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ACCOUNTANTS & ADVISORS

Practice Strategies

A Newsletter for Healthcare Professionals

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Claim Denials

Prepare Your Strategy for ICD-10

The Centers for Medicare and Medicaid Services estimates that claim denial rates could soar 100 percent to 200 percent in the early stages of the ICD-10 rollout. At the practice level, this could result in a significant amount of re-work and lost productivity, as well as a major hit to cash flow.

Ultimately, practices may see a multitude of denied charges — from tests that don't meet medical necessity to procedures that are rejected or denied due to a lack of specificity.

Watch for Coding Mismatches

The reasons are pretty straightforward: With a change in diagnosis codes to the more specific ICD-10 coding, mismatches are apt to occur with medical necessity and provider payment guidelines. It will be an ongoing process as payers work through their payment determinations for the new codes.

Common denials that are likely to occur in ICD-10 include:

Technical denials — These denials center around flaws in the sending, receiving and processing of the claim. Hopefully, you have performed end-to-end testing with as many payers as possible during the lead-up to implementation to ensure that accurately coded claims are being sent. Moving forward, proofread all claim packages, including the originating documents, and clarify entries or codes that appear confusing. Expecting payers to fix errors and sort out conflicting entries is a recipe for denial.

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Logic-based denials — Denials may also occur when the ICD-10-PCS or CPT procedure codes don't logically match the corresponding ICD-10-CM diagnosis code. For example, ICD-10 codes now require reporting of laterality (the side of the body affected by the condition). So a problem occurs when a procedure to treat carpal tunnel syndrome on the right hand does not match the diagnosis of the left hand (or is left out comletely). Practices with more sophisticated software may be able to rely on claims scrubbers to catch these errors. However, coders will need to pay close attention to ensure that the laterality distinction is specified in the medical record.

Denials for unspecified codes — ICD-10 gives payers the opportunity to revise entire coverage policies. Here, updated Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) may be more specific in terms of what payers will and will not cover — and practices will need to absorb this new information. Practices should closely review contracts with commercial payers and be ready to revisit these contracts based on ICD-10.

Plan for Problem-free Reimbursement

To increase the likelihood of clean claims under 1CD-10, practices will need to have a strong denial management strategy in place. Consider these smart moves for heading off problems:

Invest in expertise. To get clean claims out the door, practices may want to consider bringing in addi-

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Signing Bonuses

The Icing on the Recruitment Cake

Incentives and signing bonuses are certainly nothing new. As far back as 1922, Babe Ruth was receiving $500 for every homer he hit. In 2011, right-handed pitcher Gerrit Cole became the first player to receive an $8 million-dollar signing bonus when he was signed by the Pittsburgh Pirates.

These days, it seems physicians are going the way of top athletes. The most recent MGMA Physician Placement Starting Salary Survey shows that more physicians are receiving signing bonuses — 60.3 percent of physician respondents, in fact. Amounts differ substantially among physicians and regions, but the median signing bonus was reported to be $20,000.

Mid-levels have gotten in on the act as competition for these professionals increases. In 2014, 50 percent of non-physician providers were offered a signing bonus, compared to 11 percent in 2013, according to the annual provider placement summary performed by physician search consultancy The Medicus Firm. The firm reports that the average signing bonus for a PA or NP increased from $3,000 in 2013 to $7,500 in 2014.

A Carrot with Win-Win Potential

Structured properly, a generous signing bonus can be a key differentiator in a tight labor market — and a real boon for newly minted physicians struggling to get on solid financial footing after years of expensive training.

For the practice: Signing bonuses provide a recruiting leg up for practices competing for a finite pool of providers — primary care physicians in particular. With hospitals, health systems and physicians groups all competing for the same talent, anything that a potential employer can do to stand out is a good thing.

Adjusting compensation through a signing bonus can also provide employers with some negotiating flexibility. For example, if an annual salary of $160,000 has been approved, adjusting it might require a new vote of the board. A one-time signing bonus might just seal the deal without the administrative hassle of adjusting annual salary.

For the physician: For newly minted physicians, signing bonuses can establish some financial stability — helping with down payments on houses and tackling student loan debt. The upfront money can also help physicians get through the interim period while they ramp up and begin earning production- or productivity-based incentive compensation.

Seal the Deal

If incentives will be part of your recruitment plan, consider these steps for structuring an attractive signing bonus:

Offer what you can afford. Given the competitiveness of the market, physician recruiters suggest stepping forward with your best offer as opposed to starting low and negotiating higher.

Design with retention in mind. Consider devising a bonus structure with elements of a retention incentive. So, for example, physicians joining the practice might receive an initial signing bonus of 5 percent of their first-year total compensation. At the beginning of year two, they would receive a slightly larger percentage. The largest chunk is then paid out at year three.

Spell out the details. Signing bonuses are often pro-rated. If that's the case, clearly spell out in the employment contract what happens if the recruited physician leaves before the time stipulated.

Finding the perfect match for your practice can be a challenge. But a well-structured signing bonus can help get ink on paper and your next great hire in the door. ■

With plenty of experience in day-to-day practice management, we can provide valuable guidance on employment practices. Call today to speak with one of our professionals.

How the Benefits Play Out

Recruitment incentives go well beyond paid health insurance and signing bonuses, according to Merritt Hawkins' annual *Review of Physician and Advanced Practitioner Recruiting Incentives*, now in its 21st year:

Relocation Allowance — 90 percent of recruitment searches involved an allowance for moving expenses, travel and other relocation expenses.

Low	High	Average
$1,000	$25,000	$9,849

Housing Allowance — An allowance to offset the loss of selling a home for less than its purchase price was offered to 4 percent of relocating physicians.

Loan Forgiveness — Paying off part or all of a new physician's student loans — typically spread out over three years — was an inducement in 26 percent of job searches.

Low	High	Average
$4,000	$336,000	$77,000

CME Allowance — In 91 percent of searches, employers offered to pay continuing medical education.

Low	High	Average
$1,000	$15,000	$3,515

ICD-10 Strategies

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tional medical coding or billing staff or outsourcing these functions. The Healthcare Financial Management Association (HFMA) notes that managing claim denials will likely require an added level of expertise and may no longer simply be something that can be handled by a nonclinical person in the billing office. In its report *Readying Your Denials Management Strategy for ICD-10*, HFMA notes that questions regarding medical necessity or the medical documentation supporting a particular code will require input from physicians and nurse specialists.

Crunch the numbers. Closely monitor both the amount and age of outstanding balances by payer and measure them against a baseline to spot any trends that may impact practice revenue. Medical groups that file claims electronically should also contact their clearinghouse for trending data on denials and underpayments.

Analyze the denial. Identify your most common denials to see if there are identifiable patterns. Was it a matter of insufficient documentation, or was there inaccurate and incomplete coding? If there was an error, did it occur at the coding/submitter stage or upstream? Likewise, is the denial payer-specific, or is it occurring across two or more payers?

Don't Get Overwhelmed

Documenting carefully and paying attention to the details will certainly ease the transition to the new code set. Just to be sure, establish a financial reserve that will see you through three to six months of payment delays as the inevitable improperly coded claims work their way through the system. ■

Questions? Contact our office for guidance on managing ICD-10 conversion in your practice.

CMS Provides Interim Relief

The Centers for Medicare and Medicaid Services has taken several steps designed to ease the transition to ICD-10. In particular, it promises that claims will not be denied simply because the wrong ICD-10 code was used.

In a recent guidance document, CMS officials wrote: "While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family."

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Likewise, CMS has established an advance payment mechanism to address payment delays caused by administrative problems. The official guidance notes: "When the Part B Medicare Contractors are unable to process claims within established time limits because of administrative problems, such as contractor system malfunction or implementation problems, an advance payment may be available. An advance payment is a conditional partial payment, which requires repayment, and may be issued when the conditions described in CMS regulations at 42 CFR Section 421.214 are met.

"To apply for an advance payment, the Medicare physician/supplier is required to submit the request to their appropriate Medicare Administrative Contractor (MAC). Should there be Medicare systems issues that interfere with claims processing, CMS and the MACs will post information on how to access advance payments."

A Closer Look at Direct Primary Care

It's been called "concierge care for the common person." Like the concierge medicine model, Direct Primary Care (DPC) is retainer-based. Patients pay a monthly fee in return for same-day appointments, longer visits and increased access via e-mail or telemedicine. Typically included are annual wellness evaluations, office visits and in-office labs such as urinalysis, strep screens and pregnancy tests.

Yet what makes DPC different is that practitioners are paid directly for their services. That means "no" to health plans and insurance companies and "yes" to monthly retainers. According to the American Academy of Family Physicians, those average between $50 and $150 per month. Some practices add a one-time enrollment fee, while others keep membership fees low by charging modest per-visit fees.

As with the concierge model, providers are able to keep their practice small – typically 600 to 800 patients. They don't have to worry about credentialing and contracting with insurance companies. And they don't have to bother with pre-certifications, co-pays and following up on denied claims.

Financially, all the overhead associated with claims, coding, write-offs and billing staff is eliminated. The biggest drawback? Patient payments are the sole source of revenue. Practices considering the DPC model must run the numbers and be diligent in their operations to ensure that patient fees are sufficient to support the practice.

Ultimately, practitioners tired of overwhelming patient loads and dealing with third-party payers might find DPC an attractive alternative. The DPC model is still emerging, and states are still working through how they will regulate DPC practices. In some cases, they are placing them under existing insurance regulations.

To follow the evolution of this new payment model, visit the Direct Primary Care Coalition (http://www.dpcare.org) and Access Healthcare Direct (http://www.directcarecoalition.org).