Part B Insider (Multispecialty) Coding Alert

Billing: 3 Steps Can Correct Your Cash Flow Woes

These simple strategies can improve your bottom line.

If your accounts receivables (A/R) seem to be fluctuating from month to month, you could be making mistakes that are jeopardizing your cash flow. Follow these three simple recommendations to stabilize your A/R and cash flow.

1. Start Penalizing Those No-Shows. Every practice has the occasional patient who doesn't show up for an appointment, but if no-shows are becoming commonplace in your practice, you're clearly losing out on reimbursement. In most cases, you should be able to charge patients a fee when they miss an appointment without giving you sufficient notice.

Medicare specifics: As of 2007, Medicare allows you to bill for no show appointments. You're allowed to bill a Medicare patient a no-show fee as long as you don't discriminate and only charge your Medicare patients. Apply the same no-show policy and fee to all of your patients. Remember to bill that fee directly to the patient--not to Medicare.

You should incorporate information about your no-show fee into your new patient financial policy paperwork. Have the patient sign two copies of the policy: one that he keeps, plus one you will keep with his chart.

Handy tool: See our clip-and-save sample letter on page 28 for assistance in explaining your no-show policy to patients.

2. Monitor Each Claim You Send Out, Then Follow Up. It may sound obvious, but many practices overlook this step--you should ensure that someone in your practice is paying attention to what happens to every claim you submit. Ask questions such as, "Did the insurance company even receive the claim?" and "Did the patient pay her copay portion of the bill?"

Following up on your submitted claims early in the game can save you time. First, ensure that once your practice submits a claim that it is accepted. If the claim is rejected, the first order of business is to research why. Catching it in the initial submission phase saves you time in the long run and ultimately gets your money in the door faster.

Once your claim is at the payer, you can't forget about it. You should continually review and monitor your explanations of benefits (EOBs), paying special attention to your denials. You can glean a lot of information from your EOBs, such as how quickly insurers are paying you, whether your fee schedule is adequate, if your coders are coding properly, why insurance companies are denying your claims, and if you're getting paid according to your contracted rates.

Appeal inappropriately denied or partially paid claims with your documentation, notes, and payer coverage decisions to recover wrongfully denied reimbursement.

3. Want to Collect 15 Percent More for NPP Claims? Ensure You Follow Incident-To Rules. If you don't know how to correctly bill the services the non-physician practitioners (NPPs) in your office perform, you could be forfeiting the 15 percent difference in reimbursement rates.

To qualify for incident to, you must first ensure the visit meets a few criteria. CMS' Benefit Policy Manual defines "incident to" as "services furnished as an integral although incidental part of a physician's personal professional service." CMS pays NPP office service reported under a physician's NPI at 100 percent, provided you meet these requirements:

1. The NPP performs the service in a physician's office (place of service 11).

2. The NPP performs the service within the scope of her practice and in accordance with state law.

3. The physician should establish the care plan for the new patient to the practice or any established patient with a new

medical condition. NPPs may implement the established plan of care.

4. The physician must be on site when the NPP is rendering the service.

As noted in the first criterion, you should not report services rendered in a hospital setting -- either outpatient, inpatient, or in the emergency department -- as incident-to. Medicare doesn't allow it. In addition, the physician must have seen the Medicare patient during a prior visit and established a clear plan of care. If the NPP is treating a new problem for the patient, or if the physician has not established a care plan for the patient, then you cannot report the visit incident to.

"Direct supervision" means a supervising physician must be immediately available in the office suite. The supervising physician, however, does not need to be the physician who initiated the treatment plan. You should bill in the name of the physician present in the office suite and providing the supervision at the time of the visit by the NPP, whether or not he initially saw the patient and developed the plan of care.

Watch out: You need to know your state's laws governing the scope of practice for your different NPPs as well. Medicare guidelines specify that "coverage is limited to the services a PA or NP is legally authorized to perform in accordance with state law."

Added bonus: Staying on track with incident-to regulations is not only good for cash flow--it's good for your compliance efforts. Why? Because as part of its 2012 Work Plan, released on last October, the HHS Office of Inspector General (OIG) plans to scrutinize incident to services this year.