Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: 10 Tips Ensure You Aren't Losing Thousands This Year

Coordinate back office and front desk staff to keep cash flow positive.

From ABNs to ZPICs, it can be hard to keep track of the A to Z of patient billing and coding, but these are the factors that will keep your practice in the black. To ensure that you aren't missing out on reimbursement, check out these ten tips.

1. Advise employees to inform patients of their payment responsibility prior to the appointment. The most important step that you can take to get your patients to pay their share of medical bills promptly is to talk to them about their responsibility. When employees schedule appointments and gather insurance information, you should also have them advise patients that copayments are payable when they come in for their visit.

2. Stay on top of SNF patient status. Skilled nursing facilities (SNFs) must consolidate their billing for Medicare beneficiaries who are in a Part B non-covered SNF stay in which their Part A benefits are exhausted. When these patients present to private practices or clinics, you can't bill Medicare directly for certain services, such as the technical component of x-rays. In these cases, you must bill the physician's x-ray interpretation to Medicare with modifier 26 (Professional component) appended, but bill the technical component directly to the SNF.

3. No insurance card? No problem. Often, you'll see patients with new insurance coverage who haven't gotten updated insurance cards yet□this is a situation where a pre-visit confirmation can clear up any issues before they start. Ideally, when patients call to make appointments, you should have the appointment scheduler confirm their insurance coverage. This is when you find out if they have new coverage. Finding out about insurance changes before the appointment gives you time to check if you are a participating provider with the payer and verify coverage. Ask for the name of the insurer and the policy number from the patient, or from the patient's employer. Then, call the insurer and verify the coverage and the date of eligibility, and get the appropriate information to identify the patient on your claim.

The date of eligibility is an important question to ask the insurer because many employers don't make health insurance coverage immediately available to new workers. A patient with a new job and new insurance coverage may be in your office for a visit today, but his insurance isn't effective for two months.

Although verifying coverage in advance is preferable, most practices have patients confirm their insurance coverage and note any changes when they check in for their appointments. If you are unable to verify the insurance coverage, or you find that the patient is not eligible for coverage on the day of the visit, inform the patient of the problem and ask if he or she wants to reschedule the appointment unless it's an emergency or urgent visit. Otherwise, explain to the patient that the visit and services may not be covered, and that the patient must pay the bill. Make sure the patient signs an ABN in this situation.

4. Cross-reference your practice log against a charge sheet. If your equipment creates a log of everything that happens in your practice, you should make sure you check it against your charge sheet from time to time to ensure you're billing everything you performed. For example, an EKG or pacer system will show events that may not end up on your posted charges. If you see an incidence of this taking place, you should ensure that you not only bill for the missed charges, but that you also educate your staff to ensure that it doesn't happen in the future.

5. Properly train front desk to collect financial information. Improving your practice's financial picture starts with the information your practice collects from patients when you first meet them, so you need to focus on both your front desk and your back office to improve your revenue. Your front-desk staffers should be checking on insurance information and whether your physician participates with that payer, plus whether the claim is related to motor-vehicle or workers-compensation insurance. At the visit, your staff should be examining a photo ID to make sure the patient is who he says

he is, as well as obtaining a copy of the patient's insurance card. For motor-vehicle or workers- compensation claims, you'll need to collect a whole set of documents from the patient up front. And of course, there's the copayment and deductible to collect, if any.

6. Differentiate PC/TC components. Suppose your physician performs a sleeping or comatose EEG in the hospital ICU with a facility's equipment. You should use 95822 (Electroencephalogram [EEG]; recording in coma or sleep only) and append modifier 26 (Professional component).

Some coders might mistakenly report the diagnostic study without any modifiers. But EEG code 95822 is made up of two components: the technical component (modifier TC) and the professional component (modifier 26). The TC component applies to the person or facility which actually owns the equipment. The 26 modifier is for the professional interpretation.

Reminder: Use these modifiers only on procedures having both the professional and technical components. You should not use modifier 26 with procedures that are either 100 percent technical or 100 percent professional. Check the Medicare Physician Fee Schedule to determine when these modifiers are applicable.

7. Code locum tenens accurately. When you report locum tenens (stand-in physician) services, don't confuse modifier Q6 (Service furnished by a locum tenens physician) with reciprocal billing modifier Q5 (Service furnished by a substitute physician under a reciprocal billing arrangement). Reciprocal billing arrangements typically describe a two-way exchange between providers.

For example: Your physician and another doctor agree to see each other's patients on weekends off and agree to a reciprocal billing agreement. These services would fall under modifier Q5. In these situations, the doctor who "owns" the patients, not necessarily the one who saw them at those visits, bills out the provided services under his national provider identifier (NPI) and appends modifier Q5 to indicate he really did not see the patient. The physicians don't exchange any money because the services will even out over time.

By comparison: Locum tenens describes a one-way exchange between providers. Your physician would retain a substitute physician to take over the practice for such reasons as illness, pregnancy, vacation, or continuing medical education. The substitute physician generally is paid a fixed amount per diem or similar for-time basis. To report the locum tenens services, you would append modifier Q6 to all of the temporary physician's claims and bill under your physician's (who the locum is replacing) NPI. CMS limits both of these modifiers to 60 days of use per fill-in physician.

8. When applicable, collect copays for nurse visits. Although some patients erroneously consider nurse visits "freebies," you must collect a copayment if a visit with the nurse is a chargeable, medically necessary visit. In other words, if the visit with the nurse is coded and charged, the patient must pay the copayment.

That does not mean, however, that a practice can charge for every patient who sees the nurse and collect a copayment. For example, if the patient sees the nurse for a blood-pressure measurement because the physician, as a courtesy, told the patient to stop in any time and have the check, there is no medical necessity to code the visit and, therefore, it is not charged. As a result, no copayment can be collected. But, if the physician gives written orders that a patient needs to come in for blood-pressure checks and medication monitoring with the nurse, medical necessity exists to code the nurse visit and charge it. The copayment must be collected.

9. Collect from patients when the insurer sends payment directly to them. It happens from time to time your practice files a claim with the benefits assigned to your office. However, the insurance company sends the payment to the patient instead of to you, and the patient isn't very eager to pay you the amount.

You should send a letter to the patient and inform her that you are aware the insurance carrier paid her directly and that the money should have been turned over to you. Inform her that a check was cashed that was meant for your practice and that she has a certain number of days to make full payment.

10. Prep for ICD-10 now. How does this help you improve your revenue? If you aren't correctly reporting your diagnoses as of Oct. 1, your claims will be denied. So in actuality, your mastering of the ICD-10 coding system could be the single most lucrative thing you do for your practice all year because it keeps reimbursement coming into your

accounts.