What You Don't Know Could Hurt Your Practice—Get Up to Speed

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Last month, *EyeNet* suggested three complementary resources that can help you stay current with the latest coding developments. This month, *EyeNet* discusses a few more things that you might not know, with a focus on several scenarios that are sometimes misunderstood or overlooked.

Do You Know ...

Why ASCs have been failing audits for cataract cases? Earlier this year, Recovery Audit Contractors (RACs) audited ambulatory surgical centers (ASCs) on their cataract cases. Many ASCs failed because their documentation didn't include the clinical indications for surgery. In order to pass the subsequent appeals, some ASCs are asking the physicians who use their facilities to provide that information from their office charts. Doctors can provide ASCs with evidence of the surgery's medical necessity by having the patient complete the Visual Functioning Index form VF-8R. This CMS-approved form serves three purposes:

- It indicates to the payer how the visual impairment impacts the patient's daily activities.
- It is one of the two preoperative forms to use when reporting the Cataracts Measures Group for PQRS.
- It supports the ASC requirements for documentation.

Where to get a copy of the VF-8R form? Go to www.aao.org/coding, click "Coding Tools," and then click "VF-8R Visual Functioning Questionnaire."

How to code for hospital inpatients? When inpatients are seen in your office rather than a hospital, the place of service (POS) should be hospital inpatient (POS 21) rather than office.

How often to complete ROS and PFSH? The review of systems and the past, family, and social history don't need to be done annually. The comprehensive ROS and PFSH is completed for the initial new patient exam and referenced as needed for subsequent visits. Many practices erroneously think new paperwork is required annually.

How to code for bilateral surgeries? According to medically unlikely edits (MUEs), when Medicare Part B patients undergo bilateral surgeries on the same day in the same surgical encounter, the appropriate claim submission is a single-line CPT code appended with modifier –50 *Bilateral procedure* and a "1" listed in the unit field. This is contrary to correct code submission for commercial plans or even Medicare Advantage Plans. Requirements vary by payer. For example, some payers require a two-line item with modifier –RT and –LT; others, a one-line item with modifier –50 and "2" in the unit field. Regardless of the claim submission format, practices must verify that correct payment has been made. Payment should be 100 percent of the first procedure and 50 percent of the second procedure for a total of 150 percent of the payer's allowable.

Whether suture removal is part of postop care during the global period? When the original surgeon removes the sutures, it is. When somebody else does so, it is part of the level of E&M or Eye code billed. Suture removal should never be coded using CPT code 65222 for corneal foreign body removal, or CPT code 66250 for wound repair.

Why the OIG is targeting Medicare Advantage (MA) plans? The OIG included MA plans as part of its 2014 Work Plan because prior OIG reviews revealed that medical record documentation does not always support the diagnoses that the MA organizations submitted to CMS. Payments to MA organizations are adjusted on the basis of the health status of each patient, so inaccurate diagnoses may cause CMS to pay MA plans improper amounts.

What gets providers excluded from Medicare? In fiscal year 2013, the OIG excluded 3,214 individual providers and entities from participation in federal health care programs. Reasons included convictions for improper coding, patient abuse or neglect, and disciplinary actions imposed by licensing boards. ■