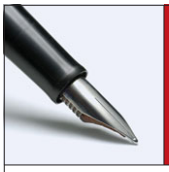

LETTER FROM THE EDITOR-IN-CHIEF

Minding Your E's & M's

Nothing hurts a business more than leaving money on the table. It is hard enough to attract business; the last thing you want to do is not get paid once services are rendered. There are a number of steps in the coding and billing process, and errors at any level can lead to bad debt, missed charges, and poor reimbursement.

Let's look at a few I would call the "low-hanging fruit."

Collection at the Time of Service

Copays and deductibles often make up 25% to 50% of the reimbursement. That means the patient is responsible for nearly half of the fee. Everyone likes to take pride in how well they manage their receivables on the payor side. Very few can tell you the percent of patient responsibility collected at time of service.

Excuses galore for this one. Notably, the staff don't want confrontation, and lack the skills or accountability to make sure it gets done. If you don't train your staff to communicate effectively, if you don't hold them accountable, and if you don't track the trends, you will be left with untenable levels of bad debt, revenue outstanding, and collection expenses.

Charge Capture

- You must ensure you are getting paid for what you do. Every urine dip, every IV, every fiberglass splint applied.
- Know all the correct codes and documentation requirements for all commonly used procedures, meds, and durable medical equipment.
- Do a *random* audit and identify trends for missed charges; train those responsible.
- Do a *directed* audit for all fractures and make sure you are capturing and properly documenting all splint applications. You will be shocked to see how infrequently this is correctly billed.

Code Right

This is perhaps the most overlooked, misunderstood, mismanaged, and most important piece of the reimbursement puzzle.

Most practices use primary care benchmarks (if any at all), and these do not apply to urgent care. Consider:

- Most of our patients are presenting with a new undifferentiated problem.
- Most of our patients receive a prescription.
- Many of our patients have diagnostic work-ups that require interpretations by the provider (e.g., x-rays, EKGs).
- Many of our patients present with potentially threatening acute conditions.

While a detailed discussion of E&M coding is beyond the scope of this column, all the above-mentioned contribute to moderately complex or highly complex "medical decision making" (level 4 and level 5).

Since we do not maintain a continuity record on our patients, and many of our patients are new, a complete history and physical is clinically indicated in most circumstances. You will be amazed what you can pick up when you do this regularly. This is just good medicine.

- The review of systems can be filled out by the patient while waiting to be seen, as long as the provider reviews and signs it.
- If monitored and managed, clinically appropriate level 4 and level 5 visits will increase. When appropriately documented, this is entirely consistent with the CPT guidelines and represents the medically indicated care.
- Finally, the practice must make an investment in training, coding audits, and trending the coding bell curve to successfully instill compliant coding habits.

Managing the low-hanging fruit can have a marked impact on revenue, bad debt, and collections expenses. This can account for an infusion of upwards of 20% in additional income. And everyone—not just owners—should feel the obligation to contribute. ■

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