3 keys to getting paid and thriving in private practice

JUN 7, 2019

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Private practice lays the responsibility for operations and financial management of the practice into the hands of physicians. That responsibility is a topic that too often goes unaddressed in medical school and residency training.

The AMA has developed a wealth of information to help new and established physicians understand, keep current and confidently navigate the complexities and frequent changes in getting paid, including advice on private practice revenue cycle management, the Medicare Quality Payment Program, and medical coding and billing.

Many of the resources are collected in the AMA’s STEPS Forward™, an open-access platform featuring more than 50 modules that offer actionable, expert-driven strategies and insights supported by practical resources and tools.

STEPS Forward is part of the AMA Ed Hub™, an online platform that consolidates all the high-quality CME, maintenance of certification, and educational content you need—in one place—with activities relevant to you, automated credit tracking and reporting for some states and specialty boards.

These and other AMA resources tackle the revenue side of medicine in-depth, but three major themes warrant immediate and sustained attention.

Be efficient in collecting revenue

The STEPS Forward module, “Revenue Cycle Management in Medical Practice,” provides a fundamental overview of how to receive all the payment due to the practice. Here are some essentials.

Choose the right practice-management system (PMS). The module includes an 11-page checklist to consider and prioritize requirements for scheduling, filing claims, billing, collections and more for each patient encounter.
“Soliciting input from all staff who use and interface with a PMS and including them in the selection process will ensure that you pick a vendor and product that matches your practice’s priorities and needs,” the module says. The system selected not only has to work well with people, but with the practice’s electronic health record.

Make full use of what can be done electronically. That applies to both submitting health plan claims and collecting payments by electronic funds transfer. Determining the status of claims is also easier and faster, as is using an electronic remittance advice in place of a paper explanation of benefits when further action on a claim is warranted. Electronic pre-appointment verification of patient insurance eligibility can avoid unpleasant financial surprises for both the patient and the practice.

Pay special attention to prompt patient’s-share payments. The rise of high deductible health plans means more patient-driven revenue is at stake. Pre-visit verification of coverage eligibility helps make it possible to calculate the point-of-care pricing amount. The module includes scripts for front office staff to use in discussing payment due with patients.

MIPS: Get bonus or avoid penalty

Enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) formalized a new dimension of practice revenue tied to value-based care. Understanding Medicare’s Merit-based Incentive Payment System (MIPS) is the AMA’s starting point for most physicians to understand how to qualify for incentives for reporting on activities and to avoid a penalty. Another Quality Payment Program track, advanced alternative payment models, affects far fewer practices.

The AMA has prepared a MIPS Action Plan for 2019 that details how a practice can take part in the incentive payment plan, or determine that the practice is exempt due to low Medicare participation. The plan covers 10 steps governing participation and requirements, and is used with a Strategic Scoring Guide to determine if MIPS-covered practices will target the 30 points required to avoid a 2021 penalty of 7%, enough points (75) for the maximum standard bonus of 7%, or even more points in hopes of bigger incentive.

Avoid being tripped up on coding

That “fraud and abuse” is the federal government’s go-to language about Medicare and Medicaid billing disputes sends a powerful signal—along with reports of sky-high penalties—of how serious correct coding should be taken at every practice.
The AMA’s in-depth guide to its coding resources provides an overview of a wide variety of products to help accurately seek payment using Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System codes.

The U.S. Department of Health and Human Services’ Office of the Inspector General’s physician primer on what to not to do, “A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse,” points to some egregious fraudulent situations and carries a special warning about upcoding—seeking payment for an inappropriately high level of service—underscoring the need for scrupulously accurate coding.