### Friday, June 26

#### 7:00‒8:00 AM
**Registration and Breakfast**  
*South Ballroom Foyer*

#### 8:00‒10:00 AM
**2015 Medicare Update**  
- Physician & ASC Fee Schedule Changes
- Quality Reporting Initiatives
- CPOE Requirements
- CPT Code Changers
- New CCI Modifiers

**2015 OIG Work Plan**  
- New Issues Affecting Ophthalmology

**Questions & Answers**

#### 10:00‒10:15 AM
**Break**  
*South Ballroom Foyer*

#### 10:15 AM –12:00 PM
**General Coding Issues**  
- Premium IOLs
- Co-Managing Premium IOLs
- Femtosecond Assisted Cataract Surgery
- High Audited Modifiers
- Eye Codes vs. E&M Codes
- Medically Unlikely Edits
- Cloned Documentation
- Diagnostic Test Requirements
- Documenting Cataracts, YAGs and Blepharoplasties

**Questions & Answers**

#### 12:00‒1:00 PM
**Lunch**  
*Gold Room*

#### 1:00–2:30 PM
**ICD-10 Update**  
- Why the Change
- ICD-9 vs. ICD-10 Differences
- What You Should Be Doing Now to Prepare
- Case Scenarios
- It’s October 1, Now What

**Questions & Answers**

#### 2:30 PM
**Adjourn**
TARGET AUDIENCE
This program has been designed for physicians, nurses, coders, technicians and administrators with a fairly good understanding of Medicare requirements, CPT and diagnosis code usage, and billing for services rendered.

LEARNING OBJECTIVES
Upon completion of the educational activity, participants should be able to:

- Implement the Medicare changes for 2015;
- Recognize the importance of implementing current guidelines for maintaining Medicare compliance;
- Discuss documentation changes required for ICD-10.

ACCREDITATION
CME/CE Credit provided by AKH Inc., Advancing Knowledge in Healthcare

Physicians
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Statements of credit will be awarded based on the participant’s attendance and submission of the activity evaluation form. A statement of credit will be available upon completion of an online evaluation/claimed credit form at www.ophmasters.com/cme. You may claim credit online for this meeting until July 31, 2015. If you have questions about this CME/CE activity, please contact AKH Inc. at tbrignoni@akhcme.com.

Commercial Support
No commercial support was received for this course.
Ann Rose is owner and president of Rose & Associates, a Medicare reimbursement and compliance consultant who has been associated with the health care industry for over 40 years. Rose & Associates specializes in Medicare coding and billing with medical record auditing being their main focus.

Ann is a member of the American Society of Ophthalmic Administrators (ASOA), the Medical Group Management Association, and the American Academy of Professional Coders. She is also editor and publisher of The Messenger, a newsletter written and developed specifically for the specialty of ophthalmology, a regular contributor to ASOA’s Administrative Eyecare magazine, and serves on the editorial board of the reimbursement section of Ocular Surgery News.
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<table>
<thead>
<tr>
<th>FACULTY DISCLOSURES</th>
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<tbody>
<tr>
<td>NAME</td>
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<tr>
<td>E. Ann Rose</td>
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<tbody>
<tr>
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</tbody>
</table>
E. Ann Rose
8:00 AM – 2:30 PM
Physician Fee Schedule

• 2015 Physician Fee Schedule Final Rule
  – Called for 21.2% reduction in physician fees
    • Included a -0.06% budget-neutrality adjustment and ending conversion factor of $28.2239
  – Protecting Access to Medicare Act (PAMA)
    – Preserved 0% update for January 1 through March 31, 2015
      • Malpractice RVU corrections and other RVU technical changes resulted in final conversion factor of $35.7547

Physician Fee Schedule

• On April 14, 2015, new legislation was passed that:
  – Fully repealed flawed SGR used to calculate physician fees
    • Averted 21% cut in physician fees
  – Guarantees annual increases of 0.5% starting in July 2015 – December 2019
    • Will also provide bonuses to physicians who transition from fee-for-service to other payment models

Physician Fee Schedule

• Physician Fee Schedule conversion effective July 1, 2015 will be:
  – $35.9335
  • A nice increase for the remainder of the year
• MACs should be posting new fee schedules toward the end of June

National Fee Schedule Payments July 1, 2015 – December 31, 2015

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>6/31/15</th>
<th>7/1/15</th>
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</thead>
<tbody>
<tr>
<td>92004 - Comp, New patient</td>
<td>$149</td>
<td>$149</td>
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<tr>
<td>92012 - Intern, Est. Patient</td>
<td>$ 85</td>
<td>$ 86</td>
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<tr>
<td>92014 - Comp, Est. Patient</td>
<td>$124</td>
<td>$124</td>
</tr>
<tr>
<td>99203 - Detailed, New Patient</td>
<td>$109</td>
<td>$110</td>
</tr>
<tr>
<td>99213 - Exp. Prob. Focused, Est. Patient</td>
<td>$72</td>
<td>$73</td>
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<tr>
<td>99214 - Detailed, Est. Patient</td>
<td>$108</td>
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<tr>
<td>99215 - Comp, Est. Patient</td>
<td>$146</td>
<td>$147</td>
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<tr>
<td>*92014 est. pt. still pays more than 99214 est. pt. exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99204 - Comp, New Patient</td>
<td>$165</td>
<td>$167</td>
</tr>
<tr>
<td>99205 - Comp, New Patient</td>
<td>$208</td>
<td>$210</td>
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</tbody>
</table>
Physician Fee Schedule

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<th>CPT Code</th>
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</thead>
<tbody>
<tr>
<td>92083 - Visual field</td>
<td>$64</td>
<td>$65</td>
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<tr>
<td>92133 - OCT, optic nerve</td>
<td>$44</td>
<td>$45</td>
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<tr>
<td>92134 - OCT, retina</td>
<td>$45</td>
<td>$46</td>
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<tr>
<td>92225 - Extended Ophthalmoscopy, Initial</td>
<td>$27</td>
<td>$27</td>
</tr>
<tr>
<td>92226 - Extended Ophthalmoscopy, Subsequent</td>
<td>$25</td>
<td>$25</td>
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<tr>
<td>92250 - Fundus Photo</td>
<td>$79</td>
<td>$80</td>
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<tr>
<td>92235 - Fluorescein angiography</td>
<td>$110</td>
<td>$111</td>
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<tr>
<td>92285 - External ocular photography</td>
<td>$20</td>
<td>$21</td>
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</table>

Physician Fee Schedule

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<th>CPT Code</th>
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<tbody>
<tr>
<td>15823 - Blepharoplasty</td>
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<tr>
<td>65756 - DSAEK</td>
<td>$1,198</td>
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<tr>
<td>66170 - Trabeculectomy</td>
<td>$1,213</td>
<td>$1,220</td>
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<tr>
<td>66180 - Aqueous Shunt</td>
<td>$1,150</td>
<td>$1,156</td>
</tr>
<tr>
<td>66183 - Express shunt</td>
<td>$1,041</td>
<td>$1,047</td>
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<tr>
<td>66185 - Revise Aqueous shunt/graft</td>
<td>$854</td>
<td>$859</td>
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<tr>
<td>66821 - YAG – Office</td>
<td>$333</td>
<td>$335</td>
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<tr>
<td>66821 - YAG – Facility</td>
<td>$314</td>
<td>$316</td>
</tr>
<tr>
<td>66982 - Complex Ct w/IOL</td>
<td>$804</td>
<td>$808</td>
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Physician Fee Schedule

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<tr>
<th>CPT Code</th>
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<th>7/1/15</th>
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<tbody>
<tr>
<td>66984 - Cataract w/IOL</td>
<td>$647</td>
<td>$650</td>
</tr>
<tr>
<td>67028 - Intravitreal injection</td>
<td>$102</td>
<td>$103</td>
</tr>
<tr>
<td>67036 - Vitrectomy</td>
<td>$911</td>
<td>$916</td>
</tr>
<tr>
<td>67039 - Laser treatment of retina</td>
<td>$976</td>
<td>$981</td>
</tr>
<tr>
<td>67040 - Laser treatment of retina</td>
<td>$1,055</td>
<td>$1,060</td>
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<tr>
<td>67041 - Vitrectomy – macular pucker</td>
<td>$1,166</td>
<td>$1,173</td>
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<td>67042 - Vitrectomy – macular hole</td>
<td>$1,166</td>
<td>$1,173</td>
</tr>
<tr>
<td>67043 - Vitrectomy – Membrane dissect</td>
<td>$1,231</td>
<td>$1,237</td>
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</table>

Physician Fee Schedule

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<th>CPT Code</th>
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<th>7/1/15</th>
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<tr>
<td>67108 - Repair Detach. Retina</td>
<td>$1,622</td>
<td>$1,631</td>
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<tr>
<td>67113 - Complex Retina Repair</td>
<td>$1,764</td>
<td>$1,773</td>
</tr>
<tr>
<td>68761 - Punctum Plug Insertion</td>
<td>$149</td>
<td>$150</td>
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Physician Fee Schedule

• As indicated, CMS’s decision to eliminate global fee periods has been reversed
  – CMS plans to take a look at this again in 2017
    • May start collecting data to make decision at that time
  – Will still need to pay close attention to use of global fee modifiers for compliance
    • Particularly -25 modifier which is under scrutiny

Physician Fee Schedule

• Sequestration (Medicare spending) cuts still in effect through 2024
  • Remittance Advice (RA) will include denial message “223 – Sequestration reduction in federal spending”
  • Permanent Geographic Practice Cost Index (GPCI) floor of 1.000% still in place
    • States with smaller GPCIs will not be reduced below 1.000%
MPPR

- Multiple Procedure Payment Reduction (MPPR) Continues
  - Technical component (-TC modifier) of second and subsequent tests performed on same patient, same day is reduced by 20%
    - CMS will monitor practice patterns to ensure MPPR not being bypassed
      - Expects physicians to continue treating patients under same medical standards

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Diagnostic Tests Subject to Multiple Procedure Reduction

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>2015</th>
<th>2016</th>
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<tbody>
<tr>
<td>76510</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>76514</td>
<td></td>
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<td>92060</td>
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<tr>
<td>92284</td>
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</tbody>
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ASC Fee Schedule

- 2015 ASC Fee Schedule
  - Conversion factor for ASCs increased to 1.4% for facilities meeting quality reporting requirements
    - Results in small increases in ASC facility fee payments
  - HOPD 2015 Reimbursement
    - Rates increase about 2.3% in 2015

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ASC Fee Schedule

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
<th>2014</th>
<th>2015</th>
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</thead>
<tbody>
<tr>
<td>65755</td>
<td>Keratoplasty</td>
<td>$1,783</td>
<td>$1,711</td>
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<tr>
<td>66170</td>
<td>Trabeculectomy</td>
<td>$  96</td>
<td>$  96</td>
</tr>
<tr>
<td>66183</td>
<td>Express shunt</td>
<td>$1,678</td>
<td>$1,711</td>
</tr>
<tr>
<td>66821</td>
<td>YAG Laser</td>
<td>$  237</td>
<td>$  243</td>
</tr>
<tr>
<td>66882</td>
<td>Complex cataract</td>
<td>$  976</td>
<td>$  960</td>
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<tr>
<td>66884</td>
<td>Cataract with IOL</td>
<td>$  976</td>
<td>$  960</td>
</tr>
<tr>
<td>67028</td>
<td>Intravitreal injection</td>
<td>$   48</td>
<td>$   47</td>
</tr>
<tr>
<td>67036</td>
<td>Retina (Codes 67036 - 67043)</td>
<td>$1,691</td>
<td>$1,711</td>
</tr>
<tr>
<td>67108</td>
<td>Retina Detach</td>
<td>$1,691</td>
<td>$1,711</td>
</tr>
</tbody>
</table>

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ASC Fee Schedule

- ASC Quality Measure Reporting
  - ASCs that satisfactorily report on quality measures in 2015:
    - ASC Conversion Factor is $44.071
  - ASCs that failed to meet ASC quality reporting:
    - Are paid a lower ASC Conversion Factor of $43.202

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ASC Fee Schedule

- Cataract ASC-11 Reporting Measure
  - ASCs were going to initially be required to report on pre- and post-operative patient visual function
    - ASCRS, ASOA and other ophthalmology societies strongly advocated that this was not an appropriate measure for the ASC setting
  - CMS has now determined that ASC-11 is a voluntary reporting measure
ASC Fee Schedule

• ASC supplies billable separately
  – Corneal tissue - Processing, preserving and transporting
    • Report Code V2785
  – Corneal allograft - Used with aqueous shunt codes 66180 and 66185 (Effective 4/1/15)
    • Must also report Code V2785
  – These are the only two supplies billable separately for ophthalmology
    • Will need to fax copy of invoice when electronic claim filed

ASC Fee Schedule

• ASC pass-through drugs
  – Certain drugs are considered pass-through drugs and payable separately to the ASC
    • These are identified in the ASC Fee Schedule with a “K2” payment indicator
  – The drug codes should be billed on the same claim form as the related surgical service
    • If not the claim could be returned as unprocessable
  • The OPPS drug payments are updated quarterly

ASC Fee Schedule

<table>
<thead>
<tr>
<th>Code</th>
<th>Drug</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3300</td>
<td>Triamcinolone – preservative free</td>
<td>$ 3.72</td>
</tr>
<tr>
<td>J3396</td>
<td>Verteporfin – bill 150 units</td>
<td>$ 10.89</td>
</tr>
<tr>
<td>J7310</td>
<td>Ganciclovir Implant</td>
<td>$16,960.00</td>
</tr>
<tr>
<td>J7311</td>
<td>Fluocinolone acetamide (Retisert implant)</td>
<td>$19,710.73</td>
</tr>
<tr>
<td>J7312</td>
<td>Durasert – 7 units</td>
<td>$ 201.21</td>
</tr>
<tr>
<td>J7315</td>
<td>Mitomycin, 9.2mg (Mitosol) – 1 unit</td>
<td>$ 373.97</td>
</tr>
<tr>
<td>J7316</td>
<td>Ozurdex</td>
<td>$ 1,046.75</td>
</tr>
<tr>
<td>J9280</td>
<td>Mitomycin – 5 mg</td>
<td>$ 65.85</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$ 3.72</td>
</tr>
</tbody>
</table>

Most Common Ophthalmology ASC Pass-Through Drugs

** Effective 4/1/15 - Payments updated quarterly

ASC Fee Schedule

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<td></td>
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<td>$ 3.72</td>
</tr>
</tbody>
</table>

Most Common Ophthalmology ASC Pass-Through Drugs

** Effective 4/1/15 - Payments updated quarterly

ASC Sterilization

• CMS initially stated that flash sterilization could no longer be routinely used in surgical center settings
  • There was confusion between “flash” and “short-cycle” sterilization
  – ASCRS, and OOSS were able to explain the difference in flash sterilization vs. short-cycle to CMS

ASC Sterilization

– CMS has now clarified ASC sterilization guidelines
  • Short-cycle steam sterilization is now permitted in ambulatory surgery centers
  • Must follow manufacturer’s directions for use
  – This is a big win for ASCs
Quality Reporting

PQRS

- Physician Quality Reporting System (PQRS)
  - Encourages eligible professionals (EPs) to report information on quality of care to Medicare
    - Also gives EPs opportunity to assess quality of care they provide to their patients
    - Helps ensure patients are getting the right care at the right time

PQRS

- EPs must report PQRS quality measures
  - Can quantify how often they are meeting a particular quality measure
- EPs have several options to report PQRS
  - Claims-based reporting
    - Measure must be on each claim that applies
  - Qualified registry reporting
  - EHR reporting
  - Clinical data registry

PQRS

- 2015 PQRS changes
  - CMS retained many ophthalmology claims based measures in 2015
  - Number of measures EPs must report increased from 3 to 9 in order to avoid 2% penalty in 2017
    - Will be required to report on at least 3 National Quality Strategy (NQS) domains for 50% of Medicare Part B patients
    - Must also report on at least 1 cross-cutting measure

PQRS

- PQRS is mandatory for 2015
  - No bonus payments in 2015
    - Providers who did not successfully report PQRS in 2013
      - Will receive 1.5% reduction in Medicare Fee Schedule payments in 2015
    - Providers who did not successfully report PQRS in 2014
      - Will receive 2% reduction in Medicare Fee Schedule payments in 2016

PQRS

- If providers have less than 9 measures to report
  - Will be subject to Measure Applicability Validation (MAV) review
  - Can report general measures such as:
    - Measure 130 – Documentation of Current Medications in the Medical Record
    - Measure 226 – Preventative Care Screening: Tobacco Use: Screening and Cessation Intervention
PQRS

• Can choose to report Cataract Measures Group via Registry reporting
  – Number of measures in Cataract Measures Group increased from 4 to 8 measures in 2015
  • Must report on 20 patients via Registry, 50% (or 11) of which must be Medicare Part B beneficiaries

PQRS

<table>
<thead>
<tr>
<th>Cataract Measures Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
</tr>
<tr>
<td>#130</td>
</tr>
<tr>
<td>#191</td>
</tr>
<tr>
<td>#192</td>
</tr>
<tr>
<td>#226</td>
</tr>
<tr>
<td>#303</td>
</tr>
</tbody>
</table>

PQRS

• CMS will publicly report 2015 physician-level quality performance data on Physician Compare website in 2016
• Physicians will have option to continue reporting PQRS through:
  – Claims and qualified registry reporting
  – Direct electronic health record submission
  – Participation in a qualified clinic data registry

PQRS

• New Clinical Data registry permits EPs to report quality measures used by clinical data registry instead of PQRS measure
  – Must capture at least 9 measures covering at least 3 National Quality Strategy (NQS) domains
• Can find a list of the Clinical Data registries on CMS website

EHR

• What is an EHR
  – An electronic health record (EHR)
    • Sometimes called an electronic medical record (EMR)
  – Allows recording of patient information electronically instead of using paper records
• The EHR program asks providers to use their EHRs to achieve benchmarks
  • Per CMS can lead to improved patient care
EHR

• CMS initially provided incentive payments to show that EPs were “meaningfully using” their EHRs
  – EPs had to meet thresholds for a number of objectives
    • This is called Meaningful Use
  – It was not enough just to own an EHR
    • EPs had to show that they were using their EHRs in ways that positively affect patient care

• The EHR incentive bonuses were finalized in 2014
  – There are no more incentive payments for using EHR
  – Effective 1/1/2015, Meaningful Use is mandatory
    • EPs who did not meet the requirements for MU by 2015 and in each subsequent year are subject to payment adjustments to Medicare payments
      – Starting at 1% per year, up to 5% maximum adjustment annually

Meaningful Use

• Meaningful Use reporting in 2015
  • Must have full year of MU participation for any provider beyond one year reporting

• Providers who did not qualify for a hardship exception or meet MU attestation Stage 1, by October 1, 2014
  • Receiving a 1% reduction of Medicare Fee Schedule payments in 2015

• Stage 1 Meaningful Use requirements for 2015
  – Must report all 13 Core Set Objectives and Measures
  – 5 out of 9 Menu Set Objectives and Measures
    • Including public health measure
  – 9 Clinical Quality Measures (CQM) relevant to practice
    • Must cover 3 of the National Quality Strategy domains

Meaningful Use

• Stage 2 Meaningful Use requirements for 2015
  – 17 core objectives
  – 3 menu objectives

• Vital signs (height, weight, blood pressure) are not relevant to ophthalmologist’s scope of practice
  • Can just report on blood pressure and exclude height and weight

• Two Meaningful Use measures require patients to take action
  • Patient Electronic Access
    • Must provide patients with electronic copy of their medical record
      – Requires that 50% of patients have access to their information
      – 5% have used electronic capability to access and download information from practice website
    • Can have patients log in to the website while in the office
Meaningful Use

- Secure Electronic Messaging
  - Must use secure electronic messaging to communicate with patients on their health information
  - Patients must be offered secure messaging online
    - At least 5% of patients (or authorized representatives) must have sent messages online
  - Secure messaging can be used to:
    - Address patient questions
    - Medication refills
    - Handle routine health issues, etc.

CPOE

- Computerized physician order entry (CPOE) guidelines included in Stage 2 Meaningful Use
  - CMS initial ruling: Only licensed personnel can enter orders into a medical record
    - e.g., licensed medical assistants
  - COAs, COTs, COMTs meet the criteria

CPOE

- Since ophthalmologists use “scribes” in their practices, this was a big issue
- ASCRS and ASOA was able to convince CMS to change their mind
  - Ophthalmic “certified” scribes now qualify for entering CPOE in electronic health records
    - Only pertains to scribes in ophthalmology that have been certified

CPOE

- ASOA joined with American College of Medical Scribe Specialists (ACMSS)
  - Non-Profit partner
  - ACMSS will offer ASOA members an ophthalmic specific certified scribe program
  - JCAHPO also has a new Scribe certification program

Physician Compare Website

- Physician Compare is a CMS website that helps beneficiaries choose providers enrolled in Medicare
  - Helps patients make informed choices about healthcare they get
    - Required by Affordable Care Act (ACA) of 2010
  - Patients can compare group practices on Physician Compare website
    - Individual physicians will be included in the future

Physician Compare Website

- Patients can find out which physicians, other healthcare professionals, and group practices take part in quality reporting programs
  - PQRS including Group Practice Reporting Option (GPRO)
  - PQRS Maintenance of Certification Program (MOC)
    - must successfully complete a MOC program practice assessment
  - Electronic Prescribing (eRx)
  - Electronic Health Record (EHR)
**Physician Compare Website**

- CMS is expanding public reporting via Physician Compare website
  - Group level measures for public reporting on the Physician Compare website will be expanded in 2016 to include:
    - 2015 PQRS GPRO web interface, registry and EHR measures for group practices of 2 or more eligible professionals and Accountability Care Organizations

**Value Based Payment Modifier**

- What is VBPM?
  - Provides for differential payment to a physician or group of physicians based on quality of care furnished compared to cost of care during a performance period
    - Adjustment is made on a per claim basis for items and services under the Medicare Physician Fee Schedule
  - 2015 VBPM is based on performance in 2013

- CMS will continue to phase in the VBPM
  - Adjusts traditional Medicare payments based on quality and cost of care
    - Providers who deliver higher quality care at a better value will receive upward adjustments in payments
    - Providers who underperform may be subject to a payment reduction
  - Based on participation in PQRS

- Practices with 10 or more EPs that do not successfully report PQRS in 2015
  - Will receive payment reductions of 4% in 2017
  - Quality Tiering
    - Maximum upward or downward adjustment +/-4 times adjustment factor in 2017

- Group practices or solo providers and solo practitioners that do not successfully participate in PQRS in 2015
  - Will receive automatic payment reductions of 2% - 4% in 2017 depending on group size
  - Successful PQRS participants will be subject to second "quality tiering" step
    - Groups are compared nationally on quality and cost measures and have the potential to earn a bonus or penalty
Value Based Payment Modifier

- Groups of 2-9 and solo EPs that do not successfully report PQRS in 2015
  - Will receive a 2% penalty in 2017
- Quality Tiering:
  - +2 times the adjustment factor
  - Will not be subject to negative adjustments in 2017

Quality Reporting Penalties

<table>
<thead>
<tr>
<th>Program</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>eRx</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>PQRS</td>
<td>1.5%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>3 or 4% # of MDs?</td>
</tr>
<tr>
<td>VBPM</td>
<td>1%</td>
<td>2%</td>
<td>2-4%</td>
<td>TBD</td>
</tr>
<tr>
<td>Practices of 100 or more</td>
<td>Varies depends on practice size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sequestration</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>6.5%</td>
<td>8%</td>
<td>9-11%</td>
<td>12% +</td>
</tr>
</tbody>
</table>

Source: ASCRS Slide

Aqueous Shunts

- AMA and RUC
  - Determined that frequency of use of grafts in aqueous shunt procedures warranted new code structure
  - Codes 66180 and 67255 reported together 73% of the time
  - Revised codes 66180 and 66185 to include graft
  - Created new codes for the non-graft procedures

Aqueous Shunts

<table>
<thead>
<tr>
<th>New and Revised Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>New 66179</td>
</tr>
<tr>
<td>Revised 66180</td>
</tr>
<tr>
<td>New 66184</td>
</tr>
<tr>
<td>Revised 66185</td>
</tr>
<tr>
<td>Deleted 66165</td>
</tr>
</tbody>
</table>

Corneal Hysteresis

<table>
<thead>
<tr>
<th>New and Revised Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>New 92145</td>
</tr>
<tr>
<td>Code describes a test performed on a single or both eyes (e.g., unilateral or bilateral)</td>
</tr>
<tr>
<td>Replaces Category III code 0181T due to increase in usage</td>
</tr>
</tbody>
</table>
## Category III Code Changes

### New and Revised Codes

**Revised** 0191T  
Insertion of anterior segment aqueous drainage device, without extracorpuscular reservoir, internal approach, into the trabecular meshwork; initial insertion

**New** +0376T  
…………..  
(Can use to report each additional stent beyond the first implanted stent)  
(List separately in addition to code for primary procedure)

**Revised** 0253T  
Insertion of anterior segment aqueous drainage device, without extracorpuscular reservoir, internal approach, into the suprachoroidal space  
(Now a stand alone code)

### Visual Field Assessment

- **New code created to report visual field assessment up to 30 days**
- **Assessment**
  - Patient transmits daily test data to monitoring center (IDTF) for input into secured database
  - Technician with physician analyzes the data and prepares report
  - Results are then interpreted by physician

### Professional Component

- Physician bills service to Medicare or other insurance

### Technical Component

- Can also bill separately for technical component of device set-up and patient instructions for daily testing and transmission with technical staff report

### Category III Code Changes

- **New code to report analysis of retinal images to monitor disease progression (e.g., glaucoma, other structural damage)**
  - May be performed on one or both eyes
  - **May only be reported once**

**New and Revised Codes**

**New** 0380T  
Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report

### Codes Implemented July 1, 2014

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New 0341T</td>
<td>Quantitative pupillometry with interpretation and report, unilateral and bilateral</td>
</tr>
<tr>
<td>New 0356T</td>
<td>Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each</td>
</tr>
</tbody>
</table>

Reminder: Since CMS does not assign RVUs to Category III codes, payment is made by contractor discretion. Billing Category III codes will help develop billing history for possible conversion to CPT permanent codes.
New CCI “X” Modifiers

- New “X” modifiers developed to assist providers in correct use of unbundling codes under the CCI edits
  - Effective for dates of service on or after January 1, 2015
    - Modifier -XE: Separate Encounter
      - Service occurred during a separate encounter

- Modifier -XS: Separate Structure
  - Service occurred on a separate organ or structure

- Modifier -XP: Separate Practitioner
  - Service was performed by different practitioner

- Modifier -XU: Unusual Non-Overlapping Service
  - Service does not overlap usual components of main service
    - Pterygium same time as cataract surgery perhaps

CMS will continue to recognize -59 modifier for now
- Should not be used when more appropriate modifier exists, however
  - CMS may begin to identify code pairs as only payable with the “X” modifiers
  - Would result in denials if “X” modifier not used
- CMS encourages providers to use “X” modifiers when appropriate

Documentation Issues

Compliance Concerns

Amending Medical Record

- Paper Charts
  - Medicare expects to see:
    - S.L.I.D.E.
      - Single Line through error
      - Initials of the person making the amendment
      - Date the amendment is made
      - Entry for correction
    - White-out/oblation of original entry not acceptable

- EMR
  - Addendums
    - Should be made in system where documentation was originally created
    - Make sure any addendums are forwarded to any place where information has been previously sent
      - Referring doctor for example
  - Amendments
    - Should be timely and bear the current date of documentation
Amending Medical Record

- Corrections after final signature
  - Usually only one individual has ability to "unlock" a document once it has been signed
  - Corrections should be made in the system where the document was created
    - Entries should be flagged as corrections and should be carefully monitored and audited
  - Current date and time should be entered
  - Person making change should be identified
  - Reason for correction should be noted in record

- Deletions
  - If system allows "strike-through" lines, practice should follow S.L.I.D.E guidelines
  - Some systems may not permit deletions after record is signed and considered "locked"
    - May need to see how vendor and/or malpractice provider wants you to handle deletions in EMR
    - Create practice policy for future reference
  - Total elimination of information should NEVER occur

Physician Signatures

- Medicare requires the physician providing the service be identified in the medical record
  - Chart is usually signed at the bottom by the physician
    - Signature attests to the fact that all the documentation is true and accurate for the service performed at that visit
    - Stamped signatures are NEVER acceptable

- Electronic signatures – new challenge
  - Samples of acceptable electronic signatures include:
    - Chart “Accepted by” with provider’s name
    - “Electronically signed by” with provider’s name
    - “Verified by” with provider’s name
    - “Reviewed by” with provider’s name
    - “Released by” with provider’s name
    - “Signed before import by” with provider’s name

- Digitalized signature
  - Handwritten and scanned into the computer
  - “This is an electronically verified report by John Smith, M.D.”
  - “Authenticated by John Smith, M.D.”
  - “Authorized by John Smith, M.D.”
  - “Digital Signature: John Smith, M.D.”
  - “Confirmed by”: with provider’s name

- “Closed by” with provider’s name
- “Finalized by” with provider’s name
- “Electronically approved by” with provider’s name

- Medicare contractors have published guidelines in their newsletters
  - Also available on MAC website
  - If signature requirements not met CMS will require attestation statement when submitting medical records for review
Use of Scribes

• Medical record must be clear as to physician who performed the service
• Use of scribe should be documented in both paper chart and EMR
  – “Scribed by M. Moore for John Smith, MD on 1/3/13”
• EMR log-in passwords should not be shared with anyone else

Use of Scribes

• If technician is also the scribe
  – Need statement by MD that information obtained by technician was reviewed and verified
  • Exception: MD must personally obtain and document or scribe the HPI when billing higher level E&M services (99 codes)

On-Going Issues

2015 OIG Work Plan

• Ambulatory Surgery Center (ASC) Payment System
  – Will continue to review methodology for setting ASC payment rates under revised system
  • ASC payments modeled on Outpatient Prospective Payment System (OPPS) since 2008
  – Will determine if disparity exists between ASC and HOPD payment rates for similar procedures

On-Going Issues

• Avoiding Scrutiny
  – There is nothing you need to do regarding this issue
  – This is a CMS/OIG Issue

On-Going Issues

• Payments for Personally Performed Anesthesia Services
  – Will review claims to determine whether personally performed anesthesia services were billed correctly
  • Must be reported with “AA” modifier
  – Reporting incorrect modifier as though the service was personally performed when it was not results in higher (incorrect) payments
On-Going Issues

• Avoiding Scrutiny
  – Most ophthalmology ASCs use CNRAs for anesthesia
  • If anesthesiologist (MDA) used in your surgery, review ASC claims for correct modifier

• Imaging Services
  – Will review Medicare payments to determine if they accurately reflect expenses incurred and that utilization rates reflect industry practices
  • Will continue to focus on Practice Expense component including equipment utilization rates

• Questionable Billing and Payments to Ophthalmologists
  – OIG still reviewing claims for 2012
  – Will identify certain geographic locations for providers exhibiting questionable billing
  • In 2012 CMS allowed over $6.8 billion for services provided by ophthalmologists

• Avoiding Scrutiny
  – There is nothing you need to do regarding these two issues
  • These are CMS/OIG issues

• Place of Service Coding Errors
  • Still looking at ASC and HOPD claims to see if correct place of service used
  – Some claims show “office” when place of service should have been HOPD or ASC
  • Medicare pays physician higher amount when services performed in office vs. HOPD or ASC

• Avoiding Scrutiny
  – If lasers performed in laser room in ASC instead of an actual “OR”
  • Make sure Place of Service is billed as ASC, not office
On-Going Issues

- Security of certified EHR records under Meaningful Use
  - Will most likely be ongoing issue for quite some time
    - Nothing provider needs to do

On-Going Issues

- Avoiding Scrutiny
  - There is nothing you need to do regarding this issue
  - This is a CMS/OIG issue

New Issue

- Provider Eligibility
  - Enhanced enrollment screening for Medicare Providers
    - Stepping up effort to prevent fraud, waste, and abuse resulting from vulnerabilities in Medicare enrollment process
    - Implementing new authorities that will include:
      - Site visits, fingerprinting, background checks, and automated provider screening process

New Issue

- Avoiding Scrutiny
  - Before hiring any employee
    - Physician, Administrator, coder, biller, AR clerk, etc.
  - Need to check out OIG’s “Excluded Individuals” database
    - http://exclusions.oig.hhs.gov/
  - It’s a simple name search that can prevent you from hiring the wrong employees

Questions

Then 15 minute break slide
General Coding Issues

Hot topics of special interest

Premium IOLs

- Physicians may bill patient for extra work involved in implanting premium IOLs
  - The portion considered refractive and excluded from coverage
- Currently two types of premium IOLs
  - Astigmatism-correcting
  - Presbyopia-correcting

Premium IOLs

- Bill conventional cataract to Medicare
- Bill patient:
  - V2787 - Astigmatism-Correcting IOL extra charges
  - V2788 - Presbyopia-Correcting IOL extra charges
- Not required to bill Medicare unless patient desires secondary payer denial

Premium IOLs

- What services may an ASC bill when premium IOL implanted?
  - Bill facility fee to Medicare for conventional cataract procedure
  - Bill patient:
    - Coinsurance and deductible for facility fee
    - Extra work and cost involved in implanting premium IOL

Dropless Cataract Surgery

- Use of intraocular or periocular injections of anti-inflammatory drugs and antibiotics at time of cataract surgery has increased
  - For example: triamcinolone and moxifloxacin with or without vancomycin
    - Referred to as "dropless cataract surgery"
- Eliminates need for post-operative antibiotic eye drops

Dropless Cataract Surgery

- According to CCI:
  - Injection of drugs during a cataract extraction or other ophthalmic procedure is not billable separately
  - Injections are considered part of ocular surgery and included in code used to report the surgical procedure
**Dropless Cataract Surgery**

- What about the medications?
  - Compounded drugs must be billed with code J3490 (unclassified drugs), regardless of the site of service
  - ASCs do not get paid separately for NOC drugs or supplies
    - Packaged as part of ASC facility fee
    - Cannot report J3490 or C9399

**Femtosecond Laser**

- Femtosecond laser role in cataract surgery
  - Used to assist or replace several aspects of the manual cataract surgery including:
    - Creation of initial surgical incisions in the cornea
    - Creation of capsulotomy
    - Initial fragmenting (breaking up) of the lens
  - These services are included in the ASC facility fee reimbursement
    - Not billable separately

**Femtosecond Laser**

- CMS will allow beneficiaries, however, to pay additional charges associated with FS laser imaging
  - Applies only to services associated with the insertion of premium IOLs
  - Imaging performed as part of FS laser surgery is considered a non-covered service
    - Services are not to be used routinely with implanting conventional IOLs

**Femtosecond Revisited**

- Refractive imaging component of FS laser performed on premium AC-IOL and PC-IOL cataract patients before surgery has begun is a non-covered service
  - Can bill premium IOL patients for OCT imaging
  - Fee usually included in premium IOL charge
  - Cannot charge fee for Femtosecond laser used intraoperatively (during surgery) such as:
    - Phaco incision, capsulotomy, lens fragmentation

**Femtosecond Revisited**

- Billing patient for FS laser OCT imaging performed on conventional IOL patients
  - CMS expects FS laser on these patients to be rare
    - Even if not charged
  - Will negate argument that only premium IOL patients need this special imaging
  - LRI/CRI performed with FS laser at same time as conventional IOL surgery
    - Still billable to patient separately
      - When performed on premium IOL patients fee usually included in premium IOL charge

**Medically Unlikely Edits**

- Medically Unlikely Edit (MUE)
  - This is a unit of service claim edit applied to Medicare claims against a procedure code rendered by one provider to one patient on the same day
  - Why did CMS develop MUEs?
    - To reduce the paid claims error rate for Part B claims
      - Implemented January 1, 2007
Medically Unlikely Edits

- How MUEs affect billing
  - The edits are based on:
    • Anatomic considerations (-LT or -RT)
    • HCPCS/CPT code descriptors
    • CPT instructions
    • CMS policies
    • Nature of service/procedure
    • Nature of equipment
    • Clinical judgment

- When procedures or services are performed on both eyes at the same session physicians should:
  • Append the -50 modifier on one line only
  • Bill “1” unit and increase your charge
  • Can no longer submit –RT or –LT modifiers to Medicare for bilateral surgeries
  • ASCs still required to bill bilateral services on two lines
  • Must use the -RT and -LT modifiers

New Patient Definition

- CMS previously edited new patient exams based solely on Tax ID # of practice
  - CMS now edits new patient exams by NPI number not just Tax ID #
    • Exam will be denied if provider saw that patient anywhere during the past 3 years regardless of where he/she worked

- If new physician joins practice and sees old patients in new practice
  • Cannot bill as a new patient exam
  - Patient sent to practice for test because referring doctor does not have equipment
    • No exam conducted - just I&R of test
    • If patient returns for exam within 3 years of the test, can bill as new patient since no exam or other face-to-face service was performed by the doctor

Place of Service

- Normally POS code reflects actual setting where beneficiary receives face-to-face service
  - There are a few exceptions:
    • Inpatient
      - If inpatient seen in your office must bill place of service as hospital (21), not office
    • Outpatient or Rehab Patient
      - If patient seen in your office must bill place of service as outpatient or rehab (22), not office

Co-Management
Legal Requirements

- In 2013, the Florida Legislature passed Chapter 2013-26, Laws of Florida to amend Florida’s Optometric Practice Act
  - The new law expressly relates to co-management practices and thus directly impacts ophthalmologists that “co-manage” surgical patients with optometrists

Source: FSO General Counsel

Legal Requirements

- The new law does not prohibit co-management. However, it does impose new requirements on optometrists and ophthalmologists who co-manage patients
  - Co-management must be conducted pursuant to a written “patient-specific” transfer of care agreement wherein the operating ophthalmologist (the surgeon) must evaluate and confirm that it is not “medically necessary” for the surgeon to provide post-operative care to the patient, and that it is “clinically appropriate” for the optometrist to provide such post-operative care

Source: FSO General Counsel

Legal Requirements

- The patient must be informed in writing that he or she has the right to be seen by the surgeon during the entire post-operative period
- The patient must be informed of the fees, if any, to be charged by the optometrist and the surgeon
- The patient must be fully informed of, and consent in writing to, the co-management relationship
- The new law also imposes billing transparency requirements for post-operative care provided in a co-managed setting

Source: FSO General Counsel

Legal Requirements

- It requires that the surgeon and the optometrist provide the patient “with an accurate and comprehensive itemized statement of the specific post-operative services that the physician performing the surgery and the licensed practitioner [the optometrist] render, along with the charge for each service”
  - See § 6, Ch. 2013-26 (emphasis added.)

Source: FSO General Counsel

Co-Management

- Per CMS, decision to co-manage can only be made between surgeon and patient
  - No pre-arranged date of transfer with co-manager
  - Co-manager cannot submit claim until he/she first sees the patient
  - Can bill from date patient was transferred even if patient not seen for 3 weeks

Source: FSO General Counsel

Co-Management

- Surgeon bills surgical code and -54 modifier (e.g., 66984-54)
- Co-manager bills surgical code and -55 modifier when transfer of care has occurred (e.g., 66984-55)
  - Date of service must be date of surgery
  - Item 19 must contain date care assumed and date care relinquished
Co-Management

Ophthalmologist performing surgery and portion of follow-up care

- Surgery performed on 02/02/15
  - Follow-up care provided through 02/12/15

<table>
<thead>
<tr>
<th>Item 19</th>
<th>24a (Dates of Service)</th>
<th>24d (Procedure/Mod)</th>
<th>24g (Units)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>02/02/15</td>
<td>66984-54LT</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>02/02/15</td>
<td>66984-55LT</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Some Medicare contractors require number of post-op days in 24G

---

Co-Management

Optometrist or other MD providing portion of follow-up care

- Surgery performed on 02/02/15
  - Follow-up care provided through 02/12/15 by surgeon

<table>
<thead>
<tr>
<th>Item 19</th>
<th>24a (Dates of Service)</th>
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<td>1</td>
</tr>
</tbody>
</table>

Note: Some Medicare contractors require number of post-op days in 24G

---

Co-Management

- Surgeon should forward a copy of patient’s signed transfer of care form indicating desire to be co-managed
  - Copy of form must be maintained in both the surgeon’s file and the co-manager’s file
    • This is mandated by CMS
  • Make sure you have a copy of this Transfer of Care form in your files

---

Co-Managing Premium IOLs

- OIG issued favorable advisory opinion
  - OD receiving additional fee from patient for non-covered, post-op care following premium IOL surgery does not violate Anti-Kickback statutes based on following rationale:
    • Requestor has no written or unwritten agreements to co-manage
    • Requestor informs patients if they return to OD for post-operative care, OD may charge additional fee

* OIG Advisory Opinion No. 11-14, September 30, 2011

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Co-Managing Premium IOLs

- The costs are not covered by Medicare
  - Requestor would only transfer patient back to optometrist upon the patient’s request

- Sharing premium IOL fees with referring doctors
  - Some states have strict fee-splitting laws prohibiting paying another doctor for services provided to your own patients

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Cataracts, YAGs, and Blepharoplasties
Lifestyle Impairment

- Besides having to meet medical necessity with a patient complaint and diagnostic tests, Cataracts, YAGs, and Blepharoplasties also require:
  - A lifestyle complaint explaining how the patient’s decreased vision is affecting their activities of daily living

Lifestyle Impairment

- Lifestyle impairments are required by Medicare to support the need for some surgeries
- This information should be obtained in some type of questionnaire
  - Can be completed by the technician or the patient

Lifestyle Impairment

- Ask questions such as:
  - Are you having difficulty watching TV, reading, with bright sunlight, etc.?
  - Do you drive? If yes, do you have difficulty at night with bright lights?
- Important
  - Functional impairment must be documented prior to each eye surgery

Lifestyle Impairment

- Second Eye Cataract Surgery
  - Must re-qualify second eye prior to surgery
  - Requirements
    - A continued complaint of distance, near or glare
    - Does not need new visual acuity
    - Complaint of anisometropia requires MR to document at least 2 diopter difference
    - If over 90 days since initial evaluation, must re-test for best corrected visual acuity according to complaint

Lifestyle Impairment

- YAG laser surgery
  - Can use a questionnaire similar to cataract questionnaire
  - In absence of a published LCD regarding lifestyle impairments
    - At least document a statement in the patient’s own words as to how the decreased vision is affecting the patient’s activities of daily living
      - e.g., TV is foggy, room seems darker

Lifestyle Impairment

- Blepharoplasty surgery
  - Chart should document:
    - Complaints of eyelids resting on eyelashes
    - Having to raise eyelids to see better
    - Restricted peripheral vision, etc.
    - Lifestyle impairment must be supported by visual fields and external photos
Eye Codes vs. E&M Codes

- Ophthalmology and Optometry still only specialty who has choice of using both sets of codes
- Eye codes require a lot less documentation
- Eye codes pay more

Documenting Exams

**Comprehensive Exam**

- **Eye Codes**
  - Ocular History, CC
  - 8-10 Exam elements
  - Dilation Performed
  - Treatment Program Initiated
    - Only need 1 Dx and 1 Mgmt option
    - Can be Rx for new glasses, dx test, recommend surgery, etc.

- **E&M Codes**
  - Complete History
    - Ext. HPI, Complete ROS & PFSH
  - All 13 Exam Elements
  - Dilation Performed
  - Medical Decision
    - Multiple DX/MO (5-6)
    - Moderate amount of data
    - Moderate to High Risk

**Intermediate Exam**

- **Eye Codes**
  - Brief Ocular History, CC
  - 3-7 Exam Elements
  - Dilation Not Required
  - No Initiation of Treatment Program Required
    - Only need 1 Dx

- **E&M Codes**
  - Expanded Problem Focused History
    - Brief HPI, Pertinent ROS
  - 6-8 Exam Elements
  - Dilation Not Required
  - Medical Decision
    - Limited DX/MO (3-4)
    - Limited amount of data to be reviewed
    - Low Risk - requires minimal treatment plan

Physician Fee Schedule

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>92004 - Comp, New patient</td>
<td>$149</td>
</tr>
<tr>
<td>92012 - Intern, Est. Patient</td>
<td>$ 86</td>
</tr>
<tr>
<td>92014 - Comp, Est. Patient</td>
<td>$124</td>
</tr>
<tr>
<td>99203 - Detailed, New Patient</td>
<td>$110</td>
</tr>
<tr>
<td>99213 - Exp. Prob, Focused, Est. Patient</td>
<td>$73</td>
</tr>
<tr>
<td>99214 - Detailed, Est. Patient</td>
<td>$109</td>
</tr>
<tr>
<td>99215 – Comp, Est. Patient</td>
<td>$147</td>
</tr>
<tr>
<td>*92014 est. pt. still pays more than 99214 est. pt. exam</td>
<td></td>
</tr>
<tr>
<td>99204 - Comp, New Patient</td>
<td>$167</td>
</tr>
<tr>
<td>99205 - Comp, New Patient</td>
<td>$210</td>
</tr>
</tbody>
</table>

*National Fee Schedule Payment Effective July 1, 2015

Eye Codes vs. E&M Codes

- To bill an eye code most Medicare contractors expect to see performance of at least:
  - Slit lamp exam, and
  - Fundus exam (dilated or not)
  - If not performed, bill E/M code
- Comprehensive eye exam requires dilation and initiation of diagnostic or therapeutic treatment program
Eye Codes vs. E&M Codes

- Remember …… coverage of eye exam based on the purpose of exam, not on findings
- Without complaint, exam not covered even though doctor finds pathological condition
  - Must always ask: Why is the patient here today?
    - Found in Chief Complaint or Plan of previous visit
      - Can be new complaint/symptom or previously diagnosed condition

Highly Audited Modifiers

Misuse can cause denials in a post-payment audit

Modifier -24

- Unrelated service during post-op period
  - In other words, office visit is not related to:
    - Underlying condition for which surgery was performed, or
    - Surgical episode itself such as complications
  - Before appending modifier -24 should always ask:
    - Would patient have needed exam if the surgery had not been performed
      - If answer is yes, then modifier -24 is appropriate

Modifier -25

- Significant, separately identifiable service by same physician on day of minor procedure
  - Exam is not just incidental to surgery
    - Modifier -25 indicates office visit is above and beyond usual pre- and post-operative care associated with minor procedure
  - Should be appended to office visit not minor procedure code or diagnostic test
**Modifier -25**

- Cannot be used as decision for surgery like modifier -57
  - *Most common misconception among doctors*
- Exam must be substantial, distinct and unique and able to stand alone
  - *Take the exam for the minor surgery or injection out of the mix for a minute*
  - *Do you have anything left?*
    - If yes, append the -25 modifier
    - If no, office visit should not be billed

**Example:**

- Patient presents with complaint of pain and foreign body sensation after being hit in eye with tree limb
- Complete exam performed to determine extent of injury and cause of pain – FB removed
- Modifier -25 is appropriate
  - *If only slit lamp performed and foreign body removed without complete eye exam, office visit not billable*

- When considering whether or not to use modifier -25 first consider this:
  - Take the exam for the minor surgery out of the mix for a minute
    - *Do you have anything left in the chart?*
    - *If no, then do not append the -25 modifier*
      - Exam is considered incidental

**Modifier -57**

- *Initial evaluation to determine need for major surgery*
  - 90 day global fee period
- Use if decision is made *day before or day of* major surgery
  - Not to be used for re-examination of patient after surgical decision has been made

**Diagnostic Tests**

What’s required for billing
Diagnostic Tests

- Diagnostic tests have special circumstances in order to be billed
  - Chart must be clear as to who ordered the test and who performed the service
  - The ordering physician must be the treating physician and responsible for the patient’s care

- Medical necessity must be clearly noted or evident in the patient chart
- All special diagnostic tests are billable with eye examinations both E&M and “92” codes
- Most ophthalmic diagnostic tests require an interpretation and report

Interpretation & Report

- Increasing lack of compliance with Interpretation & Report requirements
  - Seems to be a particular problem in EHR systems
  - An “interpretation and report” should address the findings, relevant clinical issues, and comparative data (when available)
    - Source: Medicare Claims Processing Manual, 100-4, 13-§100

- At minimum MD should address:
  - What was seen or not seen but anticipated
    - Glaucoma
  - What findings suggest as to status of illness
    - Stable, worsening, improving
  - What impact the test results have on treatment
    - Continue present meds, surgery as indicated, see Plan, etc.
  - Physician must sign and date I&R

Test Results

- All test results must be readily available
  - In some instances, photos and results of tests may not be in the paper chart or the EMR
    - Sometimes stored digitally
  - The medical record must document the location of the diagnostic test in this case
    - Disc C, dated 4/1/13, etc., or
    - Notation as to where test result can be found

Diagnostic Tests

- Refractions
  - Code 92015 considered non-covered and excluded from the Medicare program
  - Refraction does not require medical necessity waiver
  - Medicare WILL NOT reduce your payment for exam if you do not bill a refraction
Diagnostic Tests

Refractions for the purpose of prescribing lenses
  • Are usually billed to the patient

Refractions for the purpose of determining patient’s best corrected visual acuity prior to surgery or as a surgical follow-up
  • Are generally not billed to the patient

Diagnostic Tests

Most diagnostic tests are bilateral (includes both eyes)

Some tests are unilateral and can be billed “per eye”
  • 76512 – Contact B-scan
  • 92225 – Extended ophthalmoscopy, initial
  • 92226 – Extended ophthalmoscopy, subsequent

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  • 92226 – Extended ophthalmoscopy, subsequent

Diagnostic Test Results

• Diagnosis Coding
  – If diagnosis confirmed based on test results
    • Code that diagnosis
  – If no definitive diagnosis or test was normal
    • Code sign(s) or symptom(s) that prompted the test
    • This is big change
      • Previously permitted to use suspected diagnosis

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Problematic Diagnostic Tests

These tests require special attention
Diagnostic Tests

• **A-Scan-76519 & IOLMaster-92136**
  - Submit code 76519 or 92136 (no modifiers) prior to first eye
    - Will permit payment of the technical component for both eyes and one IOL calculation
  - Prior to the second eye surgery, submit code 76519-26 or 92136-26 to receive payment for the second IOL calculation
    - Surgeon should date and initial test strip if 2nd IOL calculation performed on different date

• **Extended Ophthalmoscopy**
  - Limited to posterior segment disease or conditions
    - Includes glaucoma when dictated by complaints or correlative findings
  - Requires separate, detailed sketch, minimal size of 3-4 inches
  - All items noted must be identified and labeled
  - Color (4-6 standard colors) is preferred
    - Non-colored drawings also
  - Drawing must be anatomically correct
    - Abnormal findings must be labeled

• **Serial Tonometry** – code 92100
  - Tonometry is the measurement of intraocular pressure
  - Is considered part of the ophthalmic examination unless done in a series
    - At least three separate “timed” pressure readings must be noted
  - Use extreme caution – highly visible for audit

• **Gonioscopy** – Code 92020 – Separate Procedure
  - Billable to Medicare with visual fields or other tests even though it’s a “separate procedure"
    - Not billable on same day as external photos, code 92285, if photos performed through gonio lens
  - Not billable for diagnosis of cataract only
    - Must report glaucoma, narrow angles, cupping of optic disc, etc., as primary diagnosis
    - Cataract as secondary diagnosis

• **Bundled with ALT/SLT if performed at same session**
  - Gonio performed in office and ALT performed in ASC later that same day
  - Can append -XE modifier to gonioscopy as it was performed at a separate encounter
  - When performed merely as screening, billable only to patient
  - 3rd most frequently billed diagnostic test
    - Watch frequency to avoid audit
Audit Contractor Issues

Recovery Auditor (RA)

• In 2014 RAs started auditing physician blepharoplasties on a pre-pay basis
  – Still ongoing in 2015
  – What can you do to prevent future scrutiny?
    • A lot of MACs updated their Blepharoplasty LCD
    • Review LCD – some removed the visual field requirement for medical necessity
      – If dates of service audited were “after” the LCD revision, then appeal the denials

ZPIC

• Zone Program Integrity Contractor (ZPIC)
  – When RA or other contract auditor detects repeated offenses, may turn issue over to ZPIC as potential fraud
    • Repeated upcoding of office visits when unsupported by chart data
    • Frequent use of modifiers -24 and -25 when chart documentation does not support separate payment of exam
    • Overbilling drugs and DME supplies

ZPIC

• ZPICs can:
  – Request medical records for review
  – Interview physicians and staff
  – Visit office for on-site inspection of charts
  – Institute pre-payment audits and/or automatic denial edits for some or all claims
  – Suspend payments
  – Bring in law enforcement including OIG and DOJ

ZPIC

• Potential consequences of a ZPIC audit
  – Provider education
  – Overpayments and refunds requests
  – Referral to law enforcement entities for civil litigation and/or criminal prosecution
    • ZPIC audits should not be taken lightly
    • It is not a random audit, it is focused
  – If you get a ZPIC audit contact your attorney

Compliance

• As with any contractor audit
  – Audit billing practices regularly
    • Both internal and external audits
  – Make sure Medicare billing policies are followed
    • Review Medicare LCDs on a regular basis
  – Modify habits to be in compliance
    • Develop internal policies if needed
  – Follow single dose vial package instructions
Q&A Then Lunch

ICD-10 Update

ICD-10 Implementation

• October 1, 2015
  • New target go live date for ICD-10
• Don’t be caught off guard you only have a few months left
  • Understanding the ICD-10 differences and training needs are critical
• Having a good transition plan is critical
  • Will make your job much easier

Why The Change?

• ICD-9 is outdated and obsolete
  – Need to move away from 30 year-old code set
    • Inaccurate data
    • Outgrown level of specificity
    • Technology and medicine has changed
  – Many ICD-9 codes no longer accurately describe diagnoses they are assigned to represent

Why the Change?

• Very few unassigned codes left in ICD-9
  – ICD-10 has much greater specificity
    • Getting away from need to use unspecified codes
• Will better substantiate medical necessity
  • Will require more (or improved) chart documentation in some areas
  • Has more specific diagnosis codes

Why the Change?

• ICD-10 far exceeds ICD-9 by number of diagnosis codes and concepts
  – 69,000 codes in ICD-10 compared to 14,000 in ICD-9
• Additional 6th and 7th digits to identify greater specificity will now be required
  • Some were optional in ICD-9
Why the Change?

• According to CMS ICD-10 will provide better information for:
  – Measuring care
    • Improved disease management
  – Processing claims
    • Better and more accurate payment
    • Fewer rejections and denials
  – Tracking public health
  – Identifying fraud and abuse issues

Who Must Convert

• With few exceptions, all providers covered by HIPAA must convert
  – Includes providers other than Medicare and Medicaid
  – Exceptions
    • Workers’ Compensation
    • Auto Insurance
    • Home owners’ insurance
    • Business owner liability

ICD-10 Differences

<table>
<thead>
<tr>
<th>Differences</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 - 5 Characters</td>
<td>3 - 7 Characters</td>
<td></td>
</tr>
<tr>
<td>All Characters are Numeric</td>
<td>No laterality</td>
<td>Character 1 is alpha (A-Z, not case sensitive) Character 2 is numeric Characters 3-7 are alpha or numeric Laterality</td>
</tr>
<tr>
<td>Supplemental chapters</td>
<td>Incorporated into code set</td>
<td></td>
</tr>
</tbody>
</table>

ICD-10 Differences

• Specificity and detail have been greatly expanded in ICD-10
  – Expanded codes
    • Injuries
    • Diabetes
    • Glaucoma
    • Post-operative complications
    • Alcohol/substance abuse
  – Includes more combination codes

ICD-10 Differences

• Laterality plays a big part in ICD-10
  – Assessment must be specific to each eye:
    • 1 – Right eye
    • 2 – Left eye
    • 3 – Bilateral
    • 9 – Unspecified eye

ICD-10 Differences

• When coding injuries and traumas
  – Will need to review requirement for 7th character under each subheading
    • S00 - Superficial injury of head
      – Includes injuries to eyelids
    • S02 - Fracture of skull and facial bones
      – Includes injuries to orbital floor
    • S04 - Injury of cranial nerve
      – Includes injuries to optic nerve
    • S05 - Injury of eye and orbit
      • Etc.
ICD-10 - Differences

- Specificity is more important than ever
  - Impression must be as specific as it can be for a particular complaint or condition
  - Particularly important for injuries
- Manifestation is critical where applicable
  - Must list disease and manifestation

Manual Organization

- Pay particular attention to the ICD-10 manual
  - Introduction
    - History and future of ICD-10
    - Instructions on How to Use ICD-10
    - Official Conventions
      - Format
      - Punctuation
      - Abbreviations
      - General Notes

Manual Organization

- Official Coding & Reporting Guidelines
- Illustrations – including eye
  - May help new coders
- Alphabetic Index to Diseases and Injuries
  - Assists in identifying where codes are located in Tabular list
- Neoplasm Table

Manual Organization

- Table of Drugs and Chemicals
- Index to External Causes
- Tabular List of Diseases and Injuries
  - Listing of actual diagnosis ICD-10 diagnosis codes
  - This will explain a lot about how the ICD-10 codes are used

Conventions & Terms

- Introduction of ICD-10 Manual will also provide essential terms used in selecting codes
  - “see,” “see also,” and “see category”
  - “omit code” notes
  - “due to” subterms
  - “includes” notes
  - “excludes” notes
  - “use additional code” and “code first underlying disease” instructions

Conventions & Terms

- “code also”
- Placeholder “X”
- “code by site”
- Seventh-character extension requirements
- Age and sex symbols
  - Includes other instructions on:
    - Punctuations
    - Abbreviations
    - NOS (Not Otherwise Specified) phrase
    - Importance of typeface and italics
Conventions & Terms

- Default codes
- Syndromes
- Explanation of the word “and” which may be interpreted and meaning “and/or”
- With/Without
  - Default is always “without”
- Instructional notes used in tabular list
  - Code First/use additional code
  - Code Also

Documentation

- ICD-10 will require more (and improved) chart documentation
  - Has more unique, precise diagnosis codes
  - Substantiates medical necessity
  - ICD-10 will impact how you do your job
    - How you deal with patients
      - More questions specific to patient’s complaint or condition
    - How you interact with physicians and billers
    - Documentation will require more specificity

Documentation

- ICD-10 has greater specificity regarding type and cause of eye disorders
  - Must be documented in the medical record
    - Example: Cataract complicated
      - With neovascularization
      - With ocular disorder
    - Requires thorough documentation in chart
      - Still need to document upper or lower eyelid and laterality (OD, OS, OU)

Documentation

- Also remember:
  - Exam may be bilateral
  - Test or surgery may be bilateral or unilateral
  - It will be important to document each visit (procedure) accordingly so coder will know how to report diagnosis code for payment
  - Technicians will need to pay closer attention to this as well

Documentation

- Make sure documentation reflects what happens at “today’s” visit
  - Permits coders to code principal diagnosis
    - Can list conditions that coexist and affect patient care that day
      - Do not document (or bring forward from EMR) conditions previously treated or that no longer exist
    - Can document signs or symptoms
  - Do not document probable, suspected, rule-out or questionable

Documentation

- Documentation becomes more critical with trauma or injuries
- May need to ask more questions specific to the patient’s complaint
  - External cause
    - Provide cause of injury
      - How did injury happen?
      - Was injury related to military, work, other?
Documentation

- **Place of Occurrence**
  - Where was patient when it happened?
    - Home, work, car, boat, etc.?

- **Activity**
  - What was patient doing at time of injury?
    - Playing a sport, using a tool, cooking?

Preparing for ICD-10

- Identify how ICD-10 will affect your practice
  - Arm yourself with information for smooth transition
    - Review differences in ICD-9 and ICD-10 with staff
    - Understand how differences will impact your practice
    - How they will impact ASC and Optical if applicable
    - Think about how to budget for implementation
  - This needs to be a team effort

Preparing for ICD-10

- Take a cursory look at ICD-10 coding manual
  - **Introduction and General Conventions**
  - Even if you aren’t a coder, you will be surprised what you will learn
    - Make this mandatory for your coders
  - Review Chapter 7: Diseases of Eye and Adnexa
    - Diagnosis codes H00-H59
    - A little knowledge will go a long way with all staff

Preparing for ICD-10

- Determine your top 80% of ICD-9 codes and devise ICD-10 crosswalk
  - Share with doctors, technicians, coders and billers
  - Will give them a chance to become familiar with the differences in the codes
  - Consider investing other tools to help with coding if not on EMR

Preparing for ICD-10

- Review all documents involving a diagnosis code, disease management, tracking or appeals process
  - Will need to add ICD-10 codes on existing forms
    - Most MACs now have LCDs with ICD-10 codes on their websites
  - Make checklist of everything you need to do to prepare for ICD-10
    - Checklist will be your best tool

ICD-10 Checklist

- Review ICD-10 Resources
  - CMS
  - Specialty Societies
  - Payers
  - Vendors
- Inform staff (particularly physicians) of upcoming changes
  - Need to do ASAP

Source: CMS - ICD-10 Implementation Guide
ICD-10 Checklist

- Reach out to software vendor
  - Will they offer any training?
  - Will they allow you to use both ICD-9 and ICD-10 simultaneously?
  - Will vendor be able to upload ICD-10 codes for you?
  - What type of assistance will they offer if you encounter problems during implementation of ICD-10?

Source: CMS - ICD-10 Implementation Guide

ICD-10 Checklist

- Touch base with clearinghouse
  - Have they completed upgrades to comply with ICD-10?
  - Are they making any additional changes to their software you need to know about?
  - Will they offer any assistance during transition?
  - Will they have ample staff on hand to assist you during the transition?

Source: CMS - ICD-10 Implementation Guide

ICD-10 Checklist

- Improve chart documentation
  - May be your most challenging task
  - Begin by pulling charts from your 10 most frequently billed CPT codes
  - Review the documentation against the ICD-10 codes
  - Determine what needs to be changed to meet requirements if ICD-10 diagnosis code
  - Go over findings with staff

Source: CMS - ICD-10 Implementation Guide

ICD-10 Checklist

- Set aside cash reserves
  - Hiring extra staff to work denials, etc.
- Establish bigger line of credit at bank
- Should have a 3-4 month reserve to allow time for billing issues to get corrected and claims to be refiled

ICD-10 Checklist

- Schedule ICD-10 Training NOW
  - Identify who needs training and what type of training
    - Documentation only
    - Documentation and coding
    - Coding only
  - When and how should they be trained
    - Online, face-to-face, seminars and lectures
    - Include doctors, nurses, technicians, coders and billers

Source: CMS - ICD-10 Implementation Guide

- Prepare for contingencies
  - Decreased staff productivity
  - Clearinghouse not being able to resolve ICD-10 issues
  - Health plans not prepared to accept ICD-10
  - Rejected or pending claims
  - Staff turnover
    - Some people are just not willing to make changes and this is a big one
ICD-10 Checklist

- Identify solutions not problems
  - Appoint someone ahead of time to handle denials on a daily basis
  - Communicate with physicians regularly
  - Don’t assign blame during the transition
    - If the physician’s documentation that is lacking, let him/her know what needs to be done in order to get the service billed
    - Best done in a meeting, not in the hallway outside a patient lane

Coding Scenarios

- Coding Scenario
  - 67 year-old male presents to office for ongoing care of glaucoma
    - Diagnosed two years ago with angle-closure glaucoma bilaterally
      - Eye pressure was initially difficult to control
      - Left eye progressed fairly rapidly to moderate stage glaucoma
      - Stage in right eye was difficult to determine, but both eyes appeared stable at exam 6 months ago

- Coding Scenario
  - Upon examination his visual field is unchanged in both eyes
    - Only minimal visual loss in outer periphery of right eye but arcuate in left eye
    - Visual acuity unchanged in right eye but slightly improved in left eye
    - States doing fine with current glasses
    - Testing confirms disease is stable at this time
    - Patient anxious about surgery as long as medications are working and prefers no treatment at this time
    - Told to return in 6 months, sooner if symptoms worsen

- Coding Scenario
  - Alphabetic Index:
    - Glaucoma ➔ angle closure ➔ chronic ➔ H40.22-
  - Tabular List:
    - ✓ H40.222 Chronic angle-closure glaucoma, left eye
      - “2” as 6th character indicates left eye
    - H40.2222 ➔ Chronic angle-closure glaucoma, left eye, moderate stage
      - “2” as 7th character indicates moderate glaucoma stage
  - Correct code sequence:
    - ✓ x7th H40.221 ➔ Chronic angle-closure glaucoma, right eye
      - “1” as 6th character indicates right eye
    - H40.2214 - Chronic angle-closure glaucoma, right eye, indeterminate stage
      - “4” as 7th character indicates indeterminate glaucoma stage
    - H40.222 (Chronic angle-closure glaucoma, left eye, moderate stage) plus
    - H40.2214 (Chronic angle-closure glaucoma, right eye, indeterminate stage)
Coding Scenario

• 45 year-old male presents to clinic concerned about excessive tearing and patchy white growths in both eyes and occasional blurred vision in left eye
  • Patient teaches PE at local high school and is avid outdoorsman
  • Snowboards in winter, plays golf 9 months out of year, enjoys water sports on local lake in summer
  • Always wears sunglasses and/or hat outside

Coding Scenario

• Upon examination visual acuity is 20/20 near and far
  – Mild redness of conjunctiva in both eyes with no evidence of blepharitis
    • Slit lamp confirms bilateral nasal pterygia with encroachment on both corneas, left greater than right with
    • Typical of amyloid pterygium

Coding Scenario

• Lesion documented, corneal topography and photography performed to document size and shape
  – Distortion of cornea noted
  – Patient counseled these are usually benign growths
    • Would be wise to remove lesion on left because it is starting to affect his vision
  – Patient in agreement and referred for surgical counseling

Coding Scenario

• A patient who had cataract surgery on the right eye two days ago now experiencing pain in right eye
  • Following a slit lamp exam of affected eye, physician discovered lens fragments in right eye
    – Returned patient to OR to remove fragments
• Alphabetic Index:
  • Pterygium (eye) ➔ amyloid ➔ H11.01-
• Tabular List:
  • H11.01 Amyloid pterygium
  • H11.013 Amyloid pterygium of eye, bilateral
    – “3” is to indicate bilateral pterygia
• Correct code sequence:
  • H11.013, Amyloid pterygium of eye, bilateral

Coding Scenario

• Tabular List:
  • H59.021 - Cataract (lens) fragments in eye following cataract surgery, right eye
  • Correct Code Sequence:
    • H59.021
    • H57.11 – Ocular Pain
      – Chapter 7 (Eye and Adnexa) includes instructional note to use external cause code following code for eye condition, if applicable, to identify cause of eye condition
82 year-old female presents with caregiver for continued monitoring of eye disease

- Appears at ease and in control of her surroundings
  - Previously treated for senile degenerative choroidal atrophy, and retinal neovascularization in both eyes
  - Visual field defect shows significant central loss in both eyes but has fairly wide peripheral fields bilaterally

Previously treated with Avastin injections for retinal neovascularization

- Fluorescein angiography shows dye leakage from retinal neovascularization but disease appears stable
- Told to return in 3 months for recheck

Alphabetic Index:

- Atrophy ➔ choroid ➔ senile – H31.11

Tabular List:

- 6th H31.11 – Age-related choroidal atrophy

Correct code sequence:

- H31.113 – Age-related choroidal atrophy, bilateral
  - 6th digit required
- H35.053 – Retinal neovascularization, unspecified bilateral
  - Use as secondary diagnosis not inherent part of the disease process for age-related choroidal atrophy
  - No 7th digit required

69 year-old female on vacation with her girlfriends

- Group decides to take streetcar tour of city
- Trolley collides with horse-drawn carriage in downtown tourist area
  - Patient struck head on side of streetcar injuring right eye
  - Presented to office next morning with pain in right eye and a slight decrease in vision

On exam, there is bruising of the right eye but no other apparent signs of trauma

- No symptoms of diplopia, flashes, floaters, or visual field loss
- Visual acuity is 20/20 and 20/50 corrected in the right and left eyes, respectively
- Extraocular movements and confrontational visual fields are normal
- Other aspects of exam within normal limits
- Patient told to return in 3-5 days for re-check

Alphabetic index:

- Injury ➔ eyeball ➔ contusion – S05.1

Tabular list:

- √7th S05.1XA – Contusion of eyeball and orbital tissues, right eye
  - No 6th digit available
  - "X" place holder must fill empty space
  - "A" is 7th digit required to indicate initial encounter
- Note: Must also use secondary code to indicate cause of injury
Coding Scenario

• Correct Code Sequence:
  • S05.11XA – Contusion of eyeball and orbital tissues, right eye
  • ✓7th V82.8XXA – Occupant of streetcar (e.g., trolley) injured in other specified transport accident
    – “No 5th & 6th digits available
    – “X” place holder must fill empty spaces
    – “A” is 7th character to identify “initial” encounter

• 67 year-old male jet skiing at area lake
  – Was driving recklessly and fell off jet ski
    • Hit in left eye with handle bar before entering water
  – Admits to drinking too many beers before getting on jet ski
    • Presented to office next day with complaint of eye swelling when he blows his nose
    • Diagnosed with orbital floor fracture

Coding Scenario

• Alphabetic index:
  • Fracture, traumatic ➔ orbit ➔ floor (blow out) – S02.3

• Tabular list:
  • S02.3 – Fracture of orbital floor (notice no laterality)

• Correct code sequence:
  • ✓7th S02.3XXA – Fracture of orbital floor
    – No 5th & 6th digits available
    – “X” place holder must fill empty spaces
    – “A” is 7th digit for initial encounter for closed fracture

• V93.33XA – Fall on board jet ski
  – “X” is place holder since no 6th character available and diagnosis requires 7 digits
  – “A” is for initial encounter [for injury]

• Note: Injury requires secondary code for external cause of accident

Coding Scenario

• Examples of crazy diagnosis codes related to injuries
  • Bitten, struck, or crushed by a crocodile
  • Struck in eye by shark
  • Toxic effect of contact with venomous frog, assault, initial encounter
  • Forced landing of spacecraft injuring occupant, initial encounter

TRAINING
Training

- ICD-10 training should begin NOW!
  - Look for ophthalmology specific training
  - After training:
    - Create sample charts for testing throughout the next few months
    - Retrain coding staff that don’t appear to be grasping new ICD-10 codes
      - Or doctors/technicians who aren’t improving documentation
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Training

- Types of training available
  - Regional seminars
  - Web based courses
  - On-Site training for entire staff
    - Book in advance – classes will fill up fast

Training

- Physicians/nurses/technicians should get training at same time
  - Helps ensure they will be on board with same information
- Documentation for some conditions will need to improve
  - Physician input may be key to proper documentation
    - This will be coder’s biggest task

Training

- May want non-certified staff to take refresher on-line anatomy course
  - Eye anatomy becomes important in ICD-10
    - Knowing anatomy not required in ICD-9
  - Understanding the differences between ICD-9 and ICD-10 will also be key
    - And the impact it will have on the practice

Implementation

- It’s October 1, 2015
  - Now What?
    - Must be able to run both ICD-9 and ICD-10 simultaneously until all previous services/appeals have been cleared
      - ICD-9 codes will be used for dates of service prior to October 1, 2015, but billed after October 1
      - For now, only ICD-10 codes will be reported for services performed on or after October 1, 2015
Implementation

• Monitor coding and billing daily
  – Work all denials immediately (or at least daily)
• If documentation is the problem, work with staff to correct issues
  – May require one-on-one training
    • Designate a staff person to handle the extra training if needed

Implementation

• Anticipate problems!
  – Possible delays in payment from carriers until everyone is fully trained
  – Inaccurate coding, reporting, and processing increasing delays in payment
    • Denials, and/or rejections
• Biggest obstacle to overcome may be resistance to change
  • May have some staff turnover during transition

Resources

• CMS
  – www.cms.gov/ICD10
    • Latest News
    • Access to ICD-10 GEMS
    • Payer Resources
    • Provider Resources
    • Implementation Timelines
    • Sign up for Email Updates
    • Listing of Teleconferences

Resources

– Free Apps you can download to Smart Phones or Tablets to assist in coding ICD-10
  • ICD-10 Search (The Coding Institute)
    – My personal favorite
    • Find-A-Code

Questions