Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: Keep Money Flowing With These 6 Income Opportunities

Take the time to ensure that you aren't bleeding revenue in these areas.

Just because Medicare's regulations are complex and challenging doesn't mean you can't collect all of the revenue that your MAC owes you. Heed these six quick tips to make sure you aren't losing cash.

1. Update Your ICD-9 codes.

It's that time of year when you should be finalizing your new superbills. Oct. 1 has arrived, and that means the new ICD-9 codes are in effect.

Remember: Your ICD-9 codes prove medical necessity for your claims. Your CPT coding might be completely buttoned-up, but without accurate diagnoses, you can say goodbye to reimbursement.

2. Ensure That Your Nurse's Notes Are Ironclad

If your nurse is performing and documenting your HPI, you could be asking for an audit.

The only parts of the E/M visit that an RN can document independently are the review of systems (ROS); past, family, and social history (PFSH); and vital signs, according to Palmetto GBA, a Part B MAC. The physician or mid-level provider must review those three areas and write a statement that the nurse's documentation is correct or add to it.

Only the physician or non-physician practitioner who conducts the E/M service can perform the history of present illness (HPI), Palmetto adds.

Exception: In some cases, an office or emergency department triage nurse can document "pertinent information" regarding the chief complaint (CC) or HPI, Palmetto says. But you should treat those notes as "preliminary information." The doctor providing the E/M service must "document that he or she explored the HPI in more detail," Palmetto explains.

Other payers expand on Palmetto's stance, letting physicians know that they cannot simply initial the nurse's documentation. For example, Noridian Medicare publishes a policy that states, "Reviewing information obtained by ancillary staff and writing a declarative sentence does not suffice for the history of present illness (HPI). An example of unacceptable HPI documentation would be 'I have reviewed the HPI and agree with above.'"

Not everybody greets the Palmetto FAQ with open arms. This clarification may cause more confusion, because there's no definition of the word "preliminary." Also, Palmetto does not explain how much extra documentation could be required to comply with the guidelines.

Bottom line: Get your MAC's documentation rules in writing before you have the nurse fill out any of the E/M notes.

3. 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.

Snafu: Unfortunately, even if you know these rules, you could still end up dealing with problems when you treat a patient and don't realize that they are a SNF patient. It's very frustrating to find out on the back end that a patient was in a SNF when they came to your office even when you have notices posted at your front desk to please tell the receptionist of SNF status.

4. Bill your supplies, when reimbursable. Medicare includes the cost of most supplies in your pay for the service. For instance, if you perform a biopsy, the tray and bandages that you use are already bundled into the biopsy codes. However, some supplies, such as casts or splints, can be billable, depending on the circumstances.

CMS has approximately 50 "Q" HCPCS codes that address supply issues with casting/splinting applications. For instance, if the physician applies a short-leg, fiberglass cast to a 69-year-old patient with fractures of the calcaneus and talus, you should report the appropriate fracture care or casting code, along with Q4038 (Cast supplies, short leg cast, adult [11 years +], fiberglass).

5. Don't wait to get your new physician credentialed. When you sign a new practitioner on board your practice, don't wait too long before you apply for his NPI.

Here's why: You can retroactively bill Medicare for services your physician rendered up to 30 days prior to the date of filing a Medicare enrollment application that the contractor subsequently approves, the Medicare Fee Schedule says.

What this means: You have 30 days from the day you submitted the enrollment application to the Medicare carrier and the carrier receives your signed certification via mail, if you're filing via PECOS. If you file via paper application, the filing date is the day the carrier receives your application.

6. Follow Up on Unpaid and Denied Claim

The number one way to make sure your practice isn't hemorrhaging money is to follow up on denials and appeal as necessary, experts say.

Almost every practice has hidden money waiting to be discovered, from sources such as unpaid claims, claims paid incorrectly, denials not appealed or appealed incorrectly, and denials appealed with no follow-up.

You should continually review and monitor your explanations of benefits (EOBs), paying special attention to your denials. You can glean a lot of information from your EOBs, such as how quickly insurers are paying you, whether your fee schedule is adequate, if your coders are coding properly, why insurance companies are denying your claims, and if you're getting paid according to your contracted rates.

Appeal inappropriately denied or partially paid claims. Unless you schedule time to actively look at denials and appeal them, you're never going to have the chance to be effective at it and get the money that is owed to you.