Codify
BY AAPC

Optometry Coding & Billing Alert

Denial Management: Make Sure Optometrists Are Listed Under Correct Specialty Code

Medicare contractor reports confusion over specialty codes leads to denied claims.

If you report a new patient code and your MAC rejects it, stating that the patient is already established at your practice, you could be facing a problem that began when you enrolled your physician in Medicare. Doctors who are assigned to the wrong specialties in Medicare's systems can create a host of billing problems down the line.

That's the word from a June 27 NGS Medicare "Ask the Contractor" teleconference, in which a caller presented the following scenario: Her internal medicine physician saw a new patient and reported a code from the 99201-99205 series. However, the MAC denied the claim saying that it did not meet new patient qualifications since the practice's cardiologist had seen the patient in the past.

"That should normally be a new patient visit as long as the doctors are of different specialties," said NGS's **Jim Bavoso** during the call. "But what we have come across more often than not is that the specialties of both members of the group are listed as the same, and that would cause this to bump. What we have found is that we have doctors that are cardiologists who may not have changed their specialty in the program."

Tip: If you come up against this issue, you can change your specialty in your contractor's system. Contact your local MAC to confirm which specialty codes your physicians enrolled under, and let the payer know if you need to change any of them.

Practices Stuck in 'No-Pay Zone'

Another caller presented a scenario in which she is being forced to write off vast sums of money due to primary vs. secondary payer issues.

Scenario: A patient presents to the practice, and says he has private payer insurance only, without any Medicare coverage. Because he is under the age of 65, the practice does not press him on this issue, bills the claim to the private payer, and collects the full reimbursement amount. Two years later, the private payer contacts the practice for a refund, noting that the patient actually had Medicare as primary at the time of service. The claim cannot be submitted to Medicare at that point, because Medicare's one-year payment window has passed.

Unfortunately, Bavoso told the caller, MACs are powerless to pay providers in this scenario. "You should really voice your concern to CMS to make this change," he said. "There's no change on the horizon for this issue that we can see at this point," but contractors' hands are tied until CMS formally changes the policy. Bavoso recommends that practices facing this issue should submit a written complaint to their local CMS offices.

But, added NGS's medical director **Lawrence Clark, MD,** "It's absolutely essential that you verify the patient's coverage at the beginning. It's easy in the sense that with patients age 65 and up, you would assume they've applied for Social Security. But if you have anyone with any chronic disability [younger than that], that's your tipoff that you have to pay attention to, particularly those with behavioral disturbances, because they are not honestly giving you an answer because they can't give you a good one, so you have to go to their caretaker."

Tip: Ensure that your front-office staff specifically asks patients for all insurance cards, including Medicare and Medicaid, so you don't face similar payment issues.

5010 reminder: The deadline for using the 5010 format has now passed, said NGS's Tony Carbone during the call. "Any

CPT® 2023 American Medical Association. All rights reserved.

claims sent using the 4010 format after July 1 will be rejected and you will not be paid."

CPT® 2023 American Medical Association. All rights reserved.