1/10/24

Testimony for House Committee for Healthcare- Claims Processing

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My Background:

- Only dermatology practice north of Chittenden County
- Provide care to a large geographic area and an underserved population for dermatology
    - Some patients travel hours to see us from out of state and even some from Canada.
- Wait times are very long for dermatology for new patient appointments in the entire state. (4-5 months)
- If our office does not survive due to the administrative burdens, patients who need dermatology services would have to travel to Chittenden County for care.

Introduction and Current Landscape:

- Discuss the administrative burden of insurance billing and the impact it has on patient care.
- Administrative burden contributes to provider/physician burnout in a state where there is already a shortage of providers.
- There is no one standard way to get paid, each insurer has their own processes and policies, and each year it gets more onerous to keep track of the changes and abide by new rules.
- It has been a national trend for insurance companies to implement additional software to automatically perform "***claims edits***".
- Claims editing is the process of reviewing claims for coding validity and accuracy.
- Claims are processed through computer algorithms that ***automatically*** flag claims with specific codes or modifiers for review and may lower payment or withhold payment for various reasons, depending on the policies of the payers.
- Payment may be withheld until a copy of the medical note is submitted and deemed appropriate to justify use of the modifier.
- If it is denied, there is an opportunity for "reconsideration" but ultimately the final decision is made by the insurance company.
- If a claim is ultimately denied, the physician does not get paid and by contract they are not allowed to seek payment from the patient (unless an ABN was signed).

Coding and Claims Processing 101:

1. When a patient is seen, based on the clinical services performed and documented in the medical record - the services are translated into a 5-digit CPT code.
    1. CPT is short for "current procedural terminology". CPT codes are developed by the CPT Editorial Panel of the American Medical Association and include a detailed and standardized description of the code for every medical procedure that is performed. (See https://www.ama-assn.org/about/cpt-editorial-panel/cpt-code-process for a description of the process of developing CPT codes).
    2. A subset of CPT codes are Evaluation and Management or E/M codes. These are for the most common types of office visits. (See a description of E/M codes here: https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/evaluation-management.html)

    Some examples of the most common codes I use are:

    99202: Office or other outpatient visit for the evaluation and management of a **new patient,** which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, **15-29 minutes** of total time is spent on the date of the encounter).

    99212: Office or other outpatient visit for the evaluation and management of an **established patient**, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, **10-19 minutes** of total time is spent on the date of the encounter.

    99213: Office or other outpatient visit for the evaluation and management of an **established patient**, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, **20-29 minutes** of total time is spent on the date of the encounter.

2. A "**modifier**" can also be added to CPT codes. A medical coding modifier is two characters (letters or numbers) appended to a CPT and provides additional information about the medical procedure, service, or supply involved.

    Some examples of when a modifier may be used include:

    - Providing the anatomical location of the procedure
    - More than one provider performed the service or procedure.
    - More than one location was involved.
    - Telemedicine was performed

    Specific modifiers being addressed today include:

- **Modifier -25**, which is added when: a significant, separately identifiable evaluation and management service is provided by the same physician or other qualified healthcare professional on the same day as the first procedure or other service.
- **Modifier 59**: Added when a distinct procedural service is offered on the same date as another procedural service

3. A **diagnosis code** is also added to claims. These are called **ICD** (International Classification of Diseases) **codes** and explain what diagnosis or disorder the patient may have that led to the need for the appointment or procedure.

1. The ICD-10-CM is maintained by the National Center for Health Statistics (NCHS). Some examples of ICD codes used in dermatology are:
   C44.321 Squamous cell carcinoma of skin of nose
   D18.01 Hemangioma of skin and subcutaneous tissue
   L98.1 Factitial dermatitis

4. Once the codes are submitted for the services provided (typically through an electronic health record, drop to paper or to a specific portal), the payer compiles them into what's called a "claim." This claim contains all the CPT and relevant diagnosis codes for the services rendered to the patient. The claim is sent off to the patient's insurance company or payer for reimbursement.

5. The insurance company reviews the claim, checks for errors, verifies that the services align with the patient's coverage, and then processes it. If everything checks out, the insurance company pays me according to the agreed-upon rates for each service.

In summary, medical billing involves translating what a healthcare provider does into these special codes, compiling them into a claim, and sending it to the insurance company to get paid for the services provided to the patient.

The turnaround time for payment can take weeks to months. So there is a lag in reimbursement and this lag has worsened as insurance companies institute new claims edits and administrative requirements

My Personal Experience with New Claims Edits:

We are a small office of 2 physicians and have a very small operating margin. What that means is - when there are long delays in insurance reimbursements it’s challenging to run a small business. We run lean, there is no office manager, we do not outsource for our coding and billing. It’s the elbow grease of 2 doctors and the very dedicated staff of 5 people and 2 remote assistants who wear many hats to keep the lights on.

Once we realized that a new claims editing process was in place for certain insurance companies, the delay in payment led us to change our approach to patient care. The claim edits that affected our specialty the most were 25 and 59 modifiers which are placed on the claim when a procedure is performed in addition to an office visit. The most common scenario is when a skin cancer screening exam is performed, if we find a suspicious lesion, we do a skin biopsy on the same day. A 25 modifier is placed on this type of visit

For example if I see a patient for psoriasis and a history of melanoma where I suspect a suspicious lesion, I would bill 2 CPT codes: E/M for the management of the psoriasis and a skin cancer screening skin check and a procedure code for a skin biopsy. Typically you associate all your diagnoses in the visit with an E/M code and if you performed a procedure - you associate that diagnosis with the appropriate CPT code. A 25 modifier is then placed on the E/M code to note that a separate and identifiable procedure was performed. If an additional procedure was performed a 59 modifier would be added to a procedure code. Providers have ongoing training on how to “code”. Because I did an office visit and performed a skin biopsy, this visit now requires a 25 modifier to show that 2 different services were performed on that same day.

With the new claims editing software put into place by Blue Cross last January, payment is automatically withheld if there is a 25 modifier. This policy adds an onerous process of resubmitting every claim with these modifiers along with a copy of the office visit note. It is required that each claim be submitted individually. So, if 25 claims were denied - 25 individual emails had to be sent with individual office notes for each visit attached to individual emails with the designated claim. Even once we submit documentation, payment can still be denied and we have to appeal or resubmit which is also fraught with problems (other associates are here today to elaborate on this)

This flips typical insurance payment on its head - where we get paid based on the codes we submit and if there is a question of improper coding or billing, the insurance company can require an audit and recoup incorrect payments. Instead EVERY claim with these modifiers is being held up and requires documentation **before** payment.

Our operating margin cannot tolerate this delay in payment and there is also no guarantee of payment for a procedure performed on the same day of an office visit. The increase in administrative burden required increasing our staffing to process the claims. We specifically had to hire additional billing staff.

In addition we started to be transparent with our local patients and explain what was happening. We asked if they would be willing to come back at a later date if a non-urgent procedure was recommended. Because if these two appointments happen on two separate days we can still bill for them separately and be fully reimbursed with no extra paperwork burden or payment delays. Thankfully most patients were gracious and agreed to come back even if it might cost them an additional day off of work or an additional copay or deductible. Our wait times are already very long for our specialty, so

to add additional visits for separate procedures takes away visit slots for other patients with other medical needs or we double booked and ran late in clinic.

Since the new claims editing process, this has put me in a difficult position of needing to do the right thing for my patients and making decisions for the survival of a small medical office. I want to give high quality care to my patients and not have to be concerned about whether I get paid in order to keep the office open. If I see a patient and suspect a melanoma, I don't ever want to delay a procedure due to an administrative burden.