Defensive Management Strategies for Dermatology Billing and Coding

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The military strategies of Sun Tzu have been used by many world armies as well as several Fortune 500 corporations. He used a defensive philosophy; instead of directly attacking his enemies, he concentrated on improving the weaknesses in his own defenses. Time and time again, Sun Tzu proved that even the largest opponents cannot penetrate a strong defense. There are many ways for you, as a dermatologist, to strengthen your dermatology practice's defenses against big "opponents" such as Medicare and other insurance companies, which in turn will provide protection against the scrutiny of an audit. Strong defenses also will assure that you have proper documentation to support and appeal your charges if an insurance company denies your claims. When you begin to evaluate your management processes, you will be able to improve your revenue cycles by developing a greater understanding of the appropriate methods of communicating your charges to insurance companies while ensuring their payments for services are timely and appropriate.

This article will discuss 4 defensive management strategies for dermatology billers and coders to use to help you identify any billing, coding, or documentation weaknesses in your practice before your opponents.

Know Your Profile

Medicare and other commercial insurance payers utilize a benchmark profile or bell curve to monitor the way your health care providers are billing evaluation and management (E/M) services and compare it to other dermatology practices. Insurance companies know what to expect when looking at levels of service by specialty. They are counting your use of Current Procedural Terminology (CPT) codes 99201 to 99215, and auditors will see red flags if a practice's billing levels are either too low (a quality assurance issue) or too high (a compliance issue).

To get an idea of your practice's benchmark profile, run a report of all CPT E/M codes for a full calendar year and then calculate the percentage of each level in comparison to your total annual visit count. It also is helpful to run this report for each individual provider within your practice, which will indicate any variation within the practice.

The Table represents benchmarks in dermatology based on published profiles for fiscal year 2010.[1] Whether you are above or below the standard levels, a medical record audit is absolutely necessary to establish how your documentation correlates to the charge. If you are above the national levels of service, you must be sure that you are capturing all the necessary elements of documentation, including medical necessity, for a high-level evaluation and management service. If you are below the standard levels, you could be losing precious revenue. Again, a sample audit would illustrate when more extensive services may be needed, which will help you to train your providers on coding guidelines.

If your practice falls within these benchmarks, your profile probably is not attracting any attention from insurance companies; however, you should continue to monitor levels for both the practice and the providers to be sure this profile is maintained. You should have a formal compliance program in place that educates and audits your providers on a periodic basis.

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Dermatology Benchmarks

CPT Code (Description)	Medicare Curve
99201 (new patient visit, problem focused)	10%
99202 (new patient visit, expanded problem focused)	45%
99203 (new patient visit, detailed)	40%
99204 (new patient visit, complete/moderate complexity)	5%
99205 (new patient visit, complete/high complexity)	<1%
99212 (established patient visit, problem focused)	30%
99213 (established patient visit, expanded problem focused)	60%
99214 (established patient visit, detailed)	10%
99215 (established patient visit, complete)	<1%

Abbreviation: CPT, Current Procedural Terminology.

Data from Harper.[1]

Design an Audit Process

Audit a random number of your medical records from each level of service. Use the E/M score sheets available on the Centers for Medicare and Medicaid Services Web site (http://www.cms.gov/Medicare/Medicare.html) to count elements of the history, physical, and medical decision-making process. These score sheets can help your staff standardize coding processes and also can be used as educational tools to help your providers understand what is required when choosing or justifying services that are charged. Based on your benchmark, pull medical records from each level of service and from each provider to evaluate if the necessary elements are documented to achieve the level of service that was charged.

The US Office of the Inspector General expects every medical practice to have a compliance program in place that institutes education, monitoring, and penalization of any providers who do not adhere to national documentation and billing guidelines. As part of this program, you should take steps to design an audit process that is carried out every month to assure that providers and coders are consistent in their documentation of submitted charges. You also should have an outside auditor review your records at least once per year.

Be sure to institute a provider education process. Medicare expects providers to know what documentation is required for all charges submitted, and it is not fair to audit your providers if they have never been instructed on what is required.

Establish and Enforce Viable Payment Policies

Your accounts receivable (A/R) are broken down into 2 categories: the amount owed to you by the patient and the amount owed to you by third-party payers. It is essential that you keep a close eye on both.

Patient Responsibility

Policies on balances for patients should be set prior to providing services and should be communicated to your patients so they understand your expectations once a balance is issued. Co-pays should be collected at the time of registration. Take full advantage of multipayer Web sites such as Availity (http://www.availity.com) that have real-time information on patient deductibles so they also can be collected at the time of service.

It also is important to have a written payment policy that can be distributed to patients to inform them of their responsibilities. For cosmetic procedures and services, collect a credit card deposit when the appointment is scheduled and then collect the remainder of the balance when they arrive for their appointment. For medical services, you may want to allow your patients the courtesy of a payment plan; however, it must be communicated that your practice will not allow a personal bill to go unpaid beyond a reasonable time period. It is not recommended to let any personal balance go beyond 90 days. Even if the patient is making monthly payments, the administrative costs of producing statements adds up quickly. If you effectively communicate your practice's policies to patients, they will be prepared to meet your expectations and handle payments appropriately.

When personal balances exceed the time frame you established (eg, 2 or 3 months), do not hesitate to turn

these accounts over to your collection agency. You fulfilled your end of the bargain by providing medical care, and patients should understand that they will be held responsible for outstanding payments.

Third-Party Responsibility

When handling balances for insurance companies, there are several guidelines to follow. Your month-end reports should include an A/R summary that shows your total A/R broken down by insurance company and how long the charge has been in your system, which usually is set up as 30, 60, or 90 days. Your total A/R should not exceed 2 months' production; for example, if the total charges for 1 month equal $100,000, then the total A/R should not exceed $200,000.

You must call the insurance company for all claims that are more than 30 days old to see if further information is required and determine when you can expect payment. Keep in mind that most states have quick-pay policies under which it is mandatory that carriers either pay or deny a claim or request additional information that is needed for processing. Most contracts with insurance companies define the time frame that applies to payment of claims. If a specific payer continues to violate either state laws or contractual obligations, make a formal complaint to the insurance company contract representative for a contract breech. If one of your payers continues to delay payment of claims, confirm your state's prompt-pay requirements and file a complaint to your state's Department of Insurance. Direct your complaints to the Commissioner of Insurance, which can be found online (http://www.naic.org/state_web_map.htm). Time is money and you cannot allow carriers to delay your payments

Develop a Strong Appeals Process

Denied claims should be appealed. If you are sure your documentation supports the claim, do not be intimidated by an initial denial or sometimes even a second-level denial. Usually you can find information on your appeal rights on the explanation of benefits (EOB) for an initial denial. For Medicare, these initial appeals are known as redeterminations. If the outcome of the redetermination process is unsatisfactory, you can request a second-level review called a reconsideration; if you still are not satisfied with the results, you can proceed to have your case heard by an administrative law judge. Most insurance companies have similar levels of appeals. Although appeals can be tricky and time consuming, mastering the process is paramount for ensuring appropriate payment. Insurance companies do not always interpret their own policies accurately. If you arm yourself with the proper appeals tools, you can easily and effortlessly defend your charges.

It is important to know your top 5 insurance companies and identify the top 10 to 15 codes that you usually submit to them. Your practice management software will be able to sort this information for you. Learn all payment policies for these insurance companies and their procedures.

Most medical necessity denials from your Medicare carrier are determined by the local carriers; therefore, you must visit your Medicare carrier's Web site for specific information regarding the diagnostic requirements of the services that were denied. Other insurance companies include payment policies on their Web sites. Finding these policies may be time consuming if you are not familiar with the Web site, but do not give up. Call the insurance company's customer service line for help navigating the Web site or to request a billing manual.

Be sure to consult the EOB for each appeal you plan to write, which is essential to the success of the appeal but also to know if you have appeal rights. Medicare and other electronic commercial payers often will use the denial code MA130, which indicates the claim was incomplete and/or invalid. You cannot appeal this type of claim; you must correct the information and resubmit it. All other denial reasons are appealable. It is important to understand the insurance company's appeal process, including the time frame for appeals and how the appeal should be submitted (ie, submit online, complete special forms).

It is essential to provide all of the appropriate materials to support your appeal, including the original EOB, an appeals request form that is specific to the insurance company, a letter stating the rationale for your appeal (eg, separate lesions, a different diagnosis, medical necessity), and documentation (ie, medical record notes, biopsy reports, E/M score sheets) that supports your coding choices.

After sending the appeal, call the insurance company within 10 days to verify that all of the necessary materials have been received. Although most insurance companies advise that it will take at least 30 days to receive a response, it can be frustrating to wait this long only to find out they never got your appeal. If the information is received in a timely manner, hopefully the claim will be paid before you have to call at the 30-day mark. Be sure to confirm the mailing address and/or seek a specific contact to direct a fax if the company does not receive

your appeal. Also ask for a tentative date for completion of reviewing the appeal and follow-up if you do not receive a reply by the date given to you.

Summary

Sun Tzu's philosophy is true even for dermatology practices; improving weaknesses can make a team stronger. For medical billing and coding, the practice's vitality is dependent on finding weaknesses and correcting them.

Reference

1. Harper S. E/M benchmarking: strategies to minimize your audit risk. *AAPC Coding Edge*. May 2012:46-47. ■