

Payer-specific Coding Issues

Today's practices deal with multiple private insurers as well as Medicare. Each payer has its own policies for coding and billing. It pays to keep abreast of the differences among payers as well as the ever-changing list of requirements.

Chapter in Brief:

- ▲ *When comparing Medicare with commercial payers, it's important to recognize why Medicare rules often differ from those of private payers. Medicare focuses largely on illness and injury. Most commercial plans, on the other hand, have a greater focus on preventive care and provide a wider range of benefits.*
- ▲ *Practices should develop their own payer report card to ensure payers are upholding their part of the contract. Statistics to track include average days to initial payment, actual payment versus contracted amount, and number of outstanding claims.*
- ▲ *Medicare's pilot Recovery Audit Contractor (RAC) program brought \$693.6 million back into government coffers. Of this, \$37.8 million came from outpatient providers. The program has been expanded from a handful of states to the entire country.*

Most medical billers have had experiences with private payers who try to avoid paying claims or pay less than the contracted amount. While billers generally find that Medicare delivers promised reimbursement based on current policies, those policies are subject to change and are often very different from those of most payers.

How do you work with private payers and Medicare to run

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 Rx to Pharmacy _____
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Coding
 _____ minutes spent in telephone medical discussion
 billable not billable

Telephone service	Physician	NPP
5-10 minutes	99441	98965
11-20 minutes	99442	98967
21-30 minutes	99443	98968
Online encounter	99444	98969

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your practice efficiently? Patricia Hubbard, CPC, CPC-OBGYN, a medical practice manager in New York State, notes that both CPT and ICD-9 provide systematic methods for correct coding, intending that doctors be fairly compensated for their work. The existing CPT and ICD guidelines could be recognized and accepted uniformly by all commercial payers, she says, but “payer-specific” guidelines exist for certain services “for no

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other reason, I think, than to streamline their own proprietary claims processing systems and data collection.”

When comparing Medicare and commercial payers, it’s important to recognize why Medicare rules often differ from those of private payers. The Medicare program, funded by tax dollars, was implemented to provide medical coverage to a targeted segment of the population who often could not afford insurance: the elderly and the disabled. Although Medicare has added some screening and preventive benefits in recent years, the basic intent of the program is to provide coverage for illness and injury. Commercial plans, on the other hand, serve a much larger and healthier segment of our population and have a greater focus on preventive care, providing benefits for many types of service that are excluded under the Medicare program.

Nancy Enos, FACMPE, CPC, CPC-I, CPC-E/M, a consultant and coding instructor in Warwick, R.I., says that knowing these differences can help practices bill more accurately and effectively. “The billing staff should be able to send bills out that are payer specific,” she says. She recommends using software edits that are payer specific or claims-scrubbing software that examines the insurance coverage on the claim and holds off sending a claim that may trigger an edit. She recommends using payer-specific edits or claims-scrubbing software that will double-check your claims before they are sent to the payer.

Not only do offices need to know each insurer's coding policy, but they also need to know the provisions of the contract that the offices have signed, says Marie Felger, CPC, CCS-P, a medical practice auditor and former office manager in Illinois. "Often the items that are covered are spelled out in that contract," she says.

Ms. Hubbard notes that coders dealing with commercial payers are taught that it is always correct to code according to CPT and ICD-9-CM guidelines. When claims are denied, they can appeal on the basis of those guidelines. But this doesn't always work. "Commercial plans are not compelled to follow those rules and can make up their own," she says. "They pick and choose between CPT and Medicare, mostly with issues like bundled procedure codes, modifier usage, global packages, and complications."

Managed Care Contracts

When negotiating or renewing a managed care contract, practices can save hassles and money down the road by asking the payer specific questions about its policies. The AMA provides a list of 15 recommended questions in a brochure available on its Website. For example, will the payer quickly and accurately verify the patient's enrollment in the plan? Doctors should also find out the payment schedule for their most commonly billed procedures so they can determine if payment will cover costs.

Once the contract is in hand, practices should develop their own payer report card to ensure payers are upholding their part of the contract, says Deborah Walker Keegan, PhD, FACMPE, president of Medical Practice Dimensions, Inc., and co-author of *The Physician Billing Process: 12 Potholes to Avoid in the Road to Getting Paid* (MGMA, 2009). Practices should track the following information:

- net collections
- percent of claims outstanding at 90 days
- average number of days until initial payment
- actual payment versus contracted payment
- success rate for collecting patient portion of payment

While that last point seems outside the payer's realm, Dr. Keegan insists that it isn't. "What is the payer doing to help its

insured members understand what they owe?” Dr. Keegan asks.

Dr. Keegan also suggests keeping a log of administrative costs per payer. This might include the “contact failure rate,” which examines how many times the office tried to contact the payer

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but got a busy signal, for example. Another consideration is whether the payer offers electronic fund transfers.

Dr. Keegan says that if a payer is costly to do business with in terms of denials and administrative hassles, the practice can negotiate for higher payments or decide not to renew the contract.

Build Relationships With Payer Representatives

While it can be tough to reach a live representative by phone, it pays to take some time to build relationships at each payer’s office. Having a specific person to whom you can bring questions and concerns can help the billing staff make sense of differences among payers. “There’s a wide difference in the requirements for private payers,” Ms. Felger notes. “Staff should try to develop a relationship with a person at each of the private payers—a go-to person for when there’s a problem. When there’s a solution, ask for the solution in writing and keep a file.”

This can be more easily said than done. Ms. Sword shared these tips:

- If someone from the insurance company is helpful, note his or her name and ask for that person whenever you need help in the future.
- To ensure better follow-through, ask for a tracking number. If you have to call back, give this number to the representative.
- Ask for the supervisor, who is usually the same person from month to month. If all else fails, call the carrier’s provider relations representative and complain. The problem is usually handled quickly, or you’ll get another contact name.

When you call an insurance carrier, Ms. Sword recommends prioritizing your questions. “Most carriers will only let you ask about three to four questions at once; then you have to hang up and call again,” she says. “There’s a limit, and you can’t stay on the phone forever.” She adds that most carriers have an automated line or a Website where you can check claims status or hear why a claim was denied. It may be better to use these services for routine information and save more complicated questions for the live representative.

Ms. Sword notes that it’s helpful not only to make connections with insurance carrier representatives, but to learn how to approach them for help. When a claim is denied, she suggests calling and saying, “I’m not sure what I did wrong; can you help me figure this out?” “They’ll sometimes reprocess it on the spot,” she says.

Another way to get to know payer representatives is to join the local chapter of the Medical Group Management Association (MGMA), which has affiliates in every state, says Ms. Enos. The major payers have representatives who attend MGMA meetings, she says. “Having that face-to-face opportunity to speak to the provider rep on a regular basis at the meetings helps foster a good working relationship. If there’s a glitch that comes up, they’re very willing to work with the practice manager in order to solve them.”

Talking to payer representatives has one more advantage. They may be able to help get system edits changed if there’s an error on the payer’s side, says Cindy Hughes, CPC, PCS, coding and compliance specialist for the American Academy of Family Physicians. “If it turns out there’s an edit set incorrectly in the payer’s system, the payer representative is the best way to get that edit fixed. The customer service person isn’t going to be able to do that.”

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Special Medicare Policies

Medicare has been lauded as the most transparent of all payers because it publishes extensive guidelines on its comprehensive (but not necessarily easy-to-navigate) Website (www.cms.gov). The agency is often praised for following its own rules.

“Medicare spells it out,” says Ms. Felger. “They’ve got policies on everything. If you can navigate their Website and find the policy, you can [confidently] bill it. You know what’s covered, what diagnosis code to use. The appeals process in place now is user friendly.”

“Medicare publishes national and local coverage determinations right on its Website and also lists the diagnosis codes that support medical necessity for these services,” adds Ms. Hubbard. “But Medicare does have complex and ever-changing rules and regulations, and it’s important to stay on top of them.”

Medicare starts using updated CPT codes on January 1 of each year, with no grandfathering clause. Ms. Weis finds it helpful to download the new codes at the end of December, during the holiday break, so the updated codes and pricing will be in place at the start of the year. “Then Medicare won’t reject you because you’re using old codes,” she says. Updated ICD codes are implemented each October 1.

Ms. Hubbard adds that Medicare’s correct surgery coding edits are updated quarterly—in January, March, June, and September—so coders need to look for those changes, too.

Thomas Felger, MD, FAAP, a family practitioner who teaches residents at Indiana School of Medicine and coding courses for the AAFP, adds that Medicare sends out e-mail alerts with news on changes (which, he warns, are sometimes 150 pages long).

Medicare Quirks

Just as private payers have billing quirks, so does Medicare. Ms. Sword says one of these is that Medicare doesn’t give patients a group number, but requires the patient’s Social Security Number for all Medicare A, B, or D claims. However, claim forms have a box—11A—that calls for the group number. “You must tell them ‘none’ for group number,” she says, “or they will reject your claim.”

Special Situation: Laboratory Services

Billing issues can sometimes lead to changes in the breadth of services offered by medical practices. Anita Weis, office manager for a Chicago, Ill., practice, says that for years, her office ran an in-house lab. They finally closed it down when they realized Medicare wasn't compensating them for certain lab tests. She says the practice ended up absorbing too many unpaid lab fees. She now refers patients to outside labs like Quest, Genesis, or the hospital lab, leaving those labs to deal with the billing issues.

Not all practices have the same problems with Medicare's reimbursing fees from in-house labs, says Thomas Felger, MD, FAAP, a family practitioner who teaches residents at Indiana School of Medicine and coding courses for the AAFP. "There are still offices that have Medicare labs and do okay by them," he says, adding that the payments are "not generous" but enough to justify continuing to offer the service. "It's different in different towns or states." Dr. Felger says a practice should look into whether it is using the right codes for doing a blood sugar or prothrombin time test in the office versus the lab.

Another issue to consider is lab certification, which can solve many reimbursement problems. No matter what ancillary or diagnostic service an office provides, Nancy Enos, a consultant and coding instructor in Warwick, R.I., recommends getting recognized and credentialed by the payer prior to providing that service. Many payers publish a list showing which lab tests are payable in the office setting.

Ms. Sword notes that Medicare uses codes for injections and certain lab work that differ from those of private payers. She says that a code used by Medicare to administer a flu shot would be an HCPCS code, starting with "G," whereas private payers use the CPT code for injections.

Ms. Hubbard agrees that Medicare often requires codes that aren't needed by other payers and has billing requirements peculiar to Medicare. "It's not arbitrary, but it is burdensome to providers, coders, and billers who must be aware of all the different Medicare coding and billing requirements and coverage restrictions," she says.

Despite these quirks, Medicare is quite consistent in other ways. "Their denial codes never change from EOB to EOB," Ms. Sword says. "CO16 means you're missing info on the claim. CO18 is always a duplicate claim," she says. "With Blue Cross

or other commercials, they don't number it the same way on each EOB."

Medicare is also easier to work with in terms of secondary payers because the system was designed to work with "Medigap" insurance. "If payers are on the Medigap list, they auto-forward the claim to them," says Ms. Sword. "Very few have to be printed and sent separately. If patients have Medicare and Blue Cross, they pay nothing, owe nothing, and never get a bill."

However, not all billers find this process seamless. Ms. Weis has run into problems in this area, although she doesn't blame

"Sometimes that payer will send the medical office a letter claiming that it didn't get the Medicare EOB, and it won't send payment until it receives that," Ms. Weis says. **"So while the original claim came directly from Medicare, now I have to copy the EOB and send it back to the insurance carrier. Sometimes it goes back and forth several times, and the private payer then denies the claim because it wasn't filed in a timely fashion."**

Medicare. After Medicare pays its part and forwards the claim directly to the secondary payer, those insurers often create frustrating problems. "Sometimes that payer will send the medical office a letter claiming that it didn't get the Medicare EOB, and it won't send payment until it receives that," she says. "So while the original claim came directly from Medicare, now I have to copy the EOB and send it back to the insurance carrier. Sometimes it goes back and forth several times, and the private payer then denies the claim because it wasn't filed in a timely fashion. Then the doctor has to appeal."

It also helps to know when to bill Medicare and when to go directly to the secondary insurance or to the patient. "Medicare doesn't cover an annual checkup," Ms. Enos says. If a patient presents with a problem, the office should bill Medicare for a problem visit. If the patient is there for a check-up, this should be billed as a preventative visit, then collect payment from the secondary insurance or the patient.

Medicare Compliance Issues

Compliance is an important issue for billing Medicare. Donna

Wilson, RHIA, CCS, senior director in the consulting division of Pennsylvania-based Compliance Concepts, Inc., points out that Medicare's Correct Coding Initiative (CCI) must be followed. "Medicare has CCI edits that it puts in place where you can't use code A with code B," she says. "

Ms. Wilson, who assists providers with the Recovery Audit Contractor (RAC) initiative, recommends avoiding external audits from government agencies by being aware of the targets of investigation. The OIG's 2009 work plan details its areas of focus. For example, the OIG will review the accuracy of Medicare payments for unlisted services. It will also look into use of the modifier GY on claims used for services not covered by Medicare (thereby shifting financial responsibility to the patient). The OIG says Medicare received 53 million claims using modifier GY during 2006, with associated denied claims totaling more than \$400 million. The OIG is concerned that patients will be responsible for high medical bills without advance knowledge. Given that Medicare receives 1.2 billion claims per year from more than a million providers, it is bound to find errors. Almost all errors (96 percent) were overpayments to providers who didn't follow Medicare coding rules for coverage. This includes billing several times for one procedure or submitting (and getting paid for) duplicate claims. Around 14 percent of those claims were appealed by providers, but only 4.6 percent of those appeals were overturned. The program also found that the remaining four percent of errors were underpayment issues, and money was returned to the providers.

Medicare's pilot RAC program restored \$693.6 million to government coffers while more than \$1 billion in improper payments was discovered during investigations from 2005 to 2008. While 85 percent of the funds came from hospitals, four percent—or \$37.8 million—came from outpatient providers. The program was considered so successful that it's now permanent, expanded from a handful of states to the entire country.

The new RAC program will search back three years on Medicare claims. It will focus initially on clearly indisputable



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ing edits, says Ms. Wilson. For example, she notes that the Medicare rule for established versus new patients states that a patient is considered established if he or she has been seen within the past three years. This applies to the patient seeing any physician of the same specialty filing under the same tax ID number.

Therefore, if a patient switches from a physician at one practice location to another physician of the same specialty at a different location, he or she is still considered an established patient, even if the patient is new to a physician and a practice location.

Ms. Wilson says that governmental agencies are focusing on coding errors like these. In Florida the RAC initiative turned up \$2.5 million in overpayments for this coding error alone in an 18-month period, she says.

Still, Medicare notes that error rates declined from 14.2 percent in 1996 to 3.9 percent in 2007.