

Foundation, a conservative public policy group in Washington. “Quality health care that is affordable can never be achieved through the imposition of price controls – nor can Americans enjoy cost control or efficiency in the delivery of care outside a free-market discipline,” he said.

The AMA stated Congress should strengthen the public-private mix of health insurance and increase the value of the nation’s health care spending. “President Obama’s call for greater investments in research, preventive care and electronic health records will help physicians keep patients healthy,” said Nancy Nielsen MD, AMA president. — *C. Fiegl*

Internal control

It’s 4 p.m. do you know where the day’s revenue is?

A computer glitch on the carrier’s end, plus a failure to check electronic remittance advices, multiplied by three months, equaled a \$600,000 loss for a 10-doctor practice.

This isn’t a unique example of an unusually ill-run practice. An imaging center that didn’t track its Medicare payments lost between \$600,000 to \$700,000 over a five-month period and there are dozens more ways practices can and do steadily leak money.

“When we do audits we always find things missing,” says Belinda Holmes CPC, senior medical consultant for Kerkering, Barberio & Co. in Sarasota, Fla. Holmes gives four common examples to illustrate her point:

1. **External billing glitches.** Holmes has seen practices lose revenue because the clearinghouse never processed the claim. Don’t assume the confirmation that it received your claim means your claim was sent, warns Holmes. Follow up to make sure claims were sent to the payer.

2. **Missed charges.** The causes can range from being tripped up by Medicare’s secondary

payer rules to a mishandling of superbills.

Example: The doctor sees a patient, performs a number of services, but only checks off the E/M visit on the superbill. Because there’s no record of the ancillary services he provided, he’ll only get paid for the visit. This also means the practice will lose money spent on medical supplies.

Holmes has also seen instances where superbills regularly aren’t entered into the system. “The doctor may keep it or the patient may walk out with it,” Holmes says. Either way, the practice will lose the payment for that visit.

3. **No one checks the invoices.** In addition to medical and office supplies, “more and more physicians are getting into ancillary services,” Holmes notes. Make sure what you paid for matches what you receive when the shipment comes.

4. **Poor inventory control.** Keep an eye on your entire inventory once it has been stored. A few years ago it may not have been a big deal to send someone to the drug store for pens or to pay extra for a rush order of syringes, but at a time when every penny is precious, these costs can quickly add up.

Keep in mind the tight economy is personally impacting employees in the practice. Track your office supplies and cash carefully. Make sure employees are not raiding practice petty cash to use money to pay for lunch. You may find unexpected trends, such as the need to order more toilet paper because rolls are disappearing.

Once you determine you’re losing money you still have to figure out why and how to stop it. Good internal control is the answer.

“Internal control is an accounting principle that ensures a business’ assets are properly accounted for and protected,” Holmes says, by creating a system of checks and balances for every financial transaction in the office. Anyone who has ever worked as a cashier for store is familiar with

internal control. At the end of his shift, the cashier counts out his drawer to make sure the money matches the receipts. He then takes it to the manager’s office where the drawer is counted a second time.

“The beauty of internal control is it doesn’t matter if money is being lost through mistakes or embezzlement,” Holmes says (PBN 2/4/08).

With a system of internal controls in place, the practice will catch the error on the same day, fix it and create a record that the day’s receipts balanced out, Holmes explains. Holmes notes that this transparency protects the practice from embezzlement and employees from accusations of theft. She shared four more basic tenets of good internal control:

1. **Separate the duties of staff who handle**

money. “One person should open the mail, remove any checks and make deposits. A second person should balance the day’s receipts and deposits,” Holmes says. The same applies to handling the practice’s inventory. The person who unpacks the boxes and checks the invoices shouldn’t be the person who placed the order and writes the check for payment.

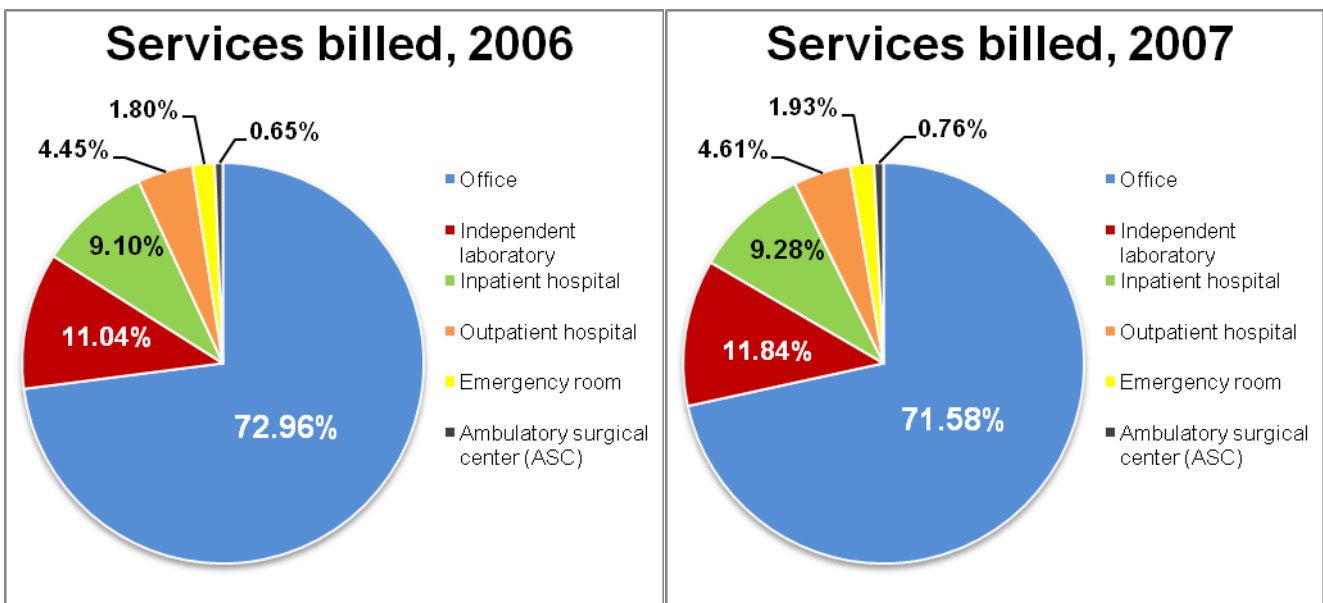
2. **Make sure the doctors do their part.**

“The doctor should be involved in making sure all of the charges are posted every day,” Holmes says. As was noted in the missed charges example, the doctor must fill out the superbill completely and make sure he didn’t tuck it into the patient’s chart. In addition, the physician is responsible for making sure staff have the information they need to bill for hospital charges.

Have a policy that physicians and other pro-

Benchmark of the Week: Utilization by site of service, 2006 vs. 2007

This chart compares 2006 and 2007 Medicare utilization rates by site of service. The percentages indicate what portion of all Medicare claims billed that each site was responsible for in 2006 and 2007. Sites with less than 1 million claims billed annually, such as federally qualified health centers (FQHCs), were excluded from analysis. While the overall *proportional* changes are very small, the utilization figures are huge, so any slight percentage change represents a large number of claims. For example, the office setting – which clearly enjoys the greatest share of Medicare utilization – fell by 1.38% over the one-year period. This represents a decline of **more than 25.2 million claims** billed. The biggest trend here: claims for *every other setting* have increased. The independent laboratory setting gets the greatest boost of 0.8%, which is an increase of more than 9.8 million claims. **NOTE:** Even with its 1.38% drop, the office setting remains by far the most common source of Medicare claims, being the site of service for 1.7 billion claims in 2007. All data comes from a **Part B News** analysis of 2007 CMS claims data.



viders must turn in all of their paperwork at the end of the day.

3. **“Practices have to have a mechanism for accounting for every superbill,”** Holmes says. Pull the day’s schedule and compare the number of patient’s who came in that day to the number of superbills.

It will be much easier to track down the bill or reconstruct the visit at the end of the day versus the end of the week or even months later. Holmes also notes that internal controls work with whatever type of billing system a provider has in place.

4. **Know your due dates.** Holmes has been to practices that were losing money because they didn’t file in a timely manner (PBN 2/16/09). But you also need to know when your practice should be receiving money from payers and following up when the check isn’t in the mail.

Good internal control should not cost your practice a lot of time or money. It shouldn’t take more than half a day to determine where the holes are, Holmes says. Balancing out at the end of the day should only take a quarter to half an hour.

However, when looking for a consultant who can give your practice internal control, make sure the accounting professional has experience with medical practices (PBN 5/19/08). — *J. Kyles*

New billing opportunity

Get paid for bariatric surgery on eligible diabetic patients

You’ll have an easier time getting Medicare to pay you for three common types of bariatric surgery, thanks to looser patient eligibility criteria, CMS announced in a Feb. 12 decision memo.

The three procedures are:

- **43846** (Roux-en-Y gastric bypass, open, \$1,467.19) and **43644** (Roux-en-Y gastric bypass, laparoscopic, \$1,557.72)
- **43845** (biliopancreatic diversion with duo-

Reminder: Toss out your old ABNs, use new form

You must start using the new advance beneficiary notice of noncoverage (ABN) by March 1. Versions prior to the new ABN that was revised in March 2008 will no longer valid after the deadline (PBN 9/08/08).

The new ABN – CMS-R-131 – replaces the old ABN, which was the general use ABN (CMS-R-131-G), and the lab ABN (CMS-R-131-L) for physician-ordered laboratory tests. You may also use CMS-R-131 for voluntary notifications in the place of the Notice of Exclusion from Medicare Benefits (CMS Form 20007).

“Form CMS-R-131 (03/08)” is printed in the bottom left corner of the revised ABN.

On the Internet:

- The Beneficiary Notice Initiative: www.cms.hhs.gov/bni

Editor’s note: If you don’t use the new ABN some of your payments could get lost forever in a reimbursement black hole. Failing to learn how to use the new form can cost you. The all-purpose ABN is now three forms in one. Find out how to use this form correctly during “Master the New ABN and Patient Notification Rules” with consultant Jo Ann Steigerwald. Please sign-up today at: www.decisionhealth.com/conferences/A1731/home.html.

denal switch, \$1,763.66)

- **43770** (laparoscopic adjustable gastric banding, \$1,001.21)

These services were first addressed in a 2006 national coverage determination (PBN 2/27/06), which remains valid; this new decision merely adds type 2 diabetes as a comorbidity CMS will consider in deciding whether to cover bariatric surgery for morbidly obese patients, CMS says.

“This is not a broad expansion of coverage, in that it’s not a blanket coverage for type 2 patients to get bariatric surgery,” says Elizabeth Hoy, assistant director for regulatory affairs and quality improvement programs at the American College of Surgeons (ACS) in Washington.

Instead, it adds type 2 diabetes to the existing