# Recovery Audits, Part 2: What Sparks a Review?

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Last month, *EyeNet* provided basic information about the four Recovery Audit entities (RAs). This month, learn about the types of coding issues that can prompt an RA to initiate a review. Also, get a heads-up on recent changes to the RA program.

## What Prompts a Review?

There are two types of RA review.

**In automated (or data driven) reviews, you won't be asked for medical records.** A number of practices have told the AAOE exactly what caught the RA's attention. Examples include:

- Billing an established patient for a new patient exam.
- Neglecting to append modifier –57 to the appropriate level of exam when a major surgical procedure (one with 90 days of postoperative care) was performed the same day.
- Billing 992XX–24 for a patient with a complaint of floaters during the global period of a cataract surgery. The RA presumed this was a complication of the cataract surgery.
- Having billed for 1 unit of Lucentis instead of 5, with $1,500 inappropriately written off. RAs are supposed to investigate all improper Medicare payments—even, as in this case, underpayments.
- Mislinking intravitreal injections to a diagnosis of dry AMD rather than wet AMD.

**In complex audits, the RA asks to see the patient's medical record.** In several recent blepharoplasty cases, practices have prevailed in the medical review and/or appeals process. The key to their success? They were well versed with the requirements specified in their Medicare administrative contractor's (MAC) local coverage determination (LCD) on the date of surgery.

**If you are subject to an RA audit,** please e-mail svicchrilli@aao.org.

## Changes to the RA Program

The RA program has recently addressed several areas of concern.

**Discussion period.** Upon notification of an appeal by a physician, the RA is required to stop the discussion period. This has meant that physicians have had to choose between a discussion or an appeal. However, RAs must now wait 30 days to allow for a discussion before sending the claim to the MAC for payment adjustment.

**Confirmation of discussion request.** RAs must now confirm receipt of a discussion request within three days of receiving it.

**Physicians' denial rates are now taken into account.** Previously, the number of requests for information had been the same for all physicians in practices of similar size. Now, when physicians are asked for additional documentation, those with low denial rates will be asked for fewer records than those with high denial rates. ■

## Coding for Optos Testing Services

Savvy Coder occasionally highlights particular technologies—this month, the Optomap.

**How do you code for the Optomap's use in detection of disease or abnormal findings in the posterior segment?** For the Optomap Plus Medical Retinal Exam, you may use CPT code 92250 *Fundus photography with interpretation and report;* for an Optomap fluorescein angiogram, you may use CPT code 92235 *Fluorescein angiography.*

**What if it's used for screening?** The Optomap is a noncovered service. If the patient insists that you submit a claim anyway, then consider HCPCS code S9986 *Not medically necessary service (patient is aware that the service not medically necessary)* for commercial plans, or CPT code 92250–GY for Medicare patients. Modifier –GY indicates the claim should be denied. There is no need to have the Medicare patient sign an Advance Beneficiary Notice (ABN).

**What diagnosis code do you use?** For ICD-9, use V72.0 *Examination of eyes and vision.* Following conversion to ICD-10, use Z01.00 *Encounter for examination of eyes and vision without abnormal findings.*