Common Errors in Documentation and Coding

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Donna McCune is a consultant for Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

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Objectives

- Describe common errors in documentation and coding
- Establish a plan to avoid or minimize errors before they occur

Common Errors

- Vision vs. Medical exams
- History of Present Illness mistakes
- Missing exam elements
- Lack of support for procedures
- Uncertainty over billing for refraction

Different Payers, Different Policies

Medical Plan
- Deductible
- Co-payment
- No optical coverage
- Referrals may be necessary

Vision Plan
- Low or no deductible
- Minimal or no co-payment
- “Ticket” to optical
- No referrals required

Chief Complaint

- In the patient’s own words
- Identifies the reason for visit
- Along with primary Dx, CC helps determine who is responsible for payment

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**Diagnosis Code Disconnect**

<table>
<thead>
<tr>
<th>CHIEF COMPLAINT</th>
<th>ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• &quot;Routine eye exam&quot;</td>
<td>• Dx: AMD</td>
</tr>
<tr>
<td>• &quot;Annual check-up&quot;</td>
<td>• Dx: Diabetes w/BDR</td>
</tr>
<tr>
<td>• &quot;Want to update my glasses&quot;</td>
<td>• Dx: Cataracts – proceed with cataract surgery</td>
</tr>
</tbody>
</table>

**Guidelines for Diagnosis Coding**

“During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code.”

Source: *Introduction to ICD-9-CM*

**Vision Plan or Medical Plan? Where do we start this discussion?**

- Initial call to the office
- Upon arrival for appointment
- Technician intake
- What is the reason for today’s office visit?

**Common Errors**

- Vision vs. Medical exams
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**History**

**History of Present Illness**

“The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present.”

Source: *1997 E/M Documentation Guidelines (DG)*

**History**

**History of Present Illness**

- History of Present Illness (HPI)
  - Location
  - Quality
  - Severity
  - Modifying factors
  - Timing
  - Context
  - Duration
  - Associated signs and symptoms
History of Present Illness
• Elements of HPI must be performed by the physician in order to be counted for E/M coding
  • Consultations (9924x, 9925x)
  • Office visits (9920x, 9921x)
  • Hospital and nursing home visits (9922x, 9923x, 993xx)
• Chart notes may be dictated to a scribe
• Use an attestation:
  • Performed by Dr. I. M. Better and scribed by Sally Scribe

Source: CMS, WPS (10/06), Palmetto (3/07), Noridian (5/07)

Common Errors
• Vision vs. Medical exams
• History of Present Illness mistakes
• Missing exam elements
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Comprehensive Eye Exam
92004, 92014 – Required Elements
• History
  • General medical observations
  • Gross visual fields (confrontation)
  • Basic sensorimotor exam
  • External adnexa
  • Ophthalmoscopy
  • Dilation not required (some carriers disagree)

Comprehensive Eye Exam
92004, 92014 – Required Elements
• Elements not specifically mentioned:
  • Measure visual acuity
  • IOP
  • Biomicroscopy
  • Color vision testing
  • Patient orients to person, place, time

Comprehensive Eye Exam (920x4)
Key Points
• Flexible history taking, appropriate for each case
• Fewer elements than E/M comprehensive service
• Independent of medical decision making
• Requires diagnostic and treatment program
• Dilation not absolutely required

Common Errors
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**Top 10 Ophthalmic Procedures**

<table>
<thead>
<tr>
<th>Rank</th>
<th>CPT</th>
<th>Procedure</th>
<th>Rank</th>
<th>CPT</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>67028</td>
<td>Intravitreal Injection</td>
<td>6</td>
<td>66982</td>
<td>Complex Cataract</td>
</tr>
<tr>
<td>2</td>
<td>66984</td>
<td>Cataract w/IOL</td>
<td>7</td>
<td>65855</td>
<td>Lx Trabeculoplasty</td>
</tr>
<tr>
<td>3</td>
<td>66821</td>
<td>YAG capsulotomy</td>
<td>8</td>
<td>67210</td>
<td>Focal Laser</td>
</tr>
<tr>
<td>4</td>
<td>68761</td>
<td>Punctum plug</td>
<td>9</td>
<td>15823</td>
<td>Blepharoplasty</td>
</tr>
<tr>
<td>5</td>
<td>67820</td>
<td>Epilation</td>
<td>10</td>
<td>67228</td>
<td>PRP</td>
</tr>
</tbody>
</table>

Source: CMS data 2012, 18 - Ophthalmology

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**Criteria for Cataract Surgery**

- Objective evidence of a cataract
- Reduced visual acuity
- Lifestyle complaints
- Good prognosis for improvement
  - Alternate – to aid in treatment of retina
- Patient can tolerate anesthesia
- Patient awareness

Source: AAO Preferred Practice Pattern, Adult Cataract

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**Illustrative Chart Note**

**CC:** Patient states “He said to come back today to check my cataracts.” No changes in vision

**Assessment:** visually significant cataracts OD > OS

**Plan:** Schedule cataract surgery w/IOL OD

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**Medicare Coverage Policy – Example**

The patient has impairment of visual function due to cataract(s) and the following criteria are met and clearly documented:

- Decreased ability to carry out activities of daily living including (but not limited to): reading, watching television, driving, or meeting occupational or vocational expectations; and
- The patient has a best corrected visual acuity of 20/50 or worse at distant or near; or additional testing shows one of the following:
  - Consensual light testing decreases visual acuity by two lines, or
  - Glare testing decreases visual acuity by two lines

Source: NGS LCD L26853

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**Medicare Coverage Policy – Example**

**Medical Necessity**

Lens extraction is considered medically necessary and therefore covered by Medicare when one (or more) of the following conditions or circumstances exists:

1. Cataract causing symptomatic (i.e., causing the patient to seek medical attention) impairment of visual function not correctable with a tolerable change in glasses or contact lenses resulting in specific activity limitations and/or participation restrictions including, but not limited to reading, viewing television, driving, or meeting vocational or recreational needs

Source: Palmetto LCD 32379 Revision 12/6/12
**Medicare Coverage Policy – Example**

**Documentation Requirements (excerpt)**

A statement indicating that specific symptomatic (i.e., causing the patient to seek medical attention) impairment of visual function resulting in specific activity limitations and/or participation restrictions. Such activities would typically include, but are not limited to, reading, viewing television, driving, or meeting vocational or recreational expectations. The patient’s words should be included in the statement where possible.

*Source: Palmetto LCD 32379 Revision 12/6/12*

**Medical Necessity**

- Patient survey
  - Activities of daily vision scale
  - VF-14
  - Pre-surgical questionnaire

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**Illustrative Chart Note**

CC: Patient states “My eyelids droop.”
Dx: Blepharochalasis, both UL
Tx: Schedule Blepharoplasty, both UL
Test:Bleph VF

**Medicare Coverage Policy – Example**

For Medicare coverage, the following criteria (A, B, C, and D (if applicable), must be met to establish medical necessity:

A. Documented patient complaints which justify functional surgery and are commonly found in patients with ptosis, pseudoptosis, or dermatochalasis may include: interference with vision or visual field, difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin, or chronic blepharitis.

B. Documentation of one or more of the following:
   1) The upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex; or
   2) The upper eyelid skin rests on the eyelashes; or
   3) The upper eyelid indicates the presence of dermatitis; or
   4) The upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmia socket.

*Source: Palmetto LCD L31696*

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**92015 Refraction**

- “Determination of refractive state”
- “Special ophthalmological services describes services in which a special evaluation of part of the visual system is made, which goes beyond the services included under general ophthalmological services…may be reported in addition to the general ophthalmological services or E/M services.”
- Includes prescription of lens(es) when required
92015
Refraction

• Potential trouble areas
  • Explaining the term “refraction” to a lay person
  • Overlooked charge
  • Angry patient refuses to pay for non-covered service
  • Waiting too long to collect your fee
  • Some third party payers consider it bundled with exam
  • Notifying patient concerning financial responsibility
  • Separate line item on CMS-1500 claim form
  • Misuse of modifiers

Addressing the Errors and Being Proactive

• Our experience
• Knowledge to share

Practice Implications Without a Plan

• Regulatory trouble
• Unsuccessful Audits
• Retracted reimbursements

• Unhappy Patients!

Practice Applications

• Establish a plan to avoid or minimize errors
• Leads to being more proactive, less reactive

Who Does it?

• Team effort
• Administrator oversees/develops plan w/ Managers
• Department Managers implement and monitor
• Staff and Doctors are active participants

Direct Protocols

• Policy for handling vision vs. medical exams
  • Starts with reason for office visit
  • Patient returns for 2nd visit
  • Or understands shift in insurance usage
  • Or practice provides medical services for free

• Requires detailed education for staff
  • Patient inconvenience or double co-pays
  • Monitoring important. Easy to slip here.
Direct Protocols

- HPI protocol
  - By the doctor only
  - We modified exam sheet
  - EMR solution

Direct Protocols

- Missing exam elements & Lack of support for procedures
  - Annual education by consultant
  - Cheat sheets in each exam room as reminder
  - Chart audits

Tools to Catch and Monitor Discrepancies

- Billing for refractions
  - Huge revenue opportunity
  - Doing the work so charge for it
  - Educate patients to reduce their resistance
  - Repeat at appt schedule, check-in and in writing
  - Routinely monitored report

Tools to Catch and Monitor Discrepancies

- A/R aging report
- Are the collections increasing/decreasing?
- Below 12% goal; Sub 8% in well run practices
- Narrow it down by payor or CPT codes
- Are there common rejections/trends?

Tools to Catch and Monitor Discrepancies

- Billing staff productivity
  - Benchmark: $1M per FTE
  - Annual collections divided by department FTE’s (those employees are doing the charge entry, posting and collections work, not insurance verification).
  - More production than this range? Either be very efficient or you could be leaving money uncollected because the department is overwhelmed.
  - If this metric is lower, it’s time to review workflow requirements and management oversight.

Tools to Catch and Monitor Discrepancies

- Collection ratio
  - Benchmark: 95% or higher of allowed charges
  - Divide collections by the allowable charges
Tools to Catch and Monitor Discrepancies

• Evaluate claims management rejection rates
  • Pull random samples of EOB’s from high volume payors
  • Run claims rejection reports
  • Spot check each employee’s work
  • Look for rejection trends and errors (mismatched dx’s, demographics gaps)
  • Re-educate the coders or posters

Communication Processes

1. Make goals clear and educate staff
   • Techs/Doctors
     • Coding requirements
     • How to include and educate pts in the process
   • Billing Department Goals
     • Follow regulatory compliance – most important
     • Identify to mgmt the potential problem areas or where things can just be improved
     • Collecting EVERY dollar legitimately earned is important and required

Communication Processes

2. Perform audit to be sure it’s all being done.
   • Charts and EOB’s

3. Take corrective action when issues are identified

3. Continually educate staff
   • On-line opportunities
   • Local meetings
   • Consultant audits and training sessions

Some Days

I keep hitting ‘escape,’ but I’m still here.

More help…

For additional assistance or confidential consultation, please contact us at:

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