Claims Denials:
What causes them?
How to manage them?

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True-or-False Quiz

• When a claim is denied, simply resubmit until payment is made.

• Conducting internal chart audits is mandatory as part of your compliance plan.

• All payers must follow rules and regulations according to CMS policies.

Is Coding for Me?

Coding is not for amateurs

• With impending fee cuts and increase in overhead, practices can’t afford to chronically submit incorrect claims with the hopes that the errors can be corrected the second or third time around.

• A little known fact is that perpetual resubmission of claims triggers audits.

Where Can I Get Help?

• Many sources for coding information are available — the Academy, the American Academy of Ophthalmic Executives, independent consultants and colleagues. Unfortunately, they don’t all agree on the same things.

• Physicians decide what information is best for them and their practice

Where to Start?

• Ophthalmologists tend to see similar types of patients. Focus on the top 10 patient types by diagnosis that you see.
  – If you research documentation requirements that are specific to each payer and routinely conduct internal chart audits to assure that documentation is made, you’ll not only sleep better, you’ll feel confident when the request for records arrives.
  – While conducting internal chart audits is not mandatory, it clearly demonstrates the desire to be compliant and you’ll catch errors before the payer does!
• Most practices experience ongoing problems with denied claims and claims paid in error

• Attention to detail will help your practice obtain the payments it deserves.

• According to a report from RemitDATA, the top 10 billed ophthalmology procedures with the highest denial rates are:
  1) 92004
  2) 66982
  3) 92012
  4) 92014
  5) 92134
  6) 66821
  7) J2778
  8) 67029
  9) 66984
  10) J0178

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**The Process**

- Check-in
- Technician
- Billing
- Check-out
- Doctor

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**Front End**

- First point of contact drives payment
  - Know why the patient is here
    - Vision vs. medical exam
    - Determines coverage
  - Notify them of required paperwork
  - Collect the correct insurance information

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**Doctor/Tech Responsible**

- Chart and code correctly, chart notes must support the codes selected.
- Confirm that the services provided are authorized and covered
- Make sure the charge ticket is complete, link diagnosis codes to CPT codes, mark all services performed, indicate next step
- Review reports for accuracy

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**Billing**

- Post charges and payments daily
- Scrub your claims before you transmit
- Transmit and print claims daily
- Fix transmission errors daily
- Work denials as soon as they arrive
- Payment posting – utilize electronic posting
- Use event driven billing for your patient statements
Examples

Vision vs Medical

Upon checkout patient instructs office to bill vision plan despite the medical record showing a complaint and diagnosis that support a medical claim.

How could this have been avoided?

Vision vs Medical

• Listen carefully patient’s reason(s) for visit.
• Do not copy over previous medical diagnosis as a reason for “recheck”
• Verify the complaint supports a claim to the appropriate payer

Global Period

CC: 2 week post CE/IOL OD. Vision good, no pain.
SLE performed OU, today. Retina exam deferred.
Plan: Schedule cataract surgery OS
Billed 92014-24
Agree?

Minor Surgery Billing Rules

Your patient uses artificial tears for DES but is unhappy with the treatment. She asks for an alternative. You offer a trial of punctum plugs in the lower puncta and she agrees. The rest of the exam is unremarkable.

Billed 920xx-25
68761-E2
68761-E4
Minor Surgery Billing Rules

Billing Issues
• No unrelated, billable exam
• Exam performed to determine the need for surgery
• Bill for procedure only

Cosmetic Denial

Patient is scheduled for a bilateral blepharoplasty. Surgery Scheduling contacts payer for verification of benefits and pre-certification requirements. Verbally told no pre-cert needed. No pre-operative testing was performed.

Surgery is performed and claim is denied as cosmetic.

How could this have been avoided?

Cosmetic Denial

Clinic/Surgery Scheduling – perform all necessary testing, chart supports functional diagnosis, obtain written pre-certification - regardless of what rep may tell you, get ABN or Notice of Exclusion signed

Know the payer policy and keep clinic updated

Billed with wrong doctor

Credentialing – new doctor joined the practice but his Medicare ID number is still pending.
Clinic – Dr. A sees the patient, Dr. B reviews the chart and signs off
Billing – Claim is filed under Dr. B

Agree?

Billed with wrong doctor

Appointment – Don’t make appointment until you receive notice of application processing, hold claims until final

Title 42, Section 424.535 (a)(7):

§ 424.535 Revocation of enrollment and billing privileges in the Medicare program.

(a) Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

(7) Misuse of billing number. The provider or supplier knowingly sells to or allows another individual or entity to use its billing number.

Place of Service

Data Entry - You have a new employee entering surgery charges to your practice management system. She selects place of service office (POS 11) instead of ambulatory surgical center (POS 24) over a 3 month period

Now what?
Place of Service

**Billing** – Identify those procedures that were overpaid (i.e., YAG 66821, Bleph 15823) vs. those that need just need POS corrected (CEIOI 66984)

Attempt to submit a reopening for those claims that were not overpaid correcting the POS.

Submit a voluntary refund for the overpayment (the difference only) on the other claims. This may or may not be accepted.

Surprise Bill

**Appointment scheduling** - scheduled patient for office visit with Dr. Retina

**Front desk check in** - gets patient's ID card, they are Medicare only

**Clinic** – doctor performs an OCT and intravitreal injection with expensive anti-VEGF drug

**Check out** – attempts to collect 20% but patient is irate and refuses to pay

How could this been avoided?

Surprise Bill

**Front desk check in** - gets patient's ID card, they are Medicare only - advise patient they will be responsible for 20%, can give estimate at this time

**Clinic** – prior to test advise patient of out of pocket and confirm they want to proceed

Clean Claim

- Educate your doctors and staff
  - Modifiers
  - Diagnosis code linkage
  - Frequency of exams and tests
  - NCCI bundles
  - National and Local Medicare Policies
- Make sure claim write-offs are accurate

Optimize Collections

- Maximize the practice’s ability to collect
  - Gather and confirm patient’s insurance
  - Notify patients of your collection policy
  - Collect patient responsible balance at time of service
  - Follow procedure when patient’s don’t pay

Adjust and Prevent

- All practice employees have the ability to positively or negatively impact collections
- Submit Clean claims
- Verify insurance eligibility
- Collect patient responsible balances at time of service
- Use of ABNs when appropriate
- Internal auditing and modify your process when it's not working
- Training and continual monitoring
- Use the Resources
Thank you

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More help...

For additional assistance or confidential consultation, please contact us at:

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