



CODING ADVISOR

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HOW TO AVOID BUY-AND-BILL DRUG MISTAKES



Address claim issues as they arise to avoid disruption to your revenue cycle.

BY JOY WOODKE, COE, OCS, OCSR

Even a streamlined billing process for retina drugs can be sabotaged by a few mistakes and oversights. Due to low margins, neglecting even a handful of claims or underpayments from payers can significantly and quickly reduce your practice's profitability. A shared commitment to monitoring and addressing claim issues requires constant attention from all practice stakeholders. Included here are common pitfalls that can dramatically disrupt the revenue cycle.

PAYER CONTRACTS

Within insurance payer contracts, practice managers can find the agreed-upon terms for the fee schedule. Properly reviewing and understanding the terms of these agreements is essential because they can significantly affect the practice's reimbursement.

Often, medication reimbursement is a separate clause and is paid as a percentage of the CMS average sales price payment limit. Alternatively, some contracts will assign a unique fee schedule or pay a percentage of the invoiced cost. Some agreements state that the payment will be a percentage of the billed fee. This term is often specified when a not-otherwise-classified (NOC) HCPCS code is billed, which is the initial code used for new drugs until a permanent HCPCS code is assigned.

For example, let's say your practice purchases a newly FDA-approved drug for \$2,000 and you bill a payer with an NOC HCPCS code with the usual and customary fee of \$2,500. If this specific payer's contract states that it pays 60% of the billed fee, the practice will be grossly

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underpaid \$1,500 for the drug. This payment is correct according to the agreed terms, and the remaining balance is a contractual write-off. Carefully review the terms of all payer contracts, and determine an appropriate billed fee to ensure appropriate reimbursement.

CODING MISTAKES

We all make mistakes, but some are more costly than others. Identifying and promptly correcting coding errors related to drug billing is a critical component of managing the revenue cycle in a retina practice. Possible errors can include billing for 1 unit instead of 2, 3, 5, or even 60 units. This expensive mistake is not only an underpayment, but if not corrected, can also be highlighted during a payer audit as a failure. At that point, options to correct the claim may be fairly limited due to timely filing limitations.

Additionally, billing for the incorrect medication will also dramatically affect the bottom line.

To avoid these types of errors, create internal audit reports that target these and other coding mistakes. Once you identify mistakes using the internal audit process, you can submit a voluntary refund followed by a corrected claim.

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INADEQUATE DENIAL MANAGEMENT

Ideally in a retina practice, the appropriate staff are assigned to denial management with a priority focus on drug reimbursement. Nearly 17% of claims are denied initially, which can dramatically affect the accounts receivable and cash flow, especially when considering the volume of drug claims submitted in a retina practice.

A calculated internal process should facilitate the management of each denial to identify if the cause is internal (eg, coding error, incorrect payer, registration mistake) or external (eg, payer not following their own policy, underpayment). When an internal cause is identified, a corrected claim should be submitted promptly, and the encounter should be tracked internally until the full payment is received. Alternatively, when the denial is an external payer-related cause, take immediate action, including sending an appeal or working directly with a provider representative to resolve it.

Here are a few of the most common claim denials caused by internal mistakes:

- using a drug with an off-label frequency or for an off-label diagnosis;
- lacking prior authorization or not following a payer's step-therapy policy;
- missing the necessary anatomical modifiers (eg, -RT, -LT, or -50) for an intravitreal injection, CPT code 67028;
- not reporting modifiers -JW or -JZ appropriately;
- billing the incorrect HCPCS code for bevacizumab (Avastin, Genentech/Roche) per the payer policy (eg, J9035, J7999, or J3490); and
- for commercial and Medicaid payers, not reporting the unit of measure in item 24 following the National Drug Code or incorrect reporting (eg, UN1 instead of ML0.05). ■

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Learn more about managing medication coding, billing, and profitability through the AAO's Medication Inventory Management.



For other practice management tools, visit the AAO's Practice Management for Retina website.

