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

Joe W DeLoach, OD, FAAO
CEO, practice compliance Solutions
Former Clinical Professor, UHCO

1

Financial Disclosures Joe DeLoach, OD, FAAO

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

- Vision Source
- Alcon
- 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
- AACO
- UHCO, NOVA, RSO, UAB, Berkley, *and other colleges*

Over half the state optometric associations in the United States

Practice Compliance Solutions – President and CEO
Former Clinical Professor – University of Houston College of Optometry

2

ADDITIONAL DISCLAIMERS

I am a consultant and contract auditor for CMS and several major medical payers.

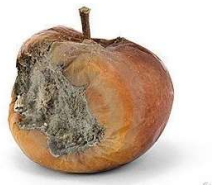
Policies presented/discussed are specific to your state and predominantly based on Medicare, CPT and Federal Fraud and Abuse guidelines. Individual payer policies are unique, regional and sometimes not clearly published.

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

3

Let's start in reverse….

What's Rotten?



4

The Bipolar World of Coding *"Experts"*

Practice Centric Care	**Patient** Centric Care
MAXIMIZE your revenue	Do what's right for the patient and the money will follow
Do what puts the most money in the bank	Use common sense
MAXIMUM use of examinations, testing and technology	Medically necessary use of examinations, testing and technology
Twist the system in an attempt to get around the rules	95% of rules are pretty clear – just follow them
RESULT	**RESULT**
Indefensible care – often "worthless" per CMS	Defensible, medically necessary care
Massive audit exposure	Minimal audit exposure
Doctors getting severely hurt	Make as much or more money just doing what's right
Sleepless nights	Sleep like a baby

5

So there are tons of coding "experts" out there…why listen to me?

- Recognized national authority / lecturer for 25 years *(big deal)*
- Chairman emeritis of Texas Optometric Association Third Party Committee *(so what)*
- Run a company that provide RCM management *(could be important)*
- Consultant to Medicare *(hmmmm….)*
- Serve on Medicare Carrier Advisory Committee for 20 years *(likely important)*
- Contract auditor for Medicare and medical payers ***(IMPORTANT)***

6

Why the focus on fraud and abuse? *Latest really bad data…*

- 2019 Medicare fraud and abuse - $60 BILLION
- 2019 Medicaid fraud and abuse - $140 BILLION
- 2018 total fraud and abuse (RAND Study) - >**$290 BILLION**
- ***But surely optometry is not a problem….***
  - **2016 CERT study puts us at #10**
  - **2019 we got better - #32**
  - **But in DME claims – we are #1**

7

What did CERT say?

Both cases….main issue is lack of documented medical necessity

THINGS THAT APPLY TO US

SERVICE	PERCENT IMPROPER PAYMENT	MAIN REASON
Diagnostic Testing	16.3%	Insufficient documentation
Minor Procedures	12.8%	Insufficient documentation
New Office Visits	12.7%	Incorrect coding
Established Office Visits	6.6%	Incorrect coding

THIS EXCLUDES THE CROOKS…THIS RELATES TO AVERAGE CLAIMS FOR REIMBURSEMENT

8

And that DME thing…#1? *WHY?*

? Do you know the rules regarding provision of ophthalmic good under Medicare/Mediaid?

? Do you know you have a checklist of things you must have in your office if a DME inspector shows up (and CMS has an outside contract right now just for that!)?

? Do you know your warranty obligations under DME?

? Do you know what your patient has to sign when you dispense ophthalmic goods to them?

Didn't think so….

9

Why are optometrists messing up?

Poor/no understanding of the two core concepts of medical billing

1. Reason for the visit
2. Medical necessity

Greed *(there, I said it)*

1. Too much time on blogs
2. Too much time trying to "get around" the rules

BIG ISSUE: WE SIMPLY WEREN'T TAUGHT THE DIFFERENCE BETWEEN WELLNESS CARE AND MEDICAL CARE!

10

Sources of our sadly earned reputation

- Our education
- "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…)*

11

Where a lot of it comes from….

A lot of improper, 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"

12

Typical situation – February 2018

DOC: *We were just audited by Medicare and have to pay back $62,544 – said we are billing unnecessary 92004/14*

JOE: (after review of 20 charts that were audited) It looks like they let you off easily – I would consider NONE of these 20 encounters as medical visits

DOC: *But the patient has Medicare – we have to bill medical*

JOE: No, you CAN bill Medicare if the reason for the visit leads to a medical diagnosis

DOC: *But Dr XXXX, a coding expert, told us at XXX (meeting) to "take a stance" and always bill medical*

JOE: You should contact Dr XXXX and ask him to pay the $62,544 back to Medicare for you

13

Conversation 1.24.2018

DR: *Joe, BCBS is denying my claims for 92132 saying It is investigational. That's bullsh…Dr. Z is a coding expert and he said that is wrong.*
ME: *I would agree the policy stinks but that is their policy and they have every right to make it.*
DR: *That can't be right – they have an obligation to the patient.*
ME: *Actually their only obligations are to the state insurance commission and their board of directors*
DR: *Never mind…I'll call someone else.*

TWO HOUR PAUSE – CALL FROM OCT COMPANY REP

REP: *Joe, Dr X is reporting you AND Dr. Rumpakis said he can't get paid for 92132 – that's usually a submission error. If I send you the claim form can you tell me what he is doing wrong.*
ME: *Actually, BCBS published policy says they do not pay for 92132. It's not a claim error.*
REP: *PAUSE….. No shi….. What can we do about this?*
ME: ***Pray to the god of your choosing***

14

This is also just wrong!

Typical Email…

Dear Dr. DeLoach,

On December 17th a special interactive webinar, "[redacted] Trenches," highlighting how to get the maximum return on your Investment in your [redacted]"

15

Examples from crooks…

- Punctal plugs on **227%** of Medicare patients
- Corneal topography on **76%** of Medicare patients
- Sensorimotor evaluation on **133%** of Medicare patients
- Fundus photography on **86%** of Medicare patients
- Anterior segment photography on **99%** of Medicare patients
- **1411 VEPS** on 2711 Medicare patients
- **1901 amniotic membranes** on 2711 Medicare patients

WHY SHOULD THIS CONCERN ME?
I'M NOT A CROOK!

16

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

Actions now considered as FRAUD

(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

17

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 *(rarely fair and very severe – hear about California????)*
3. Aetna *(looking for anything – King of payment policies)*
4. BCBS *(fair is a four letter word)*
5. EyeMed *(pretty fair and not too severe – unless…)*
6. On the horizon…**Medicaid**

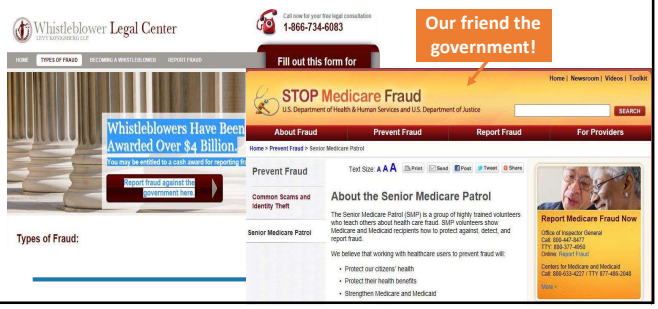
18

Audits Due to Whistleblowing (*"Qui tam"*)

- The perfect answer….free labor *(kinda)* for the government
- Who becomes a Whistleblower
  - Opportunists – trained by the government
  - Unhappy employees
  - Unhappy patients

19

How about this – Everyone wants to help



20

How Much Does the Government Like Whistleblowers

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

BUT 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)

21

Sources of Coding *Truth*!

www.cms.gov (Medicare)

www.noridianmedicare.com
Jurisdiction F *(that's you)* Carrier

www.*whoever-medicalpayor*.com

CPT and ICD-10 Manuals

www.CodeSAFEPLUS.com

www.practicecompliancessolutions.com

22

Real Definition of Reimbursement

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

23

Ever read what you sign?

"In submitting this claim for payment from federal funds, I certify that 1)the information on this form is true, accurate and complete 2)I have familiarized myself with all laws, regulations and program instructions available from the Medicare contractor 3)I have provided or can provide sufficient information required to allow the government to make an informed eligibility and payment decision 4) this claim complies with all Medicare program instructions and…"

lists all five Federal F/A laws most of you can't name!

24

So what are they???

- False Claims Act *(granddaddy of them all)*
- Anti-Kickback Statute
  - And 2019 - the Eliminating Kickbacks in Recovery Act (EKRA)
- Self Referral Law
- Exclusion Statute
- Civil Monetary Penalties Law

25

But first….the most important concepts to understand

The PILLARS OF REIMBURSEMENT

- Reason for the visit
- Medical Necessity

26

PILLAR ONE
NUMERO UNO!

REASON FOR THE VISIT

27

What Is The Reason for the Visit - RFV

- 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

- Do not address the reason for the visit, an auditor can/will deny the entire encounter as not medically necessary
- **It doesn't matter what YOU want to do, the only reimbursable care is that which answers the RFV!**

28

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 finding 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****."*

29

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!!!

30

Summary - Reason For the Visit

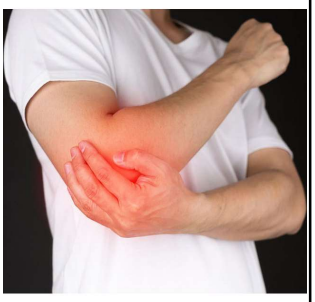
Unless dictated by the patient's payor or unless you have to fulfill some mindless requirements of your state law or vision plan, you perform a symptom oriented exam just like the rest of the medical world does

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

31

This is so simple!

"Doc…my elbow hurts!"



32

PILLAR TWO

MEDICAL NECESSITY

33

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

34

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?

35

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)**

36

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 (ouch!)

Why is medical care different?

37

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)

38

Interesting Item

Top 5 Claim Submission Errors – Novitas Solutions 2020

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)**

39

So…

Myths, Legends, Truth and Lies in Optometry Medical Reimbursement

40

#1 - Upcoding EM

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%**

41

THE CARE DICTATES THE CODE

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

- THIS IS THE WAY IT WORKS

1. Why is the patient here
2. What do I do to answer that need
3. What code(s) represent the care I delivered

- ***NOT THE OTHER WAY AROUND!!!***

42

Historically Why?
PERTINENT

1. Over-estimation of history – because not pertinent
2. *Over-estimation of examination – because not pertinent*
3. *Over-estimation of medical decision making based on #1, #2 and overall misunderstanding of EM system*

43

DID ALL THIS REALLY CHANGE?

Yes it did!

But does ANYONE understand it?

44

Old system

The three key components of selecting the level of the E&M code are:

- History
- Examination
- Medical Decision Making

Each key had four levels….then there was two of three, all four, exceptions, subjectivity, ambiguity…..

Bottom line it was a very ugly animal

45

Changes

Effective January 2021, CPT has fundamentally changed the evaluation and management code system.

The major changes are

- **elimination of** 99201
- a total change in how your level of service is determined **- the only criteria is the level of medical decision making**
- Definition of **time as the sole factor has changed**
- Level determinants are the **same for new/established**

46

New Definitions

- **99202** - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **straightforward medical decision making**.
- **99203** - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **low level of medical decision making**,
- **99204** - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **moderate level of medical decision making**.
- **99205** - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **high level of medical decision making**.

47

New Definitions

- **99212** - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination **and straightforward medical decision making**.
- **99213** - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **low level of medical decision making**.
- **99214** - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **moderate level of medical decision making**.
- **99215** - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **high level of medical decision making**.

48

So how did they change…

In EVERY definition:

- The level of medical decision making is defined for each level of service
- The requirements **do not differentiate between new and established** patients
- There are **no stated levels for history and examination elements**
- **Every level contains the** statement that the history and examination elements must be "**medically appropriate**"

49

Medically appropriate history and examination….*MEANS WHAT?*

For services to be adjudicated as reimbursable…you must pass two tests:

MEDICAL NECESSITY

Medically appropriate history/examination

COMPLETE REQUIREMENTS OF CPT DEFINITION

You MUST understand the new system of medical decision making

50

MEANS WHAT???

Basic tenet of reimbursement DOES NOT CHANGE

1. The ONLY services you are legally allowed to be reimbursed for are those **BASED ON THE REASON FOR THE VISIT**
2. Medical decision making is defined by the **medically necessary services provided based on the reason for the visit**

51

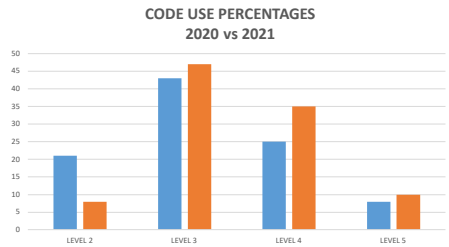
Does this really change much?

Overall, these changes will result in:

- ✓ A shift to more appropriate Level 3 visits
- ✓ A moderate shift to more appropriate Level 4 visits
- ✓ A very slight shift to more appropriate Level 5 visits….VERY SLIGHT

52

A DeLoach estimation - but your billing percentages may look more like this

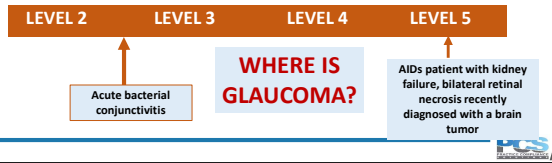


53

Since it is all based on medical decision making…where is the mindset of many Ods?

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



54

2021 changes DEFINITELY make this easier, if you're willing to memorize some stuff

55

Three Elements of Medical Decision Making (MDM)

1. **Number and complexity of problem(s) that are addressed during encounter**
2. **Amount and/or complexity of data to be reviewed and analyzed – Includes:**
   - Medical records
   - Tests
   - Other information obtained, ordered, reviewed, and analyzed
3. **Risk:**
   - Complications, morbidity, and/or mortality of patient management decisions made at the visit
   - Associated patient's problem(s)
   - Diagnostic procedure(s) and treatment (s)
   - Possible management options selected **and** those considered, but not selected
   - Includes shared medical decision making with the patient and/or family

56

Medical Decision Making (MDM)

First Element of MDM

Number and complexity of problem(s) that are addressed during encounter

57

"Problem addressed" defined

- A problem is **addressed** or managed **when it is evaluated or treated at the encounter**
- **Includes consideration** of further testing or treatment **even if not done**
- **Notation that another professional is managing** the problem without additional assessment or care coordination **does not qualify**
- **Referral without adequate evaluation or consideration** of treatment **does not qualify**

NOTE: Providers should be very cautious regarding this definition and its effect on use of legal scope and referrals.

58

"Problem" Defined

- Disease
- Condition
- Illness
- Injury
- Symptom
- Sign
- Finding
- Complaint
- Other issues noted at encounter

Problem can be:
- Minimal *(applies only to 99211 – we will ignore)*
- Minor, self-limited
- Chronic, stable
- Acute, uncomplicated
- Chronic with exacerbation, progression, treatment complications
- New with uncertain prognosis
- Acute with systemic complications
- Acute complicated injury
- Chronic with SEVERE exacerbation, progression, treatment complications
- Acute or chronic that poses threat to life or function

Sounds complicated **but at least they are defined!**

59

Minor, self-limited

A problem that runs a **definite and prescribed course**, is **transient** in nature, and is **not likely to permanently alter** health status.

Examples: a lot of potential applications but only applies to Level 2

Chronic, stable

- A problem with an **expected duration of at least a y**
- Conditions are treated as chronic **whether or not st** **changes** (e.g., uncontrolled diabetes and controlled additional complications are same chronic condition)
- Stable is defined as **meeting specific treatment goals** for an individual patient

Examples: might include **dry eyes, diabetic complications, glaucoma, allergies, choroidal nevus**

BIG COMMENT REGARDING THE "EXAMPLES"

60

Acute, uncomplicated

- A recent or new short-term problem with low risk of morbidity for which treatment is considered
- Little to no risk of mortality with treatment and full recovery without functional impairment is expected
- A problem that is normally self-limited or minor but is not resolving despite a prescribed course of treatment

Examples: might include dry eyes, blepharitis, episcleritis, conjunctivitis, myokemia

Chronic, with exacerbation, progression, complications of Tx

- A chronic illness that is acutely worsening, poorly controlled or progressing despite attempts to control progression and requiring additional care
- Also includes additional or change in treatment required due to side effects of current treatment

Examples: might include glaucoma, diabetic complications, macular degeneration, central serous retinopathy, allergic reaction to Alphagan

61

New with uncertain prognosis

- A new problem that represents a condition likely to result in a high risk of morbidity without treatment

Examples: might include corneal laceration, swollen disc, EKC, macular hole

Acute with systemic complications

- An illness that causes systemic symptoms and has a high risk of morbidity without treatment
- Symptoms must be specific and can include the whole body or a designated single organ system (the eye)

Examples: might include uveitis, scleritis, retinitis, optic neuritis

62

Acute, complicated injury

- An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity

Examples: might include ocular contusion, head trauma

Chronic with severe exacerbation, progression or complications from treatment

- The severe exacerbation or progression of a chronic illness or
- Severe side effects of treatment that have significant risk of morbidity and may require hospital level of care

Examples: might include gonococcal keratitis, TIA, uveitic, steroid responder, Steven's Johnson

63

Acute or chronic illness or injury that poses threat to life or function

An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment.

Examples: might include choroidal melanoma, third nerve palsy, orbital cellulitis

64

Medical Decision Making (MDM)

Second Element of MDM

Amount and/or complexity of data to be reviewed and analyzed – Includes:

- Medical records
- Tests
- Other information obtained, ordered, reviewed, and analyzed

65

Medical records and tests might be YOURS or from EXTERNAL source

YOURS (the patient's)

- Review of existing and/or current medical record data YOU GENERATED does not count
- Review of testing YOU ORDERED AND PERFORMED (independent diagnostic procedures) **DOES** count

External

- From data from external physician or other qualified health care professional not in the same group practice or is a different specialty or subspecialty
- Also includes from a facility or organizational provider such as a hospital, nursing facility, or home health care agency

66

External sources can also be

Independent historian

- An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided / attempted by the patient who is unable to provide a complete or reliable history

Other non-healthcare professionals involved in the management of the patient

- Lawyer, parole officer, case manager, teacher
- It does not include simple discussion with family or informal caregivers

67

Medical Decision Making (MDM)

Third Element of MDM

Risk - includes:

- Complications, morbidity, and/or mortality of patient management decisions made at the visit
- Associated patient's problem(s)
- Risk of diagnostic procedure(s) and treatment(s)
- Possible management options selected and those considered, but not selected
- Shared medical decision making with the patient and/or family

68

Risk

- The probability and/or consequences of an event
- The assessment of the level of risk is affected by the nature of the event under consideration
- Based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty
- Trained clinicians apply common language usage meanings to terms such as 'high', 'medium', 'low', or 'minimal' risk and do not require quantification for these definitions, unless evidence-based quantifications are published (e.g. glaucoma)
- Based upon consequences of the problem(s) addressed at the encounter when appropriately treated
- Also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization

69

Morbidity

A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment

Mortality

Risk of acute or imminent death

70

Other terms that pop up…

Social determinants of health

- Economic and social conditions that influence the health of people and communities (living conditions, nutrition, drug use, abuse etc.)

Drug therapy requiring intensive monitoring for toxicity

- Therapeutic agent that has the potential to cause serious morbidity or death
  - service performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy
  - should be that which is generally accepted practice for the agent but may be patient specific in some cases
  - may be by a lab test, a physiologic test or imaging…***BUT***
- Monitoring by history or examination ALONE does not qualify

71

Drum roll….

Let's put it all together!

72

Summary Level 2

MUST MEET TWO OF THREE

CPT Code	MDM Level	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity
99202/12	**Straightforward**	**Minimal** 1 self-limiting or minor problem	**Minimal to none**	**Minimal risk** of morbidity from additional testing or treatment

OBVIOUS CONCLUSION: Under the new system, it takes very little to meet the requirements of a Level 2 service

73

Summary Level 3

MUST MEET TWO OF THREE

CPT Code	MDM Level	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity
99203/13	**Low**	**Low** 2 or more self-limiting or minor problems **-or-** 1 stable chronic illness **-or-** 1 acute, uncomplicated illness or injury	**Limited (must meet 1)** Category One Order and review of tests you ordered and reviewed, **or** Additional external documents analyzed Category Two Assessment by Independent Historian	**Low risk** of morbidity from additional testing or treatment

74

Summary Level 4

MUST MEET TWO OF THREE

CPT Code	MDM Level	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity
99204/14	**Moderate**	**Moderate** 1 or more chronic illness with exacerbation, progression or side effects of treatment **-or-** 2 or more chronic illnesses **-or-** 1 undiagnosed new problem with uncertain prognosis **-or-** 1 acute illness with systemic symptoms **-or-** 1 acute complicated injury	**Moderate (any 1 of)** Category One (any 3 of): • Tests you ordered and reviewed • Review of tests with independent historian • Review of prior notes from external source • Review of test results from external source • Assessment requiring an independent historian **-or-** Category Two: Independent interpretation of test performed by another physician **-or-** Category Three Discussion of management or test interpretation with external physician	**Moderate risk of morbidity from additional testing or treatment** • Prescription drug management • Decision regarding minor surgery with patient or procedure risks • Decision regarding major surgery without patient or procedure risks • Diagnosis or treatment significantly limited by social determinants of health

75

Summary Level 5

MUST MEET TWO OF THREE

CPT Code	MDM Level	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity
99205/15	**High**	**High** 1 or more chronic illness with severe exacerbation, progression or side effects of Tx **-or-** 1 acute or chronic illness with threat to life or function	**Extensive (any 2 of)** Category One (any 3 of): • Tests you ordered and reviewed • Review of tests with independent historian • Review of prior notes from external source • Review of test results from external source • Assessment requiring an independent historian **-or-** Category Two: Independent interpretation of test performed by another physician **-or-** Category Three Discussion of management or test interpretation with external physician	**High risk of morbidity from additional testing or treatment** • Drug therapy requiring extensive monitoring • Decision for major elective surgery • Decision for major emergency surgery • Decision to hospitalize • Decision to not resuscitate or deescalate care due to poor prognosis

76

BIG POINT

- Your "coding assistant" in your EMR was highly questionable prior to January 1, 2021
- You may officially consider them **USELESS** at this point
- At current level of technology, **there is NO WAY your EMR can determine medical decision making and now, that is ALL that matters in code level determination**

77

Joe…that was painful. Can you simplify?

To some degree, YES. Let's start with when you might want to use an EM vs Ophthalmologic code. To understand that, when **CAN** you use an Ophthalmologic code.

REQUIRED EXAM ELEMENTS	92004 / 92014	92002 / 92012
History	✓	✓
General medical observation	✓	✓
External and adnexal examination	✓	✓
Internal examination	✓	
Gross visual field	✓	
Sensorimotor evaluation	✓	
Assessment and treatment plan	✓	✓

78

So I have determined it is 100% correct for me to use EITHER code

(remember, you can ALWAYS use an EM code)

The, AND ONLY THEN, can you consider which code could be most financially beneficial. In general….*

NEW 99202<92002<99203<92004<99204<99205

ESTABLISHED 99212<92012=/<99213<92014=/<99214<99215

*Can vary with regional payers

*Original concept credit to Chris Wolfe, OD

79

Determination of Level Based on Time

- As before, you may make your level of service determination based on time spent.
- The 2021 guidelines make a huge change in the definition of time – **time now includes the total time the physician and qualified healthcare professional* spend with the patient**, not ONLY the time spent in counseling and coordination of care.
  - ➢It is still **only the time spent with the patient** (excludes waiting time, processing/intake time etc.) and
  - ➢**excludes time spent in any other activity where separate reimbursement** is available (e.g. consultation with other providers).
- Obviously eliminates the requirement that the counseling and coordination time be at least 50% of the total time the patient is in care.

**** Your assistants and technicians do not qualify under the definition of qualified healthcare professional!***

80

EM Code Level Based on Time

Time amounts per Level are:

NEW PATIENT	TIME	ESTABLISHED PATIENT	TIME
99202	15-29 MINUTES	99212	10-19 MINUTES
99203	30-44 MINUTES	99213	20-29 MINUTES
99204	45-59 MINUTES	99214	30-39 MINUTES
99205	60-74 MINUTES	99215	40-54 MINUTES

It is unlikely this will impact routine medical care but may be a HUGE help for specialty care

81

While we're at it…what else changed in 2021?

82

Prolonged Services

83

There are four options…here is 1-3

- Prolonged service with direct patient contact (99354-7)
- Prolonged service without direct patient contact (99358-9)
- Prolonged clinical staff services with physician supervision (99415-6)

These all involve hospitals and physician supervision…they would have very rare, if any, application to most modes of optometric practice

84

POSSIBLE application

Prolonged Service with or Without Direct Patient Contact on the Date of an Office Service (99417)

This code allows billing for additional time spent for a Level 5 Evaluation and Management service beyond the time requirement* where the time spent is in direct patient care, in preparation for the care and for certain aspects of coordination of care or care reporting *(only those not covered/billed under any other service code – like interpretation and reports or consultative services).*

So beyond 60 minutes for new patient and beyond 45 minutes for established patient – ONLY physician time counts

85

Correct Billing 99417 and 99215

TOTAL PROLONGED SERVICE	CODE(S)
Less than 45	Not applicable
60-74	99215 x 1 PLUS 99417 x 1
75-89	99215 x 1 PLUS 99417 x 2
90-104 etc.	99215 x 1 PLUS 99417 x 3 (or more)

PROBLEMS

1. How did you get to 99215?
2. 60 MINUTES OR MORE??? *(remember – JUST physician time)*

Can be very valuable for specialty services!!!

86

Correct Billing 99417 and 99205

TOTAL PROLONGED SERVICE	CODE(S)
Less than 60	Not applicable
75-89	99205 x 1 PLUS 99417 x 1
90-104	99205 x 1 PLUS 99417 x 2
105-119 etc.	99205 x 1 PLUS 99417 x 3 (or more)

PROBLEMS

Same issues ***(75 MINUTES???)*** but….

REPEAT…very valuable for specialty services!!!

87

Consultation Codes

88

Once again…new stuff that would RARELY apply

CPT 99446 - Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician, Including A Verbal And Written Report To The Patient's Treating/Requesting Physician Or Other Qualified Health Care Professional; 5-10 Minutes Of Medical Consultative Discussion And Review - $18.4

CPT 99447 - Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician, Including A Verbal And Written Report To The Patient's Treating/Requesting Physician Or Other Qualified Health Care Professional; 11-20 Minutes Of Medical Consultative Discussion And Review - $37

CPT 99448 - Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician, Including A Verbal And Written Report To The Patient's Treating/Requesting Physician Or Other Qualified Health Care Professional; 21-30 Minutes Of Medical Consultative Discussion And Review - $55.3

CPT 99449 - Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician, Including A Verbal And Written Report To The Patient's Treating/Requesting Physician Or Other Qualified Health Care Professional; 31 Minutes Or More Of Medical Consultative Discussion And Review - $73.98

Verbal AND written reports with moderate to significant time requirements for not a lot of money *(just to be blunt)*

89

Better stuff…

99451 - Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service **Provided By A Consultative Physician**, Including A Written Report **To The Patient's Treating/Requesting Physician** Or Other Qualified Health Care Professional, 5 Minutes Or More Of Medical Consultative Time - $37.53 (**consulted** doctor can get paid)

99452 - Interprofessional Telephone/Internet/Electronic Health Record Referral Service(s) **Provided By A Treating/Requesting Physician** Or Other Qualified Health Care Professional, 30 Minutes - $37.53 (**consulting** doctor can get paid)

90

Few key points…

- Verbal patient consent must be documented in the patient's medical record for each consultation. The patient's consent must include assurance that the patient is aware of applicable cost-sharing…***because***
- Providers must collect the requisite copayment from the patient for each service billed
- The consultation must be undertaken for the benefit of the patient – NOT edification of the practitioner, such as **information shared without real use,** as a **professional courtesy** or as continuing education

91

#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%

92

Why? *PERTINENT*

- 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

93

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

94

Remember experts? What did recent Optometry Management article just say?

Patient presents for a routine examination with symptoms of allergic conjunctivitis – which service code do you use?

WRONG answer
- 92004 as a MEDICAL visit

RIGHT answer
- **POSSIBLE** answer #1 - 92004 as a WELLNESS visit
- **POSSIBLE** answer #2 – 92002 or 99202 as a MEDICAL visit

95

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

96

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?

97

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*

98

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

BIG POINT

Dilation does **NOT** equate with a comprehensive code

99

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

REMEMBER?

Allergic conjunctivitis??????

100

#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!***

101

Excessive Testing – Just a few examples to make you think

- The American College of Physicians estimates excessive testing costs the health care between $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,"***
- 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

102

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)

103

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

104

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.

105

#4 – Mis-Use of Modifiers. -59 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 in glaucoma***

(refer to Medicare Carrier First Coast for the most common list of diagnoses that MIGHT justify both tests – HINT: ***NO*** glaucoma diagnoses listed!)

106

#4 – Mis-Use of Modifiers. -25 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

107

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?

108

#4 – Mis-Use of Modifiers. -52 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?***

109

#5 – Bulk Claims

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

2018 CMS per patient revenue - national ave. $108.47

Want examples of why optometry is in trouble?

110

#6 – Major Medical Payers Love Vision Therapy Claims

No so much…..

See position paper written by AOA

Its not a matter of whether or not it's valuable…it's a matter of DO THEY PAY FOR IT!

UNLESS YOU HAVE IN WRITING THAT EVERY CPT CODE YOU WANT TO SUBMIT IS CONSIDERED A COVERED EXPENSE UNDER THE PATIENT'S PLAN…..MAKE THE PATIENT PAY

111

#7 – Photography is fun…photo EVERYTHING

Biggest issues

- Cannot document the absence of disease *(a few exceptions)*
- Cannot document absence of change *(no exceptions)*
- Screening vs medically necessary photos
- Photos substituting for ophthalmoscopy

112

#8 – Not Making Vision Plan Happy – Part 1

Exam Requirements

- Read the history requirements, they are extensive
- Read the examination requirements, they are extensive
- Read the dilation requirements
- While you're at it, read what the agreement says about compliance issues

And understand they are ruthless, relentless and unforgiving. Let's talk about their new law…

113

#8 – Not Making Vision Plan Happy – Part 2

Contact Lens Requirements

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

114

But Joe….what about all those rules?

115

First…

- Payment policies are REGIONAL – information from your coding expert in California may not apply to South Dakota.
- This applies to major medical AND Medicare
- This does not apply to vision plans – their rules are:
  - National *(except when made up on the spot)*
  - Spelled out in the provider agreement *(except when made up on the spot)*
  - Ruthlessly applied

Strongly recommend use of a program that can help you keep up with all the rules and guidelines

116

And Medicare – that's Noridian for you

Few points about National Government Services

1. They are one of the least active in medical policy specific to eye care (2 policies)
   1. Blepharoplasty – L36286
   2. Cataract surgery – L37027
2. They are not very active in the audit market

117

BUT….

New CMS Statement: The audits will resume in full force despite ANY pandemic crisis

AND

When a Medicare auditor conducts an audit of your records, they can use the published Noridian LCDs…

BUT THEY CAN ALSO USE ANY PUBLISHED POLICY FROM ANY OTHER CARRIER – especially if Noridian does not have a policy specific to the issue in question

118

What's HOT in the eye care LCD market across the country

- Electrodiagnostic testing
- Scanning computerized ophthalmic diagnostic imaging
- Cataract surgery
- Provider qualification statements *(watch for this!!!!!)*

119

Things major medical sometimes have medical policy to support

- ✓ SCODI (common)
- ✓ Visual fields
- ✓ Electrodiagnostics (NOT for glaucoma – a sad story)
- ✓ Punctal plugs (some dry eye tx in general)
- ✓ Photography

120

Things major medical commonly have policy on NOT paying

- × Vision care / glasses
- × Vision therapy *(be very careful!)*
- × Anterior segment OCT *(changing – and you're lucky here)*
- × Macular pigment testing
- × Any ocular genetic testing
- × Pachymetry (new)

MAJOR MEDICAL PAYMENT POLICIES ARE OFTEN MORE ABOUT WHAT THEY **WILL NOT** PAY FOR THAN WHAT THEY **WILL** PAY FOR

121

THANK YOU!

Any questions… maybe at the bar or email me

joe@PCScomply.com

122

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

- ➢ FIRST AND FOREMOST – the reason for the visit determines that – **NOT YOU**
- ➢ 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

123

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?

124

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)*

125

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?

126

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…)*

127

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?

128

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. Your examination is unremarkable. She has VSP refractive insurance and United Health Care medical insurance.

Is this a vision or medical encounter?

129

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?

130

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 moderate diabetic retinopathy and CSME OD. Patient has VSP and BCBS.

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

131

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

132

Most important advice on this matter…

Whenever possible, keep vision care and medical care separate

133