Coding for the Care of the Thyroid Patient

A "Coding News" Special Feature

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Abstract:

The clinical endocrinologist has the opportunity to prevent, detect and treat some of the most common disorders known, those of the thyroid. He/she can provide the preventive counseling and consultative evaluation services for patients at risk of or with thyroid disease. He/she can perform the laboratory testing and other diagnostic procedures such as ultrasonography, radionuclide scanning and/or treatment. This paper reviews the coding and reimbursement for the most common of these services and provides guidance to enhance the likelihood of appropriate payment of submitted claims.

KEY WORDS: coding, CPT, ICD-9-CM, reimbursement, thyroid disease, evaluation and management (E & M)

King Pharmaceuticals played no part in the development of the content of this supplement, and takes no responsibility for the information therein. Accurate reporting, coding and billing remains the responsibility of each health care provider. Each health care provider should understand and confirm applicable payor policies governing coding and billing before submitting claims.

The clinical endocrinologist can prevent, detect and treat many common thyroid disorders by providing preventive counseling and consultative evaluation services for patients with or at risk of thyroid disease and who require performance of laboratory testing and procedures (e.g., ultrasonography, radionuclide scanning and/or treatment). This article reviews coding and reimbursement for such services.

Preventive Medicine Services

The clinical endocrinologist has a responsibility to provide timely guidance to those at risk of thyroid disease and to help prevent the development of thyroid disorders. In some cases, this should begin during a patient's childhood and, as genomic insights unfold, this will become even more important. The preventive services codes (which do not require a diagnosis code and should not be used for care of a patient's complaints or disease) describe these services. While other insurers usually do cover these services, Medicare does not, in most cases, and consequently the policy for non-covered services should be used [see section below on non-covered services].

Current Procedural Terminology cpt 2004 (cpt 2004) includes current procedural terminology (CPT) codes for preventive services and these are summarized in Table 1.[1] These include codes for preventive medicine care for new or established patients, preventive medicine counseling codes, and codes for administration and interpretation of health risk assessment instruments. Review the detailed information in *cpt 2004* to further understand and apply these codes and, as for all services you provide, carefully document your services to ensure proper consideration of them by payers.

Outpatient Services For Patients With Complaints and Disease

Current CPT codes for *outpatient* services are shown in Table 2, including codes for office visits and/or counseling for new and established patients, observation care and discharge from observation care, consultation and confirmatory consultation or second opinion services, prolonged physician services, physician- provided education, medical conferences by a physician with a multidisciplinary team to coordinate patient care, telephone calls by physician to patient or for consultation with another health care professional, medical and educational supplies provided to the patient at cost, special reports or forms conveying more than the usual standard report form, analysis of information data stored in computers, care plan oversight, physician supervision, basic life and/or disability evaluation services, work-related or medical disability evaluation services, and unlisted evaluation and management services.

Inpatient and Emergency Room Services

Codes for *inpatient, observation care* or *emergency room* services, are shown in Table 3. These include codes for observation care (as presented above under outpatient services), inpatient hospital care and discharge day management, inpatient consultations and confirmatory consultations or second opinions, emergency department visits, physician direction of emergency medical systems (EMS)

TABLE 1. CPT CODES FOR* PREVENTIVE *SERVICES

99381, 2, 3, 4, 5, 6 or 7*	Initial comprehensive preventive medicine evaluation and management, new patient
99391, 2, 3, 4, 5, 6 or 7*	Periodic comprehensive preventive medicine reevaluation and management, established patient
99401, 2, 3 or 4*	Preventive medicine counseling and/or risk factor reduction intervention to an individual, by minutes (15,30,45 or 60)
99411 or 99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individual in a group setting, 30 or 60 minutes
99420	Administration and interpretation of health risk assessment instrument
99429	Unlisted preventive medicine service

** Multiple codes exist to describe the levels of this service.*

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TABLE 2. CPT CODES FOR* OUTPATIENT *SERVICES FOR PATIENTS WITH COMPLAINTS OR DISEASE

99201, 2, 3, 4 or 5*	Office or other outpatient visit for evaluation & management (new patient)
99211, 2, 3, 4 or 5*	Office or other outpatient visit for evaluation & management (established patient)
99217	Observation care discharge day management
99218, 9 or 20*	Initial observation care, per day for evaluation & management
99241, 2, 3, 4 or 5*	Office consultation for a new or established patient
99271, 2, 3, 4 or 5*	Confirmatory consultation for a new or established patient **
99354 and 5*	Prolonged physician services, outpatient, requiring direct (face-to-face) patient contact***
99358 and 9*	Prolonged evaluation & management service before and/or after direct (face-to-face) patient care***
99078	Physician educational services rendered to patients in a group setting (e.g., diabetic instructions)***
99499	Unlisted evaluation and management service
99361 and 99362*	Medical conference by physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present)***
99371, 2 or 3*	Telephone call by physician to patient or for consultation or medical management with other health care professionals***
99070	Supplies and materials provided by physician (over/above normal)
99071	Educational supplies provided by physician for patient education, at cost
99080	Special reports/forms conveying more than usual communications or standard reporting form
99090	Analysis of data stored in computers (e.g., blood pressures)
99199	Unlisted special service, procedure or report
99455*	Work related or medical disability evaluation by the treating physician
99499	Unlisted evaluation & management service

* *Multiple codes exist to describe the levels of this service. When the service is prolonged beyond that described under this code, additional codes may be used as well.*

** *Unless mandated (e.g., required second opinion) by the insurer, payment for this service is often denied or non-covered. Use an ABN or consider, if in doubt about coverage, use of consultation codes.*

***Payment for this service is often denied, non-covered, or considered bundled in other service codes.*

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emergency care, advanced life support, critical care evaluation and management, and inpatient prolonged physician services.

Modifier Codes for CPT Services

Under some circumstances a CPT code requires further modification so CPT modifiers may be used. Avoid use of modifier –21. Most insurers fail to pay any additional amount for the –21 modifier. Instead, use the prolonged physician services codes 99354 to 99359 where services are unusually prolonged. CPT modifiers are described in Table 4.

Laboratory Studies and Diagnostic Procedures

Assessment of a patient may include laboratory studies or diagnostic procedures such as ultrasonography or radionuclide scanning. Codes for the tests and procedures performed by clinical endocrinologists in thyroid patients are provided in Tables 5 and 6.

Insurer Policies For Tests—Performer Beware

Coverage and requirements, such as pre-certification, for tests and procedures are determined by the patient's health insurer policy and significant differences in these policies are seen between insurers. Requirements for reimbursement for services vary from state-to-state and insurer to insurer. When unclear on what to do, contact the insurer in advance for information on how best to submit your claim.

For the Medicare patient, considerable consistency has developed among carriers because of acts of Congress requiring development of national policies, such as the negotiated laboratory rule-making legislation. For current na-

TABLE 3. CPT CODES FOR* INPATIENT *AND* EMERGENCY DEPARTMENT *SERVICES

99217	Observation care discharge day management
99218, 9 or 20*	Initial observation care, per day
99221, 2 or 3*	Initial hospital care, per day
99231, 2 or 3*	Subsequent hospital care, per day
99234, 5 or 6*	Observation or inpatient hospital care
99238 and 99239*	Hospital discharge day management
99251, 2, 3, 4 or 5*	Initial inpatient consultation for new or established patient
99261, 2 or 3*	Follow-up inpatient consultation for an established patient
99271, 2, 3, 4 or 5*	Confirmatory consultation for a new or established patient
99281, 2, 3, 4 or 5*	Emergency department visit for evaluation and management of a patient
99288	Physician direction of emergency medical systems (EMS) emergency care, advanced life support
99291 and 99292*	Critical care, evaluation and management of the critically ill or critically injured patient
99356 and 99357*	Prolonged physician services in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (List separately in addition to code for inpatient evaluation and management service)

* *Multiple codes exist to describe the levels of this service. When the service is prolonged beyond that described under this code additional codes may be used as well.*

There are also specific codes for nursing facility services (99301 etc), domiciliary, rest home or custodial care services (99321 etc) and home services (99341 etc), and care plan oversight services (99374 etc).

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tional coverage policies for Medicare, see *http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd*. Even in the face of efforts to standardize Medicare coverage and payment policies, some Medicare carriers may modify, ease or further restrict or define conditions for coverage, creating local policies.

TABLE 4. MODIFIERS FOR CPT CODES

-21	Prolonged evaluation and management services
-22	Unusual procedural services
-25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service (not used for evaluation and management service that resulted in a decision to perform surgery; in that case, use –57
-26	Professional component (to report the physician component separately from the technical component of a procedure)
-32	Mandated services
-50	Bilateral procedure at same session
-51	Multiple procedures: use for the lesser procedures done on the same day as the major procedure
-52	Reduced services (signifies a reduced service)
-53	Discontinued procedure
-56	Preoperative management only
-57	Decision for surgery
-59	Distinct procedural service
-76	Repeat procedure by same physician
-77	Repeat procedure by another physician
-90	Reference (outside) laboratory performed test
-91	Repeat clinical diagnostic laboratory test on same day on same patient

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Diagnosis Codes For Thyroid Disease

The International Classification of Diseases-9-Clinical Modification (ICD-9-CM) codes used for the more common thyroid diseases are depicted in Table 7.[2] The signs and symptoms codes should be used in the still undiagnosed thyroid patient with complaints justifying a search for thyroid disease. For the patient presenting with fatigue (ICD-9-CM code 780.79) or atrial fibrillation (ICD-9-CM code 427.31), use one or more signs or symptoms code(s) until a definitive diagnosis is established. When monitoring a patient for effectiveness of or adverse effects of medication, eg, methimazole or propylthiouracil, use the thyroid diagnosis code (eg, 242.00 for Graves' disease) to support the visits and tests.

TABLE 5. CPT and OTHER CODES FOR COMMONLY PERFORMED THYROID TESTS AND PROCEDURES

84432	Thyroglobulin
84436	Thyroxine; total
84439	Thyroxine; free
84442	Thyroxine binding globulin (TBG)
84443	Thyroid stimulating hormone (TSH)
84445	Thyroid stimulating immunoglobulins (TSI)
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)
84480	Triiodothyronine T3; total (TT-3)
84481	Triiodothyronine T3; free
84482	Triiodothyronine T3; reverse
86376	Microsomal antibodies (eg, thyroid or liver-kidney), each
86800	Thyroglobulin antibody
80410	Calcitonin stimulation panel (e.g., calcium, pentagastrin)
80418	Combined rapid anterior pituitary evaluation panel
80438	Thyrotropin releasing hormone (TRH) stimulation panel; one hour
80439	Thyrotropin releasing hormone (TRH) stimulation panel; two hour
90782	Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular
90784	Therapeutic, prophylactic or diagnostic injection (specify material injected); intravenous
J2725	Injection, protirelin (TRH), per 250 mcg
10021	Fine needle aspiration; without imaging guidance (for percutaneous needle biopsy other than FNA, use 60100 for thyroid)
10022	Fine needle aspiration; with imaging guidance (see also, as needed, 76003;76360 and/or 76942)
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)
76536	Ultrasound, soft tissues of head and neck (eg thyroid, parathyroid, parotid), B-scan and/or real time with image documentation
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

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Examples of Coding for Thyroid Services—Evaluation of Enlarging Thyroid Mass in a 29 Year Old Female

A 29 year old female with a mass in the left side of the neck is seen in consultation referred by her primary care physician. The mass appeared six to 12 months ago and is slowly enlarging, causing mild pressure on swallowing solid foods or when the patient is recumbent for sleep. Family history includes goiter in her mother. Exam reveals bradycardia (heart rate regular at 54/minute) and an enlarged thyroid gland (estimated weight 25 grams) with a three cm somewhat firm, non-fixed mass in the left lateral lobe area. Consent is obtained and investigative studies conducted including thyroid function tests (free T4, free T3, TSH), serum thyroglobulin and anti-TPO antibodies. Thyroid ultrasonography is performed and fine needle aspiration (FNA) biopsy of the left thyroid mass under ultrasound guidance is carried out at the next visit, and, at that time, the adequacy of the obtained samples is assessed and specimens sent to an outside pathology laboratory for cytological evaluation. At this same visit the patient is informed of the results of the thyroid laboratory study results. Free T4 is within the reference range at 0.9 ng/dl, TSH is elevated at 18 mU/L, thyroglobulin is within reference range, thyroglobulin antibody is negative and anti-TPO antibodies are elevated/positive. Counseling regarding possible need for thyroid hormone replacement is discussed and repeat TSH sample is obtained. A return appointment is scheduled for two weeks later.

The FNA procedure is well-tolerated and no subsequent complications (pain, bleeding) occur. At the next visit the findings on FNA cytology are presented. No evidence of malignancy was noted and treatment with levothyroxine is recommended since the repeat TSH was once again elevated (22 mU/L) The patient agrees with the recommendation for levothyroxine replacement and schedules a follow-up visit in six weeks.

Codes for this Example

The coding of the services for this patient could properly include CPT code 99244 or 99245 for the initial consultation for this patient. ICD-9-CM diagnosis codes could

TABLE 6. CPT CODES FOR SELECTED THYROID NUCLEAR MEDICINE PROCEDURES

78000	Thyroid uptake; single determination
78001	Thyroid uptake; multiple determinations
78003	Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)
78006	Thyroid imaging, with uptake; single determination
78007	Thyroid imaging, with uptake; multiple determinations
78010	Thyroid imaging; only
78011	Thyroid imaging; with vascular flow
78015	Thyroid carcinoma metastases imaging; limited area (e.g., neck and chest only)
78016	Thyroid carcinoma metastases imaging; with additional studies (e.g., urinary recovery)
78018	Thyroid carcinoma metastases imaging; whole body
78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure) List 78020 in conjunction with code 78018 only
79000	Radiopharmaceutical therapy, hyper-thyroidism; initial, including evaluation of patient
79001	Radiopharmaceutical therapy, hyper-thyroidism; subsequent, each therapy
79020	Radiopharmaceutical therapy, thyroid suppression (euthyroid cardiac disease), including evaluation of patient
79030	Radiopharmaceutical ablation of gland for thyroid carcinoma
79035	Radiopharmaceutical therapy for metastases of thyroid carcinoma
79999	Unlisted radiopharmaceutical therapeutic procedure

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include 784.2 for a neck mass, 240.9 for goiter, 787.2 for dysphagia and 427.89 for bradycardia. The thyroid function and antibody tests, done in the physician's own laboratory, would be coded CPT 84443 (TSH), 84439 (free T4), 884432 (serum thyroglobulin), 86800 (thyroglobulin antibody, done to help interpret the thyroglobulin result), and 86376 (anti-microsomal AKA anti-TPO antibody). Since the tests were not sent out, a -90 modifier is not required.

At the patient's next visit neck/thyroid ultrasonography is done and coded as 76536. Also, at this visit,

TABLE 7. ICD-9-CM CODES FOR COMMON THYROID DISEASES AND CONDITIONS

ICD-9-CM Code	*Disorder or Disease State*
240.0	Goiter, specified as simple
240.9	Goiter, unspecified
241.0	Non-toxic uninodular goiter
241.1	Non-toxic multinodular goiter
241.9	Unspecified nontoxic nodular goiter
242.00	Toxic diffuse goiter without mention of thyrotoxic crisis or storm *
242.10	Toxic uninodular goiter without mention of thyrotoxic crisis or storm *
242.20	Toxic multinodular goiter without mention of thyrotoxic crisis or storm *
242.30	Toxic nodular goiter, unspecified *
242.80	Thyrotoxicosis of other specified origin (eg, excess TSH, T4**) *
243	Congenital hypothyroidism
244.0	Acquired hypothyroidism, post-surgical
244.1	Acquired hypothyroidism, other post-ablative
244.2	Acquired hypothyroidism, iodine induced
244.9	Acquired hypothyroidism, unspecified
245.0	Acute thyroiditis
245.1	Subacute thyroiditis
245.2	Chronic lymphocytic thyroiditis
245.9	Thyroiditis, unspecified
246.2	Cyst of thyroid
246.8	Other specified disorders of thyroid (eg, TBG excess)
246.9	Unspecified disorder of thyroid
193	Malignant neoplasm of thyroid gland
226	Benign neoplasm of thyroid glands
376.21	Thyrotoxic exophthalmos
648.10	Thyroid dysfunction related to pregnancy, unspecified as to episode to care of not applicable
790.94	Euthyroid sick syndrome
794.5	Nonspecific abnormal results of function studies, thyroid scan or uptake
V77.0	Special screening for endocrine, nutritional, metabolic, and immunity disorders, thyroid disorders [in person without reported diagnosis encountered during examination and investigation of individuals and populations]

* *In the case of the presence of thyrotoxic crisis or storm, the fifth digit is 1 instead of 0; i.e., Graves' with crisis or storm is 242.01*

** *Use additional E code to identify cause, if drug-induced (e.g., use E932.7 if thyroid hormone and thyroid derivatives were cause)*

FNA biopsy is done under ultrasound guidance and this procedure is coded 76942. The physician assessment of the adequacy of the FNA specimens is coded 88172 and the specimens are forwarded to a laboratory for cytological evaluation. Since the patient is also informed of the thyroid function test results, suggesting hypothyroidism, at this visit and since treatment is discussed and a repeat TSH specimen is obtained, these services are also coded since they are distinct from the procedures performed at that same visit. The office visit code could be 99211-99215, depending on the extent of service provided, and the -25 modifier is added. The TSH drawn and performed in the physician's laboratory is coded 84443.

At a follow-up visit two weeks later, the patient's problem is determined to be a nontoxic nodular goiter and hypothyroidism and these are given ICD-9-CM diagnosis codes 241.0 and 244.9, respectively. Note, usually code 241.0 implies absence of hypothyroidism but, in this patient, both the goiter and hypothyroidism were diagnosed. Treatment with levothyroxine is initiated and this visit is coded as an established patient office visit (99211-99215). Subsequent visits for this treatment will be coded as established patient visits too.

Examples of Coding for Thyroid Services—Neck Mass of Recent Onset in 74 Year Old Female

A 74 year old female is seen at her regular follow-up visit for diabetes mellitus, type 2. The patient has a two year history of diabetes that is well-controlled on oral agents. At this visit, she reports having recently discovered a new lump in her right neck. Family history is negative for thyroid disease or malignancy. The only pertinent physical findings are a firm, non-tender, non-fixed 1 cm nodule in the right lateral neck and a thyroid gland which feels normal in size and consistency on palpation. Further evaluation is advised and the patient agrees to ultrasonography of the neck, including the thyroid gland, and thyroid function tests. The ultrasonography examination is carried out the following week. TSH, free T4 and anti-TPO antibody results are within the reference ranges for the physician's laboratory. Neck ultrasonography reveals a one cm mass in the right lateral neck, just lateral to the right lateral lobe of the thyroid, and a 1.5 cm solid nodule in an otherwise normal appearing thyroid gland. Further evaluation is suggested, to include thyroid ^{123}Iodine scanning of the thyroid, open biopsy of the lateral neck mass, and fine needle biopsy of the thyroid nodule. The open biopsy is carried out by a general surgeon and the FNA and ^{123}Iodine scan by the clinical endocrinologist. Results indicate the lateral neck mass to be a lymph node with metastatic papillary carcinoma while the FNA cytology from the intra-thyroidal nodule is also a papillary carcinoma. The ^{123}I scan reveals the intra-thyroidal nodule to manifest poor uptake (cold). There is good uptake in the remainder of the thyroid gland but none in the area of the right sided lymph node mass. The patient is seen for a follow-up visit to discuss the findings and recommendations. Near total thyroidectomy and post-thyroidectomy ^{131}Iodine ablation of the thyroid remnant is recommended. These are scheduled and completed without incident.

Codes for this Example:

The coding of the services for this patient could properly include CPT code 99215 for the initial visit of this established patient with ICD-9-CM diagnosis codes 250.00 for the controlled, uncomplicated diabetes mellitus and 784.2 for a neck mass. Assuming the thyroid function and antibody tests were done in the physician's own laboratory, those would be coded CPT 84443 (TSH), 84439 (free T4), and 86376 (anti-microsomal AKA anti-TPO antibody). If the tests were sent out, a -90 modifier should be added. The CPT code for the neck/thyroid ultrasonography is 76536. The neck mass biopsy is coded by the surgeon as 21550. FNA biopsy of the nodule, done under ultrasound guidance since the nodule was not palpable, is coded 76942. The ^{123}I scan CPT code is 78010; no uptake was performed. The outside laboratory pathologist performed the cytological evaluation. At the follow-up visit, once the pathological diagnosis is known, the ICD-9-CM diagnosis code used is 193, for malignant neoplasm of the thyroid gland. Finally, the ablation treatment is coded as 79030 or 79035.

Additional Coding Suggestions

Additional suggestions for coding when submitting claims (and a requirement for Medicare and

some other insurers) are to use the highest level of specificity for the ICD-9 code (required by Medicare and most insurers); if you are only performing a test or procedure on request of the patient's treating physician or qualified non-physician practitioner, do not bill an evaluation and management (E & M) code. If you are the *treating* physician and you perform a test or procedure, an E & M code may be billed if it represents a *separate and distinct* evaluation of the patient. If you perform both a test or procedure and an E & M service on the same date, use a -25 modifier on the E & M code (e.g., for a consultation at the level of 99245, submit the service as code 99245-25).

With respect to documentation requirements, an appropriate diagnosis code must be submitted for any service, including a laboratory test. The patient's medical record must document the signs/symptoms and risk factors exhibited by the patient that required ordering the diagnostic test. For Medicare patient services, this is spelled out under the 'Indications & Limitations' specifications of the Medicare carrier policy and the required documentation must be available to Medicare upon request.

Non-covered Services, Denials and Waiver Notices

Note that insurers may not accept the necessity of, or reimburse for, performance of a test or procedure or even an E & M service in certain situations and/or the insurer's coverage policy may make the patient responsible for paying for it. In situations of possible denial and non-coverage, obtain an advance beneficiary notice (ABN) prior to performing testing, just as in the case for other tests which may be non-covered, denied as not medically necessary, or for which frequency intervals that apply may be exceeded. [Appendix 1] An example of a test which may be considered investigational and therefore non-covered is serum thyroglobulin. Here, an ABN notice could be used for a Medicare patient (a waiver statement) and a similar form could be used for the non-Medicare patient. [Appendix 2] When using an ABN form, be certain to inform the patient of his/her responsibility for payment for the test and complete such an ABN form before the test is even drawn. Discussion and suggested solutions on non-covered services are further presented in Appendix 3. Ideas for securing timely payment for claims are found in Appendix 4.

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OTHER USEFUL REFERENCES:

HCPCS Level II Codes *(e.g., J codes for injectables) Order from the AMA or other suppliers.*

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Appendix 1: Example of Waiver Statement

THYROID CARE CENTER, LLC

WAIVER STATEMENT

Provider Notice

Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that that.

I believe that, in your case, Medicare is likely to deny payment for _____ (in this space you need to specify the particular services) for the following reasons: _____ (here you need to specify the reason(s) you believe these services will be denied by Medicare)

Beneficiary Agreement

"I have been notified by my physician that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed, _____
(MEDICARE BENEFICIARY)

Date _____ /_____ / 2004

Amount $_____

Appendix 2: Example of Waiver Statement for Patient Testing

THYROID CARE CENTER, LLC

WAIVER STATEMENT FOR PATIENT TESTING

Provider Notice

Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for the test. The following test(s) are considered for research or investigational use only by Medicare. Your physician, nevertheless, believes the test(s) are necessary and payment for them will be your responsibility. Accordingly, you are asked to sign this advance beneficiary notice agreeing to pay for the test below:

_____ Serum thyroglobulin level

Beneficiary Agreement

"I have been notified by my physician that he believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ Date _____ /_____ / 2004
BENEFICIARY'S SIGNATURE

_____ _____
BENEFICIARY'S NAME (PRINTED) BENEFICIARY'S INSURER ID #

Appendix 3: Non-covered Services

The distinction between an insurer's "covered" and "non-covered" services and procedures is often unclear. It seems that an insurer will pay one claim, deny a similar one the next week as "non-covered", and down-code another shortly thereafter as "medically unnecessary".

There appears to be confusion between services which are "non-covered" (e.g., screening and preventive services) and services which are "covered" but for which payment is denied as when the insurer considerers them "not reasonable and necessary". Coverage usually depends on the circumstances surrounding the provision of care. Generally, where the physician determines that a service or procedure is "for the diagnosis or treatment of illness or injury," it will be covered. Even if a service would be "covered" in a given instance, it is not guaranteed that it will be paid; such services may be denied on the basis of medical necessity and the physician may be required to refund any payments denied as "medically unnecessary" unless a waiver form was properly completed in advance.

Screening for possible illness in an asymptomatic patient is often non-covered. Preventive services and counseling on avoidance of risk factors and screening services unrelated to a patient's symptoms or diagnoses are non-covered by many insurers (e.g., rectal exam on a beneficiary with arthritis). If a symptom or diagnosis necessitates the medical service provided, then that should be a covered service.

Physicians can bill their usual patient fee for any non-covered services and need not submit a claim for this. The patient should be fully informed in advance that the service in question is probably non-covered and the patient is liable for payment. Bill the patient directly at your full, normal rate.

Some situations require the physician to make a subjective medical decision on whether to submit a claim to the insurer. If there is any doubt as to whether the insurer will pay for a given service, the physician should code conscientiously and let the insurer make the determination. Thus, the beneficiary has the opportunity to receive payment benefits to which he/she is entitled.

Occasionally, a portion of a visit will be covered (e.g., that portion involved in treating a patient's hypertension) but the remainder involves a non-covered evaluation, such as screening. In such an instance, obtain in advance a signed ABN/waiver form from the beneficiary stating that the insurer usually does not pay for such a comprehensive level of care and that the patient accepts responsibility for payment of any portion of the visit deemed "medically unnecessary" by the insurer. Submit the signed waiver with the original claim form. Of course, the physician always has the option of performing the non-covered services at a separate visit and directly billing that charge to the patient.

Appendix 4: Securing Timely Payments for Claims

There are several ideas that may help you get paid in a timely fashion for your claims. Health insurers respond in a number of ways to complaints from physicians who assert claims are not being paid promptly. Although a insurer is justified in investigating claims presented for payment, there is no justification for a insurer to hold and earn interest on funds, while the physician who provided the service is deprived of a legitimate payment.

Another reason cited by insurers for payment delays is that the physician has submitted a claim that is not "clean." A insurer considers a claim "clean" when all the necessary information is submitted on the claim. Certainly, insurers can legitimately require physicians to submit specified information in order for the insurer to determine if they are liable for payment on the claim. Physicians seeking to combat chronic late payment by health insurers must commit to systematic documentation and follow-up on claims.

General Strategies for Physicians to Secure Timely Payments

Negotiate for contract language establishing clear rights to prompt payment and interest on the amount overdue. Most contracts presented to physicians do not contain a clause requiring prompt payment of "clean" claims or penalties for late payments and insurers have no incentive to include such provisions. Consider including in your contract(s) a provision addressing both issues as follows:

Promptness of Payment: Each insurer shall remit to the (physician/physician group) the company compensation within thirty (30) days of its receipt of the submission of a claim by (physician/physician group) sufficient in detail that the insurer is able to reasonable determine the amount to be paid. If additional information is needed by insurer to evaluate any claim for payment by (physician/physician group), insurer shall request any additional information in writing within forty-five (45) days of receipt of the Claim. Insurer shall affirm and pay any valid Claims within thirty (30) days of receipt of such additional information…In the event that a insurer fails to make payment in a timely fashion as specified herein, insurer shall be obligated for payment of such amounts plus interest accruing at the annualized rate of the Wall Street Journal prime rate of interest on the first day of the month on which such amounts were due plus three (3) percent. All payments to (physician/physician group) will be considered final unless adjustments are requested in writing by (physician/physician group) within ninety (90) days after receipt of payment explanation from insurer.

Document! Document! Document!

One key to timely payment of claims is documentation. If claims are regularly being returned to your practice due to lack of documentation/information, assign a specific staff member or hire a practice management consultant to develop and implement more efficient procedures to correct any existing problems.

Have your staff develop a collegial relationship with both the claims processors and provider relations' representative, asking for their input on how to help them process your claims smoothly.

Update Your Billing System

An appropriate computerized billing system and electronic claims submission can have a tremendous impact on both your ability to secure prompt reimbursement and your ability to track claims payment. Electronic claims are generally paid much more quickly than non-electronic claims. The process itself reduces opportunities for mistakes by lessening the number of times information must be entered. Your accounts payable software should have the capacity to develop "aging reports."

Contact Your Association or Society for Help

Document in writing any particularly egregious situation involving the payment of claims and share the information with your professional organizations (e.g., state medical society, American Medical Association, or National Specialty Society). Each can then develop a strategy, working with other such organizations, to use the power of organized medicine to combat unfair or abusive insurer payment practices. The American Medical Association (AMA) is gathering information on the late payment crisis occurring across the nation, and is working with state medical societies to address the problem in individual states.

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