Dermatology Coding Alert

Part B Mythbuster: These 7 Deadly Myths Could Damage Your Practice

Test yourself against these coding and compliance pitfalls

Does your staff subscribe to any of the most common myths in the medical industry? Make sure you educate them about the truth behind these misconceptions, experts say. Check out the following seven myths, along with the realities behind them.

Myth 1: You have to bill everyone the same amount.

Fact: You can't bill your Medicare patients more than you do all your other patients, says **Suzan Berman, CPC, CEMC, CEDC**, senior manager of coding education and documentation compliance in the Physician Services Division with UPMC in Pittsburgh.

If your practice maintains several fee schedules, the government payers should be the lowest-priced among the group, she advises.

However, as long as you are following a contract or have consistent non-discriminatory billing policies in writing, billing may vary within your practice. But practically speaking, you should keep your billing policies consistent to avoid accusations of discrimination.

Myth 2: Before you write something off, you have to send three bills.

Fact: You have to make a reasonable attempt at collecting the co-pay, deductible, and, when applicable, the balance of the bill, but that doesn't necessarily mean sending three bills.

Routinely waiving deductibles and copayments can violate several federal laws and regulations, including the federal False Claims Act, anti-kickback statutes, and compliance guidelines for individual and small group physician practices. In the Federal False Claims Act, the OIG identifies three criteria that can result in a violation: The waivers are routine, the waiver is given without regard to the individual's financial hardship, and the provider fails to pass on to the payer its proportional share of the discount.

Watch out: OIG regulations aren't your only concern when it comes to collecting copays. Check you payer contracts as well. Many contracts require that copays are collected at the time of service. A provider can lose participating status if they fail to follow the guidelines.

One reason you may be able to write off a patient's copay, deductible, or balance is if the patient meets financial hardship criteria. In order for your practice to accept financial hardship as terms for a debt write-off, the patient needs to be able to prove he is unable to pay. In the event that you cannot establish financial hardship, CMS requires that you make a "reasonable effort" to collect money from a patient. This might consist of sending three bills, followed by two phone calls, and a final notice. That cycle is up to your practice's discretion. If you ultimately can't collect, be sure to document your efforts.

Myth 3: You can only bill one diagnosis code per claim.

Fact: You should bill as many diagnosis codes as you need to establish medical necessity for the services you're billing. Some payers' computer systems used to be able to read only one diagnosis code per line. But now, you should always be able to report all pertinent diagnoses for each visit, and link the correct diagnoses to each service on each line.

This will become particularly important when ICD-10 codes come into play in 2013, at which point diagnosis coding will

expand significantly.

Myth 4: E/M codes are assigned solely by the level of medical decision-making (MDM).

Fact: MDM is only one of three key components. People confuse MDM with medical necessity, experts say.

Key: You should assign E/M codes based on two or three of the E/M components, depending on the category of the code. But you should always consider the nature of the patient's presenting problem when determining which code is most accurate.

Myth 5: If you're a Medicaid provider, you have to accept all Medicaid patients.

Fact: Some states may allow you to limit the number of Medicaid patients that you see, says **Quinten A. Buechner, MS, M.Div., CPC, PCS, ACS FP/GI/PEDS, CCP, CMSC**, program chair in the Medical Billing and Insurance Coding department with Herzing University in Kenosha, Wisc.

"As Medicaid is partially state-funded and state-designed, it is hard to give a general rule," Buechner advises. "I have found many states will allow some flexibility allowing you to limit new admits to your patient mix. Most Medicaids recognize that you can go broke without the ability to keep a viable patient mix."

Check with your state: If you are unclear regarding whether your state allows limitation of Medicaid patients, contact your state's Department of Health and Human Services rather than contacting your payer, Buechner advises.

Myth 6: Medicare HMOs have to follow the same rules as Medicare.

Fact: Medicare HMOs have a set of guidelines that they must follow, and they have to cover everything Medicare would cover. But they can also choose to cover other things, and they can require referrals, authorizations, and other things that Medicare wouldn't require.

Myth 7: Secondary insurance always pays what Medicare doesn't.

Fact: Secondary insurance is more likely to pick up what Medicare doesn't pay, but secondary insurance doesn't have to pay for everything Medicare doesn't. Sometimes, secondary payers will only pay up to a certain amount, and if Medicare has already paid that amount, they won't pay any more. Supplemental insurance will only pay Medicare's copays and deductibles, not everything else Medicare doesn't pay reimburse.