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Optometry Coding & Billing Alert

Take 4 Steps to Fight for E/M Payment With Punctal Plug Insertion

Don't let faulty documentation take up to $120 out of your pocket

You-ve coded what you-re sure is a bulletproof claim for an evaluation and management and punctal plug insertion. You were sure to append modifier 25 to the E/M code to show that it was separate from the procedure. Your carrier, however, denies payment for the E/M service.

Should you:
1 look at your documentation?
2. check the insurer's policy?
3. contact the payer's medical director?
4. appeal citing HIPAA and CPT rules?

Actually, coding experts recommend you do all four.

1. Verify That the Encounter Meets Modifier 25 Criteria

With national average reimbursement for an evaluation and management service (99201-99215) reaching as high as $120 (based on Medicare's 2006 Physician Fee Schedule), a denial is no trivial matter to your practice.

You should first check that your chart note supports billing the E/M with modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service). -Every procedure has a small E/M built into it- to represent the preoperative work associated with rendering a procedure, says **Kay Faught**, coding consultant for CPT Coding and Clinic Management in Jacksonville, Ore. So you must show that you performed a significant, separate service from the procedure or other service.

Medical necessity must exist and be documented to support an E/M service. This could be the result of an established patient with new symptoms or worsening symptoms for whom a new exam and medical decision-making are necessary.

Smart idea: -Always ask yourself: Could my documentation for the E/M visit stand alone for payment if the punctal plugs hadn't been inserted?- says **David Gibson, OD, FAAO**, a practicing optometrist in Lubbock, Texas.

Example: A patient reports dry, itchy eyes and generalized pain. The optometrist performs a complete eye exam -- separate from the procedure -- to rule out other causes, and he diagnoses dry eyes. He places collagen punctal plugs in the two lower puncta to see if this resolves the problem.

Report 68761 (**Closure of the lacrimal punctum; by plug, each**) on two lines and append E2 (Lower left, eyelid) and E4 (Lower right, eyelid), plus modifier 51 (Multiple procedures) to the second procedure. For example, you would report 68761-E2, 68761-51-E4. Check with your carrier, though; some prefer that you omit modifier 51 from multiple-procedure claims.

Link 375.15 (Other disorders of lacrimal gland; tear film insufficiency, unspecified) to the punctal plug closure codes. Also report the appropriate-level E/M service (for example, 99203, Office or other outpatient visit for the evaluation and management of a new patient -) with modifier 25 and link it to 379.91 (Pain in or around eye).

Tip: When your chart note's E/M documentation can stand on its own, fight for modifier 25 pay if no carrier policies disallow the particular code combination. You don't have to write the notes on a separate sheet, but visually separating

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the services or service and procedure will help show you whether the E/M is separately reimbursable.

-Also ask yourself if an E/M is really the best code for this situation,- Gibson says. -This could be a great time for an ophthalmic exam (92002-92014), which has fewer documentation requirements.-

2. Read the Payer's Rules

Some insurers will not pay for an E/M service in addition to certain procedures or other E/M codes, regardless of your documentation, says **Elizabeth Schultz, CPC**, administrator at Bausch and Jones Eye Associates in Allentown, Pa. And if your contract specifies these restrictions, she says, you shouldn't waste time appealing the decision.

Better method: Know your payers- rules. If your contract includes rules that require you to report services differently from CPT guidelines, you must follow the contract. But make sure you address these variations when your contract comes up for renewal.

Non-Medicare payer bundles -vary across the country,- Faught says. Midwest insurers don't impose too many modifier 25 restrictions, she says.

3. Involve Others in Across-the-Board Rejections

But how do you know when a payer's denials have gone from contract-approved denials to inappropriate activity? -If an insurer never pays a modifier 25 service, you should find out why,- Faught says. Insurers should recognize that an optometrist may sometimes have to provide a separate service.

If a payer consistently rejects modifier 25 claims, raise the ante. -Talk to the medical director- and involve your state optometric association, Faught says.

4. Appeal With Regulation, Documentation

When you appeal a modifier 25 decision, remind the insurer of two facts:

1. HIPAA requires that government and third-party payers use ICD-9 and CPT as the official code set. Because CPT clearly defines the appropriate use of modifier 25, the insurer must accept the modifier.

2. You have submitted the claim based on documentation that supports using modifier 25. Include a copy of CPT's -Appendix A -- Modifiers- description of modifier 25 along with a standard form letter.

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