Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

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

Hint: Modifiers are key to collecting for screening-turned-diagnostic colonoscopy.

Answer 1: In this case, you should report the colonoscopy with polyp removal via snare technique (such as 45385, Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s], or other lesion[s], by snare technique) with modifier PT (CRC 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.

Revenue collected: If you had reported the screening code G0105 alone as a non-facility procedure, you'd collect about $395, but for 45385, you'll collect about $533. That means you'd surrender about $138 in rightful reimbursement if you erroneously reported the screening colonoscopy code for this procedure.

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 (Chest x-ray, Professional component). The MAC denies your charge, which amounts to about $9.00. 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 noshows.

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.