Part B Insider (Multispecialty) Coding Alert

Part B Coding: Check These Answers to 5 Burning Medicare Questions

From coding to billing and beyond, get the answers you're seeking straight from the source.

Medicare guidelines are not only confusing because they are ever-changing, but they're also difficult to interpret because we hear advice from so many varying sources. However, even if you get coding tips from a colleague, that doesn't mean that Medicare agrees with them.

That's why we've culled five of the most common questions that our readers submit to the Insider and answered them based on Medicare's own guidelines. We've also included links to the official guidance for reference.

Examine 3-Year Rule

Question 1: We submitted a claim for our doctor but it was denied with the error note, "This patient was seen by your group within the last three years" but this doctor never saw the patient before. What did I do wrong?

Answer: Most likely, someone else in your practice saw the patient within the last three years, even if the specific doctor from this visit hadn't previously seen her. "Interpret the phrase 'new patient' to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years," CMS says in Section 30.6.7.A of its Claims Processing Manual.

Many practices overlook the statement "from the physician **or physician group practice**" when they submit new patient claims, but if another practitioner of the same specialty as your doctor within the same practice saw the patient two years ago, that would be considered an established patient at this point.

Source: To read the Medicare Claims Processing Manual that includes this advice, visit www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

Timely Filing Exceptions Are Rare

Question 2: Our patient gave us her Medicare card but said Medicare was her secondary payer. She took a long time to get us her primary insurance card, and when we finally submitted the claim, the insurer was slow to get back to us. They eventually denied the claim. But when we tried to submit it to Medicare as secondary, the MAC said we exceeded the limit on timely filing requirements and rejected the claim. Can we file an exception report for this?

Answer: Unfortunately, it doesn't sound like your situation warrants an exception to the timely filing requirements, which demand that you submit your claims within a year of the date of service. The exceptions are as follows:

- If you missed the deadline due to an error or misrepresentation of an employee, Medicare contractor, or agent of the department that was performing Medicare functions
- When a beneficiary receives notification of Medicare entitlement retroactive to or before the date of service
- When a state Medicaid agency retroactively recoups money from a provider six months or more after the date of service was furnished to a dually eligible beneficiary
- Retroactive disenrollment from a Medicare Advantage plan or Program of All-inclusive Care of the Elderly provider organization.

In your case, it sounds more like the patient was too slow to give you her insurance card and then the primary insurer must have taken a while to process the claim.

Source: You can read about the timely filing exceptions in the Medicare Claims Processing Manual at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf.

Submit Documentation With Modifier 52

Question 3: We submitted a claim for a reduced service and appended modifier 52 to the procedure code to indicate the reduction of service. However, the claim was returned as unprocessable. Does Medicare no longer recognize this modifier?

Answer: Medicare still recognizes modifier 52 (Reduced services) but maintains strict requirements about how to report it. "When the 52 modifier is used on a claim, Medicare is looking for documentation either in the narrative field of the electronic claim or block 19 on the 1500 claim form," Novitas Solutions, a Medicare contractor in 11 states, says on its website. "If there is not enough room for the documentation then you can submit the documentation separately. Medicare will reject the claim without the documentation explaining why the service was reduced."

Source: For information on how to submit documentation with electronic claims, check the CMS website at http://cms.hhs.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/index.html.

Avoid Double Dipping

Question 4: We had a patient who came in for a procedure which we thought that Medicare wouldn't pay. We had the patient fill out an ABN and submitted the claim to Medicare so the patient could get the EOB to send to her secondary payer. Surprisingly, Medicare paid the claim. Are we required to give the patient her money back, or does the ABN cover us for keeping it?

Answer: You aren't allowed to double-dip, which is what it sounds like you're doing here.

On occasion, you might administer a service that your MAC traditionally denies, so you ask the patient to sign an ABN before you submit the claim but the carrier surprises you by reimbursing you for the service after all. Some practices may see this as a quick and easy way to make a little extra money by charging the patient anyway (or holding on to money that the patient already paid for the visit), thus doubling their income for one service. But this is absolutely inappropriate.

"If Medicare pays all or part of the claim for items or services previously paid by the beneficiary, or if Medicare finds you liable, you must refund the beneficiary the proper amount in a timely manner," CMS says on page 13 of the MLN Matters publication, "Advance Beneficiary Notice of Noncoverage." "Medicare considers refunds timely when made within 30 days after you get the Remittance Advice from Medicare or within 15 days after a determination on an appeal, if you or the beneficiary files an appeal."

Therefore, if your contractor pays for the service, don't bill the patient. And if you already collected from the patient, you must pay them back quickly.

Source: You can read the MLN Matters publication, "Advance Beneficiary Notice of Noncoverage" at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf.

Reference the ASC List When Possible

Question 5: How can I find out which procedures our physicians perform are covered by Medicare when performed in an

ASC?

Answer: Medicare posts the lists of allowed procedures Ambulatory Surgical Center (ASC) payment at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html. Remember that Medicare pays the physician services separate from the ASC services.

Addendum AA shows the surgical procedures Medicare will pay the ASC for when performed in the ASC setting. For instance, you'll find breast lesion excision on the list: 19120 (Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion [except 19300], open, male or female, 1 or more lesions).

Addendum BB includes ancillary services the ASC will be reimbursed for. Ancillary refers to non-surgical procedures, such as 75822 (Venography, extremity, bilateral, radiological supervision and interpretation).

Source: You can find quarterly updates at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.