Part B Insider (Multispecialty) Coding Alert

PART B MYTH BUSTER: 4 Deadly Myths That Could Wreck Your Practice

Test yourself against these coding and compliance pitfalls

Does your staff subscribe to any of the most common myths in the medical industry? Make sure you educate them about the truth behind these misconceptions, which Auburn, AL coding consultant **Kim Garner Huey** collected for a recent coding compliance presentation:

Myth: You have to bill everyone the same amount.

Fact: -As long as you are following a contract or have consistent non-discriminatory billing policies in writing, billing may vary,- notes **Jan Rasmussen** with **Professional Coding Solutions** in Eau Claire, WI. But you should keep your billing policies consistent to avoid accusations of discrimination.

It's true that you can't bill your Medicare patients more than you do all your other patients, says **Suzan Hvizdash**, physician education specialist for the department of surgery at **UPMC Presbyterian-Shadyside** in Pittsburgh.

Myth: Before you write something off, you have to send three bills.

Fact: You have to make a reasonable attempt at collecting the co-pay, deductible, and, when applicable, the balance of the bill, says Hvizdash. That doesn't necessarily mean sending three bills.

Myth: You can only bill one diagnosis code.

Fact: You should bill as many diagnosis codes as you need to establish medical necessity for the services you-re billing, says **Dianne Wilkinson**, compliance officer and quality manager with **MedSouth Healthcare** in Dyersburg, TN.

Some payors- computer systems used to be able to read only one diagnosis code per line, says Rasmussen. But now, you should always be able to report all pertinent diagnoses for each visit, and link the correct diagnoses to each service on each line.

Myth: Evaluation & management (E/M) codes are assigned by the level of medical decision-making (MDM).

Fact: MDM is only one of three key components. People confuse MDM with medical necessity, says Wilkinson.

You should assign E/M codes based on two or three of the E/M components, depending on the category of the code, says Rasmussen. But you should always consider the nature of the patient's presenting problem.

Editor's Note: See next week's PBI for more deadly coding/compliance myths.