BILLING AND CODING NOTES

- EVERYONE should have a written policy on how to process Medicare recipient's refunds AND a written policy on how you: 1-Look for Medicare Overpayments and, 2- how you will refund them their money. Medicare is putting the bonus on doctors to look for overpayments. Having a written and periodically reviewed (and followed) policy can make the difference between a letter or financial penalty. THIS IS A BIG DEAL! IT'S CONSIDERED FRAUD IF YOU DONT ACTIVELY LOOK FOR OVERPAYMENTS AND FAIL TO REIMBURSE THEM IN A TIMELY MANNER. YOU HAVE 60 DAYS TO REFUND THEM!!

-You CANNOT bill Medicare recipients if they have Medicaid secondary, even if you are not in network with Medicaid. It is a violation of federal law for Medicare providers to balance bill QMBs for Medicare cost sharing amounts, including deductibles and coinsurance.

-NEW BUNION CODES. Added bunionette codes and separated BUNIONS from HAV M21.611 Bunion, Right Foot M21.612 Bunion, left foot - M21.621 Bunionette, Right M21.622 Bunionette Left

-Your 2019 fee schedule will be changed pending your 2017 MIPS Score (remember that's the new name for how physicians are graded). It can be +/- 4%.

-70% of Podiatrists 99213 did NOT meet requirements. Auditors are LPNs with a checklist of what's required, pretty simple. Review of Systems was the most commonly missed area costing any takeback.

-Don't use consultation codes for Medicare. And IF you use for private insurances, realize that you are supposed to render an opinion, and transfer care. Some people use it because it pays more but not transferring care. This is one of the reasons Medicare stopped paying them...

-Medicare has prepayment audit for 99204 and 99205s. Make sure your documentation is up to snuff.

-ECSW therapy code is going away Jan 2018.

-Sclerosing alcohol injections cpt 64640 is NOT appropriate for Morton's neuromas, use 64632. There's a huge payment disparity but audits are coming on these codes. Be honest and use the right code.

-11305, 11036, 11037. Shaving of lesions. THIS IS MORE OF A BIOPSY CODE, YOU HAVE TO SEND A SPECIMEN TO PATHOLOGY. Apparently, some people are using this for debriding calluses. It's fraud, don't bend the definition to get a procedure covered.

-11730. Being knocked down in payments. Have to use anesthesia or document no sensation! Too many people fraudulently billed slant backs as 11730, treat it as a procedure with consents, documentation, etc.

-11755. Biopsy of a NAIL UNIT. Not nail trimmings. And has to be sent to pathologists. Again, don't get fancy to get paid more.

-77077- X-ray joint survey, 2 or more joints. Just on the radar for over utilization, be careful.

DME codes being monitored
L1832 – knee orthosis. Some people are billing this? Don't...
L3908 – Wrist Brace. Again, why are people billing this brace for the foot again? I can only assume someone blindly is believing what a DME rep is selling. That won't hold up in an audit folks...
L2114 – TibFib fracture device. This isn't a fracture boot or CAM walker. It's a specific type of AFO. Don't get fancy.

L3000 – Medicare. Does. Not. Cover. Orthotics. Unless attached to a brace. Attaching a KX modifier makes it fraud, it's not a trick to just get it covered. KX means you meet the policy requirements for that DME item, and the policy requirements are ridiculous. If you don't even know what I'm talking about, you shouldn't bill L3000.

99201 – Some people are still using this visit code, I had to even see if it's a thing. I can't even find written documentation requirements for this. Should bill a 99202 (after making sure your note meets the 99202 requirements).

MACRA MIPS and APM

It is not within the scope of the conference or this letter to make anyone an expert on MACRA. The final rules were only recently published. From what I know and see coming, if you use an EMR please take the time to see how they are going to help you meet the requirements, similar to how they submitted PQRS.

For those of you using paper charts, 25 out of 100 points of the MIPS score requires use of an EMR. This does NOT mean your payment will be deducted 25%, but whenever they decide where the penalty line is to be drawn, it makes it harder to get a passing score. There may be some way to get the other points through submission of paper charts, I recommend following the APMA news and looking for consultants who might be able to help in this regard.