Correct Coding

• Physicians depend on good medical coding and billing for income
  – Coder/biller is main line of communication between provider and payer
    • Medicare or commercial
  – When errors occur it requires a corrected claim
    • This delays payment
  – Better to get it right the first time

• Proper coding requires
  – Well-trained or certified coders
  – Good coding and billing protocols
  – Up-to-date medical billing and coding software
  – Access to Medicare contractor (and other payer) medical policies
    • Local Coverage Determinations (LCDs)
    • National Coverage Determinations (NCDs)
  – Make sure coders and billers have current coding manuals every year
    • CPT
    • ICD-10
    • HCPCS
  – Provide access to continuing education and staff training
    • Has direct effect on cash flow and profits for practice
Top Coding Errors

CCI Edits

- Appears to be a growing lack of awareness of Correct Coding Initiative (CCI) edits
  - CMS developed CCI edits to control improper coding
    - CCI procedure-to-procedure code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together

CCI Edits

- Always access the CCI edits before billing any surgeries
  - Can be found on CMS website
  - May have CCI software
  - May be part of your Practice Management System
- Whatever source is available, the CCI edits must be reviewed before billing all surgeries
  - Particularly if you are not familiar with procedures being billed

CCI Edits

- CCI coding tips
  - Injections bundled with all surgeries
  - OCTs bundled with fundus photography
  - Fundus photography bundled with ICG
  - Extended ophthalmoscopy bundled with all retinal surgeries
  - Gonioscopy bundled with trabeculoplasty by laser (ALT, SLT)
  - Fitting of bandage lens bundled with corneal surgeries

CCI Edits

- Cannot unbundle services unless:
  - Performed at different session
  - Performed in different segment of eye (anterior vs. posterior)
  - Performed by different surgeon
  - Service was non-overlapping
- "Unbundling" codes on a regular basis could result in lost revenue
  - Medicare only pays the code with lowest allowable
    - Other codes are denied

CCI Modifiers

- New “X” modifiers created to provide clarity for when codes can be unbundled
  - Effective for dates of service on or after January 1, 2015
    - Modifier -XE: Separate Encounter
      - A service that is distinct because it occurred during a separate encounter
**CCI Modifiers**

- **Modifier -XS**: Separate Structure
  - A service that is distinct because it was performed on a separate organ/structure
- **Modifier -XP**: Separate Practitioner
  - A service that is distinct because it was performed by a different practitioner
- **Modifier -XU**: Unusual Non-Overlapping Service
  - The use of a service that is distinct because it does not overlap usual components of the main service

**Misuse of Modifiers**

- **Modifiers -RT and -LT**
  - Using -RT and -LT modifiers to bill bilateral surgeries for physician’s service is incorrect
  - When procedures are performed on both eyes at the same session must now bill as follows:
    - Append modifier -50 on one line only
    - Bill "1" unit
    - Double the charge
      - Commercial payers may still require -LT/-RT modifiers

- **Modifier -25**
  - Only use when office visit is a “significant separately identifiable exam” performed on same day as minor surgery (0 or 10 day global)
  - If exam performed solely to confirm need for minor surgery performed on same day
    - Exam not billable
    - Cannot be used as “decision for surgery” like modifier -57

**Misuse of Modifiers**

- CMS still recognizes -59 modifier
  - Should not be used when more appropriate modifier exists though
    - CMS may begin to identify code pairs as only payable with the “X” modifiers and not the -59 modifier
    - Would result in denials if “X” modifier not used
  - Unbundling” codes on a regular basis may also make your practice appear fraudulent

**Misuse of Modifiers**

- Applies to surgeries only for Medicare
  - Both minor (0 or 10 day global) and major (90 day global) surgeries
  - ASCs still required to bill bilateral services on two line items
    - Must use the -RT and -LT modifiers
    - Medicare will not accept the -50 modifier for ASC claims

- Exam is not just incidental to surgery
  - Office visit must be above and beyond usual pre-and post-operative care associated with minor procedure
  - Must be substantial, distinct, and able to stand alone
    - Take the exam for the minor surgery or injection out of the mix for a minute
    - Do you have anything left?
      - If yes, append the -25 modifier
      - If no, office visit should not be billed
Misuse of Modifiers

Example:

- Patient presents with complaint of pain and foreign body sensation after being hit in eye with tree limb
- Complete exam performed to determine extent of injury and cause of pain – FB removed
- Modifier -25 is appropriate

  - If only slit lamp performed and foreign body removed without complete eye exam, office visit not billable

Misc use of Modifiers

• Modifier -57
  - Initial evaluation to determine the need for major surgery (90 day global)
  - Use if decision is made day before or day of major surgery
  - Not to be used for re-examination of patient after surgical decision has been made
  - Some billers forget to add -57 modifier on today’s exam when YAG scheduled for next day

Misuse of Modifiers

• Modifier -58
  - Staged or related procedure by same physician during post-op period
  - Usually used when:
    - Second procedure was planned pre-operatively
      - Patient had iridotomy (66761) and now needs an SLT (65855-58) in the global fee period
    - Second procedure was more extensive than original procedure
      - A scleral buckle (67107-58) following repair of retinal detachment (67105)

Misuse of Modifiers

• For therapy performed following a diagnostic surgical procedure

  - Patient presents during post-op period of trabeculectomy and a 5-FU injection is performed
    - Bill 68200-58 plus J9190
  - Most billers tend to use the -78 modifier for these procedures
    - Modifier -78 reduces surgical fee
    - Modifier -58 does not

Misuse of Modifiers

• Modifiers -78 and -79
  - Modifier -78 is used to report return to OR for “related” procedures in global fee period of previous surgery
    - YAG Laser performed following cataract surgery
    - Return to OR for repair of revision of operative wound
      - OR defined as operating room in hospital or ASC, or dedicated procedure room in physician’s office
  - Reimbursement for procedure is reduced
Misuse of Modifiers

– Modifier -79 is used to report “unrelated” procedures during the global fee period of a previous surgery
  • Cataract surgery on fellow eye
  • PRP on same eye following YAG laser capsulotomy
  • PRP on right eye following PRP on left eye
– Modifier -79 allows payment in full for unrelated procedures

A-scan/IOLMaster

• Codes 76519 and 92136 are still being reported incorrectly
  – Results in denials or lost income
• Correct way to bill:
  – Submit code 76519 or 92136 (with no modifiers) prior to first eye surgery
    • Will permit payment of the technical component for both eyes and one IOL calculation
      – Medicare now pays for the taking of the test only once and will pay for each IOL calculation
  A-scan/IOLMaster

• Prior to the second eye surgery, submit code 76519-26 or 92136-26 to receive payment for second IOL calculation
  • Surgeon should date and initial test strip if 2nd IOL calculation performed on different date
  • Must always bill the second eye IOL calculation using the date the IOL was actually calculated
– Most practices find it easier to just bill the ophthalmic biometry with each eye surgery
  • Eliminates missed charges

Injectables

• Lucentis, code J2778
  – 5 units
• Triamcinolone (e.g., Triesence), J3300
  – 40 units
• Verteporfin, code J3396
  – 150 Units
• Ozurdex, code J7312
  – 7 units
• Jetrea, code J7316
  – 4 units

• Avastin, code J7999, J9035
  – 5 units
• Eylea, code J0178
  – 2 units

Injectables

• Kenalog, code J3301
  – Billable per every 10 mg
  – 4 mg – 1 unit
  – 12 mg – 2 units
• Botulinum
  – Per injection unit
  – Waste with Modifier -JW

• Not billing correctly causes lost revenue
**New Patient Billing**

- CPT definition of new patient
  - "A new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years."
  - Note: Medicare does not recognize sub-specialties in ophthalmology for reimbursement purposes

**New Patient Billing**

- CMS previously edited new patient exams based solely on Tax ID # of practice
  - Caused incorrect payment of new patient exams
  - CMS now edits new patient exams by NPI number not just Tax ID #
    - Exam denied if provider saw that patient during the past 3 years regardless of where he/she worked

**New Patient Billing**

- If new physician joins practice and sees his/her patients in new practice, should not bill new patient exam
  - Medicare should deny claim, but not all MACs do initially
    - Will ask for refund upon audit
  - If patient sent to you for test because referring doctor did not have equipment
    - No exam conducted - just I&R of test

**Consolidated Billing**

- Consolidated billing continues to be a problem
  - What is consolidated billing?
    - Medicare Part A covers skilled nursing home stays for patients for a period of time if they were in the hospital for at least 3 days
    - The SNF must bill Medicare for all services SNF patients receive during their Part A stay
      - With some exceptions

**Consolidated Billing**

- Services excluded under Consolidated Billing include:
  - A physician’s professional service (e.g., exam)
  - Professional component of any diagnostic test performed on the SNF patient
    - Test must be billed to Medicare with -26 modifier only
  - Technical component of test is included in the SNF’s reimbursement
    - Practices should work with SNFs to invoice the SNF directly for the technical component of the test
Consolidated Billing

– SNF also responsible for DME services furnished to their patients
  • Optical shops should invoice SNF for glasses provided to patients in a Part A stay
    – Do not bill DME MAC
  • If glasses provided outside the 100-day SNF covered Part A stay
    – Okay to bill DME MAC

Place of Service

• Normally POS code reflects actual setting where beneficiary receives face-to-face service
  – There are a few exceptions:
    • Inpatient
      – If inpatient seen in your office must bill place of service as hospital (21), not office
    • Outpatient or Rehab Patient
      – If patient seen in your office must bill place of service as outpatient or rehab (22), not office

Claims Filing Errors

• Easy to overlook parts of a claim when submitting many claims in a given day
  – Identifying most common mistakes may help avoid errors
    • Entering incorrect information for provider
    • Entering incorrect information for patient
      – Wrong name, sex, date of birth, insurance information
    • Entering wrong codes
      – CPT, diagnosis, place of service, modifiers

Claims Filing Errors

• Entering too few or too many characters for ICD-10 diagnosis codes
• Selecting diagnosis code that doesn’t match procedure performed
• Not submitting a diagnosis pointer on claim
  – Must be entered (A, B, C, etc.) in field 21 of CMS-1500 or EMR equivalent
  – CMS generally only accepts “1” pointer per line item (e.g., A) even though you can report up to 12 diagnosis codes on the claim
• Selecting CPT codes that were not valid for date of service

Claims Filing Errors

• Medical necessity denials big issue
  – Claim was denied due to “medical necessity”
    • You know claim was medically necessary and medically appropriate
      – Can’t understand why claim was denied
    • Medical necessity denials usually mean a wrong diagnosis code was submitted
      – If a diagnosis cannot be determined, ask physician for a more appropriate diagnosis code to resubmit claim

Claims Filing Errors

• Submitting duplicate claims is another big issue and could cause an audit if done routinely
  – Claims are often denied as duplicates for following reasons:
    • Claim was previously processed and no payment was made
      – Allowed amount applied to deductible on initial claim
    • Claim refilled to “correct” the denied claim
Claims Filing Errors

- Re-filing a claim if initial claim not paid timely
  - Do not simply resubmit a claim because it's been a while since claim was submitted
  - Payer may be reviewing claim on a pre-pay basis
- Re-filing a claim for non-covered services such as:
  - Self administered drugs
  - Cosmetic surgery
  - Routine eye exams
  - Personal preference items for post-cataract eyeglasses not ordered by the physician

Negative Effects of Coding & Billing Errors

Financial Instability

- If claim submitted with errors or is incomplete
  - Will be rejected
  - Rejection results in more time spent to correct claim and resubmit it
    - If mistakes are numerous, can result in large amount of reimbursement being delayed
    - Could greatly impede practice cash flow

Audits

- Ongoing errors in billing may trigger an audit
  - Audits are time consuming and stressful
    - Can put drain on staff time and cause distraction
  - If audit determines problems with past claims
    - Practice may be required to repay money to Medicare or other payer
  - Best way to avoid audit
    - Make sure billing and coding is complete and accurate the first time

Patient Problems

- Billing errors will jeopardize patient’s claims being paid properly
  - If commercial payer, could even jeopardize patient’s medical services, benefits, or their ability to see specialist such as the ophthalmologist
    - Patient may get anxious and become uncomfortable with physician or practice if errors are frequent
    - May even call Medicare

Fraud Investigation

- Repeated billing errors and inadequate documentation could trigger a concern about fraud
  - This would be very stressful for the practice, very time consuming and costly
  - Even though the errors are benign
    - Any bit of suspicion can cause a full blown investigation
    - Causes practice to be suspect and puts practice livelihood at risk
Summary

- Common coding errors can cost your practice time and money
  - Ways to prevent coding errors
    - Hire well-trained billing staff
    - Determine what errors you have
    - Educate staff on better coding
    - Improve documentation
    - Be proactive and continue to assess coding procedures regularly

Summary

- Problems must be addressed immediately
  - Delays may cost practice money
    - Work denials on a daily basis
    - Make sure billers/coders have direct access to supervisor or administrator
    - Billing staff must be able to get answers to questions promptly

Summary

- Physician reimbursement has decreased significantly over the past few years
  - Proper billing is more important than ever
  - Good and conscientious billers and coders are in high demand
    - You are an important part of a practice
    - Make compliance and excellence part of your mission in the company

Summary

- Remember:
  - If it isn’t in the chart, it wasn’t done!
  - If it wasn’t done, don’t bill for it!
  - Be proactive and take pride in your job
    - Doing your job well helps avoid adverse audits
  - If there’s ever a question……….ask your administrator or supervisor for assistance!
Questions