What Every Doctor Billing for Services Should Know:

Tips For More Effective Billing

✓ **Documentation is the key to payment and the means to survive any audit.**
Always include some notation of everything you've done. Although using a SOAP format or the equivalent is best for office notes, if you choose not to do that, be sure you have some written records of the clinical examination and what was done.
Include all separate parts to a surgical procedure. For example, during ENT procedures where a single nerve, e.g. the facial nerve, is at risk, be sure to detail the setup for the nerve monitoring (CPT code 95867) as well as the intraoperative nerve monitoring (CPT code 95920) done throughout the procedure. This can be accomplished in three sentences:
A baseline electrophysiologic study (CPT 95867) was performed after placing the needle electrodes in the muscles around the eyes and mouth and the ground electrodes into the subcu layer of the chest. Each electrode was then tested to be sure the monitoring equipment was working. The facial nerve was then monitored (CPT 95920) throughout the surgery for a total time of x hours.

✓ **Time is of the essence! Watch your appeal dates carefully.**
Meritorious claims appealed even one day late will not be considered. The time for subsequent appeals can be very short. Most insurance companies write their time limit for appeals directly on the EOB.

✓ **The documentation required for payment of CPT codes can be short.**
In order to get paid you have to spell out what you did and why you did it, but the documentation itself does not need to be tedious. Make sure there is some written evidence of everything you did.

✓ **Read and understand the claim denial reasons; many are easily curable for that claim or the next.**
Most insurance companies are required to provide intelligible reasons for denying a procedure. If you have an EOB that does not explain why you did not receive payment, contact the insurance company. If they do not/will not give you a satisfactory response, call our office.

✓ **Bill for everything you do.**
The CPT Manual will give you directions on which codes are properly bundled and not billed separately, but you should be sure to bill for separately identifiable services.

✓ **Bill for everything you use.**
Don't forget to bill for supplies and injections. These are identified in the appropriate sections for CPT or HCPCS codes, such as the J series for injections.

✓ **Vary your E&M codes.**
It is simply not believable that every visit is at 3 or 4 level. Audits are tripped when the computer at the insurance company or Medicare identifies that you are billing more of a certain code than your peers in your area.

✓ **Use modifiers correctly.**
These inform the insurance company or Medicare about multiple or specific procedures, or separate significant and additional E&M services.

✓ **Remember to bill the level 1 codes, such as 99221.**
This code represents your additional services but does not even require patient contact.

✓ **Complete documentation must be sufficient to show that the medical services were medically reasonable and necessary — include different parts of the chart if necessary.**
Sometimes this information is included separately in the History & Physical, not with the documentation the insurance company would look at. If you are asked to submit documentation, either submit the H&P, or note at the time of the visit the continuing diagnoses that warrant the procedure, evaluation, or lab work ordered.

✓ **Don't ignore your lesser services that would warrant the 2 or 1 level E&M codes.**
Read the CPT descriptions carefully to determine if your services justify the use of lower level codes.

✓ **Appealing claims strengthens your billing position and makes you less vulnerable to being dropped from an insurance company's provider panel.**
You cannot lose by appealing your claims. There are reversals for payment at every level of appeal, and except for the cost of arbitration, the costs are very minimal.
Furthermore, an insurance company specifically cannot drop a contracted doctor appealing a claim. Once you protest non-payment of a claim, an insurance company would have the burden of proving their action was not retaliatory. For more information, see article "Fighting Payor Abuse in California".

✓ **An attorney claims appeals service, such as that offered by The Law Office of David Mullens, can file appeals for you if you are experiencing continued payment denials.**
You may not only get paid for previously denied claims, you may also change the insurance company payment policies for the future regarding that denied code. All payment comes from the insurance payments resulting from your successful appeal- you will not have to reach into your own pocket for anything.

Information contained in this article does not constitute legal advice and is not a substitute for the professional judgment of an attorney.