Top Coding & Billing Errors

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Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.

Correct Coding Important

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

Correct Coding

• 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

• 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)
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

- 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 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 trabeculectomy by laser (ALT, SLT)
  - Fitting of bandage lens bundled with corneal surgeries

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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

- 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

- **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

- 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

- 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
  - 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

- **Example:**
  - Patient presents for Lucentis injection #4 in left eye
    - States vision not that great but stable
  - Surgeon recommends intravitreal injection today and FU in 2 months with OCT
    - No new complaints or medical necessity to perform exam over and above need for injection
  - Modifier -25 is not appropriate

- **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

- **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)

- **Modifiers -78 and -79**
  - 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

- **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

- Incorrectly billing number of units for medications
  - Some drugs require specific units be billed
- Correct units:
  - Avastin, code J7999
    - 5 units
  - Eylea, code J0178
    - 2 units

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

Injectables

- Kenalog, code J3301
  - Billable per every 10 mg
  - 4 mg – 1 unit
  - 12 mg – 2 units
  - and so on
- 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.

- **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.

- **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

- **Can bill that patient as a new patient if the patient returns to practice within the 3-year period since no exam or other face-to-face service was performed by the doctor**
  - This is a hard one to catch
  - But is a commonly missed new patient billing error

**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

  - 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

- 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

- 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
To Summarize

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