

**Maximizing Third Party Reimbursement  
Region 8 Training**

George H.W. "Gerry" Christie  
114 Dewberry Lane  
Syracuse, NY 13219  
315-435-3685  
ghchristie@att.net

---

---

---

---

---

---

---

---

**Areas For Review**

- 1. The Importance of CPT Codes.**
- 2. Establishing Charges For Family Planning Programs**
- 3. *Billing: Third Party Payers.***

Health Policy Analysts

---

---

---

---

---

---

---

---

**Areas For Review**

- 4. *Collections: Elements of a good collection process.***
- 5. *Discussion, Questions and Answers.***

Health Policy Analysts

---

---

---

---

---

---

---

---

# Review of HCPCS/CPT Codes.

---

---

---

---

---

---

---

---

## Relationship Between Visit Types And CPT Codes

- ❖ Determine the best fit between:  
*Traditional Family Planning Visit Types and CPT Codes*
- May need initially to do a "crosswalk".

Health Policy Analysts

---

---

---

---

---

---

---

---

## Consistent Definitions of Visit Types

- ❖ The goal is to establish a list of visit types which define your family planning services in terms that medical PAYORS recognize and accept.
- ❖ Definitions of these visit types will be governed by CPT codes, not traditional Title X definitions.

Health Policy Analysts

---

---

---

---

---

---

---

---

## HCPCS

HCFA's Common Procedure Coding System

- ❖ Level 1- CPT Codes
- ❖ Level 2- National "J" codes (Drugs)
- ❖ Level 3- Local codes (WXYZ codes)

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

Current Procedure Terminology (CPT) of the American Medical Association is a listing of descriptive terms and five digit numeric identifying codes and modifiers for reporting medical services.

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

- ❖ An agency must first identify which CPT codes are relevant to the services provided by their family planning program.

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

In this session, we are only looking at:  
"Office or Other Outpatient Services",  
"Preventive Services",  
"Consultation",  
"Prolonged Services."

---

---

---

---

---

---

---

---

## What CPT Codes Should We Use?

- ❖ Evaluation and Management (E/M) Services guidelines
- ❖ Preventive Services codes for routine family planning visits.
- ❖ Other FP related services (IUD insertion/removal, diaphragm/cap fitting, insertion of Implanon, wart treatment, etc.)

---

---

---

---

---

---

---

---

## CPT Codes

- ❖ Evaluation and Management (E/M) Services guidelines are preferred for office visits (including Family Planning).
- ❖ These are generally considered as "problem focused" codes.

---

---

---

---

---

---

---

---

## CPT Codes

- ❖ While considered an objective approach to identifying services, the application of codes may vary by program and provider.
- ❖ The application of a specific code to a given set of services is a matter of the individual practitioner determining the appropriate code and the documentation in the chart.

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

The First question that must be answered before selecting a code -

Is the patient **new** or **established**?

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

**New Patients** are patients who have not received any face-to-face professional services from this clinician or another clinician of the same specialty at your practice facility within the last three-year.

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

**Established patients** have received face-to-face professional services from the clinician or practice within the last three years.

---

---

---

---

---

---

---

---

## CPT Codes

- ❖ Programs may also decide to use the **Preventive Services** codes for routine family planning visits:

**These codes are age-based for new and established clients.**

---

---

---

---

---

---

---

---

## CPT Codes

- ❖ Programs must be sure they are the primary provider for the client when using Preventive Services codes for routine family planning visits.
- ❖ **If the client is receiving primary care from another source you may not be paid if another provider has billed this code. (Usually can not re-bill for E/M.)**

---

---

---

---

---

---

---

---

## CPT Codes

The only time you can use a preventive care service with an E/M office visit code is when the patient brings up a problem during the preventive exam and you treat it.

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

You will need to add modifier – 25 for significant, separate identifiable E/M service on the same day, as another procedure.

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

- ❖ Counseling and coordination of care can increase reimbursement.
- ❖ Track how long a visit is in *real* clock time.
- ❖ Must be explained in the medical note.
- ❖ What have you done to justify an increased level?

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

Office or Other Outpatient Consultations:  
CPT Codes 99241-99245

- ❖ Risk reduction and behavior modification.
- ❖ Should be provided by person with special training or skill in the area.
- ❖ Based on clock time that must be documented in the record.

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

Prolonged Service:

With Direct Patient Contact.....99354-99357

Without Direct Patient Contact.....99358-99359

Physician Standby Services.....99360

Add ons:

After hours.....99050

Sundays & Holidays (federal ).....99054

Emergency Access.....99058

**Be Sure to understand the definitions!**

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

- ❖ Careful reading and understanding of the rules and guidelines is essential to correct E/M code assignment or validation.
- ❖ Need one volume of the “CPT Expert” coding book on site.
- ❖ See *Coding For Better Reimbursement*  
[www.medscape.com/viewarticle/449693](http://www.medscape.com/viewarticle/449693)  
(Now need a membership!)

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

- ❖ Want to code to the highest possible (**legitimate**) level.
  - Each CPT code has a dollar amount assigned to it by payers (these may vary from payer to payer).
  - Submitting codes that are not supported by documentation in the record may constitute fraud and abuse. That is: documenting a visit at one level and coding for another level, can be considered to be fraud.

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

- ❖ E/M visits can only be conducted by certain staff.
- ❖ Your goal is to provide services by “billable” providers. (When a Nurse Practitioner “walks into the room” you immediately move to the next level.)
- ❖ Satellite facilities staff may be at a lower level and the agency may miss billing opportunities.

Health Policy Analysts

---

---

---

---

---

---

---

---

## CPT Codes

On an encounter form, the E/M codes (including the Preventive codes) should be placed so they are the first section to complete.

Health Policy Analysts

---

---

---

---

---

---

---

---

# Establishing Charges for Family Planning Programs

Health Policy Analysts

---

---

---

---

---

---

---

---

## Charges

- ❖ Charges are established based on a cost analysis and are published on the fee schedule.
- ❖ Fees should reflect the “reasonable” cost of providing services in the practice.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Charges

- ❖ The program should compare their fees to the Medicaid reimbursement rate.
- ❖ The fees **MUST** be equal to, or higher than, their rates.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Charges

- ❖ You will be paid the lesser of your charge or their payment level.

**Need to update your fee structure.**

- ❖ Verify MCO (HMO) fees; Charge more than they pay (30-35% adjustment, on average).

Health Policy Analysts

---

---

---

---

---

---

---

---

## Charges

- ❖ *Medicare* fees (based on the National Physician Fee Schedule Relative Value File ) are an important standard.
- ❖ Your maximum charge should be between 125% to 150% of *Medicare* fee. (If you are at 140% of *Medicare* fee you should be ok.).

Health Policy Analysts

---

---

---

---

---

---

---

---

## Charges

Example:

Example RVU for 99203.....	\$96.79
85% of payment value.....	\$82.27
125% of payment.....	\$102.84
140% of payment.....	\$115.18

You can safely charge \$103.00 to \$115.00

Health Policy Analysts

---

---

---

---

---

---

---

---

## Charges

- ❖ Physicians and mid-level providers generate charges through entries in the record during a patient visit.
- ❖ Others *MAY* generate charges but payers have specific guidelines about how to submit claims for non-clinician charges.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Charges

- ❖ Some payers may credential non-physicians to allow charges to be submitted under their own provider number.
- ❖ Others only allow billing under a physician.

Whatever the rules, be sure that your health record documentation backs up the billing.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Charges

- ❖ *Charges should be consistent with other providers in the area.*
- ❖ *There are ways to determine if your fees are competitive.*

Health Policy Analysts

---

---

---

---

---

---

---

---

*Ingenix*

Item #: 1699  
 Edition: 2010  
 Format: Softbound  
 8.5" X 11"  
 Availability Date: IN STOCK

Your Price: \$159.95

Health Policy Analysts

---

---

---

---

---

---

---

---

---

---

## Charges

- ❖ *Need to pay attention to Profit and Loss. Programs can generate a "profit" or "Margin".*
- ❖ *Depreciation- recognizes annual value with reduction of value.*
- ❖ *Profits can fund depreciation.*

Health Policy Analysts

---

---

---

---

---

---

---

---

---

---

## Establishing Charges

***Not for profit is a tax status, not a business plan.***

Health Policy Analysts

---

---

---

---

---

---

---

---

---

---

# ***Billing***

---

---

---

---

---

---

---

---

***Billing and collection procedures must have the following characteristics:***

***Projects must bill all third parties authorized or legally obligated to pay for services.***

Health Policy Analysts Guidelines 6.3

---

---

---

---

---

---

---

---

***Ability to Bill Starts at the First Contact***

- Patient Telephone Call or Walk-in allows us to “set the stage”.

Private physicians office asks:  
“How do you intend to pay your bill”  
(This is difficult for public health programs.)

Health Policy Analysts

---

---

---

---

---

---

---

---

## Ability to Bill Starts at the First Contact

People are more compliant in providing needed information *before* they see a provider.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Billing Practices

- ❖ Be sure to bill for **ALL** the services you provide at the visit.
- ❖ Many items are overlooked, not coded, or intentionally left off the encounter form.
- ❖ Educate providers not to worry about the clients ability to pay – that is dealt with elsewhere.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Billing Practices

- ❖ Consider “economies of scale”. It may pay for two or three agencies to combine their billing departments (computers, staff, etc.).
- ❖ Consider outsourcing. Billing vendors may be cost effective. Check references! You are still liable for everything they do in your name.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Billing Practices

### ❖ Prompt Pay Discount

- Afford this to **any** entity settling account at time of service.
- This is not a reduced charge but an **adjustment** (language is critical).
- Provides “time value” to money.
- Different from financial hardship, i.e., hardship should be slightly more to encourage prompt payment.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Billing Practices

- ❖ This concept allows for the scale to go above 250% in family planning programs.
- ❖ Insurance companies are afforded the same discount **IF** they can pay at the time of service.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Billing Practices

- ❖ Coding drives the bill. ICD-9 (diagnosis codes) are tied to the CPT codes.
- Identify all diagnoses, symptoms, conditions, problems, complaints, or reason for service or procedure.
- List primary condition first, then current active conditions / issues.
- Utilize all five digits if possible; be as specific as possible.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Billing Practices

- ❖ Probable, suspected, rule out, or questionable diagnoses should not be coded until the diagnosis is confirmed.
- ❖ Ancillary diagnostic service: list diagnosis or problem initiating service First, "V" code second.

Health Policy Analysts

---

---

---

---

---

---

---

---

## ICD To CPT Linkage

- ❖ ICD- (coding guidelines can be found at:  
<http://www.cdc.gov/nchs/data/icd9/icdguide.pdf>

Health Policy Analysts

---

---

---

---

---

---

---

---

## Semantics Matter

- ❖ Case Management may be billable
- ❖ We call it Care Coordination or Enabling services

Health Policy Analysts

---

---

---

---

---

---

---

---

# Collections

---

---

---

---

---

---

---

---

- ## Collections
- ❖ The older bills are allowed to age, the less likely they are to be paid.
  - ❖ Pay attention to Accounts Receivable as soon as possible.
  - ❖ Set a time to review outstanding bills to individuals and third party providers.
- Health Policy Analysts

---

---

---

---

---

---

---

---

- ## Collections
- ❖ Verify coverage before visit and on each occasion of a visit.
  - ❖ Different plans cover different things under different circumstances for different rates.
  - ❖ Never assume Third Party rates are “cast in stone”. At least ask for a different rate, especially if you can show your costs!
- Health Policy Analysts

---

---

---

---

---

---

---

---

## Collections

- ❖ Explanation of Benefits (EOB) codes are important.
- ❖ They help us to obtain cash.
- ❖ Request the “key” (codes) from all payers with which you have a relationship.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Collections

- ❖ Rejection of bills need prompt attention.
- ❖ Being “out of network” provider is not an admirable position to be in.
- ❖ Get a contract quickly to become network provider.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Collections

- ❖ Family Planning **MUST** maintain the confidentiality of the client.
- ❖ Must be extremely careful in using a collection agency.
  - This is discouraged by Title X.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Collections

- ❖ Develop a plan to advise clients of outstanding bills.
- ❖ Place a copy in the chart and have a counselor discuss the outstanding amount at the next visit.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Collections

- ❖ While clients must not be denied because of the inability to pay, they also have an obligation to settle any outstanding bills.
- ❖ Be willing to establish **payment plans** and to re-evaluate their position on the scale.
- ❖ **DO NOT** establish barriers by only giving one pack of pills or requiring clients to return based on finances rather than sound medical practice.

Health Policy Analysts

---

---

---

---

---

---

---

---

## Collections

- ❖ Develop a business plan to increase Third Party Reimbursement.  
(See handout.)
- ❖ Helps evaluate new programs and implementation.
- ❖ Helps retool current operations.

Health Policy Analysts

---

---

---

---

---

---

---

---

Be sure that you and the payer are speaking the same language.

Health Policy Analysts

---

---

---

---

---

---

---

---

**Discussion**

---

---

---

---

---

---

---

---

Adjourn  
Please be sure to complete the evaluation.  
Thank you for attending!

George H.W. "Gerry" Christie  
ghchristie@att.net

---

---

---

---

---

---

---

---