Nickels and Dimes Can Add Up to Real Money

BY HEIDI SPLETE
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ORLANDO — Pediatricians have a reputation for being generous in caring for—and about—their patients. But that doesn't mean they should cut corners on coding, said Charles Scott, M.D., a pediatrician in private practice in Medford, N.J.

Pediatricians should be coding for every service that is done, Dr. Scott said at a meeting sponsored by the American Academy of Pediatrics. "Don't apologize for the care you have rendered on the child's behalf."

Shrinking third-party payments, along with increasing expenses, more paperwork, and less patient appreciation, all eat into a pediatrician's pockets at the end of the day, and it's important to find legitimate ways to generate revenue, preferably without adding office personnel, Dr. Scott said.

"Those nickels and dimes add up," he said. "Insurers won't allow us to pass our costs on to consumers, so accurate and thorough billing is essential to help your practice survive and thrive."

Principles that can help manage costs and maximize payments in pediatric practice include avoiding freebies—such as "just taking a peek" at the second child—and avoiding professional courtesy with respect to copays. Physicians should also use additional codes when appropriate, such as those for visits after hours and on Sundays.

In addition, collecting copayments; charging for emergency visits; splinting and strapping supplies; and charging to complete forms for school, camp, or day care can make a significant difference in the bottom line.

"The small charges that some people forget can really add to your bottom line," Dr. Scott said.

The insurance companies, unlike physicians, aren't concerned about the costs of operating a practice, so the challenge for doctors is to find innovative, ethical ways to generate revenue, Dr. Scott said. By being diligent about coding, as well as adding a few procedures, a physician can keep work exciting and generate extra revenue without increasing overhead costs, Dr. Scott added. He noted some small charges that can add up to big money:

► **Don't leave any copayments on the table.** Every patient has to pay, including those who are fellow physicians. Collect the copayments prior to the visit.

► **Charge for second-child tagalongs.** If a parent asks you to take a look at a second child, register the patient, collect the copay, conduct a thorough and appropriate evaluation, and bill for the visit.

► **Don't offer professional courtesies.** Most colleagues will take their kids to a pediatrician. But it's illegal to charge only the amount that the insurance will pay. You can't write off copays as a professional courtesy—that's considered fraud.

► **Remember the copayment usually is higher for the emergency department than for the office visit.** Tell patients that. And if the insurance won't pay for the relatively lower office charge plus the emergency code, remind the insurer that you saved them money by preventing an ED visit—something you won't do in the future should one of their plan's patients call again. Further, let the patient know that the insurer doesn't want you to see them if there should be an emergency in the future. Let the patient yell at the insurer for lack of recognition of a code that benefits all parties.

Events that constitute office emergencies include lacerations, respiratory distress, seizures, trauma, parents rushing in to demand an appointment, and a child who needs an immediate evaluation before a specialist's office closes. These deserve an additional premium for your immediate availability for that emergency.

► **Consider simultaneous sick and well exams.** There's no question that you can find some additional diagnosis at every well-child visit. It is rare that a child comes in who is 100% healthy. To code for a sick visit at the same time, the other diagnosis has to have taken more of your time than the well visit alone would have taken. Simultaneous sick and well exams don't always take much more time than a simple checkup, and you can code for the extra work. However, it has to be reasonable to spend time this way, and sometimes a separate second visit is the better bet when an insurer is intransigent.

For example, if a child comes in for a well visit and you identify an illness such as otitis media, writing a prescription takes time. You can use codes for both sick and well exams simultaneously. You can use the –25 modifier to identify that the "sick visit" part of the examination was separate.

In another example, if a child comes in for a well visit, and you want to talk in depth about an issue that arises, spend the time to do so if you prefer—but also code for that time. Alternatively, reschedule a separate visit to discuss the specific problem—such as school issues, bed-wetting, or attention-deficit hyperactivity disorder—and use a higher-level E/M (evaluation and management) code for that second visit.

► **Bill for supplies.** Consider relying on parents' good will and ask them to replace the item used, such as an ace bandage, sling, crutches, or a splint. But check the Health Care Financing Administration's Common Procedural Coding System for the codes to use if you need to bill for supplies you have purchased.

► **Charge for filling out forms.** Consider setting a fee, posted in your office, to fill out forms for camp, school sports, and day care centers. Collect this fee up front.

► **When dealing with insurance companies, try to speak with a pediatric medical director.** He or she may be more responsive to a pediatrician's issues, but remember that the insurance companies can do whatever they want. They can even pay two different doctors different amounts for the same service.

The process of deciding which code is the most appropriate depends on several factors. Complex or chronic conditions that take more time, such as checkups for premature infants, should have some expectation of added E/M codes.

The bottom line is that pediatrics is a business as well as a calling, and you need to stay in business to help patients, Dr. Scott said. Do not apologize for fees, he added, saying it makes sense—and cents—to charge appropriately for services given. ■

Know the Codes

Telephone Time	
Simple/brief calls	99371
Intermediate calls	99372
Complex/lengthy calls	99373
Valuable Office Visits	
After regular hours	99050
After 10 p.m.	99052
Sundays/holidays	99054
Emergencies/"walk-ins"	99058
Vaccine Administration	
Patient <8 years, physician advising family about vaccine	90465-6
Patient seen only by nurse (or ≥8 years old)	90471-3
Some Routine Items	
Vision screen	99173
Finger stick (add to Hemoglobin 85018)	36416
Venipuncture	36415
Audiometry	92551-2
Peak flow measurement	No code*
Specimen handling	99000
Other nurse visit:	
Patient seen only by nurse	99211
Physician is involved	99212 (or higher)
Preventive visits	99381-5, 99391-5
Items Not to Be Bundled	
Urine dip	81002
Hemoglobin measurement	85018
Hemoccult test	82270
Nosebleed control (any method)	30901
Often Forgotten Procedures	
Lysis of penile adhesions	54450
Lysis of labial adhesions	56441
Splinter removal	10120
Incision and drainage	10060
Incision and drainage (hematoma)	10160
Cerumen removal	69210
Silver nitrate application to granuloma	17250
Asthma inhaler/nebulizer demonstration	94664
Multiple Procedures	
Use the following modifiers with the appropriate codes:	
Bilateral procedures	modifier –50
Multiple procedures	modifier –51
Repeat procedures	modifier –76
Splinting and Strapping	
Strap codes depend on the location of the injury:	
Upper extremities	29105-29280
Lower extremities	29505-29590
Application of short arm splint	29125
Application of finger splint	29130
Strapping finger or hand	29280
Strapping knee (ace bandage)	29530
Strapping ankle/foot	29540
Strapping toes	29550

*Consider higher level of service.

Source: Dr. Scott

Pay-for-Performance Shortfalls

WASHINGTON — The much talked about "pay-for-performance" style of reimbursement system is still largely untested and is not designed to reap cost savings, "particularly since most of the quality measures it targets are measures of underuse," Meredith B. Rosenthal, Ph.D., of Harvard School of Public Health, Boston, said during testimony before a subcommittee of the House Committee on Education and the Workforce.

In addition, there is little guidance in the literature for purchasers and health plans to reference when they set out to design pay-for-performance programs.

Coordination among payers in using these measures is needed, she said. "If only a few of the many payers that a provider contracts with are paying for performance, or if each payer focuses on a different measure set, the effects of pay for performance may be dulled." She suggested that Congress fund more research by the Agency for Healthcare Research and Quality to identify approaches that would improve this method's cost-effectiveness and increase the likely gains in quality of care.

—Jennifer Silverman