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THE OFFICE

Ten Things I Wish I'd Learned in Residency

Do you ever wish your residency years prepped you better for managing the business side of your practice? It's critical to learn how to get paid for what we do, yet my experience in residency provided little preparation for doing just that. Here are a few tips I wish I had learned back in residency and that I think are important to pass along to the residents who I teach:

1. Always read your mail. Delegating this task to an office manager means you're out of the loop when it comes to knowing the trends occurring with your explanations of benefits and denials for payment. It's important to know what you are—and are not—getting paid for. Don't assume that if you bill for a service, you'll get paid for it. And don't assume that the amount you bill always covers your own costs. Manufacturers of vaccines and devices can change their charges on a dime, and that can eat into your margin if you're not paying attention. If you can't find the time to read your mail, train someone on your staff to push the information to you.

2. Develop solid relationships with patients. Medicare patients are constantly receiving reminders in the mail to report cases of fraud. Although absolutely no one should ever take advantage of these patients, sometimes they feel they are being taken advantage of due to miscommunication. A Medicare patient of mine recently called to question why I had billed for tobacco cessation, since she believed our discussion about her plans to quit smoking was just part of being a good doctor. I was relieved to be given the opportunity to explain to her that it was a legitimate claim, given that Medicare now reimburses physicians for providing such counseling. Not all your patients are going to like you. The aim is to develop an open relationship so they feel that they can come to you first if they have a question about their bill.

3. Be complete on review of systems. In cases of audit, inadequate review of systems (ROS) is the leading reason for physicians to write checks back to insurance companies. If you're doing the work of an ROS for a higher level of visit, make sure that you're documenting that fact. With any code, you need to at least spell out the pertinent ROS to justify payment.

4. Understand the difference between 99213 and 99214. Over the course of a year, the cumulative difference between billing for a level-3 visit versus a level-4 visit can be huge. Unfortunately, because residents are not allowed to bill above a 99213, they never really become used to doing the expanded documentation required for a 99214. And that's what they stick to once they are in practice, even when they are doing the work of a 99214.

5. Learn how to code based on time in situations that warrant it. Family physicians in particular manage patients who may not always involve a high level of complexity but who do require a lot of time. The patient who has just been diagnosed with diabetes or the patient with depression, for example, both require considerable counseling time. To get paid for that time, you need to document that you spent at least 50% of the visit counseling and educating these patients on issues related to their diagnosis.

6. Remember consultation codes are a thing of the past. Learn how to add AI modifiers if you are the principal provider or consultant for a Medicare patient. AI modifiers help explain to Medicare how there can be two codes for the same patient on the same day. They explain who is the principal provider and who is the consultant on the case, and if you don't use them your claim may be denied.

7. Use tobacco cessation counseling codes when appropriate. Codes 99406 and 99407 have been around since 2005, but a lot of physicians still aren't using them. In a patient with a disease or condition affected by tobacco use, these

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UnitedHealth Group Owes Doctors $350 Million

BY MARY ELLEN SCHNEIDER

Check your mailbox. If you provided covered out-of-network services to patients insured by UnitedHealth Group between March 1994 and November 2009, you may be eligible to receive payments as part of a $350 million settlement reached last year.

The $350 million settlement comes after a nearly decade-long legal battle between UnitedHealth Group and several plaintiffs, including the American Medical Association, the Medical Society of the State of New York, and the Missouri State Medical Association. The groups alleged that UnitedHealth Group conspired to systematically underpay physicians for out-of-network medical services by using an industry database of charges to justify lower reimbursements.

Last year, UnitedHealth Group reached a settlement with New York State Attorney General Andrew Cuomo to discontinue use of the database, and the company committed $50 million to fund the development of a new, independent database that will determine the rates paid for out-of-network care.

In a separate settlement, the company agreed to pay $350 million to reimburse health plan members and out-of-network providers who were underpaid as a result of the flawed database calculations.

Physicians and patients have until July 27, 2010, to opt out of the settlement. Claims for payments from the settlement fund are due by Oct. 5, 2010.

To be eligible to receive part of the settlement, physicians must have provided covered out-of-network services or supplies between March 15, 1994, and Nov. 18, 2009, to patients covered by a health plan that was either administered or insured by UnitedHealthcare, Oxford Health Plans, Metropolitan Life Insurance Companies, American Airlines, or one of their affiliates. In addition, in order to be eligible, physicians must have been given an assignment by the patient to bill the health plan.

Physicians billed via an assignment if they received a payment directly from the health plan, if they completed box 13 on the HCFA/CMS 1500 form, or if they marked yes in the benefits assignment indicator on an electronic health care claim, according to the AMA. ■

For more information, contact the Berdon Claims Administration LLC at 800-443-1073 or unitedhealthcare@berdonclaimsllc.com.

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codes allow reimbursement for smoking cessation counseling for two quit attempts per patient during the year, and coverage is for four counseling interactions for each quit attempt. For 99406, the physician must document 3-10 minutes of counseling per interaction; for 99407, more than 10 minutes of counseling must be documented.

8. Use all the codes for diabetic foot exams and care. Physicians can bill for an initial foot exam for loss of protective sensation, or LOPS (G0245), as well as a follow-up exam code for LOPS at subsequent visits. In addition to the LOPS code, the code for routine foot care (G0247) can be used if you address the causes of LOPS, by shaving calluses, for example.

9. Keep au courant. Even if you think you know all there is to know about coding, take a coding class every now and then because things change. I pay very close attention to coding and I still find myself looking up the rules and coding changes.

10. Count your time for home health or hospice care plan certification and recertification. If you spend 30 minutes every month reviewing the care plan for a patient in home health or hospice, you can bill for that. A lot of home heath care companies have cheat sheets to help you keep track of your time. Reviewing a new care plan can be coded as G0180. Recertification of the care plan after 60 days can be coded as G0179. ■

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