



COMPLIANT BILLING SERVICES, LLC.

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PRACTICE SOLUTIONS MANAGEMENT

MAXIMIZE YOUR REIMBURSEMENT STAY COMPLIANT

Maximizing reimbursement and promoting compliance go hand in hand. With the OIG looking closely at billing procedures of small practices, it is very important to know and obey the rules. Knowing the rules will put you in a position to be paid the first time around and to come through any audit smiling.

Scrutinizing your billing procedures will often find areas where you are losing money. For instance, do your providers routinely code 99213 because they are unsure of the elements of a 99214. Many providers are unclear on E/M guidelines. Provide tools in your office like an E/M slide rule and schedule educational talks. This will make your pro-

viders more sensitive to the process and realize that their documentation is the bottom line. Do prepayment audits and give feedback to your providers.

Do you bill 99211 for a nurse or MA visit for blood pressure check, in house PT/INR or blood glucose check? Minimal documentation is needed to qualify and this is incident to.

Do you understand when you can bill a preventive medicine code with an E/M code? If there is a separate problem that required significant attention, you can do this. You need to put the

25 modifier on the E/M. There are payment restrictions on this with Medicare. Be sure you do not change a preventive medicine visit to a E/M code for payment sake. This is fraud.

Do you understand when it is appropriate to bill a consult as a primary care provider? Consult codes in general reimburse at a higher rate. If it is requested that you see a patient, for instance to clear them for surgery, and you provide feedback to the requesting physician, it is a consult, even if you are the primary care physician.

These are just a few topics. Read on.

Karen Jeghers, PA-C

PROVIDER OPERATED MEDICAL BILLING:

Compliant Billing Services is a billing company that is based on a few simple principles. We develop a relationship with every office we service and keep an open line of communication. We educate your providers on updated guidelines to keep their documentation compli-

ant. We let you know what procedures reimburse and what ones do not. We encourage you to look at your EOB's. Our focus is on maximizing reimbursement and promoting compliance. We are owned and operated by a Physician Assistant with 13 years clinical experience.

This gives us an advantage because we understand the process and we understand what actually goes on in the exam room. For this reason, we can code and bill the visit more efficiently.

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Special points of interest:

- IS SPECIFICITY REALLY IMPORTANT?
- BILLING PEARLS FOR THE PROVIDER
- GET HIP ON HIPAA
- TAKE OUR CODING CHALLENGE

ARE YOU SPECIFIC? DOES YOUR ICD-9 FOR CHEST PAIN REIMBURSE?

Are you still coding off a superbill? Did you know that insurance companies keep a profile of your ICD-9 codes and if your coding spectrum is narrow, you could be flagged for an audit?

The key is specificity. Most codes go to the 4th or 5th digit. Being specific increases your chance of being paid for services rendered, but also gives a more accurate picture of the patient problem. Many payers do not reimburse for the general code of chest pain (786.50) for an E/M or an EKG. You

must be specific: was it pleuritic, substernal, etc. Hospital visits are another area where this ICD-9 can be a problem, even if the patient has had an MI. Let your biller/coder know the area of the MI and whether this was an initial or subsequent event. This definitely makes a difference in speed of reimbursement.



Injuries are another area where specificity matters. Adding an E code will tell the payer the specifics and may allow quicker payment of the claim. Without the E code, the payer may request further information from the patient to be sure it is not an MVA or worker's compensation case.

Give as much information as you can and don't code your diagnoses from a superbill.

MAKING SENSE OF MODIFIERS

Modifiers are a way to communicate to the payer that a particular procedure was done under special circumstances. It is important for the biller/coder to be aware of these, but when the provider is also aware of how they are used, it makes for more efficient communication of information.

Use **modifier 25** to show that a service is separate and identifiable. For instance, if a patient comes to the office for a bronchitis and you notice an actinic keratosis that needs

CORRECT USE OF MODIFIERS WILL HELP YOU GET REIMBURSED APPROPRIATELY FOR SERVICES RENDERED.

cryotherapy, put the 25 modifier on the E/M.

Modifier 51 is for multiple procedures.

Modifier 76 shows repeat procedure by the same physician. **Modifier 24** shows an unrelated E/M by same physician in postoperative period.

Mass Health has its own modifiers for

EPSDT screening when done by PCP. They are **EP** for new patients and **Y3** for established patients. Are you using these to maximize your reimbursement for your MassHealth patients under 21. Do you use the **QW** modifier for CLIA waived tests done in the office.

These are just a few. Become familiar with the ones most applicable to your specialty.

TAKE OUR CODING CHALLENGE

Question 1 : A diabetic patient comes into the office for an abscess and you perform an I&D. Two days later the patient is admitted to the hospital for 3 days of IV antibiotics and treatment. You submit the billing to the patient's insurance company and the whole hospitalization is denied. Why?

Answer 1: The hospitalization is in the

global period of the I&D and you need to add modifier 24 to every hospital visit in order to show this was a separate E/M in global period.

Question 2: A patient comes in for follow up on her hypertension. She mentions she has not had a pap or breast exam in several years. You decide to do it at that visit. How do you code this?

Answer 2: You would code the E/M with a modifier 25 with the ICD-9 for hypertension. You would also code the G0101 and Q0091 with the V72.3 (GYN exam).



More challenges at
www.compliantbilling.com

E/M DOCUMENTATION MADE EASY

When a provider sees a patient, the utmost concern is for the evaluation and management of that patient. Clear documentation is essential both for billing purposes and also for future management of that patient. Determining the correct E/M code can be difficult when you are hurrying to see your next patient. A good way to approach this is to determine the risk first. If a patient has a new problem that requires management with prescriptive medicine, you can justify a 99214 if you document accordingly. Always document chief complaint and always document 4 elements

of HPI. Reference a pre-established social, family and past medical history and 2 of 3 elements are there. A new patient requires 3 of 3 elements.

Chart review is important. If a provider is not documenting sufficiently, give him/her the tools to do so. It will be worth your while. Many practices use specialty specific preprinted progress notes. When a provider uses either a lined or a blank piece of paper to record progress note findings, proper documentation generally does not occur. There is no need to re-invent the wheel. Many companies have produced E/M

code, documentation compliant pre-printed progress notes. If you are not comfortable with any that exist, customize a progress note to meet your needs. Be sure, however, to cross reference HCFA and AMA documentation requirements.

HIPAA: SHOULD YOU BE CONCERNED?

The Health Insurance Portability and Accountability Act (HIPAA) was created in 1996. The Administrative Simplification provisions of HIPAA include privacy regulations aimed at improving privacy and security of electronic health data.

There are a number of things you can do to begin preparing for HIPAA's implementation. If you are a covered entity or have a contract with a covered entity, you will be affected. Healthcare providers, health plans and clearinghouses are all covered entities.

Start by Obtaining approval for a notice of information practices that states the uses and disclosure the cov-

ered entity intends to make with health information.

Develop a mechanism to account for all disclosure of protected health information for purposes other than treatment, payment and healthcare operations.

Develop a procedure that allows individuals to inspect and copy their protected health information. Establish safeguards to protect identifiable health information from unauthorized access.

Create a policy regarding the covered entity's response to requests of

amendments or corrections of inaccurate or incomplete protected health information

Develop a privacy training program for employees and develop sanctions for employees violating such policies.

Assess your organization's needs and take steps to move toward compliance.

Develop a mechanism to account for all disclosure of protected health information

“INCIDENT TO” Are you compliant?

Do all your midlevel practitioners have their Medicare numbers and do your NPs have their BC/BS provider numbers? “Incident to” is an area that needs to be closely monitored. Violating these rules is considered fraud. Medicare will pay a PA or an NP at 85% of the Physician's fee schedule if they see a patient during an encounter that is not “incident-to”.

Incident-to means that a visit is incidental to the physician encounter. The following must occur for a visit to be “incident to”: The supervising physician must be present in the suite; the PA/NP must be seeing the patient for a problem which was previously evaluated by the physician and no new problems are addressed. If a visit does not meet the

criteria, it should be billed under the PA/NP provider number.



WHOSE PIN DO YOU USE IN THIS SITUATION?

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▶ YOUR MEDICAL BILLING
SOLUTION

**WE'RE ON THE WEB
WWW.COMPLIANTBILLING.COM**

TO THE PROFESSIONAL PRACTICE OF:

BILLING PEARLS

1. Always collect copays at the time of service. This will increase your cash flow and cut down the cost of billing the patient. Insurance companies consider it fraud to not bill the copay or deductible.
2. Always get a copy of the insurance card at every visit. It is the only way to be sure your information is accurate
3. Use POS devices or other ways of verifying eligibility
4. Know your coding so you can complete your encounter forms more accurately. When providers know the ins and outs of coding, the whole process goes smoother. In the end, it is your provider number and you are responsible for the billing, regardless of who performs it.
5. Get to know the representatives from your top 5-10 payers. It is easier to get their assistance when they know who you are.
6. Keep an eye on approved amounts. When they get within 10% of your fee, it is time to raise that fee.
7. Know what is reimbursed and what is not. Don't muddy your accounts receivable reports with false hope by billing charges that will never be paid. This way your collection people can focus on what is truly viable money.
8. Make it easy for your patients to question their bills. People are quicker to pay when they understand why. A friendly, helpful person should always be available to answer questions during normal business hours.
9. If a patient doesn't pay after 3 bills, send the account to collections or write it off (keeping in mind that routine write-offs are illegal). Don't waste time, paper and postage sending additional bills.

