Best Coding Tips of 2015: Part 2, Lessons Learned From Costly Errors

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Throughout the year, questions received at coding@aao.org reveal errors in and misunderstandings about claim submission. By drawing lessons from the examples below, which are derived from those emails, you can avoid costly mistakes.

Specialized IOLs

One rule does not fit all payers. Here's the scenario: A patient who has commercial insurance requested a presbyopia-correcting IOL at the time of her cataract surgery. The office staff processed the claim following Medicare Part B guidelines published in May 2005. The patient paid the out-of-pocket expense in full up front but asked the practice to submit a claim for that amount to her commercial payer. The office submitted 66984-LT for the cataract surgery, and also submitted V2788 for the presbyopia-correcting IOL, appended with modifier –GY to indicate that the additional amount, over monofocal lens reimbursement, for the presbyopia-correcting IOL should be denied. The remittance advice to the office and the patient indicates that the payer has an allowed amount that is less than the physician's out-of-pocket fee. The patient asked the practice to refund the difference.

Tips:

• Not all payers follow CMS rules regarding presbyopia-correcting IOLs.

• Some payers have their own payment/coverage policy, and if you're "par" (participating) in their plan, you need to follow their rules. Best practice is to verify what the insurance coverage is on all procedures performed. You also should check what you agreed to in the contract with the payer.

• Don't assume that the payer won't cover a particular service.

• HCPCS modifiers, such as –GY, are not recognized by all payers.

• Follow the remittance advice.

Testing Services

Testing services are billable and payable during the global period, provided they are medically necessary. A physician asked why tests performed during the global period of any surgery are not separately payable by federal and commercial payers. The answer is—they are! Unfortunately, the 3 ophthalmologists in this particular practice had never been paid. Why? Their billing staff was under the erroneous impression that tests are considered part of the global period.

Bundling Edits

Every payer has bundling edits. These are pairs of codes that should not both be billed when performed by the same physician on the same eye on the same day. For example, bundling edits may apply with the following pairs of services: exams with tests; exams with surgical procedures; tests with tests; tests with surgeries; and surgeries with additional surgeries.

Many payers follow the National Correct Coding Initiative's edits (NCCI, often shortened to CCI). Here are some of CCI's most-often-ignored bundling edit combinations:

• Injection codes are bundled with all major and minor surgeries.

• Extended and subsequent ophthalmoscopies are bundled with all retinal major and minor surgical procedures.

• Fitting of a bandage contact lens is bundled with all corneal major and minor surgical procedures.

• Gonioscopy is bundled with argon laser trabeculoplasty (ALT), selective laser trabeculoplasty (SLT), and multipulse laser trabeculoplasty (MLT).

• Fundus photography is bundled with retina and glaucoma SCODI (scanning computerized ophthalmic diagnostic imaging).

• Technician code 99211 is bundled with all ophthalmological testing services, including the refraction.

What if you ignore CCI bundling edits? If you submit 2 CPT codes, the payer is likely to just reimburse you for the code that pays the least. To see all the CCI edits, go to www.aao.org/practice-management, click "Coding," and then select "Coding Updates and Resources." (Some commercial payers have their own edits that can be accessed from their websites.) ■