Best Coding Tips of 2015: Part 1 — Know Your Payers

BY DAVID B. GLASSER, MD, CHAIR OF THE ACADEMY HEALTH POLICY COMMITTEE, MICHAEL X. REPKA, MD, MBA, ACADEMY MEDICAL DIRECTOR FOR HEALTH POLICY, AND SUE VICCHRILLI, COT, OCS, ACADEMY DIRECTOR OF CODING AND REIMBURSEMENT

Since documentation and coding is a complex process, it is not a surprise that the Academy receives more than 4,000 coding questions annually. Below and next month, we look at the most helpful coding tips of 2015.

Know Your Payers

You can't assume that the rules for coding and documentation are consistent across all your payers.

Coding for bilateral surgeries. For Medicare Part B, a medically unlikely edit (MUE) published in April 2014 changed the way physicians submit bilateral surgeries. When filling out the CMS 1500 form for Medicare Part B, submit the surgical code as a single-line entry appended with modifier –50, and place a 1 in the unit field.

The rules of commercial payers vary. Some follow Medicare Part B. Others require you to append surgical codes with modifier –50 and to put a 2 in the unit field. Other variations include a 2-line item with the surgical code appended with modifiers –RT and –LT. There are a few payers that require a 2-line item, with the surgical code appended with modifier –RT on the first line and with modifiers –50 and –LT on the second line. In all cases, payment should be 150% of the allowable.

Coding for bilateral testing. Ophthalmology is one of the few medical specialties that still has tests that are payable for the right and left sides of the body—CPT codes 92225 *Extended ophthalmoscopy,* 92226 *Subsequent ophthalmoscopy,* 92235 *Fluorescein angiography,* and 92240 *ICG.* It is appropriate to bill for both eyes only when pathology is in both eyes. For Medicare Part B, a single-line item should be appended with modifier –50, but—unlike coding for bilateral surgery—you put a 2 in the unit field. (For more on bilateral testing, see last month's Savvy Coder at www.eyenet.org.)

Documenting need for cataract surgery. Some practices are under the impression that all payers require a visual acuity (VA) of 20/50 or worse as justification for cataract surgery. However, there is not a national policy that sets a visual acuity requirement for cataract surgery. Indeed, very few payers have a VA requirement. When there is no VA requirement, what is the best documentation, in addition to documenting the exam, to show medical necessity? You should document the patient's unique lifestyle complaint. Auditors may deny or seek to recoup payments if they determine that a practice is "cloning" patient lifestyle complaints.

Some payers, like Novitas, require the lengthy VF-14 questionnaire or equivalent, such as the VF-8R. The VF-8R, which is significantly shorter than VF-14, serves several purposes:

- It is a nationally recognized form that can document medical necessity for the payer.
- It provides the facility with documentation of medical necessity in the case of an audit.
- It is required if you are reporting the Cataracts Measures Group for PQRS.

If you are using VF-8R, the form must be filled out and the patient must sign it prior to each cataract surgery. (Download VF-8R from www.aao.org/practice-management—select "Coding," then "Coding Updates and Resources"—and then add your practice name and a patient signature line to the form.) ■

Denial of Testing Services

When payers deny payment for testing services, common reasons include:

- **Missing physician information.** The ordering or referring physician's name and/or National Provider Identifier (NPI) is missing from box 17.
- **Wrong diagnosis code.** Mislinking the diagnosis code or reporting a diagnosis code that is not a covered benefit.
- **Unbundling error.** Inappropriately unbundling 2 codes that are bundled in National Correct Coding Initiative (NCCI) edits.
- **Billed too often.** Exceeding a frequency edit as determined by the payer's Local Coverage Determination.