5 Lesser-Known Nuances of Reimbursement

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Coding correctly is a constant challenge. As soon as you think you've got a handle on it, the requirements change. This month's Savvy Coder focuses on some of the lesser-known nuances of reimbursement.

Standing orders are not billable services. Suppose a practice has a standing order to provide services to patients with a certain diagnosis (or suspected diagnosis) before those patients have seen a physician. Payers will not pay for those services. They insist that a physician must see and assess the patient before those services are provided.

Respond to an ADR within 45 days, or you won't get paid. Additional documentation requests (ADRs) are authorized under various CMS claims review programs. The entities that implement those programs—such as Medicare Administrative Contractors (MACs) and Zone Program Integrity Contractors (ZPICs)—send ADRs when they are reviewing a practice's claim but need more information to make a determination. As stated earlier this year in a CMS article (MLN Matters, Number MM8583), the physician has only 45 calendar days to reply. Failure to respond in that time frame will result in denial of the claim. There will be no extension allowing additional time to comply. (For MLN Matters articles, go to www.cms.gov, click " Outreach & Education," then "Find Resources," and "MLN Matters Articles.")

Bill for hospice patients using modifier –GW. A patient who is receiving hospice care must go through his or her designated hospice provider to schedule appointments at your office; otherwise, the patient may be responsible for payment. How do you designate on the CMS 1500 form that the care you are rendering is unrelated to the patient's terminal prognosis? Append modifier –GW to any test, exam, or surgery. (To learn more, see MLN Matters, Number SE1321.)

Different billing rules apply to patients from skilled nursing facilities. When patients are in a skilled nursing facility (SNF), Medicare pays the SNF a set per diem rate for each patient. This payment is supposed to cover all the medically necessary services that the average SNF patient needs in order to recuperate. This coverage can have repercussions for your practice when you see an SNF patient in your office. Here's how: If you perform diagnostic tests, you won't be able to bill the technical component (–TC) of those services to the payer. Similarly, you can't bill injectable drugs or postcataract glasses to the payer. One option would be to have an open dialogue with the patient to see if these services can wait until he or she is discharged from the SNF. If waiting isn't an option, contact the SNF ahead of time to arrange payment.

ASCs can now bill for donor tissue for glaucoma shunt grafts. As of April 1, 2015, ASCs may use HCPCS code V2785 to be reimbursed for donor tissue used when a graft is needed to either implant (CPT code 66180) or revise (66185) an aqueous shunt. (For more information, read MLN Matters, Number M9100.) ■

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Use AAOE resources. In addition to signing up for the AAOE's E-Talk (www.aao.org/practice-management/listserv), you should visit AAOE "Coding Updates and Resources" at www.aao.org/practice-management/coding/updates-resources. This Web page provides links to the latest Correct Coding Initiative edits, a database of Local Coverage Determinations (LCDs), the NPI Locator, the Advance Beneficiary Notice, and much more.

Sign up for your MAC's weekly listserv. Make sure you are in the loop on policy news and changes in local coverage determinations (LCDs), which are the guidelines you'll be held accountable to in an audit. For your MAC's website, go to the AAOE "Coding Updates and Resources" Web page (see above) and click "Medicare Carrier Website Addresses."