Part B Insider (Multispecialty) Coding Alert

REIMBURSEMENT: 5 Coding Opportunities You May Have Overlooked

You could be turning away your rightful reimbursement for scores of services.

Medicare coding rules are complex and challenging, and sometimes it's hard to know which services you can rightfully bill. But if you're up to speed on these key billing practices,you'll be raking in deserved pay:

1. Mine those modifier 59 opportunities. Some coders assume that if the Correct Coding Initiative (CCI) forbids billing two codes on the same date, that's the end of the story. But in fact, you may be missing out on some legitimate cases where CCI allows you to use modifier 59 (Distinct procedural service) to override an edit.

Always scan the CCI edits to see which code pairs a modifier can override. Of course, you should only use the 59 modifier when the services are separate, distinct, and medically necessary.

2. Collect copays at the visit.

You'll save yourself time and money later on if you calculate copays following a patient's service and collect that money before they leave your office.

Remember: "If it's not a copay, you can't collect it before the patient sees the doctor," says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CENTC, CHCC,** president of CRN Healthcare Solutions. "I went to a doctor and they tried to charge me for a 99214 before the service because I hadn't yet met my deductible. But I told them that they can only collect after they know what services have been performed and documented. Just because a physician plans to perform a certain service doesn't mean he will always document that service," she says.

"There is no reason to be guessing how much a patient owes with today's technology," Cobuzzi says. If the doctor is nonparticipating with Medicare, they should collect the limiting charge amount before the patient leaves the office.

Tip: If you aren't collecting your limiting fee the day of the service, you should not be nonpar with Medicare. "The chance of collecting later is too low that you'll end up losing money as a nonpar provider,"Cobuzzi says. "The only way you should be nonpar is if you're really good at collecting at the visit."

3. Keep modifier 50 in mind:

Many procedures are inherently unilateral, and you won't receive full reimbursement for bilateral versions of those procedures unless you append modifier 50 (Bilateral procedure).

Watch out: Coders often forget the 50 modifier for bilateral spinal injection and diagnostic ophthalmologyprocedures. (See page 204 for more tips on bilateral billing.)

4. Watch for supervision and interpretation: For many invasive/diagnostic radiology codes, you need two codes, the S&I code plus a surgical code. Often, coders forget to append the surgical code, especially on outpatient hospital claims.

Example: You may remember to report CT guided needle biopsy code 76360 but leave out the associated site-specific percutaneous needle biopsy code.

5. Appeal when you feel you've been wronged. Because many practices fear being labeled "troublemakers" or even worse yet, non-compliant with the False Claims Act's regulations, they accept Medicare payers at their word -- and this isn't always a good idea.

If your MAC denies your claim or requests a refund, research the issue before you take the payer's word for it.

"At the outset, I would caution against rolling over with regard to 'alleged' overpayments, says **Robert Liles, Esq.**, a health care fraud defense attorney with Liles Parker in Washington, DC. "If it is a clear overpayment, sure, give the money back. However, if the claims were properly submitted and billed, fight it!" he says.

You should appeal any time you feel your payer has wrongly denied your claim or incorrectly requested a refund. Medicare payers "are getting to be almost as bad as third-party payers," Liles says. "There seems to be a knee-jerk reaction to certain claims and they are automatically denied, regardless of their merit."