12 Ways to Supercharge Your Practice in 2012: #12 – 9 Ways to Maximize Your Medicare Payments

Medicare has so many programs that have the potential to increase or decrease your payments that practices need a list to keep them straight.

Here's your list with information on which programs are mutually exclusive and which can be combined.

1. Electronic Health Records (EHR) Incentive Program

- You must be an eligible provider to participate.
- You must be the owner of the EHR, although you do not need to have paid for the EHR.
- The EHR must be certified.
- You can choose to participate in Medicare (federally administered) or Medicaid (state administered) program.
- You must register for the programs.
- You must attest or document that you have adopted, implemented, upgraded or demonstrate meaningful use.
- Eligible professionals choosing to participate the Medicare program can each earn up to $44K over 5 years, and eligible professionals choosing to participate in

the Medicaid program can each earn up to $63,750 over 6 years.

2. ePrescribing Incentive Program

- Eligible professionals do not need to register for the program.
- You can participate in one of three ways: via submitting codes on claim forms, via an EHR or via a registry
- Each professional needs to report 10 eRx events for Medicare patients for dates of service before June 30, 2012 OR apply for one of five exclusions or four exemptions.
- EPs who are successful e-prescribers can qualify to earn an incentive payment based on a percentage of their total estimated Medicare PFS allowed charges processed not later than 2 months after the end of the reporting period. For reporting year 2012, EPs who are successful e-prescribers can qualify to earn an incentive payment equal to 1.0 percent of allowed charges. For reporting year 2013, EPs can qualify to earn an incentive payment of 0.5 percent of allowed charges. Beginning in 2012, EPs who are not successful e-prescribers in 2011 and do not qualify for a hardship exception will be subject to a payment adjustment equal to 1.0 percent of their Medicare PFS allowed charges. The payment adjustment increases to 1.5 percent in 2013 and 2.0 percent in 2014.

3. PQRS (Physician Quality Reporting System)

- Originally called PQRI (Physician Quality Reporting Initiative) is the basis for pay-for-performance models.

- Physicians may report individually or practices may choose a set of three measures that relate to the type of patients they see. Measures are performed and modifiers are attached to claims.
- Bonuses are available until 2014; starting in 2015 practices not participating in PQRS will receive a negative payment adjustment.
- For reporting years 2012 through 2014, EPs who satisfactorily report Physician Quality Reporting System measures will earn an incentive payment equal to 0.5 percent of allowed charges. Additionally, for reporting years 2011 through 2014, EPs who satisfactorily report Physician Quality Reporting System measures can qualify to earn an additional 0.5 percent incentive payment by, more frequently than is required to qualify for or maintain board certification status, participating in a maintenance of certification program and successfully completing a qualified maintenance of certification program practice assessment. Beginning in 2015, EPs who do not satisfactorily report under the Physician Quality Reporting System will be subject to a payment adjustment equal to 1.5 percent of their Medicare PFS allowed charges. The payment adjustment increases to 2.0 percent in 2016 and beyond.

4. Medicare Wellness Visits

- Many practices are losing money due to the confusion over what Medicare pays for and what Medicare doesn't pay for. Medicare introduced three new visits in 2010 and many providers continue to have trouble understanding and providing them correctly.
- The "Welcome to Medicare" visit is technically called the "Initial Patient Physical Examination" (IPPE), but to everyone's dismay, it is not a physical examination at all, with the exception of basic visits such as

height, weight, BMI, blood pressure and pulse, and the potential for an EKG and an Abdominal Aortic Aneurysm screening. The Annual Wellness Visit (AWV) and the Subsequent Annual Wellness Visit are not physical examinations either, yet almost ALL patients believe that Medicare now gives free annual physicals.

- Practices must train all staff and physicians to use the correct terminology first. I suggest everyone stop using the phrases “annual physical” or “complete physical” with Medicare patients. Patients can request and receive:
    - A Welcome to Medicare Visit with no exam (no deductible, no co-insurance)
    - A first annual Wellness Visit with no exam (no deductible, no co-insurance)
    - A Subsequent Annual Wellness Visit with no exam every year thereafter (no deductible, no co-insurance)
- What patients think they want is either a preventive visit, which Medicare will NOT pay for, or a standard Evaluation & Management (E/M) visit, which their deductible and co-insurance will apply to.
- The only way the practice can win is by driving home to patients what Medicare does pay for and doesn’t pay for and making sure your documentation matches the code you submit to Medicare.

5. The ABN (Advance Beneficiary Notice)

- Many practices miss revenue when they provide services to Medicare patients that are statutorily excluded from Medicare benefits.
- These may be services that do not meet the Medicare

definition of medical necessity or are provided at more frequent intervals than Medicare approves.

- Identifying these non-covered services is the hard thing, however, unless your EMR can alert you to a service that will not be paid by Medicare, and if the patient requests the service and signs an ABN prior to the provision of the service In this case, the practice may collect the full fee from the patient.

6. Primary Care Incentive Payment Program (PCIP)

- Eligible Providers (Clinical Nurse Specialists, Nurse Practitioners, Physician Assistants, and Physicians who have their primary specialty designation in family medicine, internal medicine, geriatric medicine or pediatric medicine) can receive a 10% incentive payment for services under Part B.
- The PCIP program, which was created by the Patient Protection and Affordable Care Act, requires Medicare to pay primary care providers, whose primary care billings comprise at least 60 percent of their total Medicare allowed charges, a quarterly 10-percent bonus from Jan. 1, 2011, until the end of December 2015.
- Eligible primary care physicians furnishing a primary care service in a Health Professional Shortage Area (HPSA) area may receive both a HPSA and a PCIP payment.

7. HPSA (Health Professional Shortage Area)

- Medicare makes bonus payments annually of 10% to physicians who provide medical care services in

geographic areas that lack sufficient health care providers to meet the needs of the population.

- Payments are automatic; there is no need to register or report anything on the claim for
- If services are provided in ZIP code areas that do not fall entirely within a full county HPSA or partial county HPSA, the AQ modifier must be entered on the claim to receive the bonus.

8. HPSA (Health Professional Shortage Area) Surgical Incentive Payment (HSIP)

- The Affordable Care Act of 2010, Section 5501 (b)(4) expands bonus payments for general surgeons in HPSAs. Effective January 1, 2011 through December 31, 2015, physicians serving in designated HPSAs will receive an additional 10% bonus for major surgical procedures with a 10 or 90 day global period.
- Payments are automatic; there is no need to register or report anything on the claim form.
- If services are provided in ZIP code areas that do not fall entirely within a full county HPSA or partial county HPSA, the AQ modifier must be entered on the claim to receive the bonus.

9. NEW! Comprehensive Primary Care Initiative (CPCi)

- Payment model per beneficiary per month (PBPM) for care management of Medicaid and Medicare patients
- Markets in Arkansas, Colorado, New jersey, New York,

Ohio/Kentucky, Oklahoma and Oregon for Medicaid patients
- Arkansas, Colorado, Ohio and Oregon are the four states for Medicaid pilots.
- Multiple payers, including CMS, will be paying a monthly care management fee to support the 5 primary care functions of:
    - Risk-stratified care management
    - Access and continuity
    - Planned care for chronic care & preventive care
    - Patient & caregiver engagement
    - Coordination of care across the medical neighborhood
- Primary care practices in the states and markets can apply from June 15 to July 20, 2012 **(application here.**)

What Medicare Bonus or Incentive Programs Can Be Claimed Together?

- PQRS can claimed with eRx.
- PQRS can be claimed with EHR.
- HPSA and PCIP are automatic and are not affected by any other programs
- EHR and eRx can both be claimed but you cannot earn both an eRx incentive and an EHR incentive in the same year if you elect to receive the EHR incentive payment through Medicare. **NOTE: Just because you cannot claim the eRx bonus in conjunction with EHR incentive, you must still continue to ePrescribe to avoid the eRx penalty!**

Mary Pat and Dr. Peter Polack Discuss (Approximately) 101 Ideas to Increase Revenue and Decrease Costs in a Two Part Podcast

Mary Pat recently sat down with Peter Polack, MD of **Medical Practice Trends** for another podcast to talk about one of the most important parts of any practice: The Bottom Line. In this two-part podcast series, Dr. Polack and MP discuss ideas for cutting costs and raising revenue to strengthen any group's financial position.

Click here to listen to part 1

Click here to listen to part 2

A Manage My Practice Classic: 101 Ideas for Increasing

Revenue and Decreasing Expenses in Your Medical Practice

Mary Pat's Note: This post has always been popular because it answers one of the most burning questions in Healthcare: "How can I improve my bottom line?" If you have used any of these ideas in your practice- or have some of your own to share- let us know in the comments below!

BUILD ON WHAT YOU'RE CURRENTLY DOING:

1. **Add physician hours** – add evening or weekend hours; start your office hours earlier and end hours later.

2. **Reduce physician time off** – decrease vacation or change weekly days off to 1/2 days off.

3. Set a minimum number of providers to be in the office **seeing patients at all times** the office is open.

4. Have each provider add **one new patient visit** to his/her schedule weekly.

5. Add **ePrescribing** to recoup additional Medicare revenue and streamline prescribing (there are free ePrescribing software packages available, but evaluate them carefully so they don't add more complexity to the system instead of less.)

6. Report **PQRI** measures to recoup additional Medicare revenue.

7. Charge patients an out-of-pocket fee for completing **patient forms** – disability forms, etc. and reserve office visits for

treating patients.

8. Choose an **EMR** that qualifies your practice for the ARRA money (although it has been widely promoted that in a larger practice, an EMR and its associated work will cost more than you will get from the government.)

9. If you are in an underserved or rural area, check to see if there might be **grants or funds available** locally, in the state or federally, for adding a service to your practice.

10. If your practice does **Independent Medical Exams (IMEs), reviews records or depositions**, make sure that your fee schedule for such services is current and that the fees are collected before the physician provides the service.

ADD TO YOUR CURRENT SERVICES:

11. Allergy testing & treatment

12. Dispensing pharmaceuticals

13. Dispensing nutriceuticals

14. Dispensing Durable Medical Equipment

15. Group patient visits

16. Coumadin Clinic

17. Heart Failure Clinic

18. Diabetes Education Classes

19. Add primary care to specialty care practices

20. Add specialty care to primary care practices

21. Research

22. Joint Ventures with other practices or hospital

23. Lease space to other entities

24. eVisits (virtual visits or email visits)

25. Elective procedures or services

26. Mid-level providers

27. Walk-in clinic

28. Occupational medicine: drug screens, employment physicals, etc.

29. Hospitalists

30. Medical Director of local nursing homes

31. Complementary & alternative medicine (CAM)

32. Aging in Place services

33. Social worker

34. Concierge practice

35. School team physician

EVALUATE YOUR REVENUE CYCLE MANAGEMENT:

36. Are you **renegotiating payer contracts** regularly?

37. Do your scheduling staff know how to educate patients about what payers you have contracts with and are in network with and what the **patient's financial responsibility** will be?

38. Do staff know what typical **new patient charges** are to tell the patient?

39. Do you check every **patient's eligibility** for insurance benefits immediately prior to every service?

40. Do you have patients sign a **financial policy** to acknowledge what they are responsible for based on their payer type?

41. Do you **copy the patient's insurance cards** at every visit, or at least compare their current card to the card you have on file? Are you able to scan patient insurance cards and driver's licenses into your practice management (PM) system?

42. Is your PM system able to download the information from the scan into the patient registration screen? If not, do you have a way to **confirm that demographic and insurance information has been entered correctly** from the cards?

43. Are your **charges being posted daily**?

44. Does the person who **provides the service, or a documentation coding specialist, choose the CPT and ICD9 code**?

45. Is the **documentation** for the charges being completed within 24 hours of the service?

46. Is your **encounter form up-to-date** with current CPT and ICD9 codes; do you order smaller batches of them so you can change the codes as new services are added in the practice?

47. Do you check the **CPT and ICDD9 matching** to make sure the codes are valid for the year, the codes adhere to NCCI and LCD edits before you finalize the charges?

48. Do you regularly **audit medical records for coding and documentation** and give providers feedback on where coding could be improved?

49. Are you using **ABNs for Medicare patients** who want services that Medicare might not pay for?

50. Do you **file claims daily**?

51. Do you **correct claims daily** when they are rejected at the practice management, claims clearinghouse or payer level?

52. Do you **correct claims daily when they are rejected at the claim level** and are not paid for for reasons that can be corrected?

53. Do you have your **contract allowables** in your PM system so you know when you are not being paid correctly by contract?

54. Do you **appeal unpaid or underpaid claims**?

55. Do you **check recoupments** or requests for refunds from payers and make sure they truly should be refunded?

56. Do you send insurance and patient payments to a **lockbox** to be scanned and stored digitally for your staff to post from?

57. Do you make **payment arrangements** in the office for balances after insurance has paid, or payment plans by drafting credit or debit cards?

58. Do you have a **policy of not sending statements**?

59. Do you **collect the patient's portion** of the service at the time of service?

60. Do you **collect fees for elective services** prior to providing these services?

61. Can your patients **make payments online** through your website?

62. Do you file a **claim with a patient's estate** if they have died?

63. Do you accept **cash only from patients who have passed bad checks**?

64. Do you accept **cash only from patients who have filed bankruptcy** with your practice?

65. Do you inadvertently **see patients who have been dismissed from your practice**?

66. When adding a physician to the practice, do you **timeline the credentialing** appropriately so the physician can see patients with insurance as well as those without?

67. If your new physician is only partially credentialed with payers, do you have him/her see the patients with payers they are credentialed with and **add payers to their schedule load as the credentialing comes through**?

68. Do you **meet with representatives from your largest payers monthly** to establish relationships and bring problems to their attention? (the squeeky wheel theory of payer relations)

69. Are you **pre-certing** everything that needs pre-certification or pre-authorization or pre-notification to be sure the service will be paid?

70. Are you receiving payments via **electronic funds transfer** (EFT)?

71. Are you receiving **explanation of benefits (EOBs) or remittance advice (RA) electronically?**

72. Are you **posting your RA electronically**?

73. Are you **protecting your practice from embezzlement?** (**see my post on this here**.)

74. Is someone in the practice responsible for staying current on **changing coding requirements** for Medicare, Medicaid, Tricare and commercial payers?

DECREASE EXPENSES:

75. Eliminate **overtime**. Evaluate the need for additional staff (part-time?) vs. overtime.

76. **Send some staff home** (sometimes called “low census”) when there are no patients to be seen.

77. Use **volunteers.** Tap into the local hospital volunteers, or recruit and train your own.

78. Hire an after-school **student** employee to do routine jobs.

79. **Discontinue paying staff for inclement weather closings** when the practice is not open.

80. **Shop everything.** Negotiate existing service contracts. Do not assume anything is non-negotiable. Negotiate the rent.

81. **Get rid of yellow pages advertising.** It rarely brings you new patients and is primarily a place to look up phone numbers. You will still get your white pages listing free with your phone service.

82. Utilize **pre-employment testing** to make sure job applicants have the skills you need.

83. Shop postage machines or look into **stamps.com.**

84. Join a **group purchasing entity** (hospital, professional association, etc.)

85. Improve your **accounting cycle.** Invoices and statements are matched up with packing slips and negotiated prices. Use purchase order numbers.

86. Get the **payment discount** by paying on time or early – ask vendors for an on-time or early payment discount.

87. Make sure **office supplies** are not going home with the employees. Make sure office supplies that are ordered are

“really need” and not “sure would be nice.”

88. Remind patients of their appointments to **decrease no-shows**. Call patients who no-show and attempt to reschedule (unless they feel better!) Track no-shows and evaluate the reasons for them.

89. Consider **charging for no-shows** or dismissing patients for no-shows.

90. Have a good **recall system** in place. If patients leave without scheduling a needed follow-up, make sure that they are called if they have not scheduled within a certain amount of time. Keep track of annual wellness visits and remind patients to schedule them.

91. Take advantage of any **discounts offered by your malpractice carrier** by completing risk management surveys and having speakers give annual updates on decreasing malpractice claims. Some carriers give discounts for managers who are members of **MGMA** or Fellows in the **ACMPE.**

92. Evaluate any **discounts on services or products offered by your physicians’ professional associations** and societies.

93. **Evaluate your leases** – are those big old copiers and faxes worth paying for a service contract?

94. Consider **speech recognition/voice recognition** and eliminate transcription.

95. Review your **computer maintenance contracts.** Are you paying for maintenance on equipment or software that is no longer being used?

96. Take advantage of **online CME** for physicians, midlevel providers, clinical staff and managers.

97. Make plans to attend face-to-face seminars well in advance to take advantage of **early enrollment discounts and good**

flight deals.

98. **Evaluate outsourcing.** Think about outsourcing transcription, coding, billing, pre-authorizations, credentialing, switchboard, payroll, accounting and medical records copying.

99. Replace your **answering service** with an answering machine educating patients on the limited reasons for calling after hours and giving the number of the physician on call.

100. **Destroy archived financial and medical records** that you are paying to store, once you have ascertained that they exceed the required time limit.

101. Hold a **brainstorming session with the staff** and ask for their ideas for increasing revenue and reducing expenses. The people on the front lines will have excellent ideas. In return, do not nickle and dime the staff to death by charging for coffee, reducing parking stipends or eliminating uniform allowances. Keep in mind that for your rank and file staff, having to pay for their own uniforms or paying more for parking might be a deal-breaker that causes them to search for work elsewhere. Try to focus on the bigger items for savings and make sure the staff know you are trying to keep their small benefits in place in appreciation for their work.

Everybody's Favorite Form:

New Advance Beneficiary Notice of Noncoverage (ABN) Form Begins in 2012

NOTE: We have just added an educational webinar on using the ABN form. This is an expanded webinar with 75 minutes of content and 15 minutes of Q & A with the attendees. **Click here to go to our webinar page for more information.**

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CMS recently released an updated version of the Advance Beneficiary Notice of Noncoverage (ABN) (form CMS-R-131), which will replace the 2008 version of this form. The 2008 and 2011 ABN notices are identical except that the release date of "3/11" is printed in the lower left hand corner of the new version. The ABN is used by all providers, practitioners, and suppliers paid under **Medicare Part B**, as well as hospice providers and religious non-medical healthcare institutions (RNHCIs) paid exclusively under **Medicare Part A.**

Providers and suppliers may use either the 2008 or 2011 version of the ABN through the end of 2011; beginning Sunday, January 1, 2012, they must begin using the 2011 version. ABNs issued after Sunday, January 1, that are prepared using the 2008 version of the notice will be considered invalid by Medicare contractors. 2008 versions of the ABN that were issued prior to Sunday, January 1 as long-term notification for repetitive services delivered for up to one year will remain effective for the length of time specified on the notice.

Okay, here's the good stuff that I get questions on all day every day – how do I use the ABN?

First, let's understand WHEN you should use the ABN.

The ABN's reason for being is to allow the physician practice to collect from the patient for services that the patient wants, but are not covered by Medicare. Practices are not expected to give ABNs to patients to cover services that are never covered (called statutory exclusions), however, many find that it helps the patients understand when they receive a bill for the service. (Note: you may collect in full at time of service if you so choose.) With 2011's new wellness benefits, some of the primary reasons for using the ABN have gone away. Patients receive a Welcome to Medicare Visit (not an exam) within the first 12 months of the effective date of Medicare Part B coverage. Medicare beneficiaries are eligible for one Annual Wellness Visit (AWV) every 12 months after they have had Medicare Part B for more than 12 months. This is a "visit" and not a physical examination.

Here's a good example of WHEN you would use the ABN.

A Medicare patient wants an EKG even though she does not have any diagnoses that would point to an EKG being medically necessary. She is not in her first 12 months of Medicare coverage, therefore she does not qualify for an EKG as a part of her Welcome to Medicare Visit (not an exam.) She believes there may be something wrong with her heart, even though she cannot name any symptoms that would warrant a diagnostic EKG.

In this case, without a diagnosis to support the EKG, an ABN would be appropriate. You would advise the patient that Medicare may not pay for the EKG, in fact probably won't pay for the EKG, and you complete the ABN, showing the patient what she will be paying out of pocket for the test. In the case of Medicare not covering the test, you may charge the patient your full rate for an EKG and are not restricted by the Medicare allowable. If the patient agrees to have the test and signs the ABN stating she understands she will be responsible for the cost of the test if Medicare does not pay, you will provide the patient with a copy of the signed form and will will attach the completed form to the patient's encounter form so the EKG will be billed with the modifier "GA" which indicates an ABN was executed for a service that might be covered by Medicare. In the case where a service is never covered (i.e. statutory exclusions) your Medicare Administrative Carrier (MAC) may require you to append a modifer "GY" when an ABN is signed and on file.

The ABN should be scanned with the encounter form or any other financial paperwork from the visit so it can be retrieved if requested by Medicare during an audit. If you do not archive your paperwork electronically, you should file the ABNs alphabetically by patient name by month. You can also scan the ABN into your EMR.

What are statutory exclusions (services that are never covered) under Part B?

- Oral drugs and medicines from either a physician or a pharmacy. **Exceptions: oral cancer drugs, oral antiemetic cancer drugs and inhalation solutions.**
- Routine eyeglasses, eye examinations, and refractions for prescribing, fitting, or changing eye glasses. **Exceptions: post cataract surgery. Refer to benefits under DME prosthetic category.**
- Hearing aids and hearing evaluations for prescribing,

fitting, or changing hearing aids.
- Routine dental services, including dentures.
- Routine foot care without evidence of a systemic condition.
- Injections which can be self-administered. **Exceptions: EPO, and clotting factors.**
- Naturopath's services.
- Nursing care on a full-time basis in the home and private duty nursing. (Refer to benefits under Medicare Part A).
- Services performed by immediate relatives or members of the household. Services payable under another government program.
- Services for which neither the patient nor another party on his or her behalf has a legal obligation to pay.
- Immunizations. **Exceptions: Influenza, Pneumovax and Hepatitis B .**
- Wheelchair van ambulance services.
- Cosmetic surgery.

What services doesn't Medicare cover that you would use an ABN for?

Services that are covered under the Medicare Program may be limited in coverage due to the following:

- **Certain diagnoses** – a service may be covered, but that coverage may be limited to certain diagnoses. For example, vitamin B-12 injections are covered, but only for diagnoses such as pernicious anemia and dementias secondary to vitamin B-12 deficiency.

- **Frequency/Utilization parameters** – a service may be covered, but that coverage may be limited if the service is provided more frequently than allowed under a national coverage determination (NCD), a local coverage determination (LCD), or a clinically accepted standard of practice. For example, a screening colonoscopy (G0105) may be paid once every 24 months for beneficiaries who are at high risk for colorectal cancer otherwise the service is limited to once every 10 years and not within 48 months of a screening sigmoidoscopy.
- **Proven clinical efficacy** – if a service is considered investigational, experimental, or of questionable usefulness, the service may be denied as not reasonable and necessary. For example, Acupuncture is considered experimental/investigational in the diagnosis or treatment of illness or injury. Claims will deny because procedure/treatment has not been deemed "proven to be effective" by the payer.

Probably the hardest question to answer is : WHO should be responsible for getting the ABN signed by the patient?

The Answer is : EVERYONE!

Remember, you can't have a patient sign a "blanket ABN" to use any time Medicare denies a service as non-covered. That's fraud. You cannot have the patient sign the ABN after the procedure or service is provided. That's fraud, too. The only time you may get the ABN signed is before the patient receives the service and after you clearly explain what Medicare might not cover, why they might not cover it, and if they don't cover it, what the cost will be to the patient.

The WHO is so hard because often the person who has the most

knowledge about Medicare (your coder, biller, or manager) sits in the back of the office and might never even see the patient on their way in or out the office. Many practices have given up on the ABN process because figuring out the workflow can be challenging.

Don’t give up! You can implement ABNs in your practice and here’s how:

If you have an EMR, this is a slam dunk because your system should be preloaded with the Medicare service limitations and when you place an order for a service that may not be covered, your EMR should warn you and generate an ABN. Nice!

If you don’t have an EMR, follow these steps:

1. Review the Medicare coverage guidelines and **compile a list of services** your group provides or orders.
2. **Print the list with price range**s on the back of the ABN form (turn them over and run them through your printer or copier). You can print your own ABNs with your services and prices, but if you have very many services, you may not have enough room on the ABN. You may also choose to have more than one preprinted ABN – one with labs, one with services.
3. **Have a full staff meeting** to discuss the ABN and your plan to implement a program to use ABNs when appropriate. Discuss the Medicare guidelines and what services your practice provides and educate the staff on the circumstances for which an ABN is appropriate. EVERYONE needs to help each other learn and master ABNs. Make sure everyone understands that the ABN is not in place to take money from Medicare patients – it is an opportunity to educate the Medicare patient
4. **Create a custom chart** for your group that combines the services you provide with the associated rules. Post the chart in each exam room, the lab, the check-out station,

on the EKG or other medical test equipment and anywhere where an employee should stop and think “Do I need an ABN for this?” Make sure blank ABN forms are available nearby. If you dislike having charts everywhere, create a short word or phrase and print it on bright paper, then post it appropriately. It might be “ABN CHECK” or something like that. Every few months, move the paper to a different place in the exam room, etc. and/or print it on a different color paper. Make sure those most likely to identify the need for an ABN – physicians, mid-level providers, nurses, medical assistants, referral clerks, lab techs – know they can ask for help with the ABN process when they need it.

5. **Some in-house or referral lab systems** also furnish ABN information for mismatches on lab services and supporting diagnoses. Make sure and check the lab system before you begin a service!

You can find information and a copy of the 2011 version of the ABN (form CMS-R-131) **here** under the “FFS Revised ABN” link.

How To Be A Billing Advocate for Your Patients

Most patients would be shocked to know that experienced medical office billing staff struggle with understanding the detailed complexities of coding, billing and insurance reimbursement. Even though there are standards for translating services and diagnoses into codes that identify the medical event, insurance companies **each have their own rules** for how they accept and/or pay for those codes- rules that are subject to change with minimal notice.

I have to admit that at one time I felt strongly that patients needed to take responsibility for understanding their medical benefits plan and advocating for themselves. Everything has become much more complex though, and I have come to believe that as the experts it is our job to understand patients' benefits and help them receive them. Patients have difficulties understanding their own coverage for a myriad of reasons:

Reasons Why Patients Don't Understand Their Benefits:

1. The benefit book is not written in a way that many subscribers can understand.
2. Most subscribers will not take the time to read the benefit book and ask questions about the plan at the time they receive the benefit.
3. The benefit book is usually accompanied by a sheet or two of paper that alters the verbiage in the basic book to describe the exact information for the patient's plan.
4. Not all businesses have an assigned employee to translate benefit books for the staff.
5. Many employers change their plans annually.
6. Most plans do not send representatives to workplaces to review plans with new employees.

To be sure there is the self-serving aspect of advocating for the patient in that we have less to collect from the patient, but I believe it is our job to minimize the patient's out-of-pocket for them.

Who Are The Stakeholders?

The employer, the insurer/payer, and the healthcare service provider each have different motivations when it comes to paying for patient's medical service. There is little motivation for each to communicate and collaborate for a good outcome for all. Assuming we are taking for granted each of

these entities' desire to make sure the patient receives excellent quality care, what is the viewpoint of each of these stakeholders?

The **employer** is concerned with keeping monthly health insurance premiums affordable, and minimizing claims experience. Employers try to keep premiums from increasing at a rapid rate so they can afford the coverage and satisfy employees.

The **insurer/payer** is concerned with paying out less money in claims than it collects in premiums. Because most insurance companies are for-profit, there is extreme pressure to deliver dividends to shareholders and bonuses to executives.

The **healthcare service provider** is concerned with charging an amount that does not leave any money on the table, making up for the underpayments of Medicare and Medicaid by the charges to other insurance companies, and keeping expenses as low as possible to offset decreasing reimbursement.

The **patien**t is the ultimate stakeholder and the one responsible for paying an average of 30% of the contracted charge. The patient is typically the least knowledgeable and the least able to walk the maze of terminology and rules to achieve the needed outcome.

How Do Insurers Avoid Paying Claims?

1. Pre-existing condition (if no proof of continuous coverage exists)
2. Other payer responsible (worker's comp, auto accident, liability)
3. No pre-certification or pre-authorization
4. Did not advise of emergency within 24 hours
5. Not medically necessary
6. Medical records must accompany claim
7. Provider not in network
8. Ineligible on date of service

9. Untimely filing – did not file within deadline which is different for every insurer
10. Non-covered service
11. Not enrolled within timeframe (babies)
12. Escalating premiums to the point that employers seek other coverage.

What Can Medical Offices Do to Advocate for Patients?

1. Provide patients with a brief handout explaining health insurance terminology. Have this information on your website.
2. Compile information about each insurer and each plan that your patients have. A wiki is ideal for this, but a good old-fashioned 3 x 5 card file will do. Yes, the patient has the agreement with the insurer so technically knowing their plan is not your job, but who loses if the insurer doesn't pay? Yep, you do.
3. Use eligibility software or call the insurers to get the plan information and document this in your master file AND on the patient's record. Include deductible, co-pay, co-insurance, network information and non-covered services.
4. When the patient arrives in the office, let them know you've checked on their plan and what you found out that will relate to this visit. If you find out something that will alter the patient's payment requirement, call them before the appointment to let them know about it and give them a chance to cancel or reschedule. No surprises!
5. Thoroughly explain any waivers or ABNs (Advance Beneficiary Notice for Medicare patients) you have patients sign for services that their insurers may not pay for.
6. Make sure that any test or service (including lab work) that you send the patient for is provided by an entity approved by their insurer.

7. If you are scheduling the patient for a procedure with your provider, give patients complete information on your charges. Also give them information on estimated charges from any other provider involved in the procedure (assistant surgeon, physician assistant, radiologist, anesthesiologist, pathologist) as well as any facility charges from the hospital or ASC (ambulatory surgery center.) Help patients to check on physician/practices to make sure they are approved for the patient's plan.
8. If you plan to send the patient a statement for any services, give the patient a sample bill and review how to read it. Have the same thing on your website for patients to refer to.
9. Encourage patients to call, email or make an appointment to talk to you face-to-face about their billing questions. Make it clear your office is glad to help them. Do not become defensive if a patient asks about their bill or questions if it is correct.
10. Don't be afraid to admit to the patient that your office made a billing mistake if indeed you did. Everyone makes mistakes and as long as you apologize and do not try to shift the blame to the patient or the insurance company, all should be well.
11. If need be, help the patient take the next step in filing a complaint against their insurance company if the company is not fulfilling their responsibility in paying the claim. As the insurance companies often do, arrange a three-way call to discuss the patient's claim and why it is not paid. Medicare patients receive a quarterly notice that lists claims for the previous 90 days and lists appeal details on the back of the notice.

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The ABN: The Most Misunderstood and Underutilized Document in Healthcare

There's a new ABN form required to be in use in January 2012 – read about it **here in my article "Everybody's Favorite Form: New Advance Beneficiary Notice of Noncoverage (ABN) Form Begins in 2012"**

Note from Mary Pat: The Advance Beneficiary Notice of Noncoverage (ABN) is a collection tool that many medical practices do not know how to implement. It is particularly difficult to determine who has ownership of this process, because the form must be completed and signed by the patient before the service is provided. The patient is in the exam room or the lab, ready for the service or test, and a knowledgeable staff person must step in, explain the rules and pricing and obtain the patient's signature.

Blogger Charlene Burgett does a great job of explaining the ins and outs of using the ABN, and has agreed to share an article originally published on her blog ***"Conundrum"*** *with MMP readers.*

The use of the ABN is required by Medicare to alert patients when a service will not be paid by **Medicare** and to allow the patient to choose to pay for the service or to refuse the service.

If the practice does not have a signed ABN from the patient and Medicare denies the service, the charge must be written off and the patient cannot be billed for it. The only exception is for statutorily excluded services (those that Medicare never covers like cosmetic surgery and complete physicals for example). In this case, a practice can bill the patient for the non-covered service despite not having an ABN. It is, however, a good idea to have the ABN signed for non-covered services so the patient is made aware that they are responsible.

If the patient signs the ABN and is made aware of their financial responsibility **you may require the patient to pay for this service on the date the service is provided.** You may also charge the patient 100 percent of your fee. You do not have to reduce your charge to the Medicare allowable.

With a signed ABN, the practice has proof of the patient's informed consent to provide the service and their agreement to be financially responsible for the service. In the past, Medicare had a "Notice of Exclusion of Medicare Benefits" (NEMB) that we could provide to the patient (no signature required) to alert them of Medicare's non-covered services. The ABN has replaced the NEMB.

The typical reasons that Medicare will not cover certain services and that would be applicable are:

1. **Statutorily Excluded service/procedure (non-covered service)**
2. **Frequency Limitations**
3. **Not Medically Necessary**

Statutorily Excluded items are services that Medicare will never cover, such as (not a complete list):

- Complete physicals (excluding Welcome to Medicare Screenings, with caveats)
- Most immunizations (Hepatitis A, Td)

- Personal comfort items
- Cosmetic surgery

For these items, it is a good idea (not a requirement) to complete the ABN and have the patient check the appropriate box under options and sign the ABN. For the sake of the billing department, I strongly encourage the use of ABN's for statutorily excluded items.

Frequency Limitations are for services that have a specific time frame between services. For example, Medicare allows one pap smear every 24 months if the pap is normal. If the patient wants one every 12 months for their peace of mind, Medicare will pay for year one and the patient will pay for year two and that pattern continues. The ABN needs to be on file for the year that the patient is responsible for paying. If the patient fits Medicare's guidelines for "high risk" they are allowed to have the pap every 12 months and no ABN is required.

Services that are not considered **Medically Necessary** are those that do not have a covered diagnosis code based on Local Coverage Determinations (LCD). One example is for excision of a lesion. If the lesion is being removed because the patient just doesn't like how it looks, that is considered cosmetic surgery. If the lesion is showing some changes (i.e. bleeding, growing, changing color, etc), then it is considered medically necessary because it potentially can be malignant. The removal needs to have diagnosis coding to substantiate the medical necessity and Medicare has Local Coverage Determinations that list all the codes/coding combinations that Medicare will approve for payment.

A rule of thumb in trying to discern the necessity of ABNs is to ask yourself if there may be some times that the service isn't covered by Medicare. The times the service isn't covered, an ABN is required. To illustrate this point, here are two examples:

- *EKGs are covered for certain cardiac and respiratory conditions. The only time an EKG is covered for preventive screening is during the patient's first year enrolled in the Medicare program and when being done during the Welcome to Medicare screening. After that time, Medicare will never cover an EKG for preventive screening. To notify the patient of this and to show that the patient agrees to be financially responsible for the EKG, an ABN should be completed.*

- *Another example is for the Tetanus immunization. Medicare will cover tetanus when medically necessary; if the patient has cut themselves and the tetanus is provided due to that injury. If the tetanus is provided to the patient because it has been ten years since the last tetanus and the tetanus is not in response to a recent injury, then it will be non-covered because it is not "medically necessary" and the ABN will need to be on file.*

ABNs need to be completed in their entirety. The "Options" box can only be completed by the patient and it states that "We cannot choose a box for you". That would appear to be coercion.

A "blanket" ABN, one that is signed by the patient for all services provided within a certain time period, is not acceptable and is illegal.

In addition, there is a small area to provide additional information that can be used by either the patient or the provider's office. This could be anything pertinent to the information that the ABN covers. The bottom of the form is

where the patient signs and dates. We keep the original ABN in the chart behind the progress note for that day. Providers **MUST** provide a copy of the signed ABN to the patient.

The current ABN form with instructions can be found **here.**

If a service is denied by Medicare and the physician does not have a signed ABN prior to the service being rendered, the service can not be billed to the patient and will need to be written off. Sometimes a patient may refuse to sign the ABN – if this happens it is appropriate for the physician to document the refusal and sign, along with having a witness sign. Medicare will accept this and the patient can be billed for the service if denied by Medicare.

How does Medicare know whether or not you have a signed ABN? You tell them, by adding a modifier to the CPT code when completing the claim form. The appropriate modifiers are:

GA: The ABN is signed, but the service may not be covered.

GY: A "statutorily excluded" service.

GZ: The service is expected to be denied as not reasonable or necessary. This is typically used when there is a secondary payer that requires the Medicare denial before they pay benefits.

The use of the ABN is often misunderstood; however, it is the only way a patient can be informed about their financial responsibility prior to agreeing to a service being rendered. This is an issue that the OIG has reportedly been interested in investigating for fraud and abuse.

Charlene Burgett, MA-HCM

Note: Readers, how do you make the ABN work in your practice? Do you train the clinical staff, the physicians, or other staff to recognize the "ABN Moment"? How do you make it work? Please share your ideas by responding with a comment.

101 Ideas for Increasing Revenue and Decreasing Expenses in Your Medical Practice

BUILD ON WHAT YOU'RE CURRENTLY DOING:

1. **Add physician hours** – add evening or weekend hours; start your office hours earlier and end hours later.

2. **Reduce physician time off** – decrease vacation or change weekly days off to 1/2 days off.

3. Set a minimum number of providers to be in the office **seeing patients at all times** the office is open.

4. Have each provider add **one new patient visit** to his/her schedule weekly.

5. Add **ePrescribing** to recoup additional Medicare revenue and streamline prescribing (there are free ePrescribing software packages available, but evaluate them carefully so they don't add more complexity to the system instead of less.)

6. Report **PQRI** measures to recoup additional Medicare revenue.

7. Charge patients an out-of-pocket fee for completing **patient forms** – disability forms, etc. and reserve office visits for treating patients.

8. Choose an **EMR** that qualifies your practice for the ARRA money (although it has been widely promoted that in a larger practice, an EMR and its associated work will cost more than you will get from the government.)

9. If you are in an underserved or rural area, check to see if there might be **grants or funds available** locally, in the state or federally, for adding a service to your practice.

10. If your practice does **Independent Medical Exams (IMEs), reviews records or depositions**, make sure that your fee schedule for such services is current and that the fees are collected before the physician provides the service.

ADD TO YOUR CURRENT SERVICES:

11. Allergy testing & treatment

12. Dispensing pharmaceuticals

13. Dispensing nutriceuticals

14. Dispensing Durable Medical Equipment

15. Group patient visits

16. Coumadin Clinic

17. Heart Failure Clinic

18. Diabetes Education Classes

19. Add primary care to specialty care practices

20. Add specialty care to primary care practices

21. Research

22. Joint Ventures with other practices or hospital

23. Lease space to other entities

24. eVisits (virtual visits or email visits)

25. Elective procedures or services

26. Mid-level providers

27. Walk-in clinic

28. Occupational medicine: drug screens, employment physicals, etc.

29. Hospitalists

30. Medical Director of local nursing homes

31. Complementary & alternative medicine (CAM)

32. Aging in Place services

33. Social worker

34. Concierge practice

35. School team physician

EVALUATE YOUR REVENUE CYCLE MANAGEMENT:

36. Are you **renegotiating payer contracts** regularly?

37. Do your scheduling staff know how to educate patients about what payers you have contracts with and are in network with and what the **patient's financial responsibility** will be?

38. Do staff know what typical **new patient charges** are to tell the patient?

39. Do you check every **patient's eligibility** for insurance

benefits immediately prior to every service?

40. Do you have patients sign a **financial policy** to acknowledge what they are responsible for based on their payer type?

41. Do you **copy the patient's insurance cards** at every visit, or at least compare their current card to the card you have on file? Are you able to scan patient insurance cards and driver's licenses into your practice management (PM) system?

42. Is your PM system able to download the information from the scan into the patient registration screen? If not, do you have a way to **confirm that demographic and insurance information has been entered correctly** from the cards?

43. Are your **charges being posted daily**?

44. Does the person who **provides the service, or a documentation coding specialist, choose the CPT and ICD9 code**?

45. Is the **documentation** for the charges being completed within 24 hours of the service?

46. Is your **encounter form up-to-date** with current CPT and ICD9 codes; do you order smaller batches of them so you can change the codes as new services are added in the practice?

47. Do you check the **CPT and ICDD9 matching** to make sure the codes are valid for the year, the codes adhere to NCCI and LCD edits before you finalize the charges?

48. Do you regularly **audit medical records for coding and documentation** and give providers feedback on where coding could be improved?

49. Are you using **ABNs for Medicare patients** who want services that Medicare might not pay for?

50. Do you **file claims daily**?

51. Do you **correct claims daily** when they are rejected at the practice management, claims clearinghouse or payer level?

52. Do you **correct claims daily when they are rejected at the claim level** and are not paid for for reasons that can be corrected?

53. Do you have your **contract allowables** in your PM system so you know when you are not being paid correctly by contract?

54. Do you **appeal unpaid or underpaid claims**?

55. Do you **check recoupments** or requests for refunds from payers and make sure they truly should be refunded?

56. Do you send insurance and patient payments to a **lockbox** to be scanned and stored digitally for your staff to post from?

57. Do you make **payment arrangements** in the office for balances after insurance has paid, or payment plans by drafting credit or debit cards?

58. Do you have a **policy of not sending statements**?

59. Do you **collect the patient's portion** of the service at the time of service?

60. Do you **collect fees for elective services** prior to providing these services?

61. Can your patients **make payments online** through your website?

62. Do you file a **claim with a patient's estate** if they have died?

63. Do you accept **cash only from patients who have passed bad checks**?

64. Do you accept **cash only from patients who have filed**

bankruptcy with your practice?

65. Do you inadvertently **see patients who have been dismissed from your practice**?

66. When adding a physician to the practice, do you **timeline the credentialing** appropriately so the physician can see patients with insurance as well as those without?

67. If your new physician is only partially credentialed with payers, do you have him/her see the patients with payers they are credentialed with and **add payers to their schedule load as the credentialing comes through**?

68. Do you **meet with representatives from your largest payers monthly** to establish relationships and bring problems to their attention? (the squeeky wheel theory of payer relations)

69. Are you **pre-certing** everything that needs pre-certification or pre-authorization or pre-notification to be sure the service will be paid?

70. Are you receiving payments via **electronic funds transfer** (EFT)?

71. Are you receiving **explanation of benefits (EOBs) or remittance advice (RA) electronically?**

72. Are you **posting your RA electronically**?

73. Are you **protecting your practice from embezzlement?** (**see my post on this here**.)

74. Is someone in the practice responsible for staying current on **changing coding requirements** for Medicare, Medicaid, Tricare and commercial payers?

DECREASE EXPENSES:

75. Eliminate **overtime**. Evaluate the need for additional staff (part-time?) vs. overtime.

76. **Send some staff home** (sometimes called “low census”) when there are no patients to be seen.

77. Use **volunteers.** Tap into the local hospital volunteers, or recruit and train your own.

78. Hire an after-school **student** employee to do routine jobs.

79. **Discontinue paying staff for inclement weather closings** when the practice is not open.

80. **Shop everything.** Negotiate existing service contracts. Do not assume anything is non-negotiable. Negotiate the rent.

81. **Get rid of yellow pages advertising.** It rarely brings you new patients and is primarily a place to look up phone numbers. You will still get your white pages listing free with your phone service.

82. Utilize **pre-employment testing** to make sure job applicants have the skills you need.

83. Shop postage machines or look into **stamps.com.**

84. Join a **group purchasing entity** (hospital, professional association, etc.)

85. Improve your **accounting cycle.** Invoices and statements are matched up with packing slips and negotiated prices. Use purchase order numbers.

86. Get the **payment discount** by paying on time or early – ask vendors for an on-time or early payment discount.

87. Make sure **office supplies** are not going home with the employees. Make sure office supplies that are ordered are “really need” and not “sure would be nice.”

88. Remind patients of their appointments to **decrease no-shows**. Call patients who no-show and attempt to reschedule (unless they feel better!) Track no-shows and evaluate the reasons for them.

89. Consider **charging for no-shows** or dismissing patients for no-shows.

90. Have a good **recall system** in place. If patients leave without scheduling a needed follow-up, make sure that they are called if they have not scheduled within a certain amount of time. Keep track of annual wellness visits and remind patients to schedule them.

91. Take advantage of any **discounts offered by your malpractice carrier** by completing risk management surveys and having speakers give annual updates on decreasing malpractice claims. Some carriers give discounts for managers who are members of **MGMA** or Fellows in the **ACMPE.**

92. Evaluate any **discounts on services or products offered by your physicians' professional associations** and societies.

93. **Evaluate your leases** – are those big old copiers and faxes worth paying for a service contract?

94. Consider **speech recognition/voice recognition** and eliminate transcription.

95. Review your **computer maintenance contracts.** Are you paying for maintenance on equipment or software that is no longer being used?

96. Take advantage of **online CME** for physicians, midlevel providers, clinical staff and managers.

97. Make plans to attend face-to-face seminars well in advance to take advantage of **early enrollment discounts and good flight deals.**

98. **Evaluate outsourcing.** Think about outsourcing transcription, coding, billing, pre-authorizations, credentialing, switchboard, payroll, accounting and medical records copying.

99. Replace your **answering service** with an answering machine educating patients on the limited reasons for calling after hours and giving the number of the physician on call.

100. **Destroy archived financial and medical records** that you are paying to store, once you have ascertained that they exceed the required time limit.

101. Hold a **brainstorming session with the staff** and ask for their ideas for increasing revenue and reducing expenses. The people on the front lines will have excellent ideas. In return, do not nickle and dime the staff to death by charging for coffee, reducing parking stipends or eliminating uniform allowances. Keep in mind that for your rank and file staff, having to pay for their own uniforms or paying more for parking might be a deal-breaker that causes them to search for work elsewhere. Try to focus on the bigger items for savings and make sure the staff know you are trying to keep their small benefits in place in appreciation for their work.