Billing and Insurances

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Introduction

Before we even get to the discussion of billing, please take note of the following recommendation. Make credentialing with insurers a priority!

The very first task you should prioritize when hired by a practice is to get credentialed with the insurance companies immediately. Your employer will likely help you navigate this tedious process, but you should make certain the job is being done efficiently and effectively. Be prepared for this to take many months. If not completed in a timely fashion, it can affect the date that you can start seeing patients.

Now on to Coding

One of the most challenging things to learn when first in practice is how to navigate medical insurers and appropriate coding. This crucial topic is not typically covered in depth during residency

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and is often learned by trial and error once in practice. That being said, if you are provided any opportunity during your residency training to obtain coding education either through your residency program or a preceptorship, take full advantage. It's a difficult and critical task to learn. You need to familiarize yourself with the codes you will be using. CPT codes, encounter codes, procedural codes, and modifier codes are just a few. What is going to make this task of learning more difficult, even for those of us who've been doing this for awhile, are the new coding changes now in effect since January 1, 2021.

So What Is a "CPT" Code?

Wikipedia says it best here:

> The Current Procedural Terminology (CPT) code set is a medical code set maintained by the American Medical Association through the CPT Editorial Panel [1]. The CPT code set (copyright protected by the AMA) describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

Simply put, insurance companies use these numbers attached to the services we provide to determine the amount of reimbursement we will be paid.

How Do You Determine the Level of CPT Code Taking into Consideration the New 2021 Coding Changes?

As of publication time of this book, the way we have been coding for the past 20 years has just changed. The new system focuses less on the components of the history and physical exam docu-

mented and will be based solely on either the time spent on the visit or the medical decision-making involved in the visit. It is imperative to familiarize yourself with this complex new system. There are many resources and recorded presentations on the subject. There are even coding calculators available.

1 Time

While previously we could code based on our time only if more than half of the visit time was spent either counseling the patient or for care coordination, we will now be able to include the total time spent on the patient on the date of the encounter. This can and should include time spent reviewing the chart, ordering and interpreting tests and lab results, writing and sending prescriptions, communicating with specialists, care coordination, and time documenting the note. Of course, this is in addition to the face-to-face time spent during the appointment. Be warned, your time pertains only to the day of service. You cannot bill for time spent the day before or after seeing the patient.

2 Medical Decision-Making or MDM

The level of medical decision-making is determined by three components:

1. The number and complexity of the problems addressed at the visit
2. The amount and complexity of the data that is reviewed and analyzed
3. The risk of complications associated with the management decisions made

Two out of three of these components must be met or exceeded for the level you are coding.

Be Cautious with EMR "Calculating" Your Encounter Code!

EMRs, can have a tendency to draw you into upcoding just by the nature of habitually clicking. In the end, if you are audited, you could face penalties unless you have the proper documentation to support your coding. This includes both time-based explanations and MDM components, as mentioned above. Keep in mind, downcoding is also considered fraud; you can face penalties for this, as well.

To Substantiate Your Coding, Consider the Following Important Concepts

Document anything and everything you discuss and examine.

If you discuss a patient's school and friends, document that in the social history. If you discuss family history, make sure to document this. If you obtain the history from someone other than the patient, be sure to document that since having an independent historian can increase your MDM level. Document everything you examine. The more you adequately document, the less likely you are to face issues if audited. Furthermore, the patient's visit is as complete as it deserves to be. In general, aim to be as complete as possible.

In your assessment, make certain to put in any ICD-10 codes that may apply to substantiate your claim and hopefully to prevent insurance costly denials, as they can be very time consuming for both you and your billing team.

For instance, if a patient has gingivostomatitis, also consider adding mouth pain, aphthous ulcers, or any other symptom a patient complains of and any physical exam findings relating to the patient's chief complaint. The insurance companies will often deny certain visits based on a code, but with multiple codes, this makes a denial more difficult. Also, it is important to document any chronic conditions that you address during a visit. For instance, if a patient came in for mouth ulcers, but you discussed their asthma control and refilled maintenance medication, be sure

to document the discussion. Not only does this provide complete care, but it also helps you bill more effectively.

Other Billing Tips to Keep in Mind

You've worked very hard to become a physician and you deserve to be compensated for your skills and expertise, no differently than any other profession! Therefore, remember the following:

1 Your Time Is Valuable!

Therefore, if you spend more than 5 minutes on the phone with a family, consider charging them for a phone consultation. If you order labs on a patient and the explanation of findings will require a lengthy discussion, consider having them follow up in the office or offer a telemed appointment. Your time and knowledge are your biggest assets!

2 Bill for Everything You Do!

One of the easiest ways to improve your billing is by coding for EVERYTHING that you do and the time you spend. Examples of procedures and codes that are often forgotten include the following:

- Nursemaids elbow reduction.
- Foreign body extraction (anything from removing a bead in the nose to a splinter in a foot is billable).
- Silver nitrate application.
- Cerumen removal.
- Specimen handling fee.
- Capillary or venous blood draw fee.
- Small-volume nebulizer treatment.
- Peak flow teaching.
- After hours and weekend/holiday hours.

- Charging for a well visit and sick visit on the same day when appropriate. This will require a separate encounter note and use of a "modifier" which for this is a 25.
- Screening tests (developmental, depression, Vanderbilts).
- Lysis of penile and labial adhesions.
- Cryotherapy.
- Drainage of subungual hematomas.
- Burn care.
- Splint placement and associated supplies.
- Tympanometry.
- Incision and drainage of anything.

Take Advantage of Your Billing Team

If you have access, spend a day or two with your billers. We both still regularly ask questions of our own teams! Have your billers notify you of any denials and then coach you through how to prevent them in the future. If your encounters are being down-coded, find out why. Your billing team is a valuable asset to your success.

Conclusions

Investing the time to learn efficient and effective coding early in your career will not only save you precious time in the short and long term, but will often increase your compensation without increasing your workload. This mission will also set up essential documentation habits that will serve you and your patients well throughout your time in practice.

References

1. CPT® Process – How a code becomes a code. Why is CPT important? 1 Mar 2016. web.archive.org/web/20160511115308/www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/cpt-process-faq/code-becomes-cpt.page.

Coding Resources

AAP Coding Newsletter.
AAP Coding Hotline- submit questions at https://coding.solutions.aap.org/ss/coding_hotline.aspx.
Coding for pediatrics 2021: A manual for pediatric documentation and payment. American Academy of Pediatrics Committee on Coding and Nomenclature, 2020.
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Pediatric office-based evaluation and management coding 2021 revisions. Elk Grove Village: American Academy of Pediatrics, 2020.