Part B Insider (Multispecialty) Coding Alert

Cash Flow: 5 Hidden Income Opportunities Ease the Pain of Sequestration Cuts

Your Medicare pay was slashed by two percent on April 1these tips will help bring in cash.

Now that it's mid-April, you've probably already noticed that some of your Medicare reimbursements have been a bit smaller than what you expected. That's because the government's sequestration cuts have impacted the Medicare program with two percent across-the-board pay cuts that kicked in on April 1.

Your claims with dates of service of April 1 or thereafter will not only have a reduction, but will also have adjustment code 223, which refers to a mandated regulation. The two percent cut will come from the calculated payment amount, or the amount that your MAC pays after applying the deductible and coinsurance, according to a list of frequently-asked questions on the Novitas Medicare (a Part B payer) Web site, which offers this example:

"A provider bills a service with an approved amount of $100.00, and $50.00 is applied to the deductible. A balance of $50.00 remains. We normally would pay 80 percent of the approved amount after the deductible is met, which is $40.00 ($50.00 x 80 percent = $40.00). The patient is responsible for the remaining 20 percent coinsurance amount of $10.00 ($50.00 - $40.00 = $10.00). However, due to the sequestration reduction, 2 percent of the $40.00 calculated payment amount is not paid, resulting in a payment of $39.20 instead of $40.00 ($40.00 x 2 percent = $0.80)."

If you're concerned about how these reductions will impact your practice's bottom line, it's a good time to start considering alternative ways to bring in additional dollars. The following tips can help you compensate for the sequestration cuts.

1. Consider a No-Show Fee

Missed appointments have an impact on the physician's schedule or the physician's availability to other patients, and cost the practice real dollars. But deciding what to do about it depends on your providers, your practice, and your location. In some cases, charging patients a fee when they miss a visit will help your practice offset the lost time and money the open appointment time cost.

Your first step in evaluating whether to charge a fee to patients who do not show up for appointments is to check with your payers. Medicare allows charging for no-shows as long as it is the office policy and done universally to all patients (except Medicaid, which doesn't allow no-show fees).

Key: Even if your contract allows you to bill for no-show visits, that doesn't mean you can bill the payer. You need to bill the patient for the missed appointment. You should tell all of your patients about the policy and have them sign the policy with their other annual financial documents.

Your no-show policy should spell out exactly what fee you will charge for a missed appointment. Some may charge a fixed amount of $25 or $50, which won't cover the missed reimbursement. Others may charge the actual amount of the missed visit; for example, a behavioral health professional may charge their normal fee for a one hour counseling appointment.

CPT® 2023 American Medical Association. All rights reserved.

Be proactive: Sending reminder notices or making appointment reminder phone calls can help alleviate some of your missed appointment concerns. Check to see if your electronic record systems will generate automatic phone or secure message via your patient portal with a detailed reminder 48 hours before the appointment with an email to send the patient to the patient portal's secure messaging inbox.

2. Realize Your Mid-level Provider's Potential to Boost Productivity

You can improve your revenue drastically by integrating mid-level providers (MLPs) such as physician assistants (PAs) and nurse practitioners (NPs), into your practice properly. MLPs can be indirect and direct revenue boosters if integrated properly. You might add MLPs to increase the number of patients your practice can see in a day, give your doctors free time, or improve patient access, among other reasons.

Do the math: PAs and NPs can allow your practice to see an average of three new patients per day, gaining an extra approximately $92 per 99203 visit. With 15 extra patients per week, this adds up to an extra $71,760 per year. Also, the MLP may see on average 18 to 26 established patients per day, netting about $73 per 99213.

Note: The approximate $92 per 99203 noted above is based on the MLP's charge (which is 15 percent less than a physician would collect). That's because you can't collect 100 percent of the fee schedule for patients who haven't first seen the physician, and therefore you can't bill incident-to for new patients.

3. If It's In Your Log, It Should Be in Your Charge Sheet

If your equipment creates a log of everything that happens, make sure you check it against your charge sheet -- or you could be losing cash.

Many practices perform charge verification checks by perusing various logs that are available, to see if they are missing revenue. For example, a cardiologist's pacer/defib system can create a log of events.

If the log on the pacer (or other system) shows events that didn't show up on your posted charges, you should make sure you're capturing all revenue. If you find discrepancies, take the charge issues back to those who are responsible for processing charges for any appropriate changes in process to ensure revenue capture.

4. Avoid Resubmitting Claims

Your practice could be wasting money and administrative resources by re-filing and re-billing bounced claims. Make sure claims go through the first time by paying attention to these issues:

- Enter the correct **place of service** (POS) on the claim. Medicare reimbursement may be different for some codes, depending on whether the POS is code 11 (Office) or code 22 (Hospital outpatient).
- Keep track of **remittance notices** and watch out for remark codes that may point to a problem that's holding up claims or causing denials. Be poised to submit reconsiderations or appeals whenever applicable - and within the time frame.
- Make sure your **front desk** is obtaining a copy of the patient's insurance card. That way, you can be sure to list the correct health insurance claim (HIC) number and name on the claim.
- Keep on top of **Correct Coding Initiative** (CCI) edits so that you're not submitting forbidden code pairs. Remind staff about how to use modifiers to override these edits where appropriate and medically necessary.

5. Ensure That Your Front Desk Is on the Front Lines of Capturing Reimbursement

CPT® 2023 American Medical Association. All rights reserved.

Improving your practice's financial picture starts with the information your practice collects from patients at the beginning. So you need to focus on both your front desk and your back office to improve your revenue.

Your practice will be sunk without clear-cut policies and procedures spelling out who does what. Revenue maximization starts from the time your patient calls to make the appointment. Your front-desk staff members should be checking on insurance information and whether your physician participates with that payer, plus whether the claim is related to motor-vehicle or workers' compensation insurance.

At the visit, your staff should be examining a photo ID to make sure the patient is who he says he is, as well as obtaining a copy of the patient's insurance card. For motor-vehicle or workers' compensation claims, you'll need to collect a whole set of documents from the patient up front. And of course, there's the copayment and deductible, if any.

CPT® 2023 American Medical Association. All rights reserved.