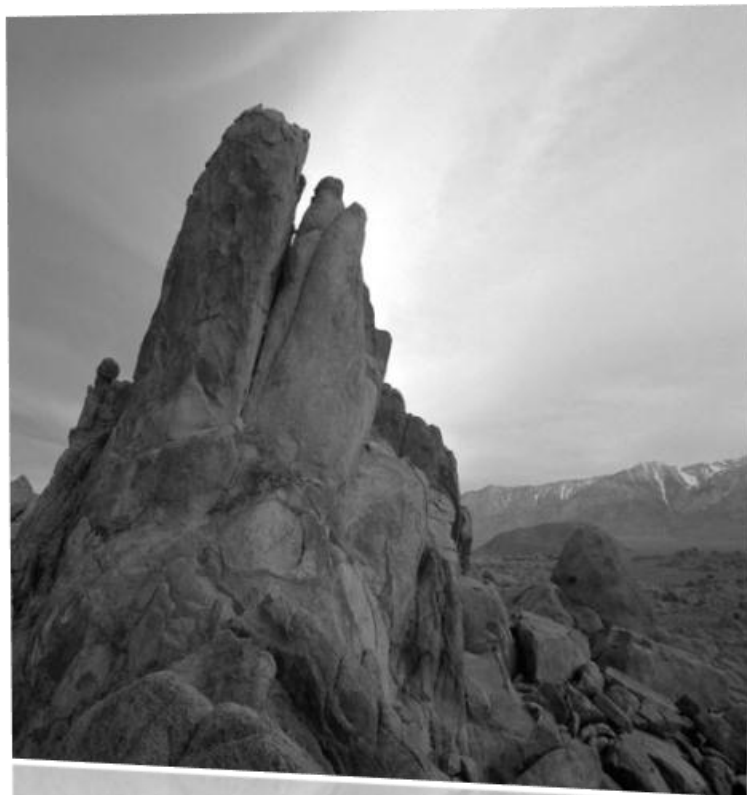




Medical Billing is a Marathon

Train for It

"I pulled a hamstring during the New York City Marathon. An hour into the race, I jumped off the couch..."-- David Letterman.



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A marathon is 26.2 miles. That is a long way! On one early December morning I was getting ready to find out just how long. Up to that moment, my longest running distance was 13.1 miles. I had completed 3 or 4 events of that distance, the most recent about 3 weeks earlier. For those unfamiliar with the “recommended” training regimen for a marathon, by race day the runner should have completed more than one training run of 20+ miles. Needless to say, I was highly under-qualified.

With that in mind, I bet you are wondering why I was there. I had to be. The person next to me, a long-time friend had completed her triathlon of breast cancer treatment (mastectomy, chemotherapy and radiation therapy).

We had “agreed” the previous year, that now that I was running, “I had to do a marathon.” Those were her words as an accomplished, previously very competitive runner. But after the “agreement”, the diagnosis came with all the subsequent associated events, so the plans to race were postponed.

Then it happened, the last piece of the treatment, the reconstruction was postponed until early the next year, but at this point the race was still not back on. She did start her training again and by a wine tasting party in mid-October, I was informed she was already back up to 9 mile runs several times a week.

I mention the wine, because aren’t all challenges entered into by good friends tied to alcohol usually somewhere along the way. I brought up the first challenge, “Then you can do the half-marathon with me in 4 weeks”. She agreed on one condition, “I will do it, but then we have to do the marathon in December”.

So now you get it, there was no way I could refuse the request of this strong, brave woman sitting in front of me. Since there was too little time to ramp up my training safely, I would be running a marathon with only 13.1 miles as my longest run under my belt.

Note: I do not recommend this approach to running a marathon under-trained. Sheer dumb luck combined with determination and encouragement took us to the finish line.

You cannot rely on any of that to expertly perform your medical billing tasks. Proper, complete and up-to-date training is crucial to ensure that you are optimizing **claim reimbursement** for the **medical practice**.

Mile Marker 0

Understanding insurance benefits, payer LCDs and medical policies

It is important to have front office staff verify benefit and coverage information for all new patients on or before their first visit. Established patients should have theirs checked once annually in case changes to the coverage have been made.

Insurance Benefits: Staff members need to understand the terms **deductible**, **co-insurance**, **co-payment**, and **out of pocket** in order to provide the patient with accurate financial responsibility information. It is important that staff understand payer authorization requirements and protocols in case the physician orders any diagnostic or other treatment type procedures.

Payer LCDs and Medical Policies: Medicare publishes **Local Coverage Determinations (LCDs)** that are guidelines which outline the payment criteria for certain procedures. For **Commercial Payers**, these same types of guidelines are typically referred to as **Medical Policies**. Staff should be instructed that review of these documents is crucial in pre-determining the “**medical necessity**” coverage of potential procedures. As these documents are periodically updated, assigning a time to check for changes is invaluable in preventing unnecessary denials.

Mile Marker 6.2

Verifying proper medical documentation

Documentation: In the world of **EHR/EMR**, there have been attempts to provide a fool-proof way of documenting a procedure. But not all systems are created equal and some may be lacking or have ways that staff can “skip” some of the requested details. Before any charges are sent off to the payer, staff should review the medical records to verify the proper codes are being submitted.

For **Evaluation and Management Services**, [CMS](#) provides an entire section of their website dedicated to these procedures. The Florida **MAC**, **FCSO**, provides a free [E/M interactive worksheet](#) so staff can properly “score” the visit and determine the code. Audits and fraud can be scary words, by careful documentation review prior to submitting charges, you will not be afraid.

Mile Marker 12.4

Knowledge of CCI edits

The Correct Coding Initiative (CCI): To understand and prevent denials that read “mutually exclusive”, a thorough knowledge of the concept of CCI edits is crucial. Medical billing software with a [built-in claim scrubber](#) can automatically identify CCI code pair conflicts. Even with this type of technology, staff should know three basic things.

Where to locate the most recent version of these edits. They are published quarterly on the Medicare portion of the [CMS](#) website.

How to read the edit tables. There are 3 columns. Columns 1 and 2 show code pairs. If codes you are considering billing show as a code pair, then in most instances they are not both reimbursed, only the code listed in column 1. If a medically indicated modifier, typically 59, can be appended to the column 2 code to “override” the edit, a “1” will show in column 3. If column 3 indicates “0”, then no modifier will “override” the automatic edit.

What is the rationale behind the edits. The code pair edit may represent two codes that should not be reported together, unless an appropriate modifier is used or may be mutually exclusive procedures that cannot reasonably be performed at the same anatomic site or same encounter. Understanding the nature of the two procedures will help staff know whether they are “mutually exclusive” or if appending a modifier is appropriate.

Mile Marker 15.5

Utilizing EDI transactions

Electronic Data Interchange (EDI) transactions: In the field of medical billing we are used to numerical identifiers for many terms. Procedures are converted to 5 digit codes. Diagnoses are indicated by alpha-numeric codes from 3 to five characters long. EDI transactions are no exception.

270/271 represents Health Care Eligibility Benefit Inquiry and Response, also known as **Real Time Eligibility (RTE)**. By utilizing RTE, you can within seconds verify the eligibility and coverage of your patient reducing time consuming phone calls to the payer.

276/277 represents Health Care Claim Status Request and Response.

278 represents Health Care Services Review Notification, utilized for requesting authorizations.

835 represents Health Care Electronic Remittance Advice, commonly referred to as **ERA**. Many ERAs can be automatically adjudicated by **the best practice management systems**, like **Iridium Suite**.

837 represents Health Care **Electronic Claims** Submission. This can virtually eliminate printing and mailing of paper claim forms. When combined with ERA, the turnaround time on claim payments can be less than 10 business days for many payers.

Mile Marker 18.6

Investigating rejections and denials

Rejections and denials: In medical billing unpaid claims typically fall into two categories, rejected or denied.

A rejection in most circumstances results from incorrect data being entered on the claim or missing data. It is a biller's responsibility when receiving a rejection notice to review the rejection message and make the appropriate changes for resubmittal. For instance, if the payer indicates the claim contained an invalid policy identification number, the biller should use all means necessary to obtain the proper information. It would not be appropriate to just write off the charge or automatically invoice the patient.

Denials are typically based on medical coverage issues, either based on the patient's policy or the payers general benefit guidelines for the denied service. This goes back to our first point above, "Understanding insurance benefits, payer LCDs and medical policies ". A patient may have hospital only benefits, but was seen for an office visit. The performed procedure is not considered medically necessary for the patient's diagnosis. Reasons for denials are numerous. A medical biller must have the skills to thoroughly research the issue and determine if the claim should be appealed before it is written off or the patient invoiced.

Mile Marker 24.8

Medical billing is a complex and varied task. You should utilize all resources available to frequently increase your knowledge base. Payer websites contain a wealth of information and by subscribing to email newsletters and bulletins; you will always be the first to know of any changes that could affect your practice.

I also recommended downloading some of our other publications like:

["Check the Vital Signs of Your Medical Practice"](#)

["Medical Office Workflow"](#)

["Understanding Explanation of Benefits"](#)

["The Journey to Understanding Medicare Billing Starts Here"](#)

Mile Marker 26.2

With the proper training, you and/or your office staff can have a great "PR" (personal record) when you are facing the great challenge of medical billing.