

# Eye Care Coding and Billing in Today's Market

John W. Lahr, O.D., FAAO

## Disclaimer

Please note that this presentation is an educational tool. It is not intended to be an exhaustive review of the Medicare, insurance or managed care laws and regulations and is not intended to provide legal advice. Materials presented in this presentation should not be considered a substitute for actual statutory or regulatory language. Always refer to the current edition of CPT, ICD or other industry guidelines when making a decision on coding, billing or other submissions or filings.

## When a Patient Enters Your Practice

- What does the patient want?
- What does the patient need?
- What do you perform or provide for the patient?
- What are the patient expectations?
- What would you want if you were the patient?

## How To Develop a Level of Comfort

**Learning The System  
The Right Way, The First Time...**

## Compliance Plan

- Your compliance plan should include:
  - How to select appropriate codes
  - How to document the health record
  - How to evaluate & set your fees appropriately
- Putting these in place will allow you to
  - Survive an audit
  - Avoid financial penalties
  - Develop a system of checks & balances

## Coding-Who is Responsible?

**The Provider of the Service!**

## Just Tell Me What Codes to Use!

I Really Can Only Figure by the Time I Spend!

## Obtaining Third Party Information

- Seek information as soon as possible in the process
  - Telephone-appointment scheduling
  - In person-copies of vision and/or medical plans
- Don't expect the patient to know their plan or coverage!
- Be familiar with your local area companies and their plan coverage

## Obtaining Third Party Information

- Verify coverage as soon as possible
- Depending on the nature of the visit, determine if medical plan deductibles have been met
- Doctor and staff must exhibit confidence about the practice's role in medical eye care and plan activities

## Health Care Procedural Coding System (HCPCS)

- Level I HCPCS
  - CPT-4 Procedure codes
- Level II HCPCS
  - Alpha-numeric codes to allow billing of supplies, such as V2200 for bifocal lens
- Level III HCPCS
  - Local codes

## Resources

- Tools for success:
  - CPT 2009
  - ICD-9 2009
  - HCPCS Level II 2009
- All of these are available in AOA Codes for Optometry

## Current Procedural Terminology

- CPT is owned by the American Medical Association-AMA holds the copyright
- AMA works closely with Centers for Medicare and Medicaid Services (formerly HCFA)
- Codes are determined by the Editorial Panel (No non-MDs)
- Values of codes are determined by the Relative Value Update Committee (One non-MD)
- AOA has seat on Health Care Professional's Advisory Committee (HCPAC has one vote)

## Reimbursement System

- Resource Based Relative Value System (RBRVS)
  - Relative Value Unit (RVU)
    - Work RVU (99213=0.92)+GPCI (99213=0.8)=1.72
  - Geographic Practice Cost Index (GPCI)
    - Malpractice + Practice Expense
  - Conversion Factor
    - 2009 Medicare=\$36.0666
  - 99213 National Average Medicare Fee=\$62.03

## Diagnosis Codes

### International Classification of Diseases (ICD)

## Diagnosis Codes

- Developed and controlled by the World Health Organization (WHO)
- The key to payment of billed procedure codes
- Linked codes to procedure codes
- Valuable to payers to track conditions and statistics
- Proposed change to alpha-numeric ICD-10 in 2013

## ICD-10

- HHS has established that ICD-10 codes be used by health care providers to report diagnosis with procedures beginning October 1, 2013
- ICD-9 contains 17,000 codes where ICD-10 will increase to 155,000 codes
- Intro to HIPAA 5010 at [www.CMS.gov/MLN Matters Articles](http://www.CMS.gov/MLN Matters Articles)
- AOA Third Party Center will provide educational materials-Be proactive!

### H40 Glaucoma

Excludes: absolute glaucoma ( [H41.5](#) )  
congenital glaucoma ( [Q15.4](#) )  
traumatic glaucoma due to birth injury ( [P15.3](#) )

- H40.0 Glaucoma suspect  
Ocular hypertension
- H40.1 Primary open-angle glaucoma  
Glaucoma (primary) (residual stage):
  - capsular with pseudoexfoliation of lens
  - chronic simple
  - low-tension
  - pigmentary
- H40.2 Primary angle-closure glaucoma  
Angle-closure glaucoma (primary) (residual stage):
  - acute
  - chronic
  - intermittent
- H40.3 Glaucoma secondary to eye trauma  
Use additional code, if desired, to identify cause.
- H40.4 Glaucoma secondary to eye inflammation  
Use additional code, if desired, to identify cause.
- H40.5 Glaucoma secondary to other eye disorders  
Use additional code, if desired, to identify cause.
- H40.6 Glaucoma secondary to drugs  
Use additional external cause code (Chapter XX), if desired, to identify drug.
- H40.8 Other glaucoma
- H40.9 Glaucoma, unspecified

## ICD-9-CM Codes

- International Classification Of Disease, Ninth Edition
- Diagnosis Codes: Typically, a 5 Digit Code with Decimal Point  
123.45
- However, can be a 4 digit code  
123.4

## ICD-9-CM Codes

- Beware Of Not Following the Code Number Exactly as Published
- Diagnosis Code:

123.4  
Is Not Equal To  
123.40

## Diagnosis Codes

- List primary diagnosis code first and all other ICD codes after
- Use most detailed and specific code(s) possible for each submission
- List all pertinent diagnosis for each patient for claims
  - Some medical plans reject refractive diagnosis
  - Most vision plans **DO NOT** reject medical diagnosis
  - Many vision plans require the submission of all applicable ICD diagnosis codes for all patients (refractive and medical)
- Avoid xxx.9 codes (garbage codes) whenever possible
- May need to be line item specific for procedures linked to different diagnosis

## Diagnosis Codes

- Detailed diagnosis coding:
  - Vitreous Degeneration
    - 379.2-Disorders of vitreous body
    - 379.21-Vitreous degeneration
    - 379.9-Unspecified disorder of the eye and adnexa

## Diagnosis Codes

- 92135-Scanning laser
  - 362.85-nerve fiber bundle defects
  - 377.0x-377.4x-optic nerve
  - 365.xx-Glaucoma
- 92100-Serial tonometry
  - 365.xx-Glaucoma
- 92020-Gonioscopy
  - 365.xx-Glaucoma

## Diagnosis Codes

- 92081-92083-Visual Fields
  - 365.xx-Glaucoma
  - 340-349-Selected neuropathologic defects
- 92225/26-Ophthalmoscopy extended
  - 361.xx-363.xx-Retinal defects
- 92250-Fundus photography
  - 365.xx-Glaucoma
  - 340-349-Selected neuropathologic defects
  - 361.xx-363.xx-Retinal defects

## Diagnosis Codes

- 67820-Epilate lashes
  - 374.05-Trichiasis
  - 374.01-Senile entropion
- 65600-Multiple punctures of anterior cornea
  - 371.70-Unspecified corneal deformity
- 65205-FB conjunctiva
  - 930.1-Conjunctival FB
- 65210-FB embedded conjunctiva
  - 930.18 FB in other or combined sites

## Diagnosis Codes

- 68801-Dilation and /or irrigation of lacrimal puncta
  - 375.22-Epiphora-insufficient drainage
  - 375.42-Chronic dacryocystitis
  - 375.52-Stenosis of lacrimal puncta
  - 375.53-Stenosis of lacrimal canaliculi
  - 375.56-Stenosis of nasolacrimal duct-acquired
- 65220/65222-Remove corneal FB
  - 930.0-Corneal FB

## Diagnosis Codes

- 68761-Closure of lacrimal puncta-by plug
  - 370.21-Punctate keratitis
  - 370.23-Filamentary keratitis
  - 370.34-Exposure keratitis
  - 370.80-Other forms of keratitis
  - 371.42-Recurrent corneal erosion
  - 374.41-Eyelid retraction
  - 375.15-Unspecified tear film deficiency

## V-Diagnosis Codes

- V43.1-Pseudophakia
- V58.69-Encounter-long-term (current use) of other (high risk) medications
- V65.5-Person with feared complaint in whom no diagnosis was made
- V67.51-Follow-up exam following completed treatment with high risk medication

## V-Diagnosis Codes

- V71.8-Observation and evaluation for other specified suspected conditions
- V72.0-Special examination of eyes and vision
- V80.1-Special screening for glaucoma

## E-Diagnosis Codes

**E-Codes shall be used in addition to a code from the main chapters of ICD-9**

- E864.1-Accidental poisoning by corrosives and caustics (Acids)
- E864.2- Accidental poisoning by corrosives and caustics (Alkalis)
- E921.8-Accident caused by explosion of pressurized vessel (auto tire)
- E931.4-Substances causing adverse effects in therapeutic use-antimalarial (Plaquanil)

## Diabetes

- Diabetes Mellitus-ICD 250.xx
  - 250.0\_-Diabetes w/o complication or manifestation
  - 250.5\_-Diabetes with ophthalmic manifestations
  - 5<sup>th</sup> digit
    - 0-Type 2 or unspecified-not stated as uncontrolled
    - 1-Type 1-not stated as uncontrolled
    - 2-Type 2 or unspecified-uncontrolled
    - 3-Type 1-uncontrolled

## Diabetic Retinopathy

- If diabetic retinopathy present, appropriate coding is to list 250.5x plus:
- Type of diabetic retinopathy present
  - 362.03-Not otherwise specified (NOS)
  - 362.04-Mild Non-proliferative
  - 362.05-Moderate Non-proliferative
  - 362.06-Sever Non-proliferative
  - 362.07-Diabetic Macular Edema

## Selecting The Appropriate Procedure Code

- Identify appropriate Category of Service
  - E/M
    - Determine extent of History
    - Determine extent of Examination
    - Determine extent of Medical Decision Making
  - Ophthalmological
  - “S” Code
  - Consultation
    - Determine extent of History
    - Determine extent of Examination
    - Determine extent of Medical Decision Making

## What Code Should I Use for Eye Exams?

### 92xxx vs. 99xxx vs. S-Codes

## 92xx4-Comprehensive

- CPT 2009 Definition: “... describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmological examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.”

Source: CPT-4 2009

## 92xx4-Comprehensive

- “Intermediate and comprehensive ophthalmological services constitute integrated services in which medical decision making cannot be separated from examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, routine ophthalmoscopy, retinoscopy, tonometry or motor evaluation is not applicable.”

Source: CPT-4 2009

## 92xx2-Intermediate

- CPT 2009 Definition: “... describes an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily related to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated: may include the use of mydriasis for ophthalmoscopy.”

Source: CPT-4 2009

## 92xx2-Intermediate

- *For example:*
  - Review of history, external examination, ophthalmoscopy, biomicroscopy for an acute complicated condition (eg. Iritis) not requiring comprehensive ophthalmological services.
  - Review of interval history, external examination, ophthalmoscopy, biomicroscopy and tonometry in established patient with known cataract not requiring comprehensive ophthalmological services.

Source: CPT-4 2009

## 92xx4-Comprehensive

- *For example:* "The comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract or retinal disease , or to rule out disease of the visual system, new or established patient.

*Initiation of diagnostic and treatment program includes the prescription of medication, and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services."*

Source: CPT-4 2009

## Relative Value of Eye Exam New Patient

E/M	RVUs	Eye Code	RVUs
99201	1.02		
99202	1.76	92002	1.86
99203	2.55		
99204	3.93	92004	3.48
99205	4.96		

## Relative Value of Eye Exam Established Patient

E/M	RVUs	Eye Code	RVUs
99211	0.52		
99212	1.03		
99213	1.70		
		92012	1.95
99214	2.56	92014	2.86
99215	3.46		

## Utilization Patterns Medicare-Ophthalmology-2007

CPT	New Patients	Usage	CPT	Est Patients	Usage
99205	Level 5	1%	99215	Level 5	1%
99204	Level 4	19%	99214 92014	Level 4 Comp	46%*
99203 92004	Level 3 Comp	71%*	99213	Level 3 Int	46%*
99202 92012	Level 2 Int	8%*	99212	Level 2	7%
99201	Level 1	0%	99211	Level 1	0%

\* Combined utilization of E/M and Eye Codes

## Utilization Patterns Medicare-Optometry-2007

CPT	New Patients	Usage	CPT	Est Patients	Usage
99205	Level 5	1%	99215	Level 5	1%
99204	Level 4	8%	99214 92014	Level 4 Comp	50%*
99203 92004	Level 3 Comp	76%*	99213	Level 3 Int	37%*
99202 92012	Level 2 Int	15%*	99212	Level 2	12%
99201	Level 1	0%	99211	Level 1	1%

\* Combined utilization of E/M and Eye Codes

## S-Codes

## S-Codes

- S0500-Disposable CL-per lens
- S0512-Daily wear specialty CL-per lens
- S0514-Color CL-per lens
- S0592-Comprehensive CL evaluation
- S0581-Non-standard lens (list in addition to standard lens code)
- S0580-Polycarbonate lens (list in addition to standard lens code)

## S-Codes

- S0620-Routine comprehensive ophthalmological exam including refraction-new patient
- S0621-Routine comprehensive ophthalmological exam including refraction-established patient

## S-Codes

- S0800-LASIK
- S0810-PRK
- S0812-PTK

## S-Codes

- HIPAA mandated Standard Code Sets means no addition, subtraction or modification of published codes
  - HCPCS-Level One (CPT)
  - ICD
  - HCPCS-Level Two or Three
- Medicare and other Government Payers do not recognize S-codes
- May be useful for self pay patients and in the future for private insurers
  - Currently the standard of care for vision plan contracts is 92xx4, Comprehensive Ophthalmological Service due to detail definition of the services provided

## “The Great Debate”

**Vision Plan or Medical Plan  
Billing?**

## Case #1

- Patient presents with vision plan card (has PPO Managed Health Care Plan) and is seeking new Rx
- History and clinical findings reveal:
  - Ocular Surface Disease that appears inflammatory based
  - A quality refraction is completed and Rx determined
- What options for billing exist?

## Case #1

- Option 1
  - Bill comprehensive examination to Vision Plan
  - Self-refer/reschedule for OSD work-up
- Option 2
  - Bill comprehensive examination to PPO
  - Refraction (92015) to Vision Plan
  - Self-refer/re-schedule for follow-up to OSD treatment plan

## Billing Considerations

- Is your office a participating provider on the PPO medical plan?
- What is the time of the year?
- What were the patient's expectations entering the office?
- Does the Vision Plan have a primary eye care program to allow extended medical eye services to be billed?
- Is the billing option presented consistent with other payer types in the practice?

## Who is the Ultimate Decision Maker of What Plan Will Be Billed?

**The Holder of the Coverage!**

## Case #2

- Patient presents with vision plan card (has PPO Managed Health Care Plan) and is seeking relief from dry eye discomfort and also a new Rx
- History and clinical findings reveal:
  - Ocular Surface Disease that has compromised the cornea
  - A quality refraction can not be completed to yield a final Rx
- What billing options exist?

## Case #2

- Option 1
  - Complete and bill comprehensive examination to Vision Plan
  - Self-refer/reschedule for OSD work-up
  - Patient must be informed that a self-pay follow-up refraction will be needed after OSD is controlled
- Option 2
  - Bill 99xxx to PPO
  - Refraction (92015), if completed, to patient or Vision Plan
  - Self-refer/re-schedule for follow-up to OSD treatment plan
  - Patient must be informed that a self-pay follow-up refraction will be needed after OSD is controlled

## Success Factors

- Confidence
- Communication to patient/family
  - Explain findings as your clinical tests progress
  - Stop and recommend course of care as well as coding/billing
  - Establish expectations for care and schedule
- Managing the schedule
  - Re-schedule as indicated by condition(s)

## Case Example

- Provider collected all care coverage information for each patient
- Whenever a medical diagnosis could be determined, the provider billed the medical coverage without discussing with the patient
- Provider balance billed the patient for extra testing w/o Advanced Beneficiary Notice (ABN)
- Over a period of 18-months, three formal complaints were filed with the Insurance Commissioner over claims
- Agents seized clinical/financial records and closed office until investigation is complete

## The Consequences

Monday, May 05, 2008 - XX Dept. of Insurance

XXXXXX-area Optometrist Guilty of Insurance Fraud Totalling Nearly \$11,500

Dr. XXXX XXXXX faces six to 12 months in prison

XXXXXX – XXXX XXXXX, a XXXXXX-area optometrist investigated by the XX Department of Insurance for insurance fraud, pled no contest today to a Bill of Information charging him with one count of insurance fraud, a felony of the fifth degree thereby waiving his right to be indicted. XXXXX was found guilty of illegally billing insurance entities Anthem, United Health Care and Tricare and fraudulently receiving nearly \$11,500 for personal gain.

Department Fraud and Enforcement attorney XXXX XXXXX served as special prosecutor in the case before the XXXXXX County Court of Common Pleas. XXXXX sentencing hearing is scheduled for June 17 at 10 a.m. He faces a potential prison sentence from six to 12 months.

XXXXXX used several fraudulent schemes, including charging patients \$21 for a visual fields test procedure. He would, in some cases, advise the patients that their insurance would not cover this test but that it was important that they have it. The patients would pay him their co-payments as well as the \$21. He would only show the co-payments on the insurance submissions then bill the insurers and pocket the money. He would also bill for a bogus mucous membrane test that required a special allergen - which the office did not have - to be inserted into the eye membrane.

XXXXXX who suspect insurance fraud should call the Departments fraud hotline at 1-800-XXX-XXXX.

## Selecting and Using Evaluation/Management (E/M) Codes

## New vs. Established

- “A new patient is one that has not received any professional services from the physician or another physician of the same specialty who belongs to the same group within the past three years.”

## New vs. Established

- History, exam and medical decision making must all meet or exceed the stated requirements (3 of 3) to qualify when the patient is classified as a “new” patient.
- History, exam and medical decision making must meet or exceed the stated requirements (2 of 3) to qualify when the patient is classified as an “established” patient.

## Elements of E/M Coding

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time

## Time

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

## Typical Times in CPT-4

- |                    |                                      |
|--------------------|--------------------------------------|
| • 99205-60 minutes | • 99215-40 minutes                   |
| • 99204-45 minutes | • 99214-25 minutes                   |
| • 99203-30 minutes | • 99213-15 minutes                   |
| • 99202-20 minutes | • 99212-10 minutes                   |
| • 99201-10 minutes | • 99211-5 minutes<br>(Non physician) |

## E/M Guidelines-History

- Chief Complaint
- History of Present Illness (HPI)
- Past Ocular History
- Family History
- Social History
- Review of Systems
- Patient-New or Established

## Documentation of History (E/M)

- Problem Focused
  - Chief Complaint
  - 1 to 3 elements of History of Present Illness (HPI)
- Expanded Problem-Focused
  - Chief Complaint
  - 1 to 3 elements of HPI
  - Ocular review of systems
- Detailed
  - Chief Complaint
  - 4 elements of HPI
  - Ocular review of systems
  - 1 specific item from past, family, or social history
- Comprehensive
  - Chief Complaint
  - 4 elements of HPI
  - Ocular review of systems
  - Review of 9 additional systems (10 in total)
  - 2-3 specific items from past, family, and social history

Source: 1997 Documentation Guidelines

## History of Present Illness (HPI)

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

Source: 1997 Documentation Guidelines

## Review of Systems

- Constitutional
- Eyes
- Ears, Nose, Mouth & Throat
- Respiratory
- Gastrointestinal
- Cardiovascular
- Genitourinary
- Neurological
- Musculoskeletal
- Integumentary
- Psychiatric
- Endocrine
- Allergic/Immunological
- Hematological/Lymphatic

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

Source: 1997 Documentation Guidelines

## History Scoring

	Level 1	Level 2	Level 3	Level 4
	Problem Focused	Expanded Problem Focused	Detailed	Comp
HPI	Brief 1-3	Brief 1-3	Extended 4-8	Extended 4-8
ROS	N/A	Problem Pertinent 1 Area	Extended 2-9 Areas	Complete 10-14 Areas
PFSH	N/A	N/A	Problem Pertinent 1 Area	Complete 2 Areas-Est 3 Areas-New

Source: 1997 Documentation Guidelines

## Documentation of E/M Services

- Problem Focused
  - Limited exam of the affected body area or organ systems
  - 1 to 5 elements of the eye exam service documented
- Expanded Problem-Focused
  - Limited exam of the affected body area or organ system and other symptomatic or related organ systems
  - Minimum 6 elements of the eye exam service documented
- Detailed
  - Extended exam of the affected body area and other symptomatic or related organ systems
  - Minimum 9 elements of the eye exam service documented
- Comprehensive
  - Complete single system specialty exam
  - All elements of the eye exam service documented

Source: 1997 Documentation Guidelines

## Documentation of Eye Exam Service Elements

- Visual acuity
- Confrontation VF
- Pupils and iris
- Adnexa
- Bulbar and palpebral Conjunctiva
- Extra-ocular muscles
- Slit lamp exam cornea
- Slit lamp exam-lens
- Slit lamp exam-AC
- IOP
- Optic nerve
- Posterior segment
- Neurological (Time/Place/Person)\*
- Psychiatric: (Depression/Anxiety/Agitation)\*

Source: 1997 Documentation Guidelines

## Levels of Exam Elements

Making the Choice of Exam Level:

- 5 elements or less - - - - -Level 1
- 6-8 elements - - - - - Level 2
- 9-13 elements - - - - - Level 3
- All 14 elements - - - - - Level 4

Source: 1997 Documentation Guidelines

## Medical Decision Making

## Complexity of Data

- Diagnostic tests ordered or reviewed
- Review of diagnostic tests
- Decision to obtain previous records or history from other sources
- Contradictory or unexpected findings from previous records or other history
- Communication with other physician(s) to discuss findings and history
- Personal interpretation of previous laboratory tests, images or tracings

Source: 1997 Documentation Guidelines

## Medical Decision Making

- Minimal-One self-limited or minor problem
- Low-Two or more self-limited or minor problems; One stable chronic illness; One acute uncomplicated illness or injury-Treatment w/ OTC medication
- Moderate-One or more chronic illness...; Two or more stable chronic illnesses; Undiagnosed new problem (uncertain prognosis); Acute illness with systemic symptoms; Acute complicated injury-Treatment w/ prescription medication
- High-One or more chronic illnesses w/ progression; Acute or chronic illnesses or injuries that pose a threat to life or bodily function; abrupt change to neurological status-Treatment w/ therapy that requires toxicity monitoring

Source: 1997 Documentation Guidelines

## Medical Decision Making

	Level 1	Level 2	Level 3	Level 4
	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Number of Dx or Mgt Options	Minimal	Limited	Multiple	Extensive
Amount and/or Complexity of Data for Review	Minimal or None	Limited	Moderate	Extensive
Risk of Complication/ Morbidity/ Mortality	Minimal	Low	Moderate	High

Source: 1997 Documentation Guidelines

## Modifiers

## Selecting The Appropriate Modifier

- -24 Unrelated E/M Service, Same Physician, During Post-op period
- -25 Separate Service, Same Physician, Same Day
- -26-Professional Component
- -50 Bilateral Procedure
- -51 Multiple Procedures
- -52 Reduced Service, Informational, Not Reduced Fee
- -54 Surgical Care Only
- -55 Post-Operative Care Only
- -59 Distinct Procedural Service
- -79 Unrelated Procedure, Same Physician, During Post-Op
- -TC-Technical Component
- -RT/LT Right, Left
- -E1 – E4 Punctal/Lid Identifiers

## Modifier-25

- Significant, separately identifiable E/M service

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

## Modifier-25

- The need to perform an independent evaluation and management service may be prompted by a complaint, symptom, condition problem or circumstance which may or may not be related to the procedure (or other service) provided.
- As such, different diagnosis from those related to the procedure are not required for reporting of a significant, separately identifiable E/M service performed on the same day.
- However, the record should document an important, notable, distinct correlation with signs and symptoms to make a diagnostic classification or demonstrate a distinct problem.

## Other Common Modifiers Used

- GA – “ABN on file”\*
  - GY – “Statutory exclusions”
  - GZ – “Expected Denial, No ABN on file”
- Example:

92135-GA-RT

92135-GA-LT

\* More on ABNs in later slides

## Material Codes

### Level II HCPCS Codes

## Material Codes

- Billing sent to Durable Medical Equipment Regional Carriers (DMERC)
- Send only materials claims to this Carrier not procedure codes
- Reimbursement rates vary for state to state within the DMERC regions

## V-Material Codes

- V2020-Frames
  - V2025-Deluxe frame
  - V2100-2199-Single vision lenses
  - V2200-2299-Bifocal lenses
  - V2300-2399-Trifocal lenses
  - V2410-2499-Variable sphericity lenses
  - V2700-2799-Spectacle lens extras
- (All codes represent single lenses-bill 2 for pair)

## V-Material Codes

- V2500-2599-Contact lens materials
- V2600-2615-Low vision aids
- V2623-2632-Prosthetic eyes

## Material Coding Gaps

- More detailed codes for index of materials
- More detailed codes for levels of anti-reflective coding
- More detailed codes for levels of progressive lenses (DST/Free-form)
- Aspheric surfaces that are not post-cataract lens designs

## Surety Bond/Accreditation

- Original requirement posted for October 1, 2009 to have \$50,000 surety bond and formally accredited
- AOA and other health care organizations have gained exemptions for health care professionals (ODs and MDs) in delivering optical materials to their patients
- Areas still not completely clear:
  - Are walk-in patients exempt from the requirements?
  - Opticians with a DMEPOS numbers are not exempt so those that bill under these numbers in an optometry or ophthalmology practice will not be exempt?

## Medicare Does Not Cover

- V2761-mirror coating
- V2762-polarized lens
- V2756-eyeglass case
- V2786-specialty occupational multifocal lens
- V2797-vision supply, accessory and/or service component of another HCPCS vision code

## A-Material Codes

- A4262-Temporary, absorbable lacrimal duct implant, each
- A4263-Permanent, long term, no-dissolvable lacrimal duct plug, each
- A4214-4550-Surgical supplies

## Third Party Payer Management

- Access to plans
  - Request credentialing package (phone or mail)
  - If denied, put request in writing to plan explaining that your patients are requesting to use coverage in the office location and send certified mail (receipt of delivery)
  - If denied, send letter requesting a reason for denial, in writing
  - If no response is received, send letter indicating:
    - Not permitting office access to plan is discrimination
    - Unless a response, in writing, explaining any other reason is received within 10-days, this will serve as the basis for denial
  - Use the either letter to educate patients, provide letter template to submit complaint to employer benefit department and/or health plan

## Questions?