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BURDA ON HEALTHCARE

Motive, Means and Opportunity

Billing Codes Are Murdering Healthcare

By David Burda
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My knowledge of medical billing codes and coding has been strictly professional. My first full-time job in journalism was as a staff writer for the American Medical Record Association (AMRA), which is now the American Health Information Management Association. The first article I wrote as a full-time journalist was on Medicare's "new" DRG (diagnosis-related group) payment system.

It's been downhill ever since. In a good way.

Forty-three years later, I'm still writing about medical billing codes and coding. Credit goes to artificial intelligence (AI) supercharging the healthcare revenue cycle. AI-powered technology can find new and wonderful diagnoses, procedures and services providers can code and bill for that humans may miss. To wit, read, "AI and the Healthcare Revenue Cycle? Do the Math."

ANNUAL MEDICARE WELLNESS VISIT TAKES A TURN

Like I said, my relationship with medical billing codes and coding has been purely job-related. Until now. June 17, 2026, to be exact.

That's the date that I had my annual wellness visit with my regular primary care physician (PCP). I have traditional Medicare coverage. Annual wellness visits are free. No copays. No deductibles.

This was my second annual wellness visit with the same PCP as a Medicare beneficiary. I turned 65 last year. Before last year's visit, the front desk didn't ask me for a copay. After last year's visit, the hospital-based practice didn't send me a bill for anything that happened or was said during that visit.

This year was different.

The front desk didn't ask me for a copay. But after this year's visit, my PCP sent me a bill for $117.24. I paid it reflexively before I looked at the statement of services provided during the visit. Here are the services and what the practice charged Medicare and me for those services:

- Ppps (Personalized Prevention Plan Services), initial visit: $341.00
- Complex e/m (evaluation and management) visit add on: $49.00
- Advance Care Planning First 30 Mins (minutes): $252.00
- Office/Outpatient Established Low Mdm (medical-decision making) 20 Min (minutes): $123.00

First, as a journalist, the lack of consistency in style, abbreviations, capitalization, punctuation, spacing, tabs, margins, columns, rows, etc., was maddening. I added the parenthetical explanations. Revenue cycle departments could use a good copy editor. Anyway, the total charges were $765.00. Medicare covered (Adjustments & Payments) $647.76. That left me with an out-of-pocket balance of $117.24.

SAME AS IT EVER WAS

After looking at the description of services on my statement, I tried to reconstruct the visit with my PCP. My recollection was that the visit was pretty much identical to my first annual Medicare visit and all my previous checkups with my PCP even when I had private commercial health insurance.

- I check in at the front desk.
- The front desk makes sure it has my latest health insurance information.
- A door opens. A nurse walks out and calls my name. I follow them into the exam room hallway.
- I stop at the scale so the nurse can check and record my height and weight.
- I make my usual dad joke about my shoes and phone weighing 30 pounds.

- I follow the nurse into the exam room.
- The nurse asks me a series of social determinants of health and personal health behavior screening questions. I downplay my social drinking and overstate how much I exercise.
- The nurse reviews my medication list.
- The nurse takes my blood pressure and checks my blood oxygen level then tells me the doctor will be in shortly.
- My PCP comes in, and we exchange pleasantries.
- She asks me how I'm feeling and whether I have any health concerns or worrisome symptoms.
- She goes over the results of my routine blood work, the draw for which I did a week earlier.
- She takes out her stethoscope and listens to my heart and my lungs.
- She takes out her otoscope and looks into my ears.
- She physically checks my lymph nodes with her hands.
- She asks me if I have any questions.
- She may increase, decrease, add or end a prescription medication based on blood work results.
- She may order a diagnostic test or referral if there's anything suspicious she wants to check out.
- We exchange pleasantries again, and I leave unless the nurse comes back to give me something like a scheduled routine vaccine or a paper record from the visit.
- When the office runs on time, which it does most of the time, all of the above takes about 20 minutes from start to finish, equally split between the nurse and the PCP.

I honestly can't recall anything different about this last visit that cost me $117.24 compared with all the past visits that cost me nothing (when on traditional Medicare) or a $20 copay (when on a commercial health plan). The only thing I can think of is whether the nurse or my PCP asked me if I had any advance care directive in place. (I do.) But I may only think that now because they charged me for it.

I'LL TAKE MEDICAL BILLING CODES FOR $800

So, what's different now? It's all in the coding.

- The $341 Personalized Prevention Plan Services charge is a one-time fee that PCPs can charge for creating a personalized prevention plan for a patient moving forward until that patient needs a new PPPS because of a new medical challenge. They didn't charge me for this last year. They either forgot or didn't know they could charge me for it. (CPT Code G0438.)
- The $49 "complex e/m visit add on" is a fee that they can "add on" if the patient has a complex chronic medical condition or multiple chronic medical conditions. I have high blood pressure. I have high cholesterol. I have sleep apnea. I've had all three for a long time. I have medications and a CPAP machine to control them. (You can read about my CPAP equipment charges in "Losing Sleep Over Auto-Pay DME Supplies.") They didn't charge me for this last year because they either forgot or didn't know they could charge me for it. (CPT Code G2211.)

- The $252 charge for "Advance Care Planning First 30 Mins" is exactly what it says: talking to the patient about their advance directives, living wills, healthcare power of attorney, etc. According to the Centers for Medicare and Medicaid Services, providers can bill Medicare for the full 30 minutes if they talk to the patient for a minimum of 16 minutes. There is absolutely no way the nurse or my PCP talked to me for 16 minutes or more about my advance care planning. Maybe it was in one of the screening questions, and I forgot. But I would have remembered a 16-minute chat about whether I want someone to pull the plug if I'm brain dead. (I do, for the record.) Yet, someone decided it was OK to charge me. (CPT Code 99497.) Interestingly, though, the health system to which my PCP is affiliated sent me two follow-up messages in my patient portal to upload my advance directives into my electronic medical record. The first message came June 30, and the second on July 30. Maybe time spent sending secure messages to my portal counts toward the 16-minute minimum.
- Last is the $123 charge for "Office/Outpatient Established Low Mdm 20 Min." This is an extra charge for routine office visits with established patients during which there's a low level of medical decision-making between the doctor and patient because the patients' chronic medical conditions are stable and being managed effectively. That's me. How this charge squares with the charge for me being "complex" is a mystery. Yet, someone decided it was OK to charge me for it. (CPT Code 99213.)

One possible explanation for all these extra charges is my PCP recommending that I go on a GLP-1 drug to treat my sleep apnea. The drug helps you lose weight. Losing weight helps you with obstructive sleep apnea. I agreed. Maybe that's what triggered all these extra charges. Maybe. I don't know.

TOO MANY CODES FOR HUMANS TO MANAGE

What I do know is this. The more the hospital lobby and medical lobby can tease out things hospitals and doctors do during stays or visits, the greater their ability to create billing codes and charge fees for them. We all know this. Everyone has known this for a long time. It's the machinery that drives fee-for-service medicine.

There are about 80,000 ICD-10-PCS (procedure coding system) codes for procedures. There are about 70,000 ICD-10-CM (clinical modification) codes for diagnoses. There are about 12,000 CPT (current procedural terminology) codes for services doctors perform. There are about 9,000 HCPCS (Healthcare Common Procedure Coding System) codes for products, supplies and services not covered by CPT codes. Those are a lot of things. Those are a lot of codes. Those are a lot of itemized fees. It's like a freelance writer charging by the letter and punctuation mark rather than by the word. I understand the tactic to drive more revenue. But it's too much for humans to manage.

This is where AI comes in, aided and abetted by ambient listening and documentation technology. The tech can listen and document a hospital stay or physician office visit. AI can scan the documentation for key words and phrases and pick up all the little things that a hospital or doctor can charge for. It's charge capture on steroids.

WHERE AMBIENT LISTENING AND AI FAIL

As for my $765 in additional charges and my $117.24 out-of-pocket costs, here's my educated guess at no charge. AI scanned my visit notes and found four things that my PCP and her hospital-based practice could charge for that they previously missed. That assumed the visit notes were accurate and AI read them correctly. But no human checked the accuracy of the clinical documentation or whether AI had the ability to read them correctly. First, there was no 16-minute conversation about advance care planning. Second, how could I be "complex" yet require only "low" medical decision-making? That wouldn't make sense to a subjective human. To an objective machine? It didn't compute.

On a micro level, I paid $117.24 for nothing. On a macro level, we're going to pay billions of dollars more on healthcare for nothing. All because of medical billing codes and coding, fee-for-service medicine and AI. Means, motive and opportunity.

I knew my two-year stint an AMRA would come in handy some day. My thanks to Jill Callahan for taking a chance on me in 1983. It was quite an education.

AUTHOR

David Burda began covering healthcare in 1983 and hasn't stopped since. Dave writes this monthly column "Burda on Healthcare," contributes weekly blog posts, manages our weekly newsletter 4sight Friday, and hosts our weekly Roundup podcast. Dave believes that healthcare is a business like any other business, and customers — patients — are king. If you do what's right for patients, good business results will follow.

Dave's personal experiences with the healthcare system both as a patient and family caregiver have shaped his point of view. It's also been shaped by covering the industry for 40 years as a reporter and editor. He worked at Modern Healthcare for 25 years, the last 11 as editor.

Prior to Modern Healthcare, he did stints at the American Medical Record Association (now AHIMA) and the American Hospital Association. After Modern Healthcare, he wrote a monthly column for Twin Cities Business explaining healthcare trends to a business audience, and he developed and executed content marketing plans for leading healthcare corporations as the editorial director for healthcare strategies at MSP Communications.

When he's not reading and writing about healthcare, Dave spends his time riding the trails of DuPage County, IL, on his bike, tending his vegetable garden and daydreaming about being a lobster fisherman in Maine. He lives in Wheaton, IL, with his lovely wife of 40 years and his three children, none of whom want to be journalists or lobster fishermen.

Visit 4sight.com/insights to read more from David Burda.