Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: 5 Services You Shouldn't Offer for Free--And 3 That You Should

Not everything will be a 'freebie' in your practice.

Everyone likes free items and services, but your practice could be losing money if you're offering visits at no charge when you could legitimately be reporting them. Read on for five of the most common services that you should be billing and three things you must actually offer for free.

Collect for These Five

1. Copays and deductibles. Although there are some rare instances when you can write off a patient's copay or deductible, as a rule you should be collecting these. Financial arrangements that differ from the billing obligations laid out in your contract with government or third-party payers can result in fraud charges, penalties, and loss of carrier contracts.

According to the OIG, "the routine waiver of Medicare coinsurance and deductibles can violate the Federal anti-kickback statute if one purpose of the waiver is to generate business payable by a Federal health care program." In addition, offering inducements such as cost-sharing waivers to Medicare patients that you know might be likely to influence that patient's selection of provider can violate separate statutes, the OIG says.

Best bet: If you ever encounter a situation in which you think a waiver or discount of fees is legally and ethically appropriate, contact your payer or a health care attorney to ensure that the arrangement would be in compliance with the payer's contracts and policies.

2. Casting Materials. Although cast application coding can vary, you have one simple rule to remember for cast and splint supplies: they are always separately billable, assuming your physician incurred the expense for supplies.

Look to HCPCS for all your cast supply codes. Make your selection based on the patient's age, type of cast/splint, and the type of cast material, but typically you'll report codes Q4001-Q4048. These cover the gamut of cast supplies and application types. Each Q code fee includes the cast material, padding, and stockinette.

3. Complicated Procedures. With appropriate documentation and judicious application, modifier 22 (Increased procedural services) can yield increased payment for especially difficult or time-consuming procedures.

No payer will allow additional payment for a procedure unless you can provide convincing evidence that the service/procedure the physician provided was truly out of the ordinary or significantly more difficult or time-consuming than usual. The time to append modifier 22 is when the service(s) the physician provides are "substantially greater than typically required," according to Appendix A of the CPT® manual.

CMS guidelines stipulate that you should apply modifier 22 to indicate an increment of work infrequently encountered with a particular procedure and not described by another code. These could include situations involving excessive blood loss or trauma, in addition to other scenarios.

The op report should clearly identify additional diagnoses, pre-existing conditions or any unexpected findings or complicating factors that contributed to the extra time and effort spent performing the procedure, as well as the special circumstances of the additional time and/or effort necessary.

Include a physician's letter that explains the unusual nature of the procedure with your claim so the payer can see that

you didn't perform a typical service, and let the payer know how much extra reimbursement you believe you deserve. For instance, if a procedure took 20 percent longer than it typically should, you might ask for an extra 20 percent over the normal fee.

4. Prolonged Services. CPT® includes add-on codes that you can report along with your E/M code to describe prolonged services with direct patient contact.

When your practitioner spends at least 30 minutes or more time beyond the typical time for a particular E/M code, you will report prolonged services in the outpatient setting or office with +99354 (Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour [List separately in addition to code for office or other outpatient Evaluation and Management service]) for the first hour (actually, 30-74 minutes) of prolonged service. You can report every additional 30 minutes of direct patient contact with +99355 (Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes [List separately in addition to code for prolonged service]).

While reporting the encounter, make sure to document all the details regarding the total time spent by the physician for the encounter, the actual time of the visit spent in counseling/coordination of care and what topics were discussed.

5. No Shows. Although some practices are still hesitant to bill for missed appointments, these holes in your day have an impact on the physician's schedule or the physician's availability to other patients, and cost the practice real dollars. In some cases, charging patients a fee when they miss a visit will help your practice offset the lost time and money the open appointment time cost.

Your first step in evaluating whether to charge a fee to patients who do not show up for appointments is to check with your payers. Medicare allows charging for no-shows as long as it is the office policy and done universally to all patients (except Medicaid, which doesn't allow no-show fees).

Key: Even if your contract allows you to bill for no-show visits, that doesn't mean you can bill the payer. You need to bill the patient for the missed appointment. You should tell all of your patients about the policy and have them sign the policy with their other annual financial documents.

Your no-show policy should spell out exactly what fee you will charge for a missed appointment. Some may charge a fixed amount of $25 or $50, which won't cover the missed reimbursement. Others may charge the actual amount of the missed visit; for example, a behavioral health professional may charge their normal fee for a one hour counseling appointment.

Make Sure You Offer These at No Charge

Of course, not every service you provide at your office will generate a charge□you'll still bill nothing if the patient presents for any of the following.

1. Prescription pickups. If the only reason the patient comes into your practice is to pick up a prescription and the doctor does not see her for a documented E/M service, you cannot bill an E/M code.

In fact, CPT® specifically includes writing prescriptions as part of an E/M service. This is just part of the cost of seeing patients, much like office supplies. There is no CPT® code for writing a prescription that payers will reimburse.

2. X-Ray Re-Reads. If a patient presents to your office with x-rays from the emergency room along with the ER doctor's x-ray interpretation, you can't bill another interpretation just because your physician looks at the x-rays a second time. Each x-ray service is only billable once, and the ER physician most likely already reported it.

CPT® considers reviewing records as integral to the E/M service, and you should consider your x-ray re-read part of the E/M code that you report. Although CPT® does not include the time associated with records review in the E/M code descriptors, "the pre- and post-face-to-face work associated with an encounter was included in calculating the total work of typical services in physician surveys."

3. Removing Stitches. If the same physician who placed a patient's sutures removes them during the original procedure's global period, you cannot report the removal separately. Instead, carriers consider it to be part of the standard follow-up care.

Tip: Payers associate a zero charge with 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason[s] related to the original procedure), but you can use it to keep track of visits for risk management purposes to show that the patient did present for a follow-up visit within the surgical period.