



## COMPETENCY QUESTIONS AND ANSWERS

Protect your practice by knowing and implementing the answers to these questions.

### **General Questions**

**Q. How long do we have to keep medical records?**

A. The law varies by state. Check with your state medical association. Typically, records should be maintained for seven years since the last exam date for an audit. For children, it is typically seven years after their 21<sup>st</sup> birthday.

**Q. How far back can a payer auditor request records?**

A. There is no limit on time frame. Recovery audits can only go back three years. Other audits typically request records for the past 18 months, but they can go back much further if they choose to do so.

**Q. We are non-par with an insurance company. Can we provide the patient what they need to submit to their insurance?**

A. Submit the claim on their behalf. The patient should be notified you are non-par before making an appointment. Explain that payment is due at the time of service and if their insurance plan has an allowable for off-plan coverage, the check will come to them.

**Q. True or False? The Advance Beneficiary Notice (ABN) applies to all traditional Part B and Medicare Advantage Plan patients.**

A. This statement is false. In fact, if you forget and append modifier -GA to any MA claim, there may be no payment from the MA plan or the patient.

**Q. There are several practices in our call group. One physician sees another physician's surgical patient during the global period. Should the on-call physician submit a claim?**

A. The on-call physician should not submit a claim as this is postop. The on-call physician acts as the operating physician.

**Q. What isn't paid by Medicare Part B while the patient is in a skilled nursing facility (SNF)?**

A. The technical component of any test, any drug injected and postop cataract glasses.

**Q. True or False? You hire a new physician in your practice. It's best to check with the Office of Inspector General (OIG) first.**

A. True. If legal action has been taken against a physician, no payments can be made to them by Medicare.

### **Diagnosis Question**

**Q. How many diagnosis codes should be reported on each encounter?**

A. Only those that pertain to today's visit should be reported. While your EHR may require the status of all previous diagnoses, those should not convert to today's exam if they don't apply.

### **Examination Questions**

**Q. The retina specialist refers a patient to the glaucoma specialist in the same office. What does the glaucoma specialist bill the commercial payer patient as?**

A. An established patient E/M or Eye code.

**Q. A patient, who is in the hospital, is seen in your office for an exam. Which of the following statements is true?**

1. Place of service is office.
2. Place of service is hospital.
3. The patient is responsible for payment of this non-covered exam.

The place of service is hospital. You can't have an outpatient exam while the patient is inpatient of record. When a patient is admitted to the hospital, coding is the same whether the patient is examined in the hospital or in the office. An inpatient of record can't have an outpatient exam.

CPT codes 99251, 99252, 99253, 99254, 99255

POS 21

Whether new or established, the CPT codes are the same.

This family of codes also qualifies for telemedicine.

- Append modifier -95
- POS 2

If during the global period, your patient is admitted to the hospital and postop visits are performed at that location.

- Not separately billable
- Still postop care

**Q. Copy forward/copy paste is a time-saving feature of our EHR, yet I've heard that it is an area of vulnerability in an audit. Is this true?**

A. Yes. According to carrier medical directors and auditors, payment is made from the work performed at each patient encounter. This doesn't include information from the previous exam brought forward. Doing so also may overinflate the level of exam billed as only system pertaining to the exam should be reviewed and only elements that pertain to the chief complaint should

be performed. For this reason, often auditors will request consecutive encounters to see if copy forward/copy paste has been done.

**Q. How often do we need to have the patient fill out new paperwork for the ROS and PFSH?**

A. Paperwork can be referenced at each exam (if medically necessary) but new paperwork is only needed if/when the rules change or if the patient is "new" again.

### **Modifier Questions**

**Q. Does the modifier order make any difference?**

A. Yes. The order of the modifiers determines whether payment is made correctly. CPT modifiers should go first, followed by modifiers -RT or -LT.

**Q. True or False? Discontinued surgical procedures have a global period.**

A. False.

### **Surgery Question**

**Q. I have been told there is a national coverage rule that all patients must be examined within 90 days prior to cataract surgery. Is this true?**

A. False. The physician determines when an exam is medically necessary. Unless there is a payer policy that publishes this requirement, it is physician's decision. OIG investigation revealed "too many exams with the sole diagnosis of cataract."

### **Testing Services Questions**

**Q. We perform several tests on new patients before they see the ophthalmologist; however, we only bill when pathology is found. The sales rep told us this was okay. Is it appropriate to bill when we find pathology?**

A. No. These are considered standing orders or screening tests. The patient is responsible for payment or they are no charge.

**Q. Is it appropriate to unbundle 92133 Glaucoma OCT and 92134 Retina OCT as long as you have two separate diagnosis codes?**

A. It is not appropriate to unbundle according to the CPT description. It is also a CCI mutually exclusive edit.

**Q. True or False? Regarding subsequent ophthalmoscopy, payment is made whether there is change or not, as long as a picture is drawn.**

A. False. Payment is for drawing a change in pathology that is drawn and labeled.