Ophthalmology and Optometry Coding Alert

Coding Errors: Use Expert Examples to Avoid These Common Eye Coding Errors

CMS finds startling 13.5 percent error rate among 2016 eye procedures ⬜ don't make the mistakes these practices did.

Ophthalmologists have to code complex operative reports every day on a tight timeline ⬜ and when you add to that the fact that payer regulations are constantly changing, errors are bound to happen. However, the most recent Medicare error report seemed to indicate that errors for eye procedures are coming in at a high rate ⬜ and if you're one of the offenders, you may have to refund some payments to your contractor.

Background: Last month, CMS released its "Appendices for the Medicare Fee-for-Service 2016 Improper Payments Report" as part of its Comprehensive Error Rate Testing (CERT) program. The report breaks down the most egregious errors among Medicare claims, and covers the causes of the improperly paid charges. Overall, the government found an 11.7 percent improper payment rate among Part B claims during 2016, with the vast majority of those being classified as overpayments to providers.

The majority of Part B errors were categorized as such due to insufficient documentation (totaling $5.5 billion in errors), while incorrect coding was also a major error source (costing $2.7 billion in errors). Medical necessity and no documentation errors were also seen among Part B claims.

Eye Procedures Logged Almost $100 Million in Errors

When the government scrutinized eye procedures, it found a startling 13.5 percent error rate among these claims, which were the source of $97.5 million in errors. The CERT auditors found a 3.8 percent error rate among ophthalmology claims in general, and cataract removal/lens insertion marked another $45 million in improper payments, with a 2.3 percent improper payment rate.

The vast majority of improper payments (75 percent) made to ophthalmologists were due to insufficient documentation, while another 25 percent were due to incorrect CPT® coding.

Consider the following examples of improperly coded eye claims:

Example 1: The physician reports 65426 (Excision or transposition of pterygium; with graft) for a surgery performed on a 67-year-old patient with visually significant pterygium of the right eye. The documentation to support the claim was as follows:

The patient was prepped in a sterile fashion and anesthetized. The pterygium was separated from the underlying scar tissue of the sclera, and a muscle hook was passed through the upper conjunctiva. The head of the pterygium was dissected carefully from the apex toward the limbus, the upper angle of the conjunctiva was grasped with fine forceps. Westcott scissors were employed to separate the conjunctiva from the underlying Tenon's capsule. Bleeding was controlled using electrocautery and TobraDex was placed in the eye. The eye was patched and the patient was asked to report back to our office the next day for evaluation.

Do you see the problem with this chart? The operative note is very detailed and thorough, but does not mention placement of a graft. Therefore, this claim was incorrectly billed and the documentation was insufficient to support CPT® code 65426. The contractor would therefore change this to CPT® code 65420, and likely ask you for the financial difference between what you were paid ⬜ which is typically about $487 in a facility ⬜ and what 65420 reimburses (about $384 in a facility setting). That difference is approximately $103.

Example 2: You report 66983 (Intracapsular cataract extraction with insertion of intraocular lens prosthesis [1 stage procedure]) and the documentation for the procedure is thorough, describing the cataract excision as well as the lens insertion in great detail. However, when the Medicare contractor requests the patient's charts, the reviewer is unable to find sufficient documentation indicating that the patient's vision is impaired due to the cataracts with activities of daily living and the progression of the impairment, nor did the physician document any other exam findings for the procedure, which Medicare guidelines require. The only office visit notes say, "Patient presents for cataract evaluation. Surgery scheduled for Dec. 18."

Therefore, the documentation is insufficient to support billing 66983, medical necessity for the procedure is not met, and this would be classified as an overcoded service.

Resource: To read the full CERT document, visit
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/AppendicesMedicareFee-for-Service2016ImproperPaymentsReport.pdf.>