CODING & REIMBURSEMENT

Reimbursement 101: A Quick Guide to Getting Paid

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The reimbursement processes of federal and commercial payers have many moving parts, some of which move in mysterious ways. Fortunately, there are plenty of resources to help you learn both the standard coding rules and the idiosyncrasies of your payers' policies (see "Further Reading" and "Know your local rules," page 14). And you'll find those detailed rules much easier to absorb after reading this quick overview of 1) the billing process (including use of CPT codes, ICD-10 codes, and modifiers; coding for the office visit; and the pitfalls of global periods and bundled codes), 2) the payment process (fee schedules, allowables, patient payments, and audits), and 3) the different types of payer.

Use CPT Codes to Report What You Did

To get reimbursed for patient care by third-party payers, you must submit Current Procedural Terminology (CPT) codes along with International Classification of Disease (ICD-10) codes. The CPT codes represent what you have done (e.g., a surgical procedure) and the ICD-10 codes represent why you did it (e.g., the diagnosis that justifies that surgery). Most of the time you'll use Category I, Level I CPT codes, but there also are 3 other types of CPT codes that you might use.

Category I, Level I codes represent exams, testing services, and surgical procedures using a 5-character numeric code—e.g., 66984 *Extracapsular cataract removal with insertion of an IOL.*

Category I, Level II codes (also known as HCPCS codes) document supplies, injectable solutions, glasses, contact lenses, and screening using a 5-character alphanumeric code—e.g., J9190 for injecting 5-fluorouracil.

Category II codes report quality measures for the Physician Quality Reporting System (PQRS), which will be absorbed into the Merit-Based Incentive Payment System (MIPS), as of Jan. 1, 2017. They use a 5-character alphanumeric code—e.g., 2027F *Optic nerve head evaluation performed.*

Category III codes help the CPT Editorial Panel collect data on emerging technologies, services, and procedures.

The Billing Process

Step 1: Documentation.

Create a chart for a new patient or update the existing chart for an established patient. (An *established patient* is defined as one who has received professional services within the past 3 years from the physician or another physician within the same group practice and of the exact same specialty and subspecialty.)

The CPT and ICD-10 codes you submit to the payer must be supported by the day's chart documentation.

Step 2: Code selection.

Select a CPT code (or codes) and a corresponding ICD-10 code (or codes).

Append appropriate modifiers to CPT codes when needed.

If you performed multiple tests or surgical procedures, watch out for bundling (CCI) edits and check whether the Multiple Procedure Payment Reduction applies.

Step 3: Claim submission.

Submit the claim to the payer using the CMS-1500 form.

If you submit it electronically, a clean claim will be processed within 14 days; if on paper, within 21 days.

Step 4: Payment (or rejection).

You will be sent Remittance Advice (RA; formally known as the Explanation of Benefits [EOB]) and, if all went well, payment.

If your claim was rejected, review the RA; rethink your choice of codes, modifiers, and/or linked diagnosis; and resubmit a corrected claim.

These data are then used to determine whether new Category I codes are needed. They use a 5-character alphanumeric code ending with T—e.g., 0198T *Measurement of ocular blood flow by repetitive IOP sampling, with interpretation and report.* Insurers can choose whether or not to reimburse Category III codes; if they don't, the patient is typically responsible for payment (see "Give patients advance notice of uncovered services," page 14).

Category I and II codes are updated annually by the AMA's CPT Editorial Panel, with changes coming into effect on Jan. 1. Category III codes are updated twice a year, in January and July.

Use ICD-10 Codes to *Justify* What You Did

ICD-10 codes are alphanumeric codes that you use to show your payer why a particular service (i.e., the CPT code that you submitted) was medically necessary. They can be up to 7 characters long.

Example. H40.2232 represents bilateral chronic angle-closure glaucoma, moderate stage. Breaking that down, the first 5 characters (H40.22) represent the condition (chronic angle-closure glaucoma), the 6th position represents laterality (1, right; 2, left; and 3, bilateral) and the 7th character represents the stage of glaucoma (0, unspecified; 1, mild; 2, moderate; 3, severe; and 4, indeterminate).

Must select the most complete code. If there is a 4th, 5th, 6th, or 7th code available, you must use it.

Must select the most accurate code. The best code is the actual diagnosis, the next best is a sign or symptom, and the last resort is a circumstance (Z code). Be sure that you only code established conditions (not probable, suspected, possible, or rule-out conditions).

Be Careful When Coding the Exam

When a patient visits your office for an exam, you can choose from 2 types of CPT Category I code—Evaluation and Management (E&M) codes or Eye visit codes (previously known as Eye codes).

Documentation of exams is the number one issue in audits.

E&M codes are 5 digits long and always start with 99—e.g., 99203 *New patient, level 3.* Documentation rules are standardized for all payers nationwide, there are no frequency edits (the number of times a provider can bill a CPT code each year), and they can be linked to almost any diagnosis code.

Eye visit codes are 5 digits long and always start with 92—e.g., 92002 *Intermediate new patient exam.* These may also be used for vision exams, though payers' rules vary. Non-Medicare payers impose frequency edits (the number of times a provider can bill a CPT code each year), but Medicare Part B does not. Diagnosis coverage is limited by commercial payers, but not by Medicare Part B.

Levels of service. It takes more work to examine some patients than others, which is why E&M codes and Eye visit codes provide a range of options that represent different levels of service and are reimbursed accordingly.

10 E&M codes. There are 5 for an office visit from a new patient (99201-99205) and another 5 for the established patient (99211-99215).

4 Eye visit codes. There are 2 for the new patient (92002 and 92004) and 2 for the established patient (92012 and 92014).

Documentation is critical. Your chart documentation must support the level of service that you bill for, and that is where practices run into trouble—documentation of exams is the number one issue in audits. For instance, if you examine a new patient and submit CPT code 99205, which is the most remunerative E&M code, the patient chart must document that the patient history and exam were both "comprehensive" and that decision making of "high complexity" was involved. There is a step-by-step process for determining whether the documentation reaches those thresholds.

E&M code or Eye visit code? Some commercial payers require use of Eye visit codes for refractive or routine vision exams and E&M codes for medical exams, in which case you should consider why the patient came to see you, as deter-

MODIFIERS: When to Use Them

The CPT codes that you submit to your payer don't always tell the whole story. Suppose, for instance, you submit 2 CPT codes for the same patient—the first for surgery and the second for an eye exam that took place during the surgery's global period. Payers wouldn't reimburse you for that second CPT code because they would assume that the service was related to the initial surgery, in which case it would already be covered by their payment to you for the global surgery package (see "Be Mindful of Surgery's Global Period," page 13). To be paid, you must notify the payer that the exam had nothing to do with the surgery, which you do by appending modifier –24 to the exam's CPT code. Commonly used modifiers include the following.

For exams:

–24 *Unrelated E&M [or Eye visit code] service during postoperative period*

–25 *Significant, separate E&M [or Eye visit code] service on the same day as a minor procedure*

–57 *Decision to perform major surgery*

For surgery:

–50 *Bilateral procedure*

–54 *Surgical care only*

–55 *Postoperative care only*

–58 *Staged/related procedure during surgery*

–78 *Unplanned return to operating room (OR)/ procedure room for related procedures by the same physician during postop period*

–79 *Unrelated procedure or service by the same physician during postop period*

mined by the chief complaint.

Pick the more remunerative option. If you have the option of selecting either an E&M code or an Eye visit code, it is permissible to select the code that has the highest reimbursement: Check the documentation in the chart and determine what level of E&M code it supports and what level of Eye visit code it supports; next, see what the payer will pay (the "allowable") for each of those codes. (Many non-Medicare payers have higher allowables for E&M codes; most Medicare Part B payers have higher allowables for Eye visit codes.)

Tip—create a cheat sheet. To help you pick the more remunerative option, you should create a quick reference that lists what your main payers will pay for each E&M code and Eye visit code.

Be Mindful of Surgery's Global Period

For surgery, the payer's coverage is known as the global surgical package. This covers the surgery plus certain related services and postop visits that take place during a set number of days, known as the global period.

How long does the global period last? It depends on the CPT code and the payer. Payers classify surgical CPT codes as either minor or major.

For Medicare Part B:

- Minor procedures have either 0 or 10 days of postop care.
- Major procedures have 90 days.

For non-Medicare payers:

- Minor procedures have 0 or 10 days of postop care.
- Major procedures have 45, 60, or 90 days.

Payers' fee schedules indicate the global period of each surgical CPT code.

Why the global period matters. If a patient encounter takes place during the global period, the payer is likely to assume that it was covered by the global surgical package. Suppose, however, that the encounter was unrelated to the earlier surgery. You should flag that fact by appending a modifier (e.g., –24) to the CPT code. If you don't, you won't get paid.

Don't Bungle When You Unbundle

Bundled codes (aka CCI edits). Bundled codes are pairs of codes representing services that can't both be billed when performed by the same physician on the same eye on the same day. These pairs are also often referred to as CCI edits or, sometimes, NCCI edits, which is a reference to the National Correct Coding Initiative that publishes lists of those pairs. These lists are updated quarterly.

Unbundling CCI edits. Some CCI edits (pairs of bundled codes) can be billed separately, but only under certain circumstances. You indicate to your payer that those circumstances apply by appending an appropriate modifier to the CPT code, a process known as unbundling.

Mutually exclusive CCI edits. Some CCI edits can never be unbundled. These are known as mutually exclusive edits and have an indicator of 0 in the NCCI listings.

How do you know which CCI edits can be unbundled? In NCCI's lists of CCI edits, pairs of codes that can be unbundled (with the help of a modifier) have an indicator of 1. Pairs that can't have an indicator of 0. You'll also find this in *2016 Coding Coach* (see "Further Reading," page 14).

Why bundled codes matter. When 2 CPT codes can't be unbundled, it is best to submit only the more remunerative one. If you don't, you're likely to be paid for the less remunerative one.

Understand the Payment Process

Practices and payers each have their own fee schedule. For practices, the fee schedule shows what they will bill for each CPT code; for payers, it shows what they will pay. When you contract to participate in an insurance plan, you agree to the plan's fee schedule,

Billing for physician services is based on the practice's fee schedule. When practices bill a third-party payer for a service, they typically charge the amount that their own fee schedule lists for that service (e.g., $100), even if the third-party payer's fee schedule lists a smaller amount (e.g., $70).

Payments are based on the payer's fee schedule. The practice will get paid only the amount that is on the payer's fee schedule. This amount is known as the allowable. Suppose, for example, a service is listed as $100 on your schedule and $70 on the payer's schedule. Although you charge $100,

AUDITS: Not If, But When

Audits by third-party payers are becoming increasingly common. When they request records—whether for a postpayment audit or a prepayment review—they may put you on a tight deadline, so it is important to be prepared: Make sure your practice knows its payers' policies, maintains a response protocol, trains its staff, and conducts a self-audit.[1]

Denied payment for cataract surgery. Palmetto, one of Medicare Part B's MACs, performed a prepayment review on 137 claims for CPT code 66984, Extracapsular cataract removal with insertion of an IOL.[2]

Palmetto partially or completely denied payment for 21 claims (15.3%) after identifying 30 documentation problems:

- No evidence of patient's Snellen BCVA in record—14 occurrences
- No evidence of patient-reported impairment of visual function resulting in restriction of activities of daily living—12
- No evidence/documentation that comprehensive eye exam and a single diagnostic A-scan was done—2
- A signed operative note/report not present—2

1 aao.org/young-ophthalmologists/yo-info/article/how-to-prepare-medical-record-review. Accessed July 20, 2016.
2 http://palmettogba.com/palmetto/providers.nsf/DocsCat/Providers-JM%20Part%20A-Medical%20Review-Results-9YGLDR3375?open. Accessed June 8, 2015.

you will only get paid $70, and the patient may pay some or all of that (see "Patient payments," immediately below).

You can't bill the patient for the balance. Your contract with the payer includes a "contractual adjustment" term, which obliges you to write off (or "adjust off") the negative balance ($30, in the example above).

Patients payments can involve copays, coinsurance, and deductibles. In recent years, patients have been picking up more of the tab because of 2 trends among insurance plans: 1) the move from copays to coinsurance and 2) the boom in high-deductible health plans.

Your best source of information about commercial insurers is the payer's website or a payer's representative

The copay is when the patient pays a fixed amount for a service. This amount may vary depending on the type of service (e.g., more for a visit to the emergency room than for an office visit), and the insurance company is responsible for the balance.

Coinsurance is when the patient has to pay a percentage of the fee. Typically, the patient has a deductible—which is a dollar amount (e.g., $1,000)—and the patient pays 100% of the fees until the cumulative payments total the amount of the deductible.

Further Reading

Coding advice for YOs:
Go to aao.org/young-ophthalmologists and click "Learn to Code."

Practice management coding resources:
Go to aao.org/practice-management and select "Coding."

AAOE reference materials:

2016 Coding Coach: Complete Ophthalmic Coding Reference, a detailed 671-page guide (also available online) tells you everything you need to know about every CPT code that you're likely to use, including relevant ICD-10 codes, relevant modifiers, global surgical periods, CCI edits, and more.

2016 ICD-10-CM for Ophthalmology: The Complete Reference (available as a book or online)

2016 Retina Coding: Complete Reference Guide

2016 CPT: The Complete Pocket Ophthalmic Reference

AAOE Primers:

The *Learn to Code* series includes *Learn to Code the Essentials* and 6 subspecialty modules (cataract and anterior segment, cornea, glaucoma, oculofacial, optical shop, pediatrics and strabismus).

For more information and to purchase products, visit aao.org/store.

In both cases, the fee would be based on the insurer's fee schedule, and the practice is responsible for collecting payment from the patient.

Give patients advance notice of uncovered services. If you anticipate that Medicare will deny payment for a service, you should ask the Part B patient to sign an Advance Beneficiary Notice (ABN) of Noncoverage ahead of time. By signing the ABN, the patient accepts responsibility for making payment if Medicare denies reimbursement; without an ABN, you can't bill the patient. Note: The ABN is for Medicare Part B patients only; commercial payers may have their own form or may require prior authorization to determine coverage.

Know Your Key Payers

Most of the claims that your practice initially sends out don't go to your patients; they go to third-party payers, such as Medicare Part B, Medicare Advantage plans, and commercial insurers. Each has a detailed set of rules for reimbursement.

Medicare Part B. Medicare mainly covers people who are age 65 years or older and who have paid (or whose spouses have paid) taxes for at least 10 years. Part B of the Medicare program covers payments to physicians. Thus, unless you work in a pediatric practice, Medicare Part B is likely to be your biggest source of revenue.

Medicare Advantage (MA) plans. MA plans replace a patient's traditional Part B Medicare, and they typically do not follow traditional Medicare rules. Although they have to cover services that are covered by Medicare Part B, each MA plan can offer extra services and charge different out-of-pocket costs, and they have different rules about access. They tend to follow the rules of the commercial payer administering the plan.

Commercial insurance. From Aetna to United HealthCare, commercial insurance companies have their own rules, regulations, bundling edits, fee schedules, and global periods for surgical procedures. Your best source of information is the payer's website or a payer's representative.

Medicaid. Medicaid is insurance coverage for low-income patients. Insurance should be verified prior to each scheduled visit. Preauthorization is required in all cases.

Know your local rules. Under Medicare Part B, CMS delegates the reimbursement process to Medicare Administrative Contractors (MACs) who can develop their own coverage policies for tests and surgical procedures. They publish these policies—known as local coverage determinations (LCDs)—on their websites. LCDs can be specific to a state or to a region and are sometimes accompanied by an article that offers additional information. There is much variation among the LCDs of different contractors, so it is important to read the policies that are applicable in your locality.

For more on LCDs, go to aao.org/eyenet and read "What's in a Name? Defining and Understanding LCDs" (Savvy Coder, July 2013). To find your MAC's LCDs, go to aao.org/practice-management/coding/updates-resources, where you'll find a link to Medicare's coverage database.