Office of Billing Compliance
2016 Coding, Billing and Documentation Program

Department of Ophthalmology
Why Are We Here?

• To **EDUCATE** and **PROTECT** our providers and organization
• To provide your department/practice with every tool you need to maximize compliance and get paid what you deserve
• To update you on the latest CMS/OIG activities related to your specialty
• To give you confidence in your coding and documentation!
Why Does Documentation Matter?

- It’s our agreement with our payors
- Correct coding practice is part of good medical care
- Millions of dollars are lost each year to poor coding practices
Visit Coding Decision

Ophthalmologists can select either the “eye codes” or E/M visit codes for their services.

• **Choosing Correct Codes**
  • Most Ophthalmologists prefer using the Eye Codes, believing they are easier to use and more audit-proof. That is not necessarily so. If you use only eye codes, not only are you punishing yourself financially, but you also may be found to be upcoding or downcoding under audit.
  • For example, the intermediate eye code for established patients (CPT code 92012) is not always suitable for coding frequent follow-ups such as follow-up examination for corneal abrasion. (The correct code for healing corneal abrasion often usually is E/M code 99212).
  • However, 92012 may be used for follow-up injections

• Typically eye codes are billed in the OP setting for visits related to “routine” eye follow-ups or complaints.
• E/M codes are usually billed for specific eye injury, complaint or IP services.
Eye Codes
Intermediate and Comprehensive

Ophthalmological services constitute integrated services in which medical decision making cannot be separated from the examining techniques used.

Ophthalmological codes are appropriate for services to new or established patients when the level of service includes several basic routine optometric/ophthalmologic examination techniques, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, tonometry, and basic sensorimotor examination, that are integrated with and cannot be separated from the diagnostic evaluation.
Eye Codes

• New Patient
  • 92002 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
  • 92004 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits

• Established Patient
  • 92012 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
  • 92014 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits
Eye Codes
New  92002-04 & Established 92012-14

• Test visual acuity (does not include determination of refractive error)
• Ocular mobility (required for comprehensive level)
• Intraocular pressure
• Retina (vitreous, macula, periphery, and vessels)
• Optic disc
• Gross visual fields (required for comprehensive level)

Tech can perform items in green

• Eyelids and adnexa (required for intermediate & comprehensive level)
• Pupils
• Iris
• Conjunctiva
• Cornea
• Anterior chamber
• Lens

Illustration by Art Studio and Gallery of Rudolf Stalder
Eye Codes
Intermediate Examination 92002-92012

Includes 3 - 8 elements including external ocular and adnexal examination

• Intermediate history
• General medical observations

• If less than 3 elements are provided, then the service must be billed with an E/M code.
Eye Codes
Comprehensive Examination 92004-92014

- Includes 9 or more elements and:

  • History, general medical observation and an external ocular, adnexal examination, gross visual fields, basic sensorimotor evaluation and an ophthalmoscopic examination.

  • It often includes other testing as indicated.

  - A new patient always includes initiation of diagnostic and treatment programs.

  - An established patient always includes initiation or continuation of diagnostic and treatment programs.
Eye Codes
Intermediate Coding Examples

Intermediate New Patient 92002:

A 42 y/o woman presents with a request to evaluate “red eye”. She states that she awoke this morning, her right eye was “bloody”. She denies pain or change in vision in either eye. She reports no previous injury or any other medical problem, not taking any meds. Excellent general health. Her visual acuity is 20/20 OU. Slit lamp OU was included. The external exam, lids and lashes are unremarkable on either eye. Both corneas and anterior chambers are WNL, there is subconjunctival hemorrhage nasally OD; temporally, the conjunctiva and sclera are clear. All aspects of the OS are normal. No fundus exam performed. You reassure the patient that although a subconjunctival hemorrhage looks bad, it is usually not problematic and it should begin to resolving over the next few days. You encourage her to return should she have any other problems and recommend a complete exam every 1 – 2 years.

Intermediate Established Patient 92012:

A 65 y/o black male returns for another evaluation of his glaucoma on your instructions. This gentleman was last seen 4 months ago and his COAG was well controlled at the time. He takes Betagan 0.5% Q.D. Patient has no allergies and denies any change in vision since his last visit. He is in good health and takes no other meds. Family and social history were not addressed in this visit. Exam includes an anterior and posterior segments of the eye. He was not dilated. The VA is 20/20 OU and IOP is 19 OD and 18 OS. The lids and lashes are normal. The slit lamp exam for both eyes shows that the cornea and conjunctiva are clear, AC is deep and quiet, the lens is clear with a trace of NS cataract, PERRLA with no Marcus Gunn. The fundus exam with a small pupil lens shows vitreous is clear, macula is normal and C/D ratio is 0.4 OU. The diagnosis is COAG and instruct the patient to continue current med. Exam in 4 months, and the plan is to order a 30-2 VF and dilate after visual field.
Comprehensive New Patient 92004:

A 68 y/o male presents with “right eye” went blind except in the periphery, when awoke this morning. The OD has had lots of floaters for the past few days and OS has a lot of floaters but stated saw well enough to drive. He is nervous and anxious because of the loss of vision. He had cataract surgery in both eyes in 1995 and subsequent laser surgery OU. He’s a diabetic for 13 years with poor control over the past 2-3 years. He admits partial compliance with diabetic regimen; BS fluctuates. He recently had bronchitis and states he has HTN. BP is occasionally elevated. He is currently taking 2 pills for diabetes and a water pill. All other systems are negative. No history of injury or allergies. His family history is positive for adult onset diabetes and ASHD. He’s a widow and retired mechanic. He previously smoked and drank, socially, but quit when he was diagnosed with diabetes. Current hobbies are fishing and golf. Exam included all structures of OU. The external exam is normal; CVF full, EOMs full and ortho, PERRLA, lids and lashes WNL. The slit lamp shows OU cornea with trace arcus. There is a slight rubeosis iridis OU and capsule openings resulting from previous YAG laser capsulotomies OU. IOPs are recorded at 17 OD and 16 OS. Fundus exam shows a vitreous hemorrhage in the OD with a moderate amount of blood directly over the macula. The peripheral retina shows PDR with cottonwool spots scattered throughout the retina. The OS shows PDR to a lesser extent, and no vitreous hemorrhage. The optic disks appear normal. Plan is to order a FA concentrating on the OS. Plan another FA for the OD in a few days after hemorrhage has cleared. Order a HbA1c test for DM and confer with PCP. Have the patient come back in 5-6 days for evaluation of OD and discuss treatment options. Instruct patient to bring meds for you to check the doses, strengths and names of each drug.
Comprehensive Established Patient 92014:

A 70 y/o comes back to be seen for an annual cataract evaluation. Patient complains of decreased vision in OU while watching TV and glare while driving, at night. Symptoms have persisted for 5 months and seem to be getting worse. Patient wants to know if new glasses will help. Besides cataract the patient has a history of borderline glaucoma, HTN, and COPD. He reports intermittent difficulty breathing and occasional high blood pressure. The patient takes Digoxin and Predisone. He is not taking any glaucoma meds, at this time. All other systems are negative. He is retired, his wife passed away 6 mos. Ago, he does not smoke; he drinks 4+ oz per day. The patient is alert and oriented X3. Vitals show BP 165/95, pulse 60, respirations 18, temp. 98.2 °F. Exam included all structures of OU. VA is 20/50 OD, 20/80 OS. Refraction does not improve acuity over current glasses. Tonometry reveals pressures of 22mm of Hg OU, which represents an increase of 3 points over prior measurement. CVF is full; EOMs are full and orthophoric; conjunctivae are clear; and remainder of external exam is WNL for his age. The pupils are 5mm, equal, round and reactive to light. The SLE of OU shows mild arcus, tear film is smooth, AC is deep and quiet and 3+NS cataract in both eyes OS>OD. A dilated exam shows hazy view. Optic disk size is unchanged, the C/D is 0.6 OU and shows increasing thinning of the inferior rim. There are scattered drusen in the temporal periphery. The vessels show evidence of mild ischemia. Macula normal. The diagnosis is NS cataracts OU, COAG, mild ARMD, presbyopia. Plan is to order 24-2 VF, today, as well as an A-Scan biometry. You discuss the risks and benefits of cataract surgery with IOL. The patient is scheduled for cataract surgery next week. Request patient clearance for surgery from internist and advise the internist of patient’s new med. Patient is started on Betagan 0.25%.
Eye Code Verse E/M
92014 versus 99214

Code 92014 basically should be used when coding for comprehensive eye examinations and not for follow-up visits for serious disease.

• Use 92014 for your follow-ups where medical necessity dictates a comprehensive examination – such as a return in one year for cataract follow-up.
• The code is not intended to be used for frequent follow-up visits for serious pathological conditions.

Use 99214 when following serious diseases as long as your medical decision making is moderate and you have the medical necessity to perform nine of the elements. This code has been a target of OIG investigations and you should be confident of your coding skills and chart documentation when using it.
Eye Code Verse E/M  
92012 versus 99212

Code 92012 basically should be used when coding for eye examinations for follow-up visits for disease.

- Use 92012 for your follow-ups where medical necessity does not dictates a comprehensive examination – such as a return quarterly for glaucoma or cataract follow-up.
- The code is intended to be used for frequent follow-up visits for pathological conditions.

Bill the documented level of E/M required to medically treat an acute eye issue or follow-up.

Code 99212. Many Medicare local coverage determinations for the eye codes mandate that for minimal services code 99212 should be used – not 99213 or 92012.

- Example: Quick check-ups for conjunctivitis or healing corneal abrasions would fall into this category.
<table>
<thead>
<tr>
<th>CODE TYPE (Eye or E/M)</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total new eye codes</td>
<td>1,579,518</td>
</tr>
<tr>
<td>Total new E/M office visits</td>
<td>1,086,521</td>
</tr>
<tr>
<td>Ratio new eye code to new E/M</td>
<td>69%</td>
</tr>
<tr>
<td>Total est eye codes</td>
<td>14,917,670</td>
</tr>
<tr>
<td>Total est E/M office visits</td>
<td>4,883,847</td>
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<tr>
<td>Ratio est eye codes to est E/M</td>
<td>33%</td>
</tr>
<tr>
<td>Total eye codes</td>
<td>16,497,188</td>
</tr>
<tr>
<td>Total E/M office visits</td>
<td>5,970,368</td>
</tr>
<tr>
<td>Ratio total eye to office</td>
<td>36%</td>
</tr>
</tbody>
</table>
Ophthalmology Eye Codes Average % Distribution Established Patient

92012  Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

92014  , established patient, 1 or more visits

**Approximate Ratio:** 60% 92014 to 40% 92012

1. These are averages for the “average” ophthalmologists and not specific to more complex patients with more than “average” needs.
2. If you fall within the “averages” that does not equate to being audit proof.
   a) The correct approach is to always properly code what you do and to do what is medically necessary to provide- then you will receive the correct credit for your work and will be able to support an audit if ever required.
Ophthalmology Technician vs Medical Student

For billing purposes, a billing practitioner can utilize the below services only, when performed by a technician or student, if referenced in their note:

• Ophthalmology Technician can perform and document:
  • Visual acuity
  • Intraocular pressure (IOP)
  • Confrontation visual field exam
  • ROS and PFSH in an E/M service

• Medical Student can only perform and document:
  • ROS and PFSH in an E/M service
Ophthalmology Technician

• Cannot document the HPI to give credit toward the billable service
  • HPI needs to be documented by the physician (it does not count as an element of the encounter if only documented by the technician)

• Cannot document motility and get credit toward a billable service
  • Comprehensive eye codes (92004 and 92014) require ocular motility to be performed by the billing provider, not the ophthalmic tech. If ocular motility exam is performed by the tech you cannot bill a comprehensive eye code.
Routine Eye Examinations

• Medicare does not cover routine eye examinations or refractions

  92015

• For “statutory exclusions” (services never covered by Medicare) Advanced Beneficiary Notice (ABN) is not necessary

  HOWEVER

• For patients with secondary insurance that may cover these services, a claim can be submitted to Medicare to obtain a formal “denial” of reimbursement
  • Explain Medicare coverage policy to the patient
  • Explain that patient has the choice of having the service
  • Indicate how much the patient will be financially responsible for
  • Append appropriate modifier (GY) if you need to obtain a denial from Medicare to process secondary insurance claim
Evaluation & Management (E/M) Coding

THE THREE KEY DOCUMENTATION ELEMENTS

HISTORY
PHYSICAL EXAM
MEDICAL DECISION-MAKING

How does medical necessity fit into these components?

Knowing the answer to this question will help you to select E/M codes and reduce audit risk.
Important!

- The **Nature of the Presenting Problem (NPP)** determines the level of documentation necessary for the service.

- The level of care (**E&M service**) submitted must not exceed the level of care that is medically necessary.

**SO . . .**

- Medical Decision-Making and Medical Necessity related to the “NPP” determine the maximum E&M service.

- The amount of history and exam alone do **NOT**.
Ignoring how medical decision-making affects E/M leveling can put you at risk.

• According to the Medicare Claims Processing Manual, chapter 12, section 30.6.1:

  • Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

  • That is, a provider should not perform or order work (or bill a higher level of service) if it’s not “necessary,” based on the nature of the presenting problem.
Medical Decision Making (MDM)

DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE TODAY!!

Step 1:
• Number of possible diagnoses and/or management options affecting today’s visit. List each separately in A/P and address every diagnosis or management option from visit. Is the diagnosis and/or management options new, established, worse, self-limiting?

Step 2:
• Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed. Discussion with other healthcare professionals, review of old medical records with summary of review, decision to obtain old records?

Step 3:
• The risk of significant complications, morbidity, and/or mortality with the patient’s problem(s), diagnostic procedure(s), and/or possible management options between now and the next time you will see the patient or until a scheduled procedure.

Note: The 2 most complex MDM steps out of the 3 will determine the overall level of MDM
Medical Decision-Making

1. Number of Diagnoses or Treatment Options

Patient comes in with foreign body = LOWER COMPLEXITY

New Diagnosis Diabetic Retinopathy = HIGHER COMPLEXITY
Medical Decision-Making

2. Amount/Complexity of Data

• Were lab/scans ordered or reviewed?
• Were other more detailed studies ordered? (OCT, VF, corneal topography, MRI, CT, Cultures, pachymetry.)
• Did you review old records?
• Did you view images yourself?
• Discuss the patient with consultant?
Medical Decision-Making

3. Table of Risk

- Is the presenting problem self-limited?
- Are procedures required?
- Is there exacerbation of chronic illness?
- Is surgery or complicated management indicated?
- Are prescription medications being managed?
# Ophthalmology Table of Risk

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Min</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| One self-limited / minor problem (subconjunctival Hemorrhage) |  - Tonometry  
 - PAM  
 - Contrast sensitivity  
 - Schimir’s test  
 - Topical diagnostic agent (rose bengal)  
 - Ultrasound  
 - Color Vision  
 - Visual field  
 - Lab tests requiring venipuncture |  - Rest  
 - Elastic bandages  
 - Gargles  
 - Superficial dressings |
| **Low**            |                                 |                             |
| 2 or more self-limited/minor problems  
  1 stable chronic illness (controlled glaucoma)  
  Acute uncomplicated illness / injury (corneal abrasion) |  - Gonioscopy  
 - Ophthalmodynamamometry  
 - Conjunctival culture  
 - Oral FA  
 - Provocative glaucoma test  
 - MRI/MRA |  - OTC meds  
 - Minor surgery w/no identified risk factors  
 - Occlusion  
 - Pressure Patch  
 - IV fluids w/out additives |
| **Mod**            |                                 |                             |
| 1 > chronic illness, mod. Exacerbation, progression or side effects of Tx  
  2 or more chronic illnesses  
  Undiagnosed new problem w/uncertain prognosis (red eye)  
  Acute illness w/systemic symptoms (facial palsy with corneal exposure)  
  Acute complicated injury |  - Corneal Culture  
 - Retrobulbar injection  
 - Deep needle biopsy or incisional biopsy  
 - Physiological stress tests |  - Prescription meds  
 - Minor surgery w/identified risk factors  
 - Elective major surgery w/out risk factors  
 - Therapeutic nuclear medicine  
 - IV fluids w/additives |
| **High**           |                                 |                             |
| 1 > chronic illness, severe Exacerbation, progression or side effects of Tx  
  Acute or chronic illnesses that may pose threat to life or bodily function (trauma, endophthalmitis, retinoblastoma, malignancies, angle closure)  
  Abrupt change in neurologic status (TIA, seizure) |  - Vitreous tap  
 - Anterior Chamber tap  
 - Fine needle biopsy – orbital, ocular |  - Elective major surgery w/risk factors  
 - Emergency surgery  
 - Parenteral controlled substances  
 - Drug therapy monitoring for toxicity  
 - DNR |
Chronic Illness Selection

• The chronic illnesses should be ones that are being treated by the ophthalmologist, such as glaucoma, cataracts, recurrent corneal erosion.
  • Incidental problems should not be counted to enhance the level of risk.

• The level is also influenced by the state of the illness - whether it is stable, improving, or worsening. Some examples might be:
  • A +1 nuclear sclerosis is considered low risk; a +3 nuclear sclerosis that is causing difficulties and the decision is made to schedule surgery on that visit would be moderate risk.
  • A stable glaucoma would be low risk; a glaucoma that is not in control and requires change of medicine would be moderate risk. A patient presenting with acute glaucoma is considered high risk.
High Risk

- Some ophthalmologists think they never have circumstances defined as high risk whereas others firmly believe that most everyone they treat qualifies as high risk.
  - Obviously, neither is correct.

- Some clinical examples of high risk that would fit into the “Presenting Problems” category are perforating corneal ulcer and acute glaucoma.

- All emergency surgery (repair of ruptured globe) and a recurrent retinal detachment encroaching on the macula requiring immediate surgery are examples of circumstances qualifying for the adjective “high”.

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid.

### Final Result for Complexity

<table>
<thead>
<tr>
<th></th>
<th>Number diagnoses or treatment options</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1 Minimal</td>
<td>2 Limited</td>
<td>3 Multiple</td>
<td>≥ 4 Extensive</td>
</tr>
<tr>
<td>B</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>C</td>
<td>Minimal or low</td>
<td>2 Limited</td>
<td>3 Multiple</td>
<td>≥ 4 Extensive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>STRAIGHT-FORWARD</td>
</tr>
<tr>
<td>B</td>
<td>LOW COMPLEX.</td>
</tr>
<tr>
<td>C</td>
<td>MODERATE COMPLEX.</td>
</tr>
<tr>
<td>A</td>
<td>HIGH COMPLEX.</td>
</tr>
</tbody>
</table>
Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left.
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<table>
<thead>
<tr>
<th>A</th>
<th>Number diagnoses or treatment options</th>
<th>≤ 1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>≥ 4 Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Highest Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>C</td>
<td>Amount and complexity of data</td>
<td>≤ 1 Minimal or low</td>
<td>2 Limited</td>
<td>3 Multiple</td>
<td>≥ 4 Extensive</td>
</tr>
</tbody>
</table>

| Type of decision making | STRAIGHT-FORWARD | LOW COMPLEX. | MODERATE COMPLEX. | HIGH COMPLEX. |
FOUR ELEMENTS of HISTORY

- Chief Complaint (CC:)
- History of Present Illness (HPI)
- Past/Family/Social History (PFSHx)
  - Can be performed by anyone
- Review of Systems (ROS)
  - Can be performed by anyone
1. **Chief Complaint**
   - Concise statement describing reason for encounter ("dry eyes,", "blurred vision", "red eye", "double vision", "decreased vision", "pain in the eye")
   - Can be included in HPI

   **IMPORTANT:**
   - The visit is not billable if Chief Complaint is not somewhere in the note
   - Must be “follow-up” of ______________________
HPI: Requires 4 Elements for Higher Level Codes

Documentation of the HPI applicable elements relative to the diagnosis or signs/symptoms being managed at visit

- Location – **Left eye pain**
- Quality - **Sharp, stabbing, dull**
- Severity- **Worsening, improving, resolving**
- Duration- **Since last visit, for the past two months, lasting two hours**
- Timing-Seldom, first thing in the morning, recurrent
- Context- In windy environment, when fan is on
- Modifying factors- Took Tylenol, applied cold compress: with relief/without relief
- Associated signs and symptoms- **Headache too**

- Here is a bad example turned into a good example.
  - Patient complaining of red eye with associated pain in the right eye.
  - Patient complaining of pain and redness in the right eye x 1 day. Sudden onset. Very severe and causing headache. Tylenol not helping.
History – PFSHx
Can be documented by anyone

3. **PAST, FAMILY, AND SOCIAL HISTORY**
   - Patient’s previous illnesses, surgeries, and medications
   - Family history of important illnesses and hereditary conditions
   - Social history involving work, home issues, tobacco/alcohol/drug use, etc.

   - TWO TYPES:  
     - PERTINENT: RELATED ONLY TO HPI
     - COMPLETE: 3/3 FOR NEW/CONSULTS  
       2/3 FOR ESTABLISHED
History - ROS

4. REVIEW OF SYSTEMS

14 recognized:

- Constitutional
- Psych
- Eyes
- Respiratory
- ENT
- GI
- CV
- GU
- Skin
- MSK
- Neuro
- Endocrine
- Heme/Lymph
- Allergy/Immunology

THREE TYPES:  
PROBLEM PERTINENT (1 SYSTEM)  
EXTENDED (2-9 SYSTEMS)  
COMPLETE (10 SYSTEMS)
History

PEARLS FOR A COMPREHENSIVE HISTORY DOCUMENTATION:

• Must document \textbf{4 + elements} in the HPI or status of \textbf{3 or > chronic conditions} being addressed at the visit.

• Must have \textbf{PAST/FAMILY/SOCIAL} history for comprehensive history (ALL THREE).

• Don’t forget at least a \textbf{10-system review}!

• You cannot charge higher than a level 3 new or consult visit without \textbf{COMPREHENSIVE HISTORY}.
EYE 1997 Examination

- Test visual acuity (Does not include determination of refractive error)
- Gross visual field testing by confrontation
- Test ocular motility including primary gaze alignment
- Inspection of bulbar and palpebral conjunctivae
- Examination of ocular adnexae including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes
- Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology
- Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film
- Slit lamp examination of the anterior chambers including depth, cells, and flare
- Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus
- Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)

Ophthalmoscopic exam through dilated pupils (unless contraindicated) of:
- Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer
- Posterior segments including retina and vessels (eg, exudates and hemorrhages)

Neuro/Psych

- Brief assessment of mental status including: Orientation to time, place and person OR Mood and affect (eg, depression, anxiety, agitation)
Eye Physical Exam Definitions

**Problem Focused (PF) – 99212 or 99201**
- 1-5 elements identified by bullet in eye exam

**Expanded Problem Focused (EPF) - 99213 or 99202**
- At least 6 elements identified by bullet in eye exam

**Detailed (D) – 99214 or 99203**
- At least 9 elements identified by bullet in eye exam

**Comprehensive (C) – 99215 or 99204 or 99205**
- All 12 elements with bullet in eye exam and at least 1 in neuro / psych
Common Exam “Issues” On Audit

• Confrontation visual fields not addressed; if not done – state the reason
• Primary gaze alignment is not “versions full” – you must address the primary gaze measurement
• No reason given when IOP not measured
• Pupils not dilated and the two elements (optic nerve and posterior segment) still being counted toward the level of the exam – with no explanation why. Neurological/Psychiatric elements missing
• Dilating drops not on chart
• Failure to check off normal’s for each eye, particularly when there is a problem in the other eye and failure to describe the abnormality
• Failure to perform all elements by subspecialists who may feel they should be able to bill higher levels because of subspecialty training. In retina, you cannot count an extended ophthalmoscopy as the basic elements of optic disc and posterior segment and also as the separate diagnostic test, extended ophthalmoscopy.
## New Patient Office Visits

**ALL 3 Elements must be met or exceeded**

<table>
<thead>
<tr>
<th>Element</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
</tr>
<tr>
<td>HPI</td>
<td>1 – 3</td>
<td>1 – 3</td>
<td>4 +</td>
<td>4 +</td>
<td>4 +</td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>1</td>
<td>2 – 9</td>
<td>10 +</td>
<td>10 +</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>1 – 2</td>
<td>All</td>
<td>All</td>
</tr>
<tr>
<td>EXAM</td>
<td>1-5 (PF)</td>
<td>6-8 (EPF)</td>
<td>9 – 11 (DET)</td>
<td>12 + 1 Neuro/Psyc (COMP)</td>
<td>12 + 1 Neuro/Psyc (COMP)</td>
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<td>SF</td>
<td>SF</td>
<td>Low</td>
<td>Mod</td>
<td>High</td>
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<td>N 20</td>
<td>N 30</td>
<td>N 45</td>
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<tr>
<td>CC</td>
<td>* Dr. Presence</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
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<tr>
<td></td>
<td>Nurse Visit</td>
<td>1 – 3</td>
<td>1 – 3</td>
<td>4+</td>
<td>4+</td>
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<td>2 – 9</td>
<td>10+</td>
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<td>None</td>
<td>1</td>
<td>2 – 3</td>
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<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>1</td>
<td>2 – 3</td>
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<tr>
<td>EXAM</td>
<td>1 – 5 (PF)</td>
<td>6 – 8 (EPF)</td>
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<td>12 + 1 Neuro/Psy (COMP)</td>
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<tr>
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<td>SF</td>
<td>Low</td>
<td>Mod</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>5 Min</td>
<td>10 Min</td>
<td>15 Min</td>
<td>25 Min</td>
<td>40 Min</td>
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</table>
Using Time to Code Counseling /Coordinating Care (CCC)

In the case where counseling and/or coordination of care (CCC) dominates (more than 50%) of the physician/patient encounter (face-to-face in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services in lieu of H-E-MDM

**Counseling is defined as one or more of the following areas:**

- Diagnostic results, impressions, and/or recommended diagnostic studies;
- Prognosis;
- Risks and benefits of management (treatment) options;
- Instructions for management (treatment) and/or follow-up;
- Importance of compliance with chosen management (treatment) options;
- Risk factor reduction; and
- Patient and family education.
Using Time to Code Counseling /Coordinating Care (CCC)

Required Documentation For Billing:

1. Total time of the encounter excluding separate procedure if billed
   - The entire time to prep, perform and communicate results of a billable procedure to a patient must be carved out of the E/M encounter time!

2. The amount of time dedicated to counseling / coordination of care

3. The specific nature of counseling/coordination of care for that patient on that date of service. A template statement would not meet this requirement.
   - Only the time spent by the Physician (billing provider) face-to-face with patient and/or family that has assumed responsibility of the care or decision of the patient can be counted towards the billable service.
Counseling /Coordinating Care (CCC)

Proper Language used in documentation of time:

• “I spent ____ minutes with the patient and over 50% was in counseling about her diagnosis, treatment options including _______ and ______.”

• “I spent ____ minutes with the patient more than half of the time was spent discussing the risks and benefits of treatment with……(list risks and benefits and specific treatment)”

• “This entire ______ minute visit was spent counseling the patient regarding ________ and addressing their multiple questions.

Total time spent and the time spent on counseling and/or coordination of care must be documented in the medical record.
### Time-Based Billing for Counseling or Coordination of Care

#### Outpatient Counseling Time:

<table>
<thead>
<tr>
<th>New Outpatient</th>
<th>Time</th>
</tr>
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<tbody>
<tr>
<td>99201</td>
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</tr>
<tr>
<td>99202</td>
<td>20 min</td>
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<tr>
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<tr>
<td>99204</td>
<td>45 min</td>
</tr>
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<td>99205</td>
<td>60 min</td>
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<table>
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<td>99213</td>
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<tr>
<td>99214</td>
<td>25 min</td>
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<tr>
<td>99215</td>
<td>40 min</td>
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#### Inpatient Counseling Time:

<table>
<thead>
<tr>
<th>Initial Inpatient</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>30 min</td>
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<tr>
<td>99222</td>
<td>50 min</td>
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<tr>
<td>99223</td>
<td>70 min</td>
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</table>

<table>
<thead>
<tr>
<th>Subsequent Inpatient</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>15 min</td>
</tr>
<tr>
<td>99232</td>
<td>25 min</td>
</tr>
<tr>
<td>99233</td>
<td>35 min</td>
</tr>
</tbody>
</table>
Medicare Focused Audits 2016
New RAC and Focused Audit

• 67028 Intravitreal injection of a pharmacologic agent (separate procedure)

• J0178 Injection, aflibercept, 1 mg

• Frequency?

Novitas LCD:

• Excessive Medications –– Medications administered for treatment of a disease which exceed the frequency or duration of injections indicated by accepted standards of medical practice are not covered.

Use of modifier 25?

???
Ophthalmologist Current Audit Procedures

• 76514  Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)

• 92060  Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)

• 92132  Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral

• 92133  Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

• 92020  Gonioscopy (separate procedure)

• 92065  Orthoptic and/or pleoptic training, with continuing medical direction and evaluation

• 92250  Fundus photography with interpretation and report
<table>
<thead>
<tr>
<th>CPT</th>
<th>Code Desc</th>
<th>Justification CC: Blurred Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>92020</td>
<td>Gonioscopy (separate procedure)</td>
<td>Evaluate angle structures; baseline exam; monitor</td>
</tr>
<tr>
<td>92025</td>
<td>Computerized corneal topography, unilateral or bilateral, with interpretation and report</td>
<td>Examine for corneal surface abnormalities; corneal distortion due to bad images</td>
</tr>
<tr>
<td>92060</td>
<td>Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)</td>
<td>Evaluate phoria in all positions of gaze; no significant change from previous test (THIS IS A NEW PATIENT: DOCUMENT PREVIOUS TEST!)</td>
</tr>
<tr>
<td>92083</td>
<td>Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)</td>
<td>Rule out cause for current symptoms (blurry vision in both eyes)</td>
</tr>
<tr>
<td>92250</td>
<td>Fundus photography with interpretation and report</td>
<td>Document and monitor progression of choroidal atrophy</td>
</tr>
<tr>
<td>99203</td>
<td>New Office</td>
<td></td>
</tr>
<tr>
<td>CPT</td>
<td>Code Desc</td>
<td>Justification CC: Blurry</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>76514</td>
<td>Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)</td>
<td>Glaucoma suspect or screening; corneal thickness above normal value</td>
</tr>
<tr>
<td>92025</td>
<td>Computerized corneal topography, unilateral or bilateral, with interpretation and report</td>
<td>Comparison study. Central Cone. No significant change compared to prior study. (THIS IS A NEW PATIENT: DOCUMENT PREVIOUS TEST!)</td>
</tr>
<tr>
<td>92132</td>
<td>Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral</td>
<td>Angle and anterior chamber evaluation; monitor progression/changes</td>
</tr>
<tr>
<td>92133</td>
<td>Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve</td>
<td>Evaluate for glaucoma due to large cup/disc ratio</td>
</tr>
<tr>
<td>99204</td>
<td>New Office</td>
<td></td>
</tr>
<tr>
<td>CPT</td>
<td>Code Desc</td>
<td>Justification</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>92014</td>
<td>Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits</td>
<td></td>
</tr>
<tr>
<td>92015</td>
<td>Determination of refractive state</td>
<td>Evaluate corneal health, cause and/or progression of astigmatism, rule out or diagnose keratoconus, rule out causes of decreased visual acuity.</td>
</tr>
<tr>
<td>92025</td>
<td>Computerized corneal topography, unilateral or bilateral, with interpretation and report</td>
<td></td>
</tr>
<tr>
<td>92083</td>
<td>Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)</td>
<td>Rule out cause for current symptoms (blurry vision in both eyes)</td>
</tr>
<tr>
<td>92250</td>
<td>Fundus photography with interpretation and report</td>
<td>Document large physiologic cupping (c/d ratio)</td>
</tr>
</tbody>
</table>
Lacrimal Punctum Plugs (10 Day Global)

68761: Closure of the lacrimal punctum; by plug, each

Covered if diagnosed with one of the following conditions: –Dry eye syndrome of the lacrimal glands (right, left, bilateral, or unspecified)
  –Keratoconjunctivitis sicca, not specified as Sjögren’s (right, left, bilateral, or unspecified)
  –Lagophthalmos –Chemical burns –Ocular pemphigus –Severe punctate keratitis
  –Other similar serious anterior segment conditions

Documentation of:

• Complaints that are normally associated with dry eye syndrome.
• Have a positive Schirmer's test or some other measurement of lacrimal gland deficiency or evidence of corneal decomposition by slit lamp exam.
• Have undergone two to four weeks of conventional treatment using eye drops, gels, or ointments.
• Show no evidence of any improvements after conventional treatments.

Provider must maintain the following documentation for each claim submitted for reimbursement in the recipient’s medical record: Diagnosis code supporting the medical necessity for the procedure:

• Results of Schirmer’s test or equivalent tear break-up time, tear assay, zone-quick and slit lamp exam.
Cataract Surgery

Indications/Medical Necessity to cover Cataract Surgery (66982, 66983 and 66984):

• Cataract surgery will only be considered medically necessary and reasonable for the following conditions:
  • Symptoms such as blurred vision
  • Visual distortion
  • Reduced contrast sensitivity and/or
  • Glare associated with functional impairment
  • Functional impairment due to cataracts
    • Lost or diminished ability to perform everyday activities
    • Participate in hobbies or other leisure-time activities
    • Work in one’s occupation
    • Visual disability with Snellen acuity worse than 20/40 with impairment of ability to carry out needed or desired activities (the ocular exam should confirm that the best correctable visual acuity in the affected eye is worse than 20/40 and that the cataract is responsible for this)
  • Visual disability with Snellen acuity of 20/40 or better but documentation must support a visual impairment such as:
    • Fluctuation of visual function because of glare or reduced contrast sensitivity, which can be supported by the use of glare testing, brightness acuity testing (BAT), or contrast sensitivity testing
    • Complaints of monocular diplopia or polyopia; or
    • Visual disparity existing between the two eyes (anisometropia)
  • Lens-induced disease (Phacomorphic glaucoma, phacolytic glaucoma and other lens-induced diseases)
  • Concomitant ocular disease (e.g., retinal disease) that requires clear media and cataract extraction may be required to accurately diagnose or treat other ocular conditions such as diabetic retinopathy.
  • Surgery is not medically and reasonable just because the cataract is present.
Teaching Physicians (TP) Guidelines

Billing Services When Working With Residents Fellows and Interns

All Types of Services Involving a resident with a TP Requires Appropriate Attestations In EHR or Paper Charts To Bill
Evaluation and Management (E/M) AND Ophthalmology Codes

E/M IP or OP: TP must personally document by a personally selected macro in the EMR or handwritten at least the following:

• That s/he was present and performed key portions of the service in the presence of or at a separate time from the resident; AND
• The participation of the teaching physician in the management of the patient.

• Initial Visit: “I saw and evaluated the patient. I reviewed the resident’s note and agree, except that the picture is more consistent with a corneal tear. Will begin treatment with.........”

• Initial or Follow-up Visit: “I saw and evaluated the patient. Discussed with resident and agree with resident’s findings and plan as documented in the resident’s note.”

• Follow-up Visit: “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s finding and plans as written.”

• Follow-up Visit: “I saw and evaluated the patient. Agree with resident’s note. This is consistent with Nodular episcleritis will start with FML® suspension q.i.d. and f/up in 4 days. .”

The documentation of the Teaching Physician must be patient specific.
Evaluation and Management (E/M) AND Ophthalmology Codes

Teaching Physician Attestation In EPIC
.emattestation
Select:
I personally saw and evaluated the patient. I reviewed the resident's note and agree with the resident's findings and plan as written.
I did not personally evaluate the patient. I was available to assist in care.
Evaluation and Management (E/M)

**Time Based E/M Services:** The TP must be present and document for the period of time for which the claim is made. Examples:

- E/M codes where more than 50% of the TP time spent counseling or coordinating care

*Medical Student/Ophthalmology Student documentation for billing only counts for ROS and PFSH. All other contributions by the medical/Ophthalmology student must be re-performed and documented by a resident or teaching optometrist.*
Unacceptable TP Documentation

• Assessed and Agree
• Reviewed and Agree
• Co-signed Note
• Patient seen and examined and I agree with the note
• As documented by resident, I agree with the history, exam and assessment/plan
Minor – (< 5 Minutes): For payment, a minor procedure billed by a TP requires that s/he is physically present during the entire procedure.

Statement Example When Resident Performed With TP:
‘I was present for the entire procedure.

Statement Example When TP Performed Procedure:
‘I performed the procedure.

Minor Procedure Example: Intravitreal Injections

Considered a Major Procedure if > 5 Minutes

Example: “I was present for the entire (or key and critical portions) of the procedure and immediately available.”
Overlapping Surgeries: CMS Requires

**2 Overlapping Surgeries** - CMS will pay for two overlapping surgeries, but the teaching surgeon must be present during the critical or key portions of both operations. Consequently, the critical or key portions may not take place at the same time.

- The teaching surgeon must **personally document** in the medical record that he/she was physically present during the critical or key portion(s) of both procedures.

- When the "key or critical elements" of the first operation are finished, freeing up the primary attending to start an operation in another room while others finish the first operation.

- When a TP is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, **he or she must arrange for another qualified attending surgeon to immediately assist the resident in the other case should the need arise (this cannot be a resident or fellow.)**

- **In the case of 3 concurrent surgical procedures, the role of the teaching surgeon in each of the cases is classified as a supervisory service** to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule. Only two rooms can be managed by the primary surgeon.

**NOTE:** Under the new guidelines for Overlapping Surgeries, the surgeon must inform the patients prior to the performance of the procedure, and agree to the procedure, discuss with the patient about what “critical portion of the operation” means and who might be performing some of the noncritical portions of the operation.
Diagnostic Procedures

**General Rule:** The Teaching Physician may bill for the interpretation of diagnostic tests if the interpretation is performed or reviewed by the Teaching Physician with modifier 26 in the hospital setting.

- **Teaching Physician Documentation Requirements:**
  - Teaching Physician prepares and documents the interpretation report.
    - OR
  - Resident prepares and documents the interpretation report
    - The Teaching Physician must document/dictate: “I personally reviewed the film/recording/specimen/images and the resident’s findings and agree with the final report”.

- **A countersignature by the Teaching Physician to the resident’s interpretation is not sufficient documentation.**
• TEACHING PHYSICIANS WHO SEEK REIMBURSEMENT FOR OVERSIGHT OF PATIENT CARE BY A RESIDENT MUST PERSONALLY SUPERVISE ALL SERVICES PERFORMED BY THE RESIDENT.

• PERSONAL SUPERVISION PURSUANT TO RULE 59G-1.010(276), F.C.A, MEANS THAT THE SERVICES ARE FURNISHED WHILE THE SUPERVISING PRACTITIONER IS IN THE BUILDING AND THAT THE SUPERVISING PRACTITIONER SIGNS AND DATES THE MEDICAL RECORDS (CHART) WITHIN 24 HOURS OF THE PROVISION OF THE SERVICE.
Global Surgery
Global Service: 1 payment for procedure

Major = Day before procedure thru 90 days after
Minor = Day of procedure (some until 10 days after)

Services **Included** In The Global Surgery Fee

- Preoperative visits, beginning with the day before a surgery for major procedures and the day of procedure for minor procedures.
- Complications following procedure, which do not require additional trips to the operating room.
- Postoperative visits (follow up visits) during the postoperative period of the procedure that is related to recovery from the surgery.
- Postoperative pain management provided by the surgeon.
Services Not Included in the Global Surgery Fee

• Visits unrelated to the diagnosis for which the surgical procedure is performed. Treatment for the underlying condition or an added course of treatment which is not part of the normal recovery from surgery. Append modifier -24 to the E/M code.

• Treatment for postoperative complications that cause a return trip to the operating room, including ASCs and hospital outpatient departments. Append modifier -78 to the procedure code for the procedure provided in the operating room.

• Diagnostic tests and procedures, including diagnostic radiological procedures (no modifier required).

• Critical Care services (codes 99291 and 99292) unrelated to the surgery, or the critical care is above and beyond the specific anatomic injury or general surgical procedure performed Immunosuppressive therapy for organ transplants.
Major Surgery Modifiers

- **Modifier 24** - Separately Identifiable E/M by the Same Physician/Group during the global period.

- **Modifier 57** - Significant, Separately Identifiable E/M by the Same Physician/Group on the Day of or within 24 hours of a major procedure.

- **Modifier 52** - Surgeries for which services performed are less than usually required.

- **Modifier 58** - Staged or planned related surgical procedures done during the global period of the first procedure. Procedure may have been: Planned prospectively or at the time of the original procedure; More extensively than the original procedure; or for therapy following a diagnostic surgical procedure. A new post-operative period begins when the next procedure in the series is billed

- **Modifier 78** - Return to OR for related procedure during the post-op period including postoperative complications.

- **Modifier 79** - Procedure or service during a post-operative period unrelated to the original procedure.
Co-Surgery

Modifier 62: Co-Surgery

• Two surgeons (usually with different skills) with specialized skills act as co-surgeons. Both are primary surgeons, performing distinct parts of a single reportable procedure (same CPT code) performing the parts of the procedure simultaneously, e.g., heart transplant or bilateral knee replacements. (pays 125% of fee schedule)

• Co-surgery may be required because of the complexity of the procedure and/or the patient’s condition.

• The additional surgeon is not working as an assistant, but is performing a distinct part of the procedure.

• Each surgeon dictates his/her operative note describing his/her involvement in the procedure.
Assistant Surgeon and Assistant at Surgery

Modifier 82: Physician Assistant Surgeon in a Teaching Hospital
Modifier AS: PA or NP Assistant at Surgery in a Teaching Hospital

- In general, the services of assistants for surgeries furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service is non-payable.

- However, it is covered if such services are exceptional medical circumstances. **The TP must document in the operative note that a qualified resident was unavailable** for the procedure and **Documentation of qualifying circumstances must be included in the operating report.**

- Only one OP report is required and the primary attending physician must document in their OP report the specific participation of the assistant (Dr. XXX assisted me throughout the entire procedure...”)

- If the assistant is a physician append modifier 82 to their claim. If the assistant is a PA or CRNP append an AS modifier to their claim.
Minor Procedure With an E/M or Eye Code
Modifier 25 – Be ALERT

• Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.
  • The patient’s condition required a significant, separately identifiable E/M service, *above and beyond* the usual pre- and post-procedure care associated with the procedure or service performed
  • The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, *different diagnoses are not required* for reporting of the E/M services on the same date.

• The service could be a minor procedure, diagnostic service, E/M visit with a preventive service or E/M with a Medicare Well Visit or Well-Woman service.

• It is *STRONGLY* recommended that 2 separate and distinct notes be included in the medical record to document the procedure and then the separate E/M service

• Only a practitioner or coder should assign a modifier 25 to a Claim – Not a biller.
If you are billing for an evaluation and an intravitreal injection on the same day, make sure it is medically necessary to do so:

- if the retina specialist is managing an ocular problem unrelated to the eye being injected visit (e.g. visit for floaters follow-up/patient also receives an intravitreal injection for Wet AMD),
- if the patient has symptoms and/or complaints in the fellow eye and it is examined,
- if an underlying condition in the injected eye is examined and addressed
- If the need for the injection has already been established in a previous.

• **Modifier 25 is not needed when billing the eye codes(920XX) and injection on the same day**
Examine both eyes and address the significant separately identifiable problem in your note by including:

a) comments regarding the other eye (visit for floaters follow-up/patient also receives , or

b) additional problems on the eye receiving the injection (such as glaucoma, new floaters, etc.)

Lacking such documentation will lead to possible audit denials.

If the need for the injection has already been established in a previous visit and the patient is coming to solely be injected, the review of any imaging and any pre/post-procedure evaluation (E&M code) performed would not be appropriate for billing and E&M service with Modifier 25. Bill only the injection.

Levels 4 and 5 evaluation and management codes are currently under prepayment review by Florida Medicare MAC. **Repetitive routine performance of elements may not be counted nor considered medically necessary or reasonable**
Frequency?

• **Utilization:**

  The recommended dose and frequency of treatment for AFLIBERCEPT for neovascular (wet) age related macular degeneration is 2 mg (0.05 mL) administered by intravitreal injection every 4 weeks (monthly) for the first 3 months, followed by 2 mg (0.05 mL) via intravitreal injection once every 8 weeks (2 months). Although AFLIBERCEPT may be dosed as frequently as 2 mg every 4 weeks (monthly), additional efficacy was not demonstrated when AFLIBERCEPT was dosed every 4 weeks compared to every 8 weeks.

  The recommended dose for AFLIBERCEPT for the treatment of macular edema following central retinal vein occlusion (CRVO) is 2 mg administered by intravitreal injection every 4 weeks (monthly).
May 13, 2014

Michael Repka, MD
American Academy of Ophthalmology
Governmental Affairs Division
20 F Street, NW, Suite 400
Washington, DC 20001-6701

Dear Dr. Repka:

I thank you for your letter dated April 25, 2014 in which you comment about proposed National Correct Coding Initiative (NCCI) procedure to procedure edits. We discussed your correspondence with CMS (Centers for Medicare & Medicaid Services) which owns NCCI and makes all decisions about its contents.

The edits bundle CPT codes 92012 ((Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient) and 92014 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits)) into CPT code 67028 (Intravitreal injection of a pharmacologic agent (separate procedure)). Although these edits were scheduled for implementation on July 1, 2014, CMS has decided to defer implementation of these two edits while it considers a number of issues related to CPT code 67028.

CMS and we appreciate your assistance with the NCCI.

Sincerely,

Niles R. Rosen, M.D.
Medical Director
National Correct Coding Initiative
Correct Coding Solutions LLC
Phone: 317-752-8735

Cc: Valeria Allen, CMS COR for NCCI/MUE programs,
Linda Smith, CMS Director, DACG, ALD
Marsha Mason-Wonsley, CMS CPT Coding Specialist
Cherie McNett, AAO
Scribed Notes

- Record entries made by a "scribe" should be made upon the direction of the physician. A scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently or obtain any information independently except to ROS and PFSH. They cannot obtain the HPI, any portion of the PE or MDM.

- The scribe must note "written by xxxx, acting as scribe for Dr. yyyy." Then, Dr. yyyy indicating that the note accurately reflects work and decisions made by him/her and then authenticate with signature.

- It is inappropriate for an employee of the physician to round at one time and make entries in the record, and then for the physician to see the patient at a later time and note "agree with above...".

- AAMC does not support someone “dictating” as a scribe by an NPP, as scribing is over the shoulder immediate documenter with no services personally performed by the scribe. In this case, the physician should be dictating their own visit. Scribes can do EMRs under their own password.
Scribed Notes

- Individuals can only create a scribe note in an EHR if they have their own password/access to the EHR for the scribe role. Documents scribed in the EHR must clearly identify the scribe’s identity and authorship of the document in both the document and the audit trail.

- Scribes are required to notify the provider of any alerts in the EPIC System. Alerts must be addressed by the provider.

- Providers and scribes are required to document in compliance with all federal, state, and local laws, as well as with internal policy.

- Failure to comply with this policy may result in corrective and/or disciplinary action by the hospital and/or department under the University of Miami Medical Group disciplinary policies applicable.

- Verbal orders may neither be given to nor by scribes. Scribes may pend orders for providers based upon provider instructions.

- The following attestation must be entered by the scribe:
  - “Scribed for [Name of provider] for a visit with [patient name] by [Name of scribe] [date and time of entry].”

- The following attestation should be entered by provider when closing the encounter:
  - “I was present during the time the encounter was recorded with [patient name]. I have reviewed and verified the accuracy of the information which was performed by me.” [Name of provider][Date and time of entry].
Physician Scribe Attestation in EPIC

.mdscribeattestestation
I, (populates physician’s name), attest that above named individual is acting in scribe capacity, has observed my performance of the services and has documented them in accordance with my direction. The documentation recorded by the scribe accurately reflects the service I personally performed and the decisions made by me.
PAYORS ARE WATCHING EMR DOCUMENTATION

Once you sign your note, YOU ARE RESPONSIBLE FOR ITS CONTENT
Top Compliance Rules for EMR

Use “Copy Forward” with caution

• Each visit is unique

• **Cloned documentation** is very obvious to auditors

• If you bring a note forward it MUST reflect the activity for the CURRENT VISIT with appropriate editing

• **Strongly advise** NOT copying forward HPI, Exam, and complete Assessment/Plan
Top Compliance Rules for EMR

Don’t dump irrelevant information into your note

• (“the 10-page follow-up note”)

• Be judicious with “Auto populate”

• Consider Smart Templates instead

• Marking “Reviewed” for PFSHx or labs is OK from Compliance standpoint (as long as you did it!)
Top Compliance Rules for EMR

Never copy ANYTHING from one patient’s record into another patient’s note

• Self-explanatory
Top Compliance Rules for EMR

Only Past/Family/Social History and Review of Systems may be used from a medical student or nurse’s note

- Student or nurse may start the note
- Provider (resident or attending) must document HPI, Exam, and Assessment/Plan
Top Compliance Rules for EMR

Be careful with pre-populated “No” or “Negative” templates

• Cautious with ROS and Exam

• Macros, Check-boxes, or Free Text are safer and more individualized
Top Compliance Rules for EMR

Link diagnosis to each test ordered *(lab, imaging, referral)*

- Demonstrates Medical Necessity
- Know your covered diagnoses for your common labs
Copy/Paste Philosophy:

*Your note should reflect the reality of the visit for that day*
Use Specific Dates

• Don’t say Today, Tomorrow, or Yesterday

• Write specific dates, i.e., “continue with betagan 0.5% until 9/5”, instead of “six more days”, which could be carried forward inaccurately

• “Pred Forte stopped 6/20 due to sudden eye irritation” will always be better than “Pred Forte stopped yesterday”, which can be carried forward in error
Use Past Tense

• “Vision remains stable, will discontinue Pred Forte” can be copied forward in error

• Better – “Pred Forte stopped on 2/24”

• “Added Pred Forte on 4/26” – uses past tense and specific date for better accuracy
Copy / Paste Summary

• Copy/Paste can be a valuable tool for efficiency when used correctly

• There are major Compliance risks when used inappropriately, including potential fraud and abuse allegations, denial of hospital days, and adverse patient outcomes

• Make sure your note reflects the reality and accuracy of the service each day
“I hear there’s a new ICD-10 code for carpal tunnel syndrome caused by clicking too many times in an EMR system.”
CASE SAMPLES
"Whoa—way too much information."
Telehealth

List of covered codes does not include CPT 99174

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html

As a condition of payment, you must use an interactive audio and video telecommunications system that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site.

• The originating sites authorized by law are:
  • The offices of physicians or practitioners;
  • Hospitals;
  • Critical Access Hospitals (CAHs);
  • Rural Health Clinics;
  • Federally Qualified Health Centers;
  • Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
  • Skilled Nursing Facilities (SNFs); and
  • Community Mental Health Centers (CMHCs).

• ORIGINATING SITES
  • An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:
    • A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract; or
    • A county outside of a MSA.
2016 Code Changes
New Codes For 2016

• Code Changes - Eye & Ocular Adnexa
• **65785** Implantation of intrastromal corneal ring segments
• The 2016 CPT® code set adds **65785** to report a new procedure, intrastromal corneal ring segment implantation. Use **65785** to report when the provider implants thin semicircular or crescent-shaped soft plastic rings into channels created in the outer edges of the cornea (the transparent covering on the front of the eye) to correct its shape.

• The provider performs this procedure to treat keratoconus, a degenerative disease that changes the shape of the cornea and results in distorted vision, or to treat mild to moderate nearsightedness (myopia).
Revised CPT Codes

- **65855** – Trabeculoplasty by laser surgery;

- **67227** – Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), cryotherapy, diathermy;

- **67228** – Treatment of extensive or progressive retinopathy (e.g., diabetic retinopathy), photocoagulation.

The “one or more sessions” verbiage was removed from these three procedures.
Revised CPT Codes

The following codes contain language changes reflected by underlines:

• **67101** – Repair of retinal detachment, 1 or more sessions; cryotherapy or diathermy, *including drainage of subretinal fluid when performed*;

• **67105** – photocoagulation *including drainage of subretinal fluid, when performed*;

• **67107** – Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), *including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid*;

• **67108** – ... with vitrectomy, any method, *including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*;

• **67113** – Repair of complex retinal detachment ... with vitrectomy and membrane peeling *including, when performed, air, gas, or silicone oil, tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens*;

• **99174** – Instrument-based ocular screening (e.g., photo screening, automated-refraction), bilateral; *with remote analysis and report*. 
Contact Lenses

• Proper coding for contact lens exams?
  • Patient comes in for routine eye exam and CL fit, code 92004/14 and 92310. If a refraction was done also bill 92015.
    • 92310 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia

• First follow-up exam after the contact lenses are dispensed is included in the 92310, as its definition includes "medical supervision of adaptation".

• Patient presents for a routine eye exam, doesn't want CL's at that visit, but decides a month down the road they now want CL's.
  • Code 92310 for the fitting and supervision of adaptation.
  • If medically necessary for a specific patient a limited examination to be sure no eye changes have occurred.
HIPAA, HITECH, PRIVACY AND SECURITY

• HIPAA, HITECH, Privacy & Security Health Insurance Portability and Accountability Act – HIPAA
  – Protect the privacy of a patient’s personal health information
  – Access information for business purposes only and only the records you need to complete your work.
  – Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  – PHI is protected even after a patient’s death!!!

• Never share your password with anyone and no one use someone else’s password for any reason, ever –even if instructed to do so.

✔ If asked to share a password, report immediately.
✔ If you haven’t completed the HIPAA Privacy & Security Awareness on-line CBL module, please do so as soon as possible by going to:

http://www.miami.edu/index.php/professional_development_training_office/learning/ulearn/
HIPAA, HITECH, PRIVACY AND SECURITY

• HIPAA, HITECH, Privacy & Security

Several breaches were discovered at the University of Miami, one of which has resulted in a class action suit. As a result, “Fair Warning” was implemented.

• What is Fair Warning?

• **Fair Warning** is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.

• **Fair Warning** protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.

• **Fair Warning** is an initiative intended to reduce the cost and complexity of HIPAA auditing.

• UHealth has policies and procedures that serve to protect patient information (PHI) in oral, written, and electronic form. These are available on the Office of HIPAA Privacy & Security website: [http://www.med.miami.edu/hipaa](http://www.med.miami.edu/hipaa)
Available Resources at University of Miami, UHealth and the Miller School of Medicine

• If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:

• Helenmarie Blake-Leger, Interim AVP of Clinical Billing Compliance & HIPAA Privacy Officer @ 305-243-6000
  • Iliana De La Cruz, RMC, Director Office of Billing Compliance
  • Gema Balbin-Rodriguez, Associate Director Office of Billing Compliance
    • Phone: (305) 243-5842
    • Email: Officeofbillingcompliance@med.Miami.edu

Also available is The University’s fraud and compliance hotline via the web at www.canewatch.ethicspoint.com or toll-free at 877-415-4357 (24hours a day, seven days a week). Your inquiry or report may remain anonymous

• Office of billing Compliance website: www.obc.med.miami.edu