Optometry Coding & Billing Alert

Compliance Help Desk: Be Sure the Feds Know You're Not One of the Bad Guys

Coders and optometrists who want to avoid fraud or other criminal charges would be wise to read the 2004 Work Plan from the HHS Office of the Inspector General.

The plan outlines aspects of Medicare and Medicaid billing that federal regulators are scrutinizing this year. Here's what optometry coders and billers should pay particular attention to:

1. Consultations. The OIG will be looking into whether practices are appropriately billing for consultations. In 2000, carriers allotted $2 billion for consults.

   Consultation codes pay better than most levels of office visit (E/M) codes and eye codes, which is incentive for optometry coders to learn how to use them appropriately. As with E/M services, optometry coders should choose consult codes according to the three elements of history, examination and medical decision-making. And if consultations are not properly documented, payers may confuse them with referrals or transfers of care, a road that leads straight to denials.

2. Coding of E/M Services. If you code disproportionately large numbers of high-level E/M codes, inspectors may pay you a visit to determine if you're padding your bank account with inflated E/M codes. E/M levels are based on time spent with the patient, amount or complexity of the data reviewed, risk factors for the patient, and the complexity of the decisions you make. If, for example, you have an established patient with a detailed history and exam but a medical decision-making component of low complexity, you should code 99213, a relatively low level of E/M.

3. Use of Modifier -25. Also, keep an eye on your use of modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service). Nearly 10 percent of the $23 billion in E/M codes that were paid for claims were submitted with modifier -25.

   Inspectors will determine if the claims were billed and reimbursed appropriately. Use modifier -25 for significant, separately identifiable E/M service provided by the same physician on the same day.

   "In general, a provider should not bill evaluation and management codes on the same day as a procedure or other service unless the E/M service is unrelated to such procedure or service," says **Raequell Duran**, president of Practice Solutions in Santa Barbara, Calif. A provider reports such circumstances by using modifier -25.

   Medicare only allows payment for E/M services performed on the same day as a surgical procedure if all the following requirements are met:

4. The additional E/M service must be separately identifiable from the surgical procedure and require significant effort above and beyond the usual pre- and postoperative service routinely required for the procedure.

5. The term "separately identifiable" means that an additional service is not part of the surgery or procedure.

6. Medical records should document the E/M service to such an extent that, upon review, the extra effort may be readily identifiable.

7. The E/M service must require additional history, exam, knowledge, skill, work time and risk, above and beyond what is

usually required for the surgery or procedure.

8. Use of Modifiers With NCCI Edits. Make sure you take care when you unbundle code pairs using modifiers. For instance, be sure you know what is included in the global surgical package for any given procedure.

   Typically, surgery includes pre- and postoperative care, pain management, the resolution of complications following surgery, and typical surgical supplies.

   Things typically not included in the global include (but are not limited to) initial consultations or evaluations of the problem by the surgeon to determine the need for surgery (use the proper procedure code followed by modifier -57, Decision for surgery).

9. Other providers who are treating conditions not related to the surgery.

10. A more extensive procedure if the original fails, or diagnostic tests and procedures, including diagnostic radiological procedures.

    In 2001, $565 million was paid to providers who used modifiers to unbundle code pairs. OIG inspectors will determine if modifiers were used appropriately.

    The report states that the "initiative, one of CMS' tools for detecting and correcting improper billing, is designed to provide Medicare Part B carriers with code pair edits for use in reviewing claims. A provider may include a modifier to allow payment for both services within the code pair under certain circumstances."

    The best safeguard against OIG investigations is periodic auditing of your offices charts, says **Brenda Arendt, CMC**, of Center for Total Eye Care in Westminster, Md.

    "We do an internal audit of charts. Take a bunch of charts and make sure they match the criteria (for a given procedure or E/M code)," Arendt says.

    Making a good-faith effort can go a long way to showing the OIG, if they do come around, that your practice did not commit fraud but made an honest mistake, Arendt says.

    The entire work plan is available online at the department of Health and Human Services Web Site at http://oig.hhs.gov/publications/workplan.html#1.