How to Prepare for ICD-10 in Medical Practices: Overview and Checklist

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About the Author

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Betsy holds a Masters of Science in Organization and Management from Antioch, New England, and has worked in and around physician offices for over 20 years. She became a certified coder in 1999. Betsy is a member of the National Speakers Association, the Medical Group Management Association and the Healthcare Financial Management Association.

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Introduction

There is a major change on the horizon for health care in the next two years. CMS has established an updated implementation date of October 1, 2014 for the adoption of ICD-10-CM, (ICD means the International Statistical Classification of Diseases and Health Related problems. CM is Clinical Modification) a one-year delay to allow physician practices and other health care providers time to successfully learn and implement the new coding system. Why did CMS propose the delay? CMS had heard from small and mid-size medical groups that they might not be ready for October 1, 2013. However, practices should not count on another reprieve. The ICD-9-CM system is outdated without room for expansion and does not provide the level of detail that policy experts and payers say is needed in reporting on morbidity.
To help prepare your practice, this paper will review:

- History of diagnosis coding in the US
- Need for adoption of the new coding system
- Critical information about the complexity of the ICD-10-CM system
- Recommendations for three crucial steps medical groups must take
  - Informing themselves about ICD-10, assessing their readiness and setting up a plan, timeline and budget
  - Training
  - Determination of responsibility for assigning ICD-10 codes and sequencing these codes according to conventions and general guidelines
Medical practices can and must plan for the transition in order to prevent claims denials, lost productivity and cash flow disruption

The United States began using ICD-9 codes in 1979 to report diagnosis coding for both morbidity (sickness) and mortality (death). In 1999 the U.S. switched to using ICD-10 for mortality data but continues to use ICD-9 for morbidity. That is, in the U.S., we use ICD-10 data for reporting the cause of death but use ICD-9 data on claims to report on illness and injury. Other countries use ICD-10 data for both morbidity and mortality, but few other countries have such a complex claims system as the U.S.

The World Health Organization developed ICD-10 and the National Center for Health Statistics, part of the Centers for Disease Control and Prevention, developed the Clinical Modification data set (ICD-10-CM). ICD-10 has three volumes, an alphabetic index of diseases, a tabular index of diseases and a procedural set (ICD-10-PM), that will be used by hospitals to describe inpatient procedures. Medical practices will continue to use CPT/HCPCS codes to describe the services performed. All health care providers (HIPAA “covered entities”) will use ICD-10 diagnosis codes to describe the medical necessity of the service provided.

CMS has established an updated implementation date of October 1, 2014 for the adoption of ICD-10
Why accurate and complete diagnosis coding is essential

Currently, most medical practices are paid based on a fee schedule tied to CPT codes. Medicare sets fees based on the Relative Value Units assigned to a CPT code multiplied by a dollar conversion factor. Private payers set fees based on Medicare’s fee schedule or on their own proprietary usual and customary data. The diagnosis code describes the reason for the service; that is, the condition, symptoms, illness or injury that necessitated the reason for the medical service provided. Physician services are paid based on CPT code but often denied based on the diagnosis code. Larger physician groups, however, sometimes have an end of year risk-based adjustment to their payments based on how sick their patient population is and the cost of providing the care. Future Medicare shared savings programs, such as Accountable Care Organizations and the Value Based Modifier, will also vary payment by the acuity of the patient population and the cost of caring for them.

How does a payer know? How does a payer measure the acuity of a group of patients? Claims data. The payer analyzes the services provided (CPT codes) and the patient conditions (ICD-9 codes) based on claims submitted for their beneficiaries. This makes accurate and complete diagnosis coding critical for payment of today’s claim and for payer analysis of the acuity of the group’s patient population. Submitting a single diagnosis when multiple diagnoses are present and addressed will result in the same payment for today’s claim, but may result in lower overall payments from private payers and Medicare in future years.
Diagnosis coding is also critical to prevent denials for today’s claims. A claim may be denied because the diagnosis code is not linked to the correct CPT code and thus does not support the medical necessity for the service. For example, a patient who is referred for a cardiac test needs a symptom (chest pain) or condition (acute coronary syndrome) to support the need for the test. The medical necessity for certain procedures and diagnostic services can be found in payer policies. For Medicare, these are National and Local Coverage Determinations. Other payers will post their policies on their websites or publish them in manuals. These policies describe the service and the covered and non-covered indications for the service. Often, the specific covered diagnosis codes are listed.

This introduction, familiar to those with long experience in medical practice billing and coding, emphasizes the importance of accurate and complete diagnosis coding, whether using ICD-9 or ICD-10. Inaccurate and incomplete diagnosis coding will result in denials and lower payments. Diagnosis codes must have supporting documentation in the patient’s medical record.

Accurate and complete diagnosis coding is critical for payment of today’s claim and for payer analysis of the acuity of the group’s patient population.
The Complexity of ICD-10

As mentioned, health care providers have used ICD-9 diagnosis coding on claims since 1979. Policy experts state that the codes are not sufficiently specific and the coding scheme does not have room for needed updates. The ICD-9 codes do not reflect the clinical terms used by providers, in many cases. There are very few unassigned codes available to describe new diseases or conditions or to add specificity to existing diseases and conditions. The Federal Register on January 16, 2009 put into law the change to ICD-10. Initially, the effective date was 2011, later moved to 2013. Now, CMS has again extended the deadline for an October 1, 2014 implementation date. Some practices have decided to take a wait and see attitude towards ICD-10, hoping for further delay. However, given the limitations of ICD-9 and the urging of public health and policy experts, another delay would be highly problematic and costly. More prudent practices are assessing their current readiness, establishing a timeline and budget for training, implementation and software upgrades and making decisions about who in the practice will be responsible for both assigning and sequencing ICD-10 codes at the implementation date. Prudent practices are preparing for the momentous change that ICD-10 will bring. Failing to train and prepare will result in lost productivity, claim denials and loss of revenue. If a practice is not preparing for ICD-10, it should be saving money for the lost and delayed cash flow that will occur during the transition period.
Current and future updates

Health policy experts want to ease the transition from ICD-9 to ICD-10 as much as possible. Updates to each coding system will be limited between now and the implementation date of ICD-10. The last regular updates to both systems were made October 1, 2011. The October 1, 2012 update will be limited for both code sets. For October 1, 2013 there will again be limited code updates to ICD-10, reflecting only new technology and new diseases. Regular updates to ICD-10 will begin October 1, 2014. This will help medical practices.

What makes it so complicated

Expert diagnosis coders will find that ICD-10 looks familiar to them. The alphabetic section is an Index to Illnesses and Conditions. There is a neoplasm table, and a drugs/poisoning table. The start of the book is 100 pages of general guidelines in code selection. At the bottom of each page there is a list of symbols, just as there is in a CPT book or ICD-9 book.

ICD-9 codes are numeric, except codes beginning with a V or an E. V codes in ICD-9 are used to report on factors influencing health status and contact with health services. These codes are used for personal or family history of a condition, exposure to health hazards and examinations. V codes may be used in the first position on a claim form (V codes today will be Z codes in ICD-10). E codes are used to report on the external causes of injury or poisoning and may never be used in the first position of a claim form (E codes today will be the V, W, X, Y codes in ICD-10).
ICD-10 codes are alphanumeric. Each starts with a letter, and subsequent characters are alphabetical or numeric. The letter U is not used. The letters are not case sensitive. ICD-10 codes, like ICD-9 codes, have a specific structure. The first three digits are the category of code. The subcategory fourth through six characters indicate etiology, anatomic site, and severity. The seventh character is an extension, if required.

The complexity of ICD-10 and the difficulty in implementation comes from a number of areas:

- **Dramatically increased specificity required for code selection.** There are codes based on laterality: right ear, left ear, bilateral ear and unspecified ear. Some codes are selected based on whether this is the first occurrence or a re-occurrence of the condition. Injury codes are dramatically increased and will require more specificity in the medical record in order to select a code.

- **Expansion from about 14,000 diagnosis codes to almost 70,000 diagnosis codes. There are 21 Chapters in ICD-10.** Many coders and physicians have been using ICD-9 codes since 1997 and have memorized the most common diagnosis codes for their specialty. Practices use paper encounter forms that list the most common conditions treated for the practice. It will be difficult to memorize ICD-10 codes because of the great expansion of them. The American Academy of Family Physicians estimated that a list of common ICD-10 diagnosis codes would be up to nine pages long. This is not realistic anymore for a paper listing of common diagnosis codes.
The Complexity of ICD-10
(Continued)

- **Variation based on specialty.** Medical practices that treat trauma or care for patients who have accidents will find that coding is much more complex. Primary care groups and general surgery practices which treat patients with a wide variety of conditions will find the change challenging. Some groups that treat a more limited scope of conditions will find the transition less burdensome.

- **Complications of surgery greatly expanded.** Instead of medical complications from surgery being in one section, as they are in ICD-9, complications from surgery are listed in each chapter. For example, complications from eye surgery are in the eye chapter, complications from respiratory surgery are in the respiratory chapter.

- **Location for neoplasms greatly more specific.** The neoplasm table has greater specificity.

- **New concept of underdosing in table of drugs and chemicals.** The table of drugs and chemicals will look familiar to expert ICD-9 coders. Drugs and chemicals are listed on the left hand side of the table. The headings for the columns have been renamed from poisoning, accident, therapeutic use, suicide attempt, assault and undetermined to poisoning accidental (unintentional), poisoning intentional self harm, poisoning assault, poisoning undetermined, adverse effect and underdosing. Additional documentation in the medical record will be required to select from these codes.

**ICD-10 Concerns**

- Lack of staffing resources: 33%
- Lack of synchronization between payers and providers: 19%
- Lack of financial resources: 15%
- Inability to test appropriately to ensure compliance with guidelines/regulations: 10%
- Changes in regulations from the federal government: 9%
- Guidelines from health plans and clearing houses are inadequate: 5%
- Other: 9%

Source: KLAS ICD-10: Preparing for October 2013 report; September 2011, www.KLASresearch.com, © 2011 KLAS Enterprises, LLC. All rights reserved.
The Complexity of ICD-10 (Continued)

ICD-10 includes a placeholder character for use in the fourth, fifth or sixth position for some codes

• **Expansion from codes that are 3, 4, or 5 characters to complete codes that are 3, 4, 5, 6 or 7 characters long.** Currently, ICD-9 codes may be 3, 4 or 5 digits to be complete. In ICD-10, a complete code may be 3, 4, 5, 6 or 7 digits long. Part of the change to the 5010 electronic format was anticipation of the need for longer diagnosis codes to be transmitted electronically. Groups will also be able to transmit up to eight codes per line item using the 5010 format.

• **A placeholder character for use in the fourth, fifth or sixth position for some codes.** Some ICD-10 codes have a seventh digit extender, but do not have a character in the sixth position. Or, a code may require a seventh digit, but not have characters in the fourth, fifth or sixth position. A code may require a sixth character, but not have a fifth character. In these cases, placeholder x is used within the ICD-10 code.

• **A seventh character extender that has different meanings in different chapters.** Some chapters have codes that require a seventh character. This character has different meanings depending on the chapter. In one chapter (Chapter 18), it is the Glasgow Coma Scale. In another, it refers to the fetus when there are multiple fetuses (Chapter 15). For injuries (Chapter 19), the seventh digit extender identifies the initial encounter, the subsequent encounter or long term late effect. The seventh digit character for fractures includes information about healing status, e.g., nonunion and malunion and for some types of open fracture, the Gustillo classification that tells the amount of soft tissue damage has multiple 7th character extensions.
The possibility for five diagnosis codes for the initial visit for an injury (that’s not a typographical error: five diagnosis codes for the initial service for an injury.) When a patient presents for an injury for the first time, five codes may be considered and sequenced correctly. The first describes the injury itself: laceration, contusion, fracture. The second describes the external cause. This is analogous to current E codes that describe how the patient was injured, and is submitted in the second position. Then, three additional occurrence codes are required: where did the injury take place, what was the patient doing when it occurred (can be duplicative of the external cause) and the status of the patient (military, at work, civilian in activity not for pay.) Occurrence codes are only submitted at the first encounter. Injuries are going to hurt. Subsequent visits for the injury use the same primary injury diagnosis code with a different seventh character extender and the external cause code.

Complex sequencing guidelines. The general guidelines provide sequencing instructions for certain diseases within each chapter. There are also notes at the start of many chapters that provide guidance for codes within that chapter. Some codes have notations that instruct the clinician to “code first” the underlying condition, and code the manifestation of the underlying condition second. These sequencing instructions will probably not be available to clinicians within most electronic searching.
How to Prepare for ICD-10 in Medical Practices:
Overview and Checklist

The Complexity of ICD-10
(Continued)

- **There are two types of Excludes notations: Excludes1 and Excludes2.** Starting in the alphabetic index, a clinician or coder finds the code for the condition or symptom that supports the medical necessity for the service. Then, going to the tabular listing, the clinician or coder reviews and selects the correct code. There may be one of two Excludes notes. If there is a notation of Excludes1, there is a list of conditions, which may not be coded with the searched term (category code). If there is an Excludes2 note, the list of conditions may be used with the searched term if both conditions exist. These instructions may not be available with electronic search.

- **Need for increased documentation in the medical record to select a code.** Coders who are selecting diagnosis codes based on a written description on an encounter form or charge slip may find that they need to query the clinician for more detail about the diagnosis. Looking in the medical record may answer the question. The clinician may need to document additional specificity in the note for the encounter or respond to multiple queries in a day.

- **Notes for some three-character codes.** As in ICD-9, there are some notations and a listing of character extenders under some three-character codes that apply to all of the codes below. The difficulty with ICD-10 is that some of these codes in the injury chapters are pages and pages long. The coder or clinician will need to refer back to the three-character code to read the excludes notes and to see what seventh digit character applies to the code. This may be difficult when using an electronic search program to select a code.
• Date of service will determine which code set to use: ICD-9 or ICD-10. Practice management systems will need the ability to store and submit both libraries of diagnosis coding. The date of service—not the date of claims submission—will determine which code set is used.

What about crosswalks?

Many groups are hoping that their EMR or practice management systems will do the work for them, providing a crosswalk between ICD-9 and ICD-10 codes. In fact, CMS itself has developed a crosswalk called the General Equivalency Mapping or GEMS. It provides a crosswalk in both directions between ICD-9 and ICD-10. CMS states that the intent of this is not for claims, but to help in adapting coverage and policies. For example, if there is a National Coverage Determination that limits payment to certain ICD-9 diagnosis codes, the GEMS can provide a crosswalk to covered ICD-10 codes for that service. This crosswalk is not intended to be used for claims. Why?

For one, ICD-9 has 14,000 codes and ICD-10 has 70,000 codes. A direct, one-to-one crosswalk is not possible. There are instances in which a single ICD-9 code maps to one or five or ten or one hundred ICD-10 codes.
Partners and vendors

As with any major transition, medical practices will need their partners and vendors to be ready for the change. A group will need to be on the latest version of software in most cases. Practice management systems, billing services, EMRs, clearinghouses, denial management systems all will need to be ready to use ICD-10 codes on the implementation date. While many practices and payers were ready for the 5010 electronic format change, the health care billing system as a whole did experience problems. If one partner in the chain is unable to comply with the new seven character ICD-10 codes, the practice will not be paid.

Be prepared for decreased productivity, increased queries to physicians

The first months using a new coding system are bound to be difficult. Trained coders may find that the services that need coding don’t correspond to the examples from their coding classes. Many conditions will require multiple codes, and searching for and sequencing these codes will take more time. Coders who have memorized the most common diagnosis codes used in their practices or who are reliant on pre-printed diagnosis codes on an encounter form will find their productivity significantly decreased.
At the same time, coders may find that handwritten diagnosis codes on encounter forms do not provide the needed level of documentation to code in ICD-10. If the documentation for the service is not completed, this will require either a query to the physician or waiting for the documentation to be completed. Even when completed, a query to the physician may be required.

If the clinician is using an electronic medical record and searching for and applying diagnosis codes within that program, the clinician will probably find that process slower. And, the issue of sequencing, discussed in a later section, needs to be considered.

**Shortage of trained ICD-10 coders at the time of implementation**

Many professional organizations are concerned about the shortage of proficient, trained ICD-10 coders. Currently, there are some coders who use ICD-10 to report mortality data. However, very few coders in medical practices are knowledgeable about the new system. Coders who are trained may lack speed, as discussed in the section above. Medical practices should plan for redundancy in ICD-10 knowledge. Having only one staff member trained will put the practice at risk.
The Complexity of ICD-10 (Continued)

Coding: selection, sequencing, applying guidelines

Selecting the correct diagnosis code for reporting health care services is only the first step. The diagnosis codes must be applied to the service following the general guidelines at the start of the ICD-10 book, following chapter guidelines and sequencing instructions. Some medical practices plan to implement coding review of diagnosis coding even if the billing provider is selecting the diagnosis codes within the electronic health record. A coder will review linking and sequencing before the claim is submitted. Doing this will prevent denials and cash flow delays.
Plan, Do, Act: Your Checklist

Large groups and hospital systems are already preparing for the transition to ICD-10. Some smaller groups have held off either hoping ICD-10 won’t be implemented, or overwhelmed with how to start. What should a small- or medium-size practice do?

1. **Be up-to-date with practice management systems, billing companies, EMR software and the clearinghouse.** All practices will need to be on the latest version of these systems.

2. **Coders and billers who do not have a background in Anatomy and Physiology should take a course in A&P this year.** Community colleges or local coding chapters are good resources for this. There are on-line courses available. Some larger practices sign up their coding staff at the same time, so there are opportunities for studying together and support.

3. **Review the use of ICD-9 codes in the practice.** Diagnosis codes are used in EMRs, to submit claims and to order lab tests. Pay attention to any services that have National or Local Coverage Determinations that require specific covered indications for the service.

4. **Review the diagnosis coding in ICD-10 for those conditions.** If using a paper encounter form with pre-printed diagnosis codes, review the crosswalk to ICD-10 for those codes. The volume of these may expand and make using a paper cheat sheet impossible.
5. Print out a list of the fifty most commonly used diagnosis codes and try to code those services in ICD-10. Review the documentation for a sampling of these, and identify the additional documentation, if any, that would be required in order to code for these services.

6. Give feedback to providers now that will help them to increase the specificity of their documentation. If non-specific ICD-9 codes are on the list of the most commonly billed codes, immediately begin a process to improve documentation and select more specific diagnosis codes. Documentation improvement programs can start today.

7. Set a training schedule, and plan to train more than one key staff member. In a large group this is obvious advice, but it is critical for small practices as well. Determine a training budget and timeline. Will everyone attend a class? Will it be on-line or in person? If the group is large and there is a trained coder on staff, can this coder be the trainer for everyone else? Remember that classes may be full in the last six months before the implementation date of ICD-10.

8. Once trained, practice using the codes every week. This is critically important.

9. Determine how and when to train clinical staff, including nurses and billing providers. Most providers will have a low tolerance for a day-long course in coding. Consider breaking up the education into 1-2 hour segments. Block off time in the provider schedule to do this and consider holding the educational sessions off site to minimize interruptions. When practices
Implement a new EMR, they often lighten up the schedule to account for the longer time it takes to document the service. If the provider is selecting the ICD-10 code in the EMR, the medical group may have to decrease the number of patients seen in the first days. Schedule as many educational sessions for providers after the implementation date as before. Free up a coder to be available for on the spot questions in the first weeks.

10. **Have cash on hand.** Be prepared with cash on hand or a line of credit for unforeseen cash flow problems. These could occur because of decreased productivity and claims submission on the physician part or the inability of an insurer to process claims, despite warning and testing.

11. **Assign responsibility for ICD-10 code selection and sequencing.** Currently, there is significant variation in medical practices about who selects both procedure and diagnosis codes, who assigns modifiers and who links CPT and ICD-9 codes. CMS does not require that coding is performed by the physician or by a coder, only that the submission is accurate. A change to a major code set is an opportunity for a practice to consider this question with a fresh eye, and decide who will be responsible to select an ICD-10 code and who will check sequencing and linking. As time goes on, there may be software edits to help in this process, but it is unlikely there will be significant edits in place at the implementation date.
What Steps is Your Practice Currently Taking to Prepare for ICD-10?

- Identifying training needs: 58%
- Identifying processes/areas that will be impacted by ICD-10: 48%
- Finding out where our vendors stand with the transition: EMR, PMS, etc.: 28%
- Reviewing policies, procedures and systems for necessary updates to meet compliance needs: 25%
- Conducting training: 17%
- Identifying internal and/or external related costs: 16%
- Reviewing payer contracts: 8%
- Other: 5%
- Securing a line of credit: 1%

Results are based on the responses of 170 of the webinar attendees.

Source: GatewayEDI (http://www.gatewayedi.com/blog/2012/08/icd-10-how-to-make-the-most-of-the-proposed-delay-2/)
Plan, Do, Act: Your Checklist
(Continued)

Plan, prepare, implement

Hospital systems and large groups have formed teams, projected costs and developed timelines. Smaller groups can learn from their experiences as the deadline date for ICD-10 looms. It is easy to be overwhelmed by the complexity of the task, and the time implementation will take. But, review the steps suggested in this paper, buy an ICD-10 book, and talk to vendors. Medical practices can survive and thrive in changing payment systems.

Biggest Concerns with Regard to ICD-10

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<tr>
<th>Category</th>
<th>Percentage</th>
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<td>Training</td>
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<tr>
<td>Physician/Nurse Readiness</td>
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<tr>
<td>Time, Money &amp; Resources</td>
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<td>Productivity</td>
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</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>

“Other” includes process change and procedural coding

Source: HIMSS
Summary

What should practices do to prepare for ICD-10?

1. Be up-to-date with practice management systems, billing companies, EMR software and the clearinghouse.
2. Coders and billers who do not have a background in Anatomy and Physiology should take a course in A&P this year.
3. Review the use of ICD-9 codes in the practice.
4. Review the diagnosis coding in ICD-10 for those conditions.
5. Print out a list of the fifty most commonly used diagnosis codes and try to code those services in ICD-10.
6. Give feedback to providers now that will help them to increase the specificity of their documentation.
7. Set a training schedule, and plan to train more than one key staff member.
8. Once trained, practice using the codes every week.
9. Determine how and when to train clinical staff, including nurses and billing providers.
10. Be prepared with cash on hand or a line of credit for unforeseen cash flow problems.
11. Assign responsibility for ICD-10 code selection and sequencing.

Resources

1. Centers for Medicare and Medicaid Services (CMS)
   http://www.CMS.gov.
   • For information on ICD-10 including deadlines, go to https://www.cms.gov/ICD10/
   • For information on GEMS (General Equivalency Mapping), go to http://www.cms.gov/Medicare/Coding/ICD10/2013-ICD-10-CM-and-GEMs.html
2. Blog posts on ICD-10:
   • It’s Official: ICD-10 Deadline is Now 2014; But Don’t Wait to Get Started!
   • ICD-10: Failing to Plan Really IS Planning to Fail

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Entrust Your ICD-10 Transition—and Your Medical Billing—to the Experts

Conversion to ICD-10 is too important to your practice to entrust it to people without the time and experience to execute it correctly.

Are you confident that your billing staff or small medical billing service will be ready for ICD-10? If they’re already swamped with your day-to-day billing, the chances are not good.

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