Part B Insider (Multispecialty) Coding Alert

PART B REVENUE BUSTER: Avoid This E/M Trap And Rescue Your Profits

Focus on harvesting 'low-hanging fruit,' and you'll boost your profits

Sure, times have been especially challenging for many practices this year, due to Medicare reimbursement changes. But providers may be making the problem worse, says **Terry Fletcher**, a coding consultant in Laguna Niguel, CA.

The problem: Many specialists decided to reduce the number of E/M visits they perform. -They-re trying to bypass the E/M and get the information on the phone- before operating on a patient, Fletcher says. -They think they can be more efficient with their money by doing less E/Ms and getting more procedures in,- she says.

She sees many practices reducing their E/M visits by 20 to 30 percent, and one office had reduced its E/Ms by about 200 percent. These practices don't realize that they can make more profit by doing E/Ms - especially now that RVUs for E/M codes have gone up. A cardiac catheterization only makes $218 for 90 minutes of work, but a level-four office visit can make $80 for just 15 minutes, notes Fletcher.

-In cardiology, E/Ms is where you make money, not procedures,- Fletcher adds. The same is true for gastroenterology. Of course, you should only provide, and bill for, medically necessary E/M visits.

To figure out whether you-re billing fewer E/Ms this year than last, you should compare your billings from the same period in 2006 and 2007, says Barbara Cobuzzi, director of outreach programs for the American Association of Professional Coders, based in Salt Lake City. Also, if you-re billing E/Ms on the same date as procedures, you should make sure the carrier is allowing your use of modifier 25.

Tip: Try doing an impact analysis of your high-frequency CPT codes by payor, advises **Mary Falbo**, president of **Millennium Healthcare Consulting** in Lansdale, PA. That way, you-ll be able to see what has changed, including your -case mix- or your proportion of E/Ms and procedures.

Don't overlook basic add-ons

Many practices are also missing out on basic reimbursement that they should be billing. Fletcher looked at one office where a new coder wasn't billing for radiological supervision and interpretation with cardiac catheterizations. Another practice was only billing for insertion, not removal, when the physician replaced a battery in a pacemaker, not realizing you can bill for both.

Still another practice wasn't recognizing the difference between an aortography and an abdominal aortogram. With Medicare patients, you get about $40 more for the former than the latter, Fletcher points out.

Other culprits: Many practices suffer from backlogs in claims billing due to staffing changes or operational process. These lags can create reimbursement declines, says **Cynthia Swanson,** a coding consultant with **Seim Johnson Sestak & Quist** in Omaha, NE. Adding a new physician to your practice can cause delays, especially with the slow process of getting the new doctor enrolled in Medicare.

Not all coding experts are seeing a decline in their clients- revenues this year.

-The only practices I-m experiencing a drop with are those that have imaging equipment,- says Tom Powell, a senior consultant with Healthcare Administrative Partners in Media, PA. Practices with imaging equipment are suffering from the outpatient cap and cut to additional scans, he notes. -Everyone else I work with is doing a little better this year.-

Many cardiology practices are focusing on harvesting -low-hanging fruit- and doing better this year than last, says **Jim Collins** with the **Cardiology Coalition** in Matthews, NC. His clients are focusing on documenting services accurately--including diagnostic test indications, documenting all procedures and add-on services, and documenting E/M visits fully.

Bottom line: -Practices need to take a look at all the angles of billing and collections to determine the rationale for reimbursement decreases,- Swanson says. These can include your billing and collections processes, changes in your practice, new coding or billing staff, increases or decreases in particular services, fee schedule changes, how aggressive your collections staff are, and how much you emphasize appealing denied claims.