AAPC

CPPM®

Certified Physician Practice Manager

STUDY GUIDE

2026

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AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are *actual, redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real-world* quality of these notes for educational purposes, we have not rewritten or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially, they are as one would find them in a coding setting.

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Chapter 1

Introduction to Healthcare Business Processes and Workflow

The complexities of the revenue cycle and compliance regulations in our healthcare system, along with the required human resource knowledge and general business and management skills, make managing a medical practice an exciting and demanding profession. Successful medical practice managers find great fulfillment not only in running successful businesses, but also by providing for the health and wellbeing of their communities. The Certified Physician Practice Manager (CPPM®) credential will help identify the competencies needed to succeed and will verify you as a professional who is committed to success.

This curriculum starts with an overview of healthcare. Subsequent chapters provide education on subject matter to prepare practice managers to be successful in accounting, revenue cycle management, human resources, quality operations, compliance, data management, information technology, and health reform.

Types of Healthcare Providers

Physician and Non-Physician Practitioners

There are two types of physicians: Medical Doctor (MD) and Doctor of Osteopathic Medicine (DO). MDs are allopathic physicians and DOs are osteopathic physicians. Both MDs and DOs may use all accepted methods of treatment, including drugs and surgery. Many DOs place special emphasis on the body's musculoskeletal system, preventive medicine, and holistic patient care.

Some physicians work in small private offices or clinics, often assisted by a small staff of nurses and administrative personnel. Over the last decade there has been an increased number of physicians working in a group practice or healthcare organization. Physicians in a group practice or healthcare organization often work as part of a team that coordinates care for many patients.

Non-physician practitioners (NPPs) such as a physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), and certified nurse midwife (CNM) are eligible for reimbursement by Medicare and other payers. They may obtain their own provider identifier, which allows them to bill directly for their patients, generally at a percentage less than would be paid to a physician. Alternately, they may bill incident-to the work of a physician with the physician's patients. Incident-to billing is billed under the physician's provider identifier.

CMS definition: Incident-to services are defined as those services furnished incident to physician professional services in the physician's office or in a patient's home. To qualify incident to, services must be provided by a caregiver whom the physician directly supervises and who represents a direct financial expense (e.g, W-2, leased employee, or independent contractor).

Incident-to services supervised by non-physician practitioners are typically reimbursed at 85 percent of the Medicare physician fee schedule. The incident-to billing rules provide an exception, allowing 100 percent reimbursement for non-physician services that meet the requirements detailed in the Medicare Benefit Policy Manual, Chapter 15, Section 60 (Services and Supplies Furnished Incident to a Physician's/NPP's Professional Service: Rev. 12425; issued Dec. 21, 2023; effective Jan. 1, 2024, implementation; January 2024; B-2050). For incident-to services, the services must be part of a patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved during treatment. The NPP must provide services that are an integral part of the physician's own involvement with their patients (e.g., follow-up office visits for known diagnoses the physician is monitoring). The supervising provider does not have to be physically present in the patient's treatment room while these services are provided but must provide direct supervision (be present in the office suite to render assistance if necessary).

PAs are formally trained to provide diagnostic, therapeutic, and preventive healthcare services as delegated by a physician. They take medical histories, examine and treat patients, order and interpret laboratory tests and X-rays, and may make diagnoses. They also treat minor injuries by suturing, splinting, and casting. PAs document progress notes, instruct and counsel patients, and order or carry out therapy. They also may prescribe certain medications. The duties of PAs are determined by the supervising physician and by state law.

PAs work under the supervision of a physician but may be the principal care providers in rural or inner-city clinics where a physician is not always present. In such cases, the PA confers with the supervising physician and other medical professionals, as needed, and required by law. PAs may make house calls or go to hospitals and nursing care facilities to check on patients, after which they report back to the physician. The duties of PAs are determined by the supervising physician and by state law.

Specialist	Specialty	Specialist's Focus
Pediatrician	Pediatrics	All diseases and total healthcare of infants, children, and adolescents.
Physical Therapy, Occupational Therapy, Speech/Language Therapy, Physical Medicine Rehabilitation Physician	Physical Medicine and Rehabilitation	Diseases associated with major and minor disabilities that require restoration of functional ability such as assistance, retraining, and recondition of muscles, tendons, and extremities for ambulation and other activities of daily living.
Plastic Surgeon	Plastic Surgery	Diseases and conditions requiring surgical reconstruction for deformity, loss of a body part, or for cosmetic purposes to improve appearance or function.
Podiatrist	Podiatric Medicine: Podiatry	Disease and conditions of the foot and ankle.
Psychiatrist	Psychiatry	Diseases affecting mental health; focus on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders, including substance abuse.
Pulmonologist	Pulmonology	Diseases of the lung.
Diagnostic Radiologist	Radiology, Diagnostic	X-ray, ultrasound, and other imaging techniques such as Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI).
Nuclear Radiologist	Nuclear Medicine	Involves the application of radioactive substances in the diagnosis and treatment of disease.
Radiation Oncologist	Radiation Oncology	Treatment of cancer using ionizing radiation (X-ray therapy, radioactive isotopes, and linear accelerator particle radiation).
Reproductive Endocrinologist	Reproductive Medicine	A reproductive endocrinologist is a gynecologist who has additional training in infertility and fertility treatment; they treat both male and female fertility issues.
Rheumatologist	Rheumatology	Diseases of the musculoskeletal system and systemic autoimmune conditions commonly referred to as rheumatic diseases. These diseases can affect the joints (arthritis), muscles, and bones, causing pain, swelling, stiffness, and deformity.
Orthopedic Sports Medicine Physician	Sports Medicine	Diseases and injuries acquired in sports.
General Surgeon	Surgery, General	Diseases that require surgery for diagnosis or treatment.
Orthopedic Hand Surgeon	Surgery, Hand	Diseases and injuries of the nerves, tendons, muscles, bones, or skin of the hand requiring surgery.
Thoracic Surgeon	Surgery, Thoracic	Diseases of the chest, including lungs, heart, blood vessels, and chest wall that require surgical operation for diagnosis and/or treatment.
Vascular Surgeon	Surgery, Vascular	Diseases of the blood vessels that require surgical operation for diagnosis or treatment.
Colorectal Surgeon	Surgery, Colon and Rectum	Diseases of the large intestine (bowel), rectum, and anus that require surgical operation for diagnosis or treatment.
Urologist	Surgery, Urology	Diseases of the male and female urinary tract and the male reproductive organs, including the kidneys, ureters, and bladder; some requiring surgery.

EXAMPLE

Physician: "You are ridiculous!"

Less effective manager response: "You can't even figure out how to send an email! I am not ridiculous!"

Effective manager response: "Unfortunately, changing to an EMR may seem a bit ridiculous until you go over it completely. Let me show you how this can benefit you in ways you may not have considered…"

Be kind. One of the most powerful tactics for defusing an aggressor is a sincere "I'm sorry," even though it's not easy to say.

EXAMPLE

Physician: "You can't be serious! This EMR program has no idea how I practice medicine! Whoever wrote it wasn't a doctor! I promise you that! How on earth do you expect me to use this?"

Less Effective manager response: "I didn't make the rules!"

Effective manager response: "I'm sorry this is confusing. I understand why you feel this way."

Agree. When someone says three simple words, "You are right," it is very challenging to continue yelling at them.

EXAMPLE

Physician: "You can't be serious! This EMR program has no idea how I practice medicine! Whoever wrote it wasn't a doctor! I promise you that! How on earth do you expect me to use this?"

Less effective response: "Like everyone else uses it!"

Effective response: "I agree with you. This is a massive change. I'll do my best to show you how to use the system as painlessly as possible."

Give away "control." Providers are trained to be in complete control during crises. It is difficult for them to feel as if they have no control. It can be helpful to re-word statements from absolutes to phrases that put them in control of their actions.

EXAMPLE

Physician: "You can't be serious! This EMR program has no idea how I practice medicine! Whoever wrote it wasn't a doctor! I promise you that! How on earth do you expect me to use this?"

Less effective manager response: "This is the way that it is. You have to do it this way."

Effective manager response: "Changing to an EMR is difficult. Let's discuss how you would like to continue."

Good cop, bad cop. Deflecting the tension between you and the physician can allow the physician to place the "blame" elsewhere, which will enable you to come to a mutual resolution and agreement more effectively.

EXAMPLE

Physician: "You can't be serious! This EMR program has no idea how I practice medicine! Whoever wrote it wasn't a doctor! I promise you that! How on earth do you expect me to use this?"

Less effective manager response: "I am telling you the right way to do this."

Effective manager response: "The people who made this program probably never practiced medicine, but likely studied those who do. The good news is that I think I can show you how to get the most out of it."

Efficiency and Effectiveness

An efficient process gets to a result using fewer staff in a shorter time. An effective process delivers a product the consumer or patient is happy with. Efficiency is doing things right, while effectiveness is doing the right things. These terms are often used interchangeably but have different results.

For example, a medical practice focusing on efficiency may improve the number of patients seen in a day or do it with fewer staff. But to achieve this efficiency, the practice may cut documentation requirements and stop making follow-up appointments before the patient leaves the office. This efficiency effort increases productivity and reduces staff costs, but results in greater denials from insurance payers, a decline in patient follow-up appointments, and patient frustration.

A clinic focusing on effective care by doubling the number of staff, creating extra documentation, and increasing the amount of time the physician spends with each patient accomplishes exceptional patient satisfaction and minimal denials from insurance payers. Unfortunately, because the volume of patients decreases and the cost of staff increases, overall profits for the clinic decrease and the clinic is not able to stay financially solvent.

A skilled manager focuses on both effectiveness and efficiency. Do not create an efficient process not needed for an effective outcome. As a manager improves overall quality, he or she needs to ask: Are we doing this in the most efficient way possible? Are we being effective?

Chapter 1 Questions

1. For a visit to qualify as an incident-to service, which of the following is NOT required?
   A. Services must be part of a patient's normal course of treatment.
   B. The NPP must provide services that are an integral part of the physician's own involvement.
   C. The supervising physician must be physically present in the room with the patient and the NPP provider.
   D. The physician must have personally performed an initial service.

2. A successful practice requires a team of dedicated employees who work to achieve defined outcomes. When management creates staff accountability, it creates a shared desire for what in the workplace?
   A. Assist in continuous improvement
   B. Only focus on individual goals rather than company goals
   C. Perform the job the quickest way possible to meet the employee's deadlines, even if the outcome is substandard
   D. Expect the employee to perform job without clear expectations

3. There are differences between a manager and a leader. Which one of the following sets of characteristics is more representative of a manager?
   A. Focuses on the long-term vs. the short-term
   B. Sets direction instead of plans details
   C. Leads people instead of managing work
   D. Focuses on day-to-day tasks

4. All of the following providers can write prescriptions for medications, except who?
   A. Nurse Practitioner
   B. Physician Assistant
   C. Registered Nurse
   D. Physician

5. An efficient patient check-in process includes:
   A. Verification of patient's insurance and patient completes/updates forms
   B. Collection of co-payment and the patient's insurance card is copied/scanned
   C. Verification of patient's insurance, have patient complete/update forms, and the patient's insurance card is copied/scanned
   D. Verification of patient's insurance, collection of a co-payment, have patient complete/update forms, and the patient's insurance card is copied/scanned

Chapter 3

Healthcare Revenue Cycle Management

Revenue Cycle Management

The revenue cycle begins when a patient determines the need for services and calls to make an appointment. The cycle does not end until the account balance is resolved through reconciliation of insurance payments, contractual adjustments, write offs, and patient payments. Appropriate operational processes are critical in every step of revenue cycle management. According to Medical Group Management Association (MGMA), data has shown that 90 percent of denials are preventable. Steps for an effective revenue cycle include:

- Appointment scheduling
- Registration (patient intake)
- Charge capture for services
- Billing (claims processing)
- Denial management
- Accounts receivable follow up

Appointment Scheduling

Staff responsible for scheduling must be friendly, helpful, and knowledgeable. Insurance information must be collected to verify the patient has coverage. Questions such as "was this related to an accident or work-related condition?" can help identify the payer responsible for the services. If you identify the patient has insurance with a carrier your provider either does not participate with or is not a preferred provider for, let the patient know before the trip to your office. Communicate patient financial obligations up front, including copay and coinsurance payments. Missing this step could result in your provider not getting full payment for the services provided.

Gathering insurance and demographic information is also imperative for preregistration and prior authorization. If a patient's insurance requires prior authorization for a service, call the insurance payer before the patient arrives. Without this step, the insurance may deny the claim and the provider will have to collect from the patient or write off the balance, depending on the contract with the payer.

Appointment scheduling is also a critical time to identify the reason for services and organizing the schedule to maximize efficiency and patient flow. Organizing patients into an effective schedule and providing reminders can maximize revenue and reduce the risk of patients not showing up for their appointments. Many offices use a schedule template that specifies what types of appointments to make at different times of the day.

Registration

Inaccurate registration information can lead to claims denials, difficulty in collection efforts, and a less effective and more costly revenue cycle. Three components should be given priority and tracked regularly:

- **Insurance Verification:** Once the appointment is scheduled and the patients' information is entered into the system, the patient's insurance should be verified. When insurance is verified prior to the appointment date, it provides an opportunity to correct any issues that may arise. Reimbursement is often delayed due to insurance policy number typos, leaving out group numbers, coverage termination, etc.
- **Front Desk Collections:** Any payment that the patient is responsible for should be collected at the front desk as part of the registration process. This includes any co-pays, deductibles, current account balances, and non-covered services. There is an added cost (for example, statements to be mailed) to collect payment after the initial visit. Defining clear and specific policies for collecting payments will standardize the collection process and reduce work on the back end. Reports should be run to identify instances where staff are not collecting copays and provide additional training on the importance of collecting these at the time of service. During the registration process, it is best to ask open-ended questions, such as:
  - "How will you be paying your copay today?" instead of asking "Do you have a copay today?"
  - "Can I scan a copy of your insurance card?" instead of asking "Has your insurance changes since your last visit?" or "Do you have insurance?"
- **Data Accuracy:** The information gathered at registration is paramount for clean claims submission, authorizations for services, and future collection efforts. Incorrect information could lead to claim denials or delays, which will affect cash flow and increase overall costs due to resubmission efforts.
- **Productivity:** Because money is collected and critical information is gathered, having productive and skilled staff at this location is vital. Strong training and follow-up performance audits are valuable to maintain strength at this key position.

Registration Accuracy Audits

An effective way to measure the accuracy of front desk functions is a front desk performance audit. A sample audit process includes:

- Periodically auditing 10–15 records for each of the registration staff; the audit should consist of a review of patient registration paperwork (when available), as well as insurance company remittance advices for patient registration related denials.
- Identifying of key measurements, including address, phone numbers, employer, NPP acknowledgement, consent to treat, co-pay collected, self-pay collected, account balance collected, insurance verification, policy name and number, group number, co-pay amount, copy of insurance card, and any other important information; and
- Following up on audit results and a plan for training to reach desired improvement levels.

Sample of a registration audit.

			Patient Demographics								Chart Detail				Collections			Insurance								
	Visit/ Account	Date Auditing	Name	Address	City	State	Zip	Phone	Marital	Employer	Consent to Treat	Emergency contact	Emergency Phone	NPP Notice Signed	Copy Collected	Self Pay Collected	Collection of Past Due Balance	Insurance Verification	Policy holder	Policy Number	Group #	Copay Amount	Insurance Card Copied	Accident info entered	Total Points	Comments
1																									0	
2																									0	

Charge Capture for Services

Each time a physician or other provider performs a service for a patient, procedure and diagnosis codes must be identified to submit for proper payment. The codes chosen should be based on the services performed and documented by the medical provider in the medical record. Code selection may be done by the medical provider or by the provider's office staff, including Certified Professional Coders (CPC®). The provider is responsible for the accuracy of the codes selected.

Without the proper medical coding of services rendered, a provider may not receive appropriate payment, and he or she runs the risk of non-compliance. There are two vital components to proper medical coding.

1. Medical providers document in detail the services performed. This includes office visits, procedures, lab tests, imaging tests, other tests performed, and supplies or equipment used. It is critical to have processes and policies in place to make be every service is appropriately documented.
2. Procedure and diagnosis codes (CPT®, HCPCS Level II, ICD-10-CM) are identified based on what was documented in the patient's chart. These codes are used

Example of denial % by denial type over a year's time.

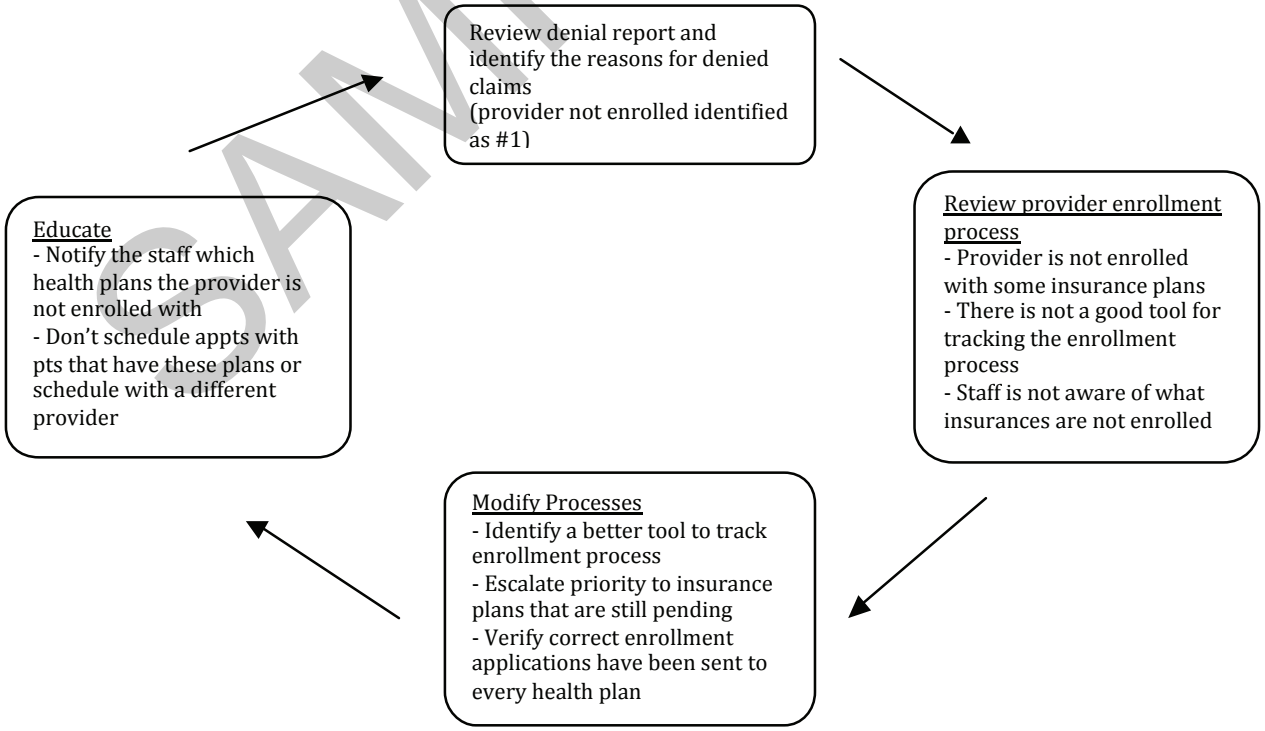
Denial Types	Jan-YR	Feb-YR	Mar-YR	Apr-YR	May-YR	Jun-YR	Jul-YR	Aug-YR	Sep-YR	Oct-YR	Nov-YR
Non-covered	39.92%	40.39%	46.3%	71%	37.0%	42.4%	53.2%	46.5%	43.2%	39.4%	47.5%
Not eligible	23.71%	29.28%	13.0%	10%	22.1%	20.8%	16.2%	21.2%	19.1%	19.5%	20.0%
Need additional info	12.75%	11.81%	8.9%	5%	13.2%	13.8%	8.9%	8.4%	9.8%	16.5%	13.3%
Included	5.12%	6.69%	8.6%	6%	6.3%	9.2%	10.0%	6.4%	6.7%	12.9%	8.4%
Modifier incomplete	1.34%	4.4%	2.4%	1%	12.0%	1.5%	1.2%	3.5%	1.8%	0.7%	
Invalid PX/DX	1.07%	0.0%	0.0%	0%	0.0%	0.0%	0.0%		0.5%	0.4%	0.5%
Provider not certified	5.93%	1.94%	15.3%	3%	3.0%	0.0%	1.5%	1.7%	0.8%	1.0%	1.0%
No auth or referral	4.46%	1.86%	1.9%	0%	1.4%	2.0%	4.6%	3.9%	1.1%	1.1%	1.7%
Pre-existing	0.0%	1.81%	1.6%	1%	0.9%	1.6%	0.7%	1.1%	1.0%	1.2%	1.3%
Non-Par	1.36%	0.0%	0.0%	0%	0.0%	1.5%	0.0%		0.0%	0.0%	
POS error	4.35%	1.3%	0.0%	0%	2.0%	3.8%	1.2%	1.9%	0.0%	0.0%	0.7%
Untimely	0.0%	0.51%	2.2%	3%	2.0%	3.6%	2.5%	5.4%	16.0%	7.4%	6.2%

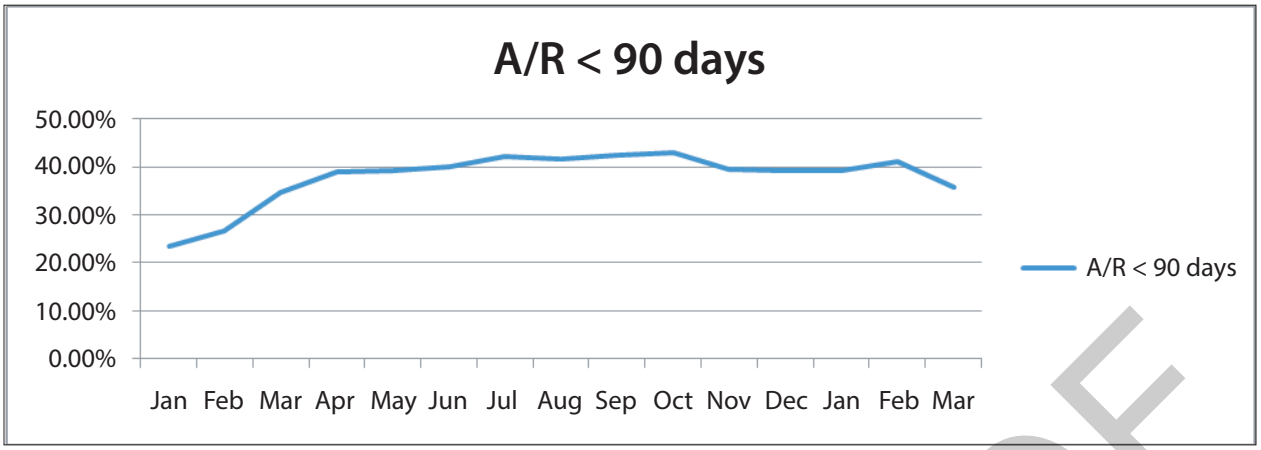
In this report, there is consistently a high percentage of non-covered services. The practice manager should start looking for systemic errors by monitoring the scheduling and check-in staff to verify proper procedures are being followed.

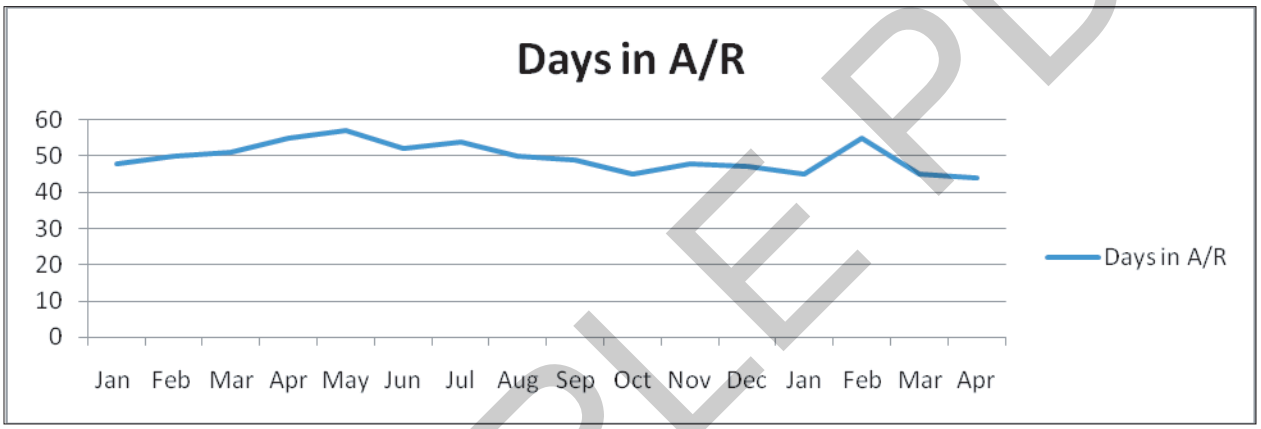
Tips for preventing denials

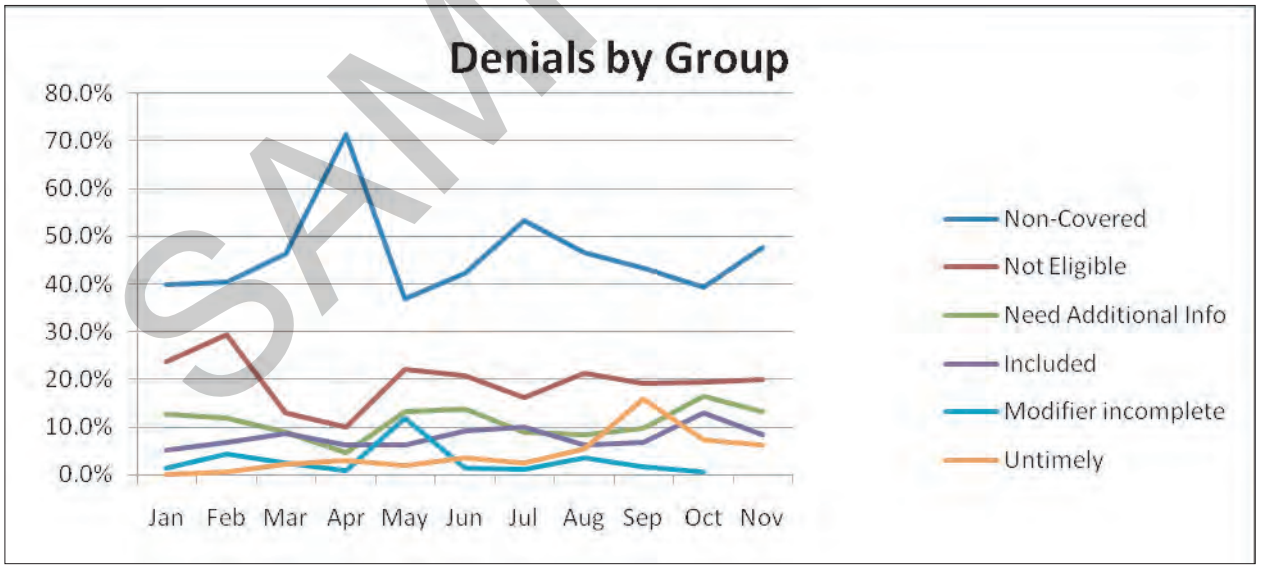
1. Use the 80/20 rule: As a rule of thumb 80% of issues are caused by 20% of the problems.
2. Determine actions needed to correct identified problems.
3. Implement updated policy and educate staff to prevent continued issues with problems identified.
4. Utilize practice management software rules engine (if available).
5. Create a culture of zero tolerance for preventable denials.

An example of an effective denials process improvement effort might include the following steps.



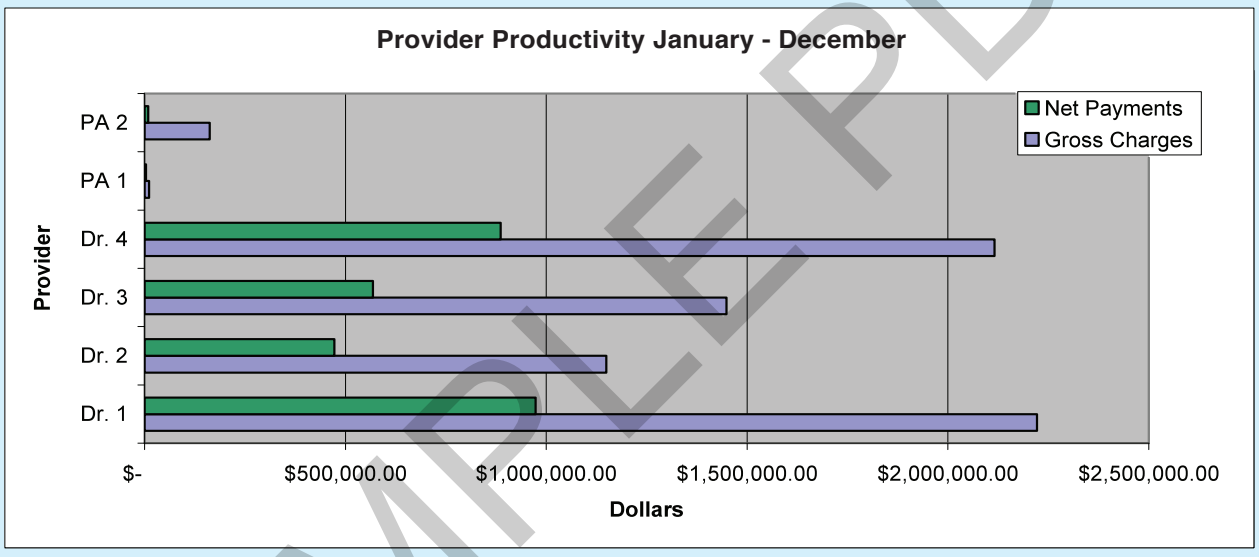






EXAMPLE 2: SIMPLIFIED PRODUCTIVITY REPORT: PRODUCTIVITY COMPARED TO NATIONAL BENCHMARK REPORT.

Provider: Dr. Wannabee				
CPT	**Units**	**Charges**	**wRVU**	**% of work**
99212	300	17316	144	2.00%
99213	2300	225216	2231	30.93%
99214	1000	147100	1500	20.80%
99202	500	65860	465	6.45%
99203	1100	210562	1562	21.66%
99204	500	148950	1215	16.85%
99205	30	11235.6	95.1	1.32%
Total	5730	826239.6	7212.1	100.00%



This sample report shows the number of new vs. established patients seen by Dr. Wannabee.

A/R By Service Date

Overall aging by month

Month-End	Balance	0 - 30	31 - 60	61 - 90	91 - 120	121 - 150	151 - 180	181+	> 360	> 90 %
11/30/20X0	$ 6,729,989	$ 2,748,658	$ 1,558,697	$ 851,354	$ 640,962	$ 440,587	$ 333,801	$ 155,929	$ 445	23.35%
12/31/20X0	$ 7,590,268	$ 2,711,144	$ 1,653,632	$ 1,207,802	$ 659,402	$ 506,452	$ 389,179	$ 462,655	$ 6,120	26.58%
1/31/20X1	$ 8,586,823	$ 2,881,490	$ 1,443,804	$ 1,292,225	$ 1,126,482	$ 570,852	$ 459,341	$ 812,629	$ 13,829	34.58%
2/28/20X1	$ 9,260,096	$ 2,882,698	$ 1,670,169	$ 1,094,471	$ 1,102,472	$ 862,558	$ 519,785	$ 1,127,942	$ 22,622	39.01%
3/31/20X1	$ 9,386,722	$ 3,101,643	$ 1,580,126	$ 1,019,417	$ 778,412	$ 827,980	$ 715,773	$ 1,363,371	$ 20,224	39.48%
4/30/20X1	$ 9,339,111	$ 2,966,403	$ 1,558,579	$ 1,060,203	$ 838,593	$ 620,951	$ 621,107	$ 1,658,209	$ 15,066	33.39%
5/31/20X1	$ 8,910,357	$ 3,039,098	$ 1,237,226	$ 883,712	$ 798,927	$ 652,467	$ 370,914	$ 1,928,013	$ 88,045	42.09%
6/30/20X1	$ 8,547,413	$ 3,034,294	$ 1,207,022	$ 740,015	$ 651,496	$ 600,687	$ 494,917	$ 1,818,982	$ 168,535	41.72%
7/31/20X1	$ 8,181,391	$ 2,670,692	$ 1,301,581	$ 734,939	$ 536,039	$ 502,362	$ 498,811	$ 1,936,966	$ 293,440	42.46%
8/31/20X1	$ 8,111,027	$ 2,965,522	$ 1,021,637	$ 633,753	$ 527,362	$ 442,848	$ 382,092	$ 2,137,813	$ 425,079	43.03%
9/30/20X1	$ 8,368,552	$ 3,290,015	$ 1,164,294	$ 601,945	$ 426,518	$ 416,090	$ 340,448	$ 2,129,242	$ 515,325	39.58%
10/31/20X1	$ 8,556,802	$ 2,970,195	$ 1,500,048	$ 727,387	$ 446,709	$ 332,096	$ 352,459	$ 2,227,909	$ 687,509	39.26%
11/30/20X1	$ 8,936,037	$ 3,075,183	$ 1,396,604	$ 961,117	$ 564,839	$ 353,952	$ 303,088	$ 2,281,254	$ 765,551	39.20%
12/31/20X1	$ 9,309,187	$ 3,207,254	$ 1,457,264	$ 811,676	$ 756,138	$ 435,534	$ 311,868	$ 2,329,452	$ 826,197	41.17%
	$ 11,264,131	$ 4,588,749	$ 1,734,422	$ 913,263	$ 590,029	$ 688,060	$ 336,078	$ 2,413,531	$ 979,833	35.76%
Current month %		**34.5%**	**15.7%**	**8.7%**	**8.1%**	**4.7%**	**3.4%**	**25.0%**		
Prev month %		**34.4%**	**15.6%**	**10.8%**	**6.3%**	**4.0%**	**3.4%**	**25.5%**		

Selfpay Aging by Month

	Total Claims	Total Balance	0 - 30 Balance	31 - 60 Balance	61 - 90 Balance	91 - 120 Balance	121 - 150 Balance	151 - 180 Balance	181 +Balance	> 90 %
11/30/20X0	7688	$ 601,188	$ 242,240	$ 141,612	$ 129,445	$ 91,485	$ 29,130	$ 14,909	$ (47,634)	14.62%
12/31/20X0	10032	$ 830,687	$ 395,194	$ 159,038	$ 110,556	$ 99,474	$ 43,657	$ 18,753	$ 4,015	19.97%
1/31/20X1	10847	$ 900,592	$ 345,417	$ 246,613	$ 120,362	$ 87,842	$ 52,502	$ 24,335	$ 23,521	20.90%
2/28/20X1	12630	$ 1,035,657	$ 369,759	$ 240,924	$ 183,529	$ 90,504	$ 57,631	$ 41,948	$ 51,363	23.31%
3/31/20X1	14155	$ 1,024,255	$ 403,684	$ 145,731	$ 176,137	$ 133,066	$ 45,937	$ 51,034	$ 68,667	29.16%
4/30/20X1	16423	$ 1,327,873	$ 556,716	$ 248,366	$ 168,031	$ 148,398	$ 87,950	$ 33,895	$ 84,518	26.72%
5/31/20X1	19348	$ 1,431,416	$ 578,616	$ 307,893	$ 187,823	$ 123,439	$ 84,863	$ 71,023	$ 77,760	24.95%
6/30/20X1	21072	$ 1,537,206	$ 658,094	$ 346,972	$ 236,663	$ 145,506	$ 30,947	$ 48,010	$ 71,015	19.22%
7/31/20X1	21628	$ 1,574,694	$ 483,356	$ 437,692	$ 266,680	$ 200,847	$ 79,801	$ 17,315	$ 89,005	24.57%
8/31/20X1	22531	$ 1,726,320	$ 627,400	$ 332,335	$ 332,849	$ 202,125	$ 134,661	$ 52,062	$ 44,888	25.12%
9/30/20X1	24071	$ 1,877,516	$ 615,968	$ 408,901	$ 262,474	$ 278,664	$ 111,735	$ 105,734	$ 94,041	31.43%
10/31/20X1	25407	$ 2,052,633	$ 576,566	$ 414,993	$ 335,409	$ 232,561	$ 183,373	$ 101,911	$ 207,820	35.35%
11/30/20X1	26296	$ 2,025,696	$ 500,156	$ 327,881	$ 318,773	$ 256,951	$ 172,043	$ 167,400	$ 282,492	43.39%
12/31/20X1	27287	$ 2,015,828	$ 453,534	$ 269,937	$ 268,654	$ 260,850	$ 172,802	$ 172,421	$ 417,630	50.78%
1/31/20X2	26486	$ 1,998,615	$ 518,387	$ 248,586	$ 211,186	$ 201,342	$ 167,765	$ 141,370	$ 509,980	51.06%

Chapter 5 Questions

1. Expanding health coverage, controlling healthcare costs, and modernizing the healthcare delivery system are the three main objectives of which healthcare legislation?

   A. American Healthcare Act
   B. Patient Protection and Affordable Care Act (ACA)
   C. Health Innovations Expansion Law
   D. Accountable Care Organization

2. Which of the following are key trends in healthcare reform?

   I. Focus on fraud and abuse
   II. Shift from acute care to prevention and wellness
   III. Care delivery expanding beyond the traditional physician office
   IV. Coordination of Care

   A. I and III only
   B. I and II only
   C. I, II and III only
   D. I, II, III, and IV

3. What are Retail Clinics, internet-based visits, and remote patient monitoring examples of?

   A. Care beyond the traditional physician office.
   B. Patients moving towards home based holistic medicine.
   C. Patients moving towards self-care instead of traditional office visits.
   D. Care in a hospital or facility.

4. An Accountable Care Organization (ACOs):

   I. Relies on a risk adjusted reimbursement methodology called Hierarchical Categories (HCCs)
   II. Is paid a fixed dollar amount to care for a patient
   III. Is paid fee for service
   IV. Must decide on the most efficient way to allocate treatment resources to manage a patient's condition(s)
   V. Must include preventive medicine as the primary goal

   A. I, III, and V
   B. I, II, and V
   C. I, II, and IV
   D. I, III, and IV

5. What is aimed at reducing growth in Medicare spending and developing alternative payment models to promote more efficient use of healthcare resources and higher quality of care?

   A. Recovery Audit Contractors (RACs)
   B. Payment Reforms
   C. Unified Program Integrity Contractors (UPICs)
   D. OIG compliance guidance

in the next stages of government incentive requirements, this benefit can be considerable. Using the installation shown in Table 3: ASP EMR Analysis as an example, you can see how this model requires about half of the up-front cost with twice the return. That can add up to $46K in total savings.

Table 3: ASP EMR Analysis

ASP EMR ANALYSIS	20X1	20X2	20X3	20X4	20X5	TOTAL
SAVINGS	**$25,152**	**$25,152**	**$25,152**	**$25,152**	**$25,152**	**$125,760**
Paper supplies: $5 per patient	$12,480	$12,480	$12,480	$12,480	$12,480	$62,400
Pharmacy Calls: $0.50 per patient	$1,248	$1,248	$1,248	$1,248	$1,248	$6,240
Improved A/R: 3% on Collections	$10,944	$10,944	$10,944	$10,944	$10,944	$54,720
Storage/Destruction: $40 per month	$480	$480	$480	$480	$480	$2,400
TOTAL SAVINGS	**$25,152**	**$25,152**	**$25,152**	**$25,152**	**$25,152**	**$125,760**
IT COST	**$17,300**	**$11,900**	**$11,900**	**$11,900**	**$11,900**	**$64,900**
Physician Computer: Tablet PC	$2,000	$-	$-	$-	$-	$2,000
Staff computers: $500 each x 2	$1,000	$-	$-	$-	$-	$1,000
Network Printer	$500	$-	$-	$-	$-	$500
High-Speed Scanner	$700	$-	$-	$-	$-	$700
Server	$-	$-	$-	$-	$-	$0
T1 Internet Service: $500	$6,000	$6,000	$6,000	$6,000	$6,000	$30,000
Modem	$200	$-	$-	$-	$-	$200
Router	$500	$-	$-	$-	$-	$500
WAP	$500	$-	$-	$-	$-	$500
Redundant Internet Connection	$1,200	$1,200	$1,200	$1,200	$1,200	$6,000
Back-up and Storage	$-	$-	$-	$-	$-	$0
Network Maintenance. $100 per hour	$3,000	$3,000	$3,000	$3,000	$3,000	$15,000
Misc. (e.g., camera, UPS, cable, etc.)	$500	$500	$500	$500	$500	$2,500
Hosting Fees: $100 x per month	$1,200	$1,200	$1,200	$1,200	$1,200	$6,000
EMR VENDOR COST	**$13,000**	**$8,000**	**$8,000**	**$8,000**	**$8,000**	**$45,000**
Software	$5,000	$5,000	$5,000	$5,000	$5,000	$25,000
Maintenance & Training	$3,000	$3,000	$3,000	$3,000	$3,000	$15,000
Interfacing with PM software	$5,000	$-	$-	$-	$-	$5,000
TOTAL COST	**$30,300**	**$19,900**	**$19,900**	**$19,900**	**$19,900**	**$109,900**
HITECH Medicare Payment	$18,000	$12,000	$8,000	$4,000	$2,000	$44,000
NET COST	**$12,300**	**$7,900**	**$11,900**	**$15,900**	**$17,900**	**$65,900**
RETURN (BEFORE INTEREST & TAX)	**$12,852**	**$17,252**	**$13,252**	**$9,252**	**$7,252**	**$59,860**

The specific numbers for your practice may vary slightly; however, a thorough analysis with a similar table that identifies all costs and benefits will be extremely valuable in making your EMR purchase. Accurate financial planning for an EMR implementation will ease the anxiety and transition that often accompanies such an effort.

Chapter 8

Modern Health Information Technology and Interoperability

The current healthcare system reflects a heavy information technology (IT) influence as federal regulators continue to attempt to reduce costs, as quality metrics become more important for outcomes measurements, and as providers seek tools to provide effective and efficient services. Just as we have seen in other industries, such as automobile manufacturing, media communications, and entertainment, a major re-tooling is taking place in healthcare. The practice of the future is dependent upon better and faster secure data to survive. This chapter will examine information technology and its impact on the delivery of healthcare.

The HITECH (Health Information Technology for Economic and Clinical Health) Act was created by executive order in 2004 and legislatively mandated in the ARRA (American Recovery and Reinvestment Act) of 2009. Through the HITECH Act, the ONC (Office of the National Coordinator for Health IT) was charged with developing an initial set of health information technology (HIT) standards. The ONC created two new federal advisory committees (The HIT Policy and HIT Standards committee) to accomplish this task.

The HIT Policy Committee is responsible for making recommendations to the ONC on policy framework for the development and adoption of a nationwide health information infrastructure. This includes standards for the exchange of patient medical information.

The HIT Standards Committee is charged with making recommendations to the ONC on standards, implementation specifications, and certification criteria for the electronic exchange and use of health information.

By focusing on the effective use of electronic health records with certain capabilities, the HITECH Act clarifies that the adoption of records is for improved patient outcomes. HITECH's incentives and assistance programs seek to Improve the health of Americans and the performance of their healthcare system through the meaningful use of electronic health records to achieve five healthcare goals:

- To Improve the quality, safety and efficiency of care while reducing disparities.
- To engage patients and families in their care.
- To promote public and population health.
- To improve care coordination.
- To promote the privacy and security of electronic health records.

The ONC oversees the Health IT Certification Program of electronic health records and the Health Information Exchanges. Using Certified Electronic Health Record Technology (CEHRT). Using CEHRT Improves care coordination through the electronic exchange of clinical-care documents. The CMS Quality Payment Program requires the use of CEHRT.

To date, ONC has issued three editions of health IT certification criteria: 2011 Edition, 2014 Edition, and the 2015 Edition. All providers are required to use the 2015 Edition certified health IT to qualify for Merit-based Incentive Payment System (MIPS).

There are 60 2015 Edition health IT certification criteria organized into eight categories:

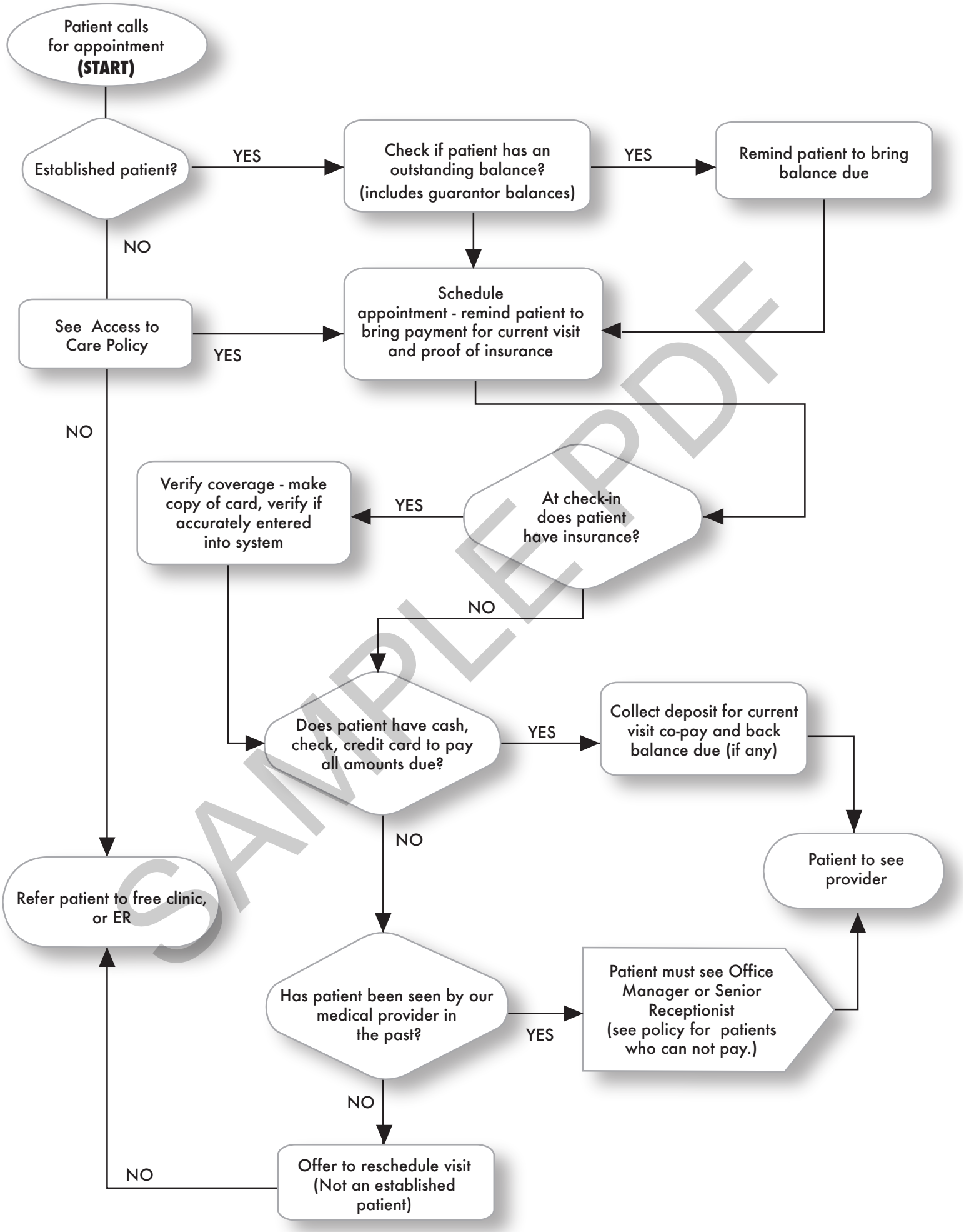
1. Clinical Processes
2. Care Coordination
3. Clinical Quality Measurement
4. Privacy & Security
5. Patient Engagement
6. Public Health
7. Health IT Design and Performances
8. Electronic Exchanges

Each category has a list of criteria to be met.

CLINICAL PROCESSES EXAMPLE

For example, the criteria for Clinical Processes include:

- Computerized Provider Order Entry (CPOE) – Medications
- Computerized Provider Order Entry (CPOE) - Laboratory
- Computerized Provider Order Entry (CPOE) – Diagnostic Imaging
- Drug-drug, Drug-allergy Interaction Checks for CPOE
- Demographics
- Problem List
- Medication List
- Medication Allergy List
- Clinical Decision Support (CDS)
- Drug-formulary And Preferred Drug List Checks
- Smoking Status
- Family Health History
- Patient-specific Education Resources
- Implantable Device List
- Social, Psychological, and Behavioral Data


Patient calls for appointment (START)
Established patient?
YES
Check if patient has an outstanding balance? (includes guarantor balances)
YES
Remind patient to bring balance due
NO
See Access to Care Policy
YES
Schedule appointment - remind patient to bring payment for current visit and proof of insurance
NO
Verify coverage - make copy of card, verify if accurately entered into system
YES
At check-in does patient have insurance?
NO
Does patient have cash, check, credit card to pay all amounts due?
YES
Collect deposit for current visit co-pay and back balance due (if any)
Patient to see provider
NO
Refer patient to free clinic, or ER
Has patient been seen by our medical provider in the past?
YES
Patient must see Office Manager or Senior Receptionist (see policy for patients who can not pay.)
NO
Offer to reschedule visit (Not an established patient)
NO

Chapter 1

1. **Answer:** C

   Rationale: The supervising provider does not have to be physically present in the patient's treatment room while these services are provided but must provide direct supervision (be present in the office suite to render assistance if necessary).

   Incident-to services supervised by non-physician practitioners are reimbursed at 85 percent of the Medicare Physician Fee Schedule. Services must be part of a patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved during treatment. The NPP must provide services that are an integral part of the physician's own involvement with his or her patients (for example, follow-up office visits for known diagnoses the physician is monitoring).

2. **Answer:** A

   Rationale: A successful practice requires a team of dedicated employees who work to achieve defined outcomes.

   Responsibility + Accountability = Positive Results

   Staff accountability creates a shared desire to:

   - Correctly perform the duties of the job
   - Understand what, why, and how to define correct performance
   - Prevent poor performance
   - Assist in continuous improvement

   Accountability is best accomplished by assigning measurable and objective goals. Positive, negative, or combined incentives provide the framework for accountability.

3. **Answer:** D

   Rationale: An effective manager will ensure work gets done, focuses on day-to-day tasks, and manages the activities of others. Managers focus on tactical activities and often have a more directive and controlling approach. Leaders are more strategically focused. Rather than directing employees through tasks, they inspire and motivate.

4. **Answer:** C

   Rationale: Medical Doctors (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), and Physician Assistant (PA) can all write prescriptions for patients. A Registered Nurse is not allowed to write prescriptions.

5. **Answer:** D

   Rationale: In a normal setting (non-emergency) setting, a patient calls the office to schedule an appointment. A front desk representative records the appointment. The patient usually answers preliminary questions about contact and demographic information and insurance data. The patient provides his or her demographic information and insurance card at the front desk. The front desk representative verifies the patient's benefits to determine if the patient's insurance is active and covers the services to be performed, and to determine patient out-of-pocket fees, such as co-pays, deductible, or co-insurance.

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