Optometry Coding & Billing Alert

Reimbursement: 3 Outdated Billing Habits You Must Overcome Now

You may already be struggling with denials for these issues -- update your processes now to straighten them out.

It's easy to follow a well-oiled routine when you're submitting your claims--but when coding and billing rules change, you may find yourself still falling under the old habits. Submitting claims using outdated methods can lead to denials and chargebacks -- which you want to avoid at all costs. Avoid these three mistakes to make sure you aren't following old advice.

1. Still Reporting Consults to Part B. If you still submit claims for consultation codes to a Part B payer, you're probably seeing denials every day.

Background: Effective January 1, 2010, CMS eliminated payment for the use of all consultation codes (99251-99255, Inpatient consultation for a new or established patient...) and outpatient (99241-99245, Office consultation for a new or established patient ...). Although you may be aware of this fact, it's possible that the codes are still billable in your system, leading many practitioners and coders to mistakenly select them when billing Medicare. Adding to the confusion, many private payers still reimburse consult codes, so some practices are still accustomed to using them and often erroneously submit them to Medicare Part B.

Tip: Instead of reporting consultation codes, you should report new or established patient office visit, initial or subsequent hospital care, or initial or subsequent nursing facility care (E/M) codes for these services when billing Part B. CMS has increased payments for some E/M codes to make up for the fact that consult codes reimbursed at a higher rate than standard E/M codes.

2. Still Using An NEMB Form. Prior to 2008, if Medicare statutorily excluded a procedure from Medicare benefits, you used the NEMB form to advise the patient of the non-payable status. But as of September 2009, CMS combined the ABN and NEMB, and you should have started using the new ABN form for either purpose. At the time, CMS noted in its ABN instructions that "the revised version of the ABN may also be used to provide voluntary notification of financial liability."

3. Not Yet Using 5010. CMS began requiring 5010 enforcement on July 1, meaning that many claims have been rejected since that time if the previous 4010 format is submitted.

CGS Medicare, for example, sent out a message on July 6 stating, "Since June 29, all Medicare FFS claims must be sent as Accredited Standards Committee (ASC) X12 Version 5010 or NCPDP D.0. Any Medicare FFS claims received in version 4010 format after normal close of business on June 29 are being rejected back to the submitter."