SAVVY CODER

Reimbursement for Young Ophthalmologists: Top Rules With Case Examples—Part 1

It is never too soon to get a handle on the fundamental rules of coding, some of which are illustrated in the cases below.

Case #1: The Locum Tenens

Scenario. An ophthalmologist leaves a practice and a temporary replacement physician fills in for her until a new permanent hire can be found. The practice plans to bill for the temporary physician's services using the National Provider Identifier (NPI) of the original physician, but the departing physician is concerned about this arrangement.

Rule. Typically, a doctor should never let anybody bill under his or her NPI. A practice should credential new physicians with insurance payers and revalidate those credentials every five years.

Applying the *exception* to the rule. The original physician's instincts were well-grounded, given the general rule. But in a valid locum tenens scenario, you can—for up to 60 days—use the original physician's NPI when billing for the temporary physician's services. When submitting CPT codes, append modifier –Q6 to flag that a locum tenens is getting paid on a "fee-for-time basis." (In another exception, when physicians from different practices agree to cover for one another, use modifier –Q5 to indicate a "reciprocal billing arrangement.")

Case #2: 99XXX or 92XXX?

Scenario. A 26-year-old new patient is evaluated after experiencing flashing lights and floaters. It is noted in the history that she had a comprehensive exam earlier this year by an optometrist. The latest exam included a dilated fundus exam with scleral depression that didn't reveal any evidence of holes, tears, or detachments. The diagnosis is subjective visual disturbance. Should an E/M code (99XXX) or Eye visit code (92XXX) be billed?

Rule. Ask, "Who is the payer?" Never apply one payer's rule (or your perception of it) to another payer.

Applying the rule. Although Medicare does not have frequency edits on Eye visit codes, many commercial payers have diagnosis and/or frequency edits that limit the use of Eye visit codes. Some of them, for example, limit the comprehensive exam (CPT code 92004 or 92014) to once a year. In such cases, bill the appropriate level of E/M code based on the chart documentation.

Case #3: New Patient?

Scenario. Following an inpatient consultation for periorbital cellulitis, a 24-year-old man sees you again in the clinic for follow-up. This time, should you bill for a new or established patient?

Rule. To be considered new, the patient must be new to the physician and the group practice, or it must be three years since the last encounter. (Note: it wouldn't matter if the previous visit to your practice involved a different clinician or place of service.)

Applying the rule. Because you saw him previously, he can't be billed as new.

Case #4: Check for Bundles

Scenario. Documentation in the operative report supports coding both an extensive ectropion repair (CPT code 67917) and a correction of trichiasis (67820). The procedures were performed on the same eye by the same physician during the same surgical session. Both codes were submitted. Why did the practice receive a denial for 67820?

Rule. The National Correct Coding Initiative, which is often abbreviated to CCI, lists pairs of codes (known as edits) that shouldn't be billed together. People often refer to the two codes in a CCI edit as being "bundled." The lists of CCI edits are updated quarterly. CCI edits can be listed with an indicator of 0, which means that they can never be billed together, or 1, which means that they can be billed together under certain circumstances. You can indicate that such circumstances apply by appending modifiers to CPT codes. This is known as "unbundling."

Applying the rule. Although 67917 and 67820 are bundled with an indicator of 1, they can't be unbundled in this case because the services weren't performed in opposite eyes or separate structures, so just report the code with the highest reimbursement: 67917.

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