Cracking The Code: Clinical Case Management & Medical Record Compliance In Coding In The ICD-10 Era
TAOP Fall Meeting – 2016

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John Rumpakis, OD, MBA
Imaging, Clinical management, Medical Record Management, Software development

Dr. Rumpakis is currently President & CEO of Practice Resource Management, Inc., a firm that has been providing a full array of consulting, appraisal, and management services for healthcare professionals and industry partners for the past 30 years. He has developed some of the leading Internet-based software applications for the medical eye field such as CodeSAFEPLUS.com® (www.CodeSAFEPLUS.com), the industry leading cloud-based EHR & ICD-10 Code Data and Information Service, and offers personal medical coding consultation through JustAskJohn (www.JustAskJohn.info). He is also the founder of Opt-ED® Professional Continuing Education (www.Opt-ED.com) which creates and delivers top continuing education around the country as well as Opt-IN® which provides optometric marketing and promotional services.

Named the Chief Medical Coding Editor for Review of Optometry & Optometric Management, he has been extensively published on the basics of third party coding & billing, strategy development and execution, practice management, head building, growing effectiveness and profitability, including the textbook "Business Aspects of Optometry." Dr. Rumpakis is a popular lecturer both nationally and internationally. In addition to having had a successful solo practice, Dr. Rumpakis developed the practice management curriculum at Pacific University College of Optometry and taught optometrics & medical economics there for over a decade and was recently named the University of Houston College of Optometry’s Benedict Professor for 2016-2017.

A 1984 graduate of Pacific University College of Optometry, he served as a volunteer for the AOA for near 17 years and sits on numerous advisory boards, and board of directors for companies both in and out of the ophthalmic industry.

Financial Disclosures – John Rumpakis, OD, MBA
I Am A Project Based Consultant & Have Received Honoraria From:
- Alcon Laboratories
- Carl Zeiss Meditec
- CooperVision
- Essilor of America
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Disclosures

- All fees represented within this presentation are the 2016 Medicare Maximum Allowable Reimbursements for each procedure listed as of October 13th, 2016 for this zip code.
- All information regarding policies, procedures, guidelines and definitions is current as of October 13th, 2016.
- Each viewer is responsible to be current in their own geographical jurisdiction with respect to implementation within their own practice.
- The coding examples contained in this presentation are examples only and each practitioner should apply these coding guidelines to what is actually recorded in the patients’ medical record before submitting any claim to a third party carrier.

Learning Objectives

- Understanding That Your Medical Record Is Nothing More Than An EXTENSION OF YOUR CLINICAL CARE which can help or hurt you
- The Medical Practice Environment
- MIPS
- Audit Triggers & Prevention
- Definitions
- Medical Necessity & The Chief Complaint
- The Resource Based Relative Value System (RBRVS)
  - Relative Value Units & Geographic Practice Cost Index
- The ICD-10
  - The 2017 Updates!
- Taught Through Clinical Examples From This Point Forward
  - Examination Services
    - S Codes vs. 920XX codes vs. E/M codes
    - The Routine Eye Exam
      - S Codes vs. 920XX codes vs. E/M codes
    - The Ophthalmic Coding Guidelines – 920XX codes
      - Compliance Issues and the medical record
    - Demystifying E/M Coding Guidelines – 992XX codes
      - 1997 E/M Guidelines
        - Compliance issues and the medical record
  - How To Translate The Exam Performed Into Coding Language
    - Scoring The E/M Encounter
    - Audit triggers and prevention
  - Special Ophthalmic Testing – 2016-17 Update
  - Interpretive Report requirements
  - The ABN & NEMB – The Official Method of Notification
  - The Resource Based Relative Value System (RBRVS)
  - Appropriate Use of Medicare
  - National & Local Coverage Determinations
  - CMS’s Correct Coding Initiative
    - What are the CCI Edits
    - Column 1/Column 2 Codes
    - Mutually Exclusive Codes
    - Appropriate use of modifiers with the CCI Edits
  - Factors For Success – John’s Top Twelve
    - Implementation & Integration Guidelines
  - Identifying Obstacles & How To Overcome Them

2017 Clinical Care Requires 2017 Rules & Resources

- Get Your Resource Material
  - By Book
    - CPT 2017
    - ICD-10 2017
    - HCPCS Level II 2017
  - Or Get Everything Updated AUTOMATICALLY
    - Online Cloud-Based Resources
Three Essential Resources

John@PRMI.com
www.CodeSAFEPLUS.com
www.JustAskJohn.info

What Is Outcome Based Care?

"Due To Recent Budget Cuts, The Light At The End Of The Tunnel Has Been Turned Off"
What Do You Think Is Happening?

Singular Events Are Converging

Some Primers
- Audits Are Increasing – Medical & Refractive Carriers
- Intense Scrutiny On Medical Necessity
- 92004/92014 Under Attack
  - Routine exams are going to be more prevalent
  - Increased MVCP Competition For Covered Lives
  - Changing product mix may lead to decreased reimbursements
  - Increased bundling of services – Asking us to do more – for less
- Our MIPS Score Will Be Critical To Participation
  - THIS IS NOT SOMETHING TO BE IGNORED
The Low-Down On MIPS

- MIPS is the combination of your MU participation, your PQRS performance, and the Value Based Modifier. **It begins in the 2017 Performance Year.**
- MIPS payment adjustments are applied to all Medicare Part B payments 2 YEARS after the Performance Year, so **2019 would be the first Adjustment Year.**
- MIPS defines for categories of physician performance contributing to a MIPS Composite Performance Score (CPS) of up to 100 points – based upon these relative weights:
  - Quality (50%)
  - Advancing Care Information (ACI formerly MU) (25%)
  - Clinical Practice Improvement Activities (CPIA) (15%)
  - Resource Use (10%)

The Low-Down On MIPS

- Your individual Composite Performance Score (CPS) will be released to the public each year by CMS
- MACRA defines two types of financial impact:
  - Small, inflationary adjustment to the Part B fee schedule
  - MIPS payment adjustments (INCENTIVES OR PENALTIES) based upon the 100 point CPS

<table>
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<tr>
<th>Program</th>
<th>Performance Year</th>
<th>Medicare Part B Payment Adjustment Year</th>
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<td>2022</td>
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The Low-Down On MIPS

- The top-to-bottom MIPS potential impact on Part B payments can widely vary:
  - For CY2018 is likely to be from a 15% incentive down to a -5% penalty, or a total 20% top-to-bottom swing.
  - For the CY2020 performance year could reach 9% x 3.0 + 10%, or a total 46% top-to-bottom swing.

For the 2017 performance year, there are four ways for organizations to either participate in or be exempt from MIPS to ease the transition. Here is a brief summary of your options:

1. Organizations can report some data to avoid a negative payment adjustment. (Awaiting Final Rule)
2. Providers can submit full performance data (ACI, Quality and CPIA—Resource Use is based on claims data and calculated by CMS) for a reduced number of days, meaning their first performance period could begin later than January 1 and the payment could be smaller. (Awaiting Final Rule)
3. Organizations who are prepared can move forward with a full year of reporting for maximum reimbursement potential.
4. Providers can elect to participate in an advanced alternative payment model, such as a Medicare Shared Savings Track 2 or 3 ACO, that has both upside and downside financial risk and is exempt from MIPS.

Organizations who participate in any one of the four options will not receive a penalty for the 2017 performance year, while organizations who opt not to participate are subject to a -4% adjustment.
The Low-Down On MIPS

- MIPS will publish each eligible clinician’s annual Composite Performance Score (CPS) and scores for each MIPS performance category within approximately 12 months after the end of the relevant performance year.
- For the first time, consumers will be able to see their providers rated on a scale of 0 to 100 and how their providers compare to peers nationally.
- This level of transparency and specificity goes beyond existing programs such as VBM, which calculates quality and resource use scores but does not publicly publish the results.

Your Episode Of Care Costs Are Critical!

- Easy To Calculate!
- Calculate chair cost per hour
- Divide chair cost per hour by 60
- That equals your chair cost by minute

Think I’m too detailed?
- every minute is either a drain on cash flow or a builder of cash flow

National Average = $1.65 per minute

So What?

THIS STUFF DOESN’T AFFECT ME AT ALL
Your Clinical Practice Is Like A Bucket

Inflows
- Refractive & Contact Lens Revenue
- Medical Eye Care Revenue

Outflows
- Internet & Contact Lens Drop Outs
- Patients Going Elsewhere For Medical Eye Care
- Audit Risk

What Is Managed Vision Care?

Managed Vision Care = Managed Competition

Where an unaffected third party controls your supply, your demand, and ultimately your profitability, through mechanisms of controlled distribution and contractual limitations.

Trends Affecting Practices

- Downward pressure on refractive reimbursements
- Increasing costs
- Increasing demand for care (baby boomers)
- Contracting supply of ophthalmologists
- More patient pay (deductibles, diagnostics, treatments)
- More savvy patients
- EMR and other technology
- Need for better-trained staff
- Practice consolidation
- Continual changes in the healthcare delivery system
Avoiding The Race To Zero...

Reimbursement (Income)

Patient Volume (Exams per hour)

Practice Profit

Another Classic Business Principle

When applied to other industries, you can generally deliver only two out of three

Speed

Price

Quality

Changes in the healthcare system of the future will require that we deliver three out of three

The trend is clear that we are shifting to a benefit structure that is borne by the recipient of the care, rather than a third party provider.

It’s Not Your Fault!

The trend is clear that we are shifting to a benefit structure that is borne by the recipient of the care, rather than a third party provider.
But John, I’m So Confused...
EVERYBODY’S AN EXPERT???: THERE ARE SO MANY DIFFERENT PEOPLE THAT SAY SO MANY DIFFERENT THINGS...

TRANSPARENCY

I Did The Clinical Care, Now How Do I Code This?
THE MOST FREQUENT QUESTION I GET...
My Favorite Medical Coding Myths...

1. If I routinely do tests but don’t write them down it still counts as if I had done them because they are routine in my practice.
2. If I undercode an encounter - I am safe in an audit because I did the patient a favor.
3. Medicare can look at only Medicare records on an audit.
4. It is o.k. to have a separate fee schedule for private pay patients and insurance patients.
5. Being reimbursed for a submitted claim means I filled the claim correctly.
6. Carriers always answer questions correctly when I call them.
7. If I find pathology on a routine vision exam, I can turn that exam into a medical exam because the reimbursement is higher.
8. I can routinely use the patient’s symptoms like blurred vision, or headaches as the diagnosis to justify doing any additional testing I want.

But One Of My Favorites Is...

My friend does it this way and he/she works for an ophthalmologist and they get paid for it, so it has to be right... Right?

If You Just Take Care Of The Patient The Code Will Take Care Of Itself!

- The patient’s condition determines everything that you do.
  - History that was required understand the patient’s complaint
  - Exam that was required to properly diagnose the condition
  - Assessment of the condition(s)
  - Plan to provide the best outcome in the most efficient way that is concurrent with local standard of care
- What you do with the patient determines what you write down in the medical record.
- What you have written down determines the codes you use to describe the care required.
Bottom Line

The individual patient presentation or what you have them returning for determines everything that you do with them, and therefore determines the services performed and the subsequent coding of those services.

What Is The ICD-10 Really About?

A NEW STANDARD IN MEDICAL RECORD CREATION, BIG DATA ANALYSIS, AND MEDICAL ECONOMICS AND IT WILL IMPACT YOU AND YOUR PRACTICE

The Hardest Part Of The ICD-10??

The most difficult part of the ICD-10 is creating a medical record that will be detailed enough to support the increased detail and specificity of the diagnosis code.
Legalities Related To Compliance

THE MEDICAL RECORD
AND THE PENALTIES ASSOCIATED WITH FAILING TO FOLLOW THE LAWS, RULES, AND GUIDELINES THAT GOVERN HOW WE CREATE IT

The U.S. False Claims Act

• A person does not violate the False Claims Act by submitting a false claim to the government;
• To violate the FCA a person must have submitted, or caused the submission of, the false claim (or made a false statement or record) with knowledge of the falsity. In § 3729(b)(1), knowledge of false information is defined as being (1) actual knowledge, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the truth or falsity of the information.

Relationships With Payers

• Relationships with patients is increasingly dominated by a third party – the payer
• Components of the provider/payer relationship include:
  ○ Accurate coding and billing
  ○ Accurate medical records documentation
  ○ Prescription authority
  ○ Assignment within the Medicare system
Relationship With Payers
Accurate Billing and Coding

The main issues involved in billing for rendered services include:
• Billing only:
  o medically necessary care
  o services actually performed
• Billing for:
  o services with no benefit or beneficial outcome
  o services provided by improperly trained or improperly supervised care
  o services provided by a provider included in the Exclusion Statute

Relationship With Payers
Medical Records Documentation

By contract with the payer, providers attest that the patient’s medical records are:
• Accurate
• Complete
• Show justification of medical necessity

• Have you ever read the back of your HCFA1500 form?
• It is a LEGAL CONTRACT assuring the necessity and truthfulness of your services.

The Contract You Sign 20x Per Day
(and have never read…)

• In submitting this claim for payment from Federal Funds, I certify that:
  1. The information on this form is true, accurate and complete
  2. I have familiarized myself with all laws, regulations and program instructions available from the Medicare contractor
  3. I have provided or can provide sufficient information required to allow the government to make an informed eligibility and payment decision
  4. This claim complies with all Medicare program instructions
And The Icing On The Cake...

“My signature is to certify that the foregoing information is true and accurate. I understand that any false claims or statements or concealment of a material fact may be prosecuted under applicable Federal and Stark laws.”

Important Definitions

FRAUD
• When someone intentionally falsifies information or deceives Medicare.

ABUSE
• When health care providers or suppliers don’t follow good medical practices, resulting in unnecessary costs, improper payments, or services that aren’t medically necessary.

The Only Difference Between Fraud & Abuse Is Intent.


The Government Recovery Is Hitting Records!
Technology Is Driving Monetary Recoveries... 
...And At A Blistering Pace

Using “Big Data” analysis returned an increase from 2014 to 11.6 to 1 return on investment in 2015!

Former Optometrist Sentenced in Medicaid Fraud Case

FOR IMMEDIATE RELEASE : Wednesday, December 5, 2012

CONTACT: Sara Rabern (605)773-3215

PIERRE, S.D.- Attorney General Marty Jackley announced today that Cary Stephen Feldman, 60, Spearfish, was sentenced to serve 15 years in prison for committing Medicaid fraud.

Seventh Circuit Court Judge Janine M. Kern suspended the execution of sentence on several conditions. Judge Kern ordered Feldman to serve 180 days in jail and ordered him to pay a total of $363,049.90 in restitution to Medicaid and Medicare. Feldman turned over a coin collection with an estimated value of $157,000, and paid an additional $80,000 to the government, so his remaining restitution balance is $126,049.90. Feldman was also ordered to serve 300 hours of community service, pay costs of $712.20 to the State and court costs of $208.

Feldman entered a plea of guilty on October 11, 2012, to grand theft by deception, a class 4 felony, and making false claims, a class 5 felony, pursuant to a plea agreement reached with the State. Feldman admitted that he knowingly and intentionally submitted false claims to the South Dakota Medicaid program and to Medicare.

Feldman began submitting the false claims in late 2008, and continued until early 2012.

The case was investigated and prosecuted by the South Dakota Medicaid Fraud Control Unit, with assistance from the South Dakota Department of Social Services, the federal Department of Health and Human Services Office of Inspector General, the South Dakota Division of Criminal Investigation, the Spearfish Police Department, the Rapid City Police Department, the Pennington County Sheriff’s Office, the Pennington County Office of State’s Attorney, the Minnehaha County Sheriff’s Office, and the South Dakota Office of United States Attorney.
The Top Three Issues For Audit Failure

1. Lack of Medical Necessity noted in record
   a) For level of visit
   b) For special ophthalmic procedures
2. Improper coding of office visits
   a) Overuse of 920X4 codes
   b) Improper use of 92012 codes
   c) Improper coding of 992XX codes – approximating the level rather than actually coding correctly
3. Improper use of modifiers -25 and -59

How You Create Your Medical Record Matters!

THERE ARE LEGAL IMPLICATIONS OF HOW YOU RECORD YOUR ENCOUNTER

Fundamental Principles Are IMPORTANT!

What do you do?  
(hint... think evidence based medicine)

What does this patient need?  
(hint... not what do you want to do)

What is in the patient’s best interest?
Medical Necessity Is...

“Services or supplies that are proper and needed for the diagnosis or treatment of the patient’s medical conditions, are provided for the diagnosis, direct care and treatment of the patient’s medical condition, meet the standards of good medical practice in the local area and aren’t mainly for the convenience of the patient or the physician.”

Source: www.Medicare.gov

So What Exactly Does That Mean?

The medical record must clearly demonstrate that the service, procedure, or test ordered & performed was absolutely necessary in order to diagnose, treat, or monitor the treatment of the patient’s condition.

Keep The Order In Mind
It’s As Easy As 1, 2, 3.

Using The CPT & ICD System Is A Legal Requirement - So learn to do it properly!

1. Always provide the Standard of Care to the patient
   a) Only the care that the patient requires unless contractually obligated
2. Tell the medical record what you did and why you did it
3. Then accurately translate what you did with the patient into CPT & ICD language for the insurance carrier and your PM system.
   • Never code first, then do testing just to reach the level that specific code requires
   • This approach would not support the concept of Medical Necessity that is required by third party carrier rules and guidelines
E&M Medical Necessity -

Medical Necessity of E&M Services

- Section 1862(a)(1)(A) of the SSA, “Exclusions From Coverage and Medicare as Secondary Payer” does not include expenses acquired for items and services which are not deemed necessary for the diagnosis or treatment of illness or injury. This applies to all services.

- CMS IOS Publication 100-04, Chapter 12, Section 30.6.1 states: “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.”

CPT CODE ERROR RATE

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>ERROR RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>70.9%</td>
</tr>
<tr>
<td>99214</td>
<td>69.6%</td>
</tr>
<tr>
<td>99223</td>
<td>78.7%</td>
</tr>
<tr>
<td>99233</td>
<td>68.5%</td>
</tr>
</tbody>
</table>

SERVICE-SPECIFIC PREPAYMENT REVIEWS OF EVALUATION AND MANAGEMENT SERVICES

National Government Services will be conducting service-specific prepayment reviews on the following CPT codes targeting E&M services for JK Part B providers:

- 99214
- 99215
- 99223
- 99233

A prepayment review consists of a medical review of claims prior to payment. Request for records are most frequently electronically generated and referred to as ADS letters. Please note that when medical records are requested for chiropractic services, it is necessary to submit all the specific documentation as notated in the ADS, which would include but is not limited to:

- Physician/nonphysician practitioner’s progress notes,
- Orders,
- Medication records,
- Procedure/operative reports,
- Relevant diagnostic/operative reports or documentation of time that would assist in supporting the service(s) submitted

The primary focus of the audits will be to better identify common billing errors, develop educational efforts, and prevent improper payments. Providers will be receiving ADSs asking for documentation to support the service billed. Medical Review encourages providers to respond with the requested documentation in a timely manner to expedite adjudication of these claims.

Providers can assist in this process by:

- Reviewing all contractor publications and LCDs
- Understanding Medicare coverage requirements
- Ensuring office staff and billing vendors are familiar with claim filing requirements
- Performing self-audits of medical records against billed claims using coverage criteria, LCD, and coding guidelines
- Responding to request(s) for records in a timely manner (CMS requires that providers respond to an ADS within 30 days of the request)
- Ensuring documentation is legible and demonstrates that the patient’s condition warrants the services being reported there.
Your Money Is At Risk

- The government is actively auditing providers and recouped over $4.3 billion in overpayments in 2013
- Approximately 21% of claims are being over-coded putting your revenue at risk
- Audits typically find 8% of claims are under-coded leaving money on the table

How Can You Fight Big Data & Technology?

LETS FIGHT BACK WITH REAL-TIME DATA & INFORMATION THAT IS SPECIFIC TO YOUR ZIP CODE & ALWAYS ACCURATE!

CodeSAFEPLUS.com

THE ULTIMATE REAL-TIME CLOUD-BASED CPT & ICD DATA SERVICE
EVERYTHING YOU NEED IN ONE PLACE & SPECIFIC TO YOUR PRACTICE
And When A More Personal Solution Is Needed...

www.JustAskJohn.info
ONE-ON-ONE PERSONAL CODING CONSULTATION SERVICES

Medical Carriers & Medical Necessity
CARRIERS GENERALLY DEFINE IT FOR US!

What Is A NCD?

- An NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare contractors are required to follow NCDs.
- If an NCD does not specifically exclude/limit an indication or circumstance, or if the item or service is not mentioned at all in an NCD or in a Medicare manual, it is up to the Medicare contractor to make the coverage decision (see LMRP).
- Prior to an NCD taking effect, CMS must first issue a Manual Transmittal, CMS ruling, or Federal Register Notice giving specific directions to our claims-processing contractors. That issuance, which includes an effective date and implementation date, is the NCD.

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What Is A LCD?

- An LCD, as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).

- The difference between LMRP’s and LCD’s is that LCDs consist only of “reasonable and necessary” information, while LMRP’s may also contain category or statutory provisions.

What Happens If The Carrier Doesn’t Have A Policy?

- But, sometime carriers will not have a specific policy regarding the indications of medical necessity, nor a list of covered diagnoses or utilization guidelines that you can refer to.

- When this is the case, then the prevailing CPT definition and guidelines in combination WITH YOUR MEDICAL EXPERTISE become the defensible rule.

Or What Happens If The Patient Is Paying?

- If the patient is paying out of pocket and it is a separate distinct financial transaction where the carrier is NOT involved (i.e. balance billing), then you are free to do what you and the patient agree to.
Medical Plans Vs. Refractive Plans

WHAT’S THE DIFFERENCE? IT IS SIMPLY A DIFFERENT DISEASE!

Refractive Disease Vs. Medical Disease
A Simple Flow Chart

John’s “Lucky Seven” Steps To Success

1. Determine Why
2. The Patient Is There
3. Determine Level of Appropriate History
4. Determine Level of Appropriate Exam
5. Determine Level of Decision Making
6. Diagnose Condition(s)
7. Prescribe Treatment(s)

Determine Responsible Party
- Patient
- Refractive Carrier For Refractive Disease
- Medical Carrier For Medical Disease

Apply Appropriate Coverage According To Contract

Refractive Plans

- Do patients need a reason to see you?
  - Do they need to have something wrong with them?

- What conditions have to be met?
  - Policy in force
  - Coverage eligibility
  - Participating provider

- What about duplicative coverage?
  - Who’s choice is it??
  - My doctor always wants to bill medical if they find something
Rule Number One

QUESTION: WHAT IS THE FIRST THING THAT MUST BE PART OF EVERY MEDICAL VISIT?

Answer: A Chief Complaint

Patients Are Not Expected To Be The Expert – WE ARE!

WHY? THINK OF THE THREE E’S

EDUCATION, EXPERTISE, & EXPERIENCE

Why Is The Patient In Your Office?

There are only THREE ways that the patient ends up in your practice.

1. They initiate the appointment by phone call, email, online booking.
2. You initiate the appointment by telling them to return to the office for a specific reason.
3. Other Physician initiates the appointment by telling them to make an appointment for a specific reason.

► Once we know who initiated the encounter we can now properly determine the Chief Complaint.
There Are TWO Ways A Chief Complaint Requirement Is Met

Physician Directed Complaint (reason for visit)  Patient Directed Complaint

The Chief Complaint
The Medicare Carriers Manual, Part 3 §2320 reads:

"The coverage of services rendered by a physician is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient’s condition. When a beneficiary goes to a physician with a complaint or symptoms of an eye disease or injury, the physician’s services (except for eye refractions) are covered regardless of the fact that only eyeglasses were prescribed. However, when a beneficiary goes to his/her physician for an eye examination with no specific complaint, the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathologic condition."
The Chief Complaint

The Medicare Carriers Manual, Part 3 §2320 reads:

"The coverage of services rendered by a physician is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient’s condition. When a beneficiary goes to a physician with a complaint or symptoms of an eye disease or injury, the physician’s services (except for eye refractions) are covered regardless of the fact that only eyeglasses were prescribed. However, when a beneficiary goes to his/her physician for an eye examination with no specific complaint, the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathologic condition."

Cloning Update

A Renewed Interest By The OIG

The OIG said that the ability to "clone" chart notes from a previous patient encounter to help document the next one can help physicians work more efficiently, but also invite fraud, especially if no one edits the cloned information to make sure it’s accurate and up to date. Government officials are worried that many physicians bill for higher levels of evaluation and management (E/M) services than warranted by cloning dense blocks of old patient information.
Cloned Documentation

The word ‘cloning’ refers to documentation that is worded exactly like previous entries. This may also be referred to as ‘cut and paste’ or ‘carried forward.’ Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.

• Palmetto GBA - Last updated on 11/06/2012

Cloned Documentation

• Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

• Palmetto GBA - Last updated on 11/06/2012

Your Contact Lens Patient With Ocular Allergy

LET'S EXPLORE HOW THE ICD-10 MAY CHANGE YOUR CLINICAL APPROACH AND CARE
Differential Diagnosis

- Dry eye presents with grittiness, burning and signs of surface disease
- Infection shows discharge
- Allergy itches + family history
- Urban allergy - vasomotor conjunctivitis varies with environmental triggers

Ocular Allergy

Patient Presentation
- New Patient
- 43 y/o AAF
  - VSP (refractive insurance)
  - Blue Cross (medical insurance)
- Presents with
  - Ran out of G.S. – New Insurance
  - O.x Blur – O.D. > O.S. (refractive in nature)
- Seasonal allergies discovered during case history, but not primary reason for visit
  - Claritin OTC, OD, Visine AC per PI

Coding Concepts
- New vs. Established
- Chief Complaint
- Medical vs. Refractive
- Contractual Obligations
- Additional Services Covered

Coding The Comprehensive Exam

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies</th>
<th>Diagnosis Code</th>
<th>Charges</th>
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</table>
Coding In The ICD-10 Era

**PROCEDURES**
- 92004
- 92015

**DIAGNOSES**
- H52.11 – Myopia, Right Eye
- H52.12 – Myopia, Left Eye
- H52.13 – Myopia, Bilateral
- H52.10 – Myopia Unspecified eye

Initiating A Treatment Plan

- What would be the Standard of Care?
- Communicate with patient
- Complete the medical record
- Prescribe a medication
- Set follow-up visit

Ocular Allergy – 1 week later

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
<th>Diagnosis Code</th>
<th>Charges</th>
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</thead>
<tbody>
<tr>
<td>From MM/DD/YY</td>
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<td></td>
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<td>62710</td>
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<td>$90.15</td>
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</tbody>
</table>

Billed To VSP, But On Claim For Educational Purposes

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Coding In The ICD-10 Era

PROCEDURES

9921X

DIAGNOSES

• H10.45 – Other Chronic Allergic Conjunctivitis
• H10.411 – Chronic Giant Papillary Conjunctivitis, Right Eye
• H10.412 – Chronic Giant Papillary Conjunctivitis, Left Eye
• H10.413 – Chronic Giant Papillary Conjunctivitis, Bilateral
• H10.419 – Chronic Giant Papillary Conjunctivitis, Unspecified Eye

Why 99213?

<table>
<thead>
<tr>
<th></th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
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<tr>
<td>Exam</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Decision Making</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

What about the 92012 code?

Use of the 92012 code could be perfectly acceptable – if & when the medical carrier accepts them as medical in nature vs. refractive and if the code definition is met.

You Often Want To Choose It Because

- Less documentation requirements
- Increased reimbursement

BUT - CPT 2016 Definition:

"... describes an evaluation of a new (condition) or an existing condition complicated with a new diagnostic or management problem not necessarily related to the primary diagnosis."
Ocular Allergy – 6 months later

Diagnosis: 372.14, Allergic Conjunctivitis, Chronic

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
<th>Diagnosis Code</th>
<th>Charges</th>
<th>Days of Service</th>
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<td>$68.52</td>
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</table>

Ocular Allergy

Profitability Per Hour

$730
Lost Opportunity Costs?

- Did the one week allergy follow-up cannibalize another annual eye exam opportunity?
  - NO! Why?
    - Allergy visit – 5 minutes
    - Can be double-booked with an annual examination
    - Maximizes revenue per Dr. hour

Key Concepts

- Allergy encounter was driven by annual exam
- Easy to diagnose
- Easy to treat
- Not a drag on schedule
- Builds other areas of business
John’s Golden Rule

You have to follow the rules... Even if they economically benefit you!

Does Medical Coding Seem Like A Foreign Language?
IT DOESN’T HAVE TO BE... WE JUST HAVE TO SPEAK THE LANGUAGE

Understanding Code Differences
WITHIN THE HCPCS SYSTEM EACH CODE SUBSET HAS IT’S OWN IMPLICIT PURPOSE...AND IT’S OWN FORMAT
Key Concepts

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Code Format</th>
<th>Ownership</th>
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</thead>
<tbody>
<tr>
<td>HCPCS I</td>
<td>CPT-4 Current Procedural Terminology (HCPCS Level I Codes)</td>
<td>5 Digits</td>
<td>AMA/</td>
</tr>
<tr>
<td>HCPCS II</td>
<td>Healthcare Procedural Coding System Level II Codes</td>
<td>4 Digits</td>
<td>AMA/</td>
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<tr>
<td>HCPCS III</td>
<td>Healthcare Procedural Coding System Level III Codes (Emerging Technology)</td>
<td>4 Digits</td>
<td>AMA/</td>
</tr>
<tr>
<td>ICD-10-CM</td>
<td>International Classification of Diseases, 10th Edition</td>
<td>7 Characters</td>
<td>WHO/</td>
</tr>
</tbody>
</table>

Health Care Procedural Coding System (HCPCS)

- **Level One HCPCS**: CPT Procedural Codes
- **Level Two HCPCS**: Non-CPT Codes for Materials, Services & PQRS
- **Level Three HCPCS**: Emerging Technology & Temporary Use Codes

Health Care Procedural Coding System (HCPCS)

- **Level One HCPCS Are The CPT®-4**
  - CPT Codes Are Always...
    - One Five Digit Code Plus Up To Four, 2 Digit Modifiers

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Health Care Procedural Coding System (HCPCS)

- Level Two - National Codes for Materials, Services & PQRS
- Level Two Codes: 5 Digit Alpha-Numeric

Health Care Procedural Coding System (HCPCS)

- Level Three - Emerging Technology & Temporary Use Codes
- Level Three Codes: Category III codes are temporary codes for emerging technology, services, and procedures. Category III codes consist of four numbers followed by the letter “T.”

Key Concepts To Reimbursement

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Resource</th>
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</thead>
<tbody>
<tr>
<td>RBRVS</td>
<td>Resource Based Relative Value System</td>
<td>CMS*</td>
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<tr>
<td>RVU</td>
<td>Relative Value Unit</td>
<td>CMS*</td>
</tr>
<tr>
<td>CPC</td>
<td>Geographic Practice Cost Index</td>
<td>CMS*</td>
</tr>
<tr>
<td>Conversion Factor</td>
<td>A “Dollar” Multiplier In The Reimbursement Calculation</td>
<td>CMS*</td>
</tr>
<tr>
<td>Maximum Allowable Reimbursement</td>
<td>Geographically Adjusted RVU’S X The Conversion Factor</td>
<td>CMS*</td>
</tr>
</tbody>
</table>

* www.cms.hhs.gov
Reimbursement Fundamentals

- RBRVS
- Determines the Maximum Allowable Fee
  - For Every Procedure
  - For Every Carrier
- Relative Value Units Are Based On:
  - Amount Of Work Associated With Procedure
  - Practice Overhead Expenses Associated With Procedure
  - Malpractice & Professional Liability Costs Associated With Procedure
  - Geographic Location Adjustments
  - GPCI – Geographic Practice Cost Indices

Calculating Reimbursements
IT’S NOT ROCKET SCIENCE... JUST MATH

Procedure Relative Value Units

<table>
<thead>
<tr>
<th>CPT</th>
<th>Code Descriptions</th>
<th>Work</th>
<th>Practice Expense</th>
<th>Malpractice</th>
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<tbody>
<tr>
<td>92014</td>
<td>Eye exam &amp; treatment</td>
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<tr>
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<td>1.49</td>
<td>0.01</td>
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<tr>
<td>92020</td>
<td>Special eye evaluation</td>
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<td>0.01</td>
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<tr>
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<td>Fitting of contact lens</td>
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Geographic Practice Cost Index (GPCI’s)

<table>
<thead>
<tr>
<th>Locality Name</th>
<th>Work GPCI</th>
<th>PE GPCI</th>
<th>MP GPCI</th>
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<tbody>
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<td>San Francisco, CA</td>
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<td>0.651</td>
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<td>Anaheim/Santa Ana, CA</td>
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<td>0.954</td>
</tr>
</tbody>
</table>

The Conversion Factor

A conversion factor is nothing more than a “Dollar Multiplier” in determining the Maximum Allowable Reimbursement for each CPT code.

\[
\text{Total Geographically Adjusted RVU's} \times \text{The Conversion Factor} = \text{The Maximum Allowable Reimbursement}
\]

Medicare Conversion Factors

- Proposed
- Final

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ICD-10-CM
INTERNATIONAL CLASSIFICATION OF DISEASE
TENTH EDITION, CLINICAL MODIFICATION

ICD-10-CM Codes
- 82,000+ codes
- Diseases and conditions and causes grouped:
  - Communicable diseases
  - General diseases that affect whole body
  - Local diseases arranged by site
  - Development of diseases
  - Injuries
  - External causes

ICD-10-CM Codes
- Increased Specificity For:
  - Laterality (differentiation of right versus left versus bilateral)
  - Injury Codes
    - Code extensions for external causes of injury
    - Code extensions for injuries
  - Postoperative complications & phases of treatment
  - Trimester information
  - Alcohol and substance abuse
ICD-10-CM Codes
- The critical relationship between an ICD-10 code and a CPT code is that the diagnosis supports the medical necessity of the procedure
- List primary diagnosis code first (systemic – always first)
  - Keep in mind that ICD-10 rules prevent you from using the patient’s symptoms as a diagnosis if you know the cause of the symptoms
- Link specific procedures to appropriate diagnosis on CMS 1500 form
- Stay away from unspecified diagnosis codes

ICD-10 Critical Points
- Having a diagnosis that supports Medical Necessity is REQUIRED for coverage
- Having ONLY a covered diagnosis is not enough to survive an audit unless you have properly established Medical Necessity in the medical record

Injuries
- Injuries are grouped by anatomical site rather than by type of injury
- Should make it easier to search for specific codes
- Example:
  - S05.02xA...Injury of conjunctiva and corneal abrasion without foreign body, left eye initial encounter

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It’s All About BIG Data!

ICD-10 Data Will Be Analyzed To:
- Determine the incidence of specific eye diseases
- Understand the difference in cost for the treatment of specific types of eye disease
- Determine the appropriateness of treatments for specific types of disease

So Why Are There Unspecified Codes?

- When sufficient clinical information is not available, it is acceptable to report an unspecified code
  - This should be the exception, not the rule
- It Remains Inappropriate to:
  - select a code not supported by the medical record
  - conduct medically unnecessary diagnostic testing to determine a more specific code
- And unspecified codes are likely to cause claim denials
  - Doctor’s responsibility to make the best diagnosis possible
  - In most cases, better to refine a diagnosis as the disease unfolds

ICD-10-CM Codes

- Is three to seven digits long
- Begins with an alphabetic character
- Has a numeral as the second digit
- Includes alpha or numeric digits as the third through seventh characters
- Decimal after first three characters
- Not case sensitive
- Pay attention! Watch for Ø for 0 to differentiate from O
- Has high levels of differentiation of right vs. left vs. bilateral
The ICD-10 For The Eyes (Chapter 7)

ICD-10 Codes & Eye Conditions (Categories)
- H38-H39 Disorders of the Eyelid, Lacrimal System, and Orbit
- H10-H11 Disorders of the Conjunctiva
- H25-H28 Disorders of the Lens
- H40-H42 Glaucoma
- H43-H44 Disorders of the Vitreous Body and Globe
- H15-H22 Disorders of the Sclera, Cornea, Iris, and Ciliary Body
- H25-H28 Disorders of the Choroid and Retina
- H46-H47 Disorders of the Optic Nerve and Visual Pathways
- H49-H52 Disorders of the Ocular Muscles, Binocular Movement, Accommodation, and Refraction
- H50-H51 Visual Disturbances and Blindness
- H50-H51 Other Disorders of the Eye and Adnexa
- H55-H57 Intraoperative and Post procedural Complications and Disorders of the Eye and Adnexa, Not Elsewhere Classified

What’s Different Between ICD-9 & ICD-10?

<table>
<thead>
<tr>
<th>Category</th>
<th>Etiology, Anatomical Site, Manifestation</th>
<th>Etiology, Anatomical Site, Manifestation &amp; Severity</th>
<th>Extension</th>
</tr>
</thead>
</table>

Structure Of The ICD-10

- Glaucoma Associated With Ocular Trauma – Left Eye - Severe

H40.32x3

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Related To The Eye, But Not In Chapter 7

- Bacterial and viral diseases are the A and B codes.
- Malignant neoplasms are the C codes.
- Benign neoplasms (nevus) are the D codes.
- There is no “senile cataract” description in ICD-10; they are now listed as “age-related.”
- E codes (Accidents, poisonings, injuries, and adverse effects) become S and T codes in ICD-10.
- W and Y codes are used to indicate activities and locations for injuries and accidents.
- All ICD-9 “V” encounter and status codes become ICD-10 Z codes.

Structure Of The ICD-10

- Diabetic Retinopathy ICD-10 E11.3213 (Example)

More On Diabetes

- Use additional code Z79.4 to indicate insulin use on the following diabetes codes:
  - E09.*** Drug or chemical-induced diabetes
  - E11.*** DM Type 2
  - E13.*** Other specified diabetes
- Code first the underlying condition; use additional code for adverse effects; use additional code for insulin use (3 additional codes) for:
  - E08series - Diabetes due to underlying condition.
  - 2017 UPDATE – Z79.84 – Long-term use of oral hypoglycemic drugs. Both Z79.4 and Z79.84 can be used if both medications are being used.
The Routine Eye Exam
- The "routine exam of eyes" code (V72.0) changes to two codes with ICD-10: without [Z01.00] and with [Z01.01] abnormal findings.
- Z01.00 Encounter for examination of eyes and vision without abnormal findings.
- Z01.01 Encounter for examination of eyes and vision with abnormal findings.
- The word "routine" is no longer in the description.
- It will be very important to monitor how vision plans and insurance companies reimburse based on the two ICD-10 codes above linked to office visits.

What does "without abnormal findings" and "with abnormal findings" mean and how do I use the Z01.XX codes?
- The use of the Z01.00 & Z01.01 ICD-10 codes that replaced the ICD-9 code, V72.0 can be confusing.
- The primary question is what constitutes abnormal vs. normal findings.
  - I would reserve the use of Z01.00 for emmetropes only.
  - The presence of any refractive error would constitute an abnormal finding, therefore I would advise everyone to use the appropriate ICD-10 refractive diagnosis codes (H52.XXXX) rather than the Z01.01 code.
  - If your refractive carrier specifies that they require the Z01.01 code to pay for the examination services, then code the Z01.01 as primary and the specific type of refractive error as secondary, tertiary, etc...

Scenario’s
- Annual Eye Exams:
  - S062* → reported with Z01.0* or H52*
    - Z01.00 for emmetropes only, Z01.01 PLUS the H52.XXXX refractive codes describing the patients refractive error
    - S0022-14 → reported with Z01.0* + 92015 → reported with HS2*
    - S0022-2014 use Z01.07 PLUS 92015 with H52.XXXX refractive codes describing the patients refractive error
    - If the patient is emmetropic, then only Z01.00 would be reported for both codes
    - If the patient has a refractive error, then Z01.01 on the S00XX, and then H52.XXXX on the 92015
- Medical Eye Visits:
  - 92002-14 → 201-XX codes or H52.XXXX codes NOT ACCEPTED
  - 99201-99215 → 201-XX codes or H52.XXXX codes NOT ACCEPTED
2017 ICD-10 Major Updates

- Dry Macular Degeneration – Includes Stage, Subfoveal Involvement and Laterality
- Wet Macular Degeneration – Includes Stage, Active/Inactive Choroidal Neo, and Laterality
- Diabetic Retinopathy – All codes now include Laterality
  - Proliferative diabetic retinopathy codes now have “stable,” “tractional,” “rhegmatogenous,” and “involving or not involving the macula” retinal detachment options, in addition to laterality.

2017 ICD-10 Major Updates

- Coding for central and branch retinal vein occlusions is slightly changed to include new options for “with macular edema,” “with retinal neovascularization,” and “stable.”
  - Remember that branch retinal veins are known as “tributary” in ICD-10. Laterality that was already there remains.
- Glaucoma – Primary Open Angle now includes Laterality

Previous Examples Of ICD-10 Issues

- Cataract – Laterality with No Severity
  - H25.011 – Cortical Age-Related Cataract, Right Eye
  - H25.012 – Cortical Age-Related Cataract, Left Eye
  - H25.013 – Cortical Age-Related Cataract, Bilateral

- Primary Open Angle Glaucoma – Severity With No Laterality
  - H40.11x1 – Primary Open-Angle Glaucoma, Mild Stage
  - H40.11x2 – Primary Open-Angle Glaucoma, Moderate Stage
  - H40.11x3 – Primary Open-Angle Glaucoma, Severe Stage

- Macular Degeneration – No Laterality & No Severity
  - H35.31 – Nonexudative Age-Related Macular Degeneration
  - H35.32 – Exudative Age-Related Macular Degeneration
Additional Circumstances (Injury & Trauma)

- Chapter 19
- Organized by anatomical site, then type of injury
- 7th character required to specify number of the encounter (initial vs subsequent or follow-up)
- Need to use Chapter 20 and indicate cause of injury (definite with “S” code, maybe for “T”)

Structure Of The ICD-10 (Clinical Example Later)

The Seventh Character

- A - Initial encounter. This describes the entire period in which a patient is receiving active treatment for the injury, poisoning, or other consequences of an external cause. So, you can use “A” as the seventh character on more than just the first claim. In fact, you can use it on multiple claims.
- D - Subsequent encounter. This describes any encounter after the active phase of treatment, when the patient is receiving routine care for the injury during the period of healing or recovery.
- S - Sequela. The seventh character extension “S” indicates a complication or condition that arises as a direct result of an injury. An example of a sequela is a scar resulting from a burn.

Injury Status

- Initial treatment is generally while the patient is undergoing the first exam.
  - Visits may occur in the ER, physicians office, or even include surgical treatment.
- Subsequent care is when the patient is done with the initial “active” treatment, and receiving follow-up care
  - Follow-up visits would all be coded subsequent to the initial encounter
- Sequela is when the patient is fully healed and returning for a complication of the initial condition.
  - For example: a recurrent corneal erosion
# Eye Injury & Trauma

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>990.0 Corneal Foreign Body</td>
<td>T15.01a – Foreign Body In Cornea, Right Eye, Initial Encounter</td>
</tr>
<tr>
<td></td>
<td>T15.01b – Foreign Body In Cornea, Right Eye, Subsequent Encounter</td>
</tr>
<tr>
<td></td>
<td>T15.01c – Foreign Body In Cornea, Right Eye, Sequela</td>
</tr>
</tbody>
</table>

## Cause Of Injury (Chapter 20)

<table>
<thead>
<tr>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>W22.8xx(A,D, Or S) – Striking Against or Struck By Other Objects, Initial (A), Subsequent (D), or Sequela (S)</td>
</tr>
<tr>
<td>W5Ø.4xx(A,D, Or S) – Accidental Scratch By Another Person, Initial (A), Subsequent (D), or Sequela (S)</td>
</tr>
</tbody>
</table>

## So Keep These Key Things In Mind

1. Classify the injury by anatomical site
2. Classify the injury by stage of visit
   - Initial (A)
   - Subsequent (D)
   - Sequela (S)
3. Classify the cause of the injury
4. Classify the place where injury happened
5. Classify the activity being performed while injury was sustained

## How Many Diagnoses Do You Need To Code An Injury? Four!

1. The injury itself with stage of care
2. Cause of the Injury
3. Place where injury was sustained
4. Activity being done while injury was sustained
High Risk Medications

**ICD-9**
- Screening for long-term use of Other Medication (ICD-9: V58.69)
- Once an adverse effect is found for Hydrochloroquine sulfate (Plaquenil), the ICD-9 code is: E931.4.

**ICD-10**
- Report Z79.899 for Plaquenil use for rheumatoid arthritis.
- Report M06.08 for rheumatoid arthritis, other, or M06.9 for rheumatoid arthritis, unspecified
- Always report both, link to both, and if the carrier does not pay on the Z code, link to the M code first (or only link to the M code above).
- The ICD-10 code is:
  - T37.2x5A - Adverse effect of antimalarials and drugs acting on other blood protozoa, initial encounter
  - T37.2x5D - Adverse effect of antimalarials and drugs acting on other blood protozoa, subsequent encounter
  - T37.2x5S - Adverse effect of antimalarials and drugs acting on other blood protozoa, Sequela

OMG!
What Happens If I Screw Up?
In July, 2015 CMS provided additional guidance for this:

Office Visits
**DEFINING THE PHYSICIAN/PATIENT ENCOUNTER (THE #1 AUDIT TRIGGER)**
Overview
Eye Examinations – Office Visits

<table>
<thead>
<tr>
<th>Code Set</th>
<th>Code Group</th>
<th>Code</th>
<th>Class</th>
<th>Relative Value</th>
<th>Units</th>
<th>Level Of Reimbursement</th>
<th>Level Of Documentation</th>
<th>Acceptance By Medical Insurance?</th>
<th>Assignment By Medical Insurance?</th>
<th>Billed To Medical Insurance?</th>
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<tbody>
<tr>
<td>HCPCS Level II</td>
<td>920XX Codes</td>
<td>92012</td>
<td>CPT</td>
<td>Yes</td>
<td>Higher</td>
<td>$140.11</td>
<td>Lower</td>
<td>Yes</td>
<td>Varied</td>
<td>Varied</td>
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<tr>
<td>HCPCS Level II</td>
<td>992XX Codes</td>
<td>99213</td>
<td>CPT</td>
<td>Yes</td>
<td>Lower</td>
<td>$90.00</td>
<td>Higher</td>
<td>Yes</td>
<td>Always</td>
<td>High</td>
</tr>
</tbody>
</table>

Why Is It Important To Use The Right Code?

- COMPLIANCE – CODE MUST MATCH SERVICE REQUIRED & PROVIDED
- ECONOMICS – EVEN SMALL DIFFERENCES IN REIMBURSEMENT ARE SIGNIFICANT

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### Ophthalmic Code Differences

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Reimbursement</th>
<th>Fee Relationship</th>
<th>% Delta</th>
</tr>
</thead>
<tbody>
<tr>
<td>92004</td>
<td>$140.11</td>
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<td></td>
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<tr>
<td>92014</td>
<td>$116.27</td>
<td>83%</td>
<td>17%</td>
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<tr>
<td>92002</td>
<td>$76.12</td>
<td>54%</td>
<td>29%</td>
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<tr>
<td>92012</td>
<td>$79.99</td>
<td>57%</td>
<td>-3%</td>
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</table>

### Evaluation & Management Code Differences

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<tr>
<th>CPT Code</th>
<th>Reimbursement</th>
<th>Fee Relationship</th>
<th>% Delta</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>$194.82</td>
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<td>99204</td>
<td>$155.12</td>
<td>80%</td>
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<td>99203</td>
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<tr>
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<td>$69.84</td>
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<td>$40.63</td>
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<td>$40.44</td>
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<td>21%</td>
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<tr>
<td>99211</td>
<td>$18.53</td>
<td>14%</td>
<td>16%</td>
</tr>
</tbody>
</table>

### The Routine Eye Examination

**SO, WHAT DOES “ROUTINE” REALLY MEAN?**
The “S” Codes

- Although Medicare and other federal payers don’t recognize the "S" codes, they can be useful for claims to some private insurers and other parties...
  - S0620 (for new patients)
  - S0621 (for established patients)
- Specifically describe routine well patient vision exams, including refraction.
- By performing a different level of service, you are required to use a different code, therefore are able to charge a separate fee.

A “S” Code Exam Is NOT A
COMPREHENSIVE EYE EXAMINATION FOR PRIVATE PAY PATIENTS!

The Ophthalmic Office Visits
THE COMPREHENSIVE EXAM & THE INTERMEDIATE EXAM
920x4 - Comprehensive

CPT 2016 Definition:
“...describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session.

- The service includes:
  - History
  - General medical observation
  - External examination
  - Ophthalmological examinations
  - Gross visual fields
  - Basic sensorimotor examination

- It often includes, as indicated:
  - Biomicroscopy
  - Examination with cycloplegia or mydriasis
  - Tonometry

- It always includes initiation of diagnostic and treatment programs.

920x2 - Intermediate

CPT 2016 Definition:
“... describes an evaluation of a new (condition) or an existing condition complicated with a new diagnostic or management problem not necessarily related to the primary diagnosis.

- The service includes:
  - History
  - General medical observation
  - External examination
  - Adnexal examination
  - Other diagnostic procedures as indicated

- It often includes, as indicated:
  - Biomicroscopy
  - And may include the use of mydriasis for ophthalmoscopy

- It always includes initiation of diagnostic and treatment programs.

920XX & Dilation

DILATION IS NOT MANDATORY WITH ANY OF THE 920XX CODES

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The Evaluation & Management Office Visits

They are not new anymore!

Evaluation & Management Coding System

New Patient  Established Patient
• 99201  • 99211
• 99202  • 99212
• 99203  • 99213
• 99204  • 99214
• 99205  • 99215

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Evaluation & Management Coding System

New Patient
- 99201
- 99202
- 99203
- 99204
- 99205

Established Patient
- 99211
- 99212
- 99213
- 99214
- 99215

Use CPT 99211, physician presence is not required, but must have initiated the service as part of a continuing plan and must be in the office suite when each service is provided.

The Big Three...

- History
  - Four levels of history
- Physical Examination
  - We are single system subspecialists
  - Four levels of physical examination
- Medical Decision Making
  - Four levels of medical decision making

Documentation of History

- Problem Focused
  - Chief Complaint
  - 1 to 3 elements of History of Present Illness (HPI)
- Expanded Problem-Focused
  - Chief Complaint
  - 1 to 3 elements of HPI
  - Ocular review of systems
- Detailed
  - Chief Complaint
  - 5 elements of HPI
  - Review of 8 systems + 1 other system
  - 1 specific item from past, family, or social history
- Comprehensive
  - Chief Complaint
  - 4 elements of HPI
  - Review of 8 systems + 1 other system
  - 2 to 3 specific item from past, family, or social history

Most Common HPI Elements

- Location
- Duration
- Severity
- Modifying Factors
Scoring A History - HPI

- History of Present Illness (HPI)
- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying Factors
- Associated Signs & Symptoms

- Brief
  - 1-3 elements

- Extended
  - 4-8 elements or at least 3 chronic or inactive conditions

Scoring A History – Review Of Systems

1. Constitutional
2. Eyes
3. Ears, Nose, Mouth & Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

How Are You Going To Get To 10?

Problem Pertinent is 1 system  Extended is 2-9 systems  Complete is 10-14 systems

Most Common HPI Elements

- Location
- Duration
- Severity
- Modifying Factors

Documentation of History

- Problem Focused
  - Chief Complaint
  - 1 to 3 elements of history of present illness (HPI)
- Expanded Problem-Focused
  - Chief Complaint
  - 1 to 3 elements of HPI
  - Ocular review of systems
- Detailed
  - Chief Complaint
  - 4 elements of HPI
  - Review of at least 1 other system
  - 1 specific item from past, family, or social history
- Comprehensive
  - Chief Complaint
  - 4 elements of HPI
  - Review of at least 9 additional systems
  - 2-3 specific items from past, family, and social history (est. vs. new)
Scoring A History - PFSH

Past, Family & Social History

- Patient's Past History
- Family History
- Social/Occupational History

- Problem Pertinent
  - 1 question

- Complete
  - 2 areas for Est Pt
  - 3 areas for New Pt

Scoring A History
Putting The Pieces Together

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Extended Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

HPI
- Brief
- 1-3

ROS
- N/A
- 1 area

PFSH
- N/A
- 1 area

Documentation of Physical Exam

- Problem Focused
  - Limited exam of the affected body area or organ systems
  - 1 to 5 elements of the eye exam documented

- Expanded Problem-Focused
  - Limited exam of the affected body area or organ system and other symptomatic or related organ systems
  - 6 elements of the eye exam documented

- Detailed
  - Extended exam of the affected body area and other symptomatic or related organ systems
  - 9 elements of the eye exam documented (can include M/S)

- Comprehensive
  - Complete single system specialty exam
  - All elements of the eye exam plus mental status documented
Elements Of An Eye Exam (1997)

1. VA's
2. OVA
3. Confrontation fields
4. Afferents
5. Lids and lid margins
6. Lacrimal glands
7. Lacrimal drainage
8. Adnexa
   - Temporals
   - Eyelashes
9. Bulbar and palpebral conjunctiva
10. Corneas
11. Lids
12. Eyelids
13. Adnexa
14. Eyeball
15. Posterior segments
16. Optic discs
17. Pupils & Irises
18. Anterior Chamber
19. Lenses
20. Orientation
21. Mood/Affect

992XX Codes & Dilation

DILATION IS MANDATORY WITH THE 992XX CODE IF THE TWO RETINAL ELEMENTS ARE USED TO COUNT TOWARDS LEVEL OF PHYSICAL EXAM, UNLESS MEDICALLY CONTRAINDICATED.

Levels Of Physical Exam

Remember The Key Numbers of 5, 6, 9, or Everything

• Any 5 elements or less = Level 1
• Any 6 – 8 elements = Level 2
• Any 9 – 13 elements = Level 3 (including mental status)
• All elements = Level 4 (including mental status)
Medical Decision Making
Diagnostic & Treatment Options

- Number of Diagnoses
  - 1 is Minimal
  - 2-3 is Limited
  - 4-5 is Multiple
  - 6+ is Extensive

- Number of Management Options

Medical Decision Making
Complexity of Data

- Diagnostic service ordered, planned, scheduled, or performed
- Review of diagnostic tests
- Decision to obtain old records, or take additional history
- Relevant finding from old records or additional history taken
- Discussion with other physician
- Independent interpretation of previously taken images, or studies

Medical Decision Making
Risk Of Complications/Morbidity

- Minimal - One self limited or minor problem
- Low - Two or more self limited or minor illnesses; One stable or chronic illness; One acute illness or injury; Uncomplicated injury or illness. Use of OTC medication.
- Moderate - One chronic illness with mild complications; Two stable chronic illnesses; An undiagnosed new problem (uncertain prognosis); Acute illness with systemic symptoms; Acute complicated injury. Prescription medication management.
- High - One or more chronic illness with severe complications, Acute or chronic illnesses or injuries posing a threat to life, or an abrupt change in neurological status
# Medical Decision Making

<table>
<thead>
<tr>
<th></th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Diagnostic &amp; Treatment Options</td>
<td>Minimal (1)</td>
<td>Limited (2-3)</td>
<td>Multiple (4-5)</td>
<td>Extensive (6+)</td>
</tr>
<tr>
<td>Amount &amp; Complexity of Data</td>
<td>Minimal or None (1)</td>
<td>Limited (2-3)</td>
<td>Moderate (4-5)</td>
<td>Extensive (6+)</td>
</tr>
<tr>
<td>Risk of Complications &amp; Mortality</td>
<td>Minimal self limited</td>
<td>Low 3 SL + C, Rx, DTC</td>
<td>Moderate CwC, C, Rx, CwC</td>
<td>High C w/high comp, threat to life</td>
</tr>
</tbody>
</table>
Medical Decision Making

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Low Complexity</td>
<td>Moderate Complexity</td>
<td>High Complexity</td>
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<tr>
<td>Number of Diagnostic &amp; Treatment Options</td>
<td>Minimal (1)</td>
<td>Limited (2-3)</td>
<td>Multiple (4-5)</td>
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<tr>
<td>Amount &amp; Complexity of Data</td>
<td>Minimal or None (1)</td>
<td>Limited (2-3)</td>
<td>Moderate (4-5)</td>
</tr>
<tr>
<td>Risk of Complications &amp; Morbidity</td>
<td>Minimal self limited</td>
<td>Low 1 SL, 1 C, VA, OTC</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

Identifying Level of Service

New Patient – Must meet or exceed 3 of 3 to qualify for that code level

<table>
<thead>
<tr>
<th>(Grade To Lowest Of Three)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>History</td>
</tr>
<tr>
<td>Exam</td>
</tr>
<tr>
<td>Decision Making</td>
</tr>
</tbody>
</table>
Established Patient – Must meet or exceed 2 of 3 to qualify for code (Grade To Middle Of Three)

<table>
<thead>
<tr>
<th>Code Range</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
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<tbody>
<tr>
<td>History</td>
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<td>1</td>
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<td>3</td>
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<tr>
<td>Exam</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Decision Making</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

See, The Code DOES Take Care Of Itself!

- The patient’s condition determines everything that you do.
  - History that was required understand the patient’s complaint
  - Exam that was required to properly diagnose the condition
  - Assessment of the condition(s)
  - Plan to provide the best outcome in the most efficient way that is concurrent with local standard of care
- What you do with the patient determines what you write down in the medical record.
- What you have written down determines the codes you use to describe the care required.
The CMS 1500 Form

- Your LEGAL document submission
  - You are attesting under penalties of perjury that everything is true and accurate as stated earlier
- Standard format accepted by all carriers for submitting claims
- Understanding this form is essential to getting properly reimbursed and for following rules in claims submissions.

Let’s Take A Look

CMS-1500 Form Detail

CMS-1500 Form Instructions

Additional instructions for CMS-1500 claim form (02/12): Enter one of the following qualifiers as appropriate to identify the role that this physician or NPP is performing:

<table>
<thead>
<tr>
<th>Qualifier</th>
<th>Provider Role</th>
<th>Qualifier</th>
<th>Provider Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN</td>
<td>Referring physician</td>
<td>DN</td>
<td>Referring physician</td>
</tr>
<tr>
<td>DK</td>
<td>Ordering physician</td>
<td>DK</td>
<td>Ordering physician</td>
</tr>
<tr>
<td>DQ</td>
<td>Supervising physician</td>
<td>DQ</td>
<td>Supervising physician</td>
</tr>
</tbody>
</table>
### Special Ophthalmological Services

**What Are They?**

**Definition:**
- Describes services in which a special evaluation of the part of the visual system is made, which goes beyond the services included under general ophthalmological services or in which special treatment is given.
- Special ophthalmological services may be reported in addition to the general ophthalmological service or evaluation and management services.
Some Frequent Questions!

- When can I do a special ophthalmic test?
  - You can perform a special ophthalmic test on the same day as any office visit.
  - They are a distinct and separate procedure and are not bundled into any examination services.
- Can I do the tests when the doctor is not in the office?
  - Yes – but you do have to pay attention to Supervision Status.
- Can I bill the test on the same day?
  - May have to use a modifier for some carriers.
- Do I have to collect two co-pays?
- Can I order tests way ahead of time?

Performing Additional Tests

Routine Procedures VS. Ordered Procedures

- The chronology of your medical record is imperative.
- Routine testing = standing orders
  - Never billable.
- Ordered testing
  - Based upon medical necessity.
  - Bill with office visit.
  - Use modifier when appropriate.
  - Be aware of specific code requirements & definitions.
  - Generally require an Interpretive Report.

How Do We Code Something That Is Different Than Its Defined Value?

iWellness Scan

iWellness

iScan

iVue
Example – Fundus Photography (92250)

- Active Code
- Bilateral By Definition
- Global Period Definition (XXX)
- Traditional Bilateral Use – 92250
- Unilateral Use – 92250 – 52 - (RT or LT)

Be sure to make the laterality of the procedure matches the laterality of the ICD-10 diagnosis code you are using.

How A Code Is Broken Down

- Example
  - 92134 – Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina.
- What Coding with modifiers means
  - 92134-TC, means you only performed the technical component
  - 92134-26, means you only performed the professional component
How A Code Is Broken Down

Definitions – Modifiers -26 & -TC

-26 Professional Component, Certain procedures are a combination of the a physician professional component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier -26

-TC Technical Component, The technical component is the equipment and technician performing the test. This is identified by adding modifier "TC" to the procedure code identified for the technical component charge.

2017 Update On MPPR

<table>
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<th>Current Policy</th>
<th>CPT Code</th>
<th>CPT Code</th>
<th>CPT Code</th>
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<td>92134</td>
<td>92250</td>
<td>92083</td>
<td>MPPR</td>
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<tr>
<td>Technical Component (-TC)</td>
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<td>469.58</td>
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Patient Notification

WHAT IT IS... AND WHY WE NEED IT
Patient Notification of Services

- Two Types Of Patient Notification
- Specific Use For Each
- The ABN and NEMB
  - ABN - Advance Beneficiary Notice (For Medicare Part B)
    - “Financial Informed Consent”
    - Patient Must Pay
    - Patient Signature Required
  - Medicare Advantage Advance Notice Of Member Responsibility
    - Specifically For Medicare Advantage Patients
  - NEMB - Notice Of Exclusion From Medicare Benefits
    - Patient Must Pay – excluded benefits
    - Patient Signature NOT Required

Modifiers For Patient Notification

- GA – “Waiver of Liability Statement Issued as Required by Payer Policy”
- GX – “Notice of Liability Issued, Voluntary Under Payer Policy”
- GY – “Statutory exclusions”
- GZ – “Expected Denial, No ABN on file”

Using The Right Modifier Is Critical

- GA indicates that the ABN is required by the payer policy. It is appended to a CPT code to report that a required ABN was issued for a service and is on file. If the service is denied, CMS will assign financial liability to the beneficiary. Because an ABN was properly obtained, the financial liability is legally transferred to the patient and the physician can bill the patient for this service.
- GX When modifier GX is appended to a CPT code, it used to report that a voluntary ABN was issued for a service that is statutorily excluded from Medicare reimbursement. Medicare rejects non-covered services appended with GX and assigns liability to the beneficiary. Because this is a voluntary ABN, the patient always has financial responsibility for the procedure or test being conducted.
Using The Right Modifier Is Critical

• -GZ indicates that a service or item is expected to be denied as unreasonable or unnecessary. It is appended to a CPT code to report that an ABN was not issued for this service. CMS will automatically deny these services and indicate that the beneficiary is not responsible for payment. Because the doctor did not obtain an ABN prior to performing the service, he cannot bill the patient.
• -GY When modifier GY is appended to a CPT code to report when a service is specifically excluded by Medicare and an ABN was not issued to the beneficiary. This indicates that the service is statutorily excluded or does not meet the definition of any Medicare benefit. CMS will deny these claims and the beneficiary will be totally responsible for all financial liability.

The Interpretation & Report

Should Contain
• Indications for testing
• Whether the test was ordered
• Test reliability
• Test results
  o Comparative findings
  o Plan
• Initiation of diagnostic/treatment plan
• Doctor’s signature

Comprehensive Reports

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Clinical Lab Testing In The Optometric Practice

OK, So What Is CLIA?

- **Definition:**
  - Clinical
  - Lab
  - Improvement
  - Amendment(s)

  Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed.

- So, where can you get additional information?

  - **Tearlab**
    - CPT Code
      - 83861 Description: Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity
      - Test both eyes; Code both eyes
        - 83861-QW-LT
        - 83861-QW-RT
        - (Do NOT use modifier -59)
        - Adhere to the policy as recommended by your carrier or billing specialist.
        - 2016 Reimbursement
          - $22.50 per test

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RPS AdenoPlus™

- CPT Code 87809-QW
  - Definition – Infectious agent antigen detection by immunoassay with direct optical observation; adenovirus
- Claim submission
  - 87809-QW-RT
  - 87809-QW-LT
- 2016 Reimbursement
  - $16.33 per test
- Rapid Pathogen Screening Website

InflammaDry

- CPT Code 83516-QW
  - Definition – immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method
- Claim submission
  - 83516-QW-RT
  - 83516-QW-LT
- 2016 Reimbursement
  - $15.71 per test

Let’s Look At More Cases
Anterior Segment Disorders

- Blepharitis
- Bacterial/Viral Conjunctivitis
- Keratitis

- Patient Presentation
- Patient- J.B.
  - 23 YOWF
  - VSP Insurance
  - Blue Cross
- Chief Complaint
  - Patient currently wearing monthly disposable contact lenses
  - Not sure of care products – buys what’s on sale
  - O.D. Painful, red, watery, light sensitive, etc...

- Uncorrected VA’s:
  - O.D. 20/15
  - O.S. 20/15
- Uncorrected Near VA:
  - O.U. J2
- Slit lamp shows....
Anterior Segment – Viral Conjunctivitis (Example)

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
<th>Diagnosis Code</th>
<th>Charges</th>
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</table>

Note: You may have to be much more specific as to the type of viral conjunctivitis and the underlying system virus that is the cause or source of the conjunctivitis.

Anterior Segment – Viral Conjunctivitis (Example)

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
<th>Diagnosis Code</th>
<th>Charges</th>
</tr>
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<tbody>
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<td>11</td>
<td>A</td>
<td>99213</td>
<td>$68.52</td>
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</tr>
</tbody>
</table>
Coding In The ICD-10 Era

- Procedures
  - 9921X

- Diagnoses During Follow-Up Visits
  - B00.53 – Herpes Viral Conjunctivitis
  - B30 – Viral Pharyngoconjunctivitis
    - B30.2 – Acute Epidemic Homorrhagic Conjunctivitis (Enteroviral)
    - B30.3 – Acute Epidemic Homorrhagic Conjunctivitis (Enteroviral)
    - B30.8 – Other Viral Conjunctivitis
    - B30.9 – Viral Conjunctivitis, Unspecified
  - Note: You may have to be much more specific as to the type of viral conjunctivitis and the underlying system virus that is the cause or source of the conjunctivitis.

Anterior Segment
Viral Conjunctivitis (Example)

$202.10

Corneal Abrasion
Corneal Abrasion

• Patient Presentation
• Patient- P.Q.
  - 34 YOAM
  - No Refractive Insurance
  - High Deductible Medical Insurance
• Wears daily disposable lenses just for sports & going out
• Thinks he scratched his right eye playing basketball.

Corneal Abrasion

• Uncorrected VA’s: O.D. 20/25 O.S. 20/20
• Uncorrected Near VA: O.U. J2
• Refraction: O.D. PLANO –0.50 X177 20/20
  - O.S. PLANO 20/20
• Slit lamp shows typical corneal abrasion with fluorescein

So what to do you now?

What Was 92070?

• Bandage Contact Lens?
• Therapeutic Contact Lens?
• Special Type Of Lens Required?
• 92070 – Fitting of a contact lens for medical or therapeutic purposes including supply of lens.
• As of January 1, 2012, 92070 Was No Longer A Valid Code
92071 (A Unilateral Code)

- CPT Code 92071 – Fitting of a contact lens for treatment of ocular surface disease.
- Please report materials IN ADDITION to this code using either 99070 or the appropriate HCPCS Level II material code.

This is now thought to be appropriate for a bandage CL situation.

Please do NOT report 92071 and 92072 on the same day of service.

Corneal Abrasion

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
<th>Diagnosis Code</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>From MM/DD/YY</td>
<td>To MM/DD/YY</td>
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<td></td>
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</tr>
<tr>
<td>1/24/2016</td>
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<td>S05.01x0A – Injury of Conjunctiva and Corneal Abrasion Without Foreign Body, Right Eye, Initial Encounter</td>
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<td>1/24/2016</td>
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<td>A</td>
<td></td>
<td>W22.8xxA – Striking Against or Struck By Other Objects, Initial Encounter</td>
<td>$36.36</td>
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<tr>
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<td>Y93.67 – Activity, Basketball</td>
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<td>B??</td>
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<td>Y92.310 – Basketball court as place of occurrence of external cause</td>
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Coding In The ICD-10 Era

- Procedures
  - 9920X
  - 92071-RT

- Diagnoses
  - S05.01x0A – Injury of Conjunctiva and Corneal Abrasion Without Foreign Body, Right Eye, Initial Encounter
  - W22.8xxA – Striking Against or Struck By Other Objects, Initial Encounter
  - Y93.67 – Activity, Basketball
  - Y92.310 – Basketball court as place of occurrence of external cause
Can We Bill For Materials?
• We are entitled to bill for materials if we are using a revenue based product, however if we are using a non-revenue product such as a trial lens (disposable) as our lens there would be no charge.

Corneal Abrasion

<table>
<thead>
<tr>
<th>Date of Service</th>
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<th>Type of Service</th>
<th>Procedures, Services, Supplies</th>
<th>Diagnosis Code</th>
<th>Charges</th>
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<td>99213</td>
<td>$68.52</td>
</tr>
</tbody>
</table>

Coding In The ICD-10 Era
• Procedures
  o 9921X

• Diagnoses During Follow-Up Visits
  o S05.01xD – Injury of Conjunctiva and Corneal Abrasion Without Foreign Body, Right Eye, Subsequent Encounter
  o W22.8xxD – Striking Against or Struck By Other Objects, Subsequent Encounter
  o Y93.67 – Activity, Basketball
  o Y92.310 – Basketball court as place of occurrence of external cause

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The OIG & Their Mission
- The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452 (as amended), is to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs.

http://oig.hhs.gov/

The OIG Work Plan
- The OIG Work Plan sets forth various projects to be addressed during the fiscal year by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General. The Work Plan includes projects planned in each of the Department’s major entities: the Centers for Medicare & Medicaid Services; the public health agencies; and the Administrations for Children, Families, and Aging.
- Information is also provided on projects related to issues that cut across departmental programs, including State and local government use of Federal funds, as well as the functional areas of the Office of the Secretary. Some of the projects described in the Work Plan are statutorily required, such as the audit of the Department’s financial statements, which is mandated by the Government Management Reform Act.

http://oig.hhs.gov/publications/workplan.asp
Surgical Codes

SPECIAL RULES & CIRCUMSTANCES

• The services provided by the physician to any patient by their very nature are variable in a given CPT surgical procedure basis, a variety of services are included in addition to the:
  - Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
  - One related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical)
  - Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
  - Writing orders
  - Typical postoperative follow-up care

Global Periods

• A Global Period is that period of time for which the follow-up care related to the surgical procedure, for that specific interval, is compensated for in the “Global” payment for the surgical procedure
Major vs. Minor Surgery

- **Minor Surgery**
  - Any surgical procedure that has a global period of LESS THAN 90 days

- **Major Surgery**
  - Any surgical procedure that has a global period of EQUAL TO or GREATER THAN 90 days

Surgical Coding

CPT CODE GROUP
6XXXX

Modifiers Of Special Note For Surgical Procedures

- **-24 Unrelated E/M Service, Same Physician, During Post-Operative Global Period**
- **-25 Separate Service, Same Physician, Same Day**
- **-50 Bilateral Procedure**
- **-51 Multiple Procedures**
- **-54 Surgical Care Only**
- **-55 Post-Operative Care Only**
- **-57 Decision To Perform Major Surgery**
- **-67 Repeat Procedure or Service, Same Physician**
- **-79 Unrelated Procedure, Same Physician, During Post-Operative Global Period**
- **-RT/LT Right, Left**
- **-E1 – E4 Punctal/Lid Identifiers**
Case Presentations

Surgical Cases

Corneal Foreign Body

- Patient Presentation
- Patient: N.P.
  - 33 YOWM
  - Blue Cross Medical - $2000 Deductible
  - Playing with kid last night in yard "wrestling around" something got in eye, still there, hurts, light sensitive, more in a.m.
Corneal Foreign Body

- Uncorrected VA's: O.D. 20/30 - O.S. 20/20
- Uncorrected Near VA: O.U. J2
- Slit lamp reveals embedded corneal foreign body at 10:00 O.D., etc...

Why Debride?

- Speed/improve healing
- Reduce chance of recurrent erosion
- Procedure:
  - Instill
    - anesthetic
    - antibiotic
    - NSAID
  - Pull defect toward center
  - Roughen basement membrane

Photos courtesy of Carl Spear, OD, FAAO
Corneal Foreign Body

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
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Coding In The ICD-10 Era

- Procedures
  - 65222-RT

- Diagnoses
  - T15.01xA – Foreign Body In Cornea, Right Eye, Initial Encounter
    - Z18.10 – Retained Metal Fragment, Unspecified
    - Y93.83 – Activity, Rough Housing And Horseplay
    - Y92.017 – Garden or Yard in Single-Family (Private) House As The Place Of Occurrence Of The External Cause
 Modifier -25

**Significant, Separately Identifiable E/M service**

"The patient’s medical record documentation is expected to clearly evidence that the evaluation and management service performed and billed was "above and beyond" the usual pre-operative and post-operative care associated with the procedure performed on that same day."

---

**Modifier -25**

**The OIG Says...**

"We will determine whether providers used modifier –25 appropriately. In general, a provider should not bill evaluation and management codes on the same day as a procedure or other service unless the evaluation and management service is unrelated to such procedure or service."

---

**Let’s Look At The Reference**

**OIG Publication On NCCI Edits**

*Specifically calls out Minor Surgical Procedures*

---

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www.PRMI.com – WhatsMyPracticeWorth.com
Modifier -25
So What’s Right?
• Be sure the record is clear regarding the patient complaint, circumstance, finding, result of diagnostic testing, complication, etc... that supports the need for a SECOND evaluation and management service.

• Reference: CMS Rule

Corneal Foreign Body

<table>
<thead>
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<th>Dates of Service</th>
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Coding In The ICD-10 Era

• Procedures
  ○ 9921X

• Diagnoses
  ○ T15.01xD – Foreign Body In Cornea, Right Eye, Subsequent Encounter
  ○ Z18.10 – Retained Metal Fragment, Unspecified
  ○ Y93.83 – Activity, Rough Housing And Horseplay
  ○ Y93.017 – Garden or Yard In Single-Family (Private) House As The Place Of Occurrence Of The External Cause
Corneal Foreign Body

Diagnosis: 992.00 Corneal Foreign Body, Monitoring Visit

<table>
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<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
<th>Diagnosis Code</th>
<th>Charges</th>
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Coding In The ICD-10 Era

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- Diagnoses
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  - Y92.017 – Garden or Yard In Single-Family (Private) House As The Place Of Occurrence Of The External Cause

Corneal Foreign Body

$171.80
Amniotic Membranes

PROKERA® SLIM

Emerging Paradigm

Key to minimizing a sight-threatening scar is controlling inflammatory response and promoting healing

CPT Definition of 65778 (Chronological)

• 2011 - Placement of amniotic membrane on the ocular surface for wound healing; self retaining
• 2012 - Placement of amniotic membrane on the ocular surface for wound healing; self retaining
• 2013 - Placement of amniotic membrane on the ocular surface for wound healing; self retaining
• 2014 - Placement of amniotic membrane on the ocular surface; without sutures
Coding For 65778

- V2790 (amniotic membrane for surgical reconstruction, per procedure) cannot be billed on same day as 65778 as it is already included in the reimbursement for the surgical code itself for CMS.

CPT Code 65778 – Things To Note

CPT CHARACTERISTICS
- Active CMS Code With Reimbursement
- Bilateral 150% Procedure
- Total Non-Facility RVU Value = 38.77
- Global Period = 0 Days
- National Average CMS Reimbursement is $1,453
- LCD's Generally Don't Cover 65778
- Include Statement Of Medical Necessity & Surgical Report

MINOR SURGICAL PROCEDURE RULES
- Office Visit Related To The Decision To Perform Surgery Is Already Included In Reimbursement For 65778
- Use of Modifier -25 Should Be Rare
- Cannot Bill Materials In Addition To Surgical Code
- V2790 Is NOT Billed In Addition To 65778 For CMS, Although Some Other Third Party Carriers May Allow

Recurrent Corneal Erosion
Recurrent Corneal Erosion

- Patient Presentation
- Patient: W.A.
  - 67 YOWM
  - Medicare
- Chief Complaint – Left Eye
  - Recurrent episodes of ocular pain
  - Foreign body sensation
  - Photophobia
  - Decreased vision
  - Watering upon awakening

Clinical Presentation

- Reduced vision (hazy)
- Positive staining
- Hard to hold eye open
- Epithelial disruption
- No folds in Descemet’s membrane

Initial Treatment Protocol
- Cycloplegia
- NSAID
- BCL?

Diagnosis: 371.42, Recurrent Erosion Of Cornea

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies</th>
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<th>Charges</th>
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Coding In The ICD-10 Era

- ICD-9
  - 371.42 Recurrent Erosion Of Cornea

- ICD-10
  - H18.832 – Recurrent Erosion Of Cornea, Left Eye
  - T15.02xS – Foreign Body In Cornea, Left Eye, Sequela

Recurrent Corneal Erosion

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<th>Dates of Service</th>
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<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
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Coding In The ICD-10 Era

- ICD-9
  - 371.42 Recurrent Erosion Of Cornea

- ICD-10
  - H18.832 – Recurrent Erosion Of Cornea, Left Eye
  - T15.02xS – Foreign Body In Cornea, Left Eye, Sequela
Recurrent Corneal Erosion - PROKERA®

<table>
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Coding In The ICD-10 Era

- **ICD-9**
  - 371.42 Recurrent Erosion Of Cornea

- **ICD-10**
  - H18.832 – Recurrent Erosion Of Cornea, Left Eye
  - T15.02xS – Foreign Body In Cornea, Left Eye, Sequela

Recurrent Corneal Erosion

WITH PROKERA [CMS] $1,838.07
Trichiasis

• Patient Presentation
• Patient- T.C.
  ○ 85 YOBF
  ○ Medicare
• Chief Complaint
  ○ "Glasses not working well, glare, hard to drive at night. Left eye waters a lot, rubs constantly.

Trichiasis

• Uncorrected VA's: O.D. 20/70 O.S. 20/30-
• Corrected Near VA: O.U. J4
• Refraction: O.D. +.75 - 0.50 X87 20/40
  • O.S. +1.00 – 50 X96 20/25-
• Near Add: +2.75 20/40+
• Slit lamp shows NS typical OD, corneal abrasion O.S. due to entropian on lower left lid.
### Trichiasis (Epilation)

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<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
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J. Rumpakis, OD, MBA
Practice Resource Management, Inc. – John@PRMI.com
www.PRMI.com – What’sMyPracticeWorth.com
**Coding In The ICD-10 Era**

**PROCEDURES**
- 92014
- 92015
- 67820-E2
- 92285-52-LT

**DIAGNOSES**
- H52.03 – Hypermetropia, Bilateral
- H52.223 – Regular Astigmatism, Bilateral
- H52.4 – Presbyopia
- H25.11 – Age Related Nuclear Cataract, Right Eye
- H02.054 – Trichiasis Without Entropian Left Lower Eyelid

---

**Trichiasis (Epilation)**

$206.63

---

**Glaucoma**
Glaucoma

- **Patient Presentation**
  - **Patient**: O.C.
    - 45 YOAAM
    - VSP Insurance
    - Blue Cross Medical
  - **1st eye exam ever**
  - **Chief Complaint**
    - Having a very difficult time reading

<table>
<thead>
<tr>
<th>Uncorrected VA's</th>
<th>Uncorrected Near VA</th>
<th>O.D.</th>
<th>O.S.</th>
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<tr>
<td>O.D. 20/25</td>
<td>O.S. 20/20</td>
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- **FDT Testing - Normal**
  - **NCT @ 8:15 a.m.**: O.D. 23 O.S. 22
  - **Refraction**: O.D. PLANO − 0.50 X 87 20/20
    - O.S. PLANO 20/20
  - **Near Add**: +1.50 20/20 @ 40cm.

- **Goldmann @ 8:45 a.m.**, O.D. 22 O.S. 22
  - DFE with 2.5% Phenylepherine, 1% Tropicamide
  - Retinal evaluation with 78D lens
  - O.D. C/D .6 x .6 O.S. .7 x .7
  - Deep cylindrical cupping
  - Goldmann @ 9:25 a.m., O.D. 20 O.S. 20
What Do You Do?

- Complete the comprehensive exam
- Closing conference with patient
- Educate regarding glaucoma
  - Several different types / basic examples
  - Need to confirm and differentiate
  - Additional testing (scheduling)
- Bill VSP for exam & optical

Coding The Initial Encounter

<table>
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<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
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<th>Procedures/Signatures (Specify Underline Services)</th>
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Coding In The ICD-10 Era

**PROCEDURES**
- 92004
- 92015

**DIAGNOSES**
- H52.4 – Presbyopia
- H52.221 – Regular Astigmatism, Right Eye
- H40.023 – Open Angle With Borderline Findings, High Risk, Bilateral
Now What Do You Do?

- Schedule additional testing (Week 1)
  - Visual Fields
  - Gonioscopy
  - Fundus Photography
  - Pachymetry

NOTE: Diagnostic tests should be ordered based on the medical necessity to evaluate the presenting glaucoma risk. It is rarely appropriate to run all your tests you have available on every suspect. The order and timing of testing should also be per your medical determination on a per patient basis.

Coding The Second Encounter

<table>
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<th>Date of Service</th>
<th>Date of Service</th>
<th>Type of Service</th>
<th>Procedures, Signed by Provider (CPT-4 &amp; HCPCS - Modifier)</th>
<th>Diagnosis Code</th>
<th>Charges</th>
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Visualization of the Epithelial Thickness

Main Report – Pachymetry Map partnered with the Epithelial Thickness Map

*ETM requires regulatory clearance and is not yet available commercially available in the United States.
Coding In The ICD-10 Era

**PROCEDURES**
- 9921X
- 92250
- 92020
- 92083
- 76514

**DIAGNOSES**
- H40.023 – Open Angle With Borderline Findings, High Risk, Bilateral

Now What Do You Do?
- Schedule additional testing (Week 2)
  - Serial Tonometry
  - Analysis of Nerve Fiber Layer
- What about VEP & ERG???
  - "I heard that I can make a lot of money by doing these tests. In fact, the sales rep virtually guaranteed it!"

Coding The Third Encounter

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
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Coding In The ICD-10 Era

**PROcedures**
- 9921X
- 92133
- 92100

**Diagnoses**
- H40.023 – Open Angle With Borderline Findings, High Risk, Bilateral

Why Can’t I Just Do What I Want?

**The National Correct Coding Initiative**

NCCI Edits

- National Correct Coding Initiative
  - These edits are updated quarterly
- Developed by:
  - CPT®
  - National & Local Policy Edits
  - National Societies Guidelines
  - Standard Medical & Surgical Practices
Format of the CCI Edits

- Two different types of edits:
  - Column 1/Column 2 Edits
    - (formerly Comprehensive/Component Edits)
  - Mutually Exclusive Edits

Column 1/Column 2 Edits

- The Column 2 code will not be paid when it is rendered by the same provider on the same date of service because it is considered to be part of the comprehensive code
  - Example
    - 92083/99211
    - 92004/92020
  - Unless a modifier is used citing special circumstances

Mutually Exclusive

- Procedures defined as those which cannot be reasonably performed by a physician in the same patient encounter.
  - 92004/92002
  - 68801/68761
  - 92250/92133
Case Example

• Going back to our Glaucoma case...
  ○ I do it all of the time...
  ○ I have never gotten in trouble...

• “Dr. Rumpakis, you must not know about certain modifiers that we use to get around the rules...”

Modifier -59 
Distinct Procedural Service

• Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day.
• Modifier –59 is used to identify procedure(s) & service(s) that are not normally reported together, but are appropriate under the circumstances.
  ○ This may represent a different session or patient encounter, different procedure, anatomy, different site or organ system, separate incision, incision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same physician.

Modifier -59 
Distinct Procedural Service

• Modifier 59 will only be recognized as valid to bypass edits when:
  • Combination of procedure codes represent procedures that would not normally be performed at the same time (e.g. procedure on head and procedure on feet, craniotomy and setting of compound fracture)
  • Different session or patient encounter is documented in patient’s medical record
  • Surgical procedures performed are not through the same incisional site (Note: doesn’t matter if instrumentation changes if incision or presentation is the same)
  • Surgical knee procedures involving multiple compartments of the same knee
  • Another modifier is not more appropriate (e.g. Modifier 51)
  • Used as a modifier of last resort
Modifier -59 & The “X Codes”

- Perspective: Modifier 59 is the most widely used HCPCS modifier:
  - It is defined for use in a wide variety of circumstances, and is often applied incorrectly to bypass National Correct Coding Initiative (NCCI) edits. This modifier is associated with considerable misuse and high levels of manual audit activity, leading to reviews, appeals, and even civil fraud and abuse cases. The introduction of subset modifiers is designed to reduce improper use of modifier 59 and help to improve claims processing for providers.

- The Centers for Medicare & Medicaid Services (CMS) is establishing four new Healthcare Common Procedure Coding System (HCPCS) modifiers to define subsets of the -59 modifier, which is used to designate a “distinct procedural service.”

- The implementation date for this change was Jan. 5, 2016. Initially, either modifier 59 or a more selective –X{EPSU} modifier will be accepted, although CMS has encouraged a rapid migration of providers to the more selective modifiers. For further instructions regarding this change check with your MAC.

- Transmittal 1422, Change Request 8863 provides that CMS is establishing the following new modifiers—referred to collectively as -X{EPSU} modifiers—to define specific subsets of the -59 modifier:
  - XE - Separate Encounter: A service that is distinct because it occurred during a separate encounter.
  - XS - Separate Structure: A service that is distinct because it was performed on a separate organ/structure.
  - XP - Separate Practitioner: A service that is distinct because it was performed by a different practitioner.
  - XU - Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.
Bypassing The Rules

WHEN IS IT LEGIT?

Now What Do You Do?

• Confirm Dx with patient
• Confirm need for treatment and consequences of not treating
• Select medication and explain your choice
• Review the use of medication
• Sample
• Schedule to monitor in 1 week

Now What Do You Do?

• Tonometry at next visit
• Educate patient as to reduction of IOP
• Confirm diagnosis
• Write prescription
• Schedule for 3 week monitoring
Cracking The Code: Clinical Case Management & Medical Record Compliance In Coding In The ICD-10 Era
TAOP Fall Meeting – 2016

Coding The Fourth Encounter

<table>
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<tr>
<th>Dates of Service</th>
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<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
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Coding In The ICD-10 Era

PROCEDURES

- 9921X

DIAGNOSIS

- H40.1131 – Primary Open-Angle Glaucoma, Bilateral, Mild Stage

New ICD-10 As Of 10/1/2017

Now What Do You Do?

- Educate patient as to reduction and stability of IOP
- Schedule for 3 month monitoring
  - Serial Tonometry
Coding The Fifth Encounter

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Diagnosis: 365.11, Primary Open Angle Glaucoma & 365.71, Mild Stage Glaucoma

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Coding In The ICD-10 Era

PROCEDURES

• 9921X
• 92100

DIAGNOSIS

• H40.1131 – Primary Open-Angle Glaucoma, Bilateral, Mild Stage

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Now What Do You Do?

• Educate stability of IOP
• Schedule for 3 month monitoring

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Now What Do You Do?

- Tonometry (7 months)
- Educate stability of IOP
- Schedule for 3 month monitoring

Coding The Sixth Encounter

<table>
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<th>Dates of Service</th>
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Diagnosis: 365.11, Primary Open Angle Glaucoma & 365.71, Mild Stage Glaucoma

Coding In The ICD-10 Era

- 9921X
- H40.1131 – Primary Open-Angle Glaucoma, Bilateral, Mild Stage
Now What Do You Do?

- Tonometry (10 months)
- Educate stability of IOP
- Schedule for 3 month monitoring

Coding The Seventh Encounter

<table>
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<th>Diagnosis Code</th>
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Coding In The ICD-10 Era

- H40.1131 – Primary Open-Angle Glaucoma, Bilateral, Mild Stage
Summary Of Care Year One

- Comprehensive exam
- 1 Primary Diagnostic Visit
- 1 Secondary Diagnostic Visit
- 4 Monitoring Visits

Summary Of Fees

YEAR ONE

Fee Summary – Year One

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Medicare
### Procedure Fees Per Procedure

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**Care For Year 2 & Beyond**

**Fee Summary – Year One**

**Typical Non-Medicare Carrier**

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**Typical Non-Medicare Carrier**

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</table>
How Would You Handle This Situation?

- Patient calls for an eye exam
- Patient is on the books for an eye exam
- Patient presents with this statement
  - “I’m here today because I have a family history of glaucoma and I want to get checked to see if I have it.”
- No refractive insurance, but has medical insurance – no deductible, $25 co-pay
- How would you handle this?

Special Glaucoma Service Codes – The G Codes

- The “G” Codes
  - G0117, reported when performed only by an optometrist or ophthalmologist
  - G0118, reported when performed under the direct supervision of an optometrist or ophthalmologist
  - Diagnosis code of V80.1 should be used
- Codes are to be used when the glaucoma screening is the only service provided or when it is provided as part of an otherwise non-Medicare covered service
- Only high-risk patients are eligible for this benefit:
  - those with a family history of glaucoma
  - those with diabetes mellitus
  - African-Americans over age 50
  - Hispanics over age 65 (Added In 2006)

Special Glaucoma Service Codes – The G Codes

- Includes:
  - Visual Acuities
  - IOP measurement
  - Dilated exam, direct or slit lamp ophthalmoscopy
Age Related Macular Degeneration

Let’s Show You A Better Way
THE MACULA RISK® CPT ADVISOR

Age Related Macular Degeneration
- Patient Presentation
- Patient - L.B.
  - 72 YOWF
  - No Refractive Insurance
  - Medicare Only
- Chief Complaint
  - Annual Eye Exam – Recall Card, but it has been longer than three years since the last date of examination.
Age Related Macular Degeneration

- Uncorrected VA’s: O.D. 20/40 O.S. 20/40
- Uncorrected Near VA: O.U. 20/200
- Refraction: O.D. +1.00 – 0.50 X 87 20/20
  - O.S. +1.00 sph
- Near Add: +2.25 20/20

Age Related Macular Degeneration

- Goldmann @ 11:45 a.m., O.D. 18 O.S. 17
- DFE with 2.5% Phenylepherine, 1% Tropicamide
- O.D. C/D .2 x .2 O.S. .2 x .3
- OD Macula showing pigmentary changes, etc. Typically associated with mild dry AMD
  - Amsler Grid positive for metamorphopsia
- OS Macula – clear, unremarkable

ARMD Dry

Diagnosis: 362.51, Non-Exudative Senile Macular Degeneration

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<th>Dates of Service</th>
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Coding In The ICD-10 Era

**PROcedures**
- 92004
- 92015

**Diagnoses**
- H52.03 – Hypermetropia, Bilateral
- H52.221 – Regular Astigmatism, Right Eye
- H52.4 – Presbyopia
- H35.3111 – Nonexudative Age-Related Macular Degeneration, Right Eye, Early Dry Stage

New ICD-10 As Of 10/1/2017

---

**Age Related Macular Degeneration**

- So now what?
  - Order the Macula Risk lab test
- How do I bill it?
  - There is no billing by the OD
  - The lab bills the insurance
  - The patient may have up to a $25 co-pay that generally is not collected... So, in essence the test is free to the patient

---

**ARMD Dry**

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<th>Dates of Service</th>
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## Coding In The ICD-10 Era

### PROCEDURES
- 9921X
- 92250
- 92083

### DIAGNOSES
- H35.3111 – Nonexudative Age-Related Macular Degeneration, Right Eye, Early Dry Stage

## ARMD Dry

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## Coding In The ICD-10 Era

### PROCEDURES
- 9921X
- 92134

### DIAGNOSES
- H35.3111 – Nonexudative Age-Related Macular Degeneration, Right Eye, Early Dry Stage
ARMD Dry

Diagnosis: 362.51, Non-Exudative Senile Macular Degeneration

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
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Coding In The ICD-10 Era

**PROCEDURES**

• 9921X

**DIAGNOSES**

• H35.3111 – Nonexudative Age-Related Macular Degeneration, Right Eye, Early Dry Stage

ARMD Dry

$539.66
Diabetes

A VERY SPECIAL CASE IN OPHTHALMIC PRACTICES

Diabetic Retinopathy

- **Patient Presentation**
- **Patient - D.B.**
  - 55 YOWM
  - VSP Insurance
  - Blue Cross Medical
- **Chief Complaint**
  - PCP just told him that he has just “a little” diabetes and should get his eyes checked.

**Uncorrected VA’s**:
- O.D. 20/25 O.S. 20/20

**Uncorrected Near VA**:
- O.U. J5

**Refraction**:
- O.D. +0.25 -0.50 x 115 20/20
- O.S. +0.50 SPH 20/20
- Near Add: +2.50 20/20
Diabetic Retinopathy

- Goldmann @ 3:45 p.m., O.D. 17 O.S. 15
- Fundus exam through dilated pupil
- Retinal findings consistent with Grade 1 background diabetic retinopathy, OU. (important notation in your record)

Non Proliferative Diabetic Retinopathy - Background

Diagnosis: 362.01, 250.5X, Non Proliferative Diabetic Retinopathy, Diabetes w/Ophthalmic Manifestations

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
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<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
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Coding In The ICD-10 Era

- 92004
- 92015
- H52.03 – Hypermetropia, Bilateral
- H52.221 – Regular Astigmatism, Right Eye
- H52.4 – Presbyopia
- E11.3293 – Type 2 Diabetes Mellitus With Mild Nonproliferative Diabetic Retinopathy Without Macular Edema, Bilateral

New ICD-10 As Of 10/1/2017
### Non Proliferative Diabetic Retinopathy - Background

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### Coding In The ICD-10 Era

- **PROCEDURES**
  - 9921X
  - 92250
  - 92083

- **DIAGNOSES**
  - E11.3293 – Type 2 Diabetes Mellitus With Mild Nonproliferative Diabetic Retinopathy Without Macular Edema, Bilateral
Coding In The ICD-10 Era

PROCEDURES

• 9921X
• 92134

DIAGNOSIS

• E11.3293 – Type 2 Diabetes Mellitus
  With Mild Nonproliferative Diabetic Retinopathy Without Macular Edema, Bilateral

Non Proliferative Diabetic Retinopathy - Background

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Coding In The ICD-10 Era

PROCEDURES

• 9921X

DIAGNOSIS

• E11.3293 – Type 2 Diabetes Mellitus
  With Mild Nonproliferative Diabetic Retinopathy Without Macular Edema, Bilateral
Non Proliferative Diabetic Retinopathy - Background

Diagnosis: 362.01, 250.5X, Non Proliferative Diabetic Retinopathy, Diabetes w/Ophthalmic Manifestations

<table>
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Coding In The ICD-10 Era

PROCEDURES

• 9921X

DIAGNOSES

• E11.3293 – Type 2 Diabetes Mellitus With Mild Nonproliferative Diabetic Retinopathy Without Macular Edema, Bilateral
Coding In The ICD-10 Era

PROCEDURES
• 9921X

DIAGNOSES
• E11.3293 – Type 2 Diabetes Mellitus With Mild Nonproliferative Diabetic Retinopathy Without Macular Edema, Bilateral

Non Proliferative Diabetic Retinopathy - Background

$676.70

Choroidal Nevus
(BENIGN NEOPLASM)
Choroidal Nevus

**Patient Presentation**
- Patient: L.B.
  - Age: 38 years
  - Insured by: Aetna
- Routine Exam: No problems, annual examination by recall

**Uncorrected VA’s**
- O.D.: 20/20
- O.S.: 20/20

**Uncorrected Near VA**
- O.U.: 20/20

**Refraction**
- O.D.: +0.25 – 0.25 X 006 20/20
- O.S.: +1.00 – 0.50 X 178 20/20

**Goldmann**
- O.D.: 15
- O.S.: 15
- O.D. C/D: 2 x 2
- O.S.: 2 x 3
- Direct ophthalmoscopy reveals suspect “Nevus” in right eye
- Patient rescheduled for follow-up

**Coding Concepts**
- New vs Established
- Medical vs Refractive
- Contractual Obligations
- Chief Complaint
- Additional Services Covered

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Choroidal Nevus

Diagnosis: 224.6 Benign Neoplasm, Choroid

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
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<th>Procedures, Services, Supplies</th>
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Choroidal Nevus

Diagnosis: 224.6 Benign Neoplasm, Choroid

<table>
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<th>Dates of Service</th>
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Coding In The ICD-10 Era

PROCEDURES

- 92004
- 92015

DIAGNOSES

- H52.03 – Hypermetropia, Bilateral
- H52.223 – Regular Astigmatism, Bilateral
- D31.31 – Benign Neoplasm Of Right Choroid
Cracking The Code: Clinical Case Management & Medical Record Compliance In Coding In The ICD-10 Era
TAOP Fall Meeting – 2016

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Coding In The ICD-10 Era

PROCEDURES
• 9921X
• 92250-02-RT
• 92083

DIAGNOSIS
• D31.31 – Benign Neoplasm Of Right Choroid

Choroidal Nevus

Diagnosis: 224.6 Benign Neoplasm, Choroid

<table>
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<th>Date of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
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Coding In The ICD-10 Era

PROCEDURES
• 9921X
• 92134

DIAGNOSIS
• D31.31 – Benign Neoplasm Of Right Choroid

What's Worth with the Chart?
Choroidal Nevus

Diagnosis: 224.6 Benign Neoplasm, Choroid

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies (Explain Unusual Circumstances)</th>
<th>Diagnosis Code</th>
<th>Days or Units</th>
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<tr>
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<td>CPT/HCPCS - Modifier</td>
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Coding In The ICD-10 Era

- 9921X
- D31.31 – Benign Neoplasm Of Right Choroid
**Coding In The ICD-10 Era**

**PROCEDURES**
- 9921X

**DIAGNOSES**
- D31.31 – Benign Neoplasm Of Right Choroid

**My Action Plan**

**WHAT DO I DO NOW?**

**John’s 12-Step Program**

*HI, MY NAME IS <BLANK...> I CAN NOW TRANSLATE MY CLINICAL CARE PROPERLY BECAUSE I AM A REFORMED CODER...*
John’s 12-Step Program

• Identify carriers with whom you want to be on their plan – it’s a business decision!
• Establish “Needs Assessment” for your situation
  ▪ Obtain resource material that you need
• Create disease protocols for your office
  ▪ Review the findings regarding the health and vision of each patient
  ▪ Develop system for appointing the patients next visit before they leave the office
  ▪ Put the process in flow chart format

John’s 12-Step Program

• Everyone in the office must be educated about the protocol and the process
  □ All staff must be onboard with providing the highest level of care
    ▪ Diagnosis
    ▪ Treatment
    ▪ Selection of Medication
• Market your ability to provide primary care to your patient base
  ▪ Set Goals, Objectives, Strategies, and Tactics for what you want to achieve

John’s 12-Step Program

• Always perform the standard of care as your baseline
• Document the medical record with your thoughts and impressions
• Be vigilant about proper coding
  ▪ Perform internal audits on a regular basis
  ▪ Use a grading sheet on a regular basis
  ▪ Keep up with change in coding protocols
  ▪ Develop office strategy for change mgmt
John’s 12-Step Program

• Develop office strategy for change management
  • Rules & requirements change frequently
• Be audit proof – a perfect medical record that accurately reflects the care provided and outcomes attained is priceless
• Never be complacent!
• Keep up on your continuing education and remember that your medical record and subsequent coding of your services is a legal requirement – it’s not an option!