SE Regional Meeting

Co$tly Coding Errors

What Every Physician, Administrator, Technician and Coder Must Know
Sue Vicchrilli, COT, OCS, is an employee of AAO/AAOE and as such has no financial interest or relationship to disclose.
Financial Disclosure

- Sue Vicchrilli, COT, OCS
- Academy Coding Executive

• Email: coding@aaoad.org
Objectives

- Stop self-imposed revenue cuts from incorrect coding and poor audit outcomes.
Objectives

- Is your documentation and claim submission your friend or foe?
- When documentation and coding errors occur, they negatively impact the medical record and the practice financial bottom line.
Objectives

- While the physician is ultimately responsible, correct documentation, claim submission and claim processing does require competent knowledge of everyone on the ophthalmic team.
Objectives

- Take corrective action now.
- Awareness of resources to help.
Error #1 Not recognizing differences in insurance rules

<table>
<thead>
<tr>
<th>Medicare Part B</th>
<th>Medicare Advantage Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Plans</td>
<td>Medicaid</td>
</tr>
</tbody>
</table>
Error #2

- Mislinking diagnosis codes to CPT codes
  - #1 Reason for Recovery Audit Contractor Audit (RAC)
  - Linking dry macular degeneration diagnosis to intravitreal injections
  - RAC can requests records for past 3 year
  - Local MAC should have denied original payment of claims
Error #2

Lesson learned:
- Internal quality controls
  - Additional training for staff
Error #3

- Lack of written protocol when request for records arrives.
  - Received by mail
  - Date receipt of letter
  - Look at due date for record submission.
    - Immediately request an extension if necessary
  - Begin gathering data to assess best/worse case scenario
Error #3

- Lack of written protocol when request for records arrives.
  - Inform the physician – after work
  - Write a cover letter
  - Call AAO/AAOE
Error #3

Lesson learned:

- Auditors can only audit what is legible
  - If not, dictate the chart note without embellishment
- Is the physician signature identifiable/secure?
  - Paper records – include signature log
# Signature Log

<table>
<thead>
<tr>
<th>Typed Name</th>
<th>Legible signature</th>
<th>Legible initials</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Q. Smith, MD</td>
<td>John Q. Smith, MD</td>
<td>JQS, MD</td>
<td>Physician/MD</td>
</tr>
<tr>
<td>Lisa Perry, COT</td>
<td>Lisa Perry, COT</td>
<td>LP, COT</td>
<td>Certified Technician</td>
</tr>
<tr>
<td>Paul James</td>
<td>Paul James</td>
<td>P.J.</td>
<td>Administrator</td>
</tr>
<tr>
<td>Barbara Jones</td>
<td>Barbara Jones</td>
<td>BJ</td>
<td>Receptionist</td>
</tr>
</tbody>
</table>
Error #3

- Example:
  - Out of the 14 records reviewed for CPT code 66984, it was determined all 14 of the claims were not supported by the medical records provided.
    - The records received were for dates of service other than the requested date of service for each patient.
Example:

- Additional associated claim lines were unsupported for CPT codes 92133, 92083 and 92250.
  - The records did not contain sufficient documentation to support the services billed.
Error #3

Lessons learned:

- All tests that are delegated to someone other than the physician to perform require a written order indicating which eye(s), which test specifically, and the chart note should reflect medical necessity for performance.
- All tests require interpretation and report.
Error #3

- Total overpayment amount due was $18,019.25
  - Practice is now in the appeals process for the cataract cases by submitting documentation for the correct dates of service.
  - Not able to appeal lack of documentation for testing services.
Error #4

- Cloned documentation
- OIG Investigation list for 2012 and 2013
- Focused Medical Review audits too
Oculoplastic surgeon

- The 76-year-old female presents for evaluation of droopy eyelids OU. It started about 3 years ago. The onset is progressive. It affects peripheral vision. The symptom is frequent. It occurs all day. The condition is worsening. The condition is described as heavy.
Cataract surgeon

- Patient complains of decreased vision OU. *Right worse than left eye.* Difficulty seeing distance and near. Requests cataract surgery.
Lesson learned:

Not all payers have a visual acuity requirement.

All payers do require the impact of activities of daily living. This should be unique to each patient.
Error #5

- Ignoring Correct Coding Initiative (CCI) or commercial payer edits
Error #5

- Effective July 1, CCI bundles
  - All established patient E/M and Eye codes with
    - Most commonly performed major and minor surgeries
Error #5

- The good news:
  - The bundling edit has an indicator of “1” indicating there are examples when unbundling of the exam is appropriate, not “0” which means the bundles can never be broken.
The bad news:

- No direction has been given as to how to break the bundle.
  - Modifier -25 won’t work
  - Incorrect application of modifier -59
- Claims are being denied
Error #5

Why did this happen?

- Disregard for modifier -25 which says the exam must be significantly, separately identifiable from the minor procedure performed today.
  - Highest volume: CPT code 67028 Intravitreal injection
Additional edits:

- CPT codes 92225 Extended ophthalmoscopy and 92226 Subsequent ophthalmoscopy are bundled with an indicator of “1” with intravitreal injection.
- Unless the diagnosis is something other than wet AMD, don’t break the bundle.
Error #6 - More on CCI

- When more than one surgical procedure is performed on:
  - The same patient
  - The same day
  - The same operative session -
  - Whether on the same or separate eye
  - CCI edits must be verified.
Error #6 – More on CCI

- Otherwise you may be paid the lowest allowable.
- Remember to check every code combination.
Scenario

- Following a traumatic injury on a 26-year-old mechanic, a vitrectomy and foreign body removal from the posterior segment of the right eye is performed.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Allowable</th>
<th>Global Period</th>
<th>CCI Edits</th>
</tr>
</thead>
<tbody>
<tr>
<td>65265</td>
<td>Removal of FB posterior segment</td>
<td>$1,100</td>
<td>90-days</td>
<td>Not bundled with 67036</td>
</tr>
<tr>
<td>67036</td>
<td>Pars plana vitrectomy</td>
<td>$950</td>
<td>90-day</td>
<td>Bundled with 65265</td>
</tr>
</tbody>
</table>
Correct claims submission:
1. Submit 65265-RT only
2. Submit 65265-RT and 67036-59-RT
3. Submit 65265-59-RT and 67036-RT
Error #6 – More on CCI

- Everyone is familiar with CCI edits:
  - Fundus photography with retina OCT
  - When to unbundle?
    - When the payer publishes in writing that you can.
Error #6 – More on CCI

- CCI edits are updated
  - January 1
  - April 1
  - July 1
  - October 1
Error #6 – More on CCI

- Direct link [www.aao.org/coding](http://www.aao.org/coding) under Coding Tools
- Ophthalmic Coding Coach
- AAOE’s Coding Bulletin
- EyeNet Savvy Coder Nov and Dec 2012: NCCI Traps Part I and Part II co-authored with Michael X. Repka, MD, MBA, Medical Director for Government Affairs
Error #7

- Impact of Medically Unlikely Edits (MUEs) effective April 1, 2013
  - All surgical procedures billed to Medicare:
    ◦ Whether major or minor
    ◦ When performed on the same day
    ◦ Must be billed as a single line item appended with modifier -50 with a “1” in the unit field.
    ◦ Modifiers -RT/-LT no longer applicable for bilateral procedures.
    ◦ Payment is the same – 150% of the allowable
The following codes, when performed on all four lids may be reported once per eyelid using modifiers E1-E4.

Report the procedure with “1” unit of service for each eyelid on separate claim lines.

- Otherwise just report once or if performed bilaterally – append modifier -50.
Error #7 More on MUEs

- 67825 Correction of trichiasis; epilation by other than forceps (eg, by electrosurgery, cryotherapy, laser surgery)
- 67835 Correction of trichiasis; incision of lid margin, with free mucous membrane graft
- 68326 Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement
- 68328 Conjunctivoplasty, reconstruction cul-de-sac; with buccal mucous membrane graft (includes obtaining graft)
Error #8

- Who is minding the global period?
  - Often in ophthalmology each eye is in its own global period!
  - Are global periods uniform by payer? No!
  - Best to confirm commercial payers global period when preauthorizing surgery.
  - All testing services, when medically indicated, are payable within the global period whether related or unrelated.
Error #9

- Modifier mismanagement
Example A

- Patient was seen on Tuesday for a retinal detachment and pneumatic retinopexy. CPT code 67110 was performed on the right eye.
Example A

- Day one postop, it was determined that the bubble didn’t hold, CPT code 67108 RD repair was performed on the same eye.
Example A

1. No claim submitted as it is part of postop care
2. Modifier -58
3. Modifier -78
4. Modifier -79
Example B

- Patient undergoes removal of several small benign lesions on 3 lids.
Example B

1. Modifier –GA
2. HCPCS E modifiers
3. Modifiers -50 and -51
4. No modifier is necessary
Example C

- For the convenience of the patient, a YAG capsulotomy is performed on the right eye the same day as cataract surgery on the left eye.
The appropriate modifier appended to the YAG is:

1. Modifier -RT
2. Modifier -79 -RT
3. Modifier -59 -RT
Example D

When a YAG capsulotomy is performed during the postoperative period of cataract surgery on the same eye, in the physician’s office, the correct coding is:

1. CPT code 66821-78-eye modifier
2. CPT code 66821-58-eye modifier
3. CPT code 66821-79-eye modifier
4. No separate billing as the procedure is not performed in a hospital or ASC
Example E

- During the global period of a major surgery, Healon 5 is injected in the AC of a patient with choroidals that are not resolving.
- Which of the following statements is correct?
1. When performed in the office, the injection is part of the global surgery. The injection would only be payable in an ASC.

2. The injection is payable by appending modifier -58 whether in the office or the ASC.

3. The injection is payable by appending modifier -78 whether in the office or ASC.
Example F

- Trabeculectomy with MMC performed on the patient’s right eye. Subsequently the patient suffers a wound leak and it fitted with a bandage contact lens which is specialty ordered. CPT code 92071-RT is submitted for the fitting of the bandage lens. As the specialty lens is not a covered benefit, the patient is billed for the supply of the lens.

- Unfortunately the bandage lens doesn’t work, so the conjunctiva is resutured at the slit-lamp in the dedicated office procedure room.
Correct coding for the wound revision?

1. No claim submitted. Without a return to the OR it is part of the global period.
2. CPT code 66250 -RT
3. CPT code 66250 -58 -RT
4. CPT code 66250 -78 -RT
Error #10

- Not knowing when to bill an E/M and when to bill an Eye code.
Error #10

- Unless it is a vision exam –
  - Determine the level of E/M
  - Determine the level of Eye code
  - Bill the one that pays the most for the particular payer.
# E/M vs. Eye Codes

<table>
<thead>
<tr>
<th>CPT code</th>
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<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>$48.00</td>
<td>$39.74</td>
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<tr>
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<td>99204</td>
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</tr>
<tr>
<td>92004</td>
<td>$179.00</td>
<td>$135.74</td>
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</thead>
<tbody>
<tr>
<td>99211</td>
<td>$22.00</td>
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<tr>
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<td>92012</td>
<td>$108.00</td>
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<tr>
<td>92014</td>
<td>$145.00</td>
<td>$112.25</td>
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</tbody>
</table>
Error #11

- PQRS and E-Prescribing
  - Bonus or penalty?
    - The choice is yours
PQRS 2013

- Practices who fail to participate in 2013 will be subject to a 1.5 percent payment adjustment in 2015.
  - Participating means attempting to report at least one PQRS measure between Jan. 1 – Dec. 31, 2013.
Important!

• Make sure your RA has C096 or N365 to verify that the measures have been reported.

• If the claim is denied, the measure is denied also and will have to be resubmitted.
PQRS 2013

- Visit www.aao.org/pqrs for all details
- Questions? Email pqrs@aao.org
If you are not receiving EHR incentive payments:

- Report G8553 a minimum of 25 times via claims or registry associated with an exam with dates of service between January 1 and December 31, 2013, to receive the payment incentive.
E-Prescribing 2013

Important!

• If reporting from your office, make sure your RA has C096 or N365 to verify that the e-prescription has been reported.

• If the claim is denied, G8553 is denied also and will have to be resubmitted.
E-Prescribing 2013

- Remember:
  - Anything the pharmacy carries can be e-prescribed.
E-Prescribing Resources

- Visit www.aao.org/e-rx for all details
- Questions? Email pqrs@aao.org
Costly Coding Errors

- Coding is not for amateurs
  - Make sure staff has all the tools they need to support the physicians correctly.
  - Ophthalmic Coding Specialist exam
    - www.aao.org/ocs
Questions?