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Optometry Coding & Billing Alert

Part B Mythbuster: These 4 Deadly Myths Could Damage Your Practice

Setting your 92014 fees higher for Medicare patients could land your optometry practice in hot water.

Does the staff in your optometry practice subscribe to any of the most common myths in the medical industry? Make sure you educate them about the truth behind these misconceptions, experts say. Check out the following seven myths, along with the realities behind them.

Myth 1: You have to bill everyone the same amount.

Fact: You can't bill your Medicare patients more than you do all your other optometry patients, says **Suzan Berman, CPC, CEMC, CEDC,** senior manager of coding education and documentation compliance in the Physician Services Division with UPMC in Pittsburgh.

If your practice maintains several fee schedules, the government payers should be the lowest-priced among the group, she advises.

However, as long as you are following a contract or have consistent non-discriminatory billing policies in writing, billing may vary within your practice. But practically speaking, you should keep your billing policies consistent to avoid accusations of discrimination.

Example: Your practice's standard charge for a comprehensive eye exam for an established patient (92014, Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits) is $100. Even though Medicare's Physician Fee Schedule values this service at $115.86 (based on 3.41 non-facility relative value units multiplied by the 2011 conversion factor of 33.9746), you may still only charge Medicare patients $100 for this exam.

Myth 2: Before you write something off, you have to send three bills.

Fact: You have to make a reasonable attempt at collecting the co-pay, deductible, and, when applicable, the balance of the bill, but that doesn't necessarily mean sending three bills.

Routinely waiving deductibles and copayments can violate several federal laws and regulations, including the federal False Claims Act, anti-kickback statutes, and compliance guidelines for individual and small group physician practices. In the Federal False Claims Act, the OIG identifies three criteria that can result in a violation:

1. Waivers that are routine,

2. Waivers given without regard to the individual's financial hardship, and

3. Failing to disclose the discounted amount of the service to the payer in order to pass on to the payer its proportional share of the discount.

Watch out: OIG regulations aren't your only concern when it comes to collecting copays. Check your payer contracts as well. Many contracts require that copays are collected at the time of service. A provider can lose participating status if they fail to follow the guidelines.

One reason you may be able to write off a patient's copay, deductible, or balance is if the patient meets financial hardship criteria. In order for your practice to accept financial hardship as terms for a debt write-off, the patient needs to be able to prove he is unable to pay. In the event that you cannot establish financial hardship, CMS requires that you

make a "reasonable effort" to collect money from a patient. This might consist of sending three bills, followed by two phone calls, and a final notice. That cycle is up to your practice's discretion. If you ultimately can't collect, be sure to document your efforts.

Keep in mind that establishing the above policy must apply consistently across the board to all patients. It is suggested that financial hardship should not be determined by the number of bills sent or phone calls to a patient. Instead, a financial hardship policy might be established based on evidence of an income tax return or current pay stub showing low income. Again, the policy for financial hardship should support the hardship. Merely sending bills and making phone calls does not justify hardship.

Myth 3: You can only bill one diagnosis code per claim.

Fact: You should bill as many diagnosis codes as you need to establish medical necessity for the services you're billing. Some payers' computer systems used to be able to read only one diagnosis code per line. But now, you should always be able to report all pertinent diagnoses for each visit, and link the correct diagnoses to each service on each line.

This will become particularly important when ICD-10 codes come into play in 2013, at which point diagnosis coding will expand significantly.

Example: An established Medicare patient complains of a scratchy sensation in his left eye and tells the optometrist thatthe problem started following some lawn work and he thinks he may have gotten something in his eye. The optometrist examines the patient and discovers lawn debris embedded in the conjunctiva of the left eye. There is no serious damage to the cornea but the physician also notes that the patient has severe blepharitis in both eyes. Following the removal of the foreign body, the physician performs a complete work-up andalso treats the blepharitis. Report the applicable E/M code (99211-99215) with modifier 25 appended linked to the diagnosis for blepharitis (373.0x, Blepharitis ...). Next, report 65210 (Removal of foreign body, external eye; conjunctival embedded [includes concretions], subconjunctival, or scleral nonperforating) linked to the appropriate foreign body diagnosis (e.g., 930.0-930.9, Foreign body on external eye).

Myth 4: If you're a Medicaid provider, you have to accept all Medicaid patients.

Fact: Some states may allow you to limit the number of Medicaid patients that you see, says **Quinten A. Buechner, MS, M.Div., CPC, PCS, ACS FP/GI/PEDS, CCP, CMSC,** program chair in the Medical Billing and Insurance Coding department with Herzing University in Kenosha, Wisc.

"As Medicaid is partially state-funded and state-designed, it is hard to give a general rule," Buechner advises. "I have found many states will allow some flexibility allowing you to limit new admits to your patient mix. Most Medicaids recognize that you can go broke without the ability to keep a viable patient mix."

Check with your state: If you are unclear regarding whether your state allows limitation of Medicaid patients, contact your state's Department of Health and Human Services rather than contacting your payer, Buechner advises.