A Commonsense Approach to Maximizing Office Reimbursement

Summary: *James Bullion and Cavan Redmond, both of whom have extensive experience with insurance claims processing systems, have some simple but effective tips to help office-based physicians and their staffs to maximize reimbursement.*

Coding and Follow-up Procedures: Two Key Areas for Review

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If physicians want to maximize reimbursement in their office-based practices, they must ensure that claims are properly coded, benefits are coordinated, and follow-up procedures are established—all of which have significant bearing on the net income of their practices.

I cannot offer any worthwhile suggestions to help physicians gain reimbursement beyond what a carrier will approve. However, there are specific functions physicians and their office staffs can engage in to ensure that the highest possible level of reimbursement is received.

First, appropriate CPT-4 and ICD-9-CM coding will do more to improve reimbursement than any other single step physicians can take. These two coding structures—ICD-9-CM for the classification of diagnoses and CPT-4 for the naming of medical procedures—have become the communication link between the medical profession and the insurance processing system. The codes that are put on insurance claims (or, for that matter, the codes that are not put on claims) will ultimately affect the level of reimbursement physicians receive, both now and in the future.

It is imperative that all diagnosis and procedure codes that are pertinent to an office visit be completely and accurately coded. This includes conditions that exist at the time of the visit, as well as those that subsequently develop.

Proper sequencing of codes is also extremely important, because it directly affects the level of reimbursement physicians receive from insurance companies. The principle diagnosis is always listed first, followed by chronic conditions listed in reverse chronological order (the most recent to the oldest). Many rejections and disallowances of claims result from a failure to make the relationship between procedures and diagnoses clear.

Other common causes of lost revenue from insurance carriers include:

- **Incorrect visit codes.** It is not sufficient to use one generic code to cover all office visits. There are 11 different codes that are used to define the type and duration of an office visit. To use one simple code leaves a physician prey to arbitrary judgments on the part of carriers about the level of service provided to the patient and, consequently, the level of reimbursement the physician will receive. Because reimbursement allowances for office visits range from $10 to $200, improper or inadequate coding can have a profound effect on reimbursement levels.
- **Failure to list all procedures separately.** It is not sufficient to simply list "therapy" and price it with a global fee. Each specific procedure should be identified, appropriately coded, and priced accordingly. For example, if a patient is receiving daily chemotherapy treatments, and the treatment plans are being regularly reviewed, each of these services should be dated and identified when the claim is processed.
- **Incorrect principle diagnoses.** Improperly coded diagnoses or the use of vague codes can result in reduced payments and denied claims, not to mention the additional administrative expense of correcting claims and the negative impact that such delays can have on patient/physician relations.
- **Failure to list secondary diagnoses.** Remember that the Health Care Financing Administration's (HCFA's) form 1500 allows for as many as four diagnoses to be listed.

The entire area of diagnosis and procedure coding emphasizes the importance of ascertaining that all coding of patient claim forms is performed by members of the office staff who are qualified to interpret increasingly complex code structures. (There are more than 35 pages of codes under six different categories for neoplasm diagnoses.) It is imperative for physicians to ensure that office staff are properly trained and to periodically review coding procedures for both diagnoses and medical procedures. Seminars that teach proper coding techniques are becoming more common and attendance by appropriate office personnel should be encouraged. The money spent in training office personnel in proper coding will be returned many times over because it will ensure appropriate reimbursement for the procedures performed by physicians, improved turnaround time for claims processing, and a decreased number of claim denials, as well as the delays that result from carrier

requests for further information.

An additional source of lost revenue is the failure to periodically spot check the data that is forwarded to carriers. This simple management responsibility should be performed at least once per year whether claims are processed manually or on a computer system. If insurance forms are being typed manually, the physician needs to periodically confirm that all sections of the form are being completed and that they are legible. If office billing is computerized, it is imperative to periodically confirm that proper ICD-9 and CPT-4 codes are in the system. Although diagnosis codes normally are not changed in code books, there are frequent changes to CPT-4 code structures. New codes are introduced and existing codes are deleted. The use of a CPT-4 code book that is older than the current year's edition increases the possibility of erroneous data being processed and, consequently, carriers are left to decide what procedures were actually performed.

For better or for worse, practitioners must recognize that coding is here to stay, and it is destined to become an increasingly important factor in the financial viability of modern health care practices. The solution, as frustrating as it may seem, is to take steps to ensure that proper ICD-9-CM diagnosis codes and correct CPT-4 codes are used so that swift and accurate claims processing is possible.

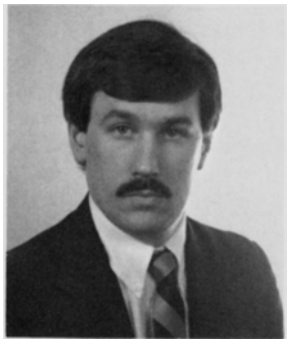
Although the processing of all patient insurance claims and the coordination of benefits is time consuming and, in reality, the responsibility of patients, these tasks are better performed by a physician's office personnel. Most of the time, patients are too ill to be concerned about the timely forwarding of billing information to their insurance carriers. Furthermore, when it comes to filing Medicare claims, many patients may not know what information is important to the carrier.

Follow-up procedures are also important to ensure maximum reimbursement within a reasonable timeframe. First of all, physicians should know what level of reimbursement is expected from each insurance carrier. A well-designed computer claims processing system should allow a physician to establish profiles of anticipated reimbursement from various carriers. As claims are paid, the payments can be compared to these profiles to determine whether or not they were properly reimbursed and to trigger reviews for inappropriately reimbursed procedures.

When it comes to insurance reimbursement, it is best not to take anything for granted. Claims data has to be entered by people, and people are prone to error. The more closely physicians monitor reimbursement and the better their edit checks, the less likely they are to be victims of carrier errors.

There are no magic formulas for maximizing physician reimbursement. It is simply a matter of consistent management with appropriate checks and balances. Many of the ideas discussed here may seem obvious, but if physicians frequently review office policies for consistency, rightfully earned fees are less likely to slip through the cracks. The alternative is the frustration of lost revenues. ■

Other Areas that Merit Review: Forms, Denials, and Appeals



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Claims processing information is often so disjointed that some offices use the services of a third party to help them learn how the reimbursement system works. Such an extreme isn't necessary if office staff adopt some of the following strategies and avoid some common pitfalls.

OBTAINING POLICY INFORMATION

- Do not disregard the materials received from carriers. Most provide updates on policy changes and reporting requirements through periodic letters, notices, or newsletters. All information that carriers send should be filed in a central reference book in case of reimbursement denials or the need to file an appeal.
- Attend carrier-sponsored seminars and conferences on reimbursement policies.
- Information on a broader range of health care insurance issues is available through the following publications (a free copy of the latest issue should be available for review):

American Medical News
312/645-5000

Health Manger's Update
202/463-1700

Health Policy Week
301/961-8777

Medicine and Health
202/463-1700

Part A News
301/961-8777

Part B News
301/961-8777

State Health Legislative Report
312/645-5000

The National Report on Computers & Health
301/961-8777

- Build a resource library that contains both carrier information and trade publication articles to help improve reimbursement management.