Improving Cash Flow

Chapter FastFACTS

1. **Filing claims and collecting co-pays promptly are key to having a profitable practice.**
2. **Staying on top of the latest requirements for coding and filing claims helps maintain positive cash flow.**
3. **Practices that succeed in maintaining positive cash flow also tend to keep a close eye on expenses.**
4. **Because of concern over physician fees, some doctors are reconsidering their participation in Medicare and reviewing other options such as cash-only practices.**
5. **Physicians exploring concierge or other practice models should be up to date on fraud and abuse rules.**

When Joseph F. Mambu, MD, started his own practice 10 years ago—after spending more than 20 years in a large group—he learned quickly the value of correct coding in keeping a small practice afloat.

"I'm not afraid of coding what I believe is the higher, right code and documenting to support it," says Dr. Mambu, one of three physicians at Family Medicine, Geriatrics, and Wellness in Lower Gwynedd, Pa. Training the other physicians and nurse practitioners not to under-code adds at least an extra $40,000 a year to his bottom line, he estimates. "If you can document everything you do, you can get the higher payment for the higher code," he says. "Knowing how to code is part of the formula for being successful in primary care now." (See "Tips for Conducting a Coding Audit.")

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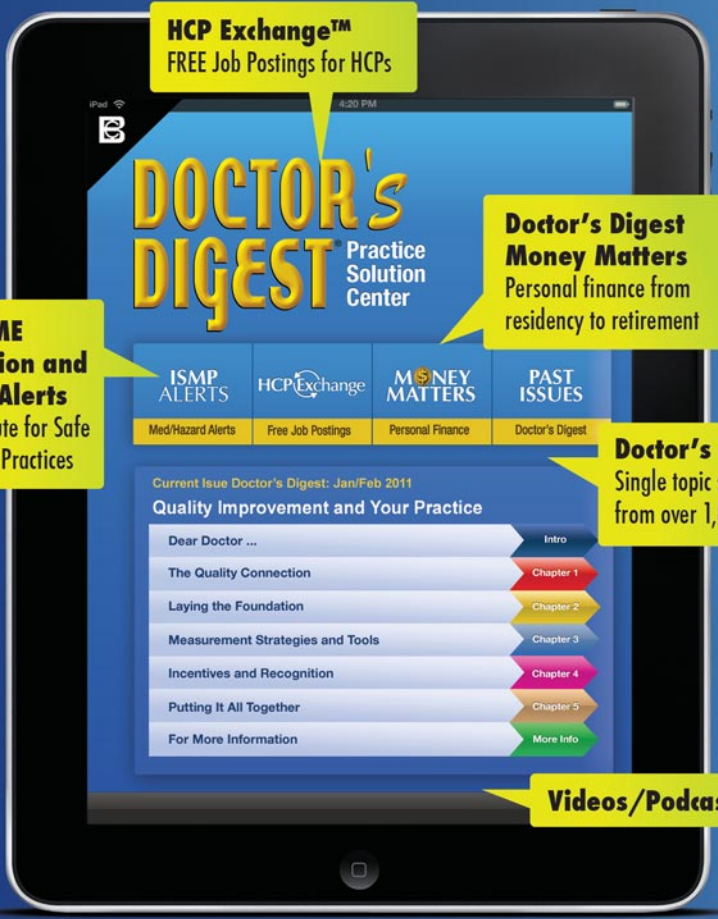

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Tips for Conducting a Coding Audit

Comparing your coding against the actual clinical documentation in your charts will give you an idea of whether you're coding appropriately, advise experts at the ACP. They recommend following these five simple rules to ensure a successful internal audit:

1. Select charts randomly. To keep the sample random, ask a staff member to create a random weekly list of 50 patients, and pull every fifth chart until you get 10 charts. It makes sense to concentrate on visits that took place over a certain time period so that you can identify trends.

2. Don't review your own charts. It's nearly impossible for you to complete an unbiased review of your own charts because you know your own handwriting and can fill in gaps based based on your typical thinking. Remember that if you do get audited, the person reviewing your charts will be unfamiliar with your penmanship, work style, and overall practice pattern. Choose another physician, nurse, or someone else familiar with coding rules to conduct an in-house review.

3. Use the same rules as the auditors. Medicare and private insurer auditors may interpret guidelines in different ways, but they usually stick

For many small practices, maintaining profitability depends on constant attention to business basics like coding, billing and collections, overhead, and expenses. Better-performing practices tend to bill their claims quickly, collect co-pays at the time of visits, keep a close eye on expenses, and self-audit to spot problems such as under-billing or visits not billed.

"You have to do a careful review of your expenses, do coding audits, and educate nurse practitioners and physicians about missed opportunities for coding and billing," says Dr. Francis, who chaired the AAP's section on administration and practice management. "You have to make sure that the way you are set up is most effective and efficient."

Collecting What's Owed

Along with getting claims filed, collecting co-payments should be a daily priority, says Mr. Arend of TransforMED. It becomes more difficult and sometimes impossible to collect co-pays after a patient leaves the office; and in an era of rising co-pays, that can translate into significant lost revenue for the

to a few simple rules. First, they are supposed to use whichever E/M documentation guidelines are more beneficial to the physician when auditing.

4. Keep coding audit results professional and educational. Physicians should be given the opportunity to review and study the results of their coding audits and to openly discuss what can be improved. Better coding results when everyone on staff is committed to complying with documentation guidelines.

5. Work at correcting errors. Completing a coding audit accomplishes little unless problems identified by the audit get fixed. Establishing an ongoing reporting and feedback system to physicians is important. It is a sign of excellence if the practice or the physician can show improvement from one quarter to the next. Correcting any systematic under-coding uncovered in an audit will enable you to collect the revenue to which you are entitled, and addressing over-coding will minimize the likelihood that you will have to pay money back to Medicare or another payer if audited.

Source: Used with permission from ACP's Center for Practice Improvement and Innovation. Adapted from "How to complete a coding audit (internal medicine)," in the Running a Practice section of ACP's Website. http://www.acponline.org/running_practice/practice_management/payment_coding/coding/coding_ audit.htm

practice. Mr. Arend says practices should strive for at least a 90% co-pay collection rate at the point of service.

Adopting a stricter co-pay collection policy doesn't have to be a negative experience for patients, write Rhondda Francis and Sarah Breshears on TransforMED's Website. Remind patients that paying the co-pay upfront eliminates the hassle of paying bills later by mail.

Practices should also clearly communicate their co-pay policy to patients, the authors note, by trying the following:

- Draft a formal letter outlining your new policy, and mail it to each patient.
- Develop a brochure concerning the new policy, and display it

prominently in the waiting room and at the checkout window.
- Post your policy prominently on your Website.
- Include an announcement about your new policy on your recorded telephone message.
- Upon check-in, have patients read and sign a form outlining your new policy.
- When patients call to make an appointment, have the scheduling desk remind them of your policy and indicate what they'll owe.

Switching to ICD-10

Another important element in maintaining positive cash flow is staying on top of the latest requirements for coding and filing claims. Even though the official transition to the International Classification of Diseases, Tenth Revision (ICD-10) doesn't occur until Oct. 1, 2013, you should be preparing for the move given the variety of system and business changes required. In order to accommodate electronic filing of claims with ICD-10 codes, providers must first transition to Version 5010 of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards by Jan. 1, 2012.

The switch to ICD-10 and Version 5010 affects everyone covered by HIPAA who files claims electronically, not just those who submit claims to The Centers for Medicare and Medicaid Services (CMS). The new system is meant to replace the outdated ICD-9 by adding codes and terminology that take into account current needs, such as preventive services, technology, and new procedures and diagnoses.

Starting on Jan. 1, 2011, CMS began accepting Version 5010 claims along with the old 4010 claims in order to allow payers and providers to test the new system. Testing should be completed by the end of this year, according to a timeline on the CMS Website.

Paring Expenses

Practices that succeed in maintaining positive cash flow also tend to keep a close eye on expenses. Although technology (especially investment in EHRs) and salaries are the most significant expenses for a medical office, innovative practices tend to

view these areas as essential investments and look elsewhere to cut costs.

Given the current economic climate and depressed commercial real estate prices, Mr. Rallison, CEO at Greenfield Health, for example, is scouting out cheaper office space in order to save on rent and pave the way for expansion. "Our goal is to reduce costs and increase capacity so we can increase the practice's panel size and generate more annual membership fees," he says. Dr. Francis reviews expenses often and tries never to "leave money on the table." For example, she instructs her staff to be proactive about contacting patients to schedule follow-up visits for chronic care, such as asthma or attention deficit disorder, and well-child exams.

Developing a robust house call service has helped mitigate overhead costs for Dr. Mambu in Pennsylvania. Two-thirds of his practice's revenue comes from work done outside his office walls—at hospitals and patients' homes—where "there is no overhead," he says. He tries to maximize his time outside the office by scheduling house calls in the same neighborhood or apartment complex on the same day. That way, he can make four or five visits in a day, which produces significantly more revenue than the same number of office visits (Medicare assigns 4.34 RVUs for a home or hospital visit vs 0.9 to 1.5 RVUs for a typical office visit, he explains).

"The overhead is where my billers are, my phone systems, etc.," he says. "Interestingly, the office is where you make the least money and have the greatest overhead costs."

Working With Insurers

Do you know your choices when it comes to participating in Medicare? While most physicians work with Medicare and other insurers, more and more physicians are reconsidering their status given their frustration over Congress's annual last-minute rush to block Medicare payment cuts called for under the sustainable growth rate (SGR) formula used to determine physician fees. Congress averted an almost 25% cut in December by extending current rates through the end of this year, but it stopped short of approving a long-term fix. The American Medical Association (AMA) has published an overview of the three

options: Sign a participating agreement (PAR), which accepts Medicare's allowed charge as payment-in-full; elect to be a non-PAR physician, which enables you to bill patients for more than the Medicare-allowed charge; or opt out of Medicare and become a private contractor that bills patients directly. (For information for new practices, see "Signing Up with Medicare or Medicaid: An Update.")

The decision whether to work with Medicare should take into account several considerations, according to the AMA:

- Medicare provides incentives for physicians to choose the first option, such as a 5% higher payment rate (100% of the approved amount vs 95% for non-PAR physicians), and faster claim processing.
- Non-PAR physicians can charge more than the Medicare-approved amount (115%), but they would need to collect the maximum charge about 35% of the time they provide Medicare services in order to equal the revenue earned by PAR physicians for the same services. Therefore, balance any potential gains against collection costs and bad debts.
- Once physicians have opted out of Medicare in favor of private contracting, they cannot submit any claims to Medicare for two years.

The Concierge Model

Physicians who charge fees for care or extra services, either instead of or in addition to accepting Medicare and other insurance, are known as retainer-based or concierge practices. According to an October 2010 report conducted for the Medicare Payment Advisory Commission (MedPAC), there are at least 750 retainer-based practices in the U.S., with the majority focused on primary care, a substantial increase from the 146 retainer practices identified by a U.S. Government Accountability Office report in 2005. The report divides retainer-based practices into three categories:

- **Fee for extra services:** The patient pays an annual fee covering an extended annual physical exam in addition to per-visit charges. These physicians usually still work with private insurers and Medicare.
- **Fee for care:** The patient pays a one-time fee for all primary

care, and the physician does not charge insurers directly.

- **Hybrid:** Physicians charge a fee to some patients for an increased level of services while continuing to see non-retainer patients.

Michelle A. Eads, MD, a solo family practitioner who owns Pinnacle Family Medicine in Colorado Springs, Colo., falls under the "fee for care" category and has been accepting cash-only patients since 2003. "I wanted to work for patients, not the insurance companies," explains Dr. Eads, who works part-time and serves just over 100 patients. "It [i.e., going cash only] saves me a lot of time and hassle chasing down claims."

Dr. Eads charges her patients an annual membership fee that varies depending on the level of service and individual needs. For example, an all-inclusive option ranges from $900 to $5,000 annually depending on the patient's age and what type of service he or she chooses (i.e., home visits vs office, e-mail, or phone visits) while her most popular option requires an annual fee ($360) plus per-visit charges ranging from $85 to $200, depending on the length of the visit. While she doesn't work directly with insurers, Dr. Eads fills out standard claim forms that patients can submit to their insurance company to receive reimbursement for out-of-network benefits and refers patients to their in-network facilities for labs and X-rays. (See Chapter 4 for more on this practice model.)

While money is not the main motivator for adopting a retainer or concierge model, some physicians who have made the switch report higher incomes, according to the MedPac report. However, the main appeal of retainer-based models appears to be the ability to make the same money—as in a traditional practice—or even more—under more favorable working conditions.

"The physicians we interviewed had between 100 and 425 patients, compared with over 2,000 before starting or joining a

retainer-based practice," the report's authors note. "Some said they make more money than they did in a non-retainer practice, but others said they make a similar amount for far less work and stress."

Preventing Fraud

While some patients are willing to pay extra fees for better access and more services, physicians must be wary of running afoul of federal laws designed to prevent fraud and abuse (see "Creating a Voluntary Compliance Program"). As a cautionary tale, the U.S. Office of Inspector General (OIG) lists on its Website the case of a physician who paid $107,000 to resolve potential liability for charging patients an annual "concierge" fee in

Signing Up With Medicare or Medicaid: An Update

If you are just now joining with Medicare or Medicaid, here's good news: The CMS has simplified and sped up its provider enrollment process with the introduction of the Web-based Provider Enrollment, Chain and Ownership System (PECOS). Using this system, you can submit, edit, and track your application online. Access is obtained using the same user name and password created when you applied for a National Provider Identifier. Using PECOS will reduce the enrollment process to about 45 to 90 days, compared with 60 to 180 days for a paper application, according to CMS. Other tips to speed up enrollment include making sure you have the most current version of the enrollment application, submitting the application to the appropriate Medicare contractor in your state or region, having your NPI ready in advance, and including the electronic funds transfer authorization agreement so you are set up to receive payments once approved.

To simplify the private insurer credentialing process, the AAFP suggests using the Universal Provider Datasource, available through the nonprofit Council for Affordable Quality Healthcare, which is supported by many large U.S. health plans and associations. Physicians can submit and regularly update one standard application stored on a common database used by participating health plans and hospitals instead of providing the same information to multiple plans.

In addition to providing evidence of liability insurance, medical licenses and other documents, most health plans also require that physicians be board certified or board eligible in order to participate in the network, says

exchange for amenities such as an annual physical exam, same-day appointments, and 24-hour access to the physician. The extra services offered by the physician weren't unusual in a concierge practice; but the offer was extended to all of his patients, including Medicare beneficiaries, resulting in double billing, the OIG states. The physician was in violation of his participation agreement with Medicare by charging in excess of Medicare-approved fees, copayments, or deductibles.

Physicians receive general education about federal statutes governing fraud and abuse from professional organizations, such as AAFP, residency programs, malpractice carriers, and programs conducted by Medicare Advantage and other health plans,

the AAFP. A physician who fails to recertify risks being dropped from a health plan's network.

Mr. Milburn offers the following tips for working with payers:

- **Understand your negotiating leverage.** Are you in a strong or weak position with the insurer? If you are a family practitioner in an urban center, you probably don't have much leverage, but if you're in a remote or underserved area your position is stronger. Negotiate reasonably, though, because a competitor could come in and undercut your rates.
- **Manage and track your payer contracts**. Know where your contracts are filed, and compare the terms of the different payers so you can focus on improving the lower performers. "You'd be surprised how many practices can't even find their contracts," says Mr. Milburn.
- **Get to know and establish a relationship with your payer representative.** Don't let a couple of years go by without calling your rep, says Mr. Milburn, and treat him or her with respect and courtesy. It will get the payer rep on your side. You may not always get more money, but you may get better terms on something else you want.
- **Ask for small, incremental increases** (1% to 3%) every year as opposed to one big increase (10% or more) every three to five years. The smaller requests are more likely to get approved.
- **Figure out what the going reimbursement rates are in your region.** Talk with colleagues in your specialty to determine a ballpark figure of the reimbursement rates in your community.

says Cynthia Hughes, coding and compliance specialist for AAFP. However, she adds, the complexity of regulations and payer policies leaves room for error and differing interpretations. "It is absolutely possible to unintentionally violate fraud and abuse laws," says Ms. Hughes. "Physicians may let a contract lapse without realizing it or bill for services under outdated payment policies because they missed an update. Even knowing when and how to self-disclose—and understanding the ramifications of that—require legal advice."

To avoid running the risk of violating fraud and abuse laws, the OIG recommends that physicians become familiar with the following three federal statutes:

- **The Civil False Claims Act** assigns liability to any person who knowingly submits a fraudulent claim for payment to the federal government. It also addresses the creation and submission of false records relating to false claims, among other provisions. Violations generally are punishable by a civil penalty up to $10,000 and three times the amount of damages incurred by the government as a result of the fraudulent claims.
- **The federal anti-kickback statute** states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal healthcare program business, including Medicare and Medicaid, can be charged with a felony. Violations are punishable by up to five years in prison and criminal fines up to $25,000. Violators may be subject to administrative civil monetary penalties up to $50,000 and exclusion from participating in federal healthcare programs.
- **The physician self-referral statute** prohibits physicians from referring patients to facilities in which they have ownership or other financial interests, with certain exceptions. Violations are punishable by a civil penalty up to $15,000 per improper claim, denial of payment, and refunds for certain past claims.

Ms. Hughes also recommends that physicians develop a compliance program, including staff training and an open-door policy inviting staff to share any compliance concerns with a designated compliance officer directly or through an anonymous disclosure process.

Creating a Voluntary Compliance Program

To help prevent erroneous or fraudulent claims, the OIG recommends that small practices develop a voluntary compliance program. Besides reducing fraud, a compliance program can have several practical advantages, the OIG says, such as speeding claim payment, minimizing billing mistakes, and reducing the possibility of a government audit.

The OIG's 2000 guidelines on compliance programs are still relevant today for any practice that does not have a full-time compliance department, according to Sarah J. Holt, PhD, in *Get the Money in the Door: Physician Billing Practices*, published in 2010 by MGMA. "The presence of a formalized compliance plan in a healthcare organization," writes Dr. Holt, "signals that a physician organization intends to conduct all of its affairs by the rules and regulations governing federal health policy."

According to the OIG, components of an effective program should include these:

- Conducting internal monitoring and auditing through periodic audits;
- Implementing compliance and practice standards through the development of written standards and procedures;
- Designating a compliance officer or contact to monitor compliance efforts and enforce practice standards;
- Conducting appropriate training and education;
- Responding appropriately to detected offenses and developing corrective action;
- Developing open lines of communication, such as discussions at staff meetings on how to avoid erroneous or fraudulent conduct; and
- Enforcing disciplinary standards through well-publicized guidelines.

The OIG acknowledges that small practices may not be able to implement all of the components at once but should begin with those most likely to benefit their practice. In addition, small practices should consider participating in established compliance programs at hospitals or other settings in which they practice, but being careful to avoid potential anti-kickback or self-referral issues. For example, a practice might participate in a larger entity's training programs or use the larger entity's procedures as a template for creating its own version.

Source: Department of Health and Human Services, Office of Inspector General. OIG Compliance Program for Individual and Small Group Physician Practices, Federal Register/ Vol. 65, No. 194/ Thursday, October 5, 2000/ Notices. http://oig.hhs.gov/fraud/PhysicianEducation/05compliance.asp