Maximizing Optometry Practice Revenue through Accurate Coding and Billing

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Top Ten Reasons Revenue not Optimized

1. Not enough medical patients
2. No cross-selling or education.
3. Unsure what level of office visit to report.
4. Improper training of staff
5. Stop sending claims after 50% or more of carriers deny the claim.
6. Do not appeal denied claims.
8. Do not understand the concept of carrier-specific guidelines.
9. Work the basics: glaucoma, cataracts, dry eye syndrome
10. Niche marketing: vision therapy, low vision, screenings.
Top Tricks

1. Marketing to older, sicker patients.
2. Educate and sell your medical business
3. Codes 99050 and 99058
4. Reporting punctal plugs
5. Billing a refraction service (92015) linked to a medical diagnosis.
6. Understanding Medical Decision Making (MDM).
7. Using Local Coverage Determinations (LCD)
9. Using time to determine the level of an office visit.
10. Selling anti-oxidant nutritional supplements.
Medical terminology and anatomy

• This is very important in coding, auditing and understand diseases and conditions.
• Know your sub-terms.
• Know your prefixes and suffixes.
• Know anterior segment, posterior segment, and external ocular adnexa.
• Know format of the ICD-10 manual: anterior of the eye (adnexa) to the posterior (retina) plus other conditions (refraction, blindness, accidents).
• See uveal tissue example.
Example of Anatomy and Coding

- 65280 Repair of laceration; cornea ... not involving "uveal tissue“ (estimated Medicare allowable amount is $772  [fully implemented non-fac RVU=20.1])
- 65285 Repair of laceration; cornea ... with ... "uveal tissue“(estimated Medicare allowable amount is $1,179 [fully implemented non-fac RVU=32.92]).
- If the coder never asks and the surgeon never documents that “uveal tissue” was involved, then this procedure will never be reported correctly. The difference is $407!
- Where and what exactly is the uvea?
  The uvea is the: iris, ciliary body and the choroid. These are all contiguous structures of the eye.
Ranking of Guidelines (CPT Concepts)

State Regulations

State Boards (Optometry / Ophthalmology)

Medicaid Guidelines

Private Payor Guidelines

Medicare Guidelines

General CPT Concepts – AMA Guidelines

If Medicare guidelines disagree with AMA CPT guidelines who do you go with?
Self-Pay Patients

Two main options:
• Offer a **discount** if paid in full at time of service.
• Some clinics use S HCPC codes (**S0620** and **S0621**).
• You should not charge customers less than you charge Medicare if you are contracted with Medicare.
• What is your “usual and customary fee?”
• Do not have two fee schedules—two prices for the same CPT code.
• Some state societies advise to never use HCPC S codes for office visits.
• I do not know of a case where an optometrist was audited and fined for self-pay.
• This is a legal issue. **Always check with a lawyer.**
Vision Plans

• VSP, EyeMed, Davis, Spectera
• Most combine a refraction exam (92015) with a routine vision exam (920xx).
• Be sure to explain to every patient that you are performing two, separate, discrete services.
• They make up their own rules, guidelines, and interpretations.
• Check their manual if dilation is required.
• Check manual if vision plan will pay a routine visit on a patient with a chronic illness.
• Determine your clinic policy on whether chronic illness patients receive their one routine vision visit once per year.
Routine Vision Exam

- No specific CPT Code
- ICD-9 code is V72.0. ICD-10 will be Z01.00 and Z01.01.
- Link to 920xx.
- S Codes S0620 and S0621
- Not a refraction exam. Always explain this to your patients!
- Can include up to 14 exam elements.
- Some optometry boards list a minimal routine vision exam.
- No national definition of what elements are included.
- The word “routine” is no longer in ICD-10.
Explain Everything!

• Always explain that a routine exam is not an exam for glasses! It is an exam to uncover medical pathology.
• Have information about diabetes and glaucoma available and be sure all your vision plan patients get a copy.
• Always ask relevant questions when scheduling every appointment. Do you have blurry vision, floaters and flashers, night blindness, glare, headaches or difficulty reading, driving, or watching television?
• Every employee should be engaged.
Conditions discovered by an Eye Exam.

- High blood pressure
- Diabetes
- Blurry vision and severe headaches (Dx: a tumor growing near the patient’s pituitary gland)
- Ocular melanoma (cancer)
- Muscular sclerosis
Maintain a good relationship with Ophthalmologists in your area

• Co-management
• You manage the stable glaucoma and cataract patients.
• Be sure that all Ophthalmologists are aware of your clinical expertise.
• Post-cataract glasses (if you provide this service)
• Any reimbursement for referrals is illegal.
Increase the suite of medical diseases you treat.

• Use coding and documentation to market your clinical ability to your patients.
• Documentation is good.
• Always be chatting up patient’s about the medical conditions you treat.
• Use vision plans as an opportunity to obtain referrals and explain your medical services.
• Use a coupon for eyeglasses as an incentive for a medical referral. Offer a discount on a second pair.
Always ask for referrals

• A refraction exam (CPT Code 92015) is to prescribe glasses. Eyeglasses will always be part of your business.
• The purpose of a 920xx exam is to determine if they have any medical problems.
• I recommend providing each patient with a list of the 14 exam elements and why each is performed.
Everyone sells

• Everyone in your office, including the receptionist and the tech’s, should be able to explain the elements of an exam, the diagnostic tests and why they are performed. This includes the refraction exam, the comprehensive exam as well as the diagnostic tests.

• Check [www.ophthobook.com](http://www.ophthobook.com) for a very good free 134 page clinical manual on Eyecare. It’s a great overview written by an ophthalmologist.
Carrier-Specific Rules

• Many consultants don’t teach this concept.
• Bob, at a national convention, told me to bill it this way.
• A consultant, who works in a particular clinic in the same city for 20 years.
• There are different Medicare jurisdictions and providers.
• There are over 50 different Blue Cross/Blue Shield plans.
• Every state Medicaid is different.
• You need to know the difference between a national rule and a carrier-specific one.
• MOD-50 vs RT/LT; MOD-59; requiring documentation, units for co-management are all examples.
• Create a carrier-specific manual in your office.
Carrier Tips and Tricks

• When calling your carrier always get the person’s name and email address if possible.
• Chat them up and compliment them on how hard they work. Be nice even if you are frustrated with them.
• When you ask them what modifier to use they will say, “we cannot tell you how to code.”
• Always work to get a carrier representative for your top carriers (Medicare, Medicaid, Blue Cross).
• Always get any unique instructions in writing. Ask for their E-mail address and send them an overview of the discussion and request an e-mail reply.
Medicare Guidelines

• Well over 1400 pages.
• Very detailed payment and documentation guidelines.
• About 74% of private carriers follow Medicare guidelines.
• Most guidelines are local and not national for Eyecare.
• Medicare and the OIG will audit you.
• Medicare never pays for refraction services or glasses.
• Medicare Concepts:
  – “Incident To” Services
  – Local Coverage Determinations
  – 1997 Exam Guidelines
Local Coverage Determinations

- LCD’s are published by your local Medicare provider.
- There are approx. 12 jurisdictions in the US.
- Medicare is not one monolithic agency regarding reimbursement. Every Medicare intermediary has slightly different rules and guidelines.
- Go to your Medicare website; find Provider information, find LCD’s or publications; review the long list of LCD’s and find all that pertain to Eyecare.
- The number of CPT codes covered will range from 6 to 18.
- If your carrier does not have an LCD find another one from another Medicare carrier (a different state).
Top Ten Medicare Part-B Denials (all specialties)

1. Duplicate Claims
2. Medical Necessity
3. Medicare Advantage Plans
4. Provider Eligibility
5. NCCI Edits
6. Screening/Routine
7. Non-Covered Service
8. Patient Supplies
9. Non-Covered Charge
10. Timely Filing
Advance Beneficiary Notice (ABN)

- Required by Medicare if you want to bill the patient for a non-covered service (does not meet medical necessity).
- Have the patient fill out the form. Explain that you may be paid, but if not then they are responsible.
- Append **modifier GA** to the code.
- Use on pachymetry.
- Use on screenings without medical necessity (e.g., fundus photography).
- Be sure you have the latest version. Download from the Medicare website.
Medicare Modifier -GY

- MOD-GY – Clinical Dx not covered by Medicare
- How is MOD-GY used in Eyecare?
- Add to refraction services 92015 when Medicare is primary and the secondary carrier pays on refraction.
- MOD-GY means the Medicare carrier will deny the claim and crossover to the secondary.
- If refraction services are a covered service, the secondary should pay.
- Note: Some Medicare carriers will cross over 92015 without MOD-GY. What should you do?
- Note: Sometimes the crossover does not automatically work and you need to send the claim manually. What should you do?
Private Medical Insurance

• BCBS, United healthcare, Anthem, Cigna, Aetna and many others.
• Most follow Medicare guidelines—but they don’t have to.
• When your claim is denied always ask if their guideline is published in their manual or a bulletin.
• They can have different interpretations or reimbursement guidelines than Medicare, other private payers, or CPT.
Medicaid

- Combined state and federal but mostly a state program.
- Reimbursement and guidelines can vary widely by state.
- May have unique guidelines or requirements unique only to them.
- Many offer refraction and routine vision services.
- Many offer vision therapy services.
- Some require Binocularity (stereo vision) and color vision.
Tips on Appeals

• State the facts.
• Be clear on your credentials or background.
• Be very specific on CPT, ICD-9 and HCPCS rules and guidelines.
• Always reference medical necessity, modifier rules, NCCI edits, the bilateral surgery modifier and global days number as necessary.
• Be clear that you understand the appeals process.
• The more informed you are (and appear) the more likely you will get paid.
Twelve Appeal Steps

1. Identify a Rejection VS Denial
2. Get organized before you call
3. Identify the Carrier / gather the manual or LCD.
4. Is this a non-covered service?
5. Is pre-authorization always required?
6. ICD-9 Linking
7. NCCI Edit?
8. Correct Modifier?
9. Is this a carrier-specific rule?
10. Is this worth appealing? Can you win?
11. Contact the carrier
12. Appeal as many times (levels) as necessary to get paid.
992xx versus 920xx codes

• A few questions everyone must know?
• What is required for Intermediate 920x2 exam?
• What is required for Comprehensive 920x4 exam?
• What is the number one reason not to report a 920x4 exam?
• How many Exam elements are there in total?
• How many HPI elements are there?
• How many ROS elements are there?
920xx codes

- **Intermediate Exam**: 920x2: 3-8 exam elements
  - Required: **external ocular adnexa**

- **Comprehensive Exam**: 920x4: 9 -14 exam elements
  - Required: **external ocular adnexa, Extra Ocular Motility, Confrontation Fields**
  - **Dilation** not required per CPT but some Medicare carriers do require it! It is a carrier-specific rule.
  - Always perform review of family Hx; recommend proper HPI and ROS even though not specifically required. MDM not an issue.
  - Initiation of a diagnostic and therapeutic treatment as indicated. [see next slide]
Comprehensive Eye Exams (92004 & 92014)

A comprehensive exam always includes “initiation of diagnostic and treatment programs as indicated.” At least one of the following must be included:

1. Prescription of medication*
2. Arranging for special ophthalmological diagnostic or treatment services
3. Consultations
4. Laboratory procedures
5. Radiological services

*a prescription for eyeglasses was included in a now retired LCD from Trailblazer MCR).

One option is to include documentation for the initiation of therapeutic anti-oxidants for ARMD and dry eyes (Even if you don’t sell them the vitamins) [Next Slide].
Do you sell supplements for ARMD?

• Educating your patient and the therapeutic regimen of nutritional supplements for ARMD, properly documented, should be sufficient to meet the requirement for the “initiation of therapeutic program as indicated.”

• Also it is PQRI measure so you get credit toward your PQRI measurements. Measure 140: Age-Related Macular Degeneration (AMD): Counseling on Antioxidant ... Antioxidant Vitamin and Mineral Supplements (4177F)

• You can earn extra income from selling the supplements.
Incident-To Services (E & M Code 99211)

• A minimal **Provider E & M visit** should be a 99212, not a 99211.
• 99211 does not require the presence of a Provider. Sometimes referred to as an “**Incident-To**” Service (Medicare Concept)
• Do not report this code whenever a tech performs a test (99211 plus 92083 or 99211 and pachymetry. It is highly unlikely the claim will be paid. That is a national NCCI edit violation.
• If a patient has an IOP check without seeing the provider then a 99211 could be reported.
• If a tech or nurse is providing nutrition-therapy services for ARMD patients including minimal exam elements and History.
E & M Exam

These are the Medicare 1997 E & M Guidelines for Eyecare

- 14 elements; 12 vision and 2 Psych.
- 1-5: Problem Focused (PF) [99212]
- 6: Expanded Problem Focused (EPF) [99213]
- 9: Detailed [99214]
- 12 + 1 is comprehensive exam (note it’s the same name as a 92014 exam!) [99215]

- 2 additional exam elements for children (VSP and Medicaid) not part of 14 above and not required by Medicare.

- **Binocularity** (stereo vision) and **color vision**. Be sure to include them in your progress notes or EMR. I, as well as most Eyecare professionals consider the cover test and/or phorias to be a subset.
### 992xx Examination Components - Eye

#### Selecting Exam Elements (14) - Example

<table>
<thead>
<tr>
<th></th>
<th>PF 1-5</th>
<th>EPF 6</th>
<th>Det 9</th>
<th>Comp 12+1</th>
</tr>
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<tbody>
<tr>
<td>1. VA</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2. CF</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3. EOM</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. Conjunctiva</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5. Pupils/Iris</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>6. IOP</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>7. Adnexa</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>8. Cornea</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9. Lens</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10. A/ C</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>11. Disks (Dil.)</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>12. Retina (Dil.)</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>13. A+OX3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>14. Mood</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Using Time to Determine the Level of an E & M Encounter

• While not part of this presentation, if the MDM clearly does not support a higher level, if the documentation supports, you might consider using Counseling and/or Coordination of Care and Time to determine the Level of E & M. That is better than upcoding.

• Always document two times: total time and counseling time and be very specific to that patient and that Date of Service on what was discussed. Recommend three sentences unique to this patient and this date of service (DOS). No cloned notes!
Special Codes : 99050

- 99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service. Medicare does not pay on this service.

<table>
<thead>
<tr>
<th>Report both codes:</th>
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<tbody>
<tr>
<td>99213</td>
</tr>
<tr>
<td>99050</td>
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</table>
Special Codes: 99058

- 99058: Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service. Not paid by Medicare.

<table>
<thead>
<tr>
<th>Report both codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
</tr>
<tr>
<td>99058</td>
</tr>
</tbody>
</table>
“Casino” Health Insurance

• The best insurance plan in your area.
• Actually, casino’s really do have good insurance.
• Use coding to find these plans. Examples are codes 99050 (non-work hours) and 99058 (disruption of schedule). Only a few carriers in any given city pay on these; those that do are considered “provider friendly” insurance companies.
• Find out which employers use this insurance.
• Market to their employer. Visit the HR director. Conduct an eye fair once a year. Sell your medical screening services.
Co-Management

• Another provider (optometrist) provides the follow-up care (post-op care, co-management) of a 90-day global surgery patient. It can be any number of days (87, 60, 45) your reimbursement will be prorated.
• The surgeon reports with Mod-54.
• The optometrist reports with Mod-55 and RT or LT.
• Your reimbursement is 20% of the Medicare allowable.
• Some Medicare carriers have slightly different reporting rules and guidelines. A few require that units = days. Always confirm with your specific Medicare carrier.
Co-Management – Cataract Surgery – First Eye

Dr. Gregory House

Assumption Date: 10/16/2012  Relinquish Date: 1/10/2013

366.16  Nuclear Cataract - Senile

<table>
<thead>
<tr>
<th>DATE(S) OF SERVICE</th>
<th>Place of Service</th>
<th>PROCEDURES, SERVICES, OR SUPPLIES</th>
<th>DIAGNOSIS CODE</th>
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<tbody>
<tr>
<td>10/15/2012</td>
<td></td>
<td>66984</td>
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</table>

NPI Number

Units

1
92015 and a medical Dx

---

<table>
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<th>DATE(S) OF SERVICE</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>PROCEDURES, SERVICES, OR SUPPLIES</th>
<th>DIAGNOSIS CODE</th>
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<tbody>
<tr>
<td>10/15/2012</td>
<td>I1</td>
<td>92014</td>
<td></td>
<td>1, 4</td>
</tr>
<tr>
<td>10/15/2012</td>
<td>I1</td>
<td>92083</td>
<td></td>
<td>1, 4</td>
</tr>
<tr>
<td>10/15/2012</td>
<td>I1</td>
<td>92015</td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

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92015 IS paid by many private medical plans if the ICD-9 code is a medical Dx and not refraction. Paid on cataract Dx. Is 92014 allowed? With MOD-25?
### Punctal Plugs: ICD-9

<table>
<thead>
<tr>
<th>Date of Current Illness</th>
<th>If Patient Has Had Same or Similar Illness</th>
<th>Name of Referring Physician or Other Source</th>
<th>Reserved for Local Use</th>
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</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>GIVE FIRST DATE MM DD YY</td>
<td>I.D. NUMBER OF REFERRING PHYSICIAN</td>
<td></td>
</tr>
</tbody>
</table>

#### Diagnosis

1. **365.02 anat. narrow angle glaucoma**
2. **333.81 blepharospasm**
3. **375.15 DES**

#### Procedures

<table>
<thead>
<tr>
<th>Date(s) of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, or Supplies</th>
<th>Diagnosis Code</th>
<th>Units</th>
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<tbody>
<tr>
<td>10/15/2012</td>
<td>11</td>
<td></td>
<td>99214</td>
<td>25</td>
<td>1, 2, 4</td>
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<tr>
<td>10/15/2012</td>
<td>11</td>
<td></td>
<td>68761</td>
<td>E1</td>
<td>3</td>
</tr>
<tr>
<td>10/15/2012</td>
<td>11</td>
<td></td>
<td>68761</td>
<td>51 E2</td>
<td>3</td>
</tr>
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</table>

**MOD-51 is added to second procedure on other eyelid.**
Punctal plug HCPC codes

• Remember, Medicare does not pay on these and has not for over ten years.
• A4262 temporary (collagen) plug
• A3463 permanent (silicone) plug
• However, occasionally, a private payer will pay. This is not a compliance issue, it’s simply a good payer and you want to find any carrier in your area that pays on these. It may only be one or two out of twenty-five. But still, it’s worth the effort. Find out which company offers this insurance and conduct an eye fair once a year.
Bandage Contact Lenses

• 92071 (corneal abrasion)
• 92072 (keratoconus) BCL Bandage Contact Lens;
• Fitting of contact lens for treatment of disease, including supply of lens. Reimbursement depends on the ICD-9 codes reported (medical necessity). These were introduced in 2012.
**Corneal Abrasion & glaucoma (contacts)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Code</th>
<th>Description</th>
<th>Units</th>
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</thead>
<tbody>
<tr>
<td>10/15/2012</td>
<td>99213</td>
<td>Low tension</td>
<td>1</td>
</tr>
<tr>
<td>10/15/2012</td>
<td>92071</td>
<td>corneal abrasion</td>
<td>2</td>
</tr>
<tr>
<td>10/15/2012</td>
<td>92285</td>
<td>2nd iritis</td>
<td>3</td>
</tr>
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</table>

*Anterior Segment Photography is inherently bilateral*
Diagnostic Tests

• In the Medicine section of CPT.
• No global period.
• No E & M component—but many insurance companies want a Mod-25 on the E & M code.
• Always include the interpretation and report.
• You cannot report an office visit based on discussing the results of a test. The Hx, Exam, and MDM must support the level. You might report a 99212 and report at least one exam element.
More on Diagnostic Tests

• Many of the diagnostic tests are covered in my next session.
• A provider does not need to perform any diagnostic test. A tech can perform it.
• Can a patient be seen for a test only? (e.g., patient comes for a visual field test, interpreted by doctor but patient is not physically examined by doctor on same day).
• The interpretation and report must be completed by the provider.
• Can I report a minimal office visit (99211) with a visual field exam or OCT? [Answer is No]
Medical Necessity

- It the one-to-one linking of a diagnosis to a CPT code to support medical necessity.
- Some CPT codes require two diagnoses.
- Some CPT codes are paid only on a very specific diagnosis.
- The source for medical necessity is the Local Coverage Determination.
- Without medical necessity, the procedure is a screening.
- This is the “catch 22” of healthcare.
- If unsure if paid, have the patient fill out an ABN (Medicare) or a similar private carrier form stating they are responsible if the carrier does not pay.
Medical Necessity

- Medicare LCD 25466 for **92225, extended ophthalmoscopy**: Symptoms suggestive of retinal defect (ex: flashes and/or floaters). ICD-9 codes listed supporting medical necessity include:
  - 368.13: Visual discomfort
  - 368.15: Subjective visual disturbances: other visual distortions and entopic phenomena (photophobia, flashers, visual halos).
  - 379.24 Disorders of vitreous body (floaters)
**Floaters - 379.24**

*What is supported?*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>76510</td>
<td>Ophthalmic US</td>
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<tr>
<td>76512</td>
<td>Ophthalmic US</td>
</tr>
<tr>
<td>76513</td>
<td>Ophthalmic US</td>
</tr>
<tr>
<td>92132</td>
<td>GDX, Int. Segment</td>
</tr>
<tr>
<td>92133</td>
<td>GDX</td>
</tr>
<tr>
<td>92134</td>
<td>GDX</td>
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<tr>
<td>92225</td>
<td>Ext. Ophthalmoscopy</td>
</tr>
<tr>
<td>92226</td>
<td>Ext. Ophthalmoscopy</td>
</tr>
<tr>
<td>92250</td>
<td>Fundus photography</td>
</tr>
</tbody>
</table>
Screenings

- Any procedure performed in the absence of a diagnosis supporting medical necessity.
- Fundus photography.
- Pachymetry
- Always link a routine vision exam (920xx code) to V72.0 if there are no medical codes to link to it.
- Two specific screening codes for glaucoma are below.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0117</td>
<td>Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist</td>
</tr>
<tr>
<td>G0118</td>
<td>Glaucoma screening for high risk patient furnished under the <strong>direct supervision</strong> of an optometrist or ophthalmologist</td>
</tr>
</tbody>
</table>
Recent Live Seminar Feedback

- July 2014 class in Hartford CT claimed that blurry vision (368.8) was paid by NGS Medicare. I do not see this nationally so recommend everyone confirm if this diagnosis is sufficient for a medical office visit encounter (e.g., 99212 or 99213). Most do not bill it as the only linked dx.

- Be sure to include in your assessment your rule-out, decision-making process to warrant the level of history and exam elements.

- Remember that you can document rule-outs, just don’t report them. Report all signs and symptoms relevant to the visit today.
Blurred Vision

Document your “rule-outs” when reporting only blurred vision as the primary medical diagnosis. Options include:

- bacterial infection, such as trachoma
- cataract
- corneal abrasion or infection
- glaucoma
- inadequate prescription glasses or contact lens
- macular degeneration
- migraine headache
- optic nerve problem
- trauma or injury to the eye
- tumor
Long-Term Use of a High-Risk Drug

• You are reimbursed for an office visit, fundus photography and visual field exam linked to code V58.69 and the related disease. **These are reimbursed screenings.** This code depends on the type of drug (steroids, NSAIDS, blood thinners, insulin).

• Follow up for **completed treatment** for a high-risk drug is V67.51

• Plaquenil
• Boniva
• Flomax
• Accutane
• Steroid use
• Dozens more…
Plaquenil toxicity

• http://www.aao.org/publications/eyenet/201105/retina1.cfm

• There are hundreds of drugs with potential retinal toxicity.
  Plaquenil toxicity isn’t even in the top 10, or the top 100” if you’re looking at incidence, he said. “It’s a pretty rare thing.”
  –Frederick W. “Rick” Fraunfelder, MD

• Hydroxychloroquine is an analogue of Plaquenil.
  “Anne E. Fung, MD, a retina specialist at Pacific Eye Associates in San Francisco, averages one Plaquenil screening a week and in 10 years of practice, she’s seen just one case of toxicity. Dr. Marmor, on the other hand, has seen at least 10 cases in the past year.”

• Plaquenil has a long half life. Nine years after discontinuing medical therapy, one patient had new scotomas, difficulty reading and progression of bull’s-eye maculopathy.
### Screening for High Risk Drug - Plaquenil

<table>
<thead>
<tr>
<th>Diagnosis/Condition</th>
<th>Code</th>
<th>Date(s) of Service</th>
<th>Place of Service</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Diagnosis Code</th>
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<tbody>
<tr>
<td>Papilledema</td>
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<td>03/1/2010</td>
<td>11</td>
<td>92225</td>
<td>-RT</td>
<td>1</td>
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<tr>
<td>Rheumatoid arthritis</td>
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<td>03/1/2010</td>
<td>11</td>
<td>99213</td>
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<td>Other adenoviral conjunctivitis</td>
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<td>03/1/2010</td>
<td>11</td>
<td>87809</td>
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</tbody>
</table>

**Screening – Plaquenil and Rheumatoid Arthritis**
Modifiers

- These are appended to CPT and HCPC codes.
- MOD-24, Unrelated E & M visit during global period.
- MOD-25, small procedure with Unrelated E & M on same DOS
- MOD-50, bilateral
- MOD-59, two procedures not normally perform on same DOS
- MOD-22, difficult procedure
- MOD-51, additional surgical procedures on same DOS (append to second procedure such as punctal plugs).
- These are covered in more detail in the next presentation.
Small surgical procedures

- Epilation: 67820 (forceps) modifiers E1-E4, or RT or LT.
- Punctal plug insertion: 68761, modifiers E1-E4, Add Mod-51 to second procedure on same DOS.
- Foreign body removal, cornea: (65220 or 65222 [slit lamp]) [global period is zero–day of service only]

- 10-day global or zero day global.
- Need adequate documentation.
- Should always be “separately identifiable” if reported with an E &M [e.g., link E & M to glaucoma or cataract] with modifier 25.
NCCI Edits

• National Correct Coding Initiative
• Not in the CPT manual
• Medicare has files you can download (excel, ASCII)
• Long lists of codes that cannot be reported on the same DOS.
• Breakable edits (integrated in procedure)
• Unbreakable edits (not considered medical necessary)
• Use Mod-59 to break an edit. This is for two procedures on the same DOS. 2nd procedure must be separately identifiable.
• Most common Eyecare edit: OCT/GDX and fundus photography. Always appeal if denied.
Question on Modifier 59

• Examples of mutually exclusive codes/tests in eye care. If we perform both fundus photos and OCT, for instance, do we bill both for accuracy or pick one or the other to bill?
• Both tests must be clinically necessary to determine “separately identifiable” problems or conditions.
• I would not report both procedures to determine the accuracy of a singular problem such as: retinal detachment, glaucoma, swollen optic discs, or a papilledema.
• OCT and Fundus photography: Append MOD-59 to the second procedure and link to two different Dx and always appeal if denied.
Professional Component

• All radiological procedures and diagnostics with an image or tracing include a professional and technical component. If you own the equipment, use your own tech, and document the interpretation and report—simply report the procedure without any modifiers.

• MOD-26: Professional Component Only

• This is the Interpretation and Report (discussed next).

• Fundus photography

• Visual Field exam

• OCT/GDX

• X-rays

• External photography
Interpretation and Report

• Three main components.
• Do not list “normal.”
• Recommend separate from office visit documentation.
• Medicare LCD. BCBS Bulletin. AMA: owner of CPT©
• Include a sentence on the three categories below:
  1. Clinical Findings
  2. Comparative Data
  3. Clinical management
Technical Component

• Report with MOD-TC
• This is the payment for the equipment and the tech’s time for the diagnostic or x-ray equipment.
• Anything with an image or tracing.
• You do not perform the professional component (MOD-26)
• The other doctor performs the interpretation and report.
• If you have the equipment and perform the test, report the procedure with MOD-TC, the other doctor reports with MOD-26.
Medicare PFSRVU database

- **Physician Fee Service and Relative Value Unit** database. An ASCII/excel file on the Medicare website. It is free to download.

- **Includes:**
  - RVU data
  - Bilateral surgery modifier
  - Global Days
  - Breakable or not breakable NCCI edit flag.
  - Professional and Technical Component
  - Much more.
Global Period

- Also called Global Fee or Global Days
- Applies to surgical procedures.
- Zero days
- 10 days
- 90 days
- Not applicable to diagnostic tests such as fundus photography, visual field exam.
- Co-management

Why do I care?
Global Days for Top Codes

• All Diagnostic Codes are XXX or no global days. They are not surgical procedures. Surgical Codes with zero global days are:

• 67820  Zero
• 65205  Zero
• 65210  Zero
• 65220  Zero
• 65222  Zero
• 65430  Zero
• 65435  Zero
Global Days for Top Codes

• Surgical Procedures with ten global days:
  • 68761 Ten
  • 67938 Ten
  • 10120 Ten
  • 10121 Ten
Bilateral surgery modifier

• 1 = Unilateral
• 2 = Bilateral
• 9 = Concept does not apply
• 3 = 150 % rule does not apply
• These flags are in the Medicare PFSRVU database.
• Some diagnostic codes are inherently bilateral such as **fundus photography** and **visual field exams**.
• These are **Not** in the CPT manual.
Bilateral Surgery Modifier = 2

<table>
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<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
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Relative Value Units (RVU’s)

- Relative Value Unit
- All reimbursable procedures/services have an RVU value.
- E & M codes, surgical procedures, diagnostics, labs, radiology.
- Small procedures have low RVU
- Large procedures have high RVU’s
- Determines your reimbursement.
- EyeCodingForum Coding Advisor has RVU’s
- Coding specialty manuals
- List CPT codes in decreasing RVU value.
- **Not** in the CPT manual.
## RVU’s 2014 (LA CA)

<table>
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<th>E &amp; M</th>
<th>Total RVU</th>
<th>Medicine Exam</th>
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<td>92002</td>
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<td>99212</td>
<td>1.22</td>
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<td>99213</td>
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<td>92012</td>
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<td>99214</td>
<td>3.01</td>
<td>92014</td>
<td>3.52</td>
</tr>
<tr>
<td>99215</td>
<td>4.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E &amp; M</td>
<td>Total</td>
<td>Medicine Exam</td>
<td>Total</td>
</tr>
<tr>
<td>-------</td>
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<tr>
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<td>$79.63</td>
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<td>$96.02</td>
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<td>99214</td>
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<td>$138.75</td>
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<tr>
<td>99215</td>
<td>$156.62</td>
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</tr>
</tbody>
</table>

Medicare Allowable 2014 (LA CA) CF: $35.822
Medicare Conversion Factor (CF)

• For new patients, E & M codes the RVU’s are higher.
• For established patients, the 9201x codes have a higher RVU.
• Total RVU’s are multiplied by the conversion factor to provide the Medicare allowable amount.
• Medicare 2014 January 1 to March 31, 2014, was $35.8228.
Upcoding/Downcoding

- **Upcoding**: reporting a higher level than documented or warranted based on documentation.
- MDM is the main culprit
- Known the 2 of 3 rule.
- Comprehensive ROS must be 10 or more. Comp Exam requires 12 plus 1.
- 50% rule – this is my concept concerning auditors.
- Suzie said so and so.
- History/Exam and MDM.
- **Downcoding** – simply losing money.
- Is it fraudulent or illegal to downcode?
What about *red flags*?

- Don’t be concerned about red flags—audit-proof your documentation.
- You **want** to be reporting higher level visits and more diagnostic tests than your competitors.
- Just be able to explain **why**.
- Common targets:
  - Modifier 25
  - Modifier 59
  - Level IV exams.
  - Excessive color vision or visual field exams.
Vision Therapy Services

• This is a great opportunity for Optometrists. Ophthalmologists don't believe in orthoptic training. Most Optometrists perform this as a cash-only service.

• Perform a Visual Training Evaluation to set up a training program. Note in CMS-1500 Box 19: Visual efficiency evaluation – 92060 (sensorimotor exam)
Sensorimotor Exam 92060

Codes used for the initial Vision Therapy Evaluation.

A sensorimotor exam includes measurement of ocular alignment in more than one field of gaze and at distance and/or near, and inclusion of at least one appropriate sensory test in patients who are able to respond.

It includes multiple measurement of ocular deviations (e.g. restrictions or paretic muscle with diplopia) with interpretation and report (separate procedure).
Vision Therapy CPT Code 92065

• Vision therapy is a sequence of activities individually prescribed and monitored by the doctor to develop efficient visual skills and processing.

• Research has demonstrated vision therapy can be an effective treatment option for individuals under the age of 21 or individuals with Acquired Brain Injury (ABI).

• Vision therapy is administered in the office under the guidance of a practitioner and requires a number of office visits depending on the severity of the diagnosis conditions.

• Some Medicaid programs will reimburse for this service. Be sure to track it by carrier and the number of sessions per year.
Vision Therapy CPT Code 92065

• Research has demonstrated vision therapy can be an effective treatment option for:
  • – Ocular motility dysfunctions (eye movement disorders)
  • – Non-strabismic binocular disorders (inefficient eye teaming)
  • – Strabismus (misalignment of the eyes)
  • – Amblyopia (poorly developing vision)
  • – Accommodative disorders (focusing problems)
  • – Visual information processing disorders, including visual motor integration and integration with other sensory modalities.
Low Vision Services

• Some carriers will pay for these services.
• For example, Aetna considers
  “low vision programs medically necessary for members with a
  moderate or severe visual impairment, which is not
  correctable by conventional refractive means. Ophthalmologic low
  vision evaluations and testing, instruction in the use of visual
  aids, interviews and counseling are medically necessary services
  typically included in a low vision therapy program.”

Always check with each individual carrier.
Low Vision Services

- **97535** ($31.21 / .45) Self-care/home management training (e.g., activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes

- **97537** ($27.36 / .45) Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/ modification analysis, work task analysis), direct one-on-one contact by provider, each 15 minutes
ICD-10 coding

• Required codes on Oct 1 2015.
• Updated coding system
• Seven digits
• Increased specificity.
• Now include Laterality (right, left, bilateral)
• Occurrence codes (A, D, S)
• Placeholder code (X)
• Diabetes codes are now combination codes.
• Glaucoma codes are now combination codes.
ICD-10 Code Format

- [ ] [ ] [ ]. [ ] [ ] [ ] [ ] Category (letter), etiology, anatomic site, severity and then a **seventh-digit** "extender"

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B20</td>
<td>Human immunodeficiency virus [HIV] disease</td>
</tr>
<tr>
<td>D31.32</td>
<td>Benign neoplasm of left choroid</td>
</tr>
<tr>
<td>E11.9</td>
<td>Type 2 diabetes mellitus without complications</td>
</tr>
<tr>
<td>H00.11</td>
<td>Chalazion right upper eyelid</td>
</tr>
<tr>
<td>H40.11X1</td>
<td>Primary open-angle glaucoma, mild stage</td>
</tr>
<tr>
<td>H52.11</td>
<td>Myopia, right eye</td>
</tr>
<tr>
<td>H52.4</td>
<td>Presbyopia</td>
</tr>
<tr>
<td>G43.009</td>
<td>Migraine w/o aura, not intractable, w/o status migrainosus</td>
</tr>
<tr>
<td>T15.02XA</td>
<td>Foreign body in cornea, left eye, initial encounter</td>
</tr>
<tr>
<td>Z96.1</td>
<td>Presence of intraocular lens</td>
</tr>
</tbody>
</table>
Action Plan to Prepare for ICD-10

1. **Circle** all unspecific ICD-9 codes in your current fee ticket/ICD-9 cheat sheet/provider documentation.

2. You should **generate a list** every ICD-9 code you have report for the last 12 months from your PM system. You can use this list to create your new ICD-10 fee ticket or cheat sheet.

3. Decide **how codes are selected**. Are you are going to code from the manual, a cheat sheet or a look-up program to select the new ICD-10 codes?

4. All fee tickets must be reworked. Recommendation is between three to six months before Oct 1 2015. Remember, the number of codes expand over 4X.
Audit for Specificity

- Accurate, specific, well-documented encounters, that clearly reflect a knowledge of coding guidelines and documentation requirements are much more likely to “sail through” an audit.

Avoid *unspecified*:

- Diabetes Mellitus
- Keratoconus
- Headaches
- ARMD
- Entropion
- Ectropion
- Lagophthalmos

- Astigmatism
- Cataracts
- Keratitis
- Conjunctivitis
- Adverse effects
- Reason and location of accidents
- Epiphora
Why does it Matter?
Ophthalmoplegia

- **Ophthalmoplegia** (Ophthalmoparesis) or ophthalmoplegia refers to weakness or paralysis of one or more extraocular muscles which are responsible for eye movements. It is a physical finding in certain neurologic illnesses.

- **Two types**, external and internal. **External** is a medical diagnosis code. **Internal** is a refraction diagnosis code.

- See next slide for external codes.
Ophthalmoplegia

Note how a zero (fifth digit) indicates an unspecified eye (exception).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>H49.30</td>
<td>Total (external) ophthalmoplegia, unspecified eye</td>
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<tr>
<td>H49.31</td>
<td>Total (external) ophthalmoplegia, right eye</td>
</tr>
<tr>
<td>H49.32</td>
<td>Total (external) ophthalmoplegia, left eye</td>
</tr>
<tr>
<td>H49.33</td>
<td>Total (external) ophthalmoplegia, bilateral</td>
</tr>
<tr>
<td>H49.40</td>
<td>Progressive external ophthalmoplegia, unspecified eye</td>
</tr>
<tr>
<td>H49.41</td>
<td>Progressive external ophthalmoplegia, right eye</td>
</tr>
<tr>
<td>H49.42</td>
<td>Progressive external ophthalmoplegia, left eye</td>
</tr>
<tr>
<td>H49.43</td>
<td>Progressive external ophthalmoplegia, bilateral</td>
</tr>
</tbody>
</table>
H52.5**: Ophthalmoplegia and Accommodation Disorders

- **Internal ophthalmoplegia** is characterized by paresis of ciliary body with loss of power of accommodation and pupil dilation because of lesions of ciliary ganglion.
- **Paresis**: a weakness of voluntary movement.
- All these codes have **laterality (1,2,3,9) options**.

<table>
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<th>Code</th>
<th>Description</th>
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<tr>
<td>H52.511</td>
<td>Internal ophthalmoplegia (complete) (total), right eye</td>
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<tr>
<td>H52.521</td>
<td>Paresis of accommodation, right eye</td>
</tr>
<tr>
<td>H52.531</td>
<td>Spasm of accommodation, right eye</td>
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</tbody>
</table>
Topics Covered in Next Presentation

• Diagnostic tests related to glaucoma
  – Fundus Photo
  – Visual Field Exam
  – OCT/GDX
  – Pachymetry

• Visual Evoked Potentials (VEP)
I am teaching ICD-10 for Eyecare

- It is a full, six-hour training session. It is ARBO, COPE approved for six-hours of CE credit.

- Nov 11  Reno Nevada
- Nov 12  Sacramento CA
- Nov 13  San Francisco CA

- Contact Cross Country Education for more information. Phone number is 800.397.0180. E-mail is customerservice@CrossCountryEducation.com
Maximizing Optometry Practice Revenue through Accurate Coding and Billing
Nov 7 2014

Questions?

For more information please visit my website below

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Additional Information

• Drugs with adverse affects
Drugs with adverse affects

- Phenothiazines Thorazine: antipsychotic
- Tamoxifen Nolvadex: antiestrogen, treat cancer
- Tamsulosin Flomax: enlarged prostate
- Corticosteroids Prednisone arthritis, lupus, breathing disorders, allergies, psoriasis

- And of course:
- Chloroquine/Plaquinil used to treat rheumatoid arthritis.
Other Drugs with adverse affects

- Pamidronate disodium (Aredia™)  malignancy
- Alendronic acid (Fosamax™)  osteoporosis
- Ibandronate (Boniva™)  osteoporosis
- Zolendronate (Zometa™)  hypercalcemia of malignancy
- Risedronate sodium (Actonel™)  osteoporosis
- Topiramate (Topamax™)  anticonvulsant drug
- Sildenafil (Viagra™)  erectile dysfunction
- Isotretinoin (Accutane™)  severe acne
- Amiodarone (Cordone™)  antiarrhythmic agent
Beyond Plaquenil: Other Drugs, Other Problems

• **Bisphosphonates** are used to manage osteoporosis and other conditions that involve loss of bone mass. Multiple clinical concerns include blurred vision, anterior uveitis and episcleritis.

• **Cetirizine** (Zyrtec and others), an antihistamine, can cause pupillary changes, blurred vision and keratoconjunctivitis sicca. Of nine cases reported to the Registry, eight involved children.

• **Erectile dysfunction drugs** cause a range of side effects that are common, dosage-dependent and, thus far, fully reversible. They include changes in color and light perception, blurred vision, conjunctival hyperemia, ocular pain and photophobia.
Beyond Plaquenil: Other Drugs, Other Problems

- **Ethambutol** (Myambutol), used to treat pulmonary tuberculosis, has generated over 800 reports to the Registry. Ethambutol is associated with optic or retrobulbar neuritis, affecting one or both eyes. An unusual form of the toxicity causes peripheral constriction of the visual field. Monthly ophthalmic exams are recommended for doses of ethambutol exceeding 15 mg/kg/day.

- **Fluoroquinolones** are associated with side effects not seen in other classes of antibiotics. Topical administration may cause precipitates in the cornea and, possibly, uveitis.

- **Hepatitis B vaccine** may have an association with uveitis.
Beyond Plaquenil: Other Drugs, Other Problems

- **Herbal medicines** and nutritional supplements generated $60 billion in sales worldwide in 2004, according to the World Health Organization. WHO has published guidelines on the use of herbal medicine, and the Registry lists common supplements and their visual symptom reactions.

- **Retinoids**, used to treat severe, recalcitrant acne and psoriasis and to induce remission of leukemia, have been linked to intracranial hypertension and papilledema when used in prescribed therapeutic doses.
Beyond Plaquenil: Other Drugs, Other Problems

• **Tamsulosin (Flomax)**, used to treat benign prostatic hyperplasia and hypertension, has been associated with intraoperative floppy iris syndrome.

• **Topiramate (Topamax)** is used to treat epilepsy and migraines. The drug also is used off-label for a number of concerns, including weight loss, bipolar disorder and depression. It has been associated with acute angle-closure glaucoma and transient myopia.

• **Statins** may be associated with diploia, ptosis and ophthalmoplegia, and they may exacerbate myasthenia gravis and cataracts.