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Part B Insider (Multispecialty) Coding Alert

Part B Payments: Boost 2022 Coding and Billing Caliber With 6 Top Tips

MAC reps can help - but not with code selection.

If you've been preoccupied by the steady stream of COVID updates the last year, you're not alone. But with the first quarter of 2022 in the books - and the pandemic starting to settle down - it's time to refocus on this year's Part B coding and billing requirements.

Check out these six helpful tips shared by CGS Medicare reps **Towanna Tripp, CPC,** and **Vanessa Williams** during the Part B MAC's webinar, "Part B Customer Service FAQs."

Tip 1: Check Code Books Often and Update Coding Resources Regularly

Make sure you have the most current CPT®, HCPCS, and ICD-10-CM code books at the beginning of every year, Tripp advised. "Please, please know that this is part of your job and that your office should be paying for that - it's material that you have to use for coding." If you aren't yet in possession of the 2022 code manuals, it's time to buy them, whether that means you get a digital copy or a paper copy of the books.

She also stressed the importance of reviewing claims before you submit rather than just assuming the provider listed the most accurate codes. "Before submitting a claim, the coder should ensure that the correct procedure and diagnosis codes are used," Tripp said. "Check the documentation and other information if necessary."

Tip 2: Ensure Your Practice Coders Determine Codes - Not the MAC Reps

If you get stuck on which code to report and you plan to call your Part B MAC rep for coding advice, think again. "Always remember that customer service representatives cannot code," Tripp said. "They're not coders, nor are they clinicians, and they cannot code for you."

For that reason, providers should always review patients' medical records and documentation, along with all appropriate resources, to ensure that the practice is submitting services correctly, she advised. If the providers' records are thorough, the coder shouldn't have trouble selecting the right codes for the service.

Tip 3: Appeal Denials in a Timely Manner

If you face a denial, "more than likely you're going to have to appeal it with documentation," Tripp said. "So now you're on time crunch. If you get this type of denial, resolve it right away, because with an appeal, you only have 120 days to appeal. Don't wait until almost a year after the denial and then try to figure out how to resolve it."

Contrary to what some practices believe, payers aren't opposed to appeal if they are trying to make something right. "We want you to ask for your money," Tripp said. "But as always, things have to have to be done in the correct order."

The process for appealing will be clearly listed on each MAC's website, she noted. You should check there before calling customer service so you can save time and see the process in writing. That way, you can swiftly follow it and file your appeal.

Tip 4: Identify Drugs You Inject/Infuse

If you inject or infuse a drug, don't forget to bill for the medication using the appropriate HCPCS code, Tripp said. "Please

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remember if you are going to send us in a charge for the administration of a drug, you've got to tell us what the drug is. We don't know and we can't automatically pay it - you have to show that a drug was given even if it wasn't a drug that your office is paying for."

Of course, there's no guarantee your claim will be paid if you report the drug code, but you know for sure that the claim is unlikely to be processed correctly without it, she added.

Tip 5: Educate Staff on the Rules for Telehealth Devices

One of the most frequently asked questions that MAC claims reps get is whether any specialized equipment is needed to furnish Medicare telehealth services, Williams said. "And the answer is that currently, CMS requires most telehealth services to be furnished using telecommunications technology that has audio and video capabilities that are used for two-way, real-time interactive communication between the patient and the distant site physician or practitioner."

During the PHE, Medicare will also pay you for codes 99441-99443 (Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment...).

These codes describe audio-only phone visits for practitioners who can independently bill for E/M services, Williams said. "As for all Medicare telehealth services furnished during the PHE, please report the place of service code that would have applied if the service had occurred in person for these telephone-only telehealth service codes along with the 95 modifier (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system)."

Tip 6: Don't Confuse Split/Shared E/M Requirements

Remember that the rules for reporting split/shared visits changed this year. When the physician and a nonphysician provider (NPP) from the same physician group share an E/M visit, "the visit is billed by the physician or practitioner who provides the substantive portion of the visit," Williams said.

"For 2022, the substantive portion can be the history, physical exam, medical decision-making, or more than half of the total time (except for critical care, which can only be more than half of the total time)," she noted.

You should append modifier FS (Split (or shared) evaluation and management visit) to the appropriate E/M visit code, Williams added. This allows the MAC to see that the physician and the NPP shared the visit.

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