Part B Insider (Multispecialty) Coding Alert

Revenue Boosting Quiz Answers: Are You Collecting Every Billable Dollar? Check Your Quiz Answers Here

Hint: Don't write off those unrelated post-surgical E/M visits.

Answer 1: If the E/M visit takes place during the global period but is truly unrelated to the surgery, you should append modifier 24 (Unrelated evaluation and management service by the same physician or other qualified healthcare professional during a postoperative period) to the E/M code.

Modifier 24 tells the payer that the surgeon is seeing the patient after the surgery for a problem unrelated to it. Therefore, the MAC should not include the E/M service in the previous procedure's global surgical package.

Modifier 24 is only for use on E/M codes provided during the post-operative period (10 days or 90 days), experts say. The very definition of the modifier states it plainly: "unrelated evaluation and management service."

Revenue collected: If your surgeon sees one patient a week for a visit unrelated to the surgery and he writes off a level-three established patient E/M code (99213) rather than appending modifier 24 to it each time, you're missing out on about $73 for each visit. Over the course of the year, this would add up to almost $3,800.

Answer 2: When you analyze your denials, determine how many of those low-dollar amount charges you wrote off over the past year and add them up--do they amount to a decent-sized sum? If so, it's worth your while to appeal the denials. If you know you've appropriately documented and billed a claim and you deserve your $10.00, you should capture it.

Example: Your physician routinely reads chest x-rays and writes the interpretive report for the radiology documentation, but you get denials when you report 71010-26 (Radiologic examination, chest; single view, frontal, Professional component). The MAC denies your charge, which amounts to about $9.30. You write off several months' worth of these charges, but then when you add them up, you realize you've been writing off nearly $1,000 a year.

Solution: Appeal these claims with documentation showing the medical necessity of your physician's interpretations of these x-rays.

Revenue collected: Nearly $1,000 annually.

Answer 3: You cannot bill your Medicare payer for no-shows, but you can bill the patient. Ever since 2007, Medicare has allowed you to charge patients fees for missed appointments. The only stipulation is that your no-show charge policy must apply to both your Medicare and non-Medicare patients--you cannot discriminate against your Medicare patients by only charging them for missed appointments. Plus, you should bill all your patients the same amount for no-shows.

Good idea: Ask all of your patients to sign your missed appointment policy when they sign your HIPAA and financial policy forms, so they know the fee.

Revenue collected: If you institute a $25 missed appointment fee that you charge once per week to absentee patients, you'll collect $1,300 annually.

Answer 4: In this case, you should report the colonoscopy with polyp removal via snare technique (such as 45385, Colonoscopy, flexible; with removal of tumor[s], polyp[s], or other lesion[s], by snare technique) with modifier PT (Colorectal cancer screening test; converted to diagnostic test or other procedure) appended to 45385.

Modifier PT tells the MAC that your procedure started off as a screening service (which would most likely have been billed

with G0105 for this patient) but the physician found an abnormality and the procedure subsequently became diagnostic or therapeutic.

"When a service began as a colorectal cancer screening test and then was moved to diagnostic test due to findings during the screening," you'll look to modifier PT, says Part B MAC WPS Medicare in its Modifier PT Fact Sheet. "Practitioners should append the modifier to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening sigmoidoscopy HCPCS code."

Revenue collected: If you had reported the screening code G0105 alone as a non-facility procedure, you'd collect about $383, but for 45385, you'll collect about $532, based on the 2015 Medicare Physician Fee Schedule (MPFS). That means you'd surrender about $149 in reimbursement if you erroneously reported the screening colonoscopy code for this procedure.

Answer 5: Because Medicare covers only one Pap test every two years unless the physician suspects cervical abnormalities, you should get the patient to sign an ABN acknowledging that she will have to pay for the test if she has had a Pap smear within the last two years. You should use a GA modifier (Waiver of liability statementissued as required by payer policy, individual case) on the claim to indicate you have the signed ABN on file.

Revenue collected: If you get the patient to sign the ABN, you can bill her directly if Medicare denies the claim, allowing you to collect about $15 for the Pap test. This could add up to almost $800 collected over the course of a year if you see one patient a week in this situation.