Part B Insider (Multispecialty) Coding Alert

The Rumor Mill: Dispel These 3 Rumors to Ensure Your Claims Run Smoothly

Modifier 59 no longer applicable? Don't believe everything you read.

You might be familiar with the Medicare rumor mill—that ever-growing nuggets of information that you heard at a seminar or from a colleague which you take as coding gospel, but may not actually be accurate. Here, we unravel a few of the most common rumors that our readers have shared with us, along with realities that may just change the way you code for these services.

Know the Modifier 59 Facts

Rumor: A practice wrote the Insider about modifier 59 (Distinct procedural service), which is one of the most commonly used modifiers. "We were just notified that modifier 59 is no longer accepted by Medicare payers," she said. "Can you tell us what we should use instead?"

Reality: You can still use modifier 59 when you need to demonstrate that two separate and distinct procedures were performed during the same session. What you can't do, however, is use this modifier for repeat procedures or other instances when a different modifier would be more appropriate.

Many Part B MACs posted instructions about modifier 59 on their websites this summer, which may have created the confusion. Cahaba GBA, for instance, a Part B payer, said, "Effective July 1, 2013, modifier 59 can only be used, when medically necessary, to unbundle a procedure code that has been bundled related to the National Correct Coding Initiative (NCCI)," the directive states. "Claims billed with the same procedure code two or more times for the same date of service should be submitted with the appropriate repeat procedure modifier rather than using modifier 59."

Cahaba points to modifiers 76 (Repeat procedure or service by same physician or other qualified health care professional) or 91 (Repeat clinical diagnostic laboratory test) as being more appropriate for repeat procedures.

Combining MSP With Consults Could Lead to Issues

Rumor: Another practice recently wrote to the Insider with a question about consultation pay when Medicare is the secondary payer, as follows: "I know Medicare doesn't reimburse consults anymore, but a new coder we hired said that at her old practice, she continued to get paid for consults if the primary payer accepted them and Medicare was secondary. She said as the secondary payer, Medicare will pay consultations. Can you direct us to the regulations on this?"

Reality: It's true that the primary payer—if it's a non-Medicare insurer—may still reimburse you for consultations. However, even if Medicare is secondary, your MAC still won't pay a dime for consults. "Medicare will no longer recognize the consultation codes for purposes of determining Medicare secondary payments (MSP)," CMS said in MLN Matters article MM6740, which indicates the following:

"In MSP cases, physicians and others must bill an appropriate E/M code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes," you should bill in one

of the following two ways:

- Bill the primary payer an E/M code, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due; or
- Bill the primary payer using a consult code, and then report the amount actually paid by the primary payer, along with an E/M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

CMS indicates in the MLN Matters article that "the first option may be easier from a billing and claims processing perspective."

Potential snag: In some cases, such as a physician seeing a hospital patient, the doctor may not know whether the patient is on Medicare or has a different insurer when he documents his consultation. Coders will need to be able to glean an appropriate E/M code from the physician's consult documentation if the patient ends up being on Medicare.

To read the MLN Matters article on MSP claims billed after Medicare's 2010 consult elimination, visit www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf.

Use Caution When Waiving Copays

Rumor: In seminar after seminar, physicians and coders have heard the advice ad infinitum: "Never waive a copay or deductible and don't offer discounts!" So many practices take this advice to heart that they could be passing on potentially problematic rumors.

Reality: There are times when you can offer patients with documented financial hardship a discount or waiver. Routinely waiving deductibles and copayments can violate several federal laws and regulations, including the federal False Claims Act, anti-kickback statutes, and compliance guidelines for individual and small group physician practices. Doing so may also violate payer contracts. However, there are some instances where it might be allowed.

In black and white: "Physicians or suppliers who routinely waive the collection of deductible or coinsurance from a beneficiary constitute a violation of the law pertaining to false claims and kickbacks," CMS says in the Medicare Claims Processing Manual Chapter 23, Fee Schedule and Coding Requirements, section 80.8.1 (http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c23.pdf). This applies not only to Medicare payers, but also those private carriers that base their regulations on Medicare rules.

Even though the rule states that you shouldn't offer waivers and discounts, you can make exceptions based on financial hardship. Waivers or discounts should be made only on the basis of demonstrated patient financial need, and you must meet the following criteria:

1. You do not offer the waiver as part of any advertisement or solicitation

2. You do not offer waivers routinely to patients

You offer the waiver after determining, in good faith, that the individual is in financial need or after reasonable collection efforts have failed. Don't just take the patient's word for it when it comes to financial hardship. Before you agree to a debt write-off, the patient needs to be able to prove he is unable to pay.

First, document the effort you took to collect the money. "Where a physician/supplier makes a reasonable collection effort for the payment of coinsurance/deductibles, failure to collect payment is not considered a reduction in the physician's/supplier's charge," CMS says in the Medicare Claims Processing Manual, section 80.8.1. "To be considered a reasonable collection effort, the effort to collect Medicare coinsurance/deductible amounts must be similar to the effort made to collect comparable amounts from non-Medicare patients. It must also involve the issuance of a bill to the

beneficiary or to the party responsible for the patient's personal financial obligations. In addition, it may include other actions, such as subsequent billings, collection letters and telephone calls or personal contacts which constitute a genuine, rather than token, collection effort."

If you want to prove financial hardship, you'll need to ask the patient to provide you with information such as income tax returns and W-2 and 1099 forms as proof of income and essential monthly household expenditures, such as mortgage/rent, utilities, insurance, and food.

The provider should keep up with legal developments related to discounts and waivers of co-payments and deductibles. If a patient applies for financial hardship and doesn't qualify the next step would be offer a payment plan for the patient.

Note: You can offer discounts to patient with no insurance who are self-paying without proving financial hardship by offering them a "Prompt Pay" discount at the time of service.