Competent Coding: 7 Tips for Physicians and Staff

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Think you know all that you need to know about coding? Congratulations—but don't relax. By the time you've finished patting yourself on the back, the rules will have changed. Here are some tips to help you stay current, plus answers to some general questions about coding policy.

Stay Up to Date

Check your local rules. Many practices audited by Recovery Audit Contractors (RACs) in 2013-2014 were unaware of the documentation requirements set by their Medicare administrative contractor (MAC). Each MAC publishes Local Coverage Determinations (LCDs), which provide the rules for particular tests or surgeries. LCDs are available online. To find the website of the MAC in your state, go to www.aao.org/aaoe/coding, click "Coding Tools," and then "Medicare Carrier Jurisdiction and Website Addresses."

Sign up for weekly updates from your MAC. Once payers have published their documentation guidelines on their respective websites, they have fulfilled their obligation to inform you. Many payers, including Medicare Part B payers, have listservs that provide weekly e-mails notifying you about any updates. Go to your MAC's website and sign up to receive these e-mails.

Join the AAOE E-Talk listserv. By monitoring the E-Talk listserv, you'll get an early heads-up on how changes in reimbursement policies are impacting practices. Go to www.aao.org/aaoe, click "Listservs" and then "E-Talk." To participate, you must be an AAOE member (www.aao.org/joinaaoe).

Do You Know ...

How to justify cataract surgery? There is no national visual acuity requirement qualification for cataract surgery. Requirements vary by state and by payer. Many Medicare Part B plans no longer have a visual acuity requirement at all. Documentation that details the impact of the reduced visual acuity on the patient's daily activities is sufficient.

When to use E&M codes? Suppose you provide an exam for patients on long-term, high-risk medications and there are no ocular findings. In that scenario, many federal and commercial insurance plans do not recognize systemic diseases such as lupus or rheumatoid arthritis as covered diagnostic codes for Eye codes (92002-92014). But the diagnostic codes for all systemic diseases are recognized for E&M office visit codes (99201-99215).

Who pays for lab tests? Many practices perform various lab tests in their offices. Medicare Part B covers most of those tests and pays 100 percent of the allowable charges. Medicare beneficiaries do not pay copayments or deductibles for such tests.

How Medicare Advantage (MA) plans differ from traditional Medicare? MA plans provide all Part A and Part B services and generally provide additional services not covered by traditional Medicare. Patients enrolled in MA plans usually pay monthly premiums and copayments that are often less than the coinsurance and deductibles under the traditional Medicare Part A and B. Although costs and benefits vary by plan, most MA plans also offer Part D prescription drug coverage. ■

PQRS Update

Practices that report PQRS via claims may see a change on their remittance advice (RA).

In an effort to streamline reporting, CMS encourages all practices to report a charge of 1 cent when submitting via claims for 2014 PQRS measures. Effective July 1, practices that do so will see the code CO246N572 on their RA. This replaces code N365, which has been deactivated. Practices that do not report the 1-cent charge will receive a N620 code in their RA.

If you report PQRS measures from your office, check your RA for codes CO246N572 or N620. The presence of either code confirms the submission was successful.

For more on PQRS, *visit www.aao.org/pqrs.*