

# Blue Collar Billing & Coding

“The Work Smarter Not Harder Approach”

Christopher J. Borgman, OD, FAAO

## My Personal Request...

- This presentation is a gift of mine to SCO as a way to show my gratitude and to give back in some small way.
- That being said....
- Do not share with your classmates
- But Please Keep It Within The Confines of SCO!

## Disclaimer

- I have no disclosures to report.
- I am not a coding/billing “consultant”.
- I am just a “blue collar optometrist in the trenches everyday like you.”---Dr. Mark Dunbar
- When in doubt refer to CPT guidelines to define exam components.
- \*\*\*Remember this talk is strictly about **minimum** coding for insurance companies, this has NOTHING to do with **legal** considerations/ramifications\*\*\*

## Ethics & Coding...

- You cannot perform all elements of an exam on every patient just to code at higher reimbursement levels.
- “Perform only what the individual patient needs at the present exam....no more, no less. Grading is done after the record is completed. Then choose codes to represent what is done, based on the content of the record.”  
---Charles Brownlow, O.D.
- “However, it is OK to play the game.”  
---Chris Borgman, O.D.

## Billing & Coding

- Master the billing and coding puzzle...
- Perhaps you can make more by seeing less patients
- A doctor with poor billing/coding skills and sees more patients (ie: 30 patients) may make the same \$\$\$ as a doctor with great billing/coding skills but sees less patients (ie: 15 patients)
- “Work smarter, not harder!”

## Monkey Wrench...

- Don’ t forget that **each state** has different requirements for what minimum tests have to be completed...  
---This has nothing to do with billing or coding.  
--- No one else’ s responsibility other than your own!!!
- **Illinois additional requirements:**  
---Color vision, measurement of binocularity, refraction to BCVA distance and near, retinoscopy/ autorefractor, etc.
- These minimum tests may be required but may not be billable procedures according to CPT guidelines  
---Ex: Color vision, Stereopsis, Cover Test/Posture testing, keratometry, etc.

## What are the coding references I need?

- Only **3** regulated by HIPAA in 1992...
- **1)** Current Procedural Terminology (CPT)  
----- (Eye Codes)
- **2)** Internal Classification of Disease (ICD-10)  
----- (as of Oct. 1, 2015)
- **3)** 1997 Documentation Guidelines for Evaluation and Management Services  
----- (E/M Codes Level 1-5)

## New vs. Established

- 3 years to calendar day of exam
- >3 years = NEW
- ≤3 years = ESTABLISHED

## Chief Complaint Revisited...

- CC = Reason for the visit
  - "blurry vision", "red eyes", "floaters", "eye pain", etc.
- "3 month FU for POAG per Dr. XXX" = Good CC
  - doctor-directed visit perfectly appropriate
- "FU" = not good enough
- "Concern over glaucoma" = not good enough
- Chief Complaint and #1 Diagnosis must match!!!

## Eye Codes vs. E/M Codes

- O.D.'s have 2 sets of codes (**14 total**) to choose from:
  - 1) Eye Codes: Comprehensive, Intermediate
  - 2) E/M Codes: Levels 1-5
- (16 total with S-Codes included)

## Narrowing Down the Codes...

- E/M Level 1 = never for O.D.'s; this is for technicians and/or nurses only
- E/M Level 5 = automatic audit; do not use unless you have a thorough understanding of criteria required
- **This leaves only 5 codes to master!**
  - 1) **Comprehensive** (92004/92014)
  - 2) **Intermediate** (92002/92012)
  - 3) **E/M Level 3** (99203/99213)
  - 4) **E/M Level 4** (99204/99214)
  - 5) **E/M Level 2** (99202/99212)

920x4

## 1) Comprehensive Exams

- Important points to remember...
- Dilation not required; only posterior pole views
- Does not have to be completed in one day; may return different day to be completed
  - returning day would not be billed
- Always includes initiation of diagnostic and treatment programs:
  - glasses/spectacle/medication Rx count
  - radiological, labwork, diagnostic testing
  - consultation
- Includes as indicated: "biomicroscopy, examination with cycloplegia or mydriasis and tonometry."
- Ex: yearly/annual diabetic exam

## Comprehensive Exam Components

- **Case History**
  - CC, HPI
- **General Medical Observation**
  - Medical conditions, allergies, medicines, etc.
- **Gross Visual Fields**
  - Confrontational VF's
- **Basic Sensorimotor Examination**
  - EOM's for sure, some may argue CT necessary
  - Depends on how sensorimotor is defined....
- **External Examination**
  - Slit lamp examination; tonometry not necessarily included
- **Ophthalmoscopic Examination**
  - Undilated 90 D counts

## Example of Comprehensive Exam

CC: "blurry vision"  
 Case History: 65 year old AAF, OD-OS, onset 2 years ago, slowly getting worse x 6 mo, (-)pain, harder to drive at night → some glare issues  
 GMO: (+)HTN—controlled with HCTZ, NKMKANKDA

VA (cc): 20/50 OD, 20/20 OS

Pupils = PERRLA, (-) APD  
 EOM's = FROM OU  
 CVF = FTFC OU

Refraction = -1.00 sph OD 20/50, plano OS 20/20 +2.50 Add

Adnexa = (+)mild dermatochalasis OU  
 Lids/Lashes = normal OU  
 Conjunctiva = mild pingueculas OU  
 Cornea = normal OU, (-)SPK  
 A/C = dark and quiet OU  
 Lens = 3+ PSC OD, trace NS OS

Dilating Drops OU:  
 Tropicamide 1%  
 Phenylephrine 2.5%  
 Cyclopentolate 1%

IOP = 15 mmHg OU with Goldmann

C/D Ratio: 0.3/0.3 OD, 0.3/0.3 OS  
 Optic Nerves = pink color, distinct margins OU  
 Macula = flat, normal, minimal FLR OU  
 Vessels = <2/3 OU, minimal crossing changes OU  
 Periphery = flat, intact 360 degrees, (-) HTD OU

**Assessment/Plan:**  
 1) PSC OD — Refer to surgeon for phaco consult given decreased ADL's  
 2) Presbyopia OU — Hold Rx pending phaco consult

## Refraction...

- Reported separately! (Since 1992!)
- Always reported in addition to eye code or E/M code used
- Noncovered by medical insurances (Medicare, BCBS); covered by most vision insurances (VSP, Eyemed)
- "Let me reiterate: The CPT definitions for comprehensive ophthalmological service and all other office visits do not include refraction. It is time for you to review your policy with respect to refraction and snap your practice right into the early 1990s."  
 --- Charles Brownlow, OD

(<http://www.healio.com/optometry/practice-management/news/practice-management-news/790670d05-9c1c-46a3-9c6f-ade7f76891b1/7d/news-flash-refraction-has-its-own-code-so-bill-separately>)

## 2) Intermediate Exams

- Important points to remember...
- Describes an "evaluation of a **new or existing condition complicated with a new diagnostic or management problem** not necessarily relating to the primary diagnosis."
- May or may not include dilation
- Main use is for ER patients b/c of "new diagnostic or management problem" criteria needed; but not solely restricted to ER patients
- Ex: subconj heme in a HTN patient, K ulcer in CL wearer

## Intermediate Exam Components

- **Case History**
  - CC, HPI
- **General Medical Observation**
  - Medical conditions, medicines, allergies, etc.
- **External Ocular and Adnexal Examination**
  - Slit lamp exam; do not forget adnexa
- **Other diagnostic procedures as indicated...**
  - Ex: tonometry, EOM's, CVF, etc.

## Example of Intermediate Exam

CC: "poked in eye by son's fingernail while playing"  
 Case History: 32 YO WF, OD only, onset 2 hours ago, water eyes, blurry vision, (+)sharp pain in OD  
 GMO: denies all, (-)pregnant, NKMKANKDA

VA (cc): 20/30 OD, 20/20 OS

Pupils = PERRLA, (-) APD  
 EOM's = FROM OU  
 CVF = FTFC OU

Adnexa = swollen RUL OD, normal OS  
 Lids/Lashes = normal OU  
 Conjunctiva = 3+ injection OD, normal OS  
 Cornea = 2+ central corneal abrasion OD, normal OS  
 A/C = dark and quiet OU  
 Lens = clear OU

IOP = 14 mmHg OU with Goldmann

**Assessment/Plan:**  
 1) Corneal Abrasion OD — In-office Homatropine OD only. Start Tobradex QID OD. NP-AT's Q1h OD. RTC tomorrow for follow up.

## E/M Codes... Utter Confusion

## E/M Codes...the confusing codes

- Defined by 1997 E&M Guidelines...
  - All E&M Codes have **3 parts** and are defined by those.
  - New E&M (>3 years) = **3** of 3 parts at that level
  - Est. E&M (≤3 years) = **2** of 3 parts at that level
  - **Parts Required:**
    - 1) Case History
    - 2) Exam Components
    - 3) Medical Decision Making
- } "New" requires 3 of 3  
"Est." requires 2 of 3

## Typical E/M's for O.D.'s

- Level 1 -----Never for O.D.'s
- Level 5 automatically raises red flag for audit according to coding experts; be careful if used...
- Level 2----depends, amblyopia follow up
- Level 3----most often, POAG IOP check, K abrasion FU
- Level 4----sometimes, Acute RD, VH 2° PDR
- However, truly depends on case Hx components

## Very Important Sidenote...

- New Level 3 ≠ Established Level 3
- New Level 4 ≠ Established Level 4
- New Level 2 ≠ Established Level 2
- New Level 3 = Established Level 4
- New Level 2 = Established Level 3
- New Level 4 = Established Level 5

## Most Common E/M Codes Used by OMD/OD's in 2010

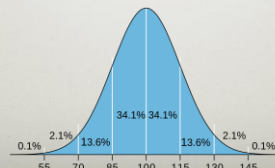
- 99211 <1%
- 99212 16%
- **99213 51%**
- 99214 28%
- 99215 4%

• <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeorSvcPartsAB/downloads/EMSspecialty2010.pdf?agree=yes&next=Accept>

• [http://associationdatabase.com/aws/OOS/pt/sd/news\\_article/61604/\\_PARENT/layout\\_details/false](http://associationdatabase.com/aws/OOS/pt/sd/news_article/61604/_PARENT/layout_details/false)

## Identifying and Describing Physicians Who Consistently Billed Higher Level E/M Codes in 2010

- "Using the 2010 NCH Carrier file, we identified all physicians who performed at least 100 Medicare E/M services in 2010. To identify physicians who consistently billed higher level E/M codes, we first identified physicians whose average E/M code level was in the **top 1 percent** of their specialties. From that subset of physicians, we identified those who billed the two highest codes within a visit type **at least 95 percent** of the time. Physicians who met both criteria are hereinafter referred to as physicians who consistently billed the two highest level E/M codes. The remaining physicians are referred to as other physicians." --- (<https://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf>).



-Top 1% of Specialty  
-95% of cases are 992x4/992x5



Specialty	Physicians Who Consistently Billed Higher Level E/M Codes	Other Physicians
Internal Medicine	19.8%	18.1%
Ophthalmology	3.2%	2.3%
Optometry	2.2%	1.8%

## CMS Response to OIG Findings...

- “...Based on the findings in this report, the average E/M error was approximately \$43. The average cost to review an E/M claim can range from \$30-\$55. Therefore, CMS and the MACs must weigh the cost benefit of these reviews against more costly part B services...”
- CMS Response (<https://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf>)

## Review & Detour...

<b>History of Present Illness:</b> Frequency Onset Location Duration Associated Sn/Sx Modifying Factors Relief Qualitative “FOLDARQ”	<b>Review of Systems:</b> Eyes Ears, Nose, Throat Cardiovascular Endocrine Respiratory Musculoskeletal Neurological Skin Gastrointestinal Genitourinary Psychiatric Blood/Lymph Allergic/Immunologic General/Constitutional	<b>PFSH:</b> <b>Past History:</b> Past Procedures/Surgeries Current Medications/gtts Patient Ocular History <b>Family History:</b> Family Ocular Diseases Family Systemic Diseases <b>Social History:</b> EIOH Tobacco Pregnancy Substance Abuse Living Situation	<b>Exam Components:</b> Visual Acuity CVF EOM' s Pupils/Iris Adnexa Lids/Lashes Conjunctiva Cornea Anterior Chamber Lens Tonometry Orientation (PTP) Mood/Affect Dilated ONH exam Dilated Retinal exam
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## History of Present Illness...

- 8 Total Categories/Descriptors:
  - Frequency
  - Onset
  - Location
  - Duration
  - Associated/Modifying Factors
  - Relief
  - Qualitative
  - Severity
  - “FOLDARQS”

## Review of Systems (ROS)...

- 14 total ROS...
  1. Eyes
  2. Ear, Nose, Throat
  3. Cardiovascular
  4. Endocrine
  5. Respiratory
  6. Musculoskeletal
  7. Neurological
  8. Skin
  9. Gastrointestinal
  10. Genitourinary
  11. Psychiatric
  12. Blood/Lymph
  13. Allergic/Immunologic
  14. General/Constitutional

## Past, Family, Social history...

<b>Past History</b> Past Procedures/Surgeries Current Medications/gtts Patient Ocular History	<b>Family History:</b> Family Ocular Diseases -Glaucoma -ARMD Family Systemic Diseases	<b>Social History:</b> EIOH Tobacco Pregnancy Substance Abuse Living Situation
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## Exam Components...

### Exam Components:

1. Visual Acuity
2. CVF
3. EOM's
4. Pupils/Iris
5. Lids/Lashes/Adnexa
6. Conjunctiva
7. Cornea
8. Anterior Chamber
9. Lens
10. Tonometry
11. Dilated ONH exam
12. Dilated Retinal Exam
13. Orientation (P,T,P)
14. Mood/Affect

## 3) Established E/M Level 3

### Case History (PART I):

- Chief Complaint
- "Concern over glc" not specific nor good enough per most experts
- "3 month FU for glc per Dr. Borgman" is much better

### 1-3 HPI (Remember FOLDARQ)

- Should be easy.....which eye(s) have glc? OD>OS

### 1 ROS

- 14 total ROS listed (cardiovascular, endocrine, allergic, etc.)
- The easiest to ask----do u have any allergies? Then document appropriately (NKDA, NKMA, or (+)sulfa)

## Established E/M Level 3

### Exam Components (6-8 required) (PART II):

1. Visual Acuity
2. Pupils and Iris
3. EOM's
4. CVF
5. Lids/Lashes/Adnexa
6. Bulbar/Palpebral Conjunctiva
7. Cornea
8. Anterior Chamber
9. Lens
10. Tonometry

## Established Level 3

### Medical Decision Making (PART III):

- Most difficult
- Some argue to ignore b/c remember only need 2 of 3 parts for Established exam; focus instead on case Hx and exam components

### Level 3 Medical Decision Making Criteria:

- 1) 2-3 Dx/Mgt options
  - 2) Limited Complexity
  - 3) 2+ self limited illnesses
    - one stable chronic
    - one acute injury
    - uncomplicated injury
- } only 1 } need 2 of 3

- REMEMBER: All components have to be medically necessary as defined by insurance auditors....may make things tricky at times

## Medically necessary means...

- "...the need for an item(s) or service(s) to be **reasonable and necessary** for the diagnosis or treatment of disease, injury or defect. The need for the item or service must be clearly documented in the patient's medical record."
- "What is not appreciated is the fact that Medicare has evolved, over the years, into a very defined benefit program. In Medicare terms, not medically necessary simply means that the service is not a benefit under this defined benefit, for **this diagnosis**, at **this time**. Time and diagnosis are the key words, in that neither is immutable. A given procedure may become medically necessary, for a given diagnosis, at future time, and vice versa.

## Example of Level 3 (99213)

CC: "3 month IOP check for POAG per Dr. Borgman"  
 Case History: 68 YO AAM, OD=OS, good compliance with Latanoprost gts QHS OU, vision stable  
 GMO: (+)HTN--controlled with HCTZ, ALL = sulfa only

VA (cc): 20/20- OD, 20/20 OS

Pupils = PERRLA, (-) APD  
 EOM's = FROM OU  
 CVF = FTFC OU

Adnexa = mild dermatochalasis OU  
 Lids/Lashes = grossly normal OU; long eyelashes  
 Conjunctiva = trace injection OD, normal OS  
 Cornea = normal OU  
 AC = dark and quiet OU  
 Lens = 1+ NS OU

IOP = 12 mmHg OU with Goldmann

### Assessment/Plan:

- 1) Mild POAG OU-- Stable. Good IOP OU. Continue Latanoprost QHS OU. RTC 3 mo for IOP check and repeat OCT and HVF to rule out progression.

## 4) Established E/M Level 4

- **Case Hx:**
    - CC
    - HPI 4-8
    - ROS 2-9
    - PFSH 1
  - **Exam Components (≥9):**
    - Visual Acuity
    - Pupils/Iris
    - Ocular Motility
    - CVF
    - Adnexa (lids/lashes)
    - Conjunctiva
    - Cornea
    - AC
    - Lens
    - Tonometry
    - Orientation (P,T,P)
    - Mood/Affect
  - **Decision Making (2 of 3):**
    1. 4-6 Dx/Mgt options
    2. Moderate Complexity
    3. One Chronic illness with complication
    - 2 stable chronic conditions
    - Un-Dx new problem
    - Acute illness with systemic Sx
    - Acute Injury
- ONH assessment } **Dilation Required**  
 • Posterior pole assessment

## Example of Level 4 (99214)

CC: "New Floaters"  
 HPI: 62 YO WM, OD only, onset this morning, (+)trauma--hit in eye by grandson, constant floaters since onset, no pain, vision slightly blurry OD, (-)relief with Ibuprofen, (-)veils/shadows  
 PMH: (+)HTN--controlled with HCTZ, (+)DM--controlled with metformin; last A1c = 7.6%, LBS = 140  
 ALL = sulfa only

VA (cc): 20/25 OD, 20/20 OS

Pupils = PERRLA, (-) APD      EOM's = FROM OU      CVF = FTFC OU

Adnexa = mild dermatochalasis OU, subtle RUL edema  
 Lids/Lashes = grossly normal OU; long eyelashes  
 Conjunctiva = normal OD, normal OS  
 Cornea = normal OU  
 A/C = dark and quiet OU  
 Lens = 1+ NS OU  
 IOP = 18 mmHg OU with Goldmann

Optic Nerves = 0.3/0.3 OU, pink/distinct  
 Macula = normal OU  
 Vessels = normal OU, (-)hemes, (-)NVD/NVE  
 Vitreous = (+)PVD OD, normal OS  
 Periphery = intact 360 degrees OU, (-)H,T,D OU with BIO and SD

Dilating Drops OU:  
 —X— Tropicamide 1%  
 —X— Phenylephrine 2.5%  
 —X— Cyclopentolate 1%

**Assessment/Plan:**  
 1) Acute PVD OD -- Monitor. RTC 3-4 weeks for repeat DFE. RTC STAT if Sn/Sx RD.

## 5) Established E/M Level 2

- **Case Hx:**
  - HPI 1-3
  - ROS = none
- **Exam Components (1-5):**
  - 1.VA
  - 2.Pupils/Iris
  - 3.EOM's
  - 4.CVF
  - 5.Tonometry? (optional)
- **Decision Making (2 of 3):**
  1. 1 Dx
  2. Minimal Complexity
  3. One self limited problem

**Typical uses:** Amblyopia follow up, AICI progress check (mainly peds stuff really), low vision device dispense, etc.

## Example of Level 2 (99212)

CC: "3 month follow up for amblyopia per Dr. Borgman"  
 Case History: 5 YO HF, OD only, good compliance with hyperopic spectacle Rx per parent

VA (cc): 20/40- OD, 20/20 OS

Habitual Rx = +4.00 sph OD, plano OS

EOM's = FROM OU  
 Cover Test = ortho distance, 4 XP' near  
 Stereo = (+)forms, (-)suppression, 40"Randot

**Assessment/Plan:**  
 1) Refractive Amblyopia OD -- Improved from baseline 20/70 OD. Continue FTW of glasses. VA check x 3 months again.

## FYI: Est. E/M Level 5 (99215)

- Case History:
- CC
  - HPI 4-8
  - ≥10 ROS
  - PFSH (2 of 3)
- Exam Components:
- All 14 exam components required
- Medical Decision Making:
- High Complexity

## What About Consultation Codes?

- 99241-99245, 99251-99255
- As of 2010, Medicare no longer pays for the CPT **consultation codes** (ranges 99241-99245 and 99251-99255).
- CMW requires that physicians bill for these consultations using one of the remaining E/M codes (992x1-992x5) that accurately represents the place of service and the complexity of the visit.

## Insurance Discrimination?

- **Beware of discrimination (yours)!**
- *"Insurance guidelines specify that **you have one fee schedule for each CPT code**. Thus when you establish a price for providing a 92004 (or any other code), **you must charge all patients the same fee for the same service, regardless of who's paying the bill**. **Multiple fee schedules are discriminatory** and, at a minimum, could lead to reduced reimbursements from your carriers if they establish a pattern of discount. In a worst-case scenario, a carrier could determine that you've been abusive in your billing patterns and demand monetary damages. S codes provide a viable method to avoid the multiple/discount fee patterns that often exist..."* --- John Rumpakis, OD, MBA

(<http://www.optometricmanagement.com/articleviewer.aspx?articleID=71233>)

## Side-Note: "S-Codes" (S0620/S0621)

- Defn: "Routine ophthalmological exam with refraction" ; new & established pts
- Subset of HCPCS codes (not part of CPT)
  - CPT=level 1 codes; HCPCS=level 2 codes
- Some insurances recognize and some do not
- Allows OD/OMD's to code for "routine eye exams"
  - CPT is designed for "sick" pts not "routine"
- Provides another avenue to charge the "cash-paying" or under-insured patient less for "routine/refractive" cases
- Some codeheads support use and some do not

## Example of S-Codes:

- New 44 YO WF with no refractive or medical insurance. CC=blurry vision at near only. Dx = presbyopia
  - **S0620**
- Established 52 YO WM with no refractive insurance but has medical insurance. CC=blurry vision at distance only. Dx = myopia
  - **S0621**
- Note: some refractive insurance contracts require use of 92xxx/99xxx codes for routine exams and will not recognize S-codes

## Advantages & Disadvantages S-Codes

- Advantages:
  - Patient-friendly; allows a way for the doctor to appropriately discount services to patients who are cash paying or have no insurance coverage for routine exams; patients more likely to return back to practice for future care
  - Ex: \$280 for CX vs. \$120 for S-Codes
- Disadvantages:
  - Same amount of work as CX exam with refraction (92004/92014 & 92015) but for a reduced overall price; less \$\$\$\$ for doctor
  - Ex: \$280 for CX vs. \$120 for S-Codes

## S-codes continued...

- *"When performing a routine examination on a healthy-eyed patient, these codes are a good alternative to the usual CPT codes that were developed with a "sick" patient in mind....This ability to be price-competitive can be an additional advantage within the competitive eyecare marketplace, allowing you to maximize per-patient profits while attracting new, price-sensitive patients for routine exams. They also allow you to maintain good compliance with insurance guidelines for single-fee schedules by enabling you to set your fees for routine examinations competitively while still capturing appropriate reimbursements for commensurate services provided by CPT guidelines. Moreover, they reduce the temptation to apply inappropriate time of service, prompt pay discounts or the misuse of the -52 modifier. They keep our practices safely within coding guidelines, our prices appropriately set for the services performed and our patients happy."* --- Dr. John Rumpakis, O.D.

(<http://www.optometricmanagement.com/articleviewer.aspx?articleid=71233>)

## How do I code you ask?

### New Exams (>3 years):

•99204 New Level 4	\$180
•92004 <b>New Comprehensive</b>	\$155
•99203 New Level 3	\$115
•92002 <b>New Intermediate</b>	\$85
•99202 New Level 2	\$80

### Established Exams (<3 years):

•99215 Est. Level 5	\$155
•92014 <b>Est. Comprehensive</b>	\$130
•99214 Est. Level 4	\$115
•92012 <b>Est. Intermediate</b>	\$90
•99213 <b>Est. Level 3</b>	\$80
•99212 Est. Level 2	\$45



## Take Away from today...

New	Established
Comprehensive (92004)	Comprehensive (92014)
Intermediate (92002)	E/M Level 4 (99214)
N/A	Intermediate (92012)
N/A	E/M Level 3 (99213)
N/A	E/M Level 2 (99212)

Routine Cases: S-Codes as needed  
(S0620/S0621)

## Billing & Coding Part 2

### Ex: Patients In IEI ER Dept

- Est. Level 3 (\$80) vs. Est. Intermediate (\$90)
- \$10 difference per patient
- 20 patients per day in IEI ER = \$200 per day!
- \$200 x 5 days per week = \$1000 per week!
- \$1000 x 50 weeks per year = **\$50,000 per year!**

### Let's Find out who is paying attention...

- 1) 27 WM new patient presents to ER. You Dx corneal ulcer 2' CL overwear and start a fluoroquinolone antibiotic. No dilation.
  - **New Intermediate**; follow up would be E&M code based on "known" condition now
- 2) 65 AAM new patient presents to ER with complaints of flashes and floaters. You dilate. You Dx PVD.
  - **New Comprehensive**
- 3) Same 65 AAM returns 1 month later for DFE/FU for PVD. No changes; stable PVD at this time.
  - **E&M Est. Level 4 or Est. Level 3** (depends on case Hx mainly)

### More examples...

- 4) Est. 33 AAM reports trauma to OD x 2 days in bar fight. You diagnose commotio retinae. Previously had comprehensive exam 2 months prior.
  - **Est. Level 4 or Est. Intermediate** (again Case Hx important for these)
  - **Level 4** pays more than Intermediate exam
- 5) Est. 55 AAF reports for 3 month IOP check for POAG. No changes to vision or changes in meds at visit.
  - **Est. Level 3** only option
  - **Est. Intermediate** not applicable; no "new problems or complications"
- 6) Est. 55 AAF reports for 3 month IOP check for POAG. Reports new photophobia, redness x 4 days. You diagnose uveitis and dilate.
  - **Est. Intermediate** or **Est. Level 4** or **Est. Level 3**
  - **Depends on case Hx** again

### One Last Example...

- New 65 WM presents with flashes and floaters. You dilate and diagnose acute PVD.
  - **New Comprehensive (92004)**
- Same 65 WM returns 3-4 weeks later for repeat DFE/FU for PVD. You find a horseshoe retinal tear and send patient to retinal specialist for laser treatment.
  - **Established Level 4 (99214)**
- Same 65 WM returns 3 months later after laser treatment and released by specialist for you to monitor. No Sn/Sx. Stable PVD at this point.
  - **Est. Level 3 (99213) or Est. Level 4 (99214)**

## Question from Dr. Harthan: Medical vs. Refractive...who is responsible for the Exam?

- **\*\*\*KEY/RULE\*\*\*:** The Chief Complaint drives the exam...
- If the patient presents with "broken glasses" as a complaint and...We find the patient is a glaucoma suspect during the exam and want to run additional tests...(Let's say the patient has VSP and Medicare)
- What insurance do you bill? Medical? Vision? Both?

## Answer...

- Technically, the medical insurance can NOT be billed in this case (based on CC) and therefore the entire exam would be billed to the patient or to the patient's vision insurance.

--Follow ups for medical reasons would be covered though...

- Q: But what if the patient "throws a fit" and asks us to "fudge" the exam?
- A: We are required to bill appropriately in order to avoid fraud:
- "Your policy should not be based upon minimizing your patients' out-of-pocket expenses. The insurance plans are the patient's plans, not yours. The rules are the insurers, not yours. Your job is to provide excellent care in a confusing and progressively more convoluted system. You are simply doing your best to send the bill or claim to the person or company who is responsible for payment."---Charles Brownlow, OD
- "It's...not...my...fault."---John Rumpakis, OD

## Dilemmas...

1. Yes Refractive; Yes Medical
  - Refractive Dx → Refractive Carrier
  - Medical Dx → medical carrier, refraction to patient or refractive carrier separately
2. Yes Refractive; No Medical
  - Refractive Dx→ Refractive Carrier
  - Medical Dx→ bill patient, refraction to patient or refractive carrier separately
3. No Refractive; Yes Medical
  - Refractive Dx→bill patient (S-codes?)
  - Medical Dx→Medical Carrier, refraction to patient separately
4. No Refractive; No Medical
  - Refractive Dx→bill patient (S-codes?)
  - Medical Dx→bill patient

## Can We Make This Easier Please?

- 1) Bill refractive carrier (VSP, Eyemed) first for comprehensive exam and refraction
- 2) Bring patient back at another date for medical issues (POAG, DES, PVD, conjunctivitis) and code appropriately

## Additional Diagnostic Testing...

- External / Ant. Segment Photos
  - Fundus Photography / Fundus Autofluorescence
  - OCT/HRT/GDx
  - Pachymetry
  - Corneal Hysteresis
  - Endothelial Cell Count
  - Corneal Topography
  - B-scan, A-scan
  - Visual Fields
  - Serial Tonometry (minimum 3 IOP readings in same day)
  - EOG/ERG/VEP
  - FANG's & ICG's
  - Sensorimotor Exam (Maddox Rod, CT in 9 DAF's, etc.)
- **All the above require "Interpretation and Reports"**

## Interpretation & Reports...

--Must be in an identifiable location in the medical record.

1. Order for the test
2. Indications for the test
3. Patient's name and date of test
4. Interpretation of the test
  - What did test say? Normal? Abnormal?
  - How Tx is affected? What are you going to b/c of test?
  - Reliability if subjective, quality if objective
5. Doctor's signature and date reviewed

### Fake OCT Example:

•Pt = Ben Dover (DOB 1-2-34)  
 •I/R = Good quality baseline scans OU, (+)inf NFL thinning OD consistent with clinical exam, NFL WNL OS → RTC 3 months for IOP check and HVF 24-2 OU to 1/0 glc -- *Anna Bergman, O.D.* (5-3-13)

## What if test is unreliable/unusable?

- “In some cases, it is apparent that the test is worthless and should not be billed at all. This may occur when the test instrument malfunctions, *the patient does not follow instructions*, or the test is aborted prior to completion. However, an imperfect test, such as the first visual field administered to a patient, is not worthless and merits reimbursement if performed for a covered indication.”

--- Kevin J. Corcoran (Corcoran Consulting Group)

• [http://endooptiks.com/articles/TheAlert\\_06\\_01\\_09\\_Corcoran\\_NewGlaucomaSurgeries.pdf](http://endooptiks.com/articles/TheAlert_06_01_09_Corcoran_NewGlaucomaSurgeries.pdf)

## Physician Quality Reporting System (PQRS)

---Formerly known as "Physician Quality Reporting Initiative or PQRI"

Medicare will start reducing reimbursement in 2015 for practitioners who do not report this on their claim forms.

## PQRS....Only with Medicare Patients

- Provides CMS a way to track quality of exams
- Must report on **≥9 out of 14** measures in at least 50% of applicable patients
  - Pick the 9 easiest for you
- Will be required in 2015 and beyond...
- If not used in 2015 and beyond, Medicare imposes 2% penalty...
- You already do these measures during the exam anyway...

## PQRS Measures...(POAG)

- 1) **2027F** – POAG optic nerve evaluation?
  - Yes = 2027F
  - No = 2027F **1P** medical reason not performed
  - No = 2027F **8P** no reason specified
- 2) **3284F** – POAG ↓IOP by ≥15% from baseline?
  - Yes = 3284F
  - No = **3285F+0517F** = POAG IOP not ≥15% from baseline but plan of care in place to ↓ IOP further

## PQRS Measures...(ARMD)

- 3) **2019F** – dilated fundus exam?
  - Yes = 2019F
  - No = 2019F **1P** medical reason
  - No = 2019F **2P** patient reason
  - No = 2019F **8P** no reason specified
- 4) **4177F** – counseled on AREDS/antioxidants?
  - Yes = 4177F
  - No = 4177F **8P** no reason specified

## PQRS Measures...(DM)

- 5) **2021F** – documentation of DM retinopathy severity and +/- presence of CSME?
  - Yes = 2021F
  - No = 2021F **1P** medical reason
  - No = 2021F **2P** patient reason/declined
  - No = 2021F **8P** no reason specified
- 6) **2022F** – dilated DM fundus exam?
  - Yes = 2022F
  - No = 2022F **1P** medical reason
  - No = 2022F **2P** patient reason/declined
  - No = 2022F **8P** no reason specified
- 7) **5010F** – findings of DFE communicated with PCP?
  - Yes = 5010F + **G8397**(dilated fundus exam)
  - No = 5010F **1P** medical reason
  - No = 5010F **2P** patient reason/declined
  - No = 5010F **8P** no reason specified

## Additional PQRS Measures...

- 8) **4004F** or **1036F**--Tobacco screening? User of tobacco?
  - Yes =4004F = Yes tobacco use----cessation recommended
  - No = 1036F = No tobacco use----no further action needed
- 9) **G8427**--Current/Updated Medication List (≥18 YO)?
  - Yes =G8427
  - No = G8428 = reason not specified
  - No = G8430 = patient not eligible to report (<18 YO)

## Surgical Guidelines...

## Surgical Guidelines For Optometry...

- Global Periods defined:
  - Major Surgery = **90** days global period
  - Minor Surgery = **0-10** days global period
- Any exam within these time frames is **free** of charge
- Unless problem unrelated to surgery arises then use modifier-24
- Modifiers allow us to otherwise code within these time frames

## Major Surgery...90 Days POP

- Phacoemulsification/ECCE
- Trabeculectomy/Drainage Implants
- YAG Capsulotomy
- Pars Plana Vitrectomy (PPV)
- Pan Retinal Photocoagulation (PRP)
- Barricade Laser/Cryo of Retina
- PKP/DSAEK
- Anterior Corneal Stromal Puncture
- Strabismus/EOM
- Eyelid Repair
- Laser Iridoplasty for plateau iris
- LASIK/PRK
- Orbit Repair/Decompression
- Intraocular FB Removal

## Minor Surgery...0-10 Day POP

- Punctal plugs (10 days)
- Trichiasis Epilation (0 days)
- Removal FB Cornea/Conjunctiva (0 days)
- Removal of Corneal Epithelium (0 days)
- Dilatation and Irrigation (0 days)
- SLT/ALT for glaucoma (10 days)
- Laser Peripheral Iridotomy for glaucoma (10 days) (as of 2011)
- Chalazion Removal (10 days)
- Corneal Culture (0 days)
- Biopsies (eyelid, conj, cornea) (0 days)
- Paracentesis of A/C (0 days)
- Intravitreal Injection (0 days)
- Subconjunctival Injection (0 days)

## Common Surgical Procedures for O.D.'s

---Typically these are stand alone codes and cannot be used in conjunction with E/M or Eye Codes (unless modifiers used)...keep this in mind when coding.

- **65205** Removal FB Conjunctiva Superficial
- **65210** Removal FB Conjunctiva Embedded  
---Might depend on state's limitations of OD's
- **65222** Remove FB Corneal w/ slit lamp  
---Golf spud anyone?
- **65435** Remove Corneal Epithelium w/out cautery  
---Alger Brush with poorly healing abrasion
- **67820** Correction of Trichiasis with Forceps
- **68761** Closure of Lacrimal Punctum by Plug

## Punctal Plugs...

- Global Period = 10 days
- 68761 = "closure of lacrimal puncta by plug"
- Use same code for temporary and/or permanent plugs
- E1 = ULL
- E2 = LLL Ex: when occluding two lower puncta use:
- E3 = URL **68761-E2 and 68761-E4**
- E4 = LRL
- If payer does not recognize -E modifiers then use -50 (bilateral) modifier

## Summary of Surgical Procedures

CPT	Procedure	Post-Op Period
67820	Eplilation for trichiasis	0 days
65222	FB removal cornea embedded	0 days
65205	FB removal conj superficial	0 days
65210	FB removal conj embedded	0 days
65435	Remove cornea epitheliam	0 days
68200	Subconj injection	0 days
11900	Chalazion injection (≤7)	0 days
11901	Chalazion injection (>7)	0 days
68761	Punctal Plugs	10 days
68801	Dilation & Irrigation	10 days
65855	SLT/ALT	10 days
66761	LPI	10 days
67800	Chalazion excision	10 days
66762	Laser iridoplasty	90 days
66821	YAG cap	90 days
67031	Laser vitreolysis	90 days

## Contact Lenses

- **92310**
- Regular contact lens fit (soft, GP, toric, etc.)
- Not used for aphakia, keratoconus, abrasions, post-PRK, etc.
- OK to have different levels of reimbursement depending on complexity of fit

## 92310 CL Fee Structure Example

- Soft sphere \$50
- Soft Toric \$75
- Soft Monovision \$85
- Soft Monovision \$95
- GP sphere \$80
- GP Toric \$100
- GP Multifocal \$150
- Hybrid \$170
- Insertion/Removal Training \$25

## Aphakia

- **92311** Unilateral CL fit for aphakia
- **92312** Bilateral CL fit for aphakia
- Typically billed to medical insurance
- Don't forget material codes in addition:
  - V2513 GP Lens, extended wear, per lens
  - V2523 Soft CL, extended wear, per lens
  - V2530 Hybrid lens, per lens
  - V2531 Scleral GP lens, per lens
  - V2599 CL lens, other type, per lens

## Therapeutic CL Fits:

- **92071**: fitting of CL for treatment of ocular surface disease
- Bill to medical insurance
- Per eye
- K abrasions, diffuse SPK, exposure keratitis, severe KCS etc.
- V2523 soft lens, hydrophilic per lens
- Replacement of BCL = **92325**

## Therapeutic CL Fit:

- **92072:** fitting of contact lens for management of keratoconus
- Bill to medical insurance
- Don't forget supply code (V codes)
  - V2513 GP lens
  - V2530 Hybrid Lens
  - V2531 Scleral GP
  - V2599 CL, other type

## Coding/Billing Using "TIME"

## Important Side Note...

- If "time" used then all three parts of *normal* E/M codes can be **IGNORED!**
  - ie. Case Hx, Exam Components, Medical Decision Making

## CPT Definition of E/M Coding Based on Time

- "When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face in the office or outpatient setting or floor/unit time in the hospital or NF), then time may be considered the key or controlling factor to qualify for a particular level of E&M service. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members."

## TIME Based Billing

- **3** Requirements needed:
  - 1) Documentation of total face-to-face time
  - 2) Document the content of "counseling and coordination of care"
  - 3) Greater than 50% of total time spent involved counseling and coordination of care

## Counseling and Coordination of Care

- **Counseling:**
  - Diagnosis, impressions, prognosis, recommended diagnostic studies
  - Risks and benefits of treatment options
  - Instructions for management, treatment and/or follow-up care
  - Importance of compliance with treatment, risk factor reduction
  - Patient and/or family education
- **Coordination of Care:**
  - may include discussing, planning, or scheduling additional and/or supporting services with other providers and/or agencies (SNF, Hospice, facility transfer, home care, etc.)

## New Patient "TIME BASED"

	10 mins	20 mins	30 mins	45 mins	60 mins
99201	XXX				
99202		XXX			
99203			XXX		
99204				XXX	
99205					XXX

TIME = **minimum** time of physician face-to-face time required to meet that level

## Est. Patient "TIME BASED"

	5 mins	10 mins	15 mins	25 mins	40 mins
99211	XXX				
99212		XXX			
99213			XXX		
99214				XXX	
99215					XXX

TIME = **minimum** time of physician face-to-face time required to meet that level

## After Hours Billing/coding

### Is this possible? YES!!!

- **99050**
- Defn: "Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service."
- Reported *in addition* to E/M or Eye Code
- Means more \$\$\$ for doctor
- Unfortunately, not all insurances cover it...
  - Medicare doesn't...

## After-Hours Example

- Est. 20 YO WM presents to your office at 8 pm on a Saturday night for trauma to his OD while welding
- Your normal hours on Saturday are 8:00 AM to 12 PM
- You diagnose K Abrasion and start patient on ABx gtts QID OD. RTC 1-2 days for follow up.
- You would bill: **92012-99050** (Intermediate Exam with "after normal hours" modifier)

## Special Situations

## How to Code Special Situations...

- Example: Consult from rheumatology to r/o toxicity secondary to Plaquenil/hydroxychloroquine
- 1) Rheumatoid Arthritis (M06.9)
- 2) High Risk Med—Plaquenil (Z79.899)

## What if patient develops Plaquenil maculopathy?

- Appropriate 99xxx or 92xxx exam code
  - HVF 10-2 (92083)
  - Macula SD-OCT (92134)
  - FP/FAF (92250)
  - Multifocal ERG (92275)
- 1) Rheumatoid Arthritis (M06.9)
- 2) Toxic maculopathy (H35.38x)

## Special Situations #2

- Example: Gastroenterologist refers patient to rule out ocular involvement secondary to ulcerative colitis
- 1) Ulcerative colitis (K51.90)
- 2) Special screening for eye condition (Z13.5)

Q: But does this also apply to sickle cell, HTN, RA, SLE, GCA, etc.???

## Special Situation #3

- Example: 30 YO WF with viral conjunctivitis, you perform AdenoPlus test and then perform a Betadine rinse. Patient given mild steroid QID in the affected eye. RTC 4-5 days for follow up.
- Dx: Viral Conjunctivitis (B30.8)
- Exam = 92012 (intermediate)
- AdenoPlus = 87809QW (must be CLIA-waived)
- Betadine in-office supplies = 99070
- 99070 not covered by Medicare

## Modifiers

## Common optometry modifiers...

- **-24** Unrelated E/M Service During POP
  - When E/M services are provided during POP for a reason unrelated to the original procedure
  - Ex: Corneal abrasion 2' trauma one month after ECCE
- **-79** Unrelated Procedure/Service During POP
  - Ex: corneal FB removal one month after ECCE



## Modifiers Continued...

- **-25 Significant and Separate E/M on Same Day of the Procedure or other service**
  - When E/M services are provided on same day as a different procedure
  - Ex: IOP check for POAG with concurrent epilation for trichiasis
- **-26 Professional Component**
  - Ex: Another facility runs OCT, you interpret it
- **-TC Technical Component**
  - Ex: You run OCT, another doctor from different practice interprets it

## Co-Management Modifiers

- **-54 Surgical Event Only**----surgeon only
- **-55 Post Operative Management Only**
  - Surgeon performs surgery, you provide all (or a portion) of post-op care during global period
  - **Ex:** The co-managing O.D. would report code **66984-55** (including dates of service) for cataract surgery
  - Need a letter from surgeon indicating transfer of care to you
  - Not applicable if you are in same practice as surgeon already
- **-56 Pre Operative Management Only**
  - You perform pre-op care, surgeon performs surgery
  - If you provide post-op care as well after surgery then refer back to -55 above

## Take Away from today...

New	Established
Comprehensive (92004)	Comprehensive (92014)
Intermediate (92002)	E/M Level 4 (99214)
N/A	Intermediate (92012)
N/A	E/M Level 3 (99213)
N/A	E/M Level 2 (99212)

Routine Cases: S-Codes as needed  
(S0620/S0621)

## Can you Rely on EHR/EMR to code for you?

- Cloning
- Medical Decision Making
- EMR tends to “over-code” according to most reviewers/doctors/experts
- Sometimes “carry-over” will not make sense
- HPI: location = right big toe....not applicable to eyes
- Bottom Line: Doctor still has to know how to code appropriately

## Conclusions...

- Insurance audits are on the rise.
- The best defense is a combination of great record keeping and a great understanding of how to code appropriately and accurately.
  - Relying **solely** on EMR Coding/Billing software is not appropriate and can be dangerous ground to be on in an audit...
- Ethics and coding...it's OK to play the game.
- Just b/c you got paid, does not mean you coded correctly...insurances may demand monetary damages YEARS later...protect yourself!

## Advice To Newbies...

- Avoid “cruise control” at all costs...
- Seeing patients on your own is scary business...
- The patients' well-being should always be your top priority.....not \$\$\$\$\$\$\$\$\$\$
  - Know “generic \$4-List” at Target, Walmart, etc...
  - Melton & Thomas' Drug Guide
- It's OK to start from the bottom rung...
- Set up a referral network...
  - There is no such thing as a bad referral...
- Never burn a bridge...
- Don't forget about SCO...

**Thank You!!!**

- Questions???
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