Health Care Reimbursement: Something Old, Something New, Something Rotten Makes Us Blue…

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Financial Disclosures Joe DeLoach, OD, FAAO

I Have Received Honoraria From or Served as a Consultant for:
(Partial Listing)

- Vision Source
- Alcon Laboratories
- Carl Zeiss Meditec
- Optos
- Diopsys
- Kowa
- Optovue
- AllDocs
- OfficeMate
- Marco
- TSO
- NVision
- Cleinman Partners
- Vision Trends
- Konan
- Essilor of America
- Pearle Vision / SNAPP
- Vision West
- UHCO, NOVA, RSO, UAB, Berkley, *and other optometry schools*

Over half the state optometric associations in the United States

Optometric Business Solutions, LLC – President and CEO *(no financial interest)*
Clinical Professor – University of Houston College of Optometry *(opinions do not necessarily reflect the views of the University)*

ADDITIONAL DISCLAIMERS

Policies presented or discussed in this presentation are specific to your state and predominantly based on Medicare (Jurisdiction F- Noridian - your Carrier) and CPT rules. Individual payer policies are unique, regional and sometimes not clearly published.

Any fees presented in this presentation are the average North Texas Medicare allowable fees. Fees presented are in no way designed to state any acceptable fee or suggest to any provider they charge certain fees

Let's start in reverse….

What's Rotten?

The Bipolar World of Coding - Experts…

Practice Centric Care

MAXIMIZE your revenue
Do what puts the most money in the bank
MAXIMUM use of examinations, testing and technology
Twist the system in an attempt to get around the rules

RESULT

Indefensible care – often "worthless" per CMS
Massive audit exposure
Doctors getting severely hurt
Sleepless nights

Patient Centric Care

Do what's right for the patient and the money will follow
Use common sense
Medically necessary use of examinations, testing and technology
95% of rules are pretty clear – just follow them

RESULT

Defensible, medically necessary care
Minimal audit exposure
Make as much or more money just doing what's right
Sleep like a baby

And the fruits of our labors…

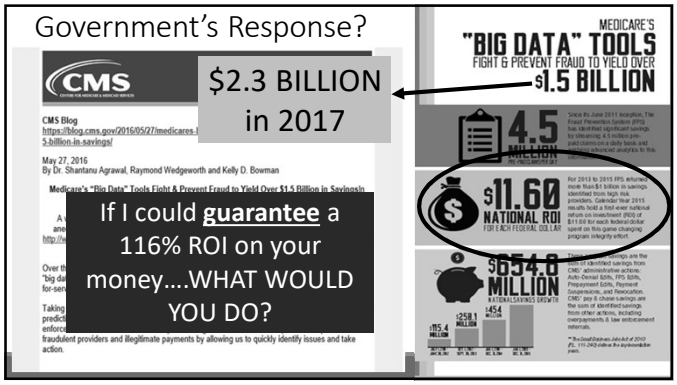
US HEALTHCARE FRAUD AND ABUSE

2016 Medicare – 41 BILLION
2016 Medicaid – **140 BILLION**

2016 RAND study – total fraud and abuse in US Healthcare

$295 BILLION

Government's Response?



But optometrists aren't involved – RIGHT?

Bad Stats from CERT 2016

Improper service payments by provider type:

OUT OF 55 PROVIDER TYPES

#1 Chiropractors
#2 PT
#3 Psychiatrists

.
.
.

#10 **OPTOMETRISTS** *(up from #25)*

And CERT tells us why!

2016 Reasons for Optometry Overpayment

#1 Insufficient documentation (80%)
#2 Incorrect coding (16.7%)

80% Of denials are based on inadequate medical record documentation – some stupidity, some ignorance and a LOT of mis-information

Per Frank Cohen, EMG Inc.

National audit authority

"You're going to get audited, so…"

Top Five Reasons Doctors Lose Audits

1. **No documentation**
2. **Inadequate documentation**
3. Lack of medical necessity (per payment policy)
4. Incorrect / non-specific diagnosis code
5. Provider issues (lack of signature, attending physician not the billing physician)

Sources of our sadly earned reputation

- "Experts"
  - Podium Experts – "I'm an expert because *(I'm on the committee; I read a lot; I'm entertaining)*"
  - Company Experts – "I'm an expert because *(Our medical director endorses this; I can make you money)*"
  - Blog Experts – "We're ALL experts ***because we say so***"
- Creative billing – **"We're getting paid!"**
- Crooks *(more on that later…)*

So why believe me?

I have lectured nationally on ethical coding for 25 years (so what)

I am CourseMaster for the UHCO Professional Ethics Course - have been since it's introduction (more so what)

I served on the TOA Third Party Committee for 20 years and as their consultant "emeritus" for the past 5 years (so what again)

I direct a company that performs audit and billing services – ***we are responsible to our clients to know what works and what doesn't*** *(very important)*

I served on the Jurisdiction H CAC for a over two decades (still on it) - CACs make Medicare policy! *(more important)*

I audit for medical payors - including Medicare *(more very important!)*

Unless I say it is my opinion, I will back up anything I tell you from the "TRUTH" sources. Or don't…you decide

Biggest problems….

Bottom line:
TOO MUCH GREED –
NOT ENOUGH ETHICS

Too much "opinion"
Too much *"getting around the rules"*
Information NOT based on **regional** payment policies
Too much "turning medical" instead of "doing medical"
"Experts" don't do it - "Experts" don't audit

Where a lot of it comes from….

A lot of improper or fraudulent or stupid coding is performed because someone said they were doing it and getting paid who was told by someone else who said they were doing it and getting paid who was told by someone else they were doing it and getting paid who was told by someone who **made it up**…
and "GOT PAID"

Sources of Coding *Truth*!

www.cms.gov (Medicare)

www.ngsmedicare.com
Jurisdiction K *(that's you)* Carrier

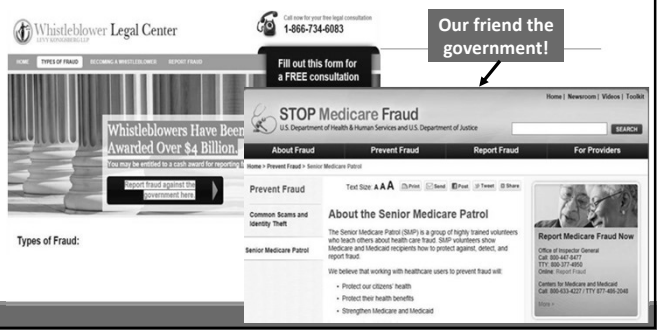
www.*whoever-medicalpayor*.com

CPT and ICD-10 Manuals

www.CodeSAFEPLUS.com

www.practicecompliancessolutions.com

How about this – Everyone wants to help



And let's invite the non-trained folks to help as well…

https://www.youtube.com/watch?v=zKZuVdL-GC0

https://www.cms.gov/Outreach-and-Education/Medicare.../fraud_and_abuse.pdf

Medicare Fraud & Abuse: Preventtion, Detection, and Reporting Facilitator Kit

http://www.howtoreportfraud.com/report-fraud/medicare-fraud-and-medicaid-fraud

THIS IS AN ATTORNEY FIRM – THERE ARE TONS OF THEM ONLINE

MORE?

This is on the CMS **general public** website!

How Much Does the Government Like Whistleblowers

1. Whistleblower Protection Act
2. Even better…Congress declared June 30 as ***"National Whistleblower Appreciation Day"***

AND YOU THINK EVERYTHING IS JUST HONKY DORY AND YOU SHOULDN'T BE CONCERNED?

(because you're just an optometrist, you're just a small practice, you do what's right, you're getting paid, you haven't been audited…yet)

Important points…

Most common reasons you will be audited

1. **BILLING AND CODING PRACTICES**
2. **IT'S YOUR TURN**

Number 1 reason you will LOSE an audit

POOR MEDICAL RECORDS DOCUMENTATION

Real Definition of Reimbursement

"Reimbursement is the money you keep when the auditor leaves"

How Do Audits Happen

RANDOM (common) – *"Getting a date is just like fishing…you just keep casting until you land one"*

You stood out – uncommon billing

Jon BonJovi-ism – ♬ *livin on a prayer* ♬

You're a crook

Don't think you're a crook? There's new crooks in town…Per CMS

Actions now considered as <u>FRAUD</u>

(amended February 2017*)

1. Upcoding claims *(in our case, Level 4/5 EM codes and overuse of Comprehensive Ophthalmologic codes 92004/14 – more later)*
2. Waving copays
3. Waving deductibles

* www.gpo.gov/fdsys/pkg/FR-2017-01-12/pdf/2016-31390.pdf

The Age of Audits

Optometry has never been a big "target" – has that changed?

If you are filing claims, you are a target!

Audit Myths
Barbara Cobuzzi, MBA, CPC, CENTC, COC

The government is on a secret witch hunt

WRONG – the TRUE information is out there; CPT, ICD, CERT, MLN, provider manuals, NCD, LCD, payment policy

Only large practices are audited

WRONG – most common audit is a small, one doctor practice

It's all really complicated – they'll give me a break

WRONG – it's your legal obligation to know, not matter how complicated

Fraud and Abuse laws only apply to Medicare/Medicare

WRONG – not any more

Audit Myths
Barbara Cobuzzi, MBA, CPC, CENTC, COC

Code a lot – just write off whatever not paid

WRONG – THE OIG CONSIDERS THIS FRAUD and has instructions to the ZPICS to actively pursue this activity

I send additional information on unusual claims (so I can use the -59 modifier). I get paid so I assume I am OK

WRONG – likely would have been paid without the additional information ***(we don't even look at it)*** and the additional information will never allow you to break the rules

I'm not a participating provider in Medicare – I am immune from audits

WRONG – if ANYONE files a claim from your services, INCLUDING THE PATIENT, you are obligated to abide by ALL rules

Audit Myth
Joe DeLoach – contact auditor

Payer audits focus on the criminals so my risk is low

WRONG – only the Medicare Fraud Strike Force is looking at the criminals. Everyone else is looking at YOU!

1. The crooks are harder to convict (really?)

2. Fisherman? Little fish don't / can't fight back as hard

3. Random audits using Predictive Analysis becoming the norm

Circa 2018 and Forward

"Predictive Analysis" rules the reimbursement recapture market

Cognitive computer analysis of billing patterns to predict who should be audited

Pre-payment denial – based on "predictive analysis" your claims look "unusual" so your money will be withheld and your only way to get it will be presenting a medical record that justifies what you did

Who Conducts Audits In Our World of Optometry

In order of activity, *not severity or fairness…*

1. Medicare *(focus on fraud – typically fair, severity based on crookedness)*
2. VSP *(often not so fair and very severe – hear about California????)*
3. Aetna *(looking for anything)*
4. BCBS *(fair is a four letter word)*
5. EyeMed *(pretty fair and not too severe – unless…)*
6. On the horizon…Medicaid

How Medicare Does It

Medicare Administrative Contractors (MACS)

- **Recovery Audit Contractors (RAC)** – total failure; on their way out
- **Medicare Integrity Contractors (MICS)** – on their way out too
- **Zone Program Integrity Contractors (ZPICS)** – the current giant, for a while
- **Unified Program Integrity Contractors (UPICS)** – the upcoming giant

Five *NEW* Components of ZPICS / UPICS

1. Strong reliance on predictive analysis
2. More standardized protocols nationwide *(major concept of UPICS)*
3. Strong inter-governmental agency communication *(Tattle-Tale Law)*
4. "***Let's Make a Deal"*** – Corporate Integrity Agreements and Medicare arbitrators
5. ***Required reporting to State licensing boards (also new requirement of OCR for HIPAA violations)***

So let's look at **THE** two issues

1. What are we doing to get audited *(coding practices)*
2. How can we defend against the inevitable audit *(medical records documentation)*

In General…What Triggers an Audit

- ✓ Specialization
- ✓ Success (The "Ladder Principle")
- ✓ Repetition
- ✓ High utilization of single codes
- ✓ Billing codes not commonly used by the majority of your colleagues
- ✓ Billing codes at a higher percentage rate than the majority of your colleagues

None inherently wrong, but…

Specifically…Most Common Audit Issues

1. Upcoding Evaluation and Management Codes
2. Overuse of Comprehensive Ophthalmologic Code
3. Mis-use of 59 and 25 modifiers
4. Medically unnecessary diagnostic testing
5. Repetitive coding
6. Use of prolonged service code
7. Billing exceeds possible workforce application
8. "Note Bloat"

More on most all these later

But first….the most important concepts to understand

The PILLARS OF REIMBURSEMENT

- ➢ Reason for the visit
- ➢ Medical Necessity

PILLAR ONE

REASON FOR THE VISIT

What Is The Reason for the Visit

Simple concept…it is why THE PATIENT is seeking care from you TODAY *(not what care YOU want to deliver)*

Understanding this concept is fundamental to the whole process of medical reimbursement

If you do not address the reason for the visit, an auditor can/will deny the entire encounter as not medically necessary

PROVE THAT? NO PROBLEM…

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 his/her physician for an eye examination with no medical complaint specific to the reason for the visit,* ***the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathologic condition****."*

Per CPT, what can qualify as a medical reason for the visit

1. Symptoms
2. Direction
   1. From the patient
   2. From another health provider
   3. From the attending physician

AND WORDS MATTER!!!

Summary - Reason For the Visit

Unless dictated by the patient's payor or unless you have to fulfill some mindless requirements of your state law or vision plan, you perform a symptom oriented exam just like the rest of the medical world does

It's SO SIMPLE…how does the rest of the health care world do it???

PILLAR TWO

MEDICAL NECESSITY

Medical Necessity

Medical necessity is the ONLY justification for reimbursement for services rendered

Specifically it dictates whether actions or testing are "necessary" in the patient's care

Medical necessity by law can ultimately be **determined** only by the attending physician, but operationally is often **dictated** by payor payment policy

Medical Necessity - Several Definitions

The easiest for me to understand

Will the results of this examination or testing influence or dictate my diagnosis and/or treatment of the patient?

Medical Necessity vs Payment Policy

Payor Payment Policy Based On

- Preferred Practice Patterns
- Established standards of care
- Scope of licensure
- Opinions / bias of payment determination panel
- Intangibles / unknowns / cost **(big and getting bigger)**

Essential concept in medical reimbursement

Medical necessity ≠ Insurance benefits
If medically necessary – SOMEONE pays!

MDs never have a problem with this concept. ODs don't seem to have a problem with that concept when it comes to upselling products in the optical the patient has to pay for out of pocket –

why is medical care different?

Making Patients Pay

- As stated, this is predominantly an issue in the mind of optometrists ***(except in the dispensary)***
- If you decide it is medically necessary, SOMEONE has to pay – and that will increasingly be the patient
- BIG POINT – **you are legally obligated to collect from the patient what they owe you**
- Same Day Discounts are fine in wellness care but regulated by the Anti-Kickback Statute in medical care (use is LIMITED only for financial need – the patient's, not yours)
- Use Advanced Beneficiary Notice (ABN)

ABNs….What Are They?

Per CMS: *The ABN allows the beneficiary to make an informed decision about whether to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay.*

SPECIAL NOTE: **Use form CMS R-131** – *THAT WAS CHANGED EFFECTIVE 6/21/2017*

ww.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf

NOTE: All Part C plans have their own ABN forms and rules

When You MUST Issue an ABN
(use – GA modifier)

When you EXPECT or KNOW Medicare may deny payment based for a service ***that normally WOULD be paid***.

Have patient select one of the three options and sign the form ***BEFORE the care is rendered.***

When You MAY Issue an ABN
(Use – GX or – GZ modifier)

When you EXPECT or KNOW Medicare will deny because Medicare NEVER pays for the service.

- Lack of medical necessity *(THEIR definition, not yours)*
- Payment policy – LCD *(Ex. visual field for a headache Dx when that Dx is not allowed under a payment policy)*
- Not a covered service *(Ex. REFRACTION)*

BUT…The patient does NOT choose an option and does NOT sign the form. Issuing an ABN in this case serves only one debated purpose but it **DOES NOT legally obligate the patient to pay for the service!**

OK – Let's Review Those Major Reasons You WILL be Audited

ALERT – Late Entry News

Top 5 Claim Submission Errors – Novitas 2018

RANK	EOB CODE	DESCRIPTION
1	CO-16	Claim cannot be adjudicated – missing/incorrect information
2	96	Non-covered service
3	18	Duplicate claim **(REALLY??? *Main reason this happens?)***
4	109	Wrong payor **(you have to be kidding!)**
5	49	Routine exam **(#1 item cited – REFRACTION)**

#1 - Upcoding EM

52

Let's start with just the facts…

SERVICE CODE		CMS AVERAGES	OPTOMETRY AVERAGES
Level 2 E/M	New /Established	20% / 9%	2% / 5%
Level 3 E/M	New /Established	44% / 57%	38% / 48%
Level 4 E/M	New /Established	25% / 28%	**56% / 39%**
Level 5 E/M	New /Established	8% / 3%	4% / **8%**

Why?

#1 - Over-estimation of history

- History details exceed medical necessity based on reason for the visit *(everyone gets comprehensive history like we are taught to do in school)*
- Review of systems not **PERTINENT** to reason for visit *(**NOTE**: 99204 and 99205 require comprehensive history – **all eleven systems pertinent to RFV** - almost impossible in eye care)*

Why?

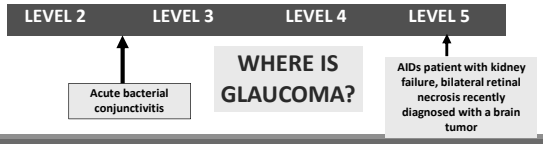
#2 Over-estimation of examination elements

- Do not understand the concept of "medically necessary based on the reason for the visit"
- JUST BECAUSE YOU DID IT OR WANT TO DO IT DOESN'T MEAN IT IS REIMBURSEABLE

Why?

#3 – Over-estimation of complexity of care

- Bottom line…it is damn complicated. That's why 66% of audited EM codes are denied or down-coded (90% due to over-estimation of code level)
- Concept behind complexity of medical decision making



IS THIS ALL GETTING READY TO CHANGE?

Yes it is!

#2 – Overuse of Comprehensive Ophthalmologic Code

More of just the facts…

SERVICE CODE	CMS AVERAGES	OPTOMETRY AVERAGES
92004 / 14	56%	**81%**
92002 / 12	44%	19%

Why?

- Refer back to explanations of reason for the visit and medical necessity
- Again – appropriate medical care is not what you WANT to do it is what you NEED to do based on the reason for the visit

Here's the way it works in medicine…

In MEDICAL encounters, services are **LIMITED** based on the concept of symptom driven care *(reason for the visit)*

Optometry in general is still stuck on the concept of ***every examination is a comprehensive examination where you do the same thing every time – regardless of the RFV.***

This, along with mis-information and greed, has fundamentally led to optometry moving from 25th to 10th most improperly paid specialty

You're kidding right – you're not saying a patient states their only concern is a "bump" on their eyelid and all I do is diagnose and treat the eyelid problem – not a comprehensive history, refraction, cover tests, ductions, screening visual fields, dilated internal, and give them three glasses prescriptions?

Actually, that is EXACTLY what the core principles of medical reimbursement say!

And talk to a health care attorney about the "liability fantasy" perpetuated by optometry

Other "myths" about comprehensive eye exams

First and foremost, they are not medically necessary and NOT medical.

- Optometry creations for medical care
  - Comprehensive eye examination
  - Comprehensive medical eye examination
  - Eye health evaluation
  - Diabetic eye examination
- But my patient expects one
- I'm bound legally to do one
- I'm bound ethically to do one

Ophthalmologic vs Evaluation and Management Codes

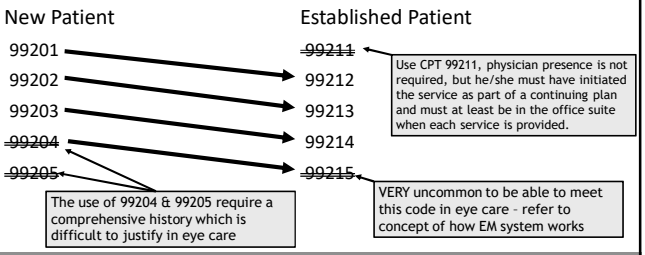
This is actually VERY simple!

1. You can ALWAYS use an evaluation and management code – conduct a problem oriented examination based on the reason for the visit and add up what you did
2. You can ONLY use an ophthalmologic code when your service meets the definition and description of the code based on the reason for the visit – means what?

#1 Most Important Slide on EM Service Code Understanding the CMS Crossover Concept

New Patient	New Patient	Established Patient	Established Patient
99201		99211	
99202	92002	99212	92012
99203		99213	
99204	92004	99214	92014
99205		99215	

#2 Most Important Slide on EM Service Code Simplifying the EM Code System



When can I use 92002 / 92012

*Ophthalmological services: **medical examination** and evaluation with initiation of diagnostic and treatment program; intermediate*

Requires:

The evaluation of a new or existing condition *complicated with a new diagnostic or management problem not necessarily related to the reason for the visit (?)*

- A medical history
- General medical observation
- Examination of external eye and adnexa

NEW: *And other services are indicated – may include the use of mydriasis or cycloplegia*

When can I use 92004 / 14?

*Ophthalmological services: **medical examination** and evaluation with initiation of diagnostic and treatment program; comprehensive, one or more visits. Requires:*

- General evaluation of the complete visual system
- A medical history
- General medical observation
- Examination of external eye and adnexa
- Ophthalmoscopic examination (***usually*** includes dilation)
- Gross visual fields
- Basic sensorimotor exam
- Always includes initiation of diagnostic and treatment programs

Here's the point usually missed…

THE REASON FOR THE VISIT ***must justify***:

1. Medical evaluation
2. History
3. General medical observation
4. External and internal examination
5. Gross visual fields
6. Basic sensorimotor (binocular) assessment
7. Diagnosis and treatment plan

#3 – Medically Unnecessary Diagnostic Testing

Wait just one minute….now you're saying I can't run pachymetry, fundus photos, OCT, VF and ERGs on my glaucoma patients every six months?

No…*you can do whatever you want.* ***You just can't bill a medical payer for it!***

Excessive Testing – Just a few examples to make you think

The American College of Physicians estimates excessive testing costs the health care between $200-$250 BILLION every year (2012 – and getting worse)

The American Cancer Society's past director Dr. Brawley said the $10 stool test has been shown to save lives equally, but **in the United States**, the $3,000 colonoscopy is mostly commonly used. ***"Everyone is getting the expensive test, even though the cheaper test is as good. But the cheaper test involves handling shi… and no one can make money off of it,"*** Brawley said.

Closer to home…

In the United States, despite the barrage of increase technology, the overall incidence of blindness from glaucoma has not changed in over two decades

One of the biggest misunderstandings in optometry – "Confirmatory Testing"

Per CMS:

Medical record documentation must clearly indicate rationale which supports the medical necessity for performing ***each*** *test. Documentation should also reflect how the test results were used in the patient's plan of care.*

"It would not be considered medically reasonable and necessary to perform any diagnostic procedure simply to provide additional confirmatory information for a diagnosis or treatment which has already been determined." (my emphasis added)

Just two examples – while too many are trying to run unnecessary tests on glaucoma and AMD patients to make more money – they leave this RECOMMENDED care on the table!

WHAT IS THE STANDARD OF CARE FOR FREQUENCY OF MONITORING A PATIENT WITH ALLERGIC CONJUNCTIVITIS?

According to the National Institute on Asthma, Allergy and Immunology – once every six months

PLAQUENIL IS NOT THE ONLY HIGH RISK MEDICATION IN EYE CARE

Patients taking ANY of the following medications should be monitored for potential ocular side effects: Thorazine, Nolvadex, Flomax, All corticosteroids, Aredia, Fosamax, Boniva, Zometa, Actonel, Topamax, Viagra etal, Accutane, Cordone, Zyrtec, Myambutol, Fluoroquinolones

Just the facts…

Medicine is NOT menu driven care. A particular disease or diagnosis does NOT support an exhaustive list of diagnostic tests just because you have the instrument.

Biggest problem in optometry – significant over testing for glaucoma. Sorry, a patient with a family history of glaucoma does not routinely need a scanning laser, fundus photo, visual field, pachymetry, gonioscopy, anterior segment OCT, color vision test, VEP, and ERG – much less all repeated six months later.

REMEMBER – WE'RE NOW #10!!!

So How Do I Decide If A Test Is Going To Be Paid?

(Remember the new definition of reimbursement)

In general, this is how an audit will come down:

- ✓ Is the need for the test related to the reason for the visit
- ✓ Is the data usable
- ✓ Does the outcome of the test contribute to the diagnosis and/or management of the condition
- ✓ Does the need for the test stand alone against other known data (not confirmatory)
- ✓ Is there a more simple or less expensive alternative test
- ✓ Was the need for the test clear (explicit or ordered)
- ✓ Was an interpretation and report documented
- ✓ If a payment policy exists, was if followed ***(NOTE: If there wasn't – all the other seven still apply!)***

What if…

52 y/o AA male presents for routine eye examination. He has no complaints other than newspaper is hard to see even with his readers (Rx is six years old). Medical history is unremarkable. Ocular history includes uncle with glaucoma.

Vision corrects fine with increase add. All findings normal. CD is .7/.7 OU with VDD is 2.3 OD / 2.4 OS. IOP by NCT is 23mmHg OU.

You consider the patient a glaucoma suspect and run baseline OCT, pachymetry and visual fields – have the patient return in a week for fundus photo, gonioscopy, extended color vision and VEP. All findings are normal. You schedule a return visit in six months to repeat the OCT, visual field and VEP.

Six months in patient is fine and you have $895 in "medically necessary" care

MOVE THE CALENDAR FIVE YEARS….

Under the new **"episode based"** payment system, a diagnosis of low risk borderline glaucoma reimburses $350 for one year of care.

Does your plan of assault change?

IF you can get on the plan. WHAT?

#4 – Mis-Use of Modifiers. Three in particular

-59 Modifier

- ➢ Ten years running still the most audited modifier in healthcare
- ➢ ALMOST never an application in primary eye care – some rare applications for complex retinal disease
- ➢ ***NEVER applicable to bill fundus photos and scanning lasers during the same encounter***

#4 – Mis-Use of Modifiers. Three in particular

-25 Modifier

- ➢ The second most abused and actively audited modifier. Two problems:
- ➢ Certain "coding experts" are teaching to add the -25 modifier to all office visits to "bypass" the rules. That is called fraud. Three important words in healthcare reimbursement start with the letter "F" – fraud, felony, you are f….
- ➢ Providers do not understand that the office visit is included in the fee for a surgical procedure with only one exception – has been since 2007

The OIG feels abuse of the -25 is a NATIONAL HEALTH CARE CONCERN and says…

"We (*NOT you…my edit*) 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."***

CLEAR ENOUGH?

#4 – Mis-Use of Modifiers. Three in particular

-52 Modifier

- Hard to swallow, but simple concept. Cannot get paid 100% of fee for 50% of the work
- Only significant application is to photos
- It's not that you did or didn't photo both eyes – ***was it medically necessary to photo both eyes?***

#5 – Prolonged Service Codes (99554/5)

This one is simple…

OIG 2017 Work Report

"The necessity of the prolonged service codes is considered to be rare and unusual"

"RARE AND UNUSUAL"…look those words up

#6 – Bulk Claims

- ZPIC now given the authority to evaluate manpower and time against volume of claims and estimated workload requirements within the claim
- ZPIC made this a 2017/18 audit target

2016 report – reimbursement per beneficiary

Rhode Island….ranked really low

Joe…since you said documentation of medical records was the major issue in optometry looking bad…shouldn't we talk about that?

ABSOLUTELY – let's do it!

Here they are…

Most common documentation errors that result in audit failure

But first…most important concept to remember:

Never document to the code – document the care delivered and the code follows"

NUMBER ONE

Not Following / Answering the Reason for the Visit

- Remember, in reality that is your ONLY job
- Your primary assessment ***(that means first one listed)*** must answer the Reason for the Visit
- If the Reason for the Visit is not addressed, an auditor can consider the entire examination and all associated testing not medically necessary
- Best to directly state association between diagnosis and reason for visit

NUMBER TWO
Not Using the Most Specific Diagnosis

- CPT coding guidelines dictate that you apply the MOST SPECIFIC diagnosis related to any procedure for which you bill services
- Using systemic codes instead of eye codes (except code first)
- Use of unspecified codes

NUMBER TWOa
Code Substitution

Using a less specific (or different) code "because it pays" (is on the list)

Ex 1: Payment policy does not cover glaucoma diagnosis for ERG but does for "glaucomatous optic atrophy" so you always use the later *(key point – suspect or confirmed)*

Ex 2: Using an unspecified diagnosis like "Unspecified disorder of choroid" (D31.9) to get paid for a retinal photo when the policy denies payment for "Benign neoplasm of choroid" (D31.30)

NUMBER THREE
Cloning Issues

Payers (and many state boards) frown heavily on record cloning issues. OIG directed CMS to address this issue.

So what's not legal?

- Lying – entering data you did not acquire or BEFORE you acquired it

So what are things to be careful with?

- Templates…in general, and why
- "Pre-fab" language (normative findings)
- Lack of physician documentation of work

Solutions / Recommendations

- Use templates only for wellness care
- If you use normative findings statements, make sure there is an "unless otherwise noted" statement
- BIG ISSUE! If you use normative findings statements, do not insert them in to the file before that was determined
- Use general physician attestation statements

"I have reviewed all record entries and participated directly in the patient care where required. JWD 1/1/2018"

- Use review of history attestation statements

"I have reviewed all history elements and directly made the history of present illness. JWD 1/1/2018"

NUMBER FOUR
Findings Do Not Support the Diagnosis(es)

Typical examples of money paid back…

1. Macula listed as normal but diagnosis of AMD with testing
2. New patient glaucoma suspect diagnosis with normal IOP, normal ON, no trauma and no patient direction
3. Dry eye diagnosis with all clinical findings stated as normal *(oooh….I get around that how?)*
4. Retinal periphery stated as normal and patient was not dilated – or "OPTOS performed"

NUMBER FIVE
Not Establishing Medical Necessity for the Examination

Refer to instructions on Reason for the Visit. This is **ONE OF THE MAIN ISSUES HERE!**

NUMBER SIX

Not Establishing Medical Necessity for Diagnostic Tests

- CPT says that for every diagnostic test…
  it must be clear to the auditor from the medical record why you performed the test

  -OR-

  The record must include a physician "order" for the test
- The second is WAY better!

Four Places for Orders

1. In the plan of the previous examination *(that the auditor does not have!)*
2. In the reason for visit for the current examination
3. In the interpretation and report
4. In the plan of the current examination or in an order section noting the test is to be performed that day

All OK… but suggest #1 (for your tech's sake) AND #2, #3 or #4 (for the auditor's sake)

Another comment on establishing medical necessity for testing…

DON'T TOTALLY RELY ON AN ORDER!

Even with an order, your findings must support the need for the order

NUMBER SEVEN

Conflicting Information

- Patient presents for evaluation of potential ocular complications from DM and medical history completely normal
- Patient symptoms stated as "not significant", "doesn't bother" or "no longer a problem" but diagnosis and plan centered on the issue
- Evaluating for risks of medication and history does not contain the medication or condition being used to treat (requirements!)

NUMBER EIGHT

Not Following Preferred Practice Patterns

Only you can determine medical necessity, but if you want to be paid you have to DEFEND YOUR DECISIONS!. The rules are defended based on:

- ✓Established standards of care *(very rare – legal issue)*
- ✓Preferred Practice Patterns of the AAO
- ✓Clinical Guidelines of the AOA
- ✓PEER REVIEWED literature

NUMBER NINE

"Note Bloat"

- **Exaggerated findings related to patient symptoms**

Ex: Patient states eyes fatigue and you document extensive anterior and posterior findings with testing with every small abnormal detail noted even though does not relate to eye fatigue

- **Exaggerated testing, assessment and plan related to patient findings**

Ex: Macula findings state "mild RPE disruption" but photos, SLOs, dark adaptation and ERGs follow right behind

OIG directs CMS to consider this a focus issue for ZPIC investigations

NUMBER TEN

Not Documenting Contact Lens Evaluation

1. History must include the lenses worn, how they are worn, solutions used
2. Examination must document the fitting characteristics of the lenses (NOTE: Simply documenting WHAT trial lenses were used is not sufficient – need to note the fit)
3. Findings must include K's and SOR (mandate of VSP)
4. Assessment must state how the patient is doing with the lenses
5. The plan must state what you are doing going forward, even if that is no change

But Joe…what about all the "rules"?

Guess what…there just aren't many

Vision plans have more rules than medical plans…by far.

Medical Payer "Rules"

- Medical payer coverage determination rules are honestly not extensive
- There are very few payment directives related to eye care
- When they exist, they often are very close to Medicare rules
- Most importantly, **THEY ARE REGIONAL!**

And Medicare – that's Noridian for you

L37027 Cataract Extraction

- One of the least restrictive; not based on Snellen acuity – based on ADL plus disease related reasons
- Standard examination only – no diagnostic testing unless warranted by medically necessary diagnosis (cataract is NOT)
- Biometry only to the operating surgeon unless coordinated

L36286 Blepharoplasty

- In general – restriction within 30 degrees fixation and/or MRD 2mm or less
- Very strict photodocumentation rules

THAT'S IT!

Time permitting (never is)….the age old question: Is it vision or medical?

- FIRST AND FOREMOST – the reason for the visit determines that
- The patient has a choice when there is duplicative coverage
- Personally, I don't think it is all that complicated but the answer is NOT drawing a line in the sand on this issue

EXAMPLE ONE

New patient presents with complaints of blurred vision when reading – no other symptoms. You examination reveals presbyopia and moderate dry eyes based on inferior corneal staining. The patient has VSP refractive insurance and Aetna medical insurance.

Is this encounter billed to VSP or Aetna?

Soooooooo…two answers

The reason for the visit is blurred vision…

1. One answer for the blurred vision is presbyopia – if this is the sole reason, this is a wellness encounter and you bill VSP comprehensive vision examination
2. The patient has dry eyes – ***can you say the dry eye contributes to the reason for the visit?*** If no, refer to answer #1. If yes, you MUST STATE THAT and then you CAN bill medical to Aetna – but what office visit code would be appropriate? *(HINT…could lose money doing it this way)*

EXAMPLE TWO

Your new patient presents with two complaints – their distance vision is blurred and they have a bump on their right upper eyelid that does not hurt. Your examination reveals an increase in their myopic correction and a non-pigmented papilloma. The patient has EyeMed refractive insurance and BCBS medical.

Is this encounter billed to EyeMed or BCBS?

What is the reason for the visit?

1. Blurred vision
2. Lid lesion

OPTION ONE: Bill vision examination to EyeMed; treat the papilloma for free. Bill a comprehensive vision code – for EyeMed that's 92004.

OPTION TWO: Bill vision examination to EyeMed; make the patient return to evaluate the papilloma. Comprehensive vision code to EyeMed today; likely 99212 or 92012 to BCBS on return

OPTION THREE: Treat the papilloma; make the patient return for a vision examination. Bill BCBS 92002 or an EM likely a 99202

OPTION FOUR: Perform a comprehensive vision examination and a medical evaluation of eyelid. Bill EyeMed (92004) and bill a 92002 or 99202 to EyeMed *(really? Really yes but no…)*

Geez, thanks for making this even more complicated. Oh don't worry - just getting started!

Factors to Consider In Deciding on Those Options

1. What copays exist – EyeMed and BCBS?
2. Does the patient have a deductible with BCBS? If yes, how much has been met?
3. What was the patient's expectation? Is the money worth making the patient mad?
4. If all the options are legal and ethical, which one makes YOU the most money?

Diabetes – the Consummate Example

New patient presents on the direction of her PCP due to a recent diagnosis of "pre-diabetes" (her BMI is 39 and A1C was 8.1). She says she needed an eye examination anyway because she is out of contact lenses. You examination is unremarkable. She has VSP refractive insurance and United Health Care medical insurance.

Is this a vision or medical encounter?

Hmmm....

Does duplicative coverage exist?

Is this a vision examination?

Is this a medical examination?

What would be the difference between those two examinations?

Can you handle this in two separate visits?

LAST EXAMPLE

Patience rewarded…can you over-ride the patient's direction?

Patient presents with complaints of blurred vision. BVA is OD 20/60 OS 20/30. Patient has mild diabetic retinopathy and CSME OD. Patient has VSP and BCBS.

Is this vision or medical – the patient wants you to bill VSP.

Let's review….

Remember all the legal options - remember the patient owns the policy – remember this possibly could be considered duplicative coverage.
BUT…when faced with this (and other) scenario, ***my opinion only.***

Does the presenting medical condition prevent me from conducting a proper comprehensive vision examination (wellness).

NO – bill vision

YES – bill medical

Most important advice on this matter…

Whenever possible, keep vision care and medical care separate

THANK YOU!

Let's take some questions - or email me

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