Optometry Coding & Billing Alert

Billing Basics: Avoid 10 Common Billing Errors With 10 Expert Tips

Hint: Benefits verification can solve a lot of your denial problems.

What's the top tool in your arsenal to avoid claims rejections? Verify patient eligibility.

That was the word from National Government Services (NGS) Medicare's **Michelle Coleman** during the MAC's recent webinar, "Minimize Errors, Maximize Revenue." Coleman not only shared the top claims submission errors submitted to NGS in December 2011, but also suggested solutions for avoiding the same mistakes. Read on for the scoop on how to keep your revenue rolling in.

1. Check Patient Eligibility

NGS saw over 49,000 claims in December alone for patients not covered by the contractor. For instance, if a patient enrolled in a Medicare Advantage plan or moved across the state line, thus changing their MAC to another contractor, they were not covered by NGS and their claims were denied.

Solution: Check the patient's eligibility information at every visit. "I know sometimes physicians do that once a year -- when the new year comes up they'll check and see if a new card was issued," Coleman said. "But with Medicare patients it's really important to make sure that you check the eligibility every time you see the patient." You can check a patient's eligibility through the MAC or via CMS's interactive voice response (IVR) system at 1-800-MEDICARE.

2. Include All Necessary Details

NGS also saw scores of denials for claims that lacked information that the MAC needed to process the claim.

Solution: Make sure you check to see if the procedure code has a local coverage determination (LCD) or national coverage determination (NCD) that guides claims submission. "It could be that the claim is missing a diagnosis or maybe a modifier," Coleman said.

3. Pay Attention to Filing Deadlines

NGS saw claims for which the time limit for filing the claim had expired. "We had 37,427 claims with this denial in December, and it's a pretty simple one to fix," Coleman said.

Solution: "You have to make sure that you submit the claim and that we receive it within one year from the date of service," Coleman said. "We do not have any appeal rights on these claims " when you receive a denial for the time limit, you cannot appeal it."

4. Screen Patients During Registration

Practices submitted 17,959 claims to NGS in December that fell under the error: Patient cannot be identified as the MAC's insured.

Solution: "This is another error where you have to verify the patient's eligibility information," Coleman said. "To reduce these types of denials, make sure you're screening your patients in the beginning before you see them, and the office personnel should review the patient's eligibility information when registering the patient."

5. Ensure Provider Can Actually Bill the Payer

NGS processed 13,000 claims in December with this error code: The provider was not eligible to collect for the procedure on the service date. For instance, the provider's NPI was expired, or the claim was submitted under an individual's PTAN that was registered as a rendering provider but not a billing provider.

Solution: "You want to make sure that you either contact customer service or the MAC's provider enrollment line to make sure the provider's files are correct," Coleman suggested.

6. Watch Your Modifiers

NGS saw over 12,000 claims in December that were denied because the procedure code was inconsistent with the modifier used or the modifier was missing.

Solution: "You need to check your LCD and NCD, or even the Correct Coding Initiative (CCI) table to see if you're even able to use a specific modifier," Coleman said. "Make sure you're using a modifier if necessary, or if the code does not allow a modifier, that you're not submitting it with one."

7. Avoid Billing Non-Covered Services

In December, NGS processed over 5,000 claims that were billing non-covered charges.

Solution: Make sure that the CPT® code you're using is accurate, and that it describes a covered service under Medicare.

8. Support Medical Necessity With Proper ICD-9 Codes

NGS also saw claims denials because the service was not deemed a "medical necessity" by the payer. "This usually has something to do with the diagnosis," Coleman said.

Solution: Verify that the diagnosis you reported is payable, up-to-date, and accurate. "Remember if you're using an ICD-9 code, it must be documented in the patient's record that the patient has that condition. You can't just put on an ICD-9 code because it's payable," she added.

9. Remember that DOS Matters

NGS saw 1,252 claims in December in which the date of death preceded the service date.

Solution: Verify that the patient's eligibility information is correct, and that you've submitted the correct date of service. If any Social Security files were updated incorrectly with the wrong date of death, the patient's family will have to get involved to rectify the situation on the Social Security records by submitting the death certificate.

10. Beware of WC Claim Differences

The tenth error Coleman addressed were claims that represented a work-related injury or illness and were therefore the liability of the workers' compensation carrier.

Solution: You must verify the patient's eligibility information to ensure that you know whether a workers' compensation payer is involved in the claim.

"Keep in mind that when we look at our eligibility information for the patient, we're getting it from a common working file, which all the carriers have access to," Coleman said. "So if that information isn't sent over to the common working file, we can't update the records. What sometimes happens is that a patient maybe has a liability case open. The patient may have closed it, but if the information isn't showing in the common working file, we deny the claim."