Beyond Coding 2009: Making Codes Matter to Payers

Gilbert I. Martin, M.D.

Jack C. Christensen, M.D.
Disclosure – Dr. Christensen

- Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services related to the content of this CME activity.

- I do not intend to discuss an unapproved or investigative use of commercial products or devices.
Disclosure – Dr. Martin

- Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services related to the content of this CME activity.

- I do not intend to discuss an unapproved or investigative use of commercial products or devices.
Reimbursement Through the Ages

◆ Kill the Physician, and the fee bestow upon the foul disease.

William Shakespeare

◆ A fashionable surgeon like a pelican. Can be recognized by the size of his bill.

J. Chalmer Da Costa
Reimbursement Through the Ages

- A physician who heals for nothing is worth nothing.  
  The Talmud

- In the midst of your illness you promise a goat, but when you have recovered, a chicken will seem sufficient.  
  African Proverb
Reimbursement Through the Ages

- A physician is an angel when employed but a devil when one must pay him.
  
  Latin Proverb

- The doctor demands his fees whether he has killed the illness or the patient.
  
  Polish Proverb
The Neonatologist’s Reimbursement Dilemma

- The views of other physicians
- Smaller patients - smaller fees
GALEN
Galen:
Four Types of Physicians

- Those who practice because they love humanity
- Those who practice because they love honor
- Those who practice because they love glory
- Those who practice because they love money
<table>
<thead>
<tr>
<th>Year</th>
<th>CF</th>
<th>Year</th>
<th>CF</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>$36.61</td>
<td>2005</td>
<td>$37.89</td>
</tr>
<tr>
<td>2001</td>
<td>$38.25</td>
<td>2006</td>
<td>$37.89</td>
</tr>
<tr>
<td>2002</td>
<td>$36.19</td>
<td>2007</td>
<td>$37.89</td>
</tr>
<tr>
<td>2003</td>
<td>$36.78</td>
<td>2008</td>
<td>$38.08</td>
</tr>
<tr>
<td>2004</td>
<td>$37.34</td>
<td>2009</td>
<td>$36.06</td>
</tr>
</tbody>
</table>
## Neonatal and Pediatric Critical Care Bundled Services

<table>
<thead>
<tr>
<th>Procedures Interpretation Monitoring</th>
<th>CPT Codes</th>
<th>Hourly Critical Care 99291, 99292</th>
<th>Neonatal/Pediatric Critical Care, Intensive Care and Pediatric Transport 99466, 99467, 99468, 99469, 99471, 99472, 99477, 99478-99480</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive/noninvasive electronic monitoring; vital signs</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cardiac output measurements</td>
<td>93561, 93562</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Chest x-rays</td>
<td>71010, 71015, 71020</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Blood gases, pulse oximetry</td>
<td>94760, 94761, 94762</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Information/data store in computers, ECG, BP hematologic data</td>
<td>99090</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Procedures</td>
<td>CPT Codes</td>
<td>Hourly Critical Care</td>
<td>Neonatal/Pediatric Critical Care, Intensive Care and Pediatric Transport</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------</td>
<td>----------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Interpretation/Monitoring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral or nasogastric intubation</td>
<td>43752, 91105</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Temporary transcutaneous pacing</td>
<td>92953</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Endotracheal intubation</td>
<td>31500</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Ventilatory management CPAP</td>
<td>94002-94004; 94660, 94662</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Surfactant administration</td>
<td>94610</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
# Neonatal and Pediatric Critical Care Bundled Services

<table>
<thead>
<tr>
<th>Procedures</th>
<th>CPT Codes</th>
<th>Hourly Critical Care</th>
<th>Neonatal/Pediatric Critical Care, Intensive Care and Pediatric Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular Access Procedures</td>
<td></td>
<td></td>
<td>99291, 99292</td>
</tr>
<tr>
<td>Central, peripheral catheterization</td>
<td>36555, 36000</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Umbilical catheterization</td>
<td>36510, 36660</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Other arterial catheterization</td>
<td>36140, 36620</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Vascular access procedures</td>
<td>36000, 36410, 36415, 36591, 36600, 36400, 36405, 36406</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Vascular punctures</td>
<td>36420, 36660</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
# Neonatal and Pediatric Critical Care Bundled Services

<table>
<thead>
<tr>
<th>Procedures</th>
<th>CPT Codes</th>
<th>Hourly Critical Care</th>
<th>Neonatal/Pediatric Critical Care, Intensive Care and Pediatric Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vascular Access Procedures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intravenous fluid administration</td>
<td>90760, 90761</td>
<td>99291, 99292</td>
<td>X</td>
</tr>
<tr>
<td>Transfusion blood components</td>
<td>36430, 36440</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pulmonary function testing</td>
<td>94375</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td>62270</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Suprapubic bladder aspiration</td>
<td>51000</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Bladder catheterization</td>
<td>51701, 51702</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Calculating Reimbursement Using The Resource-Based Relative Value Scale (RBRVS)

Elements of the RBRVS:

- Physician Work
- Practice Expense (PE)
- Professional Liability Insurance (PLI)
- Geographic Practice Cost Indices (GPCIs)
- Conversion Factor (CF)
Calculating Reimbursement Using The Resource-Based Relative Value Scale (RBRVS)

A 34 week baby is admitted to the NICU and requires intubation and ventilatory support.

- Code 99468 – Initial neonatal critical care < 28 days
- Work RVU = 18.46
- Practice Expense RVU = 4.52
- Professional Liability Insurance = 1.16
- Total RVUs = 18.46 + 4.52 + 1.16 = 24.14
Calculating Reimbursement Using The Resource-Based Relative Value Scale (RBRVS)

To determine the suggested reimbursement for this code multiply the total RVUs by the conversion factor:

\[ 24.14 \times 36.06 = \$ 870.84 \]

This is the Federal Government suggested reimbursement. Each State has the ability to decrease this number based upon Federal funding plus individual State budgets.
You hold their hand, now let us hold yours.
You hold their hand, now let us hold yours.

Billing is the lifeline of the neonatologist’s practice and you need it to be done by a trusted expert. It is a highly complex process requiring specialists in many areas: coding, electronic billing, managed care contracting, compliance, and denials management. We bill over 7 million patient visits annually at more than 265 hospitals across the country—we have all the specialists you’ll need on your team.

Everything we do is kept in the strictest confidence. Our safeguards make certain your financial information is kept private and never shared with others at your hospital.

Make us your trusted partner. We’ll watch out for your practice’s finances the same way you care for the health and well-being of your smallest babies.

1-800-443-3672, Ext. 2368
www.hcfin.com

Health Care Financial Services
of TEAMHealth
It pays to make friends with payers

Health-plan employees are people, too. That’s good to keep in mind during the next call about a denial.

By Robert Lowes
SENIOR EDITOR

When your biller phones a third-party payer about the latest underpaid or denied claim, the conversation doesn’t have to resemble the new TV show about Iraq called Over There—all verbal gunfire and explosions.

Okay, maybe it won’t be 7th Heaven, either, but the relationship between your employees and an insurer’s can be civil, constructive, and a boost to your bottom line. Many practices have learned that when it comes to collecting their money, they attract more flies with honey than vinegar. The honey can be something as simple as a Christmas card or phrasing of a complaint tactfully.

“We come from the viewpoint that the insurer is not our enemy,” says Bonnie Carlson, administrator...
MODIFIERS

- A 2-digit suffix appended to a CPT or HCPCS code i.e., (99223-25).
- A means to indicate that a service or procedure performed has been altered by circumstance, but has not changed its basic definition.
- Describe special circumstance related to a service or procedure.
Modifiers

- Required by law to correctly identify services performed when applicable.
- Payment for services may be denied when omitted in situations that require them.
- Services can be denied when modifiers are used incorrectly.
- Most payers have sophisticated edits in programs to identify modifier necessity.
Modifiers

-22 Increased Procedural Services
-24 Unrelated E/M Service by the Same Physician during a Postoperative Period
-25 Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or Other Service
-26 Professional Component
-59 Distinct Procedural Service
-63 Procedure Performed on Infants less than 4kg.
Modifiers

- A service or procedure had both a professional component and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure was increased or reduced.
- Only part of a procedure was performed.
Modifiers

- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.
Modifier Example

This is a day old (3150 grams) term infant born to a mother with history of fever and ROM x 18 hours. GBS status is unknown. The neonatologist attends the delivery and admits the baby to the regular nursery. The neonatologist draws a CBC and blood culture and infant is sent to the regular nursery in good condition. At about 12 hours of age infant develops tachypnea and grunting and the neonatologist admits the baby to the NICU.

The proper code(s) are:
- 99464, 36400-59, 99460, 99477-25
Modifier - 25

Definition: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.

- Modifier 25: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. Always attach the modifier to the E/M code.
**Modifier -59**

- **Definition: Distinct Procedural Service**
  - Modifier -59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. The procedure must not be a component of another procedure.
HCPCS Modifiers

The HCPCS level II codes and modifiers are part of the standardized coding system under the Transaction Rule of the Health Insurance Portability and Accountability Act. This system is recognized by all payers. The HCPCS modifiers should be reported with CPT codes when appropriate. Be certain that where a modifier is used that the medical necessity and justification for reporting the service is clearly supported in the medical record.
HCPCS Modifiers

- The need for modifiers is determined by payers as well as CPT coding rules.
- Some payers use these CPT modifiers.
- Others adopt their own policies or requirements.
- To prevent denials caused by modifiers review remittances (explanation of benefits) from your payers.
- BE PROACTIVE
The Business of Neonatology

- Neonatal Fellowship Programs do not discuss or emphasize “the business of neonatology”
- Neonatal directors are typically not proactive in contracting, billing and follow-up reimbursement issues
- Neonatologists are not involved with legislation regarding funding and reimbursement and therefore are passive when changes occur
The Business of Neonatology

We need to emphasize the steps which should be taken by the neonatal group in order to maximize reimbursement and be proactive in achieving a “fair share”. We will also discuss the frustrations of dealing with Federal and State allotments for healthcare.
1. The physician should select the *CPT* and diagnosis code.
2. Document services to support your code selection. “If it isn’t documented, it wasn’t done.”
3. Use separate codes to reflect the amount and breadth of work done. Use E/M codes in addition to procedure codes when appropriate.
4. Separate codes require separate fees reflecting different amounts of work or resources used (costs). Consider using the RBRVS to develop a fee schedule.
5. Use modifiers when special circumstances exist (eg. repeat procedure) or when altering the fee for a code.
Rules for Correct Physicians’ Current Procedural Terminology Coding, Reimbursement and Appeal

6. Always set your fees independent of reimbursements. The alternative of adjusting fees to match declining payments will result in declining revenues.

7. Know the reimbursement policies and fee schedule for all payers. Use this information when negotiating contracts, as well as working with denied claims.

8. At least one neonatologist in the neonatal group should be responsible to work with billing staff regarding CPT and ICD-9 codes. The neonatologist should periodically (with the staff) correct payer information, verify eligibility, understand "clean" claim submissions, establish a system for monitoring denials or reduce payments and educate the billing staff regarding proper coding.
9. Watch the explanation of benefits (EOBs)—what each payer sends back after submission of a bill. Profile denials, and work on those with patterns or high value based on volume or size of the claim.

10. Create an appeal process that deals with tracking denied claims. By not appealing, the carrier's inappropriate denials are endorsed. Know each health plan's appeal process. It is important to address issues with an authoritative individual who can make decisions.

11. Review codes and reimbursement every six months. New CPT and ICD-9-CM codes are released by October of each year. Each practice should be prepared to utilize new and revised CPT and ICD-9 codes by January of each year.

12. Design a superbill that contains commonly used CPT and ICD-9-CM codes for each individual practice. Consider using outpatient and inpatient superbills to capture all charges.
Beyond Coding: Claims and Appeals

- Appropriate claims filing
- Timely follow through
- Aggressive appeal process of denied claims
Beyond Coding: Claims and Appeals

- Neonatologists are often not part of the negotiation process with payers
- Neonatologists tend to leave submission of claims to “office managers” without periodic review
- Neonatologists believe that reduced payment can be offset by increasing volume
Beyond Coding: Claims and Appeals

- The neonatologist should periodically:
  - Correct payer information
  - Verify eligibility
  - Understand “clean” claim submission
  - Educate staff regarding proper coding
  - Establish a system for monitoring denials or reduced payments
Beyond Coding: Claims and Appeals

- **Self-Assessment: Questions to ask**
  - Does your staff track the percent of claims that are denied on the first submission?
  - Do you know the most frequent reason for claim denials?
  - Do you have claims denied because they were submitted to the wrong payer?
  - Do you consider secondary or other coverage?
  - If Medicaid is the primary payer, does your staff check if Medicaid forwards the claim to a secondary payer?
Beyond Coding: Claims and Appeals

◆ Self-Assessment: Questions to ask
  • What rebilling cycle do you use? (30 days is ideal)
  • Does your staff reconcile claim denials and payments? (10 days is ideal)
  • Does your staff know the special requirements for each healthplan or payer?
  • Do you attach an EOB (explanation of benefits) for submitting claims to secondary payors?
Reasons For Denials That Can Be Corrected

- Assignment – Accept assignment box is checked inappropriately
- Authorization – The authorization number missing
- ICD-9 – Invalid ICD-9 code is used
- CPT 2009 – Incorrect CPT code is used
- Contract Number – Subscriber’s contract number missing or invalid
- Dates – Missing or incorrect dates (admission/discharge; duplicate dates etc)
Reasons For Denials That Can Be Corrected

- **Group Number** – Missing group number on claim form
- **Identification Number** – Physician’s provider identification or license number is missing on claim form
- **Insurance Information** – Name, sex, SS#, group, and/or plan number is missing or invalid
- **Modifiers** – Missing modifiers on a procedure that mandates the use of one (-25 modifier on a multidisciplinary conference CPT code)
Reasons For Denials That Can Be Corrected

- Patient Information – Address invalid, birth date incorrect or missing
- Physician’s Notes – Procedures are not matched with documentation
- Type of Service – Listed incorrectly on claim form
Beyond Coding: Claims and Appeals

Filing Appeals

- Concern about additional administrative costs
- If there is no review process or follow up, the carrier will be encouraged to misapply CPT coding conventions
- By not appealing, the carrier’s inappropriate denials are endorsed
- By not knowing the data, the neonatologist is in a weaker position for negotiations
Beyond Coding: Claims and Appeals

Filing Appeals

- Address issues with an authoritative individual who can make decisions
- State the problem, provide medical justification as well as CPT coding guidelines
- Specify a date for when you expect a response
- Send all correspondence by certified mail
Beyond Coding: Things You Should Never Say To A Claims Representative

- You underpaid us and we want that money right away!
- You people did it again
- We just received a bunch of denials and don’t know why
- You’re completely useless. Let me talk to your supervisor
- Do you know who I am?
Beyond Coding: Negotiating

- Third-party payors can obtain data regarding billing and coding practices
- The neonatologist should be familiar with health plan policies and procedures
- Know the CPT codes and how they are used
- Diagnoses (ICD-9) does not dictate the CPT code used
Beyond Coding: Typical Appeal Letter

- Be specific: “I am writing regarding your denying code 99465 for neonatal resuscitation”
- History of the code: “This code was derived in 2002 to separate attendance at delivery (99436 now 99464) from delivery requiring resuscitation”
- A typical example: “This 3400 gram infant was born after an abruptio placenta and needed intubation, oxygen and IV fluids in the delivery room”
Beyond Coding: Typical Appeal Letter

- State how CPT guidelines apply: “The above example justifies a 99465 code as described in CPT 2009 the official guideline from the American Medical Association” (cite page and edition)

- State the carrier’s responsibility: “It is considered good faith for carriers to adhere to CPT guidelines since these guidelines are the current standards within organized medicine”

- “I urge you to reconsider your position on this issue”
Beyond Coding: Simplifying The Appeal Process

- Know the health plans appeal process
- Know how to submit a “clean” claim with medical necessity
- Know rates and reimbursement methodology
- Make sure documentation is complete
- Evaluate the health plan’s EOB (explanation of benefits) for potential processing errors and use of an inappropriate CPT code or modifier
Beyond Coding: Simplifying The Appeal Process

- Review each EOB to insure that the negotiated reimbursement schedule is correct
- Maintain a follow-up log for each patient
- Keep on appealing
- Remain aggressive
Beyond Coding:
Continued Denial or Reduced Reimbursement

Available Options:

• Contact PSA (Private Sector Advocacy) Group
  www.ama-assn.org/go/psa
  Telephone: (800) 262-3211
• File for an external review through appropriate State or Federal regulatory agency
• Ask the American Academy of Pediatrics to submit an appropriate appeal
United States v. Halper

- Manager of Lab, accused of defrauding government out of $585, by “upcoding” 65 office visits; seeking $12 per claim rather than $3
- Convicted on 65 criminal counts, sentenced to 2 years in prison and $5,000 fine

Some considerations when initiating an audit program

- Stark I, II, III
- Anti-Kickback
- Qui Tam Cases (Whistleblower)
- Sarbanes-Oxley
- HIPAA Privacy
- EMTALA (Emergency Medical Treatment & Active Labor Act)
Corporate Integrity Agreements with the Office of Inspector General (OIG)

- To date, there are 473 Corporate Integrity Agreements (CIA’s) in place
The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 306) directs the identification of underpayments and overpayments, and the recoupment of overpayments under the Medicare program.

Three year pilot in New York, California & Florida.

Pilot excluded E&M services (CPT codes 99201 – 99499)
CMS Recovery Audit Contractor (RAC) Project

- Pilot targeted:
  - Incorrect payment amounts
  - Non-covered services
  - Incorrectly coded services
  - Duplicate services

- Audits were either complex (full medical record review) or automated (using software to identify)
RAC Expansion

- Status documents of pilot program available at [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC)
- In 2006, $54.1 million was returned to the Medicare Trust Funds
- Program was deemed success!
- Tax Relief Act of 2006 (section 302)- RAC program to be implemented nationwide no later than 2010
Appendix 3: RAC Expansion Schedule

*California claims will not be available for review from March 2008–approximately Oct. 2008 due to a MAC transition

www.cms.hhs.gov/RAC
What the future holds for MDs and RACs

- To date, no determination has been released regarding:

  Physician Evaluation and Management Services. CMS excluded these services from RAC review while CMS considered a proposal by the American Medical Association that might change the way these services are reviewed.
Audits:
Preventative Measures

- Continually vigilant of the neonatal coding standards and interpretive guidance that is available
- Recognize that CPT provides guidance to physicians in most clinical cases but still falls short of giving definition to every clinical encounter
- Understand that the “provider” is ultimately responsible for CPT codes selected and billed
Audits:

Preventative Measures

- Have current* resource material available in your practice
  - CPT Professional Edition 2009
  - “CPT Changes 2009 – An Insider’s View”
  - ICD-9 2009
  - CPT Assistant
  - Coding for Pediatrics 2009
  - “Pediatric Coding Companion”

*Coding resources from previous years should also be maintained to facilitate appeal support
Audits:
Preventative Measures

- Annual updates of billing sheets to include current CPT and ICD-9 codes
- Understand resources available
  - CPT Information Services
  - AAP
  - AAP Coding Trainers
  - Consulting Firms
Group or Committee

- Each group, or if in a large practice (committee), should meet and formalize from CPT, annual Coding Guidelines
- Use available interpretive guidance for your reference
- Minutes of this meeting should be maintained
- Meet quarterly to address current issues and questions
- Review all prospective changes to CPT and ICD-9–CM and amend your group’s Guidelines annually
- Consider self-auditing your practice’s CPT code selections
- Review CPT frequency report quarterly
Group or Committee

- External validation is a possibility
- Have compliance standards and procedures for the receipt, retention and treatment of any concerns raised by members of your group and employees with respect to neonatal coding
Audits

- Routine Desk Audits
- Formal Investigations
Routine Desk Audits

- Most common type
- Usually selected claims
- Do not underestimate!
- You do not want adverse findings in someone’s file
Routine Desk Audit
(Documentation Does Not Support Code)

- Review each entire medical record for DOS in question
- Understand the “yardstick” you are being measured against
- Do not ignore!
- Evoke appeal rights if you disagree with their findings
Routine Desk Audits

- Multifactorial (multiple etiologies)
  - Duplicate billing
  - Records not found (counts against you)
  - Coordination of benefits
  - Subscriber not on plan
  - Baby not enrolled
  - “Documentation does not support code”
  - “Convenience codes”
  - Billing services under appropriate physician
Formal Investigations

- Do not panic!
- Legal counsel needs to be appropriate
  - Not your CPA or business manager
  - Not your probate attorney
  - Major cities have law firms that specialize in Health Care Law
- Know your rights
- “Spirit of cooperation” should all be orchestrated through your counsel
- Consistent communication is important
Attitudes

- Be careful of billing for unnecessary services or service not performed
- Always meet your patient to avoid: “I never saw the neonatologist yet I have a bill!” (most common in L&D services and growing premature infants receiving intensive therapies)
- Common complaint is “only the nurse saw my baby”
- Uniformed correspondence from parents/attorneys (never requested your service/ present at delivery)
Attitudes

- Do not bill for services higher than the level provided
- Understand basic concepts violations of Fair Debt Collection Act
- Unprofessional conduct
- Common to hear: “My primary care physician said....”
Attitudes

- Maximize as a group patient satisfaction
- Best to address patient issues when they are still patients
- Expect more routine desk audits in coming year
- Have you met yet as a group on the 2008 CPT code changes? What have you done to implement them?
Attitudes

- Correct coding vs. revenue enhancement
- Fresh approach and attitude towards documentation will be essential going forward
- Any guidelines or interpretive guidance you adopt should be Proprietary and Confidential and consider Copyright and time and date document
The Proactive Neonatologist

- Is involved in the negotiating process on contracts
- Has a well defined billing system based on current CPT and ICD-9 codes
- Meets frequently with billing staff to assess denials, claims for additional information and non-payment
- Installs a system where each bill can be evaluated for its place in the reimbursement cascade
- Is up to date on new and revamped CPT codes and documentation necessary
Future Considerations

- Per diem payment for neonatal claims
- Consideration of an “interest charge” for delayed payments
- Organization and restructuring of Local and State Neonatology Groups with an emphasis on coding and reimbursement (the California Association of Neonatologists, the Southeast Perinatal Association)
- A greater relationship with the Section on Perinatal Pediatrics of the American Academy of Pediatrics
...IT IS BETTER TO CURSE THE DARKNESS THAN TO LIGHT THE WRONG CANDLE.