Identifying Missed Revenue Opportunities

Caitlin Hungate & Ann Finn | October 14, 2026

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Reminder!

- Today's session will be a conversation including best practices, sustainability, and operations.
- Discussions and scenarios are meant as educational examples only.
- Always follow NYSDOH and other program/payer guidance for compliance and billing requirements.
- Review any questions with NYSDOH.

Agenda

- Introductions
- Overview
- Front End Missed Revenue Opportunities
- Clinical / Coding Opportunities
- Back End / Billing Opportunities
- Resources
- Questions / Wrap Up

Poll

What is your biggest challenge right now?

1. Front end tasks and consistency
2. Coding complexity including modifiers and capturing services correctly
3. Billing accuracy, claim denials and resolving issues
4. Staff training, monitoring data and helpful KPIs

Poll

How much of expected revenue do you believe your agency collects for your family planning services?

1. Over 90%
2. Over 50%
3. Over 25%
4. Not sure

Front End Missed Revenue

Front End Missed Opportunities

Inconsistent messaging, income and family size collection, and/or staff assumptions	Insurance verification not done at every visit	FPBP screening is not done at every visit
Translates to missed time-of-visit client collections	Translates to lost revenue if correct payer is not captured or billed	Translates to lost FPBP reimbursement

Setting Front Desk Staff up for Success

- Asking about money including fees, past due balances, insurance and program eligibility etc. can be challenging for staff
- Set and communicate expectations about paying for services when visit is scheduled, reiterate at check-in
- Have a consistent approach for all clients
- Co-develop scripts with front desk staff
- Role play and practice scenarios to get used to talking to clients about financial expectations

Script Language: FPBP Eligibility

- Ineffective client communication:
  - "Do you want to sign up for FPBP?"

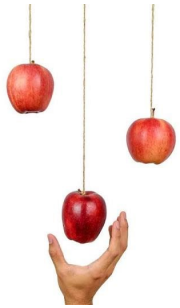
- More effective client communication:
  - "Based on your family size and income information, you may qualify for the Family Planning Benefit Program, a type of coverage that would cover the cost of this visit and other related services going forward. It should take no more than 15 minutes to enroll, and I would be glad to help you."

Script Language: Asking for payment

- Ineffective client communication:
  - "How much can you pay?" or "Can you make a payment for services today?"

- More effective client communication:
  - "How will you be paying for your services today? We accept cash, check, credit cards and Zelle."

Check Coverage So Visit Can Be Billed



- Verify coverage at every visit and check under- and uninsured clients for Medicaid / FPBP coverage

- FPBP:
  - Teens can apply separate from parent's commercial coverage including CHP for Family Planning and STI visits
  - FPBP has presumptive coverage so you can get reimbursed for visit even if screening / enrolling that day

FPBP: Presumptive Eligibility

- Requirements
  - Age: Teen, young adult, woman or man of any age
  - Residency: NYS resident
  - Citizenship: U.S. citizen or a lawfully present immigrant
  - Income: At or below 223% of the FPL (teens can use their own income not parents)
  - Insurance: Not already be enrolled in standard Medicaid. (If you have Medicaid, confidential family planning is already included)
  - Documentation: Not required
- Coverage
  - Covers same day services and can also be done up to 3 months retroactively
  - Coverage good till end of the next month following application date
  - Full FPBP coverage = 1 year
  - No limits on PE applications

Don’t Miss Out!

- FP method counseling, labs and LARC insertion:
  - **Not Billed → no FPBP screening done**:
    $0 revenue
  - **Screened for FPBP and billed presumptively**:
    ~$ revenue (APG): visit, insertion, lab, MD/DO claim if applicable
    ~$730 PLUS + Cost of LARC device - Over $1,000 revenue!



Staff Training

- Regularly observe staff to assess their performance of the various front end processes
- Performance of processes by staff should match written policies/job aides
- If it doesn't, is training needed or does the policy need to be modified? *Involve your team!*
- Incorporate review of policies/processes at regular monthly meetings

Discussion

What other strategies do you and your team use to address/mitigate missed revenue opportunities at the front end?

Clinical / Coding Missed Revenue

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Clinical / Coding Missed Revenue

- Charts not closed and signed timely
- High no-show rates and gaps in schedules
- Inconsistent coding of Z30- diagnoses
- Under and over-coding of E/M codes
- Missing POC and send out tests
- Injections, venipuncture and other ancillary services missed

Clinical Opportunities

Closing Notes:

- Clinicians should close and sign their notes for billing within 24-48 hours.
- Is this monitored by monthly reports and resolved if an issue?
- Delays billing, eats into timely billing limits (90 days from DOS NYS) and impacts revenue.

Scheduling Gaps:

- Do clinicians have full schedules and visits per day monitored?
- Do you track and adjust for no-show high rates?
- Are walk-ins accommodated?

Diagnosis Coding Missed Revenue

- Under APGs, medical visits are paid **based on the primary diagnosis not E/M level**
- Other payers, reimbursed based on E/M levels

Primary Diagnosis – 2026	**DS DTC**	**DS Hospital**
E/M CPT only with… Family planning (Z30- contraceptive mgmt.)	$271	$354
…Well visit, STD screen…	$116	$151
Increased Revenue: More than DOUBLE!		

Quality Coding Check

- Are clinicians accurately coding visits with multiple services and optimizing revenue?
  - **Helpful QA report:** Review all claims with Z30- as secondary diagnosis and non-Z30 primary diagnosis for coding accuracy.
  - Correct claims as needed for both under- and over-coding.

Practice: Aisha's Visit

- *Aisha presents to have her IUD removed. She is unsure on what method she wants to use going forward.*
- *Dr. Jones spends 20 minutes reviewing Aisha's history, counseling on different method options, consent and other related activities. Aisha decides to switch to Nexplanon.*
- *Dr. Jones spends 15 minutes removing her existing IUD and inserting the Nexplanon successfully.*
- *Dr. Jones also spends an additional 10 minutes post visit charting the visit in the medical record.*

Aisha con't

1. Can we code and bill an E/M visit along with the removal and insertion procedure codes for this visit?

A. Yes

B. No

2. What modifier(s) do we need to include and why?

3. What ICD code would we use for the E/M?

Poll - E/M using time



Aisha presents to have her IUD removed. She is unsure on what method she wants to use going forward. Dr. Jones spends 20 minutes reviewing Aisha's history, counseling on method options, consent and other related activities. Aisha decides to switch to Nexplanon. Dr. Jones spends 15 minutes removing her existing IUD and inserting the Nexplanon into her left arm. Dr. Jones also spends an additional 10 minutes post visit charting the visit in the medical record.

What time amount can be used to determine E/M code?

A. 45 minutes total time
B. 30 minutes total time
C. 20 minutes total time
D. You can't use time

Using Time

- Dr Jones spent **30 minutes total time** on date of visit method counseling and chart notes. What code would we select?

New	Time	Established	Time
99202	15–29 min	**99212**	10–19 min
99203	30–44 min	**99213**	20–29 min
99204	45–59 min	**99214**	30–39 min
99205	60–74 min	**99215**	40–54 min

Interpreter Services: Not Billed



- Provided either face-to-face or by language line including tele-visits
- Need for interpreter services must be documented in medical record and provided by a third-party interpreter
- **CPT T1013 – document time and report 1-2 units**

APG Payment	Units	DS Hosp
8 - 22 minutes of medical language interpreter services	**1**	**$14.94**
23 + minutes…	**2**	**$29.88**

HIV Counseling & Testing Missed

- If HIV counseling is provided by an HIV counselor separate from the E/M service and > 8 minutes, counseling may be billed in addition to the medical visit
- Add modifier 25 to E/M if same day
- APGs: Pays ~ $38 or more depending on documented time
  - **< 8 minutes – not billable**
  - **8 - 14 min – bill to APG claim with 99401-U5 modifier**
  - **> 15 minutes – bill to appropriate CPT (99401-99404)**

- Bill separately for any HIV testing (i.e., 86703 = $15.59)

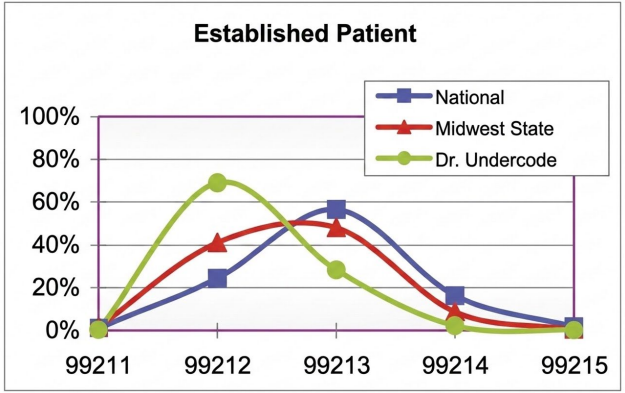
Future Coding Opportunity to Monitor

- Starting January 1, 2027, CPT codes for maternity care will be "unbundled" moving away from a global maternity care
  - Codes will be specific to antepartum care (E/M) services, new labor management codes, new delivery care codes, and postpartum care (E/M) services

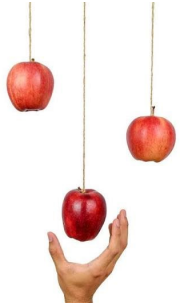
Resources: FAQ, archived webinar, and job aid from AMA

E/M Quality Checks

- E/M level often impacts reimbursement across payers
- Calculate E/M codes using both MDM and total time on the date of the encounter – choose the higher code
- Don't double dip and count separately reported services like LARC procedures in your total time
- Document time on all visits
- Do analysis of E/M coding across providers and sites to ensure optimal codes are captured and billed



Discussion: Internal Audits



What coding-related internal audits does your agency perform OR do you think would be helpful in identifying missed revenue?

Back-end / Billing Missed Revenue

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Back End / Billing Missed Revenue

- Modifiers miscoded on claims
- Rejections and denials not corrected
- Avoidable timely billing errors
- Outdated fees and sliding fee discount schedule (SFDS)
- Missing family planning indicators on claim - risk of audit / payment take back

Modifiers Impact Payment



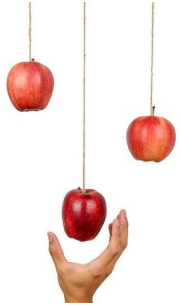
- Ensure billers understanding impact of modifiers on service and claim
- Review line item payments for missed revenue:
  - E/M and injection or other service billed without modifier 25 and E/M did not pay
  - Multiple procedures missing modifier 59 and second procedure did not pay
    - Modifier 51 billed in error (not accepted by NYS)
  - LARC insertion was stopped but billed with no modifier and overpaid

Submitting Claims Efficiently



- Ensure clinicians close charts for billing within 24-48 hours of visit
- Bill claims weekly
- Follow up weekly on rejected claims (errors kicked back by payer before processing) to avoid timely filing issues
- Verify # of submissions accepted with payers
  - Compare # of visits (use visit report) to # of claims submitted (TPP claim submission reports)

Timely Filing Errors



- Don’t miss revenue by leaving claims sit too long!
  - NYS allows 90 days from DOS to submit a claim and 60 days from error notice to correct
  - Denials for timely filing errors are missed revenue and should be closely monitored
  - Resolve root causes

Missing Family Planning Indicat



- Family planning indicators on the claim are required on both the visit and LARC claims when family planning is the primary diagnosis (Z30- Contraceptive Mgmt)
- If you don't include this, NYS can take back the payment under review
  - **"A4" FP condition code** (institutional, UB claim format- condition code box 18-24 on header)
  - **"Y" FP indicator** (1500/HCFA claim (LARC) – Box 24H next to CPT/ HCPCS code)

Understanding Root Causes

Registration denials/registration rejections

Strategy: Implement insurance verification processes, identify/ correct errors weekly, work with staff to correct manual errors

Bundled or non-covered services/modifier issues

Strategy*:* chart audits, contract term management, scrubbing software, job aides, tracking sheet updates

Medical Necessity/Coding issues

Strategy: chart audits, documentation review, training and job aids, scrubbing software

Understanding Root Causes *con't*

Past timely filing limits submission of claims
Strategy: precise front end processes, weekly claim submission, clinicians closely medical charts for billing within 48 hours, weekly follow up on rejections

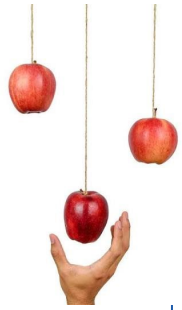
Duplicate (2nd claim for same date of service) denials
Strategy: review both claims, review ERA, correct (multiple) denials as needed, review submitting revised claims with biller

Resolve Issues



- Unresolved fixable denials are missed revenue!
- Foster a good relationship with payer contact
- Call the claims representative, ask specific questions - have claim ID and details ready
- Document findings to minimize future denials of the type investigated (tracking tool)
- Provide feedback regarding errors and corrections
- Claims may have more than one denial reason

Billing: Charge vs Full Fee



- Set your fee's above your highest TPP contractual rates to not lose out on reimbursement due you
- NYS Medicaid and FPBP require contraceptives/drugs billed at cost not your full fee - set up matters
- Not participating in 340B program when eligible costs you money

Example:

- 340B cost Nexplanon: **$450**
- Plan A Contractual rate: **$1100**
- Charge on claim: **$450**
- Payment: **$450**
- *Missed revenue: $650!*

Reviewing Full Fee Schedule

- How often do you review your full fee schedule?
- Are your full fees at or higher than the highest payer?
- Do you monitor expected payments by payer?
- Are contraceptives and drugs billed to Medicaid / FPBP at acquisition cost compared to contractual rates for other payers?

Making Adjustments to Fees and SFDS

- **Adjusting Fees:** All at once vs incrementally over time?
  - If an agency's proposed fees significantly increase, it could be burdensome for uninsured clients who pay for services on an agency's SFDS

- **Adjusting SFDS:** Can change the income groupings for discounts or the actual discount amount in each grouping per Title X

Tool to Support Work: Contractual Obligation Tracking

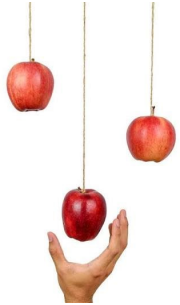
Contact Information	Private Insurance 1	Medicaid FPBP
Contact name/contact information	Cindy Smith, 888-888-8888 csmith@bcbs.com	John Jones, 999-999-9999 jjones@nysdoh.gov
Claim Submission Timeframe	3 months new claims, 6 months revised	90 days new claims, 60 days revised
Services/Meds requiring prior authorization	Colposcopy	None
LARC payments	Contractual rates	Acquisition cost
Formulary Restraints	Depo-provera must be purchased at pharmacy	none
Bill with NP/PA	Yes – 75% reimbursed rate	Yes - APG or PPS claim
RN Billing Allowed	Established patients only (99211)	No - see APG manual for exceptions

Financial Key Performance Indicators (KPIs)

- Metrics organizations use to track, measure, and analyze and optimize your clinic's financial health
  - What gets measured gets managed…and improves!
- Shows trends – enables informed decisions

Resource: Title X Key Performance Indicators Workbook (RHNTC)

KPI's: Getting Started



Selecting KPIs:

- Easy to gather data and calculate
- No more than 5
- Start with "low hanging fruit"
- Can change over time what you monitor

KPI's for the Patient Journey

- **Front End**
  - Payer Mix, Denials due to Front Desk Errors, Prior Authorization not gotten, No show/Walk-in Rates
- **During the Visit**
  - Charges per visit, E/M level distributions, E/M visits (new vs established), clinician productivity
- **Back End/After the Visit**
  - Charges by payer, A/R aging, Denial Rate, Charges and Revenue per Patient

Questions / Wrap Up

Discussion & Questions

What is one takeaway from today that you can share with your agency to reduced missed opportunities for revenue capture?

NYS Resources

- Provider manuals and helpful NYS guidance
- NYS APG website
- NYS FPBP
- NYS Family Planning Training Center

Front End Resources

- Confidential Billing: Steps for Front Desk Staff
- Defining Family Income for Title X Charges, Billing, and Collections Job Aid
- Title X Front Desk Income Verification Workshop
  Collecting Co-Pays and Applying Sliding Fee Scales: A Job Aid for Front Desk Staff
- Integrating Title X with Primary Care: Developing and Implementing Compliant Sliding Fee Discount Schedules Job Aid
- Adjusting an Agency's Sliding Fee Discount Schedule Job Aid
- Client Fees Calculator
- Title X Client Fee Collections Frequently Asked Questions
- Financial Management Focus: Monitoring and Managing Client Fee Collections Webinar

Clinical / Coding Resources

- Evaluation and Management Codes Job Aid
- Elements of MDM During Family Planning Visits Job Aid
- Coding Audit Tool
- Fiscal Chart Audit Tool
- Commonly Used CPT and HCPCS Codes in Reproductive Health Care Job Aid
- Coding Modifiers for Contraceptive Services
- Coding with Ann Podcasts (short FP coding podcasts)
- Coding for Telemedicine Visits Job Aid

Back-end Resources

- Financial Management Toolkit
- Financial Management Change Package
- Financial Mgmt Performance Report and Improvement Plan
- Accounts Receivable Management Tool
- Title X Key Performance Indicators Workbook
- Contractual Obligations Tracking Sheet
- Definitions of Key Financial Management Terms for Title X Family Planning Agencies

Thank you!

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