Part B Insider (Multispecialty) Coding Alert

Billing: Quiz Yourself on 4 Medicare Billing Basics

Know the difference between reopenings and redeterminations.

Even experienced billers can get tripped up by Medicare's complicated policies. And with all the financial fallout from the pandemic, it's more critical than ever that Part B practices get a grip on fundamentals to keep reimbursement steady.

Test your knowledge on these four important Medicare basics to refresh your billing practices.

1. Know This NPI Fact

True or false? If you're a Medicare provider and you move from Ohio to Tennessee, your national provider identifier (NPI) will change after you relocate.

False: NPIs were mandated in 2004 under the NPI rule to align with HIPAA and simplify electronic transactions. They consist of a 10-digit numeric identifier and are specifically for HIPAA-covered healthcare providers.

NPIs don't "carry information about you, such as the State where you practice, your provider type, or your specialization," Medicare guidance says. And that's why "your NPI will not change, even if your name, address, taxonomy, or other information changes," notes the MLN booklet, "NPI: What You Need to Know."

2. Avoid Duplicate Billing Blunders

True or false? If you don't hear back from your Medicare Administrative Contractor (MAC) on a claim, you should just keep resubmitting the claim until the carrier responds.

False: Simply resending a denied claim probably won't solve the problem - and will almost certainly cost you more time and effort in the long run. "Don't jump the gun and resend your claim. Wait to hear back from us,"

advises **Arlene Dunphy, CPC** of Part B MAC NGS Medicare in a webinar on duplicate billing.

Your MAC denied the claim for a reason during the first round of submission. If you don't address that reason now, your claim will likely return to you as a denial again. What's worse, once a payer has processed a claim for a date of service, they will detect the duplication in the date of service and CPT® code(s) and deny the service(s) as a duplicate claim. Then you're dealing with two denials.

If you know that you submitted a claim and you're just seeking claim status, don't resubmit the claim, counsels **Caryanne Godfrey** with Part B MAC Noridian Healthcare Solutions in a webinar. Instead, go to the MAC portal and check the status of the claim there.

Best bet: After consulting with your MAC and using your online resources to investigate your claim, you might want to consider a reopening to fix minor claims problems like mathematical mistakes, clerical errors, or slight inaccuracies.

"A reopening must be requested within one year from the date of the initial determination. The contractor has discretion in determining what meets this definition and therefore, what could be corrected through a reopening," reminds Part B MAC CGS Medicare in online guidance.

However, if you think the denial is unwarranted and not related to a minor issue, you may want to consider a

redetermination - the first level of Medicare appeals.

3. Revisit MSP Fundamentals

True or false? It is critical that patients are questioned at every visit about their insurance coverage to help determine whether Medicare is the primary or secondary payer.

True: Many patients are covered by Medicare, but also by other insurance, too. That's why it's incredibly important to ask the right questions and update patients' coverage information at every visit.

In fact, you may want to utilize your MAC's tools to compile a comprehensive insurance questionnaire, specifically targeted toward Medicare beneficiaries. This will help you and your billing staff figure out the insurance logistics - and avoid denials and overpayments.

Reminder: The term "Medicare Secondary Payer" refers to situations where another payer has primary payment responsibility for care provided to a Medicare beneficiary. Medicare Secondary Payer (MSP) is different from a "Medicare supplement insured" patient (also known as Medigap), in which Medicare is always primary and there is a secondary private health insurance policy.

Several factors determine whether Medicare is primary or secondary, such as the patient's age or employment status, as well as diagnoses such as end stage renal disease (ESRD). For instance, if the patient has Medicare as well as group coverage through a large employer, the private (employer-backed) payer would usually be primary and Medicare would be secondary.

So, determining which payer is secondary or primary comes down to who the other payer is. If the patient has Medicare and Tricare, you should submit the claim to Medicare first, and then the balance bill can go to Tricare.

Now: Currently, MACs are seeing an uptick of claims submitted with the incorrect MSP type, according to Palmetto GBA online guidance. "Medicare MSP claims are most likely rejecting because there is a mismatch of the type submitted and the Medicare MSP files. This situation can drastically impact the cash flow for your office," cautions the Part B MAC.

You may want to look over the seven MSP-type options and ensure you're using the appropriate one according to beneficiaries' insurance specifics.

4. Understand What 'Direct Supervision' Implies for Incident To

True or false? If the physician and nonphysician practitioner (NPP) are in contact over the phone - but are in different buildings - a practice can still bill "incident to" on Medicare claims.

False: Medicare stipulates an NPP must be working under "direct supervision" of a physician to bill incident to. The supervising physician cannot be across the street, three blocks away, or available via cell phone. If there is no physician physically present in the office suite during the time of the NPP service, the service must be billed to Medicare under the NPP's name and NPI.

Breakdown: According to Medicare's direct supervision guidelines, the supervising physician:

- Must be physically present in the office suite.
- Need not be physically present in the treatment room.
- Must be readily available to provide assistance and direction to the NPP.
- Need not actually see the patient.

"This means for the duration of the service if the supervising practitioner does not satisfy all requirements, the supervision component has not been met and should be billed with the NPP's NPI. Expected reimbursement is 85 percent," explains **Kelly Loya, CPC-I, CHC, CPhT, CRMA,** associate partner at Pinnacle Enterprise Risk Consulting

Services LLC in Charlotte, North Carolina.

Documentation: As a best practice, the NPP should describe in the documentation the supervising physician was in the suite at the time of the service. This will clearly illustrate that the supervision requirement has been met. "In the event this is not stated clearly, supervision must be supported in some other manner and consistently verifies the presence of the qualified physician to provide the necessary supervision," Loya says.

Important: State laws sometimes lack clarity in supervision guidelines. However, CMS directly states that Medicare's federal incident-to rules supersede any state's rules - and the feds' mandates are often more restrictive, experts say.

Some state boards may only require general supervision, or the physician be available by phone, in order to consider an NPP "directly" supervised. Don't confuse this clinical practice guideline with the reimbursement guideline for services billed under the incident-to provision.