# Part B Insider (Multispecialty) Coding Alert

## Part B Payment: Five Mistakes Each Week Could Create $25,000 Revenue Drain

**Are you staying on top of claims submissions and appealing when you know you billed properly?**

Times are getting tougher for physician practices. Are you leaving money on the table? If you're just missing five services per week, that could add up to huge losses, say experts.

Example: "Suppose your coder falls behind on claims and leaves five new patient visits in the system, forgetting to submit them to your MAC," says Atlanta-based coding consultant **Jay Neal**. "Just to pick the code in the middle of the range, we'll say they were all 99203s, which reimburse about $100. You just left $500 on the table--over the course of a year, that adds up to over $25,000 that your practice could flush away."

And the losses might be even worse, depending on which services your practice routinely reports. For example, if you aren't reporting your "Welcome to Medicare" visits (G0402), you're forfeiting about $150 per beneficiary. Common Medicarebilled surgeries like cataract removal (66984) will net you about $745, while a hip replacement (27130) brings in over $1,400. Imagine forgetting to report just two hip replacements a month--you'd be sacrificing over $33,000 annually.

**Confirm You're Collecting**

Ensure that your staff members are capturing every injection, every drug code, every separately reimbursable supply or minor procedure, and every E/M code. You should make sure your superbill includes all of the services your office typically provides--and then double check that your staff is actually capturing all the services your doctors perform on that superbill.

Also, make sure you have the most up-to-date codes on that superbill, charge ticket or encounter form. Some practices save a few bucks by opting not to buy the new ICD-9 and CPT® books every year--and end up throwing away thousands of dollars in extra reimbursement.

Don't fall in the time gap: Also, remember that the ICD-9 codes go into effect in October. The new CPT® codes go into effect in January, and neither code set has a grace period. Some practices wait to update their charge sheets until January, so they can add both ICD-9 and CPT® codes to the sheet. They could be billing incorrectly for three months as a result, and this could really have a huge impact on their reimbursement.

For example: In 2011, the code for reporting extremity ultrasounds changed from 76880 to new code 76881--but if you're still billing 76880, you'll collect nothing. That means you're sacrificing the entire $115.00 that 76881 reimburses.

Avoid time-consuming appeals: Having clean claims involves more than just following coverage procedures. Make sure you have the correct place of service (POS) code, zip code and national provider identifier (NPI) for the referring physician. However, if you do make a mistake on a claim, don't just brush it off--appeal denials if you know you have the documentation to back up the codes, and correct your processes to ensure you don't make the same mistakes in the future.