Part B Insider (Multispecialty) Coding Alert

PART B QUIZ ANSWERS: Quick Quiz Results--Did You Rate An A+?

Or do you need to go back to claims management 101?

Were you stumped on the copay waiving question? Confused on the vacationing physician challenge?

Answer 1: False. When you-re billing for a provider in a group practice, if you now have a group ID, you will need a group NPI. If you-re billing for a facility, you-ll need a facility NPI. Each individual provider also needs his own NPI.

On the claim: For providers in group practices, enter the group NPI in box 33 on the claim form and use the individual provider's NPI in 24J.

Answer 2: The answer depends on the carrier and whether a secondary payer is involved. Medicare will pay your claims retroactively from the date of the practice's new physician's NPI application. Other payers give you an effective date for when you can start billing.

Beware: You cannot bill the services under another provider while you-re waiting for the new physician's credentialing.

Answer 3: No. Waiving copays or deductibles isn't a smart practice, regardless of the carrier. Financial arrangements that differ from the billing obligations laid out in your contract can result in fraud charges, penalties and loss of carrier contracts. Discounts and waivers for Medicare beneficiaries could raise an even bigger red flag.

If Medicare finds that you have submitted claims that misrepresent the financial arrangement you made with the patient, you could be facing imprisonment, criminal fines, civil damages, civil monetary penalties, and exclusion from Medicare and state healthcare programs. In this scenario, you should urge your physician to stick with the assigned copays.

Answer 4: False. Because you-re dealing with Medicare patients, you must observe locum tenens reporting rules. These guidelines govern all services provided to Medicare patients by a substitute physician.

Explanation: The most important thing to remember when billing for substitute physicians is modifier Q6 (Service furnished by a locum tenens physician).

You must append this modifier to every procedure code on a claim for a substitute physician.

You-ll send the bill out under the regular physician's name, but the Q6 modifier alerts Medicare that the services were actually provided by a locum tenens physician.

So if the locum tenens physician provides a level-two E/M for an established patient, you should re-port 99212-Q6 (Office or other outpatient visit for the evaluation and management of an established pa-tient, which requires at least two of these three key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making) for the service.

Remember that the locum tenens physician cannot fill in for your physician for more than 60 straight days. Once the substitute has reached the 60-day limit, he must bill for his services under his own name.

Answer 5: No. Although some V codes are secondary diagnosis codes, there are times when you must use a V code as primary, and there are many instances in which you ab-solutely must use a V code as your primary diagnosis. A diabetes screening is one of the instances where a V code as a primary diagnosis comes in very handy.

On the claim, report the following diagnosis codes:

- 82947 (Glucose; quantitative, blood [except reagent strip]) for the test.

- V77.1 (Special screening for diabetes mellitus) linked to 82947 to show the reason for the test.