How to make your optometry and ophthalmology medical claims cleaner and improve cash flow

Researching unpaid or denied claims is a frustrating and time-consuming process. On average, more than 25% of lost practice revenue comes from poor medical billing and revenue cycle management practices. According to the Medical Group Management Association (MGMA), the average cost of reworking a claim is $25.

Closing these gaps requires spot-on attention to patient information, treatment and diagnostic codes, and evolving billing rules and insurance regulations. Trapping all the details so your claims get submitted and paid correctly on time is a challenge for many practices.

Listed below are a few reasons a claim may get denied and how you can troubleshoot the denial.

Missing or invalid information

Verifying a patient's insurance eligibility for the date of service and benefits is a critical first step. Always confirm pertinent information from the patient at check-in or during the data entry process for the claim. Even if one required field, such as an insurance plan ID, SSN-based Health Insurance Claim Number, or the new Medicare Beneficiary Identifier (MBI), this will trigger a rejection or denial. Fast Pay Health ensures demographic and insurance data is correct by verifying plan coverage before submitting a claim.

New or established patient not clear

Patients are considered new if they have not been seen by any physician with the same specialty and sub-specialty within a group practice in the last three years. For solo providers, this is simple—if the patient hasn't been seen in the last three years, they're considered new. But for larger group practices, it can get tricky. Keeping proper records can help avoid this type of rejection. In some instances, an insurance payer may incorrectly reject a claim for a new patient exam. Most of the time this can be cleared up with a phone call to the payer, though some cases may require an appeal with medical documentation.

Referring or ordering physician not listed

In most cases, the referring or ordering physician may be the same as the rendering physician. However, failure to include this information will result in a denial and delay payment. If a required referring physician is missing, Medicare will often split those codes from the rest of a claim to expedite payment. For example, this is most often seen with pachymetry when billed concurrent with an exam—Medicare will split off the pachymetry to return a denial for a missing referring physician while separately processing and paying on the exam.

Provider wasn't credentialed by insurance payer

Always make sure the provider has been credentialed by the insurance plan before submitting the claim, since some insurance payers may require providers to credential (get on insurance panels/board) with specific plans individually. Fast Pay Health simplifies the credentialing process by reviewing documentation to determine the participation status in the health plan, then submitting and tracking provider credentialing applications based on insurance plan requirements.

Service wasn't medically necessary, covered or pre-approved

A service/procedure that was medically necessary last year may now be a non-medical necessity, which means it isn't covered by the insurance payer. Check your Local Coverage Determinations (LCD) policies on the insurance payer's website for a list of covered diagnoses. Also, make sure the service is covered by the insurance payer and, if needed, you obtain pre-approval. For example, many medical plans are no longer paying for eye exams with a diagnosis of blurred vision or a headache. These are considered a routine vision exam.

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Incorrect/missing NPI, TIN, CPT code or modifier

Make sure you include the provider's correct National Provider Identifier (NPI) and Taxpayer Identification Number (TIN) when submitting a claim. If the payer doesn't have the correct provider IDs on file to validate the billing provider's identity, they will reject the claim.

Did you submit the incorrect procedure code or modifier on the claim, or simply leave it blank? Payers will reject your claim even if one of the procedure codes is inconsistent with the modifier used, or a required modifier is missing for the date of service being billed.

For example, modifier 59 defines a "Distinct Procedure Service" and identifies procedures/services that are not normally reported together. Some offices attempt to use modifier 59 in order to get paid for both OCT/GDX and fundus photography, but many practices frequently use the modifier improperly, which can lead to a Medicare audit and possible fines. Though the National Correct Coding Initiative (NCCI) edits do allow the use of modifier 59, determining if it is appropriate under the circumstances can be tricky.

Be careful though as modifier 59 is one of the most used modifiers, and one that is often used incorrectly. Never attach modifier 59 to an E&M service. Depending on the local policy, if the tests are necessary due to two separately identifiable conditions, you may be able to link the appropriate diagnosis code to each CPT and add modifier 59 to the second procedure. It is important to keep up with Local Coverage Determinations (LCD) for your area to ensure you are coding claims correctly.

Chief complaint was missing

When you document the chief complaint, provide a concise description of the problem or laboratory test—this will help you in case you are ever audited. A missing chief complaint can result in a claim denial based on incorrect levels of care.

Billing routine vision or medical insurance

One of the more challenging decisions eye care professionals face is when a patient has both medical and vision plan insurance. It can be confusing and difficult to decide which one to bill, especially when patients want to be part of the decision and are concerned with what they will have to pay. However, there are many circumstances where you can bill vision and/or medical.

For example, an established patient who has both vision and medical plans is seen for a routine annual vision exam. During the dilated eye exam, the doctor detects a choroidal nevus, sometimes called a freckle in the eye. Because melanoma can resemble a nevus, the doctor performs extended ophthalmology services on the same day. The exam can now be billed to the medical insurance since the doctor used medical diagnosis codes. In addition, always list the medical diagnosis codes as primary diagnosis codes to avoid rebilling.

The best practice is to select the insurance plan based on the patient's chief complaint and medical diagnosis, but sometimes it's not that simple. Our Fast Pay Health medical billing and coding experts can help you determine how to bill the visit and make sure claims are clean and free from errors, before we submit them.

Benefit exceeds allowed # of visits or services

Many insurance payers only allow a certain number of visits or services that are covered within a calendar year. Some insurance payers may also limit the number of visits within a 60-day period. For example, some insurance payers only allow one eye exam per calendar year or every other year. Always confirm the patient's eligibility benefits with the insurance payer.

Services weren't bundled

There are some services you can't file separately and may require bundling, such as laboratory profiles with multiple tests or an all-encompassing rate that covers the minor procedure and the pre- and post-procedure visits.

Duplicate claim or service

Did you submit the same claim twice? This often happens if you didn't receive reimbursement within 30 days. Before you re-file a claim, always check with the insurance payer first since they may be processing the claim.

Filing deadline has passed

If a claim is not submitted to the insurance payer within the permitted time frame, it will probably get rejected. Sometimes you only have up to 90 days from the date of service. In addition, if a patient has secondary insurance, you can run into timely filing denials. Many payers require you to bill a secondary carrier within a specific period, after you receive the primary payments.