Part B Insider (Multispecialty) Coding Alert

Medicare Claims Errors: Part B Practices Still Making Modifier, Timely Filing Mistakes, One MAC Says

Plus: Don't avoid checking LCDs to find out your MAC's rules.

Appending modifier 59 to all of your claims willy-nilly to ensure that they go through will not get you paid faster in the long run--it will have you seeing denials. That's the word from NGS Medicare's April 27 webinar, "Avoiding the Top Part B Claim Submission Errors," which focused on the main errors addressed by NGS Medicare, a Part B MAC in four states.

Use Modifiers Properly

Practices often submit claims with coding errors that cause claim denials and/or delays, and many of those involve improperly used modifiers, said NGS's **Donna Pisani** during the call. The NGS reps ran through tips for using several modifier issues, including the following, among others:

Modifier 24: You'll report modifier 24 (Unrelated evaluation and management service by the same physician during a postoperative period) "for an unrelated E/M service that falls within the global period either ten or 90 days by the same physician who performs the surgery," Pisani said. "Now, the diagnosis should be different for that E/M visit than it was for the global surgery, showing that it's unrelated."

Example: "A patient has a hip replacement, the procedure has a 90-day global period," Pisani said. "The patient returns [to the same physician] within the 90 day period for hypertension and fatigue. The physician would bill an E/M service with the 24 modifier," along with a hypertension or fatigue diagnosis code linked to the E/M. Without modifier 24, the claim will be denied, she said.

Modifier 59: "Another problem we see is the proper use of modifier 59 (Distinct procedural service)," Pisani said. "Modifier 59 is used to identify procedures or services that aren't normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, a different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury, not normally performed on the same day by the same physician."

Pisani stressed that you should only use modifier 59 as a last resort, when another, more accurate and appropriate modifier is not available.

Keep LCDs at Top of Mind

If you aren't using local coverage decisions (LCDs) to find out the rules and regulations of specific medical procedures and services, you're missing out, the NGS reps noted. A poll during the call revealed that 28 percent of the call attendees said they do not use LCDs, while 57 percent of attendees don't use supplemental instruction articles (SIAs) that the MAC maintains on its Web site.

"LCDs are Medicare regulations formulated on the concept of a reasonable and necessary service," Pisani said. The SIA is part of the LCD, which provides specific coding guidelines for a particular code, whereas the LCD will tell you how to bill the procedure correctly.

Resource: You can find your MAC's LCDs and articles on the contractor's Web site, and if you can't find one, contact your provider representative. In addition, you can find national guidelines at www.cms.gov/mcd.

Consider Timely Filing Rules

Part B practices have been calling NGS to complain when they face denials because their claim was not filed in a timely manner. "The new claim filing limits were effective Jan. 1, 2010," said NGS's **Alicia Forbes** during the call. "Starting January 1 forward, there is a one-year timely filing rule," she said. This regulation is dictated by the Patient Protection and Affordable Care Act (PPACA), which President Obama signed into law last year. The timely filing rule is not a regional issue, so all MACs must heed the one-year timely filing regulation.

For services rendered between Oct. 1, 2008 and Dec. 31, 2009, you must have filed your claim by Dec. 31, 2010. For dates of service Jan. 1, 2010 and thereafter, you have one calendar year from the date of service to file your claim, Forbes said.

Patients won't be liable: If you miss the deadline to file a claim because you waited over a year to file it, you cannot bill the patient for the charges. You, as the provider will be liable for the charge if you miss the time limit.