SAVVY CODER

Comparative Billing Reports: If Your E/M Use Is Flagged, Take These 6 Urgent Steps

If your practice receives a comparative billing report (CBR), will your staff understand its significance and know what steps to take?

Payers track your use of codes. All insurance companies track physicians' use of exams, tests, and surgical procedures. Each quarter, your payers perform an analysis to identify outliers.

Apples, oranges, and supposed outliers. Payers may flag you as an outlier if you use a particular CPT code, a modifier, or even a diagnosis code at a greater rate than your peers. But who are your peers? Despite the existence of subspecialty-specific taxonomy codes, payers will compare you against physicians across your entire specialty, which can result in an apples-to-oranges comparison (not, for example, a retina-to-retina comparison).

What's in the CBR? The CBR will indicate how far your code utilization exceeds that of your peers.

What's next? If the payer believes that physicians in your practice may be overutilizing certain codes, it may decide to audit them. You need to take this seriously and make sure you are audit-ready.

CBRs for Eye Exams
Suppose you are flagged as an outlier for your use of level 4 and 5 exam codes for new and established patients. Your first CBR will probably come from a commercial plan. When you receive it, you and your staff should promptly take the following steps.

Step 1: Read the report thoroughly and prioritize your response. A CBR often serves as a warning that if the pattern of utilization continues, an audit will soon follow.

Step 2: Make sure you are submitting from the proper family of exam codes. Ophthalmologists are unique in that they have two code families to choose from, E/M codes and Eye visit codes. Whichever one you opt for, make sure that your documentation supports the code that you use.

Step 3: Conduct your own internal chart audit to assure compliance. For each level of code for which you have been flagged as an outlier, pull a small sample of records. Make sure there is an identifiable physician signature and check that your signature log is up to date. In an actual audit, the payer would use that log to verify the signatures that appear in the charts. If you are using electronic health records (EHRs), you need an EHR protocol that guarantees the physician's signature is secure.

Step 4: Make sure your documentation justifies the level of exam billed. You can base your E/M exam either on the level of medical decision-making or on physician time.

Billing based on level of medical decision-making. The Final Determination Table for Medical Decision-Making features three components: the number and complexity of problems addressed; the amount and/or complexity of data to be reviewed and analyzed; and the risk of complications and/or morbidity or mortality of patient management. Make sure the documentation for at least two of those components meets the requirements for the level of exam that you have billed.

Billing based on physician time. If you bill based on physician time on the date of the encounter, make sure that the time is well documented and allocated to any of these areas:
- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing a separately obtained history
- Ordering medications, tests, or procedures
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient, family, or caregiver
- Documenting clinical information in the EHR or other health record
- Referring/communicating with other health care professionals (HCPs) when not reported separately
- Care coordination when not reported separately

To support use of the level 4 and 5 E/M codes, how much time does the physician need to spend in one or more of the above activities?
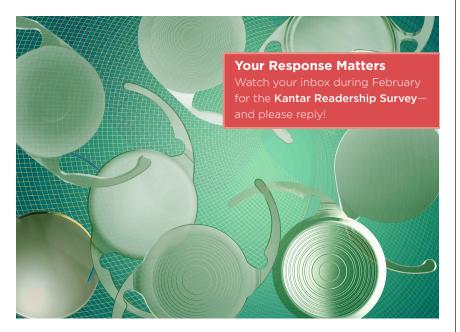
For a new patient:
- 99204: 45-59 minutes
- 99205: 60-74 minutes

For an established patient:
- 99214: 30-39 minutes
- 99215: 40-54 minutes

BY SUE VICCHRILLI, COT, OCS, OCSR, ACADEMY DIRECTOR OF CODING AND REIMBURSEMENT.

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Step 5: Make sure that the primary diagnosis relates to the chief complaint. Select ICD-10 code(s) to the highest level of specificity. Only report diagnosis codes that pertain to the day's exam.

Step 6: Review your findings. If your documentation supports the level of exam billed–well done! If not, take immediate corrective action.

Use the AAOE's resources. For primers, Q&As, and other free resources, visit aao.org/em. For an in-depth guide, purchase Conquering New E/M Documentation Guidelines for Ophthalmology (aao.org/store).

Problems to Watch For

There may be problems with documentation in the following scenarios:

• All new patient exams are routinely coded as 99204. (To bill a new patient for this level of exam, your documentation should demonstrate either 45-59 minutes of physician activity or a level of medical decision-making of moderate complexity.)

• Your biller thought that a "comprehensive dilated exam" could be billed with E/M code 99204. (Documenting the number of elements and dilation is something that could support use of the comprehensive Eye visit codes but do not fit the new E/M criteria.)

• Your practice automatically submits the exam code that your EHR system recommends. (If you are audited, it will be you—not your EHR vendor—who will be expected to justify the codes that were submitted.)

Jan. 11: Learn What's New in Coding

2022 Ophthalmology Coding Update webinar. Ms. Vicchrilli and David B. Glasser, MD, the Academy Secretary for Federal Affairs, will get you up to speed on the critical regulatory and reimbursement changes impacting ophthalmology. It takes place on Tuesday, Jan. 11, from 2:00 to 3:00 p.m. ET.

To see what topics will be covered, and to purchase your registration, visit aao.org/store.