

What's New for CPT 2016

By

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Prolonged Physician Service

- + ▲99354 Prolonged physician service in the office or outpatient setting requiring direct face to face patient contact beyond the usual service; first hour (30 to 74 min)
- + ▲99355 each add. 30 min.
- The use of the time based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook.
 - 99354 and 99355 are used with Outpatient or office services and now includes **psychotherapy (new revision this year)**
 - Add on code in addition to the basic service code
- NOT a common occurrence, only occasionally done.
- Can be used with any level of care as long as the time for the level of care was justified and then the extra time is >30 min.
 - Can only be used with codes that have time associated with them
- Can be used to report the total duration of face to face time spent by the physician on a given date even if the time is not continuous
- Now needs to be separately documented:
 - IE: Total time in visit 60 min and I spent an additional 35 min face to face time off and on re-evaluating the patient .
- **Currently in the OIG eye!!!**

New Codes for Prolonged Care for Clinical Staff!

- **+ 99415 (45-74 min): Prolonged clinical staff services with physician or other qualified health care professional supervision:**
- **+ 99416 :** each additional 30 min
 - Used when a prolonged E&M service is provided in the office setting that involves prolonged CLINICAL staff face to face time beyond the typical face-to-face time of the E/M services as stated in the code description.
 - Physician or QHP is present to provide direct supervision of the clinical staff.
 - IE: In order to bill the 99214 and a 99415 you would need 70 min. of total time.
 - Patient is present for breathing issues and multiple breathing treatments are performed as well as spirometry.
 - Patient spends 45 min of time with the clinical staff as they watch the patient carefully (time for the nebs are not counted) before and after the nebs for respiratory distress, Monitoring the heart and respiratory and O2 rate.. Patient typically will spend about 2 hours in the office.
 - Infant with feeding problems and clinical staff helps Mom who is very upset with breast feeding after the physician has evaluated the patient.
 - IV therapy in the office setting, most common.
 - Now needs to be separately documented:
 - IE: Total time in visit 70 min. Nursing staff spent an additional 45 min face to face time off and on monitoring and reporting on the patients condition while under supervision by me.

Removal of Impacted Cerumen


There are 2 codes now!!!

- **69209: New Code: Removal impacted cerumen using irrigation/lavage, unilateral**
 - Use modifier 50 if bilateral
 - Remember that the wax has to be impacted.
- **69210: Removal impacted cerumen requiring instrumentation, unilateral**
 - Use modifier 50 if cerumen is removed from both ears
 - 69210
 - 69210-50
- Both still have to be documented
- Cannot report both together
 - IE: Attempted to remove impacted cerumen per lavage and then instrumentation was used-bill only the 69210.
- ICD-10
 - H61.21-3 for right, left and bilateral

Documenting Ear Curette

- 69210 is a procedure so has to be documented as appropriate
- DO NOT document it in the exam-has to be separate
 - IE: After explaining the procedure to mom/patient, keeping patient's head stable a large amount of impacted cerumen was removed using a curette from the left ear. There was no damage to the ear and the patient tolerated the procedure well.

New Vaccines

-  90697: Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB) for IM use.
 - First vaccine to combine 6 diseases in one vaccine
 - Still FDA pending (Updates in Jan 1 and July 1)
 - Coding of Administration:
 - 90460
 - 90461 with 5 units Or 90461 and second line 90461-76 with 4 units.
 - Watch reimbursement when using units
- 90625: Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use
- 90620: Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule, for IM use
- 90621: Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for IM use.

Vaccines With Revisions

- ▲ 90632, 90633, 90634, 90644, 90647-50, 90653, 90655-62, 90664, 90666-8, 90670, 90672-3, 90680-1, 90685-88, 90696, 90698, 90702, 90714, 90716, 90732-4, 90736, 90739-40, 90743-4, 90746-8: Have all been revised to incorporate the ACIP US Vaccine Abbreviations in the CPT vaccine product codes.
- EX: Haemophilus for Hemophilus
 - Human Papilloma Virus for Human Papillomavirus
 - E to the word influenza

So What is Really in a Visit?

- History, Physical and Medical Decision Making
- Time if >50% spent in counseling or coordination of care
- Visit documentation has to be medically necessary to treat the patient for the presenting problems.

What's in a history?

- Four types of history
 - Problem Focused: (201/212/231/241/251/281)
 - HPI = 1-3
 - ROS = 0
 - PMFSH = 0
 - Expanded Problem Focused: (202/213/232/242/252/282)
 - HPI = 1-3
 - ROS = 1
 - PMFSH = 0
 - Detailed: (203/214/218/221/233/234/243/253/283)
 - HPI = 4+
 - ROS = 2-9
 - PMFSH = 1 (pertinent)
 - Comprehensive:
(204/205/215/219/220/222/223/244/245/254/255/235/236/284/ 285)
 - HPI = 4+
 - ROS = 10+ (or some with statement: Remainder of systems negative)
 - PMFSH = 3 for those that require all three key factors/ 2 for all others

Another Detailed History

- Pt presents today c/o both ears hurting (**chief complaint**), presents crying and holding both ears (**assoc. S&S**) and (**severity**). Mom also states he has a cough (**ROS**) but no fever (**ROS**). She had some old ear gtts so used those (**modifying factor**) but he seems to be getting worse (**Quality**). He does get ear infections “a lot” last one about a month ago (**PMH**).
 - 4 HPI; 2 ROS; PMH

Comprehensive History for that NBN Post Hospital Check

- 99204-5 or 99215: 4+ HPI, 10+ ROS and PM, F, S history
 - Baby presents as a four day old for post NBN check. Mom states baby not doing well (quality), will not nurse so is supplementing with formula (modifying factor). Baby seems very sleepy (associated signs and symptoms). Has only had 2 stools since left hosp yesterday (timing). No vomiting, seems to be urinating ok, no fever, remainder of systems not applicable due to age of neonate (10 ROS). Baby lives with Mom, Dad and older sister. Birth history as above, sibling had no problems as newborn (S, PMF and F history)

ADHD Comprehensive History

- 9 year old presents for evaluation of ADHD (**chief complaint**), Mom states has been acting up in class (**associated S & S**), seems he has been this way for years (**duration**), can't seem to concentrate when reading (**context**), occasionally will be able to sit through an entire movie if it is something he is really interested in (**timing**). (**4 HPI**) He does not complain of any visual problems, no hearing problems, no headaches, mom has never noticed any type of tics or outbursts, he is loud but can be quiet as well, has not had frequent illness's like URI's or abdominal pain. Denies any cardiac, GU or MS issues, some allergy's in the fall, no particular rashes or skin problems. Dad was "hyper" when he was young and still is somewhat. Pt is in 4th grade doing fair. (**10 ROS, FH, SH**)

99213

- CC: HPI: c/o ear hurting, left ear started hurting last night. Mom used some tylenol to help the pain. Also has a slight runny nose but no fever. Has had otitis in the past but only once.
- Gen: Alert, active
- ENT: Ears: Left: bulging, eardrum in tact. Right-Clear, Nose-some clear discharge; throat-neg
- Resp: CTA
- Card: No murmur
- Skin: clear no rashes.
- Plan: Left Suppurative Otitis Media without rupture of eardrum.
- Amoxil 250/5
- Return to clinic if no improvement.
 - HX: CC/location-duration-mod. Factor- assoc. Sign&Symp/1ROS/PMH: Expanded prob focused
 - Exam: 5 brief system: expanded prob. focused
 - MDM: Risk: Moderate DX: Low (est prob.) MDM= Low 2of 3 key factors = 99213

99214

- Patient presents today with c/o sore throat, also has had a fever for 2 days. Mom states has been using Motrin. Patient states sore throat has gotten worse in the last 24 hours. No rash, no nausea, vomiting or diarrhea. No other family members ill
- Exam:
 - Gen: ill appearing
 - ENT: Ears: normal, nose-no discharge, Throat-red with pustules noted as well as drainage down back of throat.
 - Resp: Clear
 - Cardiac: No Murmur
 - Abdomen: soft, no masses
 - Skin: No rash
- Assessment and Plan:
 - Strep screen: pos
 - Will treat with antibiotic, Mom informed about changing toothbrush, not sharing drinks and no school until fever gone for 24 hours-should improve in 48 to 72 hours. If not better, recheck in office.

99215

- Sarah presents c/o a severe headache, has had it for more than 3 days, also has had nausea and vomited X 1. Pain on scale of 10 of 10. She was laying on the exam table with a blanket over her head as everything hurts her head. No blurred vision, no dizziness, no Diarrhea, no resp. issues, last period normal, remainder of systems negative. Has had no ill exposures and no family members with migraines.
- Exam:
 - Gen: ill appearing, laying curled up on the exam table
 - Eyes: PERRL, no pressure points around eyes or on face
 - ENT: neg
 - Neck: supple, no pain on movement, no lymphadenopathy
 - Resp: neg
 - Cardiac: no murmur
 - Abdomen: no masses, no pain
 - Neuro: All cranial nerves in tack, appropriate to time and place
 - Skin: neg, no rashes
- Assessment and Plan
 - Due to severity of pain and duration of constant headache with no relief will obtain MRI
 - Will contact Neuro after MRI if no improvement after 48 hours.
 - Increase fluid intake, rest .
 - Medication ordered: Imitrex
 - Recheck in 48 hours if no improvement

Time as a Key Factor

- Time can be used as the key factor when: counseling constitutes more than 50% of the visit in face to face contact with the patient/parents.
- Physician has to document the amount of time spent in this discussion period and what was discussed.
- Total time spent for New Patient Visit, Established Patient Visit, Consultations:
- **Pick the code that is closest to the time noted**

99201: 10 min

99212: 10 min

99241: 15 min

99202: 20 min

99213: 15 min

99242: 30 min

99203: 30 min

99214: 25 min

99243: 40 min

99204: 45min

99215: 40 min

99244: 60 min

99205: 60 min

99245: 80 min

Documenting Time

- Don't have to do a history, physical or medical decision making
- Have to document total time in visit with amount of time spent in counseling/coordination of care (can be total amount of time with the patient/parent)
- Have to document what was discussed with the counseling.
- Has to be face to face time (or floor time)
 - Example: Pt. presents with recheck on ADHD. Taking the medication and seems to be doing well but parents concerned about the medication and think he should stop taking it.
- If add this statement: Total time spent with parents/patient is 21 min. with >50% spent in discussion of need for medication and concern that behavior and attention will slip back to initial problem.
- This is now a level 4: **99214** based on time as a key factor

Using Time Example

- Mom comes in to talk about Susie's depression. Mom feels she is depressed. Susie's grades are good but she does complain that she is tired all the time, cries a lot. Mom has tried to talk with her about what is wrong, always says nothing. Normal periods. Has a boyfriend and they seem ok. She is popular in school. This has been going on for over a month.
- No exam
- MDM: Will bring Susie in for a complete evaluation.
- Total time: 30 min/most of visit spent in counseling about depression.

CC: depression

- Assoc. S&S: tired and cries a lot
- ROS: GU
- Social History

No Exam

MDM:

Risk: acute illness (straightforward)

DX: New problem with further workup (high)

Data: none

MDM: straightforward

99212: But time was documented **HOWEVER** it does not state that >50% was spent in counseling. If it had then visit would equal 99214.



Immunization Administration

- Descriptor:
 - 90460: immunization administration through 18 years of age via any route of administration, with counseling by physician or “other qualified health care professional”; first **or only component of each vaccine/or** toxoid component administered
 - 90461: each additional/OR toxoid component administered
- A component refers to each antigen in a vaccine that prevents disease(s) caused by one organism.
- Conjugates or adjuvants contained in vaccines **ARE NOT** considered to be component parts of the vaccine. Multivalent antigens or multiple serotypes of antigens against a single organism are considered a **SINGLE** component of vaccines.
- Be sure to be specific when documenting your counseling:
 - “I counseled on MMR, Risks and Benefits explained, VIS sheet given and discussed and questions answered”
 - Be sure to list all vaccines being counseled on.
- Continue to use the 25 modifier on a visit (well or sick) when vaccines and admin codes are billed at the same time. This will over ride the NCCI edit.

Other Vaccine Administration Codes

90471 - 90474

- Vaccines administration that does not have face to face physician or qualified health care professional counseling to the patient/family or for administration of vaccines for patient older than 18 years of age use:
 - 90471: 1st vaccine (IM, SubQ, intradermal)
 - 90472: each additional vaccine (IM, SubQ, intradermal)
 - 90473: 1st vaccine oral/intranasal vaccine
 - 90474: each additional vaccine (oral/intranasal)
- As before if giving initial IM and initial intranasal use the subsequent intranasal vaccine and not the initial
 - 90471 for initial IM vaccine, 90474 for initial intranasal vaccine
 - If bill 90471 and 90473 (both initial) you will get denial for two initial vaccine administration codes on same date of service.

Developmental Screening

- 96110: Developmental Screening (eg: developmental milestone survey, speech and language delay screen), per standardized instrument
 - Revised: use to state ‘with interpretation scoring and report documentation, per form’
 - .28 RVU -pmts vary usually around \$9-\$25
 - Most Carriers follow Bright Futures recommendations on timing
 - Typical standardized instruments:
 - MCHAT
 - » 18 mo., and 24 mo
 - ASQ (Ages and Stages)
 - Early language milestone screen
 - PEDS (Parent Evaluation and Developmental Status)
 - ASAS (Australian Scale for Asperger’s Syndrome)
 - BRIEF (Behavioral Rating Inventory of Executive Functioning)
 - BASC-II (Behavior Assessment Scale for Children)

Developmental Code

- 96127: Brief emotional and behavioral assessment (eg: depression inventory, attention-deficit disorder/hyperactivity (ADHD scale) with scoring and documentation, per standardized form
 - GAPS questionnaire (Guidelines for Adolescent Preventive Services Questionnaire)
 - Used between ages 11-21
 - <http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf>
 - SDQ (Strengths and Difficulties Questionnaire)
 - The SDQ is a brief, free-of-charge, questionnaire consisting of 25 items assessing positive and negative attributes on five scales (emotional, conduct, hyperactivity, peer problems, and prosocial behavior). It takes 5-15 minutes to administer.
 - See “Guidelines for Adolescent Depression in Primary Care”

Newborn Care

- **99460:** Initial hospital/birthing center care, per day, for the E/M of the normal newborn infant
 - Includes maternal and/or fetal and newborn history
 - Newborn physical examination
 - Ordering of diagnostic tests and treatments
 - Meetings with the family
 - Documentation in the medical record
- **99461:** Initial care, per day, for the E/M of the normal newborn infant seen in other than hospital or birthing center
- **99462:** Subsequent hospital care, per day, for evaluation and management of normal newborn
- **99463:** Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date
- ICD-10 code = Z38.0?

Can you bill for an office visit and a procedure on the same day?

YES YOU CAN

- Bill a visit when the patient presents for problems and a procedure is “**needed**” to help determine a definitive diagnosis
 - Incision and drainage of an abscess
- Do NOT bill for a visit when the patient presents and the procedure has already been determined to be done at this visit at a previous visit.
 - Removal of wart (diagnosed week prior and told to come back for removal)
- You will need to use modifier 25 on the VISIT only.
- Don’t forget to use different diagnosis for visit and procedure.
- **REMEMBER: you have to make a separate notation for the procedure**
 - How procedure was performed
 - Results
 - How tolerated

What About Those Procedures!

- 2 types of procedures
 - Minor: have 0 to 10 days postoperative care
 - Does NOT include the office visit
 - If office visit performed to determine need for procedure bill visit separately
 - **There will be NO GLOBAL DAYS for minor procedures starting in 2017!!!**
 - Major: have 60 to 90 days postoperative care
 - Also does NOT include the office visit
 - If office visit performed to determine need for procedure bill visit separately
 - **There will be NO GLOBAL DAYS for major procedures starting in 2018**
- Have to have a separate documentation for both services
- Only major procedures for primary care are fracture care

Minor Procedures

- **20600:** Arthrocentesis: bursa or small joint (\$44)
- **20605:** “, intermediate joint (\$61)
- **20610:** “, large joint (\$56)
- **10060:** I & D abscess, simple (\$86)
- **11730:** Avulsion of nail plate, partial or complete, simple, single (\$73)
 - **11732:** each additional nail plate
- **11740:** Evacuation of subungual hematoma (\$37)
- **17250:** Chemical cauterization of granulation tissue (\$78)
- **10120:** FB subq tissue via simple incision (\$114.75)
 - Includes removal of splinters when physician has to go beneath the skin to remove splinter
- **28190:** FB-foot (\$196.76)
- **30300:** FB-nose (\$180.76)
- **11200:** Skin tag removal; up to 15 lesions (\$65.75)
- **41010:** Incision in the lingual frenulum to free the tongue (\$161)
- Application of splints:
 - Short arm splint (forearm to hand): static-**29125 (\$49)** dynamic-**29126 (\$58)**
 - Finger splint: static- **29130 (\$30.75)** dynamic-**29131 (\$39.25)**
 - Short leg splint (calf to foot): **29515 (\$54.50)**
 - **A4570:** Splint **S8450-S9452:** Splint, prefabricated for finger, wrist, ankle or elbow
- Strapping
 - Shoulder: **29240 (\$43)**
 - Elbow or wrist: **29260 (\$39)**
- **24640:** nursemaid elbow (10 day post op) (\$107.75)

Even More Procedures

- Fracture Care (have 90 day post op period)
 - 23500: Clavicle fx (\$164) 25500: Radial Fx (\$204)
26750: distal phalangeal fx (\$139)
 - 26720: Proximal or middle phalanx, finger or thumb fx
 - 28490: Great Toe Fx (\$111) 28470: Metatarsal Fx
28510: Fx phalanx or phalanges other than
great toe (\$93)
- 93000: Electrocardiogram, routine ECG with at least 12 leads, with interpretation and report (\$13.50)
- 93005: tracing only, without interp and report (\$7.50)
- 93010: interpretation and report only (\$6)

Let's Do a Recap on ICD-10 So, How's it going????

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Let's Talk Diagnosis Coding: Recap!

- Always use codes at the highest level of specificity
- Use more than one diagnosis as appropriate
 - Those that are pertinent to the visit for that date
- Z codes can be for information only or payable
- Chapter 19: S and T codes for injuries, accidents
 - Typically will need another code or more from Chapter 20
 - V, W, X and Y codes

Using More than One Diagnosis Code

- ESSENTIAL to use more than one dx code especially if using high levels of care or critical care
 - EX: not just Resp. distress BUT Tachypnea, Hypoxia, Asthma with acute exacerbation when billing a critical care code
- Use different dx codes for a visit and a procedure
 - Office visit: 99213-25 and dx of S90.461 Insect bite nonvenomous, right great toe
 - 10060: Simple I & D with dx of L03.031 Cellulitis of the great toe, right.

7th Digit Episode of Care

- 7th Characters

- Certain I-10 categories have a 7th character.
- The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instructs.
- The 7th character **MUST ALWAYS** be the 7th character in the data field.
- If a code that requires a 7th character is NOT 6 characters, a placeholder X must be used to fill in the empty characters.
- The following 7th character extensions are to be added to each code for this category
 - A initial encounter: initial encounter is defined as the period when a patient is receiving active treatment for an injury, poisoning or other consequences of an external cause. An “A” may be assigned on more than one claim. For example, consider a patient seen in the emergency department (ED) for a head injury that first is evaluated by an ED physician. If the ED physician requests a CT scan that subsequently is read by a radiologist , and then you see them in follow up, the seventh character “A” is used by all three physicians and also reported on the ED claim. **The A is used for the entire period when the patient receives active treatment.**
 - D: subsequent encounter: Subsequent encounter (“D”): this is an encounter occurring **after the active phase of treatment**, when a patient is receiving routine care during a period of healing or recovery. For example, a patient with an ankle sprain may return to the office to have joint stability re-evaluated to ensure that the injury is healing properly
 - S: sequela: is assigned for complications or conditions arising as a direct result of an injury. An example of a sequela is a scar resulting from a burn.

Well Care Examinations, Sports and Hearing and Vision Screening, Pre-ops

- Z00-
 - Z00.110: Health Examination for neonate under 8 days of age.
 - Z00.111: Health Examination for neonate-8 to 29 days of age
 - Z00.121: Encounter for child health examination-with abnormal findings
 - Use additional code for the abnormality found
 - Z00.129 Encounter for child health examination-without abnormal findings
 - Z00.00: General adult annual physical examination-without abnormal findings
 - Z00.01: “ , with abnormal findings.
- Z01.00/01: Encounter for eyes/vision without abnormal findings/with abnormal findings
- Z01.10/11: Encounter for ears/hearing without abnormal findings/with abnormal findings
- Z02.5: Examination for Sports Physical
- Z04.9: Encounter for examination and observation for a unspecified condition
- Z01.81: Encounter for Preprocedural Examination
 - Use this for that preoperative visit
 - Code the reason for the operative visit as secondary
 - Z01.81
 - Chronic Suppurative right Otitis Media without rupture of membrane.
- **Z23: ALL VACCINES!!!**
 - Some payers now want the Z code for the well care instead of the Z code specific to the service!!

Well Care with Abnormal Findings

- Patient presents for well care BUT also has a history of asthma
 - Chronic asthma well controlled with medications
 - Bill the Z00.129 for well care without abnormal findings
 - Bill ONLY well care
- Patient presents for well care BUT also has a history of asthma
 - Last night started with wheezing, used nebulizer but still wheezing
 - Bill the Z00.121 for well care with abnormal findings as well as dx code for asthma as appropriate as well as smoking if applicable
 - And bill both well and sick visit
- Patient presents for well care but also has a diaper rash
 - On exam appears to have diaper rash and mother given advice in treating the diaper rash
 - Bill the Z00.121 for well care with abnormal findings as well as the dx code for the diaper rash but only one note documented so
 - Bill ONLY well care visit

Signs and Symptoms

- Symptoms and signs involving emotional state
- [R45.0](#) Nervousness
- [R45.1](#) Restlessness and agitation
- [R45.2](#) Unhappiness
- [R45.3](#) Demoralization and apathy
- [R45.4](#) Irritability and anger
- [R45.5](#) Hostility
- [R45.6](#) Violent behavior
- [R45.7](#) State of emotional shock and stress, unspecified
- [R45.8](#) Other symptoms and signs involving emotional state
- [R45.81](#) Low self-esteem
- [R45.82](#) Worries
- [R45.83](#) Excessive crying of child, adolescent and adult

Pains

- Documentation: **be specific on where the pain is located, if multiple places state all of them.** ICD-10 has pain in (not just right and left arm) but in upper arm, lower arm, hand, finger even down to the specific great toe!
 - M79.601-M79.675 Pain arms, legs, hands, fingers, thigh, foot, toes.
- Don't forget about abdominal pain!
 - Right upper, right lower, left upper, left lower
- Remember to refine diagnosis codes as needed.

HOW DO DOCTORS GET PAID?

- Imagine going to your favorite restaurant. You are greeted at the door by the hostess, who seats you and takes your drink order. You order through your favorite waiter, Andrew, who recommends the special of the day: prime rib with a dinner salad and a chocolate torte for dessert. Soon after, the food is brought out and it is delicious! You have time to enjoy your food. You then receive the bill and pay for your meal, returning to your home satisfied, all your dining needs met. Let's say, for simplicity's sake, you paid \$75 for this meal: \$50 for the steak, \$10 for the salad and \$15 for the dessert.
- A change then occurs in the restaurant industry. A new form of eating out has been adopted. Your favorite restaurant has now contracted with over 30 different "restaurant insurance companies."
- Anticipating another pleasant dining experience, your return to the restaurant with your new "subscribers card." You pay your \$5 "copay." You sit in the foyer of the restaurant. You wait an hour, even though you made reservations. A harried Andrew greets you and quickly takes your order after you briefly glance at the menu. The food arrives at your table. As you take your second bite, Andrew informs you that "your time is up" and the table is reserved for another party. You are escorted outside with your hastily boxed left-overs.
- What has happened to the restaurant? Behind the scenes, the restaurant owner has learned some tough realities of the "new system." During the first month of taking insurance, the owner sends a form to the insurance company requesting payment for the \$75 steak dinner: \$50 for the steak, \$10 for the salad and \$15 for the torte. The contract with the insurance company already states that they will only pay \$45 for the \$50 steak, but the owner decides that the extra customers brought to the restaurant by contracting with this insurance company will more than off-set this small loss.
- The first attempt at collecting the \$75 dollars for the full meal is returned unpaid with the note that it was rejected due to a "coding error." The forms for payment from the insurance company require the owner to list the parts of the meal, not by name, but by the numerical codes. The owner had listed the salad by the wrong numerical code. No suggestions for the correct code are offered, so the restaurant owner purchases a series of books, at a cost of \$500, to learn how to assign the correct code to the different parts of the meals. These books will need to be bought annually due to the constant changing of the code numbers. After 30 minutes of study, the owner realizes the dinner salad should be coded as a 723.13, not the 723.1 the owner originally put on the form. The salad, it turns out, needed to have two digits after the decimal point, indicating that it was a dinner salad, and not a "main course" salad. The owner mails the corrected form.
- In response to the second request for payment, the insurance company does not send a check, but a detailed questionnaire: Was garlic used in seasoning the steak? Was it necessary to use garlic for this particular recipe? Did the restaurant ask for permission to use garlic from the insurance company before serving the steak? Why was salt, a less expensive alternative, not used instead? The owner submits the answers, emphasizing that the garlic is part of a secret family recipe that made the restaurant famous.
- The owner waits another week (it has now been 3 weeks since the dinner was served). The check arrives three and a half weeks after the meal was served. The check is for \$20 and states that it is specifically for the steak. The check also comes with a letter stating that no billing of the patron may occur for the salad, but no other explanation is enclosed. No mention is made of the \$15 dessert.

HOW DO DOCTORS GET PAID?

- The now frustrated restaurant owner calls the provider service number listed in the contract. After five separate phone calls to five different numbers (The harried voice behind phone call number four explains that the insurance company has merged with another insurance company and the phone numbers had all changed last week, sorry for the inconvenience...), the owner gets to ask why, when the contract says the steak will be paid at \$45, has the check only been written for \$20? And what happened to the payment for the \$10 salad and the \$15 dessert?
- As it turns out, this particular patron's insurance contract only pays \$45 when the patron has reached their deductible, which this patron has not at this time. The remaining portion of payment for the steak must now be billed by the restaurant to the patron directly.
- The \$10 for the salad would have been paid if the patron had ordered it on a different day, but, per page 35 in the contract, because it was billed on the same day as the steak, it is considered to be part of the payment for the steak and no extra money can be collected from the patron or the insurance company.
- The dessert, the owner learns, should have had a "modifier" number put with its particular billing code when billed with the steak and the salad.
- Realizing that the insurance billing is quite a bit harder than anticipated, the restaurant owner hires a company, who is paid 5% of any money collected to specifically make sure these coding errors do not occur again and follow up on payment rejections. For an additional \$99 per month, the billing company will "scrub" the forms submitted for payment to make sure specific clerical errors will not cause future delays in payment.
- The owner now must lay off the hostess and the bus boy to pay the billing company, so these duties are now added to the waiter's other responsibilities.
- In the meantime, the restaurant owner has also had the waiter take on the job of answering the phones due to the now high volume of phone calls from patrons questioning why they are receiving bills for meals they ate over two months ago, and why did their insurance company not pay for this portion of the meal? This extra work is now resulting in longer times patrons must wait to be seated, and grumblings from the waiters who "were not hired or trained to do this kind of work."
- The owner now realizes that, although the dinner originally cost \$75 to make, only \$25 has been paid. The remaining \$30 billed to the patron is now in its third mailing, with the first two requests for payment going unanswered by the patron. The restaurant owner realizes a collection agency must be employed in order to have any hope of receiving any portion of payment from the patron.
- Each meal served now costs at least an additional \$20 due to the added overhead of the billing company, coding books, and the collection agency. These added expenses have nothing to do with cooking food or providing any direct service to the restaurant's customers.
- Service to the restaurant's patrons has been compromised with these changes as well. The owner has now over-extended the waiter, who was an excellent waiter, but is now taking on the roles of host, phone answering and table bussing.
- In order to even meet the costs of providing fine dining, the restaurant owner now must seat twice as many patrons in the same amount of time.
- What was once an outstanding business that focused on fine dining and customer service has now been turned into a business in the business of trying to get paid.
- Alas, I wish this were a fictional tale, but it is not. The only fictional portion is that this is not your favorite restaurant, but your favorite doctor's office, which is responsible not for meeting your dining needs, but those of your health.
- Megan Lewis, M.D.
- A family physician in rural Colorado.