Practicing Prevention: Coding Compliance & Practice Management for Ophthalmic Practices

Southern Eye Congress
Sunday, July 21, 2024

Instructor

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- Academy Manager of Coding & Reimbursement

Speakers Financial Disclosure

- Speakers have no financial relationships to disclose.
- All relevant financial relationships have been mitigated.

Our Goals

Appropriately maximize reimbursement so no outside source can recoup

Recognize trusted resources to ensure coding compliance

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Topics

- Recognize & Prevent Common Coding Mistakes
- Identify & Utilize Trusted Resources
- Prepare for the Inevitable Disruption

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Recognize

Recognize & Prevent Common Ophthalmic Coding Mistakes

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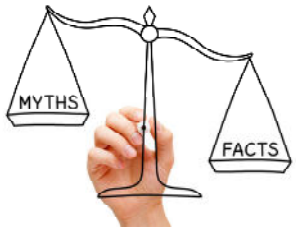
Where Do Myths Come From?



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Myth #1 Billing and Audits

Identify the Myth:

A. "If it was paid it must be policy / correct."
B. "Payers can audit on services performed even without a written policy."
C. "Payment is not final; payers can always recoup."
D. "Payers conduct pre and/or post payment audits."

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Myth-Buster #1 Billing and Audits

Facts:

- Medicare policies are published
  - NCDs, LCDs, LCAs, email updates from MACs
- Commercial payer policies
  - Online, payer rep, email updates
- Reimbursement goal
  - Payment vs Audit proof

Myth #2 E/M Requirements

Identify the Myth:

A. "Multiple complex problems managed by an ophthalmologist is always a moderate level."
B. "Documentation of continuing prescribed medication counts towards prescription drug management."
C. "Medically relevant history and exam with overall low medical decision making is always a level 3 E/M code."
D. "Dilation is no longer a requirement for higher levels of E/M."

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Myth-Buster #2 E/M

Facts:

- 2 of 3 components must meet or exceed the same level of MDM
  - Problems, data, risk
- Or total physician time the date of the encounter

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Myth #3 E/M

Identify the Myth:

A patient with the following diagnoses assessed at the encounter is always considered a moderate problem:

A. Stable cataracts and dry eyes
B. Bilateral AMD, stable
C. A choroidal lesion with suspicious malignancy
D. Glaucoma with progressing visual field loss

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Myth-Buster #3 E/M

Facts:

- Moderate Number and Complexity of Problems Addressed at the Encounter:
  - 1 or more chronic illness with exacerbation, progression or side effect of treatment
  - Or 2 or more stable chronic illnesses
  - Or 1 undiagnosed new problem with uncertain prognosis
  - 1 acute illness with systemic symptoms
  - Or 1 acute complicated injury

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Myth #4 E/M vs Eye Visit

Identify the Myth:

A. "E/M and Eye visit codes have different requirements and reimbursement."
B. "Eye visit codes are easier to bill, so always bill them."
C. "There are scenarios when you should not bill an Eye visit code."
D. "E/M codes for outpatient visits are now easier to bill."

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Myth-Buster #4 E/M vs Eye Visit

Facts:

- Process for determining E/M vs. Eye visit code:
  - Confirm the level of E/M and Eye Visit Code
  - Avoid 9 scenarios when not to use an Eye Visit Code
  - Maximize reimbursement

5 Steps to Choosing the Right E/M or Eye Visit Code

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Myth #5 Modifiers

Identify the Myth:

When using Modifier -25 or -57:

A. Modifier -25 is not always appropriate for the exam the same day as a minor surgery.
B. Our office policy is to always append modifier –25 to the exam the same day as a minor procedure.
C. Modifier –25 and –57 have different definitions.
D. When an exam documents the decision for major surgery during the post-operative period of an unrelated procedure, fellow eye, use modifiers -24 and -57.

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Myth-Buster #5 Modifiers

Facts:

- Modifier Definitions:
- **Modifier 24** is defined as an unrelated evaluation and management service by the same physician or other qualified health care professional during a post-operative period.
- **Modifier 25** is defined as a significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day of a procedure or other service.
- **Modifier 57** is used to indicate an Evaluation and Management (E/M) service resulted in the initial decision to perform surgery either the day before a major surgery (90 day global) or the day of a major surgery.

Myth #6 Testing Services

Identify the Myth:

A. "I can submit glaucoma OCTs and visual fields on the same day."
B. "Our satellite office doesn't have photography equipment, so we bill out external photos taken on a phone."
C. "For all payers, screening tests and standing orders are not billable even when pathology is found."
D. "When I perform the OCT and fundus photos, I always bill out the fundus."

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Myth-Buster #6 Testing Services

Facts:

- When two tests are bundled, bill for the test that contributes most to the treatment plan
- Tests that are delegated to staff must have a documented written order
- New patients must be examined by the physician first in order to determine what tests are medically necessary
- For established patients, the order may be documented in the previous exam note

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NCCI Bundle: OCT and Fundus Photos

Medicare Part B has policies indicating unbundling can take place in limited situations

Commercial payers that do not follow NCCI bundling edits may or may not allow.

The physician will need to defend their reasoning for needing both testing services. Documentation should support as the payer may recoup.

If both tests are performed, however only one is being submitted, bill the test that provides the most information that day.

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Medicare Policies: OCT and Fundus Photos

WPS
L34760 - SCODI

Limitations
The following procedures would generally not be necessary with SCODI. When medically needed the same day, documentation must justify the procedures.

1. Fundus photography with interpretation and report
2. Ophthalmoscopy extended with retinal drawing (e.g., For retinal detachment, melanoma) with interpretation and report initial
3. Subsequent ophthalmoscopy
4. B-scan (with or without superimposed non-quantitative A-scan)

Novitas
L35038 - SCODI

Fundus photography and posterior segment SCODI performed on the same eye on the same day are generally mutually exclusive of one another (*National Correct Coding Initiative [NCCI] Policy Manual for Medicare Services*). The provider is not precluded from performing both on the same eye on the same day when each service is necessary to evaluate and treat the patient. The medical record should clearly document the medical necessity of each service. Frequent reporting of these services together may trigger focused medical review.

Palmetto GBA
A56825 - SCODI

SCODI (92133, 92134) and fundus photography (92250) are mutually exclusive codes. However, there may be a limited number of clinical situations in which it is necessary to perform both techniques in order to evaluate and treat the patient. In these situations, both CPT codes may be reported appending modifier 59 to indicate a distinct procedural service. Documentation supportive of the need to perform both techniques should be clear in the medical record.

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Polling #8 – NCCI

Confirm MAC policies:

- SCODI at aao.org/lcds

Which test should you bill when bundled the same day?

- The test the contributes the most the treatment plan during the encounter

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Myth #7 Co-Management

Identify the Myth:

Compliant Co-Management arrangements are. . .

A. primarily patient driven.
B. billed to Medicare payers with modifiers –54 and -55.
C. inclusive of all procedures performed during the same session.
D. payments for premium services to the referring provider.

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Myth-Buster #7 Co-Management

Facts:

Co-Management Tips:

1. Review the Academy's Comprehensive Guidelines for the Co-Management of Ophthalmic Postoperative Care
2. Determine if the payer allows for co-management
3. Obtain informed consent
4. Follow payer's co-management coding rules
5. Calculate the appropriate reimbursement

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Myth #8 Postoperative Billing

Identify the Myth:

The postoperative period always remains the same if. . .

A. the additional surgery is preplanned and documented as staged.
B. the patient changes insurance.
C. the surgery was not billable due to lack of prior authorization.
D. the patient sees another internal physician for the post op exam.

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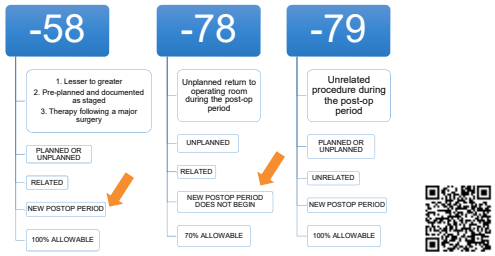
Myth-Buster #8 Postoperative Billing



58 vs 78

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Myth #9 Premium IOL Package

Identify the Myth:

"Billing the Medicare beneficiary is allowed for. . .

A. use of Femtosecond laser during standard cataract surgery."
B. correction of the patient's natural astigmatism with either blade or laser."
C. Optiwave Refractive Analysis (ORA) when a presbyopia or astigmatic correcting IOL is implanted and with patient consent."
D. the difference between the Medicare facility standard IOL payment and premium IOL cost"

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Myth-Buster #9 Premium IOL Package

Facts:

- The reimbursement is the same whether a cystotome or femtosecond (FS) laser makes the capsulotomy
- Providers may not "balance bill" a Medicare patient or his or her secondary insurer for any additional fees to perform covered components of cataract surgery with an FS laser
- Medicare Part B permits patients to be billed for additional services used specifically to implant premium refractive IOLs for medically necessary cataract

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Myth #10 New Drug Billing

Identify the Myth:

Reimbursement for a new ophthalmic drug. . .

A. may require use of NOC HCPCS codes initially.
B. is guaranteed following FDA approval.
C. is not guaranteed when assigned a permanent HCPCS code.
D. is not a confirmation of correct claim submission.

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Myth-Buster #10 New Drug Billing

Facts:

- FDA approval ≠ reimbursement
  - Expect denials if not following FDA labeled guidelines
- Know when (and how) to use the NOC HCPCS codes
- J / HCPCS Code ≠ reimbursement
- Reimbursement does not confirm the accuracy of the coding and billing

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Become a Myth-Buster

Follow the Myth-Buster Method

Identify the Myth(s)	Focus on the Facts	Verify with a Trusted Source	Communicate to the Entire Team

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Action Steps: Examinations

Learn the documentation requirements for E/M and Eye visit codes	Learn the 9 scenarios when an Eye visit code should not be used	Upload the payer allowable into your EHR, or create excel spread sheets	Identify the patient's reason for the encounter • Vision? • Medical?

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E/M and Eye visit codes

- Different documentation guidelines
- 99214 does not automatically equal 92014

Documentation Guidelines

- E/M – medically relevant history and exam, determine level of E/M from MDM or total physician time
- Eye Visit Codes – meet history, exam elements and initiation of diagnostic & treatment program

Consider both family of codes

- Confirm the level of E/M and Eye Visit Code
- Avoid 9 scenarios when not to use an Eye Visit Code
- Maximize reimbursement

SAVVY CODER

Simplifying Coding—5 Steps to Choosing the Right E/M or Eye Visit Code

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9 Scenarios When You Should Not Submit an Eye Visit Code

ICD-10 code is not a covered diagnosis	POS is not the office	Frequency exceeded	E/M required for medical diagnoses
Subject to downcoding based on diagnosis	Commercial plan still recognized consult codes	Telemedicine	Prolonged services
Payer allowable			

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2024 National Average MPFS, Mar. 9 – Dec. 31, 2024

New Patient

E/M	Office	RVU
99202	$ 72.23	2.17
99203	$ 111.51	3.35
99204	$ 167.10	5.02
99205	$ 220.36	6.62
Eye	**Office**	**RVU**
92002	$ 84.55	2.54
92004	$ 148.46	4.46

Established

E/M	Office	RVU
99212	$ 56.59	1.70
99213	$ 90.88	2.73
99214	$ 128.16	3.85
99215	$ 180.42	5.42
Eye	**Office**	**RVU**
92012	$ 88.88	2.67
92014	$ 125.49	3.77

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Action Steps: Testing Services

- What testing services do you perform?
- Do you know the coverage rules from each federal and commercial payer?
- Is the order for the delegated test documented correctly per the payer requirements?

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Action Steps: Testing Services

- Levels of Supervision
- Payment unilateral or inherently bilateral
- Modifiers:-RT/LT -GA -52 -26 -TC
- Frequency: Per Patient? Per physician
- Local coverage determinations & local coverage articles aao.org.lcds
- Standing orders/screening tests
- NCCI edits
- Skilled nursing
- Interpretation & report

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Action Steps: Minor Surgery

Minor surgery defined for coding rules:

- 0, 10 days of postoperative care
- Some variation with Medicaid and commercial plans
- Tip: Add days to superbill/charge sheet

Is the exam billable?

- New or established: **While medically necessary, if the exam is performed solely to confirm the need for the minor surgery, it is not separately billable.**
- Other eye? Is there a treatment plan for the other eye?

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Action Steps: Minor Surgery: Punctal Plugs

- Documentation requirements prior to punctal occlusion:
  - Key words: Dry, burning, redness, excessive tearing
  - Other methods have not proven successful
  - Schirmer tests/slit lamp exam/other testing
- Billing requirements vary per payer.
  - -E modifiers
  - -50
  - -RT/-LT

Action Steps: Minor Surgery: Intravitreal Injection

- Does your exam, whether billable or not, contain all these documentation requirements?

Chief complaint Visual acuity Medically relevant history	When changing med – document why.	Risk, benefits, alternatives discussed. Patient desires to proceed with surgery.
New patient: Why was specific medication chosen?	Diagnosis supporting medical necessity and appropriate indication for use per payer policy	Physician's order includes: - date of service - medication name and dosage - diagnosis - physician signature
Established patient: document response to current medication and why continuing same med.	Any relevant diagnostic testing services, with interpretation/report	Drug frequency rule

Action Steps: Minor Surgery: Intravitreal Injection

- Does your procedure note contain all these documentation requirements?

Route of administration and medication name	Site of injection – eye(s) treated
Dosage in mg and volume in ML Avastin 1.25 mg/0.05 ml and lot number.	Wastage?
Off label use? May be denied by payer unless policy has expanded coverage.	

Audits: Intravitreal Injections

Focus of SMRC, TPE, CERT and OIG investigations

29% failure

Review LCDs/LCAs

Utilize the Academy Intravitreal Injection checklist

aao.org/retinapm

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Action Steps: Major Surgery

Recognize documentation requirements

Monitor ophthalmic audit targets

Perform internal chart audit

Take corrective action

Educate the team

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Action Steps: Major Surgery: Cataract

- Does your documentation for the exam to determine the need for surgery include everything on this checklist plus whatever is unique to the payer?

✓ Chief complaint unique to each patient. - No cloning!	✓ Other eye diseases, such as AMD, DR have been ruled out as the primary cause of decreased visual function.
✓ Visual acuity and best corrected visual acuity. ✓ If complaint is at near, then BCVA at near too.	✓ Attestation that the cataract is believed to be significantly contributing to the patient's visual impairment.
✓ Only if patient complains of glare, can a glare test be performed for supporting documentation.	✓ Removal of the natural lens will improve function and lifestyle.

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Action Steps: Major Surgery: Cataract

- Does your documentation for the exam to determine the need for surgery include everything on this checklist plus whatever is unique to the payer?

✓ Surgeon reviews R/B/A with patient for informed consent.
✓ Patient determines that they are no longer able to function adequately with current visual status and desires to proceed with surgery.
✓ Tolerable change in glasses will not improve the patient's vision
✓ Patient desires surgery

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Audits: Cataract Surgery

Focus of SMRC, TPE, CERT and OIG investigations

Palmetto TPE Oct 2023 – Dec 2023
- Denial rate 14%

Novitas TPE Fall 2023 and Spring 2024
- First round 7-22% denial rates
- Second round review showed no marked improvement

!!

Noridian TPE Jan 2024 – Mar 2024
- Denial rate 55.12%

aao.org/cataract-surgery

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Action Steps: Major Surgery: Complex Cataract

✓ Everything required for cataract surgery **plus** identification of what qualifies as complex.

1. The pupil that won't dilate. Iris retractors used to stretch the pupil. Device driven.
2. Intraocular sutures or capsular ring.
3. Pediatric cataract surgery when an IOL is implanted.
4. What about dye for the mature lens? **Payer specific.**

✓ Typically known preoperatively. But not always.

✓ Best to preauthorize both 66984 and 66982

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Identify

Identify & Utilize Trusted Resources to Ensure Proper Coding and Reimbursement

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#1

Cataract extraction with toric IOL is complicated with vitreous loss requiring anterior vitrectomy by the same surgeon during the same surgery session.

A. 66982

B. 66984

C. 66982, 67010

D. 66984, 67010

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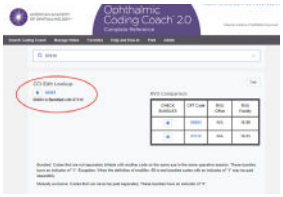
Trusted Resources

- CPT descriptors for standard and complex cataract surgery
- NCCI edits
- MAC LCDs and commercial payer policies
  - aao.org/lcds
- Academy Cataract Surgery Documentation Hub
  aao.org/cataract-surgery



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#2

An accommodative esotropia patient is seen for annual comprehensive exam and sensorimotor testing. They have medical coverage and a separate vision plan, that you participate with, which bundles refractions in the exam.

A. Appropriate E/M + 92060 to medical, 92014 to vision plan
B. 92014 to vision plan, 92060 to medical and 92015 to the patient
C. 92014 to vision plan, 92060 to medical

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B. 92014 to vision plan, 92060 to medical and 92015 to the patient
C. 92014 to vision plan, 92060 to medical

Collect the applicable copays/co-ins for each plan

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Trusted Resources

- Unique payer billing policies
- AAOE: Ask the Coding Experts
  - Coding Competency Challenge

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#3

Performed under slit lamp, anesthesia was injected into the space surrounding a 4mm lesion LUL. A sterile surgical blade was used to create a small opening in the lesion and contents drained. Topical antibiotic ointment applied.

Bill as:

A. 67840 Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure

B. 11440 Excision, other benign lesion including margins, except skin tag eyelids; excised diameter 0.5 cm or less

C. 67700 Blepharotomy, drainage of abscess, eyelid

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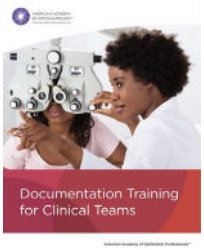
Trusted Resources

- CPT code descriptors
- Properly documented medical record
  - Properly trained clinical team



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#4

During the same surgical session, a retina specialist performed silicone oil removal (67121) + PPV (67036) and a cataract specialist from the same group performed complex cataract extraction with IOL implant (66982). How would you bill?

A. Separate claims: Retina: 67036; Cataract 66982

B. Separate claims: Retina: 67036 & 67121; Cataract: 66982

C. Separate claims: each bills 66982 -62, 67036 -62

D. One claim: 66982 -80, 67036 -80

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#4

During the same surgical session, a retina specialist performed silicone oil removal (67121) + PPV (67036) and a cataract specialist from the same group performed complex cataract extraction with IOL implant (66982). How would you bill?

A. Separate claims: Retina: 67036; Cataract 66982
   67121 is bundled with 67036, 67036 has the higher RVU

B. Separate claims: Retina: 67036 & 67121; Cataract: 66982

C. Separate claims: each bills 66982 -62, 67036 -62

D. One claim: 66982 -80, 67036 -80

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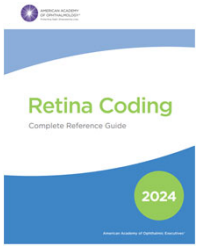
Trusted Resources

- CPT code descriptors
- Modifier definitions
- NCCI edits
- Properly documented operative report



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#5

6 yo presents with red, irritated RUL. The NP appointment had been rescheduled 3 times due to lack of transportation. Findings: chalazion RUL, blepharitis OD. Perform lid scrubs and apply warm compresses, follow up in 2 weeks.

A. 99203 H00.11 Chalazion RUL, H01.00A blepharitis RU&RLL

B. 99204 H00.11 Chalazion RUL, H01.00A blepharitis RU&RLL, Z59.82 Transportation insecurity

C. 99204 H00.11 Chalazion RUL, H01.00A blepharitis RU&RLL

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Trusted Resources

- E/M and Eye visit code guidelines
  - aao.org/em
- Savvy Coder: Why (and How) You Should Use ICD-10 Codes for Social Determinants of Health

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#6

An est. Medicare Part B patient presents during their right eye cataract global period for pre-scheduled AMD follow-up (OU) with OCT. Findings are mild drusen and stable geographic atrophy. The physician discusses how GA can progress and potential treatment with injections, the need to cease smoking, and benefits of health diet. Patient to monitor Amsler grid and return in one month. How would you code the visit?

A. 99213 -24, 92134
B. 99214 -24, 92134, G2211
C. 92014 -24, 92134, G2211
D. 92134

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#6

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G2211 Complexity Add-on Code

- Medicare Part B patient
- Office or outpatient E/M visit
- Modifiers 25, 24, or 53 are not billed on the same day.
- The primary reason for the visit is a single, serious, or complex condition:
  - Chronic uveitis, glaucoma, age-related macular degeneration (AMD), ocular oncology, etc.
  - Not an acute or time-limited condition, or one that is resolved with intervention (e.g., corneal abrasion, cataract, epiretinal membrane (ERM), etc.)
- The ophthalmologist is the managing physician providing ongoing medical care for this condition.
- Documentation supports the use of G2211.
  - Includes key words to help support visit complexity (e.g., therapeutic goals, patient-physician shared commitment to reach goals)

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Trusted Resources

- aao.org/G2211
  - Fact Sheet: Coding for G2211 Visit Complexity Add on Code
- Ask the Coding Experts
  - Topic: Coding Competency

Fact Sheet: Coding for G2211 Visit Complexity Add on Code

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Prepare

Prepare for the Inevitable Disruptions to Practice Flow

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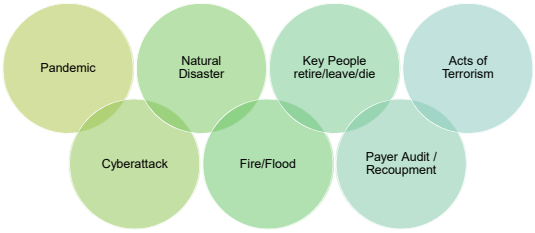
What does a practice disruption look like?



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What is essential?

- Prioritize
  - Highest priority
  - Most vulnerable
- Collaborate
  - Establish culture of teamwork
  - SWOT analysis

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We all perform better at tasks with practice. But crises are infrequent and high-impact, so the lack of practice, simulation, modeling, etc. means managing a crisis is fraught with danger. A lot could go wrong with grave consequences….

Alan Kimura, MD – AAOE Board Member 2024

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Lessons Learned from Financial Crises

Plan and prepare for the next disruption	Review insurance policies	Backup data	Reserve cash
Establish a plan	Key people	Verify backed up daily	Flexible lines of credit
Learn from prior disruptions	Property	Verify can be restored	6 months operating cost is ideal
Alternative income sources	Business interruption		
Secondary claim submission/payment receipt			

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Lessons Learned from Financial Crises

Maintain relationships	Communicate broadly	Implement lean processes	Review your agreements	Prepare to pivot
Vendors	Staff	Practice culture	Practice shareholders	Protocols
Banks/financial lenders	Patients	Lean Management		Technologies
				Establish a plan!

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Managing Financial Disruptions

- Academy webpage providing members with resources to prepare, monitor and conceivably avert financial crisis.
  - Lessons Learned
  - Action Steps to Assess Financial Impact
  - Customizable Cash Flow Worksheets

https://www.aao.org/financial-disruptions

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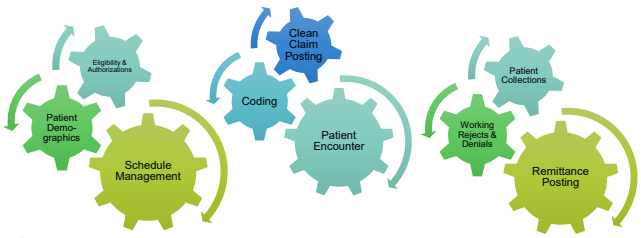
Refine Your Revenue Cycle



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Refine Your Revenue Cycle

Prioritize working denials

- Registration Errors
- Timely Filing
- Eligibility and Enrollment
- Prior Authorization
- Incorrect Coding
- Education

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Refine Your Revenue Cycle

Resolve Credit Balances

- Identify true overpayments
- Confirm who gets the refund
- Work balances from oldest to newest
- Identify preventable causes of credit balances

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  - View important coding updates
  - Test your Knowledge with periodic Pop Quizzes and more!
- @joywoodke
- @aaoeye

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Academy Resources

aao.org/coding

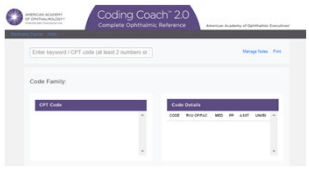
aao.org/audits

aao.org/retinapm

aao.org/em

aao.org/lcds

aao.org/consulting



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