Claim denials are frustrating for healthcare practices, even though they occur on a daily basis in the Optometry practice. They simply mean that the insurance provider/payer is rejecting or denying the coverage of a service/procedure performed by the optometrist due to certain valid reasons.

Costs associated with denials are high but preventable with continuous monitoring and analysis of the reasons for denials and consequently rectifying the mistakes thereby targeting to completely eliminate them. Consequently, claim denial management is an absolutely essential part of the revenue cycle management process.

A few reasons for denials in Optometry practices are:

Mismatched Diagnosis and Procedures: Coding can go wrong here; when the ICD-10 code does not match the CPT code (for the medical necessity and billing) triggering a denial.

Carrier error: Optometrists lose out as many carriers feel that only routine care comes under the optometry umbrella. But optometrists not only prescribe and fit lenses; they also are trained for diagnosing and treating varied eye diseases.

Coding: Sometimes, optometrists perform the same service more than once a day. For this, payers need to be informed in a different way. First report the service, and on the next line, report the same service again, appending 76 i.e. append modifier 76 which states that the same procedure was performed twice.

Incentive programs: These can be included for staff members for increasing efficiency. Also, share best practices amongst them to increase effectiveness and reimbursements.Appropriate coding practices listed below should be taken into consideration which will avoid denials or rejections

Bilateral Indicator 3 Code: For obtaining full payments, be very accurate with the coding system. For both eyes, submit a quantity of 2 (CPT modifier 50)/ submit on separate lines using HCPCS modifiers RT and LT (for bilateral indicator 1, do not submit quantity of 2).

Bilateral Indicator 2 Code (as per MPFSDB): Quantity should be 1; and do not apply the above mentioned CPT or HCPCS modifier (as applied in bilateral indicator 3 code). Payment is as performed on a bilateral basis.

CPT modifier 24: (Documentation to be applied here) Usage of ICD-10 which is unrelated to the surgery. Item 19 indicates the reason for the visit during the post op period which is not related to the surgery, along with a separate documentation indicating the reason of the visit which is unrelated to the surgery.

Revolution EHR: This is an Electronic Health Record system and a web-based practice management which can be readily used by optometrists for keeping records, accounting, and other complex IT functions. This online system lets the optometrists focus more on patient care rather than bother with billing and coding.

Also, analyze your rejection rate. It is the best indicator which lets you know if you are receiving more denials than normal. Obtain and use the CPT manual that is available from the American Optometric Association and use the apt CPT modifiers while coding to avoid denials in Optometry.