Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: 2 Tips Easily Solve Your Code Compliance Errors

Reduce denials for your practice by reading the fine print.

There are always a few tricky codes out there that can cause denials from carriers. Take a few minutes to test yourself against these quick, easily-solved issues to reduce compliance errors.

Tip 1: Beware of Tricky PC/TC Components

Scenario: 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).

Common mistake: 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).

TC is for the person or facility which actually owns the equipment, says **Peggy Stilley, CPC,** office manager for an Oklahoma University-based private physician practice in Tulsa. The 26 modifier is for the professional interpretation.

If your physician performs a sleeping or comatose EEG with a facility's equipment, you should use 95822 and append modifier 26 to reflect that he provided the professional component only -- meaning he interpreted the findings and wrote the report.

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.

Play it safe: Medicare will not pay physicians for the TC of services provided in a facility setting, such as inpatient (POS 21) or an outpatient hospital (POS 22) setting.

Tip 2: Be Careful Coding Locum Tenens

When you report locum tenens (stand-in physician) services, should you add modifier Q5 (Service furnished by a substitute physician under a reciprocal billing arrangement) to the report?

Watch your step: When you report locum tenens services, don't confuse modifier Q6 (Service furnished by a locum tenens physician) with reciprocal billing modifier Q5. Reciprocal billing arrangements typically describe a two-way exchange between providers, says **Kelly Dennis, MBA, CPC, ACS-AP,** in Leesburg, Fla.

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 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, Dennis says.

Medicare will only allow a locum tenens to provide services to Medicare patients for a 60-day continuous period. The continuous period countdown begins with the first day the substitute physician provides covered services and continues without interruption, even on days when no services are provided to your patients.