Part B Insider (Multispecialty) Coding Alert

BILLING: Avoid These 2 Pitfalls When Trying to Maximize Income

Collect all that you can -- ethically.

With uncertainty surrounding your Medicare payments and the elimination of consult pay, many practices have been trying to optimize their A/R in other areas. In many cases, finding hidden dollars can be a boon to your practice's bottom line. But be sure to avoid these pitfalls in your hunt for dollars.

Pitfall 1: Charging Medicare patients a "statement fee" when they are late in paying you.

Some practices tell the Insider that they have begun to charge a"statement fee" for late copayments or deductibles, and a few practices have been adding on a flat percentage when they send the overdue bill to a collection agency or a company that sends out reminders. But this may not be a smart idea.

Watch out: Medicare doesn't allow you to charge patients for any charges other than those listed in the Medicare Fee Schedule, says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CENTC, CHCC,** president of CRN Healthcare Solutions in Tinton Falls, N.J. "For private payers, whether or not you can bill a statement fee depends on the contracts," Cobuzzi says.

"Any fees added should be in a financial policy that is provided to the patient, and I suggest that the patient sign that they received and understand the policy," Cobuzzi advises. "This can also include charging interest for late payments."

In some states, it may be illegal for you to charge your patients an interest payment or surcharge.

What you can do: There are plenty of ways to "push the issue" of collections besides charging the patient extra. You can collect copays and deductibles before the patient receives the service. After the fact, you can warn patients, send them to a collection agency, or put them on a payment plan. You can also fire your patients -- you don't have to continue to treat people who don't pay their bills.

Pitfall 2: Listing diagnoses that will "get the claim paid," even if those diagnoses aren't found in the medical record.

As you read in last week's Insider, you should never report an ICD-9 code just because you know it will equal reimbursement. Instead, you should code from the medical record. But what if the provider lists several diagnoses in the notes? If you're billing several procedures, match each one to the most applicable diagnosis that is documented in the chart. For instance, if the patient has fracture care for a broken arm and a broken leg, link the broken leg diagnosis to the leg fracture care, and the arm diagnosis to the arm fracture care. If you aren't performing several procedures, you should bill your diagnosis codes in order from acute to chronic, says **Shannon J. Moss, CPC, COSC,** auditor with Mission Hospital in Asheville, N.C.

"If you're billing an E/M visit, report the more acute diagnosis first, followed by the chronic," Moss advises.