Part B Insider (Multispecialty) Coding Alert

PART B MYTH-BUSTER: Learn The Difference Between 'Requirements' And 'Received Wisdom'

6 more myths that could turn off your cash flow

You could be accepting patients you don't need to accept, or passing up your rightful reimbursement, if you accept some common misconceptions as gospel.

Here are some more pernicious coding and compliance myths which Auburn, AL coding consultant **Kim Garner Huey** collected for a recent presentation. (See last week's issue for more of these urban legends.)

Myth #1: If you-re a Medicaid provider, you have to accept all Medicaid patients.

Fact: Most states will allow you to turn away some Medicaid patients, says consultant **Quinten Buechner** with **ProActive Consulting** in Cumberland, WI. You should check your state's law to be sure. The **Centers for Medicare & Medicaid Services** (CMS) says you can put a cap on your number of Medicaid patients, but you can't limit your Medicaid patients in a discriminatory way, Buechner says.

Myth #2: Medicare covers everything, and you can't bill the patient for anything.

Fact: Medicare does not cover everything, says **Suzan Hvizdash**, physician education specialist for the department of surgery at **UPMC Presbyterian-Shadyside** in Pitts-burgh. For the things Medicare doesn't cover, you are able to bill the patient. If you believe Medicare may not pay for something, have your patient sign an Advanced Beneficiary Notice.

Myth #3: Medicare HMOs have to follow the same rules as Medicare.

Fact: Medicare HMOs have a set of guidelines that they must follow, and they have to cover everything Medicare would cover, says Hvizdash. But they can also choose to cover other things, and they can require referrals, authorizations, and other things that Medicare wouldn't require.

Myth #4: Your E/M level is based on how many diagnoses you have documented.

Fact: Your diagnoses can help support the level of service, and a lack of significant diagnosis codes could trigger an audit of a high-level evaluation & management code, notes **Jan Rasmussen** with **Professional Coding Solutions** in Eau Claire, WI. But your number of diagnoses isn't the only factor in determining your E/M level. Medical necessity is the -ultimate driving factor,- along with history examination and medical decision-making.

Myth #5: You have to follow Medicare's rules for everybody.

Fact: If this were true, you wouldn't need contracts with other insurance companies, says **Dianne Wilkinson**, compliance officer and quality manager with **MedSouth Healthcare** in Dyersburg, TN. And Blue Cross/Blue Shield plans would not need to print their own policies and provider instruction manuals.

-It is easier in a large group to follow one set of rules, but easy does not equal required,- Buechner points out.

Medicare's rules and guidelines are often different than the **American Medical Association-s** (AMA), notes Rasmussen. And individual insurers may have policies that are also different than either the AMA's or Medicare-s. You have to pay

attention all three authorities.

Myth #6: Secondary insurance always pays what Medicare doesn-t.

Fact: -Secondary insurance is more likely to pick up what Medicare doesn't pay,- says Hvizdash. But secondary insurance doesn't have to pay for everything Medicare doesn-t. Sometimes, secondary payors will only pay up to a certain amount, and if Medicare has already paid that amount, they won't pay any more. Supplemental insurance will only pay Medicare's copays and deductibles, not everything else Medicare doesn't pay for.