

Medical billing is as Tough as Keeping Score in Tennis

Love equals zero???



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I happened across Wimbledon tennis on the television. It reminded me of the brief time in my past that I attempted to learn to play tennis. When learning any new sport, there are the physical lessons that we are taught as well as the rules of the sport. Most often those physical lessons are relatively easy to grasp, but less than easy to perfect. The basic rules are usually the opposite, but I admit, I was more than slightly perplexed at the scoring system in tennis.

For those unfamiliar, I will let [Wikipedia](#) explain: "... scores from zero to three points are described as "*love*", "*fifteen*", "*thirty*", and "*forty*" respectively."

Okay, really, points 0 to 3 are not just 0 to 3? Also, 1 and 2 are worth "15" but 3 is only worth "10"? Who came up with that logic? The unusual scoring methods don't stop there, but I think I have made my point.

Well part of my point. In tennis, in life and in the world of medical billing, we are constantly faced with situations that may seem illogical or over complex without reason, but we must learn to accept them, and develop strategies to cope.



Point One (or Fifteen in Tennis)



"Referral required": The term referral in the medical world has two related but definitely distinct meanings.

In the good old days, a physician referral was when the current provider "recommended" you see a specific colleague for your condition. Dr. Kildare would say "Mrs. Jones, I believe you should see a dermatologist for that suspicious area. I would like to contact Dr. Welby over on Main Street. The nurse will give you his number." Tada, Mrs. Jones would call Dr. Welby's office, go in and have her issue addressed.

Then insurance plans developed the Managed Care model and that term referral was used to indicate the need for a written order by the primary care provider or the insurance company that granted permission for the patient to see a specialist.

Unfortunately in those early Managed Care days and even today with new enrollees, patients assume the "verbal" referral from Dr. Kildare to see Dr. Welby is what the insurance means by referral.



The typical conversation goes something like an Abbott and Costello routine:



Staff: "Welcome to Dr. Welby's office. May I have your referral please Mrs. Jones?"

Mrs. Jones: "Dr. Kildare referred me."

Staff: "I see. Is Dr. Kildare your primary care physician?"

Mrs. Jones: "Yes and he told me to see Dr. Welby."

Staff: "Did you bring your referral?"

Mrs. Jones: "I told you Dr. Kildare referred me to Dr. Welby."

Staff: "I understand, but your insurance company requires a referral for your visit?"

Mrs. Jones: "What does my insurance have to do with it? My doctor referred me here."

The best way to eliminate these types of frustrating encounters is to make sure to get complete insurance coverage information on your patient as soon as the appointment is made. If it comes to your attention that a referral is necessary, notify the patient immediately to explain the situation, you may still have the above conversation, but it won't be at your front desk with a waiting room full of patients. You can even go right to the source and contact the primary care physician's office to cut down on the turn-around time to receive the appropriate referral.



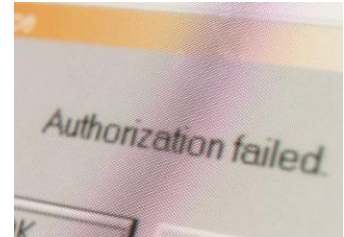
You can use the [Real Time Eligibility](#) function in [Iridium Suite Practice Management Software](#) to quickly and easily verify insurance coverage information on patients prior to visits.

Another way we often feel like our hands are tied is when we encounter the pre-authorization requirements and processes enforced by the growing number of managed care plans. We have become well aware that any procedure considered to be of a significant complexity level (cost) needs to have authorization obtained per the payer's protocols.

Some payers have even realized the effort to review the requests is so extensive that they have contracted out to third party utilization companies like MedSolutions, Availity, and Coresource. "Routine" requests are often relatively quick, but you can encounter hurdles when the provider is ordering a procedure that does not fall into the predetermined scenario set by the payer. These predetermined utilization standards are based upon the "common" accepted medical guidelines. Billers know though that we do occasionally have a patient that has one of the "special circumstances." This is when we "go to battle".



A handy tool found in [Iridium Suite Billing Software](#) is the ability to indicate when a payer requires authorization for services. When the user has this indicated on a patient account, all charges added are “scrubbed” against that requirement and the system will notify the user when the authorization is missing. This eliminates payer denials and increases your chances of quick and proper **claims reimbursement**.



Point Two (or Thirty in Tennis)

Denials

We all hate them, we try to prevent them, but despite our best efforts, they happen. One scenario as described by **Adjustment Reason Code 97** can be somewhat easily avoided.

“The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.”

This particular denial is often the result of the [National Correct Coding Initiative Edits](#). This data file contains HCPCS codes in “pair groups” that indicate the procedure listed in Column 2 is part of the more comprehensive procedure listed in Column 1.



I kind of relate this to buying a car and then also getting billed for the engine. The engine is generally included. On occasion though, maybe there is an upgrade required to the engine, this would be a separate charge.

In medical billing, when we encounter those items that are usually included but there are extenuating circumstances we are allowed for those items indicated with a “1” in the NCCI data file to add a “59” modifier and override the edit. Care must be used with this process though; the included service must be documented specifically as to why it should be considered a separate service.

How do medical billers remember what the code conflicts are and which have the potential to be overridden? The best way is to have an integrated claim scrubber in your **medical billing software**. [Iridium Suite Practice Management Software](#) contains not only all the NCCI edits, but users can request to have custom scrubber rules created that apply to the special billing situations of their practice/specialty.





Another denial often received is for duplicate of exact services, **Adjustment Reason Code 18**. Many times these are caused by simple data entry errors. Too many duplicate claim entries can cause the Accounts Receivable reports for the practice to seem inaccurate with more than the expected amount of contractual write-offs. The Iridium Suite scrubber will also notify users of duplicate code entries prior to submission to eliminate these types of issues.

Point Three (or Forty in Tennis)

Non-covered Services

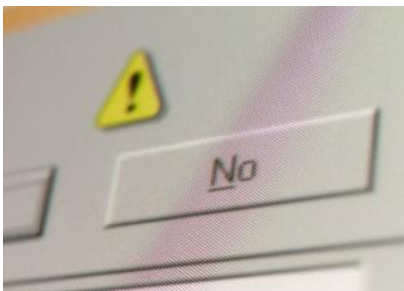
From many years of working in radiation oncology, I became all too familiar with the “non-covered service” or lack of medical necessity type of denials. Procedures that are performed but do not fall within the scope of the commercial payer’s medical policies or in the case of Medicare the **National Coverage Determinations (NCDs)** or **Local Coverage Determinations (LCDs)**.



Medical billers must have an intricate knowledge of the procedures performed in their office and the coverage exceptions for each of their payers. This often entails numerous hours of research on commercial payer websites locating and reviewing the **Medical Payment Policies** or **Coverage Guidelines**. Thankfully, CMS has a well-organized [search tool in the Medicare Coverage Database](#) that greatly facilitates finding this information for Medicare beneficiaries.



[Iridium Suite Practice Management software](#) has many advanced functions that can assist you in optimizing your workflow. Why not check it out with a [free demo](#)?



Once the research is complete, it is important to share this information with other office staff, especially those that schedule procedures. Initiate an office procedure to alert the appropriate staff when these services are planned for a patient. It is much easier to work with the situation prior to the service being rendered.

On more than one occasion, I had this conversation with the Radiation Oncologist:



Me: Sally the schedule coordinator told me you were ordering IMRT for Mr. Jones. I checked the coverage for the IMRT procedure for Mr. Jones and Medicare will not cover it for that diagnosis.

Dr.: Well, IMRT is necessary for this patient. It is the appropriate and safest treatment for his condition.

Me: If we perform this procedure, it will be denied.

Dr.: I am going to provide the best care for the patient, can we appeal it?

Me: Yes, we can appeal it, but it may still not be covered.

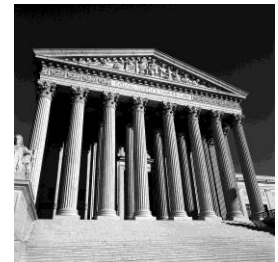
Dr.: I don't care. It's my job to help the patient and this is what he needs. If we don't get paid, that's fine.

Me: Okay, then I will need you to be very specific in your documentation that I can use for the appeal. The more details you include that justify your treatment choice will help our case.

Dr.: I will take care of the documentation.

As I predicted, the claims were denied, but because I had discussed this beforehand with my physician, the documentation was impeccable. Most of the time, the denials were overturned via the appeal process.

Commercial payers will often times allow for a pre-determination review for procedures that may fall out of the scope of the coverage guidelines. I have seen these reviews take up to 30 days, so getting it started as soon as possible is crucial and can be facilitated by that notification process mentioned earlier.



Encouraging thorough communication throughout the medical practice should be a top priority, This aids the medical billing staff in facilitating the optimum claims reimbursement for the practice.