**Clinical Chats Official Podcast Transcript**

**Title:** Coding with Ann Episode 24: Updates on Common LARC Miscodes

**Speaker:** Ann Finn

**Duration:** 00:21:31

**Katherine Atcheson (**[**00:04**](https://www.rev.com/transcript-editor/shared/Et7oOBM5jmyo2pERCwcBR_RIK8hAoLXMwu0fD52eijjaaANb0jOejicISFLotXwzJX8zngV5tr9aZA3GK9uBr4GXCF4?loadFrom=DocumentDeeplink&ts=4.95)**):**

Hello and welcome to Clinical Chats, a podcast for sexual and reproductive healthcare professionals. Clinical Chats, formerly known as the Family Planning Files, is a program of the Clinical Training Center for Sexual and Reproductive Health, or CTC-SRH, formerly known as the National Clinical Training Center for Family Planning or NCTCFP and is funded by the Office of Population Affairs in order to enhance the knowledge of Title X clinicians and other staff. Our guest today is Ann Finn, a healthcare reimbursement consultant and national trainer with many reproductive healthcare organizations and she heads her own company, Ann Finn Consulting, LLC. Welcome back to the podcast, Ann. We're so excited to have you today.

**Ann Finn (**[**00:50**](https://www.rev.com/transcript-editor/shared/kjAt6oLptbxjX17KmVHHCXiTZSrAj1nfVibzFjokGZuweEtrPJAW2sHHs3BTPROdMO8nSWmeMvwxdmm-KsSM_nP9D6I?loadFrom=DocumentDeeplink&ts=50.31)**):**

Thanks Katherine. And thanks for joining us. Welcome to all my new listeners and welcome back. If you have listened to other podcasts in our Coding with Ann series. We're very excited to be able to offer these focus coding sessions to provide you with some tips and guidance to help you effectively capture and code your services resulting in both appropriate and timely reimbursement.

**Ann Finn (**[**01:12**](https://www.rev.com/transcript-editor/shared/47CNmJpDdc9kRkGp1PQGDIfKl8MgoAedLK2KPKi3e3Nh4K5ZY4bWbVoFhz-sZgnOYwyHIvfNWP1DbKHedt4_UjkO5PA?loadFrom=DocumentDeeplink&ts=72.03)**):**

Today's podcast will focus on commonly miscoded LARC or long-acting reversible contraceptive services, which includes both IUDs and implants, or Nexplanon. We've updated this podcast to include clarifications made by the American Medical Association, or AMA, on E&M coding and the ability to include point of care tests when determining in E&M code.

**Ann Finn (**[**01:36**](https://www.rev.com/transcript-editor/shared/j5hW934OnlNpuBr-Ja35Lnj4pm64KdVqyt8QZSVv9LOn_m1pFBdBXaN4ZA-Mt5wsQrCUa7OAh28QQbuejloCGGXZ3Q8?loadFrom=DocumentDeeplink&ts=96.9)**):**

As we know, improper coding of services may lead to a reduction in reimbursement or an unintended overpayment of a service which may open a provider to payer audits and payment take backs when billing for services. Both are detrimental to a practice's fiscal health. We want to avoid this and code these services right the first time.

**Ann Finn (**[**01:59**](https://www.rev.com/transcript-editor/shared/UobZb8074a5NQnnodDueG-gwxbPOHwbi1uO7xAOBtEjZSzNQZdDwpaCejjl5vRpRt2OSsgMjXognrjJmh5eDQJm4MFI?loadFrom=DocumentDeeplink&ts=119.64)**):**

When coding and billing for LARC services, we need to first properly and fully document the services provided during the clinical visit. Did the patient present not knowing what form of birth control was the best fit and therefore received family planning counseling as well as a LARC method? Perhaps she presented for a scheduled LARC procedure after receiving contraceptive counseling on a prior visit a day or two ago. Or maybe she presents for a LARC procedure but there is another issue that is also tended to during the visit. Each of these scenarios take place in a busy family planning clinic and each scenario would be coded and typically reimbursed differently.

**Ann Finn (**[**02:39**](https://www.rev.com/transcript-editor/shared/GisvtfzLc1MvV1z_x8eQY1lojlqNflqsIRg4wlsQJRDbT_VFBcje_rwG1uyjuOFSZFdB6xxud00uArBEojyX4CmtdJI?loadFrom=DocumentDeeplink&ts=159.06)**):**

Let's start with a visit from Maggie. She is a 19-year-old female patient who recently became sexually active. Maggie is not sure what method of contraception she would like, so she and the clinician discuss the variety of methods available, their effectiveness, potential side effects, and other related topics. After discussing her options together, Maggie decides she would like an IUD. Maggie is administered a urine pregnancy test, which is negative. She is also screened for chlamydia and gonorrhea, which will be sent out to the lab. The clinician inserts the IUD during the same visit, which is a best practice. And the clinician documents 20 minutes of total time on the date of the encounter, excluding the IUD insertion. What codes would we need to capture and bill for this visit and where do we sometimes see miscoding?

**Ann Finn (**[**03:33**](https://www.rev.com/transcript-editor/shared/WafU_alNEXSWTh4UuYNVzEtdcKNd1x2hbloao-GzTPvMb9eMinewz0Sl12ASSuNaU-St7fwfVPbyHb1WCL4hz8Wmfa0?loadFrom=DocumentDeeplink&ts=213.78)**):**

First, we need to capture the medical visit and contraceptive counseling and tell the payer the service is separate and distinct from the actual LARC insertion. Depending on the extent of services provided and the codes the payer accepts, the clinician may code a preventive well visit evaluation and management or E&M code such as a 99385 or an office or outpatient problem-oriented E&M code such as 99203 or 99214 based on the medical decision-making or time or a preventive counseling code based on time such as 99401 or 2. But these preventive counseling codes are not commonly coded by providers when an office visit is billable and typically pays at a higher rate. E&M codes that are miscoded can result in an under or overpayment. It's really important to select the correct code for the visit.

**Katherine Atcheson (**[**04:28**](https://www.rev.com/transcript-editor/shared/F9Gj7Q1ooy1nfU2o8FZzUNYxSTOdfYPP4A9jqnIubFlF3dOLdpwtBydEidCEJL3nhMaxeRdSyJaZI5C5XHPWImHxnE4?loadFrom=DocumentDeeplink&ts=268.11)**):**

What factors can clinicians watch out for when they are doing their coding?

**Ann Finn (**[**04:34**](https://www.rev.com/transcript-editor/shared/g0KvqNmpGbd74EMnpdIDIN82aZMg-66ZlJMtiSX1zVbTe0CdXzN8DGYtxWJCYttuTO10g-eLgOrAQ17mi9hItsC5nXA?loadFrom=DocumentDeeplink&ts=274.17)**):**

That's an important question, Katherine. There are a few things to look out for. First, capture the right type of visit code like we've discussed. Second, is the patient considered a new or established to your practice? New patient visits are typically reimbursed at a higher rate than an established patient, so we have to think about this as we choose a code. And finally, we have to ensure capturing all the elements such as time and medical decision-making and the documentation, or we may not code the visit properly, which we'll talk more about shortly. Another big item we'll discuss is when the clinician over codes a separate medical or counseling visit on the same day as a LARC procedure that wasn't really separate from the procedure. Misses coding it all together. We'll talk more about that.

**Katherine Atcheson (**[**05:23**](https://www.rev.com/transcript-editor/shared/w6NorWlubMXEb2YjgPaVkGyVByGtl2SNAL6X_-pGjAhyid4DvwogLjonq3ns1T1cmPSJTbM8jhJR5cg0YZnxhEpR8zc?loadFrom=DocumentDeeplink&ts=323.64)**):**

Can you explain what defines whether a patient is a new patient or established to practice?

**Ann Finn (**[**05:31**](https://www.rev.com/transcript-editor/shared/wgA744esh6OHsom_cjknqYRrDKkQFpAtRBzshPjENzhHmkdTn0Fua79ZkFmMRLSAPnBJszmotlQxDKYeRolNMG4b040?loadFrom=DocumentDeeplink&ts=331.59)**):**

Sure. According to the current procedural terminology or CPT instructions, a new patient is one who has not received any professional services from the physician or other qualified healthcare professional, such as a nurse practitioner or another physician or qualified healthcare professional of the exact same specialty or subspecialty in the same group practice within the past three years. This includes prior face-to-face services such as counseling, medical visits, or surgical procedures. Improper coding of new versus established patients may also impact payments, so it's really important to be accurate here.

**Katherine Atcheson (**[**06:12**](https://www.rev.com/transcript-editor/shared/T_vt9XV0cv1t1E-MQb9NNmrgutGzNvlrztDERj-VrP6lfBpNSznun1UTt3E0ilyvk2Wtn--ydsZKUrS0mTP-sZ7hJXI?loadFrom=DocumentDeeplink&ts=372.69)**):**

How does a clinician know if the patient is new or established in the practice when they're selecting a code for a visit?

**Ann Finn (**[**06:20**](https://www.rev.com/transcript-editor/shared/WsTalBEwkDHuZe_I-vmPXQe59sXyppjvK8HtmnSNL7V8GBB_0Xo4l1D_ucKB_2VvCnDbzA6X5RTJcGdcJN5TZpv-8AQ?loadFrom=DocumentDeeplink&ts=380.28)**):**

Sometimes that's a challenge, especially in a large multi-specialty practice. A best practice is when the electronic health record pulls this information into the top of the chart note and clearly labels the patient as new or established or identifies the date of the last service. A provider I worked with a while back had a patient name new or established and the date of the last visit at the top of the chart note. Often the provider looks back through the medical record for prior visits and sometimes the front desk pulls that information. I've seen situations where a group was miscoding patients as new regardless of their status, and as a result was overbilling visit, which is a big no-no. Preventive E&M well visit codes are also based on the patient's age during the visit. These codes are pretty straightforward to assign, new versus established and how old is the patient at the time of the visit.

**Ann Finn (**[**07:10**](https://www.rev.com/transcript-editor/shared/RM4Gl9U5kyAw4RZ8AedwHPSyQoUKliELEi3cgnl-ZxKy7j3wo4Bd6r6N7D_g7GUe2fqFnPH3tx_QujHN4S01Gz7AfWM?loadFrom=DocumentDeeplink&ts=430.17)**):**

Problem oriented E&M codes, on the other hand, are a little more tricky and take some thought on the clinician's end to code properly. These codes are assigned based on either one, the clinician's total time of the date of the encounter, excluding other separately reported services such as the LARC insertion, or the clinician's medical decision making involved in the patient care. The E&M guidelines were updated beginning January 2021, so it's important that you and your clinical team are familiar with the changes and how to assign codes properly.

**Ann Finn (**[**07:45**](https://www.rev.com/transcript-editor/shared/7DdW0NhoEkepB2VPtKIV-54nCJFA2bHXUPUWKtxLK_MlQaSdsDaDHX3U0xuONPte9tC02NvfmO7bmxTFeaFQicuAN48?loadFrom=DocumentDeeplink&ts=465.51)**):**

When I review charts, I'm often looking as the clinician still documenting just their face-to-face time based on the old E&M guidelines, which means they're not capturing all the time they spend on the encounter, such as reviewing prior visit notes and lab results, documenting the visit in the EHR, ordering contraceptives and lab testing, follow-up coordination of care and so on.

**Ann Finn (**[**08:09**](https://www.rev.com/transcript-editor/shared/1sfrQvdHp-2V6nzh9BtiYVsmUXt2S38pbKSaxNCDgKnw3GTN_QfaS_F46SZaP5qCKU7tLPZZKW117yLIoY96ZR_5iBA?loadFrom=DocumentDeeplink&ts=489.33)**):**

You can see how easy it would be to under code the visit here if you don't count all the time in your basis. It's a best practice for the clinician to document both the total time and the medical decision-making level and then pick the higher code if there is a difference for each patient's visit. One method does not fit all visits, so you can interchange either method. Just make sure the codes are supported in the documentation. Performing internal audits or hiring a coder to review a sample and provide feedback is always recommended.

**Ann Finn (**[**08:43**](https://www.rev.com/transcript-editor/shared/zHGMxJKMoitwopXgNm_ZufPVPRn0n742gpIyWtOFe5ANal1aI9MgspkXPmUOBQbyyY-fbVTmQ1unDJKrBsa4ThX4Uxo?loadFrom=DocumentDeeplink&ts=523.98)**):**

Let's go back to Maggie's visit as a new patient and calculate the E&M code using medical decision-making. Maggie presents seeking contraception to avoid pregnancy or a single low-level problem. Maggie had an in-house pregnancy test and was screened for chlamydia and gonorrhea according to the updated E&M guidelines as of March 2021, tests that do not require separate interpretation. Example tests that are results only such as a urine pregnancy or HIV rapid test that are analyzed as part of MDM do not count as independent interpretation and may be counted as ordered or reviewed for selecting the MDM level. Based on this, we count all three lab tests as data, so we would have a moderate level of data.

**Ann Finn (**[**09:34**](https://www.rev.com/transcript-editor/shared/AmeWXfhevz394ljGCT5jXN7ryt3rOkaz2xuWHP1VFodaTgPuv1ukY9MLrAyPilNG8WTIkAtgof3k4mprC3pe5N3pt04?loadFrom=DocumentDeeplink&ts=574.65)**):**

Finally, the third MDM element is risk, and since we ordered a prescription level contraceptive, this qualifies for a moderate level of risk. When we put all three elements together, we have low, moderate, moderate and we select the E&M code based on the highest two that meet or exceed the level. This visit would count overall as a moderate level of MDM. We would choose a code 99204 since Maggie is a new patient and if she was established to your practice, it would be

99214.

**Ann Finn (**[**10:08**](https://www.rev.com/transcript-editor/shared/D5mJfq_j4Xwgyp0QVwXw2uqVADFm0xyyTaWTGu66uQG0-1SiCsWWG0J0O8REFY1HjxlQXvJAOVQEC6yzPbSNvWx2BRQ?loadFrom=DocumentDeeplink&ts=608.46)**):**

We have a podcast in this series that you can also listen to that focuses on the new E&M guidelines relating to family planning visits for more information.

**Katherine Atcheson (**[**10:18**](https://www.rev.com/transcript-editor/shared/P8PJAkIT_yEjhC1NWWutipF9gmX4nv3T-3m5nOQ8Q-heFaUpqFlAd5JUafXPhtAk0ZLNBdLT-Cmu3pqgMjbzRaLlSy4?loadFrom=DocumentDeeplink&ts=618.15)**):**

You mentioned a little bit earlier that clinicians or staffers sometimes over code or miscode for separate medical visit from the LARC procedure. Can you explain what you see when this happens?

**Ann Finn (**[**10:32**](https://www.rev.com/transcript-editor/shared/K3L0IyN--nDa_pcARqfuB6kpV0L-ERbQ7gguzxjTYU7ZVvh2IoKCu-6inzGG0plEewvZNRR4Qe6QqXF130DDJR9KUMc?loadFrom=DocumentDeeplink&ts=632.58)**):**

Yes. This is a big area I see miscoding with often due to poor documentation. Remember, we can only code for an evaluation and management service when it's separate and distinct from a procedure. If the patient presents for a scheduled insertion and has her vitals taken and questions answered, that alone does not constitute a billable separate service from the procedure.

**Ann Finn (**[**10:54**](https://www.rev.com/transcript-editor/shared/ggJZv4T0QeTslje4Tsrek7X6MB3z4d6UkBs938B8F8u42Yj1SIoDKkfaMZt1zYXBRSzNZcqht1YILIZWXhU2wAdf-s8?loadFrom=DocumentDeeplink&ts=654.87)**):**

The first step is the provider should clearly document the counseling that took place, such as reviewing all the methods and the decision to insert a LARC when it's the same day. When I am looking at LARCs visit documentation, I find it helpful to look at the prior visit note and check if the family planning counseling and the decision for the LARC was already done. When we bill for an E&M code along with the procedure, the biller needs to add a two-digit billing code or modifier to the E&M service to tell the payer the E&M was indeed separate from the insertion and to pay both services.

**Ann Finn (**[**11:30**](https://www.rev.com/transcript-editor/shared/z_KvCYnu9_2yzudCjAm6RdSK_sS0qb-i4oXP7lZLt41O5ap6dgVFUgJ4deXtxOlKxZo6y7yZgMBo_7H3fAOuhWqwINs?loadFrom=DocumentDeeplink&ts=690)**):**

When the modifier 25 is missing, the payer often bundles the services together, which leads to a reduced reimbursement. For Maggie's visit, we code the IUD insertion using CPT code 58300, the LARC device supply code, the point of care pregnancy test, and an E&M counseling visit code with modifier 25.

**Ann Finn (**[**11:52**](https://www.rev.com/transcript-editor/shared/5xd2nKhDRB326qQp_bWUtwO1OuuFTkp9pefVIMUYarr8uIRIYDGE14VLUxaRGGriqLwhgfD5b6CKOTWvAKqQbg6gzVI?loadFrom=DocumentDeeplink&ts=712.8)**):**

Typically, the lab bills for the send out tests like chlamydia and gonorrhea, but these tests may also need to be included on the claim if you are paying the lab directly. We also need to attach an ICD code to each service. CPT codes describe the what and I D codes described the why.

**Ann Finn (**[**12:11**](https://www.rev.com/transcript-editor/shared/224v5yJbfDoibKvbrYv7Kwx4xN-OPXahNZyWEwTvAyFE7tVVAHKJxDCIO0oehxjG_Yi_vRHSXkjuKpYTD6ugpS0fSbs?loadFrom=DocumentDeeplink&ts=731.7)**):**

Let's recap where we potentially see miscoding for Maggie's visit. First is missing codes. For Maggie's visit, we would need an E&M code for the contraceptive counseling, plus a LARC procedure code for the insertion, plus the LARC device, plus any point of care tests done during the visit to ensure full reimbursement. Over or under coding of E&M services based on new versus established patient status. Over or undercoating of E&M services based on the medical decision-making versus total time. Missed modifiers to tell the payer special circumstances impacting payments like if you don't put modifier 25 on the E&M, it may not pay. Missing ICD-10 codes to support the medical necessity of each service provided such as Z30.09 for the contraceptive options counseling, a Z30.430 for the IUD insertion and a Z32.02 for the negative pregnancy test result.

**Ann Finn (**[**13:11**](https://www.rev.com/transcript-editor/shared/aRC1suRo7yw3-yoHT0xHfn0QeUtiXZt7QaCcuQPD0s9Iq4qv7d_NiiWy0jswUdCx2cOxAwSGR0h0ABBoPqdPiHn1tAk?loadFrom=DocumentDeeplink&ts=791.37)**):**

Let's look at a second scenario. What if Maggie presents for a scheduled insertion? Our clinician reviews the potential side effects and answers any of Maggie's question and then inserts the LARC. In this case should the clinician report an E&M along with the LARC insertion? In this case the answer is no. The E&M and counseling was not significant and separate and distinct from the procedure. Part of performing a procedure includes reviewing any questions. Billing and E&M Here would be a case of overreporting of services. Depends on what happens though. Let's say our patient was still very unsure and the clinician spent time going over all the methods with Maggie or addressing another problem. In this case, we would want to capture and bill for an E&M service. The clinician should clearly document the counseling or other issues and attach proper ICD diagnosis codes to support the work.

**Ann Finn (**[**14:06**](https://www.rev.com/transcript-editor/shared/lVuvudy0uTe-HnJiwJG6Vp1z1ekvbDw54COuP7tUA5CSCcFjCtXtKSl-QLpCWPZM9Izibj85JCQDsPoibCWKWtZek2Y?loadFrom=DocumentDeeplink&ts=846.24)**):**

Documentation should clearly tell the story of what is happening and why to someone other than the clinician who is reading the note. What if Maggie presents to have her IUD exchanged for a new one? IUD reinsertions require two CPT codes to be reported for proper reimbursement. We would report both CPT code 58301 for the IUD removal and then CPT code 58300 for the IUD reinsertion. What happens if we submit these codes with auto modifier to tell the payer we are reporting multiple procedures? Without a modifier 51 or 59 for multiple or distinct procedures appended to the lower paying service, the second procedure typically bundles into that first procedure and does not pay separately resulting in an underpayment. With a correct modifier appended a second procedure will typically pay 50% in addition to the full payment for the first procedure. Miscodes for removals also mean missed revenue. Sometimes the clinician forgets to capture both codes. Ensure that there is a CPT code reported for every service documented in the medical record.

**Katherine Atcheson (**[**15:19**](https://www.rev.com/transcript-editor/shared/kbmFt9XUz9aClSbv-nqtKwCWphiPLfeoNT3XzxJ3DRj7b0ZlL9CzilulGImpxh3uk6STTkvEsiW8s_zuGtbQROXtXOg?loadFrom=DocumentDeeplink&ts=919.11)**):**

What if Maggie is having a LARC inserted, and the clinician needs to stop the procedure due to the patient having a problem like pain or if the device is for some reason unusable?

**Ann Finn (**[**15:31**](https://www.rev.com/transcript-editor/shared/orqXWVY6QDO4lcIoGnf3lKkpyM505zsot7x5-dbC0-ywhK83dG185KIphLg3pv4ufrTLCTiIpm7CANb9mUNMEAto50A?loadFrom=DocumentDeeplink&ts=931.2)**):**

We would still bill for the procedure. But again, we need a modifier to tell the payer a special circumstance. "Hey, we attempted the procedure, we did a lot of work, but we needed to stop." By appending a modifier 52 or 53 for a reduced service to a LARC procedure CPT code and including an ICD-10 code to explain any complications, a payer may often reimburse a significant portion of the expected payment for a failed insertion. If you bill for a full insertion and then the patient presents for a second attempt at the following visit, a payer may reject that second claim in full as a duplicate service. Not all payers will reimburse for multiple devices, so check with the payer for their policies along with contacting the manufacturer for a replacement device.

**Ann Finn (**[**16:20**](https://www.rev.com/transcript-editor/shared/RCjS6fRx4a5n4yj-PTUHqJzLsEaaPbXLFv2U45Rqtqhq_9y4OKqIQJUELtbwQxX3ELGX2n4R0-EL9UTUtwASPAad6fA?loadFrom=DocumentDeeplink&ts=980.04)**):**

Let's talk about the implant or Nexplanon codes now. Unlike IUDs, implants have a unique CPT code for an insertion, for a removal and for a reinsertion. We would use CPT code 11981 for the implant insertion along with the ICD code Z30.017 encounter for initial prescription or insertion of the implant. We would use either CPT code 11982 for a removal only and 11983 for an exchange or removal with a reinsertion along with the ICD code Z30.46, encounter for surveillance of the implant. And this includes a routine checking removal and reinsertion of Nexplanon.

**Katherine Atcheson (**[**17:07**](https://www.rev.com/transcript-editor/shared/pz_xIF2dV1O2M2BBTVbDOtbnugm5Oo9txTucbF6h4HeNfVu1Mz7A2YuO4G6RNtgYJ8VPY-qht_8J1wvUSMfhnEBZoO4?loadFrom=DocumentDeeplink&ts=1027.11)**):**

Do we bill for the LARC device or is that considered part of the insertion or replacement procedure?

**Ann Finn (**[**17:14**](https://www.rev.com/transcript-editor/shared/jEKtqmauTvRgC8dzn4w1QFxs9rg3_2egsSodKr0IJuFqSdIQ88RFlxic-hCm-DU0Xw4DSywDfmOo8IrZpWFPx1C7_HU?loadFrom=DocumentDeeplink&ts=1034.13)**):**

Yes, Katherine. Bill devices separately as they are expensive to a practice. There are currently five types of IUDs, and each device has a unique HCPCS supply code that are reported separate from the procedure. 7296 is the Kyleena IUD, J7297 is the Liletta, J7298 is a Mirena, J730 describes the copper Paragard IUD and finally J7301 for the Skyla brand.

**Ann Finn (**[**17:47**](https://www.rev.com/transcript-editor/shared/i5co06C8g2emMtGVAsBA0uyA8H1ap7zNNpjh-_VgH-8GSS4eWAmlXffjY2n5r5cpfsA7ZZ8GB3oevfBerGDQcJGAMxQ?loadFrom=DocumentDeeplink&ts=1067.25)**):**

Remember, the supply code J7302 for the Mirena was retired back in 2016. If you bill J7302 now, which every once in a while, I still do see, you'll most likely receive no reimbursement and lose valuable revenue to your practice. Sometimes the charge for the device reported on the claim is less than the payer's contractual amount due to you and the payer reimbursed the lower reported charge because it's not set up correctly in your system and you lose out on money that's due to you.

**Ann Finn (**[**18:17**](https://www.rev.com/transcript-editor/shared/jgx98peIFJxeHIbjYiAxijk2ifOmzupEMqYV4Isj_HGHBA9JkeE5HcVcVKZNm5YK2yZd-d-YpRUbhlCnc9aRyi4nm7Y?loadFrom=DocumentDeeplink&ts=1097.19)**):**

Make sure your fees are set at or slightly above your highest payer's contractual amount to ensure that you don't lose out on contractual money due to you. LARCs are expensive and any missed payment or denial should be a top priority for billing resolution. Billing staff should audit LARC insertions for a one-to-one match each month. For every insertion there should be a device accounted for.

**Ann Finn (**[**18:41**](https://www.rev.com/transcript-editor/shared/N16f3oeTXkkYJkdV5B6FVL_-nutiJzPF7aT2hJvh6XL3eTjqMuAlQu7ASDqByPZgcXL13jhMHKZOoFf9v4-dAfCgkX4?loadFrom=DocumentDeeplink&ts=1121.31)**):**

Finally, call your payer representative for further guidance or clarification. If you don't understand why a payer or device is unpaid. They can look directly at the claim and often give you helpful information to correct the issue. Denials that repeat over and over are a big waste of staff time and delays reimbursement so resolving root causes as soon as you see an issue will benefit your whole team. We hope these tips will help you to avoid common coding missteps impacting your reimbursement of LARC services. Remember, document all your services provided, accurately code the services on the claim, and submit claims to your payers in a timely manner to ensure proper and full reimbursement of LARC services. Thanks so much for joining us today.

**Katherine Atcheson (**[**19:26**](https://www.rev.com/transcript-editor/shared/x3VXrVydY2Al3Gj2-IF6-P-IrAa4szyCRm9RASVmCgh2v9w4JVQQ_lsFmfqTS2OKH76QvAptHabOp-gvo3wIrfYnjas?loadFrom=DocumentDeeplink&ts=1166.1)**):**

And thank you Ann so much for joining us today and for sharing your time and expertise.

**Katherine Atcheson (**[**19:32**](https://www.rev.com/transcript-editor/shared/lc1vpAPegr_AWbUtQ9ntYRKhdHKR6xHruRCqE2wS9NFHih5p51yWkjB97wJrPsGT0wdRmznk6LhFkdO5KnQKXT0TrEc?loadFrom=DocumentDeeplink&ts=1172.04)**):**

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**Katherine Atcheson (**[**19:44**](https://www.rev.com/transcript-editor/shared/BQNyAzitLPlJaehOpS4T6UUD4iJnG9K_mzrcj4IHm_dbAS5180NNnF8mkF2AN2OD3gUN-sn2SrPhL_uTcucXfM-K5Ic?loadFrom=DocumentDeeplink&ts=1184.4)**):**

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**Katherine Atcheson (**[**20:33**](https://www.rev.com/transcript-editor/shared/TH69M2Mn4Y3r3gEGee9CSGLeT8nVvTsLAR1O9N7Jd7e36f8e37WH_0zi4HSqVWPjfC6HLlgl2fQsGz6aPhX0JK_z3GE?loadFrom=DocumentDeeplink&ts=1233.54)**):**

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**Katherine Atcheson (**[**21:04**](https://www.rev.com/transcript-editor/shared/Qbjuqr-ftmkTcRI1y9mg-i8m3yIoBRVVwSNBSf_JWlfDqgWzQm_bdPr-6jZcJwc8bxUfmnbwHWLZm-mQ08E3ibcczs8?loadFrom=DocumentDeeplink&ts=1264.89)**):**

Theme music written by Dan Jones and performed by Dan Jones and the Squids. Other production support provided by the Collaborative to Advance Health Services at the University of Missouri, Kansas City School of Nursing and Health Studies. And finally, thank you to our listeners for tuning in today. We hope that you'll join us next time for another episode of Clinical Chats.