Optometry Coding & Billing Alert

Recognize Any of These 'Top 10' Denials?

Rejections are preventable - if you educate your carriers about OD's work

Our story on denial management ("Drag Your Carriers Out of Denial," page 3) suggests that you keep a running list of your office's "Top 10" denials.

Compare your list with Medicare's recently released Top 10 reasons for claim rejection to see if there's any overlap - then see how these denials manifest in your optometry practice

Remember, you should work systematically to eliminate the cause of each one of these types of denials in your office - or you may simply need to notify the payer why it was wrong in rejecting your claim.
Here's Medicare's "Top 10":

1. No documentation of service
2. No signature or authentication
3. Always assign the same level of service (LOS)
4. Consult versus outpatient/office visit
5. Invalid codes due to old resources
6. Unbundling of procedure codes
7. Misinterpreted abbreviations
8. No chief complaint listed/reflected
9. Global fee service billed separately
10. Inappropriate or no modifier used.

Key: In an optometry office, your "Top 10" may look much different, says **David Gibson, OD, FAAO**, practicing optometrist in Lubbock, Texas.

"Mismatching diagnoses and procedures" tops Gibson's list - reporting an ICD-9 code that does not support medical necessity for the CPT code you're billing can trigger a denial.

Another common reason for rejections Gibson cites is the carrier's assumption that optometrists only do routine care.

Even if the diagnosis on the claim form supports medical necessity, processors might see an OD degree and deny everything on a claim except for an eye exam, Gibson says. "Carrier error" may turn out to rank high on your own "Top 10."