

# MEDICAL INSIDER™

## A Newsletter for Physicians Using HMA Facilities

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### USING THE INTERNET FOR PAYER PROBLEMS

As you may know, large payers use artificial intelligence software to replace expensive knowledge workers in analyzing claims, sometimes in an effort to avoid payment on any plausible grounds. It would be helpful for you to have similar knowledge workers, but in reality that does not happen in small businesses. If your people “don’t have time” to protest disappointing payments and non-payments, they do have access to some high tech tools to get more efficient—not of this on the internet

**Eligibility Checking**—Many of the tasks commonly done by phone can now be done online instead. Basic front desk tasks, such as eligibility and benefits verification, notifications and referrals, can be performed online at most payers’ websites. Larger payers like WellPoint, UnitedHealthcare, Cigna and Aetna have detailed, real-time benefit information available, helping your office to collect what’s due at the time of the visit. The service is free, and it is easy to sign up on the internet.

**Online Problem Resolution**—Make sure your billing department or staff can save time and effort by using free, online claims processing applications like:

- Claims resubmissions
- Claims status enquiries
- Remittance advice look-up
- Email problem desk access

**Payer Policies**—Other information you can access on the web to streamline practice operation includes payer policies and practices. If you know why payers are rejecting or downgrading your claims, you have the beginnings of a strategy to avoid future problems. It literally pays to be proactive. Rather than leaving a message for a rep, who may never call you back, or waiting for the vagaries of the U.S. Postal Services turnaround, train your staff to first look online. Many payers state that frequently asked questions (FAQs) pages have the ability to search for answers. Items that can be looked at under payer policies include:

- Remittance advice code descriptions, coding information and descriptions of the criteria required for authorizing payment for those services
- Searchable formularies that make it quick and easy to compare drug costs
- Provider manuals detailing contact information for denial grievances.

It is likely you will also find educational materials like demonstrations, and “template sheets” on some sites that can help train your entire staff on individual payer processes. It makes sense to take advantage of the training materials the payers develop for their own employees at these sites.

### CODING—YOUR FAVORITE ACTIVITY!

Every physician needs to know how to code and be involved in the process, at least some of the time. Coding is the language that you will need to use to get paid for what you do.

- **Do it yourself**—Ideally, most physicians should code for themselves. Only you know what you have done at the office or in complex procedures. Frankly, most practices use only a limited number of codes, and having the physicians familiar with those codes and utilizing them at the time the service is rendered makes capture of precise information more accurate.
- **Keep up with the times**—The AMA CPT is the standard of the industry for describing procedures done. Each year there are hundreds of added, deleted and revised codes. It is recommended that someone from the practice carefully review all of the changes—you may find a new billable event that you had no way to describe before. The evaluation and management codes apply to all specialties and are updated clinical examples available in the current edition. Make sure to add applicable new codes to your computer system; “Index Card Cheat Sheets” and Superbill. You and every physician in your practice should read the guidelines at the beginning of each section of the CPT Code Book each year. Even if there are no changes that apply to you, you are likely to learn something in this process and your coding skill will be refreshed.
- **Bundled Codes**—Astute coding doesn’t mean trying to cheat anyone. Separately listing services that are more accurately described by a single “global” code number is known as *unbundling*. That can lead to allegations of insurance, Medicare and or Medicaid fraud. You should pick the code or combination of codes that most accurately or simply describe the service rendered.

When in doubt about codes, consult the RBRVS Medicare Fee Schedule Values Report to look for the interpretation of services included in a code. These are published in the Federal Register and are mailed to each provider each year, or you can download the file from the CMS website.

In addition to listing the relevant values assigned each CPT code for Medicare reimbursement, you will also find a status code. *Status A* indicates the code is separately payable under the Medicare Fee Schedule. *Status B* means the service is always bundled into payment for another code. *Status P* is for codes that bundled with another service are excluded from the Medicare Fee Schedule.

### ED MEDICAL DIRECTORS AND ED NURSE MANAGERS MEETING

ED Medical Directors and ED Nurse Managers will meet in Chicago on 2/18/10 to discuss a host of patient related activities, including the development of new Chest Pain Centers & Stroke Centers. Watch for information concerning the outcomes of this particular meeting and how that may impact your respective practices. For more information contact Lynne West at [lynne.west@hma.com](mailto:lynne.west@hma.com)

**Thought for the month:** *When you work for what you get, you make a living. When you live for what you give, you make a life.*—Winston Churchill

**LET US KNOW:** Please feel free to write us with your observations, suggestions or thoughts at [Ron.Riner@hma.com](mailto:Ron.Riner@hma.com) or [riner@rinergroup.com](mailto:riner@rinergroup.com).— Ronald N. Riner, MD, Chief Medical Officer