Part B Insider (Multispecialty) Coding Alert

Reimbursement: Have You Overlooked These 7 Coding Opportunities?

When your practice is feeling pinched, it's important to ensure that you aren't forgetting to bill for everything your practitioner performs and documents.

Medicare coding rules are complex and challenging, and sometimes it's hard to know which services you can rightfully bill. But if you're up to speed on these seven key billing practices, you'll be collecting all of the pay you deserve.

1. Keep modifier 50 in mind: Many procedures are inherently unilateral, and you won't receive full reimbursement for bilateral versions of those procedures unless you append modifier 50 (Bilateral procedure).

Watch out: Coders often forget the 50 modifier for bilateral spinal injection and diagnostic ophthalmology procedures. Check the Medicare Physician Fee Schedule to determine which codes are allowable with modifier 50, and if your physician performs and documents a bilateral procedure for one of those services, be sure and submit your claim for a bilateral service.

2. Collect copays at the visit. You'll save yourself time and money later on if you calculate copays following a patient's service and collect that money before they leave your office.

Remember: If it's not a copay, you can't collect it before the patient sees the doctor. Just because a physician plans to perform a certain service doesn't mean he will perform and appropriately document it. Therefore, it's a good idea to collect after the patient has already seen the practitioner.

3. Mine those modifier opportunities. Some coders assume that if the Correct Coding Initiative (CCI) forbids billing two codes on the same date, that's the end of the story. But in fact, you may be missing out on some legitimate cases where CCI allows you to use a modifier, such as 59 (Distinct procedural service) to override an edit.

Always scan the CCI edits for the procedures you performed to see which code pairs a modifier can override. Of course, you should only use the 59 modifier when the services are separate, distinct, and medically necessary, and the physician has thoroughly documented the distinct nature of both separate services.

4. Watch for supervision and interpretation (S&I): For many invasive/diagnostic radiology codes, you need two codes, the S&I code plus a surgical code. Often, coders forget to append the surgical code, especially on outpatient hospital claims.

Example: You may remember to report CT guided needle biopsy code 77012 but leave out the associated site-specific percutaneous needle biopsy code.

5. Appeal when you feel you've been wronged. Because many practices fear being labeled "troublemakers" or even worse yet, non-compliant with the False Claims Act's regulations, they accept Medicare payers at their word -- and this isn't always a good idea.

If your MAC denies your claim or requests a refund, research the issue before you take the payer's word for it. You should appeal any time you feel your payer has wrongly denied your claim or incorrectly requested a refund.

6. Make sure you have the current coding guidelines. In some medical practices, coders haven't updated their CPT, ICD-9-CM, or HCPCS coding manuals in years because they don't believe that changes are enacted often enough to warrant purchasing new books. However, outdated codes can lead to claim rejections. In addition, the modifiers, coding rules, and parenthetical notes also change from year to year, and it's difficult to know which regulations apply if you don't have current resources. If you use a computer-based program for these resources, you can usually get all the updates through there, but paper manuals should be replaced annually.

7. Combine outpatient E/M with initial hospital care record for same-day admits. If you see a patient in your office and subsequently perform initial inpatient care for the same patient on the same date, you should report just one E/M code.

When the physician provides both services on the same date, combine the work documented in the office with the work documented in the hospital to determine the appropriate level of initial inpatient care (99221-99223).

The rules: The Medicare Claims Processing Manual (Chapter 12, Section 30.6.9.1) states, "When the patient is admitted to the hospital via another site of service (e.g., hospital emergency department, physician's office, nursing facility), all services provided by the physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission."

CPT guidelines for "Initial Hospital Care" similarly instruct that "When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (e.g., hospital emergency department, observation status in a hospital, physician's office, nursing facility), all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission."