CODING COURSE SYLLABUS

June 28, 2013
The Breakers | Palm Beach, Florida

www.ophmasters.com

Sponsored by the Florida Society of Ophthalmology
Friday, June 28

7:00‒8:00 AM  REGISTRATION AND BREAKFAST
South Ballroom Foyer

8:00‒10:00 AM  Medicare Update
• Physician Fee Schedule Changes
• ASC Fee Schedule Changes
• CPT and ICD-9 Changes

QUESTIONS & ANSWERS

10:00‒10:15 AM  BREAK
West Ballroom Foyer

10:15 AM –12:00 PM  OIG Work Plan Update
• Issues affecting Ophthalmology - New and Ongoing

Issues Requiring Special Attention
• Modifiers
• Surgeries
• E&M vs. Eye Codes
• Co-Management

QUESTIONS & ANSWERS

12:00‒1:00 PM  LUNCH
Gold Room

1:00‒2:30 PM  ICD-10 Update
• Implementation and Training
• Coding scenarios

Medicare Audit Contractor Concerns

CMS Onsite Audits
• Clinic
• Optical

Compliance Issues

QUESTIONS & ANSWERS

2:30 PM  ADJOURN
TARGET AUDIENCE
This program has been designed for physicians, coders, technicians and administrators with a basic understanding of CPT and ICD-9.

LEARNING OBJECTIVES
Upon completion of the educational activity, participants should be able to:
- Appropriately select the level of Evaluation and Management or Eye code
- Describe updates to the OIG work plan that affect ophthalmology
- Implement the CPT and ICD-9 updates into the practice
- Discuss Medicare Audit Contractor concerns
- Identify practical application techniques to appropriately code for proper reimbursement in all specialties within ophthalmology

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

Physicians
This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of AKH Inc. and the Florida Society of Ophthalmology. AKH Inc. is accredited by the ACCME to provide continuing medical education for physicians. AKH Inc. designates this live for a maximum of 5.25 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Physician Assistants
NCCPA accepts AMA PRA Category 1 Credit™ from organizations accredited by ACCME.

Nursing
AKH Inc. is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s COA.
AKH Inc. designates this educational activity for 5.25 contact hours. Accreditation applies solely to educational activities and does not imply approval or endorsement of any commercial product by the ANCC-COA.

FL Nursing
AKH Inc. is an approved provider for nursing continuing education by the Florida Board of Nursing #50-2560. AKH Inc. designates this educational activity for 5.2 contact hour (.52 CEU).

Criteria for Success
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. If you have questions about this CME/CE activity, please contact AKH Inc. at akhcustomerservice@akhealthcare.com.

Commercial Support
No commercial support was received for this course.
Ann Rose, owner and president of Rose & Associates, is a Medicare reimbursement and compliance consultant who has been associated with the health care industry for 30+ years. Rose & Associates specializes in Medicare coding, billing, documentation, and training for physician practices with medical record auditing being their main focus.

Ann’s professional experience began as a member of the Medicare acquisition team at Blue Cross and Blue Shield of Texas shortly after they were awarded the Medicare contract in 1966. She was instrumental in helping develop the HCFA 1500 claim form (now known as the CMS-1500 claim form) and served as a team member in developing the paperless claims processing system known today as electronic billing.

For the past 30 years Ann has been devoted to assisting ophthalmologists with coding and reimbursement issues for maintaining compliance with government regulations. She is a member of the American Society of Ophthalmic Administrators (ASOA), the Medical Group Management Association, the American Academy of Ophthalmic Executives (AAOE), 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 and serves on the editorial board of the reimbursement section of Ocular Surgery News.
DISCLOSURE DECLARATION
It is the policy of AKH Inc. to ensure independence, balance, objectivity, scientific rigor, and integrity in all of its continuing education activities. The faculty must disclose to the participants any significant relationships with commercial interests whose products or devices may be mentioned in the activity or with the commercial supporter of this continuing education activity. Identified conflicts of interest are resolved by AKH prior to accreditation of the activity and may include any of or combination of the following: attestation to non-commercial content; notification of independent and certified CME/CE expectations; referral to National Faculty Initiative training; restriction of topic area or content; restriction to discussion of science only; amendment of content to eliminate discussion of device or technique; use of other faculty for discussion of recommendations; independent review against criteria ensuring evidence support recommendation; moderator review; and peer review. AKH/FSO planners and reviewers have no relevant financial relationships to disclose.

DISCLOSURE OF UNLABELED USE AND INVESTIGATIONAL PRODUCT
This educational activity may include discussion of uses of agents that are investigational and/or unapproved by the FDA. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, and warnings.

DISCLAIMER
This course is designed solely to provide the healthcare professional with information to assist in his/her practice and professional development and is not to be considered a diagnostic tool to replace professional advice or treatment. The course serves as a general guide to the healthcare professional, and therefore, cannot be considered as giving legal, nursing, medical, or other professional advice in specific cases. AKH Inc. specifically disclaims responsibility for any adverse consequences resulting directly or indirectly from information in the course, for undetected error, or through participant's misunderstanding of the content.

<table>
<thead>
<tr>
<th>FACULTY DISCLOSURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
</tr>
<tr>
<td>E. Ann Rose</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLANNER DISCLOSURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>AKH &amp; FSO Staff/Planners</td>
</tr>
</tbody>
</table>

*Compensation Range per Company

<table>
<thead>
<tr>
<th>1= $0-$1,000</th>
<th>2= $1,001-$10,000</th>
<th>3= $10,001-$50,000</th>
<th>4= ≥$50,001</th>
</tr>
</thead>
</table>
Medicare Coding Update 2013

Masters in Ophthalmology 2013 Coding Program Palm Beach, Florida June 28, 2013

Presented by: E. Ann Rose

Financial Interest

E. Ann Rose is President of Rose & Associates and also provides consulting services for:
- Alcon Surgical, Inc.
- Heidelberg Engineering

Physician Fee Schedule

• 2013 Physician Fee Schedule Final Rule
  – Called for 26.5% reduction in physician fees
• At 11th hour, Congress approved legislation halting fee cuts through 12/31/13
  – SGR remains flawed and ASCRS still fighting to get payment mechanism changed
  • U.S. House of Representatives expected to vote on proposal for permanent fix by August
Physician Fee Schedule

- Medicare Sequestration (spending) cuts
  - 2% cut to Medicare physician payments effective April 1, 2013
  - Also applies to ASC, DME and Incentive bonus payments
- Cuts scheduled to last through 2021
  - Co-pays should be collected on actual 2013 fee schedule allowable, not the 98% payment
- 1.000 GPCI floor extended through 2013
  - Good news for physicians practicing in areas with normally low GCPIs

Physician Fee Schedule

- Some fees increased due to RVU changes
- Some fees decreased.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>66982</td>
<td>Complex Cataract w/IOL</td>
<td>-21%</td>
</tr>
<tr>
<td>66984</td>
<td>Cataract w/IOL</td>
<td>+13%</td>
</tr>
<tr>
<td>67028</td>
<td>Intravitreal Injection</td>
<td>+9%</td>
</tr>
<tr>
<td>92235</td>
<td>Fluorescein Angiography</td>
<td>+6%</td>
</tr>
<tr>
<td>92286</td>
<td>Endothelial Cell Counts</td>
<td>-69%</td>
</tr>
</tbody>
</table>

Physician Fee Schedule

- Survey conducted jointly by ASCRS and ASOA found time to perform cataract surgery has dropped 30% in past 8 years
  - Also fewer post-op visits performed
  - Cataract cuts would have been greater without survey
- Final conversion factor for 2013
  - $34.0230
    - Included budget neutrality reduction
    - 2012 CF was $34.0376
## Physician Fee Schedule

### National Fee Schedule Payment Amounts

**Through December 31, 2013**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>66170</td>
<td>$1,178.72</td>
<td>$1,238.44</td>
</tr>
<tr>
<td>68821</td>
<td>$306.08</td>
<td>$344.99</td>
</tr>
<tr>
<td>66982</td>
<td>$1,054.48</td>
<td>$828.46</td>
</tr>
<tr>
<td>66844</td>
<td>$760.74</td>
<td>$667.87</td>
</tr>
<tr>
<td>67028</td>
<td>$115.73</td>
<td>$105.13</td>
</tr>
<tr>
<td>67028</td>
<td>$104.16</td>
<td>$103.43</td>
</tr>
<tr>
<td>67036</td>
<td>$948.97</td>
<td>$990.41</td>
</tr>
<tr>
<td>67108</td>
<td>$1,589.56</td>
<td>$1,656.58</td>
</tr>
</tbody>
</table>

### Technical component of some diagnostic tests capped at Outpatient Prospective Payment System (OPPS) rate

- RUVs for facility applied to office based tests

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92240 &amp; 92240TC</td>
<td>ICG</td>
</tr>
<tr>
<td>92250 &amp; 92250TC</td>
<td>Fundus photos</td>
</tr>
<tr>
<td>92287 &amp; 92287TC</td>
<td>Cell counts w/fluorescein</td>
</tr>
</tbody>
</table>
Physician Fee Schedule

- Multiple Procedure Payment Reduction (MPPR) applied to certain diagnostic tests
  - Technical component (-TC modifier) of second and subsequent tests performed on same patient, same day will be reduced by 20%
  - Physicians should bill as usual
    - CMS will automatically make reductions
  - CMS will monitor practice patterns to make sure doctors don’t perform additional tests on different days just to avoid multiple procedure reduction

<table>
<thead>
<tr>
<th>Diagnostic Tests Subject to MPPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>76510</td>
</tr>
<tr>
<td>92025</td>
</tr>
<tr>
<td>92134</td>
</tr>
<tr>
<td>92270</td>
</tr>
</tbody>
</table>

Physician Fee Schedule

- PQRS
  - Physicians who participate in 2013 will receive 0.5% incentive payment on all allowables
    - Except DME (glasses) and drugs
  - Glaucoma staging codes removed from Measures 12 and 141
  - Measure 124 – Health Information Technology has been eliminated
  - Physicians will now be required to report on Medicare as Secondary payer claims
Physician Fee Schedule

• Cataract Group Measure reporting lowered to 20 patients instead of 30 this year
  – Of these 20 patients, the majority must be Medicare Part B patients
  – Unable to report until second quarter (April, 2013)
• Required patient surveys will be online vs. mail in surveys
  – May be paper if patient requests
• CMS to use 2013 PQRS participation to determine cuts in future years

Physician Fee Schedule

• Physicians who do not attempt to report in 2013 will receive a 1.5% reduction in 2015 and a 2% reduction in 2016 and beyond
  – E-Prescribing
  • Two new hardship exemptions were added to avoid the 2013 and 2014 eRx penalties
  • Physicians who are receiving the penalty in 2013 will have chance to appeal if they believe their reductions are in error

Physician Fee Schedule

– Physician Compare Website
  • Website allows consumers to search for physicians/providers enrolled in Medicare
    – Helps consumers make informed choices about healthcare they receive through Medicare
  • Includes basic information
    – Names, addresses, phone numbers, specialties, clinical training, genders
    – Languages spoken, affiliated hospitals, PAR doctors, etc.
  • Now includes physicians who participate in EHR Incentive program and/or PQRS Group Practice reporting option
Physician Fee Schedule

- Physician Payment Modifier
  - Payment to some physicians will be based on quality and resource use beginning in 2015 and all physicians in 2017
  - Payment value modifier will now only apply to groups of 100 or more instead of original group practices of 25 or more
  - Smaller groups will remain unaffected until 2017

ASC Fee Schedule

- 2013 ASC Fee Schedule Includes:
  - Consumer Price Index for Urban Consumers (CPI-U) payment update of 0.6%
  - Negative -1.0007% Budget neutrality adjustment
    - Societies still working towards getting ASCs paid closer to what HOPDs are paid
  - 2013 ASC conversion factor
    - $42.917

ASC Fee Schedule

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>15823 Blepharoplasty</td>
<td>$964.64</td>
<td>$971.02</td>
</tr>
<tr>
<td>65755 Keratoplasty</td>
<td>$1,530.82</td>
<td>$1,665.08</td>
</tr>
<tr>
<td>66821 YAG laser</td>
<td>$218.59</td>
<td>$230.51</td>
</tr>
<tr>
<td>66982 Complex cataract</td>
<td>$964.64</td>
<td>$971.02</td>
</tr>
<tr>
<td>66984 Cataract with IOL</td>
<td>$964.64</td>
<td>$971.02</td>
</tr>
<tr>
<td>67028 Intravitreal Injection</td>
<td>$59.91</td>
<td>$49.33</td>
</tr>
<tr>
<td>67036 Vitrectomy</td>
<td>$1,655.65</td>
<td>$1,635.00</td>
</tr>
<tr>
<td>67108 Retina Detach</td>
<td>$1,655.65</td>
<td>$1,635.00</td>
</tr>
<tr>
<td>67040 Retina Repair</td>
<td>$1,655.65</td>
<td>$1,635.00</td>
</tr>
<tr>
<td>0192T Express Shunt</td>
<td>$1,681.49</td>
<td>$1,671.00</td>
</tr>
</tbody>
</table>
ASC Fee Schedule

- ASC Supplies
  - Code V2785, Processing, preserving and transporting corneal tissue only billable supply
    - All other supplies included in ASC facility fee payment
  - Pass-through Drugs
    - Some drugs are considered pass-through drugs and payable separately to the ASC
    - Make sure staff is aware of this and bills Medicare accordingly

ASC Fee Schedule

<table>
<thead>
<tr>
<th>Code</th>
<th>Drug Description</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9257</td>
<td>Bevacizumab (Avastin – 0.25 mg), compounded</td>
<td>$1.59</td>
</tr>
<tr>
<td>C9298</td>
<td>Oxiplatin (JETREA – 0.125mg) · (bil 4 units)</td>
<td>$4,187.00</td>
</tr>
<tr>
<td>J2178</td>
<td>Afibercept (EYLEA) Injection, 1mg (bil 2 units)</td>
<td>$386.53</td>
</tr>
<tr>
<td>J0500</td>
<td>EDTA</td>
<td>$201.40</td>
</tr>
<tr>
<td>J0503</td>
<td>Macugen</td>
<td>$1,030.43</td>
</tr>
<tr>
<td>J2778</td>
<td>Ranibizumab (Lucentis)</td>
<td>$397.72</td>
</tr>
<tr>
<td>J2997</td>
<td>Activase (TPA)</td>
<td>$52.19</td>
</tr>
<tr>
<td>J3000</td>
<td>Triamcinolone – preservative free</td>
<td>$3.67</td>
</tr>
<tr>
<td>J3398</td>
<td>Valsartan</td>
<td>$10.30</td>
</tr>
<tr>
<td>J3120</td>
<td>Ozurdex – 7 units</td>
<td>$196.92</td>
</tr>
<tr>
<td>J3130</td>
<td>Mitoxyon, 0.2 mg (MitoSol) – effective 4:1-13</td>
<td>$386.54</td>
</tr>
<tr>
<td>J9035</td>
<td>Bevacizumab (Avastin – 10 mg)</td>
<td>$63.56</td>
</tr>
<tr>
<td>J9280</td>
<td>Mitoxyon – 5 mg</td>
<td>$22.25</td>
</tr>
</tbody>
</table>

Most Common Ophthalmology ASC Pass-Through Drugs

** Payment amounts updated quarterly

ASC Quality Measures

- Quality Measures for ASCs
  - Were required to report on 5 measures
    - From October 1, 2012 – December 31, 2012
    - Reporting required to avoid a 2% payment penalty in 2014
      - Had to report on 50% of claims
  - Must also now report measures on claims for both Medicare primary and secondary
    - Effective January 1, 2013
ASC Quality Measures

- G8908 or G8909 – Patient Burn
- G8910 or G8911 – Patient Fall
- G8912 or G8913 – Wrong site, wrong side, wrong patient procedure, or wrong implant
- G8914 or G8915 – Hospital transfer/admission
- G8916 or G8917 or G8918 – Prophylactic Intravenous (IV) antibiotic timing
- G8907 – Patient documented not to have experienced any of the above events upon discharge

ASC Quality Measures

- Quality measure reporting for future payments was effective January 1, 2012
  - Had to submit data July 1 – August 15, 2013
- Should be collecting data for two measures
  - ASC Measure 6 – Safe surgery checklist use 2012
  - ASC Measure 7 – 2012 Volume of Certain Procedures
- ASC Quality Measures Specifications Manual available on CMS website

Source: ASCRS 3/30/12

ASC Safe Surgery Checklist

- ASC Safe Surgery Checklist
  - Applies to use during 3 critical peri-operative periods:
    - Prior to anesthesia administration
    - Prior to skin incision
    - Closure of incision and prior to patient leaving OR
  - Reporting is done through web-based tool on QualityNet website
    - Does facility use safe surgery checklist?
    - Must report a YES or a NO
ASC Facility Volume Data

• Measure ASC – 7
  – ASC Facility “Volume Data”
  – All Medicare certified ASCs must report this measure
  – Submission period
    • July 1, 2013 – August 15, 2013
    • Covering performance period January 1, 2012 – December 3, 2012

ASC Facility Volume Data

– Report through web-based tool on QualityNet website
– Must report on aggregate count of selected surgical procedures per category
– Two categories affecting ophthalmology
  • Eye
  • Skin

ASC Facility Volume Data

<table>
<thead>
<tr>
<th>Organ System</th>
<th>Category</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye</td>
<td>Organ transplant (eye)</td>
<td>68756, V2785</td>
</tr>
<tr>
<td></td>
<td>Laser procedure of eye</td>
<td>65855, 66761, 66821</td>
</tr>
<tr>
<td></td>
<td>Glaucoma procedure</td>
<td>66170, 66180</td>
</tr>
<tr>
<td></td>
<td>Cataract procedures</td>
<td>66982, 66984</td>
</tr>
<tr>
<td></td>
<td>Injection of eye</td>
<td>67028, J2778, J3300, J3396</td>
</tr>
<tr>
<td></td>
<td>Retina, macular and posterior segment procedures</td>
<td>67041, 67042, 67210, 67212</td>
</tr>
<tr>
<td></td>
<td>Repair of surrounding eye structure</td>
<td>67900, 67904, 67917, 67924</td>
</tr>
</tbody>
</table>
ASC Facility Volume Data

<table>
<thead>
<tr>
<th>Organ System</th>
<th>Category</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>Skin procedures</td>
<td>11042, 13132, 14040, 14060, 15260, Q4101, Q4102, Q4106</td>
</tr>
<tr>
<td></td>
<td>Repair of surrounding eye structure</td>
<td>15823</td>
</tr>
<tr>
<td>Skin</td>
<td>Skin procedures</td>
<td>11042, 13132, 14040, 14060, 15260, Q4101, Q4102, Q4106</td>
</tr>
<tr>
<td></td>
<td>Repair of surrounding eye structure</td>
<td>15823</td>
</tr>
<tr>
<td></td>
<td>Repair of surrounding eye structure</td>
<td>15823</td>
</tr>
</tbody>
</table>

CPT Code Changes

- Majority of CPT changes involved description revisions to E&M services
  - Indicate services may now be performed by "qualified physicians or other qualified health care professionals"
    - Dependent upon each state’s scope-of-practice laws
    - This is different from ancillary staff that works as "incident" to a physician’s service
**Muscle Chemodenervation**

- Code 64612
  - Revised to include the term “unilateral”
  - Parenthetical note added
    - To report a bilateral procedure, use modifier -50

- Code 64615
  - New code
  - Use to report chemodenervation of muscle(s) innervated by facial, trigeminal, cervical spinal, and accessory nerves, bilateral (e.g., for chronic migraine)
    - Report only once per session
    - Do not report with 64612, 64613, 64614

**AC Tap**

- Code 65805
  - Has been deleted
- Code 65800 revised
  - Now indicates paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous
    - Includes note instructing physicians to use code 65800 for paracentesis of anterior chamber with therapeutic release of aqueous
Biopsy of Eyelid

- Code 67810
  - Revised to clarify depth and type of biopsy required for eyelid skin lesions when malignancy suspected
    - Now classified as “incisional” biopsy
    - Involves incision of top and bottom layers of lid margin
    - Note instructs physicians to now use codes 11100, 11101, 11310-11313 when reporting biopsy of the skin of eyelid

Refraction

- Code 92015
  - Revised to include instruction to use code 99174 for instrument based ocular screening
- Code 99174
  - Is to be used for vision screening utilizing autorefractors and photoscreeners or combination of devices for routine vision
    - Often performed at well-child screenings on children ages 3-6 who can't read vision charts

SCODI

- Code 92132, SCODI, anterior segment screening
  - Includes note instructing physicians to use code 92286 for billing specular microscopy and endothelial cell analysis
Specular Microscopy

- Code 92286
  - Revised to indicate anterior segment “imaging” with interpretation and report; with specular microscopy and endothelial cell “analysis”
    - Revision required to “revalue” it more appropriately
    - Now reflects new technology
      - Cell counts, and
      - Assessment of the thickness of the cornea and angle of the iris to determine the presence of glaucoma

Monitoring Intraocular Pressure

- Code 0173T
  - Monitoring of intraocular pressure during vitrectomy surgery
  - Code has been deleted

Insertion of Ocular Telescope

- 0308T – Insertion of ocular telescope prosthesis including removal of crystalline lens
  - New Category III code effective 7/1/13
    - For implantation of prosthetic intraocular telescope for treatment of central vision loss (bilateral central scotomas) due to end-stage age-related macular degeneration (AMD)
**Insertion of Ocular Telescope**

- Not described by any current CPT code
  - Involves removal of lens and insertion and implantation of a telescope into the lens capsule
- No RVUs assigned by Medicare
  - Payment will be left up to carrier discretion
- Do not report in conjunction with codes
  - 65800-65815, 66020, 66030, 66600-66635, 66761, 66825, 66982-66986, 69990

**Glaukos I-Stent®**

- FDA approved 6/14/12
  - Implanted during cataract surgery in adults with mild to moderate open angle glaucoma being treated with medications to reduce eye pressure
  - To report use code 0191T – Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach

**Afilbercept (EYLEA™)**

- J0178, Injection, 1mg
  - New HCPCS code
  - Replaces Code Q2046
  - Considered ASC pass-through drug
  - Bill 2 units
**JETREA®**

- **JETREA®** (ocriplasmin)
  - FDA approved October, 2012
    - For treatment of symptomatic vitreomacular adhesion (VMA) – Dx: 379.27
  - When performed in office
    - Bill J3490 or J3590 – 1 unit
      - Identify name of drug, dosage and NDC number in item 19 (or EMC equivalent) of CMS claim form
  - When performed in ASC
    - Bill C9298 – 4 units
    - Has ASC pass-through status

---

**Mitosol**

- New HCPCS Code
  - J7315, Mitomycin, ophthalmic, 0.2mg
    - Antimetabolite indicated as an adjunct to ab externo glaucoma surgery
    - Used to reduce scarring and to treat severe eye inflammations and some forms of cancer
    - Should only be used for Mitosol and should not be used for compounded mitomycin or other forms of mitomycin
  - ASC pass-through drug effective 4/1/13

---

**ICD-9 Changes**

- As anticipated there were no changes to the ICD-9-CM coding manual for 2013
- ICD-10
  - Will be implemented on October 1, 2014
  - Need to start preparing now for this transition
ASC Conditions for Coverage

Two Issues Remain A Problem In Audits

ASC CfCs

- Comprehensive H&P required within 30 days of admission for all surgeries performed in ASC
  - Complete ROS
  - Exam of pertinent organ systems (e.g., head, heart, lung, abdomen, extremities)
  - MDM – Must state "patient cleared for surgery in ambulatory setting"
  - Can be performed same day as surgery but before patient has been prepped for surgery

ASC CfCs

- Separate surgical re-assessment day of surgery
  - At minimum, exam for any changes in patient's condition since H&P performed
  - If H&P performed same day, can combine findings of H&P and Re-assessment
- Discharge order must be signed by surgeon and timed
  - Ancillary staff can perform post-surgical assessment
Additional Coding & Documentation Issues

One or More Sessions

• Some procedures have the phrase “1 or more sessions” as part of their CPT description

<table>
<thead>
<tr>
<th>Laser Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>65855</td>
</tr>
<tr>
<td>66761*</td>
</tr>
<tr>
<td>66762</td>
</tr>
<tr>
<td>67101</td>
</tr>
<tr>
<td>67105</td>
</tr>
</tbody>
</table>

* States “per session” to indicate single surgical session with 10 day global

One or More Sessions

• What does “1 or more sessions” mean?
  – The intent of the phrase is to include all sessions in a complete defined treatment period
    • May occur at different encounters but may be reported only once
  – For Medicare purposes, this means the defined global fee period for the procedure
One or More Sessions

• Note:
  – If a new or different condition appears within the global fee period
    • Use appropriate modifier to indicate the treatment is not part of the original defined treatment series
      – Modifier -78 or -79 would apply

One or More Stages

• What about the phrase “1 or more stages?”
  – CPT uses these phrases interchangeably
  – The CPT codes that include the phrase “1 or more stages” aren’t necessarily “staged” procedures
    • There are very few “staged” procedures in ophthalmology
  – Should report these procedures only once during global fee period
    • 66821, 66840, 67031

Bilateral/Unilateral

• Most diagnostic tests are considered bilateral
  • Payment includes both eyes
  – If CPT description indicates “unilateral or bilateral,” Medicare inherently pays as a bilateral service
    • -52 modifier not required
  – If CPT description does not indicate unilateral or unilateral/bilateral (e.g., 92020, 92060)
    • Append -52 modifier to indicate only one eye tested
**Bilateral/Unilateral**

- Some tests are unilateral and can be billed to Medicare “per eye”
  - 76512 – Contact B-scan
  - 92071 – Fitting of contact lens, ocular disease
  - 92072 – Fitting of contact lens, keratoconus
  - 92225 – Extended ophthalmoscopy, initial
  - 92226 – Extended ophthalmoscopy, subsequent

**Bilateral/Unilateral**

- 92230 – Fluorescein angioscopy
- 92235 – Fluorescein angiography
- 92240 – ICG

- Diagnostic tests are payable during the global fee period
  - No modifier required
  - Do not use -25 modifier with diagnostic tests – may cause audit
  - Chart must be clear as to who ordered test and who performed the service

**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
Visual Fields

- Visual Fields – MN for eyelid surgery
  - Once with lids taped, and
  - Once with lids not taped
- According to CPT Assistant, this is a single isopter test
  - Code 92081 is correct code
  - Some payers may permit different codes or the use of -76 modifier on second line item
    - Check with your MAC for specific instructions

Interpretation & Report

- There appears to be an increasing lack of compliance with Interpretation & Report requirements
- 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

Interpretation & Report

- 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 also sign the I&R
### Interpretation & Report

<table>
<thead>
<tr>
<th>Diagnostic Tests Requiring an Interpretation &amp; Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corneal Topography</strong></td>
</tr>
<tr>
<td><strong>Sensorimotor Exam</strong></td>
</tr>
<tr>
<td><strong>Visual Fields</strong></td>
</tr>
<tr>
<td><strong>Serial Tonometry</strong></td>
</tr>
<tr>
<td><strong>SCODI, anterior seg.</strong></td>
</tr>
<tr>
<td><strong>SCODI, optic nerve</strong></td>
</tr>
<tr>
<td><strong>SCODI, retina</strong></td>
</tr>
<tr>
<td><strong>Prov. test/glaucoma</strong></td>
</tr>
<tr>
<td><strong>Ext. Ophthalmoscopy</strong></td>
</tr>
</tbody>
</table>

### Submitting Accurate Claims

- Medicare providers are required to protect the integrity of the Medicare program by:
  - Submitting accurate claims;
  - Maintaining current knowledge of Medicare billing policies; and
  - Ensuring all documentation required to support the medical need for the service rendered is submitted

### Submitting Accurate Claims

- Medicare requires that an item or service:
  - Meets a covered benefit category
  - Is not specifically excluded from coverage
  - Is reasonable and necessary
- Claims must also be filed in a timely manner
  - 12 months or 1 calendar year after the date of service
  - Denial of untimely claims cannot be appealed
Medically Unlikely Edits

• MUEs were created to reduce Medicare paid claims error rates
  – Automated pre-payment edits conducted on submitted claims to prevent inappropriate payments
• An MUE is the maximum units of service that would be reported for a single Medicare patient on a single date of service

Medically Unlikely Edits

• MUEs are adjudicated against each line of a claim rather than the entire claim
  – If service is reported on more than one line, each line with that same code is adjudicated against the MUEs
• MACs deny the entire claim if units of service on a single line exceed the MUEs
  • Other services on that claim can be appealed

Medically Unlikely Edits

• According to CMS anatomic modifiers (-LT, -RT, E1-E4) on separate lines will permit payment of claim in excess of MUEs
  – Unfortunately, some MACs are denying claims billed on 2 lines using the anatomical modifiers
    • According to the Medicare Claims Processing Manual, bilateral procedures are supposed to be billed on one line item using the -50 modifier
    • Bill with “1” unit and increase your charge
Reasons for Claim Denials

- First Coast indicates the following as top reasons for claim denials
  - Diagnosis is inconsistent with procedure
  - Duplicate claim or service
  - Timely filing
  - Service covered by another payer
  - Medicare coverage terminated after expenses incurred

Reasons for Claim Denials

- Routine examinations and related services
- Service deemed not medically necessary
- Inappropriate or invalid place of service
- Non-covered service submitted
- Benefit for service is included in payment/allowance for another service or procedure that has already been paid

Reasons for Claim Denials

- Medicare does not pay for this many services or supplies
- Payment adjusted when performed or billed by this type of provider
- Services are bundled and not payable separately
- Provider not eligible to provide service or procedure on this date
Reasons for Claim Denials

- Patient is enrolled in a hospice or SNF
- Go to FCO website and see how to avoid these denials
- Conduct internal audits and in-services on denials
- Continued errors will cause unwanted scrutiny by CMS

Steps to Improve Revenue

- Co-pays, co-insurance and deductibles
  - These should be collected from the patient at the time of service
  - Permits timely filing of claims
- Working claim denials
  - Denials should be worked on a daily basis
  - Find the reason for the denials and fix it right away

Steps to Improve Revenue

- Internal audits
  - Revenue can be lost if there is no one auditing codes and claims
  - Regular internal audits will assist in submitting clean and accurate claims
  - Run reports monthly and audit your most utilized codes and modifiers
Steps to Improve Revenue

• Keep staff well trained
  – Undertrained staff can be the result of significant lost revenue
  – Provide staff with an avenue to stay up-to-date on Medicare guidelines
  – Make sure staff has access to needed coding manuals
    • CPT
    • ICD-9 and ICD-10
    • CCI edits

2013 OIG Work Plan Update

Includes new and ongoing issues affecting Ophthalmology
Medicare On-site Visits

• CMS conducting on-site inspections of providers/suppliers to verify enrollment
  – Mandated by Provider Enrollment, Chain, and Ownership System (PECOS)
• OIG to determine how often these on-site visits occur
  – Prior reviews found that some suppliers did not even maintain physical facilities

Medicare On-site Visits

• **Avoiding Scrutiny**
  – Physician clinics most likely not an issue
  – Optical shops
    • Revisit DME Supplier Manual requirements
      – Post hours of operation
      – Provide patient access to Supplier Standards
      – Maintain Rx in optical shop files
      – Maintain Proof of Delivery of glasses
      – Have complaint resolution protocol
      – Etc.

EHR Audits

• Providers who received EHR bonuses are being audited
• Documentation requested includes:
  – EHR is certified
  – Claims meet objective and measures
  – ER admissions
• Documentation must be sent within 2 weeks of receipt of request
Ophthalmology Services

- 2011 claims being reviewed by OIG to identify questionable billing for services performed by ophthalmologists
  - Will also look at geographic locations of providers exhibiting questionable billing
- In 2010, Medicare allowed over $6.8 billion for services provided by ophthalmologists

Ophthalmology Services

- Avoiding Scrutiny
  - Nothing you can do about 2011 claims
  - Ensure 2013 claims are billed correctly
    - Keep billing staff up-to-date on current guidelines
    - Conduct internal audits on regular basis
    - Work claim denials on a daily basis – fix problems immediately
    - Consider having external audit conducted on an annual or semi-annual basis

Use of G Modifiers

- OIG to determine to what extent CMS improperly paid claims from 2002-2011 billed with modifiers
  - Specifically modifiers -GA, -GX, -GY, -GZ
- Considerable overpayments identified
  - Amounted to $4 million in potentially inappropriate payments
Use of G Modifiers

- **Avoiding Scrutiny**
  - Review the use of “G” modifiers
    - **-GA** and **-GZ** should be used on claims you expect Medicare to deny as not reasonable and necessary
    - **-GA modifier**
      - Test or procedure not covered for a particular diagnosis for example
    - **-GZ modifier**
      - Indicates service is non-covered but you do not intend to bill patient

- **-GX or -GY modifiers** are used for statutorily excluded services
  - **-GX modifier**
    - Lets Medicare know a voluntary notice of liability (ABN) was provided
  - **-GY modifier**
    - Indicates service excluded and no ABN needed

Error-Prone Doctors

- OIG continues to review claims submitted by error-prone providers
  - Will request refunds on projected overpayments using Comprehensive Error Rate Testing (CERT) audit data
- **Avoiding Scrutiny**
  - Work claim denials on a daily basis
    - **Fix errors immediately**
High Cumulative Payments

- OIG to identify providers with unusually high cumulative payments over a specified period
  - According to OIG audits unusually high Medicare payments may indicate incorrect billing or fraud and abuse
- **Avoiding Scrutiny**
  - Conduct periodic audits on higher billed services for accuracy of coding

ASC Payment System

- OIG continues to review appropriateness of payment methodology for setting ASC fees
  - Will also determine if payment differences exist for ASC and HOPD claims for same procedures performed in both settings
- **Avoiding Scrutiny**
  - No action required

ASC Safety/Quality Issues

- OIG will continue to review the safety and quality of care for patients having surgery in ASCs and HOPDs
  - Will identify adverse events
- **Avoiding Scrutiny**
  - ASCs should be reporting adverse events through ASC Quality Measure Reporting
Assignment Rules

- OIG looking to see if beneficiaries are inappropriately billed in excess of Medicare allowed amounts
  - PAR doctors agree to accept assignment on all services billed to Medicare
    - Can only collect 20% coinsurance and deductible

- Avoiding Scrutiny
  - Make sure patients are not inadvertently being overcharged for your services

Incident-To Services

- OIG to review claims to see if incident-to services had higher error rate than non-incident-to services
  - Ancillary staff services performed incident-to a physician’s service might include:
    - IOP check, bandage change, help with meds, etc.

- Avoiding Scrutiny
  - Make sure ancillary staff performing incident-to services are well trained

Place of Service

- OIG still looking at ASC and HOPD claims to see if correct place of service used
  - When incorrectly coded as office, physician receives higher Medicare payment

- Avoiding Scrutiny
  - If service performed inside ASC firewall, place of service must be ASC, not office
  - If you see inpatients in your office, must code POS as inpatient, not office
### E&M Services

- OIG looking at extent of inappropriate payments for E&M services
  - Also increased frequency of medical records with identical documentation
- **Avoiding Scrutiny**
  - Conduct internal and external audits of office visits on a regular basis
    - *Hold in service training for aberrant physicians*

### Modifiers

- OIG still looking at global fee modifiers
  - Global surgery payment includes related pre-operative and post-operative office visits provided in global surgery period
  - Prior OIG work shows that improper use of modifiers during global fee period resulted in inappropriate payments

### Modifiers

- **Avoiding Scrutiny**
  - Modifier -24
    - *Before appending modifier -24 ask this question:*
      - Would patient have needed service had the surgery not been performed?
    - *If answer is no, then don't bill with -24 modifier*
  - If patient presents for post-op follow-up and exam includes evaluation of surgical eye
    - *Exam will most likely be denied in post-pay audit*
Modifiers

Who’s Auditing Modifiers?

- Medicare Administrative Contractors (MACs)
  - CERT audits
    - Performed post-operatively on a statistically-valid random sample of Medicare claims
    - Look to see if claims were paid properly
    - Claims are subject to potential postpayment denials, payment adjustments, or other legal actions
  - CERT audit results are also shared with RAC auditors if audits indicate billing patterns that may suggest fraud
    - Have identified high number of office visits billed at comprehensive level
    - Some included modifiers -24 and -25
Who's Auditing Modifiers?

• Recovery Audit Contractors (RACs)
  – There are two types of RAC audits
    • Paid claims data
      – No medical record required
    • Medical record audit
      – Will receive letter requesting copies of charts
  – Most practices only audited on paid claim data not record request
  – RACs can go back 3 years to audit
    • Medicare contractors only 1 year unless fraud suspected

• Office of Inspector General (OIG)
  – The big daddy of auditors
    • Looking at global fee modifiers for several years now
      – Particularly interested in modifiers -24, -25 and -59
    • Previous audits showed significant error rates for modifiers -25 and -59
    • 35% of modifier -25 did not meet requirements
      – Resulted in $538 million in improper payment
    • 40% of modifier -59 did not meet requirements
      – Resulted in $59 million in improper payments

Global Fee Periods

• Before using modifiers, it's important to understand global fee concept
• A global fee is defined as:
  – A single fee that involves all necessary services normally furnished by the surgeon before, during and after the surgical procedure
Global Fee Periods

- **Minor Surgery - “0” day global fee period**
  - Includes day of surgery only for such procedures as:
    - Biopsies
    - A/C tap
    - Subconjunctival or Sub-Tenon injections
    - Trichiasis by forceps

- **Minor Surgery - “10” day global fee period**
  - Includes day of surgery and 10 days following surgery such as:
    - Punctum plug insertions
    - Lesion removals
    - Epilation trichiasis
    - Argon Laser Trabeculoplasty (ALT) - code 65855
    - Laser Iridotomy/Iridectomy - code 66761

- **Major Surgery – 90 day global fee period**
  - Includes day before surgery, day of surgery, and 90 days following surgery for such procedures as:
    - Blepharoplasty
    - Ectropion/Entropion repair
    - Cataracts
    - YAG laser capsulotomy
    - Retinal Detachments/Repairs
    - Laser procedures (except ALT & laser iridotomy/iridectomy)
    - Vitrectomy
    - Glaucoma filter procedures
Global Fee Periods

- Medicare considers all doctors in a group practice to be considered the “same” doctor with regard to providing post-operative care
  - Patient develops edema following cataract surgery and sent to retina doctor to treat
    - Office visit not billable
    - Treatment billable if it requires a “return to OR” (-78 modifier)

Why Modifiers Are Required

- Modifiers are:
  - Integral part of billing process
    - Let Medicare know special circumstance has occurred
    - Permit services to be paid that would otherwise be denied
  - Modifiers are needed to:
    - Ensure proper payment
    - Prevent excessive denials and lost revenue

Modifiers Under Scrutiny
# Modifier -25

**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

**Modifier -25**

- 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
Modifier -25

• Retinal injections are particular area of concern
  – Huge increase in intravitreal injection visits billed with -25 modifier
  – Modifier -25 should always be the exception not the rule
    • Does not have to be a different diagnosis
    • Must address more than the decision for surgery that extends above and beyond pre-operative care

Modifier -25

• Example:
  – Patient presents with neovascular AMD in left eye status-post Lucentis injection 4 weeks ago
    • States vision improved in left eye but now has decreased vision and distortion in right eye
  – Exam shows new AMD in right eye
    • Left eye has active AMD
    • Pt treated with Lucentis in RT eye – Told to return for Lucentis in LT eye in 3 days
  – Modifier -25 is appropriate

Modifier -25

• Example:
  – Patient presents for injection #4 in left eye
    • States vision not that great but stable
  – Surgeon recommends intravitreal injection today and FU in 2 months with OCT
    • No new complaints or medical necessity to perform exam over and above need for injection
  – Modifier -25 is not appropriate
Modifier -25

- Example:
  - Patient w/hypertension, high cholesterol, and history of heavy smoking presents for FU of Drusen, OD
    - Exam identifies AMD, OU and hypertensive retinopathy with appearance of some occlusion
    - OU IVFA and OCT shows exudative AMD OS and nonexudative AMD, OD
  - Doctor recommends Avastin injection OS/FU in 4 wks
  - Modifier -25 is appropriate
    - Multiple conditions and multiple eyes being addressed

---

Modifier -25

- In Summary
  - Modifier requires exam over and above usual pre- and post-operative care associated with procedure
  - Use with office visits only
    - Not on tests or surgeries
  - Procedure must have a "0" or "10" day global fee period
  - May sometimes need to append both -24 and -25 modifiers

---

Modifier -25

- Only applies to the physician performing the surgery
- Does not have to be used with new patients
  - New patient exams are exempt from global fee
- Can’t use on re-evaluations when patient asked to return for the surgery and no new complaints
- Diagnosis does not have to be different
  - But, different diagnosis, in itself, may not warrant the use of modifier -25 either
Modifier -59

- Procedure or service is distinct or independent from other services performed on the same day
  - Used to unbundle codes included in the Correct Coding Initiative (CCI) edits
  - Distinguishes procedures not normally reported together:
    - Different session or encounter
    - Different procedure or surgery
      - Separate excision/incision

Modifier -59

- Different site or organ system
  - Anterior segment vs. posterior segment
- Separate lesion
- Separate injury
  - Modifier -59 should not be appended to office visits
  - Should only append modifier -59 on second and subsequent procedures performed at the same session

Modifier -59

- Documentation in the medical record must satisfy the CCI bundling criteria
  - If not, claim will be denied in post-pay audit and refund requested
- One of the biggest misuses of modifier -59 is related to the definition of “different procedure or surgery”
Modifier -59

- CCI instructions clearly indicate that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter
  - Anterior vs. Posterior segment
  - Different diagnosis is also not deciding factor

Modifier -59

- Example:
  - New patient presents with cataracts, glaucoma, and high IOP
    - Surgeon performs peripheral iridotomy (66761) to lower pressure at that visit
  - Patient returns in afternoon with no improvement
    - Surgeon decides to remove cataract (66984) to aid in lowering intraocular pressure
  - Modifier -59 is appropriate
    - Different procedure/session

Modifier -59

- Example:
  - During cataract surgery (66984), vitreous prolapse occurred
    - Anterior vitrectomy (67010) performed to take care of hemorrhage
  - Modifier -59 is not appropriate
    - Since both the cataract and the anterior vitrectomy were performed in the same segment of the eye, unbundling would not be appropriate
      - Diagnosis alone does not justify unbundling
**Modifier -59**

- Modifier should never be used just to obtain payment for bundled procedures
  - Have staff (and doctors) read CCI Manual Introduction
    - *Section on ophthalmology*
    - *Amazed at what they may learn*
- Staff needs access to CCI bundles
  - Should verify if services are bundled or not before submitting claim

---

**Other Modifiers Needing Attention**

---

**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 -24**

- Do not use modifier -24 for office visits related to complications of surgery
  - Post-op follow-up visits
  - Second eye surgery exam in global period if visit addresses surgical eye and no new complaints in fellow eye
  - Known complications of surgery such as
    - Endophthalmitis
    - Conjunctivitis

**Modifier -24**

- Example:
  - Surgery patient returns in global fee period of cataract surgery for scheduled 3-month glaucoma follow-up
  - Modifier -24 is appropriate
    - Glaucoma diagnosis unrelated to cataract surgery
    - Make sure CC does not state “here for PO exam”
    - Diagnosis must be glaucoma, not cataract
      - This is a common billing error
    - Billers can’t bill appropriately if chart not correct

**Modifier -24**

- Example:
  - Patient presents during global fee period with decreased vision in the surgical eye so severe it’s affecting their ability to function
    - Exam identifies severe posterior capsular opacification and YAG laser surgery recommended same day
  - Modifier -24 is not appropriate
    - PCO is known complication of cataract surgery
      - If patient outside global fee period, then -57 modifier would apply
Modifier -58

- **Staged or related procedure by same physician during post-op period**
  - More extensive than original procedure
  - Planned procedure documented prospectively at time of original procedure
  - Therapy following a surgical procedure
  - Injection given in the lane
  - Does not apply to laser procedures indicating “per session” or “one or more sessions”
  - Not to be used for treatments requiring “return to OR”

Modifier -58

- Physician does not have to specifically state planned stages
  - Can be within stated Plan of Care or can be implied
    - Executing a more extensive procedure because original procedure did not achieve desired outcome
  - Ask these questions:
    - Is original condition being treated?
    - Is subsequent procedure more extensive than the first?

Modifier -58

- Is something being done to “finish” what was started with the prior procedure?
- Is procedure being done to facilitate therapy, or is it therapy following a prior procedure?
  - If answer is “yes” to any of these questions, modifier -58 is appropriate
Modifier -58

• Example:
  – Physician excises right lower lid lesion
  • Pathology report indicates additional tissue should be removed
  – During global fee period (day 8), larger excision performed with skin graft
  • Would be considered “staged” procedure
  • Correct billing
    – 14060-E2-58

Modifier -58

• Other examples:
  – Trabeculectomy following a failed ALT or iridotomy/iridectomy
  – Scleral buckle following a pneumatic retinopexy
  – 5-FU injections following trabeculectomy
  – Retina injections following retina surgery for same diagnosis

Surgeries Requiring Special Attention
Cataract

- Code 66984
  - BCVA 20/40 with or without glare
    - If glare used to document surgery, must have glare complaint
  - Lifestyle impairment
  - Other indications if BCVA not met:
    - Anisometropia after first eye surgery
    - Phacomorphic glaucoma
    - Phacolytic glaucoma
    - Retina disease that requires clear media

Cataract

- Second eye surgery
  - Bilateral surgery not recommended
  - Interval between eyes should be based on:
    - Patient able to provide informed consent for surgery on second eye after evaluating visual results of first eye surgery
    - Adequate time has passed to detect and treat complications following first eye surgery
    - First eye is healed and stable and patient not at risk of injury due to functional impairment

Complex Cataract Surgery

- Code: 66982
- To be used for management of complicated cases due to:
  - Previous trauma
  - Concurrent disease states
  - Congenital abnormalities
- Not intended for mishaps during regular cataract surgery
Complex Cataract Surgery

- OP report must address device or special technique used
  - Iris expansion device
  - Suture support of IOL
  - Endocapsular rings (weak zonules)
  - Use of dye for visualization
  - Posterior capsulorrhexis
    - Tear in posterior capsule does not count
  - Pediatric cataract

**Check LCDs for specific billing instructions**

66982 - Limitations

- CMS advises that 66982 should not be used for:
  - Vitrectomy required during surgery
  - Posterior capsule tear
  - Piggyback IOL
  - Trabeculectomy
  - Loose zonules
  - Intraocular bleeding
  - Vitreous prolapse
  - Dislocated IOL in the bag
  - Extracapsular–spontaneous expulsion
  - Wound leak or burn

Vitrectomy w/Cataract Surgery

- Code: 67010 – Subtotal vitrectomy
- Bundled with cataract surgery
- Can no longer unbundled using -59 modifier
  - Must be performed at different session or in different segment of eye
    - Anterior vs. posterior
  - Diagnosis alone no longer reason to unbundle
    - Vitreous prolapse
Femtosecond Laser

• CMS FS laser guidance
  – Released November 16, 2012
  – Refractive imaging component of FS laser performed on premium AC-IOL and PC-IOL cataract patients before surgery has begun is non-covered service
    • Can bill patient

YAG Laser Capsulotomy

• If 66821 performed within 4 months of cataract surgery, must document:
  – Patient is experiencing symptoms of blurred vision, visual distortion, and/or glare with associated functional lifestyle impairments
  – BCVA 20/30 or worse
    • 20/25 if performed to assist in dx and treatment of retinal detachment
  – Glare test or contrast sensitivity resulting in decreased visual acuity by 2 lines

Femtosecond Laser

– CMS does not permit physicians to bill the FS laser refractive imaging services when a conventional IOL is used
  • Using FS laser on conventional IOL patients (but not charging for the use of FS laser) should be rare and performed only on a non-routine, limited basis
– FS laser astigmatic keratometry (LRI or CRI) performed at same time as conventional IOL surgery
  • May be billed to patient
YAG Laser Capsulotomy

- YAG laser may also be performed to assist in diagnosis and treatment of:
  - Macular disease
  - Diabetic retinopathy
  - To evaluate optic nerve head
  - Diagnosis posterior pole tumors
  - Retinal detachment
- YAG is expected to be performed only once per lifetime per patient (Florida)

Source: First Coast LCD for YAG Laser Capsulotomy

Amniotic Membrane

- Code 65778
  - Placement of amniotic membrane on the ocular surface for wound healing; self-retaining (e.g., ProKera)
- Code 65779
  - Single layer, sutured
- Used for wound repair and healing
- Both have 10 day global fee periods

2013 National Fee Schedule Amounts

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>In Office</th>
<th>In Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>65778</td>
<td>$1,469.45</td>
<td>$73.83</td>
</tr>
<tr>
<td>65779</td>
<td>$1,291.85</td>
<td>$293.96</td>
</tr>
</tbody>
</table>
Amniotic Membrane

• Clinical example – Code 65778, self-retaining
  – 67-year old male presented with progressive loss of vision, severe pain, and light sensitivity in right eye immediately after a chemical burn injury
    • Patient has severe ocular inflammation and large corneal epithelial defect
    • Topical and systemic medications failed to relieve symptoms from lack of corneal healing after 1 week
    • A self-retaining amniotic membrane device placed on corneal surface

Amniotic Membrane

• Clinical example – Code 65779, single layer, sutured
  – 70-year old woman presented with decreased vision, photophobia, and irritation in right eye for 3 weeks
    • Patient diagnosed with bacterial keratitis and treated with topical antibiotics
    • Frequent lubrication and bandage contact lens applied for 5 days with no improvement
    • An amniotic membrane for healing is applied and sutured in place

Amniotic Membrane

• Amniotic membrane applied with glue must be billed with code 66999 per CPT
• Codes 65778 and 65779 not billable with codes:
  • 65420, Pterygium removal (CCI)
  • 65426, Pterygium removal with autograft (CCI)
  • 65430, Corneal scraping (CPT)
  • 65435, Removal of epithelium (CPT)
  • 65780, Ocular surface reconstruction (CPT)
  • Keratoplasty procedures
Amniotic Membrane

- 65780 – Ocular reconstruction, multiple layers
  - Usually done for corneal defects such as burns, scarring, thinning, ulcer, and perforation
    - Necrotic epithelium is usually debrided first
    - AMT is trimmed and sutured into place
    - Additional layers of AMT are placed until all areas or defect are repaired and in line with surrounding normal thickness corneal tissue

Amniotic Membrane

- Amniotic membrane tissue cost
  - Built into physician’s payment when performed in office
  - When performed in surgery center, ASC is responsible for cost of AMT
    - 2013 ASC fee schedule does not have payment amount for code 65779 (Sutured)
      - Presume if paid, it includes cost of tissue

E&M vs. Eye Codes
Eye Codes or 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 Mgt 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
**Eye Codes vs. E&M Codes**

National Fee Schedule Payment Amounts
Through December 31, 2013

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>92004 - Comp, New patient</td>
<td>$144.66</td>
<td>$151.40</td>
</tr>
<tr>
<td>92012 - Interm, Est. Patient</td>
<td>$82.71</td>
<td>$87.44</td>
</tr>
<tr>
<td>92014 - Comp, Est. Patient</td>
<td>$119.81</td>
<td>$126.23</td>
</tr>
<tr>
<td>99203 - Detailed, New Patient</td>
<td>$105.18</td>
<td>$108.19</td>
</tr>
<tr>
<td>99213 - Exp. Prob. Focused, Est. Patient</td>
<td>$70.46</td>
<td>$72.81</td>
</tr>
<tr>
<td>99214 - Detailed, Est. Patient</td>
<td>$104.16</td>
<td>$106.83</td>
</tr>
</tbody>
</table>

*Comprehensive eye codes still paying more than lower level E&M codes*

99204 - Comp, New Patient $160.66 $164.67

---

**Eye Codes vs. E&M Codes**

- To bill an eye code most Medicare contractors expect to see performance of at least:
  - 1 element of slit lamp, and
  - 1 element of the fundus (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
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-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
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 03/01/12
- Follow-up care provided through 03/17/12

<table>
<thead>
<tr>
<th>Item 19</th>
<th>LT EYE Assumed care 03/01; Relinquished care 03/17; Total Days 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>24a (Dates of Service)</td>
<td>24d (Procedure/Mod)</td>
</tr>
<tr>
<td>03/01/12</td>
<td>66984-54LT</td>
</tr>
<tr>
<td>03/01/12</td>
<td>66984-55LT</td>
</tr>
</tbody>
</table>

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

Optometrist or other MD providing portion of follow-up care

- Surgery performed on 03/01/12
- Follow-up care provided through 03/17/12 by surgeon

<table>
<thead>
<tr>
<th>Item 19</th>
<th>LT EYE Assumed care 03/18; Relinquished care 05/29; Total days 73</th>
</tr>
</thead>
<tbody>
<tr>
<td>24a (Dates of Service)</td>
<td>24d (Procedure/Mod)</td>
</tr>
<tr>
<td>03/01/12</td>
<td>66984-55LT</td>
</tr>
</tbody>
</table>

Note: Some Medicare contractors require number of post-op days in 24G
LUNCH
12:00 – 1:00 PM

ICD-10 Update

ICD-10 Implementation

• October 1, 2014 – go live date
  – Per CMS – implementation date is firm and not subject to change
    • There will be no delays
    • There will be no grace period
• ICD-10 not accepted prior to 10/1/14
• ICD-9 diagnosis not accepted on or after 10/1/14
• Planning must start now!!
Background

- ICD-9 is current diagnosis code set used in the U.S.
  - ICD-9 has outgrown level of specificity
  - No longer reflects advances in medical treatment
- Very few “unassigned” codes remain in ICD-9 for new diagnoses
  - Many codes don’t accurately describe the diagnosis they are assigned to represent

Background

- ICD-10 will be new diagnosis code set effective October 1, 2014
  - Change mandated by HIPAA
- ICD-10 required major computer system overhaul to permit billing of new codes electronically
  - Current Version 4010 was converted to new Version 5010
  - Allows computers to be able to transmit new diagnosis codes

Who’s Affected?

- Who does it affect?
  - All Healthcare
    - Providers (including nurses & technicians)
    - Payers
    - Software vendors
    - Clearinghouses
    - Third-party billers
### ICD-10 Differences

**ICD-9-CM** | **ICD-10-CM**
---|---
3 - 5 Characters | 3 - 7 Characters
All Characters are Numeric: No laterality | Character 1 is alpha (A-Z, not case sensitive); Character 2 is numeric; Characters 3-7 are alpha or numeric Laterality
Supplemental chapters: Alpha and numeric characters | 
**366.22 - Total Traumatic Cataract** | **H26.131 - Total Traumatic Cataract, Right Eye**
**H26.132 - Total Traumatic Cataract, Left Eye**
**H26.133 - Total Traumatic Cataract, Bilateral Eye**
**H26.139 - Total Traumatic Cataract, Unspecified eye**

### ICD-10 Differences

**ICD-10 Features**

| Feature | Description |
---|---|
Combination Codes | Expanded Ambulatory and managed Care Encounter Details |
Added Laterality | Timeframes Added |
Episodes of Care Added | External Cause Codes – no longer supplementary classification |
Expanded codes (diabetes, post-operative complications) | Greater Specificity |
Addition of Placeholder “X” – allows for future expansion | Enhanced Quality Reporting |

### Documentation

- ICD-10 will require more (or 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 staff
  - ICD-10 will require more specificity
Documentation

- Documentation becomes critical with trauma or injuries
  - You may need to ask more questions specific to the patient's complaint
    - What were you doing at the time of the injury?
    - Where were you?
    - Was this the first injury of this type?

- Will be required to collect more information in more detail when documenting chart
  - Will permit coders to select the right ICD-10 for symptom, disease, or provided service
  - In the past, diagnoses were general
    - In ICD-10, there's a diagnosis for just about everything
      - If chart not documented properly, could lead to denials

- New documentation to consider
  - Laterality plays a big part in ICD-10
    - Assessment must be specific to each eye or each eyelid
  - Specificity is more important than ever
    - Impression must be as specific as it can be for that particular complaint or condition
      - Particularly important for injuries
  - Manifestation is critical where applicable
    - Must list disease and manifestation
### Documentation

#### Documentation Differences

<table>
<thead>
<tr>
<th>Current</th>
<th>New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chalazion OS</td>
<td>Chalazion LLL</td>
</tr>
<tr>
<td>Cataract</td>
<td>NS cataract, OS, floppy iris syndrome</td>
</tr>
<tr>
<td>CME</td>
<td>CME OS after cataract surgery</td>
</tr>
<tr>
<td>Eyelid laceration</td>
<td>Laceration, left eyelid, hit in eye with tree branch</td>
</tr>
<tr>
<td>Diabetic</td>
<td>Type II diabetes using insulin</td>
</tr>
<tr>
<td>Myopia</td>
<td>Myopia OU; regular astigmatism OD</td>
</tr>
</tbody>
</table>

#### Documentation

- **Glaucoma**
  - Must assign as many codes from Glaucoma category H40 as needed to identify type of glaucoma, the affected eye, and the glaucoma stage
  - **Expanded chart documentation will be required**
  - In some cases, even laterally will apply
  - Nurses/technicians/physicians will need to be more specific particularly as it relates to glaucoma stage
  - Coder won’t be able to code claim unless chart is properly documented
Documentation

• Cataract
  – Some descriptors are different requiring better chart documentation
    • Age-related cataract
      – Senile
    • Age-related nuclear cataract
      – Cataracta brunescens/nuclear sclerosis cataract
    • Complicated cataract
      – Cataract with neovascularization

• Diabetes
  – 5 Categories in ICD-10
    • E08 – Diabetes mellitus due to underlying condition
    • E09 – Drug or chemical induced diabetes mellitus
    • E10 – Type 1 diabetes mellitus
    • E11 – Type 2 diabetes mellitus
    • E13 – Other specified diabetes mellitus
  – Chart documentation will have to be specific to these categories

• Diabetic retinopathy
  – Combination codes will be important
    • Three character category shows type of diabetes
    • Fourth character shows underlying conditions with specific complications
    • Fifth character defines specific manifestation
  – Diabetic cataract

• Diabetic retinopathy
  – Nonproliferative: mild/moderate/severe
  – Proliferative & unspecified
  – With/without macular edema

• Diabetic cataract
Training

- Training should focus heavily on clinical documentation excellence
  - Need to correctly and sufficiently provide clinical details to support coding in ICD-10
    - Will be critical in conversion process to avoid claim denials

Training

- ICD-10 will require more engagement with physician
  - Physician input may be key to proper documentation
  - Suggest physicians/nurses/technicians get same training at same time
    - That way everyone will be on board with same information
Training

• Prepare listing of the most frequent conditions treated with ICD-9 codes
  – Compare chart documentation to corresponding ICD-10 codes
    • Does documentation allow selection of ICD-10 code at highest level of specificity?
    • If yes, move on to next code.
    • If not, discuss with doctors and allied staff what documentation will help code that level of service in the new ICD-10 codes

Training

– Train, train, and re-train on the new ICD-10 codes
  • Discuss how your chart documentation will be impacted
  • Additional information that may be required
– Train on additional codes that may be required for specific conditions
  • Diabetes
  • Glaucoma stage diagnoses
  • Type of injury or where it occurred

Training

• Time needed to train personnel
  – Initially, 4 to 10 hours recommended
  – Other studies suggest:
    • 16 hours for experienced coding
    • 24 hours for less experienced staff
• Learning curve might not be as steep for ophthalmology
  • Limited number of codes to deal with
### Training

- May want to take refresher on-line anatomy course
  - Eye anatomy becomes important in ICD-10
    - Is not required in ICD-9
- Understanding the differences between ICD-9 and ICD-10 will be key
  - Also the impact it will have on the practice

### Training

- Staff training crucial to successful transition
  - The train has left the station
    - No time to put it off
  - Need to get involved in the process now
    - Taking baby steps a little each month is better than no progress at all

### Case Scenarios
Case Scenario

• A 68-year old male patient experiences sudden vision loss with the sensation of a veil over his right eye
  • Seen by ophthalmologist the same day
  • Ophthalmologist examines patient and diagnoses him with proliferative vitreo-retinopathy with retinal detachment
    – Patient is scheduled for laser therapy to be performed that afternoon

Case Scenario

• Alphabetic index:
  • Detachment ➔ retina ➔ serous ➔ traction ➔ H33.4
• Tabular list:
  • H33.4 ➔ Traction detachment of the retina, right eye ➔ H33.41
• Correct code:
  • H33.41

Case Scenario

• A 67-year old patient has had type 2 diabetes mellitus for 10 years
  • On insulin for blood sugar control for past 3 months
    – Blood sugar doing well on insulin and diet
  • Family doctor referred her to ophthalmologist with suspected condition related to the diabetes
  • Ophthalmologist examines patient and finds diabetic retinopathy that is nonproliferative, with macular edema – condition is moderate
    – Physician recommends surgery same day
Case Scenario

• Alphabetic index:
  - Diabetes ➔ Type 2 ➔ diabetic ➔ retinopathy ➔ nonproliferative ➔ moderate ➔ with macular edema ➔ E11.331

• Tabular list:
  - E11.331 ➔ Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema (must use addtl code to identify insulin use)
  - Z79.4 Long term insulin use

• Correct code sequence:
  - E11.331, Z79.4

Case 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:
  - Complications ➔ Postprocedural ➔ Following Cataract Surgery ➔ Cataract (lens) fragments H59.02

Case 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
Case Scenario

• 67 year old male jet skiing at South Beach
  – Was driving recklessly and fell off jet ski
    • Hit in left eye with handle bar before entering water
  – Does not recall accident and 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

Case Scenario

• Alphabetic index:
  • Fracture, traumatic\textarrow{or}t\textarrow{b}it\textarrow{e}\textarrow{r}\textarrow{a}\textarrow{f}\textarrow{i}l\textarrow{o}r (blow out) – S02.3

• Tabular list:
  • S02.3 – Fracture of orbital floor

• Correct code sequence:
  • ✓\textarrow{x}7\textarrow{th}{\textarrow{th}} – S02.3XXB – Fracture of orbital floor
    • No 5\textarrow{th} & 6\textarrow{th} digits available
    • “X” place holder must fill empty spaces
    • “B” is 7\textarrow{th} digit for initial encounter for open fracture
  • V93.33XA – Fall on board jet ski
    • Injury also requires secondary code for external cause
    • “X” is place holder – diagnosis requires 7 digits
    • “A” is for initial encounter for injury

Overcome Obstacles

• \textit{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
Medicare Audit Contractor Concerns

Code 99215
• Last October, Florida’s Recovery Audit Contractor (RAC) requested permission from CMS to start reviewing code 99215
  – The review was to be limited to a small number of providers with a high utilization of code 99215
    • However, if error rates are high, could lead to more in-depth review on additional providers
  – Conduct internal audits on your high level E&M services

Legibility of Chart Entries
• Illegibility has become an even bigger issue with CMS, MACs, RACs, and OIG
• Coverage policies specifically address need for records to be legible
  – Includes any copies scanned into EMR system
  – If auditor can’t read chart, can render a service non-covered or reduce the code
    • Could result in refund requests and lost revenue
Physician Signatures

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

Physician Signatures

- 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

Physician Signatures

- 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
Physician Signatures

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

• Medicare contractors/carries 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)
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/obliteration of original entry not acceptable

Amending Medical Record

• **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
Amending Medical 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

Amending Medical Record

- Late Entries
  - Usually applies to physician orders, progress notes or allied health assessments
  - Varies by system
    - Will need to work with vendor on how this can be done
    - Establish practice policy for future reference
  - The person making the late entry should document within the entry that it is a “late” entry

Amending Medical Record

- May want to create a practice policy for time limits on late entries/corrections to medical records
  - (days/weeks/months)
    - Audit for compliance
CMS SITE AUDITS

CMS Site Audits

- Clinic
  - May get a site visit from CMS after filing revalidation application
  - Auditors taking pictures of building and signage, state license, and requesting copies of various documents
    - Be sure to obtain a business card and look at the CMS badge closely
    - Don’t let the auditor intimidate you

- Physicians and ASCs are considered “limited risk” providers but doesn’t guarantee you won’t get a site visit
  - If the auditor asks to copy or remove records, call your attorney

- Optical Shops
  - Optical shops (DME) are considered high-risk providers
CMS Site Audits

- Auditors are looking for such things as:
  - Making sure hours of operation are posted
  - You have a good inventory of Medicare covered frames
  - Patient is given a receipt for glasses ordered
  - You have a method for patients to lodge complaints
  - Records are properly maintained in the optical

CMS Site Audits

- Patients have access to DME Supplier Standards
  - Recommend you go over the Suppliers Standards to make sure you are in full compliance

COMPLIANCE ISSUES

Non-compliance Can Affect Reimbursement
Compliance

• Conduct internal audits routinely
• Have external audits conducted at least every 2 years
  – Audits can help guard against unnecessary scrutiny by MACs, RACs, ZPICs, MICs, and OIG
• Remember, compliance is a team effort!

Compliance

• Train staff well
• Conduct regular internal and external audits regularly
• Require billing and coding staff to maintain a high level of competency
  – Coding Seminars
  – Webinars
  – On-line coding courses

Compliance

• Review all Medicare rejections and denials when received
  – Error-prone providers more likely to get audited now
• If using billing service, monitor them just like you would your own billing staff
  – Billing services make errors too
Compliance

• Run procedure reports on modifiers used most frequently
  – Conduct internal audits to make sure requirements are being met
• Hold in-services as needed if requirements not met
  – Include billers and coders as well as technicians and nurses
    • Remember, just because Medicare paid it doesn’t mean it was paid appropriately

Compliance

• Modifiers are located in the back of the CPT coding manual
  – Make sure all billing and coding staff refers to these modifiers regularly
• If in doubt whether a particular modifier is needed, ask a supervisor for assistance
  – Compliance is important for:
    • Avoiding audits
    • Getting paid appropriately

Consider Compliance Plan

• Compliance Plans will become mandatory
  – CMS to determine implementation date and timeline of core elements
• HHS published a model
  – Includes 7 elements that can easily be implemented yourself
Consider Compliance Plan

- Conducting internal monitoring and auditing;
- Implementing compliance and practice standards;
- Designating a compliance officer or contact;
- Conducting appropriate training and education;
- Responding appropriately to detected offenses and developing corrective actions;
- Enforcing disciplinary standards through well-publicized guidelines.

Consider Compliance Plan

- You don’t have to implement all 7 components of a full scale compliance program
  - These steps are geared toward implementing a voluntary compliance program
    - However, the more you work towards compliance, the more prepared you will be when Compliance Plans do become mandatory.

Questions
This program is sponsored by the

Florida Society of Ophthalmology
6816 Southpoint Parkway, Suite 1000
Jacksonville, FL 32216
Phone: 904-998-0819 Fax: 904-998-0855
www.ophmasters.com