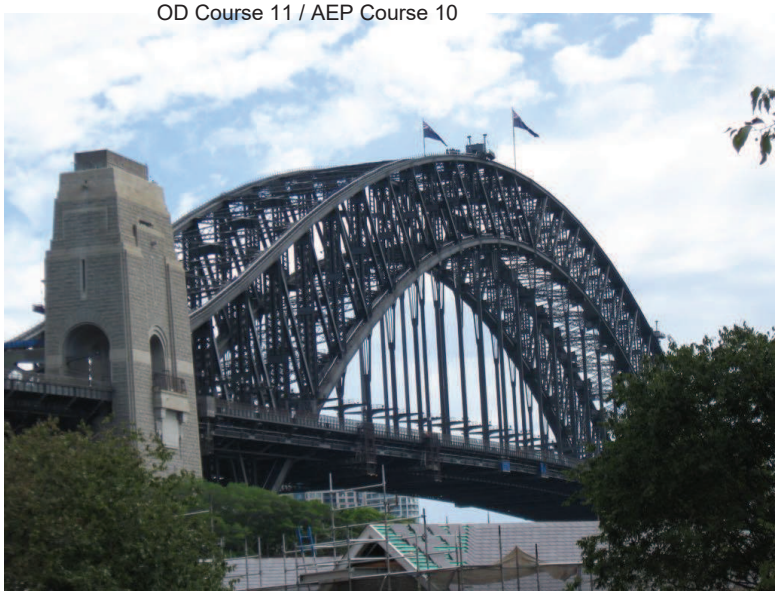

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BILLING AND CODING FROM A-Z, PART I

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"I got paid so I must have done everything right"

–Anonymous

DISCLOSURES AND DISCLAIMERS

I DO NOT CURRENTLY HAVE ANY FINANCIAL RELATIONSHIPS OR AGREEMENTS WITH ANY CORPORATIONS

THE INFORMATION PRESENTED IS CORRECT WHEN PRESENTED BUT IS SUBJECT TO CHANGE.

The Reality

You strung some numbers and letters together and submitted them to an insurance company whose computers found what you sent in acceptable for payment so they sent you a check.

QUESTIONS?

1) Based upon the documentation of the patient exam, did you file the proper code(s) to assure that you were paid properly for everything you did?

2) Could you have done something differently which would have generated more income for the exam?

3) Was anything done unnecessarily in the exam process that could expose you to problems in case of an audit?

LET'S GET VCPs OUT OF THE WAY

They can set their own rules, so throw the books out the window

Examples:

- Requiring 920xx codes for all visits
- VSP requiring color vision and binocularity testing for children as part of the exam elements - not part of the exam elements for Medicare or other major medical plans

GOALS

- Help correct errors in record keeping and billing and coding you might be making so you "do it right"
- Reduce the risk that you may fail an audit
- Hopefully, show you ways to get paid more for your services by not missing billing opportunities
- Assuming that you're doing things correctly, to confirm and congratulate you on that

A NOTE ABOUT FEES

1) NEVER CHARGE ANYONE A LOWER U&C FEE THAN CHARGED TO MEDICARE - THIS IS A CMS POLICY.

2) IN GENERAL, YOUR FEES FOR THE VARIOUS CPT CODES BILLED SHOULD BE 130 TO 150% HIGHER THAN THE MEDICARE ALLOWABLE (SEVERAL PRIVATE INSURERS PAY FEES HIGHER THAN MEDICARE)

3) IF YOU DO A REFRACTION AND DON'T CHARGE FOR IT - 92015
A) YOU'RE LOSING SIGNIFICANT REVENUE
B) MEDICARE SAYS YOU COULD BE DISCIPLINED

RESOURCES YOU CAN USE

- CPT Code Book
- ICD-10 Code Book
- HCPCS Code Book
- Medicare manual and guidelines - followed by most insurers. Available on line at www.cms.gov
- NCDs and LCDs for insurers you file with
- NCCI (CCI) Edits. Available on line
- Medicare Learning Network (MLN)
- **Coders' Specialty Guide for Ophthalmology/Optometry** which includes RVU, Medicare fees, procedure description, CCI alerts, ICD-10 codes, possible modifiers, coding tips. Available at www.AAPC.com

ROUTINE EXAMS

WHAT IS IT: A COMPREHENSIVE EXAM FOR PATHOLOGY *WITHOUT* A CHIEF COMPLAINT

TYPICAL CC: "NO PROBLEMS" "HERE FOR ANNUAL EXAM" "I NEED NEW GLASSES" "MY WIFE SENT ME"

ICD-10 CODE: Z01.00 - ROUTINE EXAM, NO ABNORMALITIES

Z01.01 - ROUTINE EXAM, ABNORMALITIES FOUND

REFRACTIVE EXAM

SEPARATE PROCEDURE FROM THE ROUTINE EXAM OR MEDICAL EXAM

ALWAYS LINK TO REFRACTIVE CODES (H52.-)

NEVER LINK TO A PATHOLOGY CODE

RECORD KEEPING DETERMINES WHAT CODES YOU CAN SELECT FOR A PATIENT VISIT

YOU CAN'T DECIDE WHAT CODES YOU WANT AND THEN MAKE THE RECORD FIT THE CODE YOU SELECT - WHY?

1) INCORRECT WAY TO DO THINGS
2) DENIED CLAIMS
3) OVER USE OF SOME CODES MAY TRIGGER AUDITS
4) AUDITS = POSSIBLE REPAYMENT AND PENALTIES
5) FRAUD RISK

A NOTE ABOUT ICD-10 DX CODES

CODE TO THE HIGHEST LEVEL OF SPECIFICITY POSSIBLE (DON'T USE "UNSPECIFIED" CODES)

IF YOU CAN'T MAKE A DEFINITIVE DIAGNOSIS, YOU MAY BILL FOR SYMPTOM CODES

PAIN IN AND AROUND THE EYES - H57.13
BLURRED VISION - H53.8
FLASHES - H53.19
TRANSIENT LOSS OF VISION - H53.12(1,2,3)

THE BASICS

NEW VS ESTABLISHED PATIENTS

NEW - 1) NEVER SEEN IN PRACTICE BEFORE

2) NOT SEEN FOR 3 YEARS BY A PHYSICIAN OR ANOTHER PHYSICIAN OF THE ***EXACT*** SAME SPECIALTY ***AND SUBSPECIALTY*** WHO BELONG TO THE SAME GROUP.

ESTABLISHED - HAS BEEN SEEN WITHIN THE PAST 3 YEARS BY A PHYSICIAN OR ANOTHER PHYSICIAN OF THE ***EXACT*** SAME SPECIALTY ***AND SUBSPECIALTY*** WHO BELONG TO THE SAME GROUP.

MEDICAL NECESSITY

BILLING FOR THE CPT CODES USED FOR PROVIDING MEDICAL EYE CARE IS BASED ON DOCUMENTING ***MEDICAL NECESSITY***

Medicare Carriers Manual Part 3 - 2320

"The coverage of services rendered by a physician is dependent on the purpose of the examination rather than the ultimate diagnosis of the patient's condition. When a beneficiary goes to a physician with a complaint or symptoms of an eye disease or injury, the physician's services (except for eye refraction) are covered regardless of the fact that only eyeglasses were prescribed. However, ***when a beneficiary goes to his/her physician for an eye examination with no specific complaint, the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathologic condition."***

DEFINITION

HEALTH CARE SERVICES OR SUPPLIES NEEDED TO PREVENT, DIAGNOSE OR TREAT AN ILLNESS, INJURY, CONDITION, DISEASE, OR ITS SYMPTOMS AND THAT MEET ACCEPTED STANDARDS OF MEDICINE.(CMS DEFINITION)

THE BIG THREE

HISTORY

EXAMINATION

COMPLEXITY OF MEDICAL DECISION MAKING

THESE ARE THE KEY COMPONENTS USED TO SELECT THE LEVEL OF E/M SERVICES PROVIDED IN ADDITION TO MEDICAL NECESSITY

Medicare Claims Manual, Chapter 12(30.6.1)

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of the CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level 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 provided.

4 HISTORY COMPONENTS

1) CHIEF COMPLAINT (***CC***)

2) HISTORY OF PRESENT ILLNESS (***HPI***) - THE HPI TIES INTO THE CC AND DESCRIBES IT IN MORE DETAIL

3) REVIEW OF SYSTEMS (***ROS***)

4) PAST, FAMILY AND/OR SOCIAL HISTORY (***PFSH***)

CHIEF COMPLAINT (CC)

DEFINITION: A SHORT STATEMENT, USUALLY IN THE PATIENT'S OWN WORDS, DESCRIBING WHY THE PATIENT IS BEING SEEN.

THESE DESCRIBE THE SYMPTOMS, PROBLEM, CONDITION, DIAGNOSIS OR OTHER FACTORS NECESSITATING THE VISIT

IMPORTANT FACTS ABOUT THE CC

1) CC MAY BE RECORDED BY STAFF OR PROVIDER

2) WORDING AFFECTS THE TYPE OF VISIT: MEDICAL VS. REFRACTIVE

3) THE CC AND FINAL DIAGNOSIS ARE THE KEYS TO THE CPT AND ICD-10 CODES YOU USE

4) THE CODES THAT THE EXAM SUPPORTS DETERMINE WHETHER A CLAIM CAN BE FILED WITH A MAJOR MEDICAL INSURER OR NOT

HX OF PRESENT ILLNESS (HPI)

DEFINITION: DESCRIPTION OF THE PATIENT'S PROBLEM FROM WHEN THEY STARTED TO THE PRESENT

EIGHT POSSIBLE COMPONENTS

1) LOCATION: ANATOMICAL LOCATION OF THE CC

2) QUALITY: PROBLEM'S CHARACTERISTICS SUCH AS HOW IT LOOKS OR FEELS (YELLOW DISCHARGE, ITCH, BURN)

3) SEVERITY: HOW BAD IS THE PROBLEM (IMPROVED, UNBEARABLE PAIN, MILD DISCOMFORT)

4) DURATION: HOW LONG HAS THE COMPLAINT BEEN OCCURRING

5) TIMING: IDEA OF WHEN OR HOW OFTEN THE PROBLEM IS NOTED (INTERMITTENT, CONSTANT, ONLY IN A.M. OR P.M.)

6) CONTEXT: WHAT THE PATIENT WAS DOING OR ENVIRONMENTAL FACTORS AFFECTING THE COMPLAINT (WORKING ON THE COMPUTER, CUTTING WOOD WITH A SAW)

7) MODIFYING FACTORS: ANYTHING THAT MAKES THE PROBLEM BETTER OR WORSE (ATS, COLD COMPRESSES)

8) ASSOCIATED SIGNS AND SYMPTOMS: ADDITIONAL RELATED COMPLAINTS

HPI LEVELS

BRIEF
ONE TO THREE ELEMENTS REQUIRED

CAN'T BILL HIGHER THAN ***99202*** FOR NEW PT OR ***99213*** FOR ESTABLISHED PT

EXTENDED
FOUR OR MORE ELEMENTS REQUIRED

REQUIRED FOR ***99203-99205*** FOR NEW PT OR ***99214-99215*** FOR ESTABLISHED PT

WHO MAY RECORD THE HPI?

MEDICARE GUIDELINES STATE THAT IF YOU ARE BILLING:

92XXX OR 99XXX CODES - DR MUST RECORD THE HPI AND RECORD SHOULD REFLECT THAT

RECORD SHOULD NOTE WHO RECORDED THE HPI

IF NOT, YOU COULD FAIL AN AUDIT

"HPI DONE BY DR. CHEEZUM"

REVIEW OF SYSTEMS (ROS)

BASICALLY A REVIEW OF THE ORGAN SYSTEMS

1) CONSTITUTIONAL - FEVER, MALAISE
2) EYES
3) EAR,NOSE, THROAT (ENT)
4) CARDIOVASCULAR
5) RESPIRATORY
6) GASTROINTESTINAL
7) GENITOURINARY
8) MUSCULOSKELETAL
9) INTEGUMENTARY - SKIN AND/OR BREAST
10) NEUROLOGICAL - ALERT/ORIENTED TO P,P AND T.
11) PSYCHIATRIC - DEPRESSED, ANXIETY, AGITATION
12) ENDOCRINE
13) HEMATOLOGIC/LYMPHATIC
14) ALLERGIC/IMMUNOLOGIC

DOS AND DON'TS FOR THE ROS

1) LIST THE SYSTEMS INDIVIDUALLY

1) NEVER WRITE "ALL SYSTEMS NORMAL"

2) NOTE WHETHER EACH INDIVIDUAL SYSTEM IS NORMAL OR ABNORMAL AND RECORD THE ABNORMALITIES

3) DON'T SUBSTITUTE DISEASES FOR SYSTEMS - STROKE, DIABETES, CANCER AREN'T ORGAN SYSTEMS

4) ROS SHOULD MATCH MEDICATIONS - DON'T SAY CARDIOVASCULAR IS NORMAL IF PT IS TAKING BP MEDS

ROS LEVELS

PROBLEM PERTINENT
SINGLE SYSTEM REVIEWED
(USUALLY RELATED TO SYSTEM IN CC/HPI)

CAN'T BILL HIGHER THAN ***99202*** FOR NEW PT OR ***99213*** FOR ESTABLISHED PT

EXTENDED
TWO TO NINE SYSTEMS REVIEWED

CAN'T BILL HIGHER THAN ***99203*** FOR NEW PT OR ***99214*** FOR ESTABLISHED PT

COMPLETE
TEN OR MORE SYSTEMS REVIEWED

SUPPORTS A ***99204*** OR ***99205*** FOR NEW PT OR ***99215*** FOR ESTABLISHED PT

PFSH

1) PAST HX NOTES PT'S PRIOR MEDICAL TREATMENTS:
- PRIOR MAJOR ILLNESSES
- PRIOR OPERATIONS
- CURRENT MEDICATIONS
- ALLERGIES

2) FAMILY HX NOTES MAJOR HEALTH ISSUES
- MAJOR DISEASES - HT, DM, CA ETC
- HEREDITARY CONDITIONS

3) SOCIAL HX NOTES CURRENT AND PAST ACTIVITIES
- EMPLOYMENT
- OCCUPATION
- DRUG, ALCOHOL AND TOBACCO USE
- EDUCATION LEVEL

WHO MAY RECORD THE ROS

1) PATIENT MAY FILL OUT A FORM LISTING THE VARIOUS SYSTEMS - ***PROVIDER MUST REVIEW IT*** WITH THE PT AND NOTE THAT THEY REVIEWED IT, INITIAL AND DATE THE FORM

2) STAFF MAY DO THE ROS BUT PROVIDER NEEDS TO NOTE REVIEW, INITIAL AND DATE IT

3) DOCTOR MAY DICTATE THE ROS IF DESIRED

PFSH LEVELS

PERTINENT
ONE AREA OF PFSH RECORDED
(USUALLY RELATED TO THE HPI)

CAN'T BILL HIGHER THAN ***99203*** FOR NEW PT OR ***99214*** FOR ESTABLISHED PT

COMPLETE
NEED AT LEAST ONE ITEM FROM TWO OF THE THREE AREAS.

IMPORTANT POINT - YOU CAN ONLY BILL FOR A COMPREHENSIVE EXAM FOR ***NEW PT*** IF YOU RECORD AT LEAST ONE ITEM FROM EACH AREA.
THIS ALLOWS BILLING ***99204*** FOR NEW PT AND ***99215*** FOR ESTABLISHED PT

WHO MAY RECORD THE PFSH

1) PATIENT MAY RECORD ON A FORM - PROVIDER ***MUST*** REVIEW, INITIAL AND DATE

2) STAFF MAY RECORD IT - PROVIDER ***MUST*** REVIEW, INITIAL AND DATE

WHAT IF THE PFSH DIDN'T CHANGE SINCE LAST VISIT?

PROVIDER MUST MAKE A NOTE SUCH AS "PFSH REVIEWED, SAME AS DOCUMENTED ON (DATE OF LAST EXAM)"

EXAMINATION CONTINUED

OPHTHALMOSCOPIC EXAM THROUGH DILATED PUPILS (UNLESS CONTRAINDICATED) OF:

- OPTIC DISCS INCLUDING SIZE, C/D, APPEARANCE AND NERVE FIBER LAYER
- POSTERIOR SEGMENTS INCLUDING RETINA AND VESSELS

NEUROLOGICAL/PSYCHIATRIC

- ORIENTED TO PERSON, PLACE AND TIME (A+O X3)
- MOOD AND EFFECT - DEPRESSED, ANXIETY ETC

MUST BE PERFORMED BY OD

(YES THIS DOES DUPLICATE WHAT YOU DID IN ROS BUT NEEDS TO BE INCLUDED IN EXAM SECTION AS WELL)

DETERMINE THE LEVEL OF HX

ALL 3 HX ELEMENTS MUST BE MET TO SUPPORT THE HX LEVEL

HPI	ROS	PFSH	HX LEVEL
BRIEF 1-3	N/A	NA	**PROBLEM FOCUSED**
BRIEF 1-3	PROBLEM PERTINENT 1	N/A	**EXP. PROB FOCUSED**
EXTENDED 4+	EXTENDED 2-9	PERTINENT 1	**DETAILED**
EXTENDED 4+	COMPLETE 10+	COMPLETE 2 AREAS	**COMPREHENSIVE**

DOS AND DON'TS FOR THE EXAM

1) DELEGATE AS MANY OF THE ELEMENTS AS YOU CAN TO IMPROVE EFFICIENCY - **SEE NEXT SLIDE**
2) RECORD THE NORMAL AND DESCRIBE ABNORMAL FINDINGS FOR EACH EYE
3) RECORD WHY YOU ***DIDN'T*** DO AN IOP
4) RECORD THE DILATING AND IOP DROPS USED AND INSTILLATION TIME
5) RECORD WHY DILATION ***WASN'T*** DONE - IT ***MUST*** BE FOR A MEDICAL CONTRAINDICATION. IS NARROW ANGLES A CONTRAINDICATION?

DILATION IS REQUIRED FOR BOTH 99XX4 COMPREHENSIVE EXAMS. 92XX4 VARIES BY CARRIER

EXAMINATION

UP TO 14 ELEMENTS FOR AN EYE EXAM

- VISUAL ACUITY (DOESN'T INCLUDE REFRACTION)
- GROSS VISUAL FIELD TESTING (CONFRONTATION)
- OCULAR MOTILITY, INCLUDING PRIMARY GAZE ALIGNMENT
- BULBAR AND PALPEBRAL CONJUNCTIVA
- OCULAR ADNEXA EXAM INCLUDING LIDS, LACRIMAL GLANDS, LACRIMAL DRAINAGE, ORBITS AND PREAURICULAR NODES
- EXAM OF PUPILS AND IRISES - SHAPE, REACTION, SIZE
- SLIT LAMP EXAM OF CORNEAS AND TEAR FILM LAYER
- SLIT LAMP EXAM OF ANTERIOR CHAMBER
- SLIT LAMP EXAM OF LENSES
- IOP - EXCEPT IN CHILDREN AND PTS W/ TRAUMA/ INFECTION

DETERMINE THE EXAM LEVEL

1-5 EXAM ELEMENTS	**PROBLEM FOCUSED**
6-8 EXAM ELEMENTS	**EXPANDED PROBLEM FOCUSED**
9 OR MORE EXAM ELEMENTS	**DETAILED**
AT LEAST 1 ELEMENT FROM NEURO/PSYCH + ALL 12 OF EYE EXAM ELEMENTS	**COMPREHENSIVE**

MEDICAL DECISION MAKING (MDM)

4 LEVELS OF MDM

- STRAIGHT FORWARD
- LOW COMPLEXITY
- MODERATE COMPLEXITY
- HIGH COMPLEXITY

3 COMPONENTS TO DETERMINE THE MDM LEVEL

- NUMBER OF DIAGNOSES OR MGMT OPTIONS
- AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW
- RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY

TABLE A: NUMBER OF DX OR MGMT OPTIONS

PROBLEM(S) STATUS	POINTS	TOTAL
SELF LIMITED OR MINOR (2 MAX)	MAX=2	
ESTABLISHED PROBLEM: STABLE OR IMPROVED	1	
ESTABLISHED PROBLEM:WORSE	1	
NEW PROBLEM: NO EXTRA WORK UP	3	
NEW PROBLEM: MORE WORK UP	4	
	TOTAL	

MDM FOR # OF DIAGNOSES

MINIMAL = 1 DX
LIMITED = 2 DX
MULTIPLE = 3 DX
EXTENSIVE = 4 DX

TABLE B: AMOUNT AND/OR COMPLEXITY OF DATA REVIEWED

REVIEWED DATA	POINTS
ORDER/REVIEW LAB TESTS (CPT 80002-89399)	1
ORDER/REVIEW RADIOLOGY TEST (CPT 70010-79999)	1
ORDER/REVIEW MEDICAL TEST (CPT 90780-99199)	1
DISCUSS TEST RESULTS W/ PERFORMING PHYSICIAN	1
DECISION TO OBTAIN OLD RECORDS	1
REVIEW OLD RECORDS OR CONSULT W/ OTHER PROVIDER	2
INDEPENDENT VISUALIZATION OF IMAGE, TRACING OR SPECIMEN	2
TOTAL POINTS	

MDM FOR AMOUNT OF DATA REVIEWED

MINIMAL = 1 POINT
LIMITED = 2 POINTS
MODERATE = 3 POINTS
EXTENSIVE = 4 POINTS

TABLE C: TABLE OF RISK

	PRESENTING PROBLEM	DX TESTS ORDERED	MGMT OPTIONS
MIN	ONE SELF LIMITED/MINOR PROBLEM	· CHEST X-RAY · EKG · UKTRASOUND · BLOOD TESTS	· REST · GARGLE · BANDAGE · DRESSING
LOW	· 2 OR MORE MINOR · 1 STABLE CHRONIC · ACUTE UNCOMPLICATED	· NON CARDIO IMAGING W/ CONTRAST · NEEDLE BIOPSY · SKIN BIOPSY	· OTC DRUGS · MINOR SX/NO RISKS · PT · OT
MODERATE	· 1 OR MORE CHRONIC PROBLS W/ MILD PROGRESS · 2 OR MORE STABLE CHRONIC PROBS · UNDXD NEW PROB W/ UNCERTAIN PROGNOSIS · ACUTE COMPLICATED INJURY	· CARDIO IMAGING W/ CONTRAST W/O RISK FACTORS · INCISIONAL BIOPSY · OBTAIN FLUID FROM BODY CAVITY	· MINOR SX W/ RISK FACTORS · ELECTIVE SX W/O RISK FACTORS · RX DRUG MGMT
HIGH	· 1 OR MORE CHRONIC PROBS W/SEVERE PROGRESSION · ACUTE/CHRONIC ILLNESS/INJURY POSING THREAT TO LIFE/BODILY FUNCTION	· CARDIO IMAGING W/ CONTRAST W/ RISK FACTORS · CARDIAC ELECTROPHYSIOLOGICAL TEST	· ELECTIVE MAJOR SX · EMERGENCY MAJOR SX · DRUG THERAPY REQUIRING INTENSIVE MONITORING

EXAMPLES FOR DETERMINING RISK LEVEL

- ANY ONE PROBLEM THAT WAS PREVIOUSLY UNDIAGNOSED OR UNIDENTIFIED ***OR*** 3 CHRONIC DXS IS **MODERATE RISK** IF NO ADDITIONAL TESTS ARE NEEDED (CHRONIC ILLNESS EXAMPLES - GLAUCOMA, CATARACTS, RCE, AMD, MGD)
- ADDITIONAL TESTS, EXAMS OR CONSULTS ARE NEEDED FOR THE NEWLY DIAGNOSED OR IDENTIFIED PROBLEM, IT IS CONSIDERED **MODERATE OR HIGH RISK** DEPENDING ON THE PROBLEM

LEVEL OF MDM	# OF DIAGNOSES	AMOUNT OF DATA	RISK
STRAIGHT FORWARD	MINIMAL (1)	MINIMAL OR NONE (1)	MINIMAL
LOW COMPLEXITY	LIMITED (2)	LIMITED (2)	LOW
MODERATE COMPLEXITY	MULTIPLE (3)	MODERATE (3)	MODERATE
HIGH COMPLEXITY	EXTENSIVE (4)	EXTENSIVE (4)	HIGH

99XXX vs 92XXX CODES

DETERMINE THE PROPER CPT CODE

NEW PATIENT

ALL **3 LEVELS** OF HX, EXAM AND MDM, AS SPECIFIED FOR THE CODE, **HAVE TO BE MET OR EXCEEDED**

ESTABLISHED PATIENT

ONLY **2 LEVELS** OF HX, EXAM AND MDM, AS SPECIFIED FOR THE CODE, **HAVE TO BE MET OR EXCEEDED**. ***MDM MUST BE ONE OF THE ELEMENTS***

REMINDER: DO WHAT IS NECESSARY FOR THE EXAM. DON'T DO UNNECESSARY STEPS JUST TO BE ABLE TO REACH A HIGHER CODE. ALSO, DON'T UNDER CODE BY SKIPPING NECESSARY STEPS

THE 99XXX E/M CODES

MAY REQUIRE MORE STEPS BUT USUALLY PAY MORE

99202
EXPANDED PROBLEM FOCUSED HX (1-3 HPI, 1 ROS)
EXPANDED PROBLEM FOCUSED EXAM (6-8 EXAM)
STRAIGHT FORWARD MDM

99203
DETAILED HX (4+ HPI, 2-9 ROS, 1 PFSH)
DETAILED EXAM (9+ EXAM)
LOW COMPLEXITY MDM

99204
COMPREHENSIVE HX (4+HPI, 10+ ROS, 2 PFSH)
COMPREHENSIVE EXAM (12 EXAM +1 NEURO/PSYCH)
MODERATE COMPLEXITY MDM

99205
COMPREHENSIVE HX (4+ HPI, 10+ ROS, 2 PFSH)
COMPREHENSIVE EXAM (12 EYE, 1+ NEURO/PSYCH)
HIGH COMPLEXITY MDM

99212
PROBLEM FOCUSED HX (1-3 HPI)
PROBLEM FOCUSED EXAM (1-5 EXAM)
STRAIGHTFORWARD MDM

99213
EXPENDED PROBLEM FOCUSED HX (1-3 HPI, 1 ROS)
EXPANDED PROBLEM FOCUSED EXAM (6-8 EXAM)
LOW COMPLEXITY MDM

99214
DETAILED HX (4+ HPI, 2-9 ROS, 1 PFSH)
DETAILED EXAM (9+ EXAM)
MODERATE COMPLEXITY MDM

99215
COMPREHENSIVE HX (4+ HPI, 10+ ROS, 2 PFSH)
COMPREHENSIVE EXAM (12+ EXAM, 1+ NEURO/PSYCH)
HIGH COMPLEXITY MDM

CAN AN O.D. BILL A 992X5 CODE?

YES!!!!

REQUIRES PROPER DOCUMENTATION

DIAGNOSIS MUST BE FOR AN ACUTE SIGHT THREATENING CONDITION (RD, CRAO ETC)

THE EYE CODES 92XXX

92002
MEDICAL EXAMINATION AND EVALUATION WITH **INITIATION** OF DIAGNOSTIC AND TREATMENT PROGRAM, INTERMEDIATE, NEW PT

92004
MEDICAL EXAMINATION AND EVALUATION WITH **INITIATION** OF DIAGNOSTIC AND TREATMENT PROGRAM, COMPREHENSIVE, NEW PT, 1 OR MORE VISITS

92012
MEDICAL EXAMINATION AND EVALUATION WITH **INITIATION** OF DIAGNOSTIC AND TREATMENT PROGRAM, INTERMEDIATE, ESTABLISHED PT

92014
MEDICAL EXAMINATION AND EVALUATION WITH **INITIATION** OF DIAGNOSTIC AND TREATMENT PROGRAM, COMPREHENSIVE, EST PT, 1 OR MORE VISITS

920X2 REQUIREMENTS

- EXTERNAL OCULAR ADNEXA EXAM
- EXAM FOR PROBLEM OR DIAGNOSIS IDENTIFIED IN CC/HPI

PT MUST ALWAYS PRESENT WITH A NEW CONDITION OR EXISTING CONDITION WHICH IS COMPLICATED WITH A NEW DIAGNOSTIC OR MANAGEMENT PROBLEM
(IF EST PT IS SEEN FOR FOLLOW UP AND ALL IS STABLE, THEN SHOULD PROBABLY USE 99213)

920X4 REQUIREMENTS

1) 9-14 EXAM ELEMENTS ***WHICH MUST INCLUDE***
- EXTERNAL OCULAR ADNEXA EXAM
- EOMS
- CONFRONTATION FIELDS (CF)
- DILATION - CARRIER SPECIFIC BUT HIGHLY RECOMMENDED ESPECIALLY FOR MEDICARE

MUST ALWAYS INCLUDE INITIATION OF DIAGNOSTIC AND TREATMENT PROGRAM

CHOOSING BETWEEN 92XXX AND 99XXX CODES

DID YOU INITIATE TREATMENT, SUCH AS PRESCRIBING OR CHANGING A MEDICATION OR ORDER DIAGNOSTIC TESTING? THEN USE 92XXX

IS EVERYTHING STABLE OR HAS A PRIOR PROBLEM, SUCH AS AN INFECTION OR ABRASION RESOLVED? THEN US 99XXX

PRESCRIBING GLASSES ISN'T CONSIDERED A TREATMENT

INTERPRETATION AND REPORT

- REQUIRED ANY TIME YOU DO AN ANCILLARY TEST SUCH AS OCT, TOPOGRAPHY, PHOTOS ETC
- I&R REQUIRES 3 ELEMENTS

1. CLINICAL FINDINGS
2. COMPARATIVE DATA
3. CLINICAL MANAGEMENT PLAN
4. DOCTOR SIGNATURE AND DATE

NEEDS TO BE A SEPARATE SECTION FROM MAIN MEDICAL RECORD

LET'S TALK ABOUT DILATION

CAN I BILL A 992X4 VISIT WITHOUT DILATING?

IN MOST CASES: NO

UNLESS: YOU DOCUMENT A MEDICAL REASON NOT TO DILATE IN THE CHART

"I DON'T WANT MY EYES DILATED" ISN'T A VALID REASON

SOME GENERAL ADVICE

- DON'T PRESELECT THE CPT CODE FOR VISITS
- HX AND EXAM ELEMENTS SHOULD VARY BASED UPON CC AND LEVELS OF EXAM PERFORMED (DON'T DO EXTRA STUFF JUST TO USE HIGHER CODE)
- ASSESSMENT-SHOULD INCLUDE DX ALONG W/ STATUS OF PROBLEM (STABLE, WORSE, IMPROVING, NOT RESPONDING AS EXPECTED)
- USE 99XXX CODES FOR NEW PTS AND 92XXX CODES FOR EST PTS AS LONG AS YOU ARE "INITIATING" SOMETHING FOR PT

IS DILATION REQUIRED FOR 920X4?

IT'S INSURER DEPENDENT. HOWEVER, IN MOST CASES, YOU DO HAVE TO DILATE

MORE ADVICE

- MEDICAL NECESSITY OF VISIT DETERMINES:
  1) WHETHER VISIT MAY BE BILLED MEDICALLY
  2) FREQUENCY OF VISITS BASED UPON DIAGNOSIS

- WITHOUT A PRESENTING PROBLEM OR CHIEF COMPLAINT, THE VISIT IS CONSIDERED "ROUTINE" OR PREVENTIVE AND CAN'T BE BILLED MEDICALLY

2018 PALMETTO FEE SCHEDULE

CODE	FEE	CODE	FEE	DIFFERENCE
99202	75.49			
99203	108.58	92002	84.13	24.43
99204	165.66	92004	152.29	13.37
99205	208.43			
99212	44.14			
99213	73.41	92012	88.38	14.97
99214	108.38	92014	127.27	18.89
99215	146.17			

MODIFIERS

WHAT IS A MODIFIER?

MODIFIERS ARE ADDED TO CPT OR HCPCS LEVEL II CODES TO INDICATE SPECIFIC CIRCUMSTANCES OR CHANGES IN A PROCEDURE, SERVICE OR MEDICAL EQUIPMENT WHILE NOT CHANGING THE DEFINITION OF THE CPT OR HCPCS CODE.

THEY HELP SPECIFY MORE ACCURATELY WHAT SERVICES WERE PROVIDED FOR THE CPT CODES YOU FILE

TYPES OF MODIFIERS

1) CPT (CURRENT PROCEDURAL TERMINOLOGY) - ALWAYS A TWO CHARACTER NUMBER

2) HCPCS (HCFA COMMON PROCEDURAL CODING SYSTEM) - ALWAYS 2 LETTERS or LETTER FOLLOWED BY A NUMBER

WHAT DO I DO IF I NEED MORE THAN ONE MODIFIER?

FIRST MODIFIER SHOULD BE THE ONE THAT AFFECTS PAYMENT (EX. 52 REDUCED SERVICES)

SUBSEQUENT MODIFIERS CLARIFY ASPECTS OF THE PROCEDURE (EX. RT or LT)

MOST COMMONLY USED CPT MODIFIERS

24 - Unrelated E/M service during post op period
25 - Significant, separately identifiable E/M on the same day of a procedure or other service
26 - Professional component of a test
50 - Bilateral procedure
51 - Multiple Procedures done at the same visit
52 - Reduced services
55 - Postoperative management only
59 - Distinct procedural service
76 - Repeat Procedure or service by same provider
79 - Unrelated procedure or service during post op period

NCCI EDIT EXAMPLE

92133	36591	20151001	*	0	CPT Manual or CMS manual coding instructions
92133	36592	20151001	*	0	CPT Manual or CMS manual coding instructions
92133	92132	20110101	20120331	1	Misuse of column two code with column one code
92133	**92134**	**20110101**	*****	**0**	**CPT Manual or CMS manual coding instructions**
92133	92227	20110101	*	0	CPT Manual or CMS manual coding instructions
92133	**92250**	**20110101**	*****	**1**	**Mutually exclusive procedures**
92133	99211	20110101	*	1	Misuse of column two code with column one code
92134	36591	20151001	*	0	CPT Manual or CMS manual coding instructions
92134	36592	20151001	*	0	CPT Manual or CMS manual coding instructions
92134	92132	20110101	20120331	1	Misuse of column two code with column one code
92134	92227	20110101	*	0	CPT Manual or CMS manual coding instr
92134	92250	20110101	*	1	Mutually exclusive procedures
92134	99211	20110101	*	1	Misuse of column two code with column one

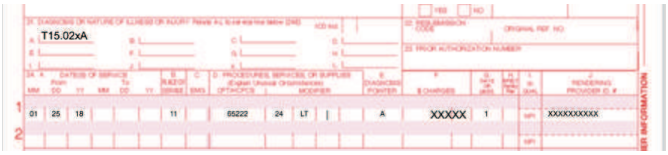
0 = CAN'T BE DONE SAME VISIT
1 = MAY BE DONE SAME VISIT W/ 59 MODIFIER

MOST COMMONLY USED HCPCS MODIFIERS

AP - Refraction not performed during diagnostic ophthalmological exam
E1 - LUL
E2 - LLL
E3 - RUL
E4 - RLL
LT - OS
RT - OD
TC - Technical component of test
QW - CLIA waived test

24 - UNRELATED E/M SERVICE DURING POST OP PERIOD PERIOD

PT HAD CATARACT SURGERY OD 10 DAYS AGO AND NOW COMES IN WITH OS FOREIGN BODY



HCPCS MODIFIERS CONTINUED

These will replace the 59 modifier

XE - Separate encounter
XP - Separate practitioner
XS - Separate structure
XU - Unusual overlapping service

25 - SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M ON THE SAME DATE AS A PROCEDURE OR OTHER SERVICE

PT SEEN FOR CATARACT PROGRESSION AND IS FOUND TO HAVE A FOREIGN BODY IN THE OD

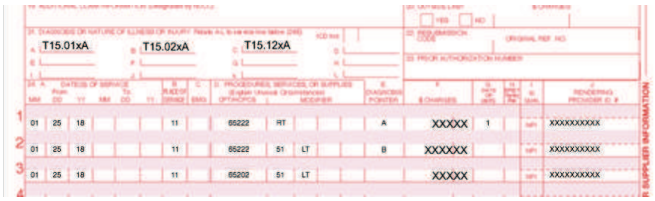
26 - PROFESSIONAL COMPONENT OF A TEST

52 - REDUCED SERVICES

DR IS INTERPRETING RETINAL PHOTOS DONE BY ANOTHER OFFICE TO DOCUMENT MODERATE NPDR W/ DME FOR THE OD ONLY

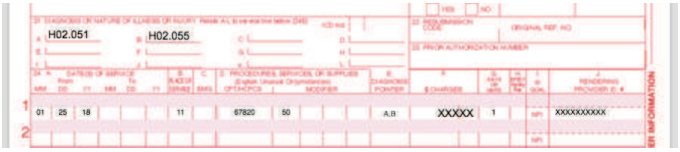
51 - CODING FOR MULTIPLE FOREIGN BODIES

PT IS SEEN WHO HAS CORNEAL FB OU AND CONJUNCTIVAL FB OS



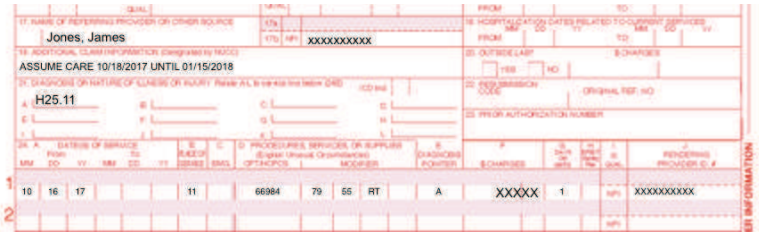
50 - BILATERAL PROCEDURE

PT COMPLAINS OF FB SENSATION OU AND IS FOUND TO HAVE TRICHIASIS OF RUL AND LLL. EYELASHES ARE EPILATED OU



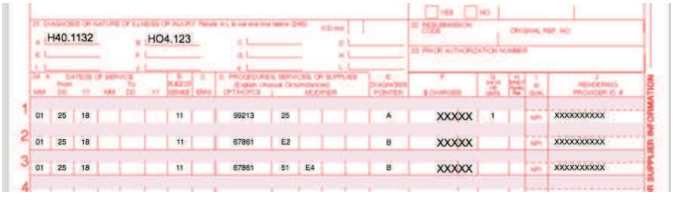
55 - POST OPERATIVE MANAGEMENT ONLY
79 - UNRELATED PROCEDURE OR SERVICE DURING

POST OP CARE FOR CATARACT SURGERY DONE ON SECOND EYE DURING GLOBAL PERIOD FOR FIRST EYE



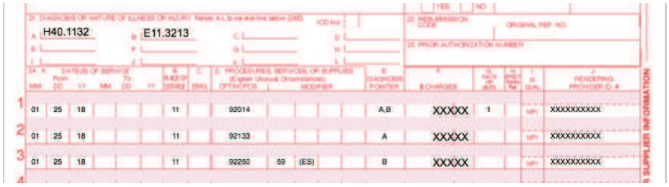
51 - MULTIPLE PROCEDURES DONE AT ONE VISIT

PT IS SEEN FOR GLAUCOMA PROGRESS CHECK (ALL IS STABLE) AND PUNCTAL PLUGS ARE INSERTED IN LOWER LIDS OU FOR DRY EYE AT SAME VISIT



59 - DISTINCT PROCEDURAL SERVICE

PT W/ MODERATE POAG OU AND MILD NPDR W/ DME OU IS SEEN FOR PROGRESS CHECK. ALL STABLE. OD ORDERS OCT OF ONH AND RETINAL PHOTOS.



SHOULD YOU USE MODIFIER 59?

IN GENERAL - NO

WHY - RED AUDIT FLAG

IF YOU USE 59 MODIFIER:
1) HAVE PT SIGN ABN FOR SECOND PROCEDURE
2) USE DIFFERENT DIAGNOSIS CODE FOR EACH PROCEDURE

76 - REPEAT PROCEDURE OR SERVICE BY SAME DR

PT PREVIOUSLY HAD PERMANENT PUNCTAL PLUGS INSERTED OU BUT NOW HAS TO HAVE THE LLL PLUG REPLACED

SOME GENERAL ADVICE

- CODE FROM HIGHEST PAYING CODE DOWN
- BE AWARE OF MODIFIER ORDER
- CHECK NCCI EDITS FOR TESTS
- SOME CARRIERS MAY WANT YOU TO USE DIFFERENT MODIFIERS (CHECK LCDs)
- DON'T OVER USE MODIFIER 59 - BEING MONITORED CLOSELY BY CMS AND OIG