Psychiatry Coding & Reimbursement Alert

Money Matters: Use This 4-Prong Approach To Recoup Untapped Profits

Reduce the April 1 sequestration reduction pinch.

If your practice is feeling the impact of the two percent across-the-board pay cuts to your Medicare income as a result of the government's sequestration cuts, effective April 1, you can try to lessen your financial woes by looking at areas where you can ethically boost your bottom line.

The skinny: 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 or not to charge a fee to patients who do not show up for their 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). For more information on this, you can check out http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5613.pdf

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, your psychiatrist may charge his normal fee for a one hour counseling appointment.

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 health record system will generate an automatic phone call reminder or send a secure message via your patient portal with a detailed reminder 48 hours before the appointment.

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 additional new patients per day, gaining an extra approximately $92 per 99203 (Office or other outpatient visit for the evaluation and management of a new patient ...) visit. With 15 extra new 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 (Office or other outpatient visit for the evaluation and management of an established patient ...).

Note: The approximate $92 per 99203 noted above is based on the Medicare allowance for an MLP billing under his or her own provider number (which is 15 percent less than a physician would collect). That's because you can't bill incident-to for new patients and collect 100 percent of the Medicare physician fee schedule allowance that would otherwise be payable under the incident-to provision.

3. 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.

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

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.