Evaluation, Diagnosis, Coding and Reimbursement Associated with Medical Vitreo-Retinal Conditions

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Top Medicare Audit problems
- Patient/staff initiated billing complaints!
- Routine exams
- Fundus photos had no I&R
- Extended ophthalmoscopy had no I&R
- Extended ophthalmoscopy had no routine ophthalmoscopy findings noted
- Medical necessity not documented in Nursing home
- Billing for services not documented

Retinal Imaging Technology
- Optos P200
  - Low resolution, ultra wide field
- Retinal Cameras
  - Low to Medium resolution, low to moderate field
  - CPT codes: 92250 (some 92255)
- HRT
  - Medium resolution, low field
  - CPT codes: 92135
- RTA
  - Medium resolution, low to moderate field
- CPT codes: 92135, 92250
- GDX
  - High resolution, low field RNFL analysis
  - CPT Codes 92136, mainly glaucoma CPT codes
- OCT
  - High resolution, low field
  - CPT codes: 92135
- OCT Spectral Domain
  - Ultra high resolution, low field
  - CPT codes: 92135 & some 92250

Optometric Medical Coding
- 92XXX General Ophthalmological codes
  - 92004, 92014
  - 92002, 92012
- 99XXX E&M codes and
- 92XXX Special Ophthalmological codes and/or
- 6XXX Surgical codes and/or
- 7XXX Radio logical codes and/or
- 8XXX Laboratory codes

Unilateral codes
- 92025 Corneal topography* (varies)
  - CPT states uni or bilateral, some carriers pricing per eye
- 92225 & 92226
- 92135
  - All 765XX (A-scans) except pachymetry
    - May need to break out TC and PC when billing OU
- Bill per eye with –RT and/or –LT
- Example
  - 92135-RT qty 1
  - 92135-LT qty 2
  - Or 92135-RT-LT qty 2

Modifiers
- -25 E&M same day as procedure/service
- -59 Distinct Procedural Modifier
- -RT Right eye
- -LT Left eye
- -E1, E2, E3, E4 eyelids
- -24 Unrelated E&M during post op
- -79 Unrelated procedure/service post op
- -GY Medicare non covered service
-59 Modifier

- Distinct procedural modifier
- Use on lesser procedure when similar procedures are required to diagnose condition
  - 92135
  - 92225 & 92226
  - 92250
  - 76513 & 76519 & 7XXXX
- 6XXXX surgical codes
  - Except treatment of retina for Medicare

Proper use of 59 CMS special edition SE0715

- Under certain circumstances, a physician may need to indicate that a procedure or service was distinct or independent from other services, and modifier 59 may be appropriate depending on the circumstances. Modifier 59 is used to identify procedures/services that are not normally reported together. This includes the following procedures/services that are not ordinarily encountered or performed on the same day by the same physician:
  - A different:
    - Session or patient encounter.
    - Procedure or surgery.
    - Site or organ system.
  - Or,
  - A separate:
    - Incision/excision.
    - Lesion.

SE0715 continued

- Use of modifier "-59" to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifier "-59". The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.
- From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site. Treatment of posterior segment structures in the eye constitute a single anatomic site.

Wellness vs. Medical Exams

- Coding 92, 99 or S codes?
- Wellness exams and medical care the same day
- Embedded wellness benefits in Medical plan
- Coordination of care
- Refractions: 92015 not included in medical exams
- Billing considerations
  - Medicare
  - Medicaid
  - Commercial Insurance
  - BCBS-920XX; pays correct amount based on ICD

Wellness procedures vs. diagnostic procedures

- Screening procedures
  - Abbreviated technical and professional component
  - Screening procedures and the problem exam patient
  - S0004 Not medically necessary
  - Can help decrease P4P cost analysis and increase quality indicators
- Diagnostic procedures
  - Professional component is extended requiring interpretation and report
  - Technical component is often extended. Ie Patient steering with optomap
  - Will increase P4P cost analysis but increase quality indicators

Medical Necessity

- Reason for diagnostic test?
- Directly stated or easily implied
- Will it effect diagnosis or treatment?
Patient Flow Considerations

- Appointment scheduling
  - Remind pt to bring in all health insurance information/ID cards-not just vision
  - Verify eligibly on vision and medical if possible prior to visit
- Patient check-in
  - Get eligibility on vision and medical benefits
- Prelim testing
  - Standing orders to technical staff
- Exam room testing
  - Doctor ordered special testing-discuss with pt.
- Check-out
  - Walk out statements to patients and collect $$

Office Visits using 92XXX codes

- 92002, 92012 Intermediate oph.
- 92004, 92014 Comprehensive oph.

- You have only one time to get 92004! (unless you don’t see them for 3 years)
- Comprehensive exams don’t have to be completed in one session.

Initiation of diagnostic and treatment programs

- Includes the prescription of medication, and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services.
- Many states add lenses and other therapy to CPT guidelines for clarification

Office Visits using 99XXX

- Levels 1-5
- Outpatient
- Consults
- Many Medicare carriers don’t allow unless less detailed ophthalmological procedures are used
- Consult your specific LCD
- 1995 or 1997 E&M guidelines can be used for Medicare

CMS 2007 National CAC Meeting

- Barton McCann, MD, MPH, Past (13 years) Senior Health Care Officer for Health Care Financing Administration
- QUOTE: “I have no explanation why any optometrist or ophthalmologist would ever use an E/M code under any condition.”

Payment Policy-be your own expert

- CPT
- IC
- NCD’s-for Medicare
  - VF’s, BCL’s, fundus photos & endothelial cell photography
- LCD’s-for Medicare and other commercial insurance
- Contracts that you signed
- Professional judgment
- The golden rule...
LCD's; Local payment policy

- Medicare payment policy
  - www.trailblazerhealth.com
  - www.cms.hhs.gov
  - www.cms.hhs.gov/mcd

- Commercial insurance payment policy
  - Web site access to policy

Documentation Requirements

- Routine ophthalmoscopy findings should be documented separately.
- The patient’s medical record should always support the medical necessity of the photographs. Images may be stored on film or electronic media.
- Documentation supporting the medical necessity should be legible, maintained in the patient’s medical record, and must be made available to Medicare upon request.

Misc. coding topics

- Pseudophakic care
  - Exams
  - Glasses

- Cataract care
  - Biometry
    - Ascans
    - IOL master
  - Specular microscopy
  - 92015

Medical Retina

- Changes in most LCD’s for medical retina have made 92135 profitable
- Extended ophthalmoscopy 92225, 92226
- Retinal photos 92250
- 92XXX Exams

- Medical Retina Services can be a large profit center for the advanced optometric medical practice

AAO Clinical Guidelines

- PVD
- Idiopathic Macular Hole
- Macular Degeneration
- Diabetic Retinopathy
- www.AAO.org

AOA guidelines

- Retinal Detachment and related peripheral Vitreoretinal Disease
- www.AOA.org
Case Examples

- PVD's; 4 visits $648
- VR Traction w/ ERM or other maculopathy 5 visits $1015
- DBR w/ DME 6 visits $1075
- PDR w/ CSME 1 visit $265
- Choroidal nevus 2 visits $375

PVD Case One $648

- Flashes and/or floaters
- PVD & subjective visual disturbance
- Exam & Optomap Plus for Extended ophthalmoscopy
- Follow 1, 3, 6, 12 mo. then yearly
- Usually get OCT looking for ERM/Traction at some point
- Optomaps prove nothing big is going on!
- 92004,92015 & 92225 –RT -LT qty 2 dx:379.21 & 368.10 – $185
- 92012 & 92226 –RT -LT qty 2 dx:379.21 and/or 368.10 – $107 per visit x 4 + refraction @ 12 mo= $463

ERM Case 2 $1015

- Decreased vision and floaters
- PVD with traction to fovea and ERM
- Exam, Refraction, OCT & Optomap w/ ResMax
- Follow 1wk, 1, 2, 3, 6, 9, 12 mo then every 6 mo
- 92004, 92015 & 92250 dx:379.21,362.56 $245
- 92012 & 92135 -LT dx:379.21,362.56 – $110 x 7= $770
DBR w/ DME Case 3 $1075
- Reduced Vision and DM (250.00)
- DBR with DME (362.05 & 362.07)
- Exam & Optomap with ResMax & OCT
- Exam and OCT for follow up
- Follow 1, 3, 6, 9, 12 mo then 3-6 mo
- 92004, 92015 & 92135 -RT -LT qty 2 dx: 362.05 & 362.07
  - $265
- 92012 & 92135 -RT -LT qty 2 dx: 362.06 & 362.07
  - $155 x 5 + 92015 $35 = $810
- I'll usually do an optomap plus with ResMax at one visit instead of OCT and bill 92250

PDR w/ CSME Case 4 $205+
- Reduced vision and DM (250.50)
- PDR with CSME (362.02 & 362.07)
- Exam & Optomap Plus w/ ResMax and OCT and refer for treatment
- 92004, 92015 & 92135 –RT –LT qty 2 dx: 362.02 & 362.07
  - $205
- Follow post treatment as needed
Choroidal Nevus Case Five $375
- Wellness or problem exams
- Choroidal nevus found on exam
- Exam and Optomap Plus
- Follow at 3-6 mo
  - 92004, 92015 & 92250 dx: 224.6
    - $235
  - 92012 & 92250 at 3-6 mo dx: 224.6
    - $140
- Follow yearly

Wellness Exams & Disease
- Reason for visit
- Orders
- Medical necessity for special testing
  - directly stated or easily implied
- Routine ophthalmoscopy findings
- Interpretation and Report
- Documentation supports ICD and CPT

Discussion
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