Best Practices for Coding, Part 2: Reduce Denials and Keep Payments on Track

To help you stay current on payers' ever-changing coding rules, *EyeNet* published "Best Practices for Coding: Six Do's and Don'ts" in the January 2019 Savvy Coder (available at aao.org/eyenet/archive). This follow-up article provides six more tried-and-true strategies.

Best Practices 7 Through 12

7. Have a consistent process for alerting staff and physicians about coding updates. The requirements for coding and documentation are constantly in flux, and your compliance plan should include procedures for communicating such changes throughout the practice, whether by email, via interoffice memo, or in a staff meeting.

8. Catalog your communications on coding updates. By keeping a record of changes to your coding policies, you create a historical resource that could be critical in an audit. Remember that documentation must support the policy that was in place at the time of the encounter. Furthermore, if an audit outcome isn't positive, the payer will take into consideration any evidence that demonstrates your desire to be compliant.

9. Verify insurance every time. For each office visit, confirm the details of the patient's insurance—ideally before the patient presents at the practice. Do this even for established patients, since they may change or lose insurance at any point during the calendar year.

10. Get preauthorization for surgeries and some tests. Preauthorization—also known as prior authorization, precertification, or prenotification—involves contacting the payer and obtaining a certification number for you to include when you submit your claim for a service. Medicare Advantage plans, Medicaid plans, and commercial plans change their preauthorization requirements often. (Medicare Part B doesn't require preauthorizations.)

Note: Preauthorization for a surgery doesn't necessarily take into consideration coverage of every test; nor does it consider Correct Coding Initiative (CCI) bundling edits, which is why you should always check with the payer to see whether multiple CPT codes can be paid when the services that they represent are performed during the same session. (Many payers have a look-up feature on their website.) To help you with preauthorization, the Academy has published a detailed checklist (see a link for it at aao.org/practice-management/coding/updates-resources).

11. Correct and resubmit denied claims within 24 hours. When submitted electronically, a clean claim—meaning one without errors—typically takes 14 days to process. If a claim is denied, promptly submit a corrected form to keep payments on track.

Common reasons for denial include:

- patient's name is not listed as it appears on his or her insurance card;
- site of service issues;
- wrong or missing modifier;
- CCI edits not followed;
- mislinked diagnosis; and
- frequency edits on Eye visit codes or testing services.

Tip: Keep a list of denials and share it with all in your practice so that the same denials are not perpetuated.

12. Know which commercial payers still recognize consultation codes. A few commercial payers still recognize the 99241-99245 code family, but CMS and Medicare discontinued payment for these consultation codes a long time ago (Jan. 1, 2010). Consequently, if you include Medicare as the secondary payer for a consultation code (whether it is for an office or an inpatient exam), you will end up writing off the 20% balance.

Help Us to Help You

Boost Academy advocacy: Tell us about your preauthorization problems. The Academy's D.C. office is working to reduce—and perhaps eliminate—the administrative burden of preauthorization. If you've had cases in which preauthorization delayed medical care and/or instances where payment was denied even with preauthorization, please email coding@aao.org.

EXTRA **MORE ONLINE.** For nine key (and free) resources, see this article at aao.org/eyenet.

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