

From Jud's Desk



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Questions about PBN or
topics in this issue? Call Jud
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When your business is "billing," it's clear to most people what you do. Yet, when a physician tries to assess the difference between one billing company and another, the factors involved are infinite.

At PBN, we detail the "billing" process into key areas we call the "4Cs": Contracts, Compliance, Coding and Collections. Success in each of these areas is required for most productive income generation for the physician.

You will note in this issue that we have added a new design element. We have identified our main stories by which of the "4Cs" the content refers. Doing so is our way of making sure that, over time, we do in our newsletter what we do in our day-to-day business; that is, attend to each area. Likewise, you will be able to better scan for subjects that most interest you.

In this issue we include two articles that address everyone's favorite "C" – Collections! Rest assured the other three "Cs" will be given their due, both quarterly in the newsletter and daily within PBN by our skilled professionals.

Enjoy,

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Provider News



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Provider News

COLLECTIONS:

Accrual or Cash?

Options for measuring your A/R

By Dave Hahner

Most physician practices use various statistics to measure the effectiveness of their A/R collections.

Two of the most common benchmarks are the GROSS COLLECTION RATE and the NET COLLECTION RATE.

The GROSS RATE is calculated by dividing Payments received for a given period by Charges entered in the same period. For example, if in July 2007 a practice entered charges of \$100,000 and collected \$50,000 in payments, this would be calculated as a 50% gross collection rate.

Seems pretty simple, but how much of the \$50,000 in payments used in the numerator are tied to the \$100,000 of charges that were used in the denominator? Given the lag in payment turnaround relative to the procedure dates, less than 10% of any month's charges will be paid in the same month.

The rest of the payments will come from charges entered in previous months. So how much weight should you put on this statistic? One way to make gross collection rates more valid is to use larger time periods such as one year.

Another way to calculate GROSS COLLECTION RATE is to wait until six months have passed and determine how much was collected on the charges from July. That means you would have to wait until January of the following year to actually know what percent



was collected against July charges. This is known as the ACCRUAL method. The first method—dividing payments by charges for the *same* month or period—is known as the CASH method.

The second way to measure AR is called the NET COLLECTION RATE. A major factor is the insurance company's ALLOWABLE rate. The Allowables are defined within payor contracts. As the name implies, it is the amount insurance companies "allow" themselves to pay for a specific service, as well as the patient portion of the total allowed charge. For instance, if a doctor charges \$50.00 for a procedure, but the contract states the insurance company will only allow you to charge \$40.00 for that procedure,

by contract, the insurance company will instruct the doctor to contractually write off \$10.00. The insurance company may tell the patient the charge has been reduced to \$40.00, and that the patient must pay 20% or \$8.00.

In the example above the \$50.00 is called the GROSS CHARGE and the \$40.00 is called the NET CHARGE. The NET COLLECTION RATE tracks how much of the NET CHARGE was actually collected. It is defined as the PAYMENTS divided by the NET CHARGE.

So let's say a practice charged \$100,000 in one month and in that same month it had contractual write-offs of \$48,000 and the payments were \$50,000. The net collection rate would be $\$50,000 / (\$100,000 - \$48,000)$. This becomes a 96.1% NET COLLECTION RATE. This is the cash method for NET COLLECTION RATE.

This statistic can have the same problem as the GROSS COLLECTION RATE. If you use the payments and write-offs occurring in the same month as the charges, only about 10% of those payments/write-offs are actually tied to this month's charges. Therefore you can see wide variances and in some cases it can actually be over 100%. Once again the ACCRUAL method provides more accurate data, but it takes more time to collect the data.

COLLECTIONS:

CMS Makes NPI Data Available

By Greg Killinger

For several years, CMS has discussed the National Provider Identification number (NPI) that will eventually replace the individual payer provider numbers and the Medicare Universal Provider Identification number (UPIN). Over the past year, the Centers for Medicare & Medicaid Services (CMS) have distributed many bulletins with requirements for how this NPI number is to be used. The process grew to be very cumbersome. Several months ago, CMS realized the need for a more streamlined approach and is now distributing NPI data in two forms, both via the Internet:

1. A query-only database, known as the NPI Registry.
2. A downloadable file.

NPI REGISTRY

CMS released on September 4, 2007 the National Plan and Provider Enumeration System (NPPES) of health care provider data. This Registry allows for the access to a provider's NPI number very similar to the process for UPIN numbers today. This has already proven very beneficial to PBN in the proper billing of client claims. Should you wish to review your Individual NPI number, the web site for this registry is: <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

DOWNLOADABLE FILE

CMS has posted on the CMS NPI web page several documents to help providers understand what the downloadable file will look like. The content includes a "Read Me" file, a header file, and a downloadable code-value document. Note: the downloadable file is extremely large and requires significant database management knowledge to make use of it. PBN has downloaded the national file and will be using this data to establish NPI numbers within our billing system.

As insurance payers begin to require referring provider and facility NPI numbers, PBN will be ahead of the curve. This will prevent claim denial issues that may be experienced by other providers that have not taken these proactive steps.



For our many readers who are not PBN clients, you can download the data file at the following link: http://www.cms.hhs.gov/nationalproviderstand/06a_data_dissemination.ast#topofpage

If you have questions about NPI numbers, please contact your PBN client liaison, credentialing specialist or management at PBN. We will make sure your questions are answered right away.

News & Notes

2008 PQRI

The Physician Quality Reporting Initiative (PQRI) was implemented by CMS on July 1, 2007. Many physician groups are now reporting CPT Category II codes in order to be eligible for a bonus payment to be issued by Medicare mid-2008 (see the Summer 2007 issue of [Provider News](#)).

PQRI for 2008 is still in its proposal stage. On July 12, 2007, the proposed rule was published in the Federal Register. The final quality measures for 2008 must be published by CMS no later than November 15, 2007.

In its current proposal, CMS will continue PQRI with modifications for a 2008 reporting period of January 1 – December 31, 2008. All such measures must be endorsed by a consensus organization, such as the National Quality Forum (NQF). Also under consideration are measures currently under development by the AMA Physicians Consortium for Performance Improvement (PCPI).

Final 2008 PQRI measures will be available on the CMS PQRI web site no later than December 31, 2007.

CMS anticipates testing the use of five different registry-based submission options for reporting 2008 PQRI quality data. It is also studying the feasibility of allowing providers to submit quality data via electronic health records. The 2008 bonus payment will likely fall between 1.5 and 2% (based on allowed Medicare claims under the physician fee schedule).

For more information regarding 2008 PQRI, see www.cms.hhs.gov/PQRI/.

New Medicare Administrative Contractor (MAC) Awarded

On September 5, 2007, the Centers for Medicare & Medicaid Services (CMS) announced that Wisconsin Physicians Service Health Insurance Corporation (WPS) has been awarded the contract for administering Part A and B claims for Jurisdiction 5 (J5).

States included in J5 are Iowa, Kansas, Missouri and Nebraska. WPS operates out of Madison, Wisconsin.

As part of Medicare Contracting Reform, CMS continues to reduce the number of carriers and centralize the processing of both Part A and B claims by the same contractor for each region. In J5, one contractor will be performing the work that had been previously distributed among seven carriers. See: <http://www.cms.hhs.gov/MedicareContractingReform/>.

Radiology Update

Carotid Artery Stenting

CMS has decided not to expand their coverage of Carotid Artery Stenting. CMS will continue to pay for CAS when the patient is at high risk for carotid endarterectomy and has a 70% or greater symptomatic stenosis.

Keep in mind when dictating that you should indicate in your operative report the percentage of stenosis, describe the patient's symptoms and the usage of distal embolic protection. Medicare won't pay for CAS without the use of an embolic protection device (CPT 37215). CMS just added ICD-9 code 433.11 occlusion of the carotid artery, with infarct to the list of covered diagnoses for CAS.

Patients who have experienced disabling strokes are not eligible for coverage. See the MLN Matters article number MM5667 for additional information.

Renal PTA / Stenting

CMS plans to develop a National Coverage Determination for renal artery PTA and stenting. At present renal artery stenting coverage is at the discretion of local contractors.

The Society of Interventional Radiology expressed its views on renal angioplasty and stenting in a letter to CMS stating that, "Attempts at balloon angioplasty alone, with provisional stenting reserved for those with suboptimal results of balloon angioplasty, are not the standard of care and are not justifiable".