SOUTHEAST EYE SPECIALISTS, PLLC

2017 CODING & BILLING UPDATE

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2016 MEDICARE DEDUCTIBLE

<table>
<thead>
<tr>
<th>PART</th>
<th>DEDUCTIBLE</th>
<th>MONTHLY DEDUCTIBLE</th>
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<tbody>
<tr>
<td>A</td>
<td>HOSPITAL</td>
<td>$413</td>
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<tr>
<td></td>
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<td>$1,316</td>
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<tr>
<td>B</td>
<td>MEDICAL</td>
<td>$109 (AVG)</td>
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<tr>
<td></td>
<td></td>
<td>$183</td>
</tr>
<tr>
<td>C</td>
<td>MEDICARE ADVANTAGE</td>
<td>VARIIES</td>
</tr>
<tr>
<td>D</td>
<td>MEDICARE PRESCRIPTION DRUG COVERAGE</td>
<td>VARIIES</td>
</tr>
</tbody>
</table>

CPT CODE UPDATES

NEW CPT CODES IN 2017

• 92242
  • Fluorescein angiography [92235] AND indocyanine-green angiography [92240] performed at the same patient encounter with interpretation and report, unilateral or bilateral

DELETED CPT CODES IN 2017

• 92140
  • Provocative tests for glaucoma, with interpretation and report, without tonography
**NEW CATEGORY III CODES IN 2017**

- **0444T**
  - Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral

- **0445T**
  - Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral

- **0449T**
  - Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device

- **0450T**
  - Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (list separately in addition to code for primary procedure)

- **0464T**
  - Visual evoked potential, testing for glaucoma, with interpretation and report

- **92235**
  - Fluorescein angiography (includes multi frame imaging) with interpretation and report, unilateral or bilateral

- **92240**
  - Indocyanine-green angiography (includes multi frame imaging) with interpretation and report, unilateral or bilateral

- **0333T**
  - Visual evoked potential, screening of visual acuity, automated, with report

**REVISED CPT AND CATEGORY III CODES IN 2017**

- **67101**
  - Repair of RD, including drainage of sub retinal fluid

- **67105**
  - Repair of RD, 1 or more sessions; photocoagulation

- **92235**
  - Fluorescein angiography (includes multi frame imaging) with interpretation and report, unilateral or bilateral

- **92240**
  - Indocyanine-green angiography (includes multi frame imaging) with interpretation and report, unilateral or bilateral

- **0333T**
  - Visual evoked potential, screening of visual acuity, automated, with report

**IF KEEPING SCORE AT HOME - VEP**

- **0333T**
  - Visual evoked potential, screening of visual acuity, automated, with report

- **0464T**
  - Visual evoked potential, testing for glaucoma, with interpretation and report

- **92235**
  - Fluorescein angiography (includes multi frame imaging) with interpretation and report, unilateral or bilateral

- **92240**
  - Indocyanine-green angiography (includes multi frame imaging) with interpretation and report, unilateral or bilateral

- **0333T**
  - Visual evoked potential, screening of visual acuity, automated, with report

**DELETED CATEGORY III CODES IN 2017**

- **0289T**
  - Corneal incisions in donor cornea created using a laser in preparation for penetrating or lamellar keratoplasty
ICD-10 CODE UPDATES

DIABETES CODES

• One of the following 7th characters is to be assigned to codes in subcategory E11.32
  • 1 - right eye
  • 2 - left eye
  • 3 - bilateral
  • 4 - unspecified eye

DIABETES CODES

• Code for insulin use
  • Z79.4 long term (current) use of insulin
• Code for oral DM medications
  • Z79.84 long term (current) use of oral hypoglycemic drugs

ARMD CODE CHANGES

• H35.31 Nonexudative age-related macular degeneration
  • Add a 7th character (staging) and code PER EYE
  • H35.311 nonexudative age-related macular degeneration, right eye
    • 0 - stage unspecified
    • 1 - early dry stage
    • 2 - intermediate dry stage
    • 3 - advanced atrophic without subfoveal involvement
    • 4 - advanced atrophic with subfoveal involvement

ARMD CODE CHANGES

• H35.32 Exudative age-related macular degeneration
  • Add a 7th character (staging) and code PER EYE
  • H35.321 exudative age-related macular degeneration, right eye
    • 0 - stage unspecified
    • 1 - with active choroidal neovascularization
    • 2 - with inactive choroidal neovascularization
      • with involuted or regressed neovascularization
    • 3 - with inactive scar

POAG CHANGES

• H40.11 Primary Open Angle Glaucoma
  • Continue to stage
  • Now code POAG by EYE
  • H40.111 Primary Open Angle Glaucoma, right eye
  • H40.112 Primary Open Angle Glaucoma, left eye
CRVO CHANGES
- H34.81 Central retinal vein occlusion
  • Still Per EYE
  • H34.811 central retinal vein occlusion, right eye
  • Now staged:
    • 0 - with macular edema
    • 1 - with retinal neovascularization
    • 2 - stable
      • old central retinal vein occlusion

BRVO CHANGES
- H34.83 Branch (tributary) retinal vein occlusion
  • Still Per EYE
  • H34.831 central retinal vein occlusion, right eye
  • Now staged:
    • 0 - with macular edema
    • 1 - with retinal neovascularization
    • 2 - stable
      • old branch (tributary) vein occlusion

AMBLYOPIA CHANGES
- New category:
  • H53.04 Amblyopia suspect
    • H53.041 amblyopia suspect, right eye
    • H53.042 amblyopia suspect, left eye
    • H53.043 amblyopia suspect, bilateral
    • H53.049 amblyopia suspect, unspecified eye

OTHER CHANGES
- Orbital floor fracture gains laterality
- Expansion of codes for postprocedural hemorrhage
- Z79.899 - Other long term (current) drug therapy (Plaquenil) [change on 10/1/2016]

NCCI - NATIONAL CORRECT CODING INITIATIVE
The CMS developed its coding policies based on:
- coding conventions defined in the AMA’s CPT Manual
- national and local policies and edits
- coding guidelines developed by national societies
- analysis of standard medical and surgical practices
- review of current coding practices
Updated annually and published on CMS website
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
**WE’RE EXCLUSIVE**

- Optic Nerve scan (92133) and the retinal scan (92134) are BUNDLED into one another
  - Cannot bill both of these on the same date of service
  - Cannot use a modifier to bill these on the same date of service
- Also bundled with 99211 and 92250 (fundus photography)
  - Medically necessary documentation is required
- 92133 (and 92134) mutually exclusive with 92250

**MODIFIER -59**

**BEWARE THE IDES OF -59**

- Per CMS publication, “For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters.”
- Therefore cannot use -59 modifier to simply by-pass a NCCI edit
- OIG has indicated this will be an area on investigation and increased risk of audit for practices that over-utilize this modifier

**UPDATE ON -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

**NOTE**: Does NOT include treatment of contiguous segments of same organ - CMS considers posterior segment structures of the eye a SINGLE anatomical site

**UPDATE ON -59 MODIFIER**

- -X codes only used by CMS
- NOT used WITH -59 Modifier
- Use INSTEAD of -59 Modifier

**MODIFIER -24 AND -25**
**E&M MODIFIERS**

- **-24**: Unrelated E&M service by the same physician performed during the post-operative period. Used when a patient requires an office visit during their post-operative cataract surgery global period (or any surgical global period) for problems that have nothing to do with their surgical procedure (USED ON E&M CODE)
- **-25**: Separately identifiable E&M service done on the same date as a procedure. Used when patient comes in for exam and you end up doing a Procedure (e.g. Punctal Plugs or Trichiasis procedure). Generally CC is separately identifying (USED ON E&M CODE)
  - Cannot be used for FB eval and removal

**PATIENT PRESENTS FOR FB REMOVAL**

- Standard before FB removal:
  - obtaining ocular and general medical history
  - performing an external exam
  - evaluating distance vision
  - slit lamp examination

**WHEN TO USE -25 MODIFIER**

- Patient presents for a glaucoma F/U and FB is identified
  - Remove FB
  - Perform appropriate E&M for glaucoma
- Exam and FB excision are filed with different diagnosis
- File exam with modifier -25 and FB removal

**DOCUMENTATION GUIDELINES**

- **Chief Complaint:**
  - a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's words

**DOCUMENTATION**

- **Documentation must include:**
  - orders for testing
  - interpretation and reports when required
  - signature of physician and date
  - signature of all who record findings
  - clear assessment and plan
  - indicate all records reviewed
  - indicate when information was acquired
DOCUMENTATION GUIDELINES

- Record Cloning:
  - Must be specific to patient and that date of service
  - Cloning = misrepresentation of medical necessity requirement
  - Mindful that records reflects THAT visit
  - Be careful to ensure record says something specific about patient at that visit
  - Auditors looking for records on same day statin the same thing
  - Auditors looking for consecutive visits stating the same thing

- Record completion/amendments:
  - Entering information into records in a timely manner
  - Enter information into record at time of service
  - Clearly identify amendment, correction, or delayed entry
  - Clearly identify date/author of amendment, correction, or delayed entry
  - Not delete, but instead, clearly identify all original content
  - Within 12-24 hours, complete and sign, amend later if necessary
  - Cannot meet this requirement if you do not sign records in timely manner

SIGNATURE REQUIREMENTS

- Signature Requirements CERT notice
  - Always sign your notes/orders
    - hand or electronic tag
  - Print name with signature
  - Initials must have printed name for clarification
  - Transcribed notes reviewed and signed
  - Legible signatures or claim denied

SIGNATURE OPTIONS

- Sign and date each chart entry
- Signature log
  - used when illegible signature
  - Used when initials only used
  - Date of creation typically not an issue
- Attestation statement
  - Per patient chart - name and patient ID
  - Detailing who signed
  - Date of creation not issue
  - NO Signature Stamps

WHO IS AUDITING?

- Comprehensive Error Rate Testing (CERT)
  - Improve accuracy of Medicare payments
  - Method for CMS to look at paid claim error rate
  - Random claims - audit - recoup dollars - report yo CMS
- Recovery Audit Contractors (RAC)
  - To identify improper over/under payments
    - Automated review
    - Complex review
    - Semi-automatic review

AUDITING
WHO IS AUDITING?

• Zone Program Integrity Contractors (ZPIC)
  • Targeted to outliers typically reviewed
• Carrier Reviews
  • Not common - typically outliers selected for review or Random selection
  • Target potentially overused/misused codes
• Private Insurers

OIG INVESTIGATIONS

OIG RECENT INVESTIGATIONS

• OIG comes out with a work plan every year
• 2017
  • OIG will review the use of prolonged service codes reported in addition to an E&M code (99354-99359)
  • Most targets areas and tasks relate to types and locations of services (medical devices, rehab, nursing facilities, mental health and home health)
  • For FY 2015, national error rate (per CERT) for Medicare Fee-for-Service payments was approximately 12.1 percent with improper payments estimated at 43.3 Billion
  • Previous years (Optometry use of -24 and -25 Modifiers)

RECENT OIG FRAUD CONVICTION

• Georgia based optometrist billed eye care services for nursing home patients was sentenced to 33 months in prison for Medicare fraud
• U.S. District Court Judge stated most troubling issue was defense’s apparent theme that bad employees and sloppy record keeping were to blame
• Billing code used most often was for most comprehensive exam possible
• Documentation completely inadequate - so minimal it wouldn’t qualify for any Medicare payment

RECENT OIG FRAUD CONVICTION

• In a single day, billed 45-minute comprehensive exam on 177 patients!
• In a single day, 59 comprehensive exams in 3 hours
  • 4 patients were never seen and 1 had no eyes
  • OD consistently billed for difficult diagnosis/very ill patient, but rarely billed for any follow-up treatment
• Another similar case is pending in Kentucky

RECENT PALMETTO REVIEW (NC, SC, VA, WV)

<table>
<thead>
<tr>
<th>PERCENT OF TOTAL DENIALS</th>
<th>DENIAL CODE</th>
<th>DENIAL DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>NC 81.06%</td>
<td>KODOC</td>
<td>NO OR PARTIAL DOCUMENTATION RECEIVED</td>
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<tr>
<td>NC 12.43%</td>
<td>KOTMN</td>
<td>INFORMATION SUBMITTED DOES NOT SUPPORT MEDICAL NECESSITY OF SERVICES</td>
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<tr>
<td>SC 54.50%</td>
<td>KODOC</td>
<td>NO OR PARTIAL DOCUMENTATION RECEIVED</td>
</tr>
<tr>
<td>SC 14.06%</td>
<td>KOTMN</td>
<td>INFORMATION SUBMITTED DOES NOT SUPPORT MEDICAL NECESSITY OF SERVICES</td>
</tr>
<tr>
<td>SC 7.84%</td>
<td>SIGN</td>
<td>INFORMATION SUBMITTED CONTAINS AN INVALID/ILLEGIBLE PROVIDER SIGNATURE</td>
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<tr>
<td>VA 97.51%</td>
<td>KODOC</td>
<td>NO OR PARTIAL DOCUMENTATION RECEIVED</td>
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<tr>
<td>WV 85.70%</td>
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<td>WV 8.61%</td>
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<td>WV 5.70%</td>
<td>SIGN</td>
<td>INFORMATION SUBMITTED CONTAINS AN INVALID/ILLEGIBLE PROVIDER SIGNATURE</td>
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RECENT OIG FRAUD CONVICTION

• Lessons Learned:
  • Do not overlook regularly trying to see huge number of patients/day
  • Proper documentation - complete and thorough
  • Proper follow-up visits as required by care standards
  • Proper understanding/application of billing rules
  • ALWAYS RESPOND TO AUDIT REQUESTS
  • You have appeal rights if negative result from an audit

HOW TO APPROACH IMPROPER DENIALS

• New or established procedure being denied when ODs allowed to perform
• Steps:
  • Ensure properly filed claim - NPI, post-op period, etc...
  • Contact carrier to determine real reason for denial
  • If necessary, appeal claim with documentation of why it should be allowed
  • If necessary, contact State Third Party Committee
  • State can contact AOA TPC for further help
  • State Board may be able to help if it is a scope of practice issue

GLOBAL PACKAGE

2017 CHANGES TO GLOBAL PACKAGE

• For CY 2017, CMS is proposing to collect data on the valuation of 10- and 90-day global surgical codes.
• CMS is conducting a survey of 5,000 practitioners to gather additional data.
• As reference, in CY 2015, CMS proposed transitioning all 10- and 90-day global surgical codes to 0-day (this was placed on hold due to the ICD-10 transition)
• MACRA delayed the implementation
• Practitioners who practice in practices that includes of 10 or more practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island will be required to report on claims data on post-operative visits furnished during the global period of a specified procedure using CPT code 99024 (specific surgical CPT codes to which this applies has yet to be announced)

MEDICARE LCDS

2017 MEDICARE DRAFT LCDS

• SCODI Draft LCD - Palmetto GBA (SC, VA, WV, NC)
  • Guidelines for pre-glaucoma patients
  • Diabetes WITHOUT retinopathy is NOT covered
• Blepharoplasty - Palmetto GBA (SC, VA, WV, NC)
  • Upper eyelid surgery is functional whereas lower lid may be functional if visual impairment can be illustrated
• Other blepharoplasty updates - may not perform surgery on traditional Medicare patients
- If you did NOT report PQRS measures in 2014, you WILL receive a payment reduction of -2.0% in Medicare payments in 2016.
- If you do NOT report PQRS measures in 2015, you WILL receive a payment reduction of -2.0% in Medicare payments in 2017.
- If you did NOT report PQRS measures in 2016, you WILL receive a payment reduction of -2.0% in Medicare payments in 2018.
- There is NO hardship exemption.

PQRS FOR ODS—THE GOOD NEWS?
PQRS INCREASING COMPLEXITY

- 2013 Performance (20% of ODs got paid)
  - Report 1 valid measure on 1 Medicare patient
- 2014 Performance (4% of ODs got paid)
  - Report 3 measures on 50% of your Medicare patients
- 2015-2016 Performance (__% of ODs got paid)
  - Report 9 measures on 50% of your Medicare patients
- 2017 MIPS Performance
  - Report 6 measures on 50% of all patients

CODING RESOURCES

- Coding manuals
- AOA/Third Party Center
- State Associations
- Medicare newsletters
- Local Carrier newsletters
- ICD-9/ICD-10 manuals
- CPT manuals
- HCPCS manuals

ONLINE RESOURCES

- CMS website (http://www.cms.gov/Medicare/Medicare.html)
  - Whole sections on Billing and coding
- CMS website dedicated to ICD-10
- AOA Eyelearn - live and recorded webinars (AOA members)
- AOA resource center (for AOA members) - AOA excelOD
  - http://www.excelod.com/
- AOA Coding Today (for AOA members only)
  - http://aoacodingtoday.prsnetwork.com

AOA CODING TODAY

AOACodingToday Includes:
- 2023 code changes, industry news, new coding resources, and more
- Entirely digital and mobile-friendly
- Live, on-demand, and recorded webinars
- Entirely digital and mobile-friendly
- Entirely digital and mobile-friendly
- Entirely digital and mobile-friendly
- Entirely digital and mobile-friendly

Assessments:
- With all-digital Coding Score
- Audit Template
- Faculty: Dr. Theresa S. and Dr. Kevin N. are leading the session. It's time to meet your counterparts for patient records to be sure your practices will be such in audits

http://aoacodingtoday.prsnetwork.com