Test Your Coding Competency: Can You Answer These 9 Questions?

This year's Codequest tour started in Columbia, S.C., and finished 14 weeks later in Portland, Ore. Along the way, we visited 28 cities and fielded hundreds of questions, including the 9 below which cover some core coding issues. How many can you answer?

Q1. *We perform several tests on new patients before they see the ophthalmologist; however, we only bill when pathology is found. Is such billing OK?* **A.** While that practice might be approved for hospital care, physicians—per insurance rules—must evaluate the new patient and assess his or her needs before ordering the appropriate tests. Otherwise, performance of these tests is considered a standing order or a screening test; either the patient is responsible for payment or there is no charge. (Note: For an established patient, the physician will often order tests to be performed at the next visit. Be sure to include the order from that previous visit as part of your documentation in case you are audited.)

Q2. *I have been told there is a national coverage rule that all patients must be examined within 90 days prior to cataract surgery. Is this true?* **A.** No. Unless there is a payer policy that publishes this requirement, it is up to the physician to determine when an exam is medically necessary. When this article went to press, only Novitas had this policy statement.

Q3. *If you append more than 1 modifier to a CPT code, does their order make any difference?* **A.** Yes. The order of the modifiers determines whether payment is made. Let's say that a patient is in the postoperative period of a major surgery. She presents for a problem in the unoperated eye, and it requires that major surgery be performed that day. You should append modifier –24 (indicating the exam is unrelated to the prior surgery) followed by modifier –57 (indicating that this is the office visit to determine the need for the major surgery). Eye modifiers –RT and –LT are typically last.

Q4. *How many diagnosis codes should be reported on each encounter?* **A.** When you submit a claim, use codes only for diagnoses that were addressed during, or were the reason for, the patient encounter. Note: Your electronic health record (EHR) may require you to enter diagnoses from prior visits, but you should not report those diagnoses on your claim.

Q5. *How long do we have to keep medical records?* **A.** The law varies by state. It's best to check with your state ophthalmological society (aao.org/statesocieties).

Q6. *How far back can a payer auditor request records?* **A.** There is no end. While recovery audits currently can only go back 3 years, other audits can go back further or do an extrapolation. The current rash of Supplemental Medical Review Contractor (SMRC) audits are requesting documentation from 2015.

Q7. *We are non-par [nonparticipating] with an insurance company. Can we provide the patient what they need (e.g., insurance forms and/or CPT and ICD-10 codes) to submit to their insurance?* **A.** Submit the claim on the patient's behalf. The patient should be notified that you are non-par and that payment is due at time of service. Exception: Medicaid and Medicare Advantage plans.

Q8. *True or false: The Advance Beneficiary Notice applies to all traditional Part B and Medicare Advantage (MA) Plan patients?* **A.** False. If you forget and accidently append modifier –GA to any MA claim, there will be no payment from the MA plan or the patient.

Q9. *There are several practices in our call group. When I see a postop patient from a physician who is in our call group but is not from my practice, is it appropriate to bill the patient?* **A.** If the patient is seen because of a complication of the surgery, there is no bill. It is as if you were the operating surgeon. If the problem is unrelated to the surgery, then it is appropriate to bill.

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