Part B Insider (Multispecialty) Coding Alert

Reimbursement: 5 Tips Help You Keep the Money Flowing Into Your Practice

Medicare conversion factor changes mean it's essential to collect every penny you can.

With CMS once again slashing the conversion factor and cutting pay to many specialists, you can't afford to let any pennies leak out of your practice. Follow these quick tips to ensure that you're bringing in maximum dollars to your practice:

1. Take Incident-To Seriously: Under Medicare's incidentto rules, qualified mid-level providers (MLPs) can treat certain patients and still bill the visit under the doctor's NPI, bringing in 100 percent of the assigned fee for the codes you report. To qualify for incident-to billing, the doctor must see the patient during an initial visit and establish a clear plan of care, and the physician must be in the immediate office suite while the MLP is performing the incident-to services.

You should bill incident to only for MLPs who have the credentials to perform the appropriate services. The MLP could be a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) -- as long as the MLP meets state and federal guidelines to report incident to.

The provider must be "licensed by the state under various programs to assist or act in the place of the physician," according to the Medicare Benefit Policy Manual, Chapter 15. If the MLP's service doesn't fit incident-to regulations, that doesn't mean you have to forego payment altogether. If you do not bill an MLP visit incident-to the physician, then you should code the service under the MLP's NPI number.

Expect Medicare to reimburse you at 85 percent of the global, or full, fee.

2. Don't Ignore Modifier 22: Catch-22: If you're using modifier 22 (Increased procedural services) on almost all your surgical cases, you're headed for an audit. But if you're not using modifier 22 at all, you could be passing by avenues for ethical reimbursement. Some coding analysts have suggested that physicians should use modifier 22 in fewer than five percent of all surgical cases, meaning you should apply modifier 22 sparingly. That doesn't, however, mean you should never use this modifier at all.

Key: When a surgery may require significant additional time or effort that falls outside the range of services described by a particular CPT code -- and no other CPT code better describes the work involved in the procedure -- modifier 22 is your best option.

3. Don't Invest in Practice Management Software Just Yet: Keeping up-to-date practice management softwareon your practice's computers can be a great way to ensure that you're keeping your practice billing and collecting properly. But if you're considering buying an electronic health record (EHR) system for your practice, don't buy separate practice management software until you know what your EHR offers.

"If you're looking at an integrated EHR, it will probably come with practice management software within it, so don't buy a new software system until you select your EHR," advises **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPCH, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J., and senior coder and auditor for The Coding Network. "Many EHRs also offers very sophisticated integrated practice management systems," she advises.

4. If You Are Non-Par With the Patient's Insurer, Always Collect At Time of Service: If you know that your practice does not participate with the patient's insurance company, you also know that the payer will send the check directly to the patient. Therefore, you can collect the fee for your services directly from the patient while he is in your office. This policy

should appear in the financial policy you give all patients, and you should put up a sign in the waiting area stating that payments are due at the time of service. You should also try to let patients know when they make their appointment (and when you call with an appointment reminder) what they will owe for the visit, as well as the payment methods your practice accepts.

5. Bill for No-Shows: Medicare used to frown upon no-show billing. However, in Oct. 2007 CMS changed the policy and since then you've been able to charge Medicare patients if they miss an appointment -- with one major stipulation: Your no-show charge policy needs to apply to both your Medicare and non-Medicare patients. You cannot discriminate against Medicare patients by only charging them and not your other patients who miss appointments. You also have to charge the same amount to all of your patients.

Remember: Even if your contract allows you to bill for noshow visits, that doesn't mean you can bill the payer. You need to bill the patient for the missed appointment. If you do bill a missed appointment to Medicare, for example, your claim will be denied citing reason code 204 (This service/equipment/drug is not covered under the patient's current benefit plan).