Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: These 5 Errors Could Be Causing You to Bleed Money

Avoid making these mistakes and you'll keep the reimbursement flowing.

Certain technological advances, such as EHRs and electronic billing forms, have created new opportunities for fast reimbursement. However, many practices are sending out claims so quickly that they may be overlooking specific opportunities to collect accurate reimbursement. If your practice doesn't seem to be living up to its earning potential, check to ensure you aren't making one of these five common mistakes.

1. Not Collecting Coinsurance and Copays

With some copays running up to $60 in the current environment, you certainly can't afford to write these off--but many practices are guilty of doing just that. Keep in mind that you can collect coinsurance amounts up-front for defined contribution copayments, which many Medicare Advantage programs offer, since they don't depend on which services you render.

Some electronic subscription services allow you to verify the patient's coinsurance amount and whether their deductible has been met before the patient arrives for his visit. Therefore, when you make the patient reminder call, tell them approximately how much they'll owe you in coinsurance or deductible amounts.

In other cases, when you must first read the chart to determine what services the patient underwent before billing a copay, make sure you collect it before the patient leaves the practice.

2. Waiting Too Long to Collect

Collecting patient balances becomes increasingly difficult after the patient leaves your office. So if you didn't follow the advice in #1 above, you should bill the patient as soon as you realize they have a balance due.

Experts say that after 90 days, you only have about a 70 percent chance of collecting the debt owed. Therefore, you should review outstanding patient balances every 30 days, with the following as a guideline in creating your timing:

- Send the first statement within five days of your system recognizing a patient-due balance exists.
- Send the second statement 30 days later.

At this point, the patient has had three opportunities to pay -- one at the time of service, and two statements. Practices handle the next steps differently based on their internal policies. For instance, some practices choose to write off balances of $50 or below, while others aggressively fight for every balance.

You might make a courtesy call next, followed by a collection letter. If you end up having to write off any balances, keep track of them to tally up how much money you lost. This should prompt you to have a staff meeting where you'll discuss how to avoid such losses in the future.

3. Consistently Undercoding

You may think that chronic undercoding will allow you to avoid raising a "red flag" to Medicare auditors, but if you're knowingly reporting the wrong code (even if it's lower than what's justified), you are still coding incorrectly. According to CMS's Comprehensive Error Rate Testing (CERT) results, CMS noted that it still owes $1.1 billion to providers who underbilled in 2010.

Even if your practitioner only undercodes one claim per week by just one level, you're still losing significant revenue. For instance, a physician whose documentation justifies 99214 but who only reports 99213 -- and does this once a week for a year -- will lose over $1,700 annually.

4. Failing to Append Modifiers

When used properly, modifiers can be the only thing between having your claims paid versus being rejected.

For instance, suppose your physician performs a maxillary nerve injection (64400) and trigger point injection on two muscles (20552). He addresses the maxillary nerve, also known as V1 of the trigeminal nerve, for trigeminal neuralgia (350.1) and injects trigger points in the left multifidus muscle at L5 (vertebral level) and left latissimus dorsi muscle at L1, both for myofascial pain (729.1). The CCI bundles 20552 (column 2 code) into the 64400 (column 1 code).

Since your doctor performed the injections in different anatomic locations, you are clear to bypass the bundling edit by appending modifier 59 to 20552. Without modifier 59, you could forfeit the entire payment for 20552, which averages about $53.00.

You should also make sure that the ICD-9 diagnosis codes are correctly linked to the corresponding CPT® codes.

Important: You should never use modifier 59 for E/M services. If you're reporting a separately identifiable E/M service with another procedure on the same day, you'll turn to modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

5. Failing to Bill A Sick Visit With an AWV When Indicated

When your physician encounters a problem during the performance of an annual wellness visit (AWV), you don't have to write off the charge for that evaluation. Although the CCI bundles office visit codes 99201-99215 into both G0438 and G0439, you can use a modifier (such as 25) to the E/M code if you have a medically necessary reason to separate these bundles.

In black and white: CMS requires you to append modifier 25 when reporting an E/M code with an AWV. CMS Transmittal 2159 noted, "When the physician or qualified NPP, or for AWV the health professional, provides a significant, separately identifiable medically necessary E/M service in addition to the IPPE or an AWV, CPT® codes 99201-99215 may be reported depending on the clinical appropriateness of the circumstances. CPT® modifier 25 shall be appended to the medically necessary E/M service."

Make sure your documentation clearly shows a difference between the services you performed for your E/M visit and those performed for the AWV, so you can demonstrate the separately identifiable nature of both services.