Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Billing: Check Your Billing Expertise With 3 FAQs

Hint: Get on top of your denial management procedures now or pay the price later.

Most Part B practices have been studying billing issues for so many years that they feel like experts. But it can be easy to let your guard down and see some of your hard-earned money stop flowing into your practice because of careless billing mistakes. Check out the following three frequently-asked questions to determine whether you're still up to speed on billing rules and regulations.

Screen Your Third Party Billers

Question 1: We're planning to hire a billing company and we are taking the advice of our new biller, who said we should use the company she used at her previous employer. Is there anything else we need to know before we hire a third party billing company?

Answer 1: Hiring a third party may appear to be a positive business move for many Part B practices, but it doesn't eliminate your responsibility to ensure that the company being hired is compliant, so it's essential that you investigate the biller further before hiring them.

When checking for compliance, make sure to ask the following questions:

- Is an active compliance program in place?
- Is there a written coding and procedures policy?
- Is there a denial review procedure?
- How is patient privacy handled?

Physicians often say, "I will have our billing company handle that, so I don't have to worry about a lot of compliance issues." This attitude is fraught with risk as there are just as many bad billing companies as good ones, and it is the practice's responsibility to do the proper research.

Keep these tips in mind when researching a third party biller:

- **Ask for a reference list.** Then, ask for more references. The best references will be on the first list; a more accurate picture will emerge from the second.
- **Make sure a compliance plan is in effect** and that the biller is continuously training its staff on compliance, especially on data security.
- Assess **their knowledge** of modifiers, appeals, and overpayments
- **Investigate** how they maintain good communication with their clients and encryption processes.
- **Find out** if training programs are available.
- **Make sure t**hey know the proper procedures for advance billing notices (ABNs).

It is essential to check references that are in the same specialty as your practice. Coding is very specialty-oriented, particularly regarding the use of modifiers. A biller that's very adept at pathology billing may not be as effective for a family practice because they won't be familiar with E/M coding, for instance.

Another way to check the professionalism and competency of the billing company is to visit the facility. Touring the office will give you quick answers, especially if your visit is unannounced and you ask to speak with the compliance officer.

During the visit, check to see whether their staff has the most recent HCPCS, CPT®, ICD-9 and ICD-10 editions. Find out how often their coding software is updated. Ask to see a copy of their compliance manual and recent memos of their

training class schedule or copies of e-mails. This will tell you how serious they are about training. Review the code-of-conduct and data security policy.

HIPAA privacy is an important issue, so it is necessary to discuss patient confidentiality. It is extremely important to know what steps are being taken to safeguard patient information. For example, they should be prudent not to leave confidential information in view. When practitioners are placed on the biller's e-mail or memo circulation list, it becomes easier to verify security and encryption procedures. You will be able to see how active the company is in training and compliance. It also helps to solidify the relationship between the provider and the billing company.

Tackle Denials in A Timely Manner

Question 2: We hired a temp to come in and deal with a stack of denials that we'd received due to an ineffective coder that recently left our practice. We discovered the denials after we had already let the coder go. Do you have any advice for preventing this in the future?

Answer 2: Denial management can be a daunting task, especially for large practices or billing companies. Create a top 10 list of the most common denials your office receives. Then go through that list with the billers, physicians and other personnel in your office to see if there are simple solutions, procedures or processes to prevent those denials before they occur. Use the explanation of benefits (EOBs) you get from your carriers to determine the ultimate reason for each denial.

Keep up-to-date: Refresh the list of common denials regularly, such as once every two months, to ensure you're focusing your efforts in the right areas.

Follow up: Appealing denials when appropriate is one key to getting all the payments your practice deserves. Consider dividing the job among people in your billing department by assigning billers to deal with certain arriers.

Benefit: For example, assign one person to deal with Medicare, one for commercial payers, and another for HMOs. Not only does this divide up the work, but it also allows billers to develop a close relationship with the claims representative at each carrier, so they will be more helpful than if a different biller calls each time.

As a bonus, this approach also makes your office more efficient with phone calls and follow-up with payers because the person in your office can call the payer he is responsible for and go through as many patients as the payer will allow in one phone call.

Tip: Create templates of your appeal letters for common denials that aren't your fault but rather are frequent payer denials, such as modifier 25 denials. This way you don't have to rewrite them each time.

Know Your Contracts

Question 3: We have a patient on private insurance who wants us to directly bill her allowable charges for a procedure so that she can pay our office this amount instead of paying her deductible since she has a very high deductible. Is this legal?

Answer 3: If your provider has a contract with the insurance company, you must submit the claim to the payer and then collect from the patient only the amount indicated by the explanation of benefits (EOB).

Pitfall: If you do not submit the claim, there is nothing to prevent the patient from submitting the claim and being reimbursed, and the practice then being accused of noncompliance with the payer-physician contract.

Additionally, without submitting a claim with all of the charges, you cannot ever be sure of the "allowable amounts." Even with a payer's fee schedule available to the physician, each patient may have a different plan, with each plan paying different amounts and with different deductibles. Without a claim and resultant EOB, your practice will not know that particular patient's allowable fees.

Don't forget: If your practice does not participate with the plan, you should not be reducing the fees to "allowable amounts" since the practice's fee schedule is allowable in any non-participating situation.