

What surgeons should know about...

Late, partial, or denied payment or lost claims

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One of the problematic issues in practice management is the fact that payments from third-party payors are either late or partial or claims are ignored or lost. Practices report significant problems with denied payments, especially when new *Current Procedural Terminology* (CPT) or *International Classification of Diseases, 9th Edition, Clinical Modification* (ICD-9-CM) codes are introduced and payors' computers are not programmed appropriately to pay for new codes.

Timely payment of health insurance claims has become a widespread issue within the arena of medical claims processing and adjudication. Tracking claims processing and the aging of your accounts receivable are good business practices. Developing a practice compliance plan, as guidelines recently suggest, looking at the reimbursement systems within your individual practice setting—solo, small group, large group, academic, and so on—just makes good business sense.

Medical billing and claims processing are systems that are vital to the cash flow in a practice. Indeed, the problem has become so severe that there have been more and more reports of physicians taking out loans to cover their practice expenses, estimated to be about 40 to 50 percent of surgical gross production.

The purpose of this article is to provide guidance on how to react to late, partial, or denied payment or lost claims. Coding and reimbursement issues and trends often are among the topics surgeons most frequently discuss. In fact, when two or more gather and are discussing

nonclinical, socioeconomic topics, reimbursement is often at the top of the list.

Q. Why does it take so long for me to receive payment for my services?

A. No other industry contends with the problems that physicians face with receiving timely reimbursement for their work. While prompt payment laws have been enacted in 41 states to advocate for timely payment to physicians for the services and procedures they provide, at press time, nine states and the District of Columbia had not enacted prompt payment laws, but seven had legislation pending. The American College of Surgeons, along with all other medical and surgical specialty organizations, supports timely payment of medical insurance claims. State chapters are encouraged to work with their state medical societies and surgical specialty organizations to advocate for legislation requiring prompt payment. Also, chapters are encouraged to monitor their local insurance plans to be certain they are obeying their state regulations regarding prompt payment. It is important to collect data at the local level to determine which insurers are not paying claims within the timeline required under the regulation and, specifically, how late they are paying. Many of the enacted laws provide a specific timeline, such as within 30 or 45 days. Data need to be collected when these timelines are being exceeded. We also encourage surgeons to work with their state attorneys general and insurance commissioners to seek redress and collect interest payments for delayed claims.

Q. What is prompt payment?

A. Prompt payment depends on the individual interpretations of all your third-party payors, including Medicare, Medicaid, TRICARE, managed care, and other sources of revenue. A recent communication from Medicare defined prompt payment as reimbursement within 30 days of the receipt of a clean claim. Payment timelines should be addressed in your individual managed care contracts. Staff should develop a listing of these timelines, which need to be tracked by your practice administrator or billing staff. If payment should be received in 30 days, on day 31 staff should contact your provider representative on nonreceived payment. Managed care contracts should spell out interest rates for late payments.

Q. How do I begin to track my accounts receivable?

A. Some surgeons have reported that they have only recently begun to pay attention to the business side of practice. Many report that they have left the accounts receivable (A/R) to their administrative and billing staff or outside medical billing companies. If you have not been tracking your A/R, it is time to develop a system to track A/R monthly. One of the first steps is to list by month your gross charges, contractual write-offs, net receipts, total accounts receivable from insurers, the change in A/R, and the percentage A/R over 90 days. Be sure to count the aging of your A/R from the date of service, not the date you filed the claim with the insurer. Many practices bill electronically. When you have collected these data, compare months from year to year.

Q. What do you recommend for collection of copays?

A. List your top 20 procedures and known payment from your major payors. It is important to include evaluation and management codes, not just surgical procedures, in your top 20 procedures. The table on pages 10 and 11 lists the top 50 CPT codes billed to Medicare by U.S. general surgeons based on the most available 1999 national utilization data.

If not already a practice, institute a policy that patients will be asked about deductibles and copays, and that copays and deductibles will be collected at the initial visit. Staff can be trained to explain your collection policy during the first telephone encounter when they are scheduling the appointment. A brochure can be developed outlining the practice's collection policy, including your expectations for payment.

Q. Why would I receive a late or inappropriate payment?

A. It has also been reported that insurers are ignoring or losing claims, as well as down-coding or bundling payments, even when claims are filed electronically. Some billing companies have reported that up to 30 percent of claims are reported to have not been received. The College is working on a resolution to the American Medical Association for their annual meeting in June, stating that insurers cannot deny payment on lost claims when the physician has proof that the claim was filed electronically, if beyond the required filing date. This requirement is being added to some prompt payment laws.

The College also has received reports of partial or down-coded payments received from third-party payors who bank on many billing staff writing off the difference. It is also important for you and your staff to learn the appropriate use of evaluation and management codes to ensure full payment for services provided. It has been reported that surgeons give away their evaluation and management

**Top 50 CPT codes billed Medicare by United States general surgeons
(sorted by CPT code)***

Alwd chrg rank	CPT	Descriptor	1999 Medicare utilization	2001 MFS nonfac RVU	2001 MFS nonfac payment	2001 MFS facility RVU	2001 MFS facility payment
27	19120	Excision, breast lesion(s), male/female; 1+	51,271	10.22	\$391.00	9.62	\$368.04
22	19125	Excision, breast lesion, radiological marker; single	52,674	11.24	430.02	10.29	393.68
34	19162	Mastectomy, partial; w/ axillary lymphadenectomy	16,316	n/a	n/a	23.52	899.83
13	19240	Mastectomy, modified radical, w/ axillary lymph nodes	32,596	n/a	n/a	26.93	1,030.29
38	27590	Amputation, thigh, through femur, any level	15,759	n/a	n/a	25.25	966.02
32	33533	Coronary artery bypass, using arterial graft(s); single arterial graft	12,265	n/a	n/a	51.36	1,964.94
46	35081	Repair direct/false aneurysm/excision & graft insert; abdominal aorta	8,322	n/a	n/a	46.59	1,782.44
4	35301	Thromboendarterectomy, w/wo patch graft; carotid, vertebral, subclavian, neck incision	50,886	n/a	n/a	32.10	1,228.09
37	35656	Bypass graft, w/ other than vein; femoral-popliteal	11,959	n/a	n/a	33.41	1,278.20
39	36489	Placement, central venous catheter, percutaneous, > age 2	135,971	4.08	156.09	2.12	81.11
9	36533	Insertion, implantable venous access device w/wo subcutaneous reservoir	97,469	10.22	391.00	9.61	367.66
15	36830	Creation, av fistula, non-direct (sep proc); non-autogenous graft	31,156	n/a	n/a	20.91	799.98
50	36832	Revision, av fistula; w/o thrombectomy, dialysis graft (sep proc)	6,972	n/a	n/a	17.98	687.88
31	43239	Upper gi endoscopy; w/ bx, single/multiple	74,283	7.48	286.17	4.59	175.60
40	44005	Enterolysis (freeing, intestinal adhesion) (sep proc)	15,842	n/a	n/a	22.51	861.19
19	44120	Enterectomy, resection, small intestine; single resection & anastomosis	27,498	n/a	n/a	23.73	907.86
3	44140	Colectomy, partial; w/ anastomosis	61,999	n/a	n/a	29.88	1,143.15
21	44143	Colectomy, partial; w/ end colostomy & closure, distal segment	17,523	n/a	n/a	34.55	1,321.82
20	44145	Colectomy, partial; w/ coloproctostomy (low pelvic anastomosis)	18,156	n/a	n/a	37.27	1,425.88
29	44160	Colectomy w/ removal, terminal ileum & ileocolostomy	17,321	n/a	n/a	26.69	1,021.11
10	45378	Colonoscopy, flexible, proximal to splenic flexure; dx, w/wo specimens/colon decomp (sep proc)	111,971	9.95	380.67	6.26	239.50
48	45380	Colonoscopy, flexible, proximal to splenic flexure; w/ bx, single/multiple	35,885	10.58	404.77	6.75	258.24
24	45385	Colonoscopy, flexible; w/ removal, lesion, snare	44,954	13.03	498.50	8.85	338.58
1	47562	Repair, initial incisional/ventral hernia; reducible	34,411	n/a	n/a	16.57	633.94
5	47563	Renal allotransplantation, implantation, graft; w/o donor & recipient nephrectomy	5,621	n/a	n/a	54.44	2,082.77
26	47600	Laparoscopy, surgical; cholecystectomy	108,506	n/a	n/a	18.17	695.15
6	49505	Laparoscopy, surgical; cholecystectomy w/ cholangiography	61,416	n/a	n/a	19.59	749.48
23	49560	Cholecystectomy	32,989	n/a	n/a	19.24	736.09
43	50360	Repair, initial inguinal hernia, age 5+ ; reducible	91,157	11.49	439.59	11.16	426.96
28	93880	Duplex scan, extracranial arteries; complete bilat study	191,014	4.94	189.00	4.94	189.00
36	99203	Office outpatient visit, new patient, level 3	165,108	2.39	91.44	1.87	71.54

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Alwd chrg rank	CPT	Descriptor	1999 Medicare utilization	2001 MFS nonfac RVU	2001 MFS nonfac payment	2001 MFS facility RVU	2001 MFS facility payment
45	99204	Office outpatient visit, new patient, level 3	92,639	3.47	132.76	2.76	105.59
7	99212	Office outpatient visit, established patient, level 2	1,183,492	0.94	35.96	0.64	24.49
2	99213	Office outpatient visit, established patient, level 3	1,529,634	1.32	50.50	0.93	35.58
8	99214	Office outpatient visit, established patient, level 4	527,768	2.06	78.81	1.51	57.77
47	99215	Office outpatient visit, established patient, level 5	101,286	3.06	117.07	2.43	92.97
44	99222	Initial hospital care, level 2	90,372	n/a	n/a	3.07	117.45
35	99223	Initial hospital care, level 3	82,498	n/a	n/a	4.20	160.68
16	99231	Subsequent hospital care, level 1	648,925	n/a	n/a	0.94	35.96
12	99232	Subsequent hospital care, level 2	495,211	n/a	n/a	1.50	57.39
33	99233	Subsequent hospital care, level 3	164,785	n/a	n/a	2.13	81.49
25	99242	Office consultation, level 2	214,672	2.34	\$89.52	1.85	70.78
11	99243	Office consultation, level 3	280,438	3.09	118.22	2.46	94.11
17	99244	Office consultation, level 4	156,487	4.38	167.57	3.61	138.11
42	99245	Office consultation, level 5	55,851	5.73	219.22	4.79	183.26
41	99252	Initial inpatient consultation, level 2	143,282	n/a	n/a	2.03	77.66
18	99253	Initial inpatient consultation, level 3	221,853	n/a	n/a	2.74	104.83
14	99254	Initial inpatient consultation, level 4	171,043	n/a	n/a	3.88	148.44
30	99255	Initial inpatient consultation, level 5	71,432	n/a	n/a	5.31	203.15
49	99291	Critical care, evaluation & management, first 30-74 minutes	43,486	5.71	218.45	5.52	211.18

*All specific references to CPT terminology and phraseology are: CPT only © 2000 American Medical Association. All rights reserved.

charges. It is also important to learn the appropriate use of modifiers that are now all listed in Appendix A of the CPT book. Previously, modifiers were listed in the E/M section and surgery section of the CPT book. Make sure that your staff appends E/M modifiers to E/M codes, and surgical modifiers to surgical codes. Using modifiers with the incorrect codes will result in denials.

Q. Insurers are complaining that nearly half of the claims they receive are coded incorrectly. What is a “clean” claim?

A. The College has heard that complaint as well. Medicare defines a clean claim as one that has no defect or impropriety (including any lack of any required substantiating documenta-

tion) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim (Section 1842(c)(2) of the Social Security Act). Many individuals believe this definition gives the payors too much flexibility. It is important that claims are completed properly with all identifying information, including appropriate ICD-9-CM diagnostic codes and CPT procedural codes with correct use of modifiers to ensure payment. It is important to provide training for staff regarding any changes related to coding and to monitor their performance for accurate and full completion of medical claim forms. Training and education are part of any practice compliance plan. For example, when Y2K problems were a concern, many insurers required reporting years with four digits, instead of only the last two. Billers need to

be trained and monitored on this and all changes that affect submission of clean claims.

Train staff to update patient information frequently and to request copies of current insurance cards. For instance, the College's staff health insurance plan recently changed the policy number, which, if not given to physician billing staff, could result in denied claims and delayed payment of four to six weeks. Some practices submit claims electronically to clearinghouses, which use scrubber software that return incomplete claims for missing information before they are filed. If you are still filing paper claims, you may be facing several weeks of delayed payment for denied claims. Also, with multiple procedures performed on the same day, the simple selection of a wrong modifier would delay payment for the entire claim, not just the procedure involved.

Q. After doing all the right tracking of medical claims in your practice, you notice certain trends among various insurers. What should you do?

A. The first thing to do with a partial payment, payment that the insurer has down-coded, or a denied claim is to appeal it, following the insurer's process for doing so. It is important to track that your staff or your billing company is not just writing off partial payments or inappropriately denied claims. For late or lost claims, communicate the trend to your national, regional, local, and state medical associations. Discuss trends at your chapter meetings to alert colleagues of your findings. It never hurts to designate a delegation to meet with a local carrier, with substantiating sample Explanation of Benefit (EOB) forms, when trends are identified. If you hear of some new coding practice in the doctor's lounge, check it out before you adopt an inappropriate or a fraudulent coding practice.

For lost and late payments or other improper

insurer policies, Fellows and their practice staff should contact their state department of insurance. The National Association of Insurance Commissioners, which is the organization of insurance regulators for the 50 U.S. states, the District of Columbia, and the four U.S. territories, oversees the \$900 billion insurance industry. Their Web site provides a listing of the state commissioners: <http://naic.org>.

Q. Medicare's Carrier Advisory Committee (CAC) meetings are held quarterly at the state level. I understand that the College is taking a proactive role in meeting with surgical CAC representatives. What can CAC representatives do?

A. Your state surgical representatives to Medicare's Carrier Advisory Committees meet with the state Medicare medical director and staff who work on coverage issues. CACs are mandated to work on coverage issues at the local level. The College has identified and met with many of the state surgical CAC representatives. However, with some representatives changing yearly, we are having difficulty keeping a current list to invite them to meetings. Please keep us informed of your current CAC representatives.

A College meeting of surgical CAC representatives is planned for October 7, so these representatives may meet and discuss issues of importance to surgeons. We have been tracking problems in some states with payment of preoperative consultations, ultrasounds, and assistants at surgery.

Q. How can the College assist Fellows with coding and reimbursement issues?

A. The College's Health Policy and Advocacy Department has as one of our primary goals to assist surgeons and their practices with

all practice management issues, including prompt payment. The College supports a CPT coding hotline (1-800/ACS-7911), and sponsors coding workshops throughout the year (for a list of locations visit the department's Web page at www.facs.org). We are also evaluating our practice management assistance to Fellows and their staffs and welcome your input.

The College has actively promoted correct coding by providing the coding hotline and workshops to assist Fellows and their staffs. This College-sponsored training and education program promotes submission of clean claims with the ultimate goal of ensuring that surgeons receive appropriate reimbursement for the procedures and services they provide. At a recent coding program, a participant stated that he has been under-coding excisions and repairs. He left the program stating that the College program saved his larger practice at least a half-million dollars! In addition, the College's *Bulletin* has a column, "Socioeconomic tips of the month," which addresses coding questions and practice management issues.

The College, as an umbrella organization for all surgeons, works closely with the other national surgical associations on coding and reimbursement issues. As explained in previous issues of the *Bulletin*, the College has organized and convened meetings with national insurers. We have met with the national Blues association and with CIGNA. We plan to meet with other insurers. In order to make the most of our visits, we need *one* sample of repeatedly denied claims, the EOB, and any correspondence related to having the claim paid.

Additionally, the College discussed the planned 2002 *Study on Physicians as Assistants at Surgery* at the March Surgical Specialty Society meeting to begin preparation for the study. The College receives reports that the 1999 study has been helpful in reversing denials for physicians as assistants for surgical procedures.

Further, the HPA Department has a State Af-

fairs Associate who tracks and monitors state legislation and periodically publishes health policy briefs on timely topics that are distributed to the College leadership; they are available on the College's Web site under HPA departmental publications. A *Health Policy Brief* was published on timely payment of health insurance claims. Contact Jon Sutton at jsutton@facs.org or 312/202-5358 for additional information.

The Health Policy and Advocacy Department stands ready to assist Fellows and their staffs with coding and reimbursement issues. Prompt payment of medical claims is the lifeblood of the surgical practices that are owned and operated by the Fellows we serve. 