Ask and Answered
Summer 2012

Q&A
Questions from
ASOA EyeMail

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Q: We had a new patient with dementia who decided he would not stay to complete his appointment. The tech had worked up the patient—va, t, conf vf, eom, pupil, hpi, hx—the whole nine yards, but the patient had to leave before the doctor could see him. Can we charge a 99211?

Answer from the expert, E. Ann Rose, Rose and Associates
It depends. If you expect the patient to return again in a few days, then the answer is no. An eye exam does not have to be completed at one session. The doctor can complete the exam at a second visit and then bill the total exam at that time. If you do not expect the patient to return, then bill code 99211.

Q: I had to terminate an employee last week due to poor performance involving fraudulently documenting things in a patient’s chart. She was already on probation due to her numerous charting errors and missed testing.

She is now requesting a copy of her termination letter. Our employee manual states that the employee, with prior notice, can review the employee file in the presence of a practice representative, but it also states that all of the contents of the file are the practice’s property. Do I have to give her a copy?

Answer from a peer
I am not sure about the legal side, but I would release it as a matter of courtesy and ensure that the termination letter clearly states the reason for termination.

I would spend a few bucks and get a quick legal opinion from your attorney.

Did she sign the termination letter, or sign for receipt of it? I believe if she signed it, she is entitled to a copy, but like I said, I’d check with a labor attorney in your state.

Q: We generally encourage patients to make their next appointment during the checkout process. Patients who don’t want to do this are entered into our recall system. These patients receive a reminder letter one month before they are due back, which has only proven to be 20% effective (instead of the 40% benchmark) for us.

Patients who do not make an appointment after receiving the letter end up on an overdue recall list the following month. The success rate of the initial call is about 20% as well. We recall the patient monthly for 5 months before closing the recall. I feel that this is too aggressive and could cause patients not to return because they feel harassed. It is also extremely costly when you consider staff time and telephone charges.

How do you handle it, and how many calls are too many?

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Answer from a peer
We send recall cards for patients who also want a reminder at 1 month, 3, 6, and of course 12 months/annually. If they do not respond, and their case is not urgent (e.g., a patient at risk with angle-closure glaucoma), we send recalls each month for five more months. If the patient is a risk patient, the front desk staff calls them to make the appointment.

I have been toying with the idea of calling all “recall” patients when the doctor is not in the office 2 days a week, if the work load will permit it, and will try this system [this summer].

Q: I have a problem with one tech not logging off EHR when she is finished working up patients. I have repeatedly asked her to make sure she logs off. She replies, “I’m tired of having to log on and off every time I leave the room.” I say, “It’s not about you, it’s about HIPAA regulations and patient confidentiality.” Do any of you have a written policy regarding this? (This is my doctor’s favorite tech who can do no wrong.)

Answers from your peers
• You might want to remind her that the penalties for HIPAA breaches now include both civil and criminal, and if there is a breach in the practice because she didn’t follow policy that she will be the one held responsible.
• We have a section in our High Tech policy that specifically addresses this issue. This policy was put in place as partial compliance with Stage 1 MU.
• Logging off computer systems should be part of your compliance plan as it is one of the primary security measures that your practice should employ. You are absolutely correct that is a significant HIPAA violation to leave patient data, and access to additional patient data, on the screen when there is a patient in the room. I suggest that you speak to the tech in the presence of the doctor and stress the importance of following protocol. I assume that the physician will support your position and indicate that he, too, logs off between patients as is required. You might want to set things up with the physician on this issue before the meeting with the tech so you get the appropriate response from him.
• When it comes to compliance, there are no “favorites.” There should be a zero tolerance policy regarding this issue and a progressive disciplinary action plan in place. If the company knows that the employee is not compliant and doesn’t enforce policy, the company could be construed as having condoned the behavior, which puts the company at risk for having willfully participated if there is a breach of patient information. The penalties increase drastically when a company doesn’t follow the policy. You might also remind the tech that if she is found to be deliberately violating policy if a breach occurs. Maybe the potential impact on her pocketbook will catch her attention.
• Alongside verbal and written warnings, have IT place an auto log off in the log in that logs a user off after a prescribed amount of inactivity.
• Your EHR should have an automatic log off after X number of minutes (user preferences). There is also bluetooth technology that will log a user in and out of windows as they enter and leave the room.

Q: We had a patient that had two lid lesions removed on the same eye—my biller wants to submit 67840-51-E2 and 67840-E2, two separate line items. Is this the correct way to bill this?

Answer from the expert, E. Ann Rose, Rose and Associates
Code 67840 is payable per session/per eye. Since lesions were removed from both eyelids of both eyes (regardless of the number of lesions removed), you should bill 67840-50. Just want to show you something from AAO that verifies my answer as well:

Case #4
Scenario: The payer audited 15 records of CPT code 67840 Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure. In order to use this code, removal must include more than skin (i.e., involving lid margin, tarsus and/or palpebral conjunctiva). On each of the 15 charts, the surgeon has removed the multiple lesions on the upper and lower lids of the same eye. The typical claim submitted was: 67840-E1 = $276; 67840-59-51-E1 = $138 (50 percent reduction); 67840-51-E2 = $138 (50 percent reduction).

Error: CPT code 67840 is payable per eye, not per lid or lesion, resulting in an overpayment of $276 per claim x 15 ($4,140 total), but that’s not the worst of it. Chart documentation did not warrant that level of service, and all 15 charts were down-coded to CPT code 11440 Excision, other benign lesion, including margins, except skin tag, eyelids. CPT code 11440 is payable per session, not per lesion, lid, or eye.