWV). CMS explains that all components of the AWV must be performed and documented prior to submitting a claim for the AWV.

The purpose of the AWV is to engage patients to take an active role in their own health journey and plan for future. Patients will leave their physician's office with an actionable plan for screening and risk reduction, as well as benefit from true coordination of care amongst all service providers. With this common goal, providers performing and billing Physical Exams (99381-99397) for their “non-Medicare patients” may find it beneficial to incorporate some of the AWV criteria into their typical physical exam documentation format.

Please note a newly enrolled Medicare Part B Beneficiary may seek a Welcome to Medicare Visit G0402, also called Initial Preventive Physical Exam (IPPE), within the first 12 months of enrollment. The “Welcome to Medicare Visit” is similar to the AWV, as it is an organizing visit, but it does contain different documentation criteria. Please check Medicare’s guideline prior to billing G0402. If your patient received their IPPE they must wait 12 months to be eligible to receive their Annual Wellness Visit (AWV) with Personalized Prevention Plan Services (PPPS).

The required documentation for an AWV includes:

- Health Risk Assessment administered
- Medical and family history for the individual
- Height
- Weight
- Body Mass Index
- Blood Pressure

The AWV with PPPS (G0438) expands to additional services in addition to the above:

- Concurrent Care Provider list. You must develop a complete list of all providers with whom your patient seeks care. This may include dentists, optometrists, OB/GYN, cardiologists, etc.
- Detection of any cognitive impairment that the individual may have
- Risk factors of depression or other mood disorders
- Observation of the individual’s functionality and level of safety
- If any risk factors or personal functionality areas are identified the record must include the provider’s plan for each issue identified. Such as fall risk planning or treatment for depression
- A written screening schedule is comprised for the next five to ten years
- Establishment of a list of risk factors and conditions identified for which primary, secondary, or tertiary interventions are recommended or are underway
- Health advice to the individual, including referrals, health education, counseling, etc.
- And anything that is determined appropriate by the Secretary of Health and Human Services through the National Coverage Determination, (NCD) process

Some information may be collected through questionnaires established with selected or standardized questions. The AWV with PPPS Subsequent (G0439) includes an update to the previous years AWV record. Each area of the original AWV is updated, dates of screenings obtained are entered, and future screening dates are planned in the subsequent AWV.

Regardless, performance of annual exams promotes good health and disease detection, while fostering the coordination of screening and preventive care.

History of Present Illness Answer

In the following statement, please pull the location HPI:

The patient returned today with a worsening sore throat; complains of fever for two days.

ANSWER: Location is throat.

Question on page 5.
All About Value-Based Payment Modifiers

How does the Value-Based Modified program affect healthcare professionals?

Introduced under Section 3007 of the Affordable Care Act, the Value-Based Modifier program (VBM) is designed to assess both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule. The VBM program is intended to provide comparative performance information to physicians as part of Medicare’s efforts to improve the quality and efficiency of medical care. By providing meaningful and pertinent information to physicians so they can improve patient care, CMS is moving toward physician reimbursement that rewards value rather than volume.

The value-based payment modifier applies to all physicians. The VBM uses PQRS quality data and Medicare cost data to determine a provider’s overall value score. It rewards high-performing providers with increased payments and reduces payments to low-performing providers. This will affect approximately 900,000 physicians.

CMS will apply the value-modifier to physician payment in all groups of 10 or more eligible professionals (EPs) beginning in 2016 based on their performance in calendar year 2014. Physicians in group practices of 100 or more EPs will be subject to the value modifier in 2015 based on their performance in calendar year 2013. CMS will institute the VBM for group practices and solo practitioners beginning in 2017 based on their performance in calendar year 2015. The VBM modifier will be applied to the Medicare paid amounts for the items and services billed under the physician fee schedule at the tax identification number (TIN) level. All physicians who participate in Fee-For-Service Medicare will be affected by the value modifier starting in January 2017.

The VBM is calculated for a physician using a quality composite score and a cost composite score. The quality composite scores are derived from six quality domain scores; each domain score is based on performance scores for PQRS measures reported, using its associated domain. Quality tiering will determine if group performance is statistically better, the same, or worse than the national mean, based on standard deviation scores for PQRS measures reported, using its associated domain. Quality tiering will determine if group performance is statistically better, the same, or worse than the national mean, based on standard deviation scores for PQRS measures reported, using its associated domain. Quality tiering will determine if group performance is statistically better, the same, or worse than the national mean, based on standard deviation scores for PQRS measures reported, using its associated domain.

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Example: CPT 99214

MFFS= $112.43

Individual Provider Non-PQRS Participant= $110.18 (-2%)

Large Physician Practice (+10) Non-PQRS Participant/Downward Adjustment= $ 107.93 (-4%)

25 patients billed as 99214= $2810.75
-2%= $2754.50
-4%= $2698.25

Compliance Corner Answers

1. Five reasons:
   - It was determined release was reasonably likely to endanger the life or safety of the individual or another person.
   - The information was obtained by a covered provider in the course of a clinical trial; the individual agreed to the denial of access in consenting to participate in the trial, and the trial was in progress.
   - The information was compiled in reasonable anticipation of, or for use in, a legal proceeding.
   - A pharmaceutical manufacturer is only a covered entity if the manufacturer provides "health care" according to the rule's definition and conducts standard transactions.
   - Yes, if the covered entity has, in accordance with § 164.520(b)(1)(v)(C), included in the notice a statement reserving its right to make such a change in its privacy practices.

2. 30 days.

3. Yes, unless there is an expressed statement to the contrary. (45CFR 164.510)

4. True.

5. True.

6. NPP is Notice of Privacy Practices.

7. The core health care activities of “Treatment,” “Payment,” and “Health Care Operations” are defined in the Privacy Rule at 45 CFR 164.501.

8. Yes, unless there is an expressed statement to the contrary. (45CFR 164.510)


10. True.

11. PHI should be disclosed to individuals (or their personal representatives) specifically when they request access; and to HHS when it is undertaking a compliance investigation or review or enforcement action.

12. A covered entity must make reasonable efforts to use, disclose and request only the minimum amount of PHI needed to accomplish the intended purpose it’s use.

You Be the Coder Answer

In this extended HPI, the elements are:

- Quality: Stable
- Duration: past 7 Years
- Modifying Factor: Tanzeum
- Severity: Home BS checks running 80-100.

Question on page 4.

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Advize Health is represented by a staff of experts who perform coding and billing audits for payers, in both private and public sectors, and have a range of certifications: RN, RHIT, CPC, CPC-H, CPC-I, CCS-P, CIRCC, CPCO, CPMA, CEMC, CHC and CFE.

Project-Focused Approach
We offer straightforward healthcare review services with a focus on clear and frequent communication.

Delivery of Clear ROI
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Advize Health provides cost-effective and efficient medical record review services to identify inconsistent documentation between clinical records and claim payment data. Our expert team of experienced healthcare professionals has extensive knowledge in auditing, coding and claims recovery, enabling us to deliver valuable results and increased savings to healthcare providers.

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For more information about Advize Health, please visit advizehealth.com

advizehealth

201 E Kennedy Blvd, Suite 1130
Tampa, FL 33602
407.583.7379
advizehealth.com