Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: Maximize Your Income With These 7 Tips

A well-oiled billing and collections program will ensure your practice doesn't lose money.

Medicare coding rules are challenging, and sometimes they seem to change every day□but that shouldn't keep you from missing out on revenue. Follow these seven quick tips to make sure you aren't losing cash.

1. 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.

2. Don't Blindly Accept Sequester Cuts on Advantage Claims

When cuts hit your Part B payments on April 1 due to Medicare's two percent sequestration cuts, you probably didn't expect Medicare Advantage to also jump on the pay-cutting bandwagon and similarly slash your payments. And, it turns out, they probably shouldn't have cut your pay at all.

Although Medicare Advantage was hit with the sequestration cut that impacted Part B payments on April 1, Medicare Advantage must still the contracts it has with practices, said Cheri Rice, director of CMS's Medicare Plan Payment Group, in a May 1 memorandum to Medicare Advantage Organizations (MAOs).

"MAOs are not permitted to modify the currently-approved benefit or cost sharing structure in any way," Rice said in the memo. "This includes increases in premiums or cost sharing, or reductions in benefits in an attempt to offset the lower payments due to sequestration."

The caveat: If you bill Medicare Advantage but you aren't contracted with the plan, then sequestration cuts will apply, Rice added. "A non-contract provider must accept, as payment in full, the amount that it could collect if the beneficiary were enrolled in the Medicare Fee-for-Service program," the letter states. Since Medicare Fee-for-Service is subject to the two percent cuts, so too will be Medicare Advantage payments to non-contracted practices.

If You See MAO Cuts: If you've noticed that your Medicare Advantage payer has been cutting your pay by two percent since April 1, double-check your contract to determine whether they are allowed to do so. If your contract does not include verbiage that lets the program pass on the cuts to you, then you should appeal your claim reductions to your Medicare Advantage payer.

3. 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).

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 at the beginning. So you need to focus on both your front desk and your back office to improve your revenue.

Your practice will be sunk without clear-cut policies and procedures spelling out who does what.

Revenue maximization starts from the time your patient calls to make the appointment. Your front-desk people 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

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).

The TC component applies to the person or facility which actually owns the equipment. 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.

7. Code Locum Tenens Accurately

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? Typically, the answer is no.

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.

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, Dennis says.