Ask the AOA Coding Experts Vision vs Medical

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AOA Third Party Center Coding Experts

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Medical Eye vs. Well Vision:

The Great Coding Dilemma

Discussing Reality

- Medical vs. Vision
  - What to do when patient has vision insurance but medical problem
  - What to do when patient has medical insurance but vision problem
  - What to do when patient has both medical and vision insurance and NO problem
  - What to do…….

Coding Basics- Don’t Fall Asleep

Coding Systems

- CPT ® Procedure Codes
  - What You Do
- ICD-9-CM/ICD-10-CM Diagnosis Codes
  - What You Find
- HCPCS Codes
  - What You Supply (sometimes what you do)
- Modifiers
  - What is Different

Supply of Ophthalmic Materials

- Medicare/Medicaid and Other Carriers
  - HCPCS Codes V2020 – V2799 (materials)
  - HCPCS Codes S series
    - Some services and material (S0500-S0625)
      - Note not all are ophthalmic codes
    - Contact Lens and Spectacle Services/materials
    - Ocular Prosthetics

New versus Established

- New patient
  - Not received any professional services from physician or another physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years

New versus Established

- Established patient
  - Received professional services from the physician or another physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years

92000 versus 99000 code choices

- Allowed to use BOTH systems BUT documentation dependent
- General ophthalmologic services as opposed to E&M:
  - Intermediate and comprehensive examination types
  - Do not require three key components
    - History
    - Examination
    - Medical decision-making
  - Do not use documentation guidelines from CMS to determine proper code selection

92000 versus 99000 code choices

- Medical decision making cannot be separated from exam techniques
- Itemization of service components is not applicable
  - Slit lamp examination
  - Keratometry
  - Routine ophthalmoscopy
  - Retinoscopy
  - Tonometry
  - Motor evaluation

CPT Definitions

- HIPAA requires **all providers and insurers** to use CPT codes and definitions for describing services provided to patients
- CPT copyright requires anyone who uses the codes to comply with the definitions for the codes
- Choosing codes by matching the content of the record to the CPT definition provides effective support in the case of a payer audit

92000 code use

- Appropriate when service includes several routine optometric/ophthalmologic examination techniques
  - Integrated procedures not separated from diagnostic evaluation
- Common physical examination elements must be documented
- Exam elements are indicated by issues being evaluated

General Ophthalmic Codes

92002

Ophthalmological services: medical examination and evaluation with **initiation** of diagnostic and treatment program; intermediate, new patient

92004

;comprehensive, new patient, 1 or more visits

General Ophthalmic Codes

92012

Ophthalmological services: medical examination and evaluation, with **initiation or continuation** of diagnostic and treatment program; intermediate, established patient

92014

;comprehensive, established patient, 1 or more visits

Note: Current Procedural Terminology(© American Medical Association) is the ***only*** accepted source of definitions for these services.

Comprehensive 92004 and 92014

Introduction in CPT®

General evaluation of the complete visual system (1 + sessions)

Includes:

- History
- General medical observation**
- External examination
- Ophthalmoscopic examination
- Gross visual fields
- Basic sensorimotor examination

Often includes:

- Biomicroscopy
- Examination with cycloplegia or mydriasis
- Tonometry

Always includes:

- Initiation/continuation of diagnostic and treatment programs

Intermediate 92002 and 92012

Introduction in CPT®

Evaluation of new/existing condition ***complicated by new diagnostic/management problem*** not necessarily related to primary diagnosis

Includes

- History
- General medical observation **
- External examination
- Adnexal examination

May Include

- Other diagnostic procedures
- Mydriasis of ophthalmoscopy

Always includes

- Initiation/continuation of diagnostic and treatment programs

Wording creating confusion
Get the FACTS!

1. CPT® is ONLY official definition for codes
2. CPT® code wording is the ONLY official definition for codes
3. CPT® code introductions are NOT official definitions- only to further explain code use

- Official Code Wording – established patients

Ophthalmological services: medical examination and evaluation, with **initiation or continuation** of diagnostic and treatment program

- Introduction to Code Wording – established patients

Evaluation of new/existing condition ***complicated by new diagnostic/management problem*** not necessarily related to primary diagnosis

Wording creating confusion
Get the FACTS!

- NEVER THE INTENTION OF CPT TO INDICATE THAT YOU CANNOT USE THE 92000 CODE SERIES FOR ALL OPHTHALMIC CARE IF DESIRED!
- Some lecturers have stated you have to switch between 92000 codes and 99000 codes and this is simply NOT TRUE!

Diagnostic and Treatment Program

- Includes, but **not complete list**:

1. Prescription of medication
2. Special ophthalmological diagnostic or treatment services
3. Consultations
4. Laboratory procedures
5. Radiological services

Many other options…

92000 Code Elements

Per CPT Assistant Article

- Confrontation fields
- Eyelids/adnexa
- Ocular motility
- Pupils/iris
- Cornea
- Anterior Chamber
- Lens
- Intraocular pressure
- Retina (vitreous, macula, periphery, and vessels)
- Optic disc

(12 elements? *acuity* and *bulbar and palpebral conjunctiva* not listed)

Elements of Examination

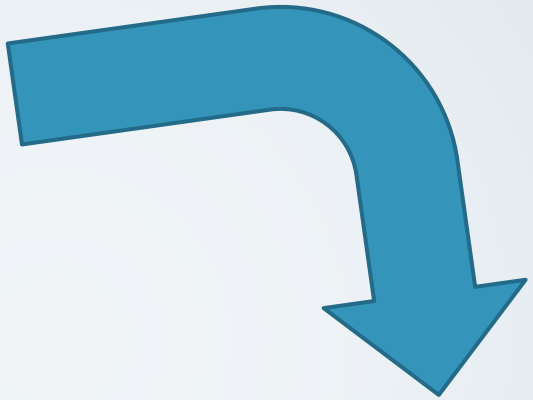
- Comprehensive has been described as 8 or more elements including:
  - Fundus examination with dilation**
  - Motor evaluation
    - (varied by carrier specific definition)
- Intermediate has been described as 7 or fewer elements

- Still good “rule of thumb” – examination varies by reason for examination

- **Note that CPT definitions do NOT require dilation but is in the introduction of codes and some carriers do- sometimes using further statement “with dilation unless contraindicated”

General Ophthalmologic Codes vs Evaluation and Management (E&M) Codes?

- No mandated use of one code set over other
- Report code(s) most accurately identifies service(s) or procedure(s) performed
- General ophthalmological service codes are specific for services typical of ophthalmological visit



Note that *some* carriers state:
Services that require minimal ophthalmologic examination techniques are reported with E/M CPT codes (99201 - 99499)

Evaluation and Management (E & M)

- 1995 or 1997 guidelines for E&M codes
  - 1997 simpler, have to specify in audit
  - Presenting 1997 guidelines from CPT®
  - 99--- codes
    - Office
    - Hospital
    - Nursing facility
    - Domiciliary/rest home
    - Home

Medicare no longer covers consultations

Elements of E & M Codes

Major elements

- Chief Complaint – Always
- History
- Examination
- Medical decision-making

Other factors considered

- Counseling
- Coordination of care
- Nature of presenting problem
- Time

Elements of E & M Codes

- Chief Complaint- TRUE WITH 92000 AND 99000 codes!
  - Always, every encounter
  - Concise statement describing
    - Symptom
    - Problem
    - Condition
    - Diagnosis
    - Physician recommended return
    - Any other factor related to reason for the encounter
  - Usually stated in the patient's words

Elements of E & M Codes

History of present illness

8 elements

2 levels

Review of systems

14 elements

3 levels

Past, family, social history

3 elements

2 levels

History of Present Illness

Elements

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated sign & symptoms

1997 documentation guidelines

Descriptions of the elements (e.g., location, quality, severity, etc.)

or

Status of three chronic/inactive diseases.

Levels

Brief: 1-3 elements

Extended: 4+ elements

Review of Systems

An inventory of body systems obtained via questions to identify signs/symptoms that patient may be experiencing or has experienced

- Constitutional
- Eyes
- Ears, nose, throat (E/N/T)
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Review of Systems

Problem oriented:

- +/- system related to problem

Extended problem oriented:

- +/- 2-9 systems

Complete:

- +/- 10 or more systems

Review of Systems

- Individually document all positives
- Individually document all negatives
- Up to the number of elements required for level
- Then may indicate all other systems negative

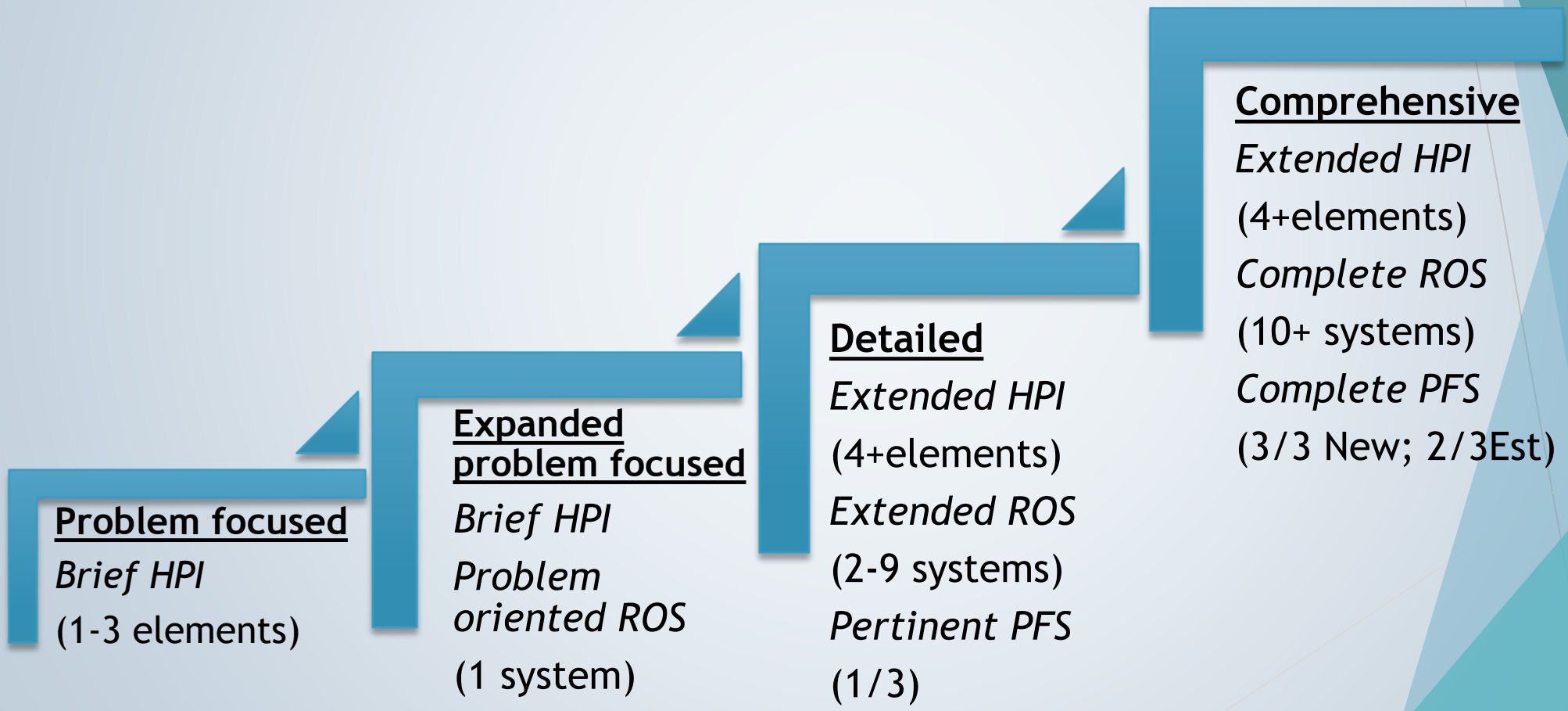
BUT

- Avoid saying “all 10 systems negative”

Past, Family, Social History

- Pertinent:
  - One in any of the three areas
- Complete:
  - One in all three areas for new
  - Two of three for established

Overall History Components

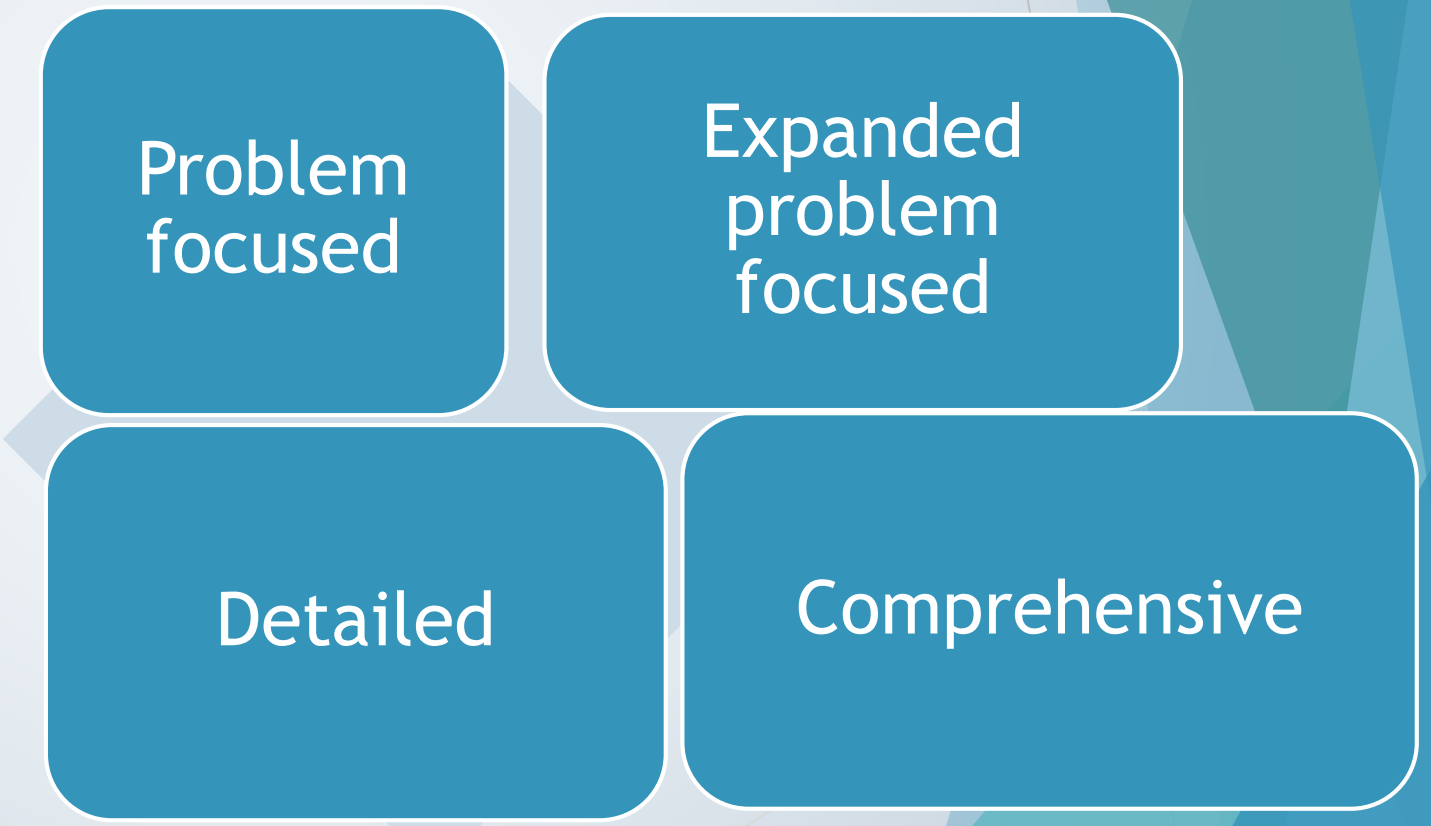


HPI Summary Table

Type of History	History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)
Problem Focused	Brief	N/A	N/A
Expanded Problem Focused	Brief	Problem Pertinent	N/A
Detailed	Extended	Extended	Pertinent
Comprehensive	Extended	Complete	Complete

Examination Elements

4 Levels (1997)



Examination Elements Single System

14 elements

- Visual Acuity
- Confrontation Field
- EOM/Alignment
- Conjunctiva
- Adnexa/lacrimal
- Pupils/iris
- IOP
- SLE – cornea/tears
- SLE – anterior chamber
- SLE - Lens
- DFE – Optic nerve
- DFE – Posterior seg
- Orientation
- Mood/affect

Examination Elements Single System

- Visual acuity (Does not include refraction)
- Gross visual field testing *by confrontation*
- Ocular motility include primary gaze alignment
- Inspection of bulbar/palpebral conjunctivae
- Examination of
  - ✓ Ocular adnexae including lids (eg, ptosis or lagophthalmos),
  - ✓ Lacrimal glands, lacrimal drainage, orbits
  - ✓ Preauricular lymph nodes
- Examination of pupils/irises
  - ✓ Shape
  - ✓ Direct and consensual reaction (afferent pupil)
  - ✓ Size (eg, anisocoria)
  - ✓ Morphology

Examination Elements Single System

- Slit lamp examination
  - ✓ Corneas
  - ✓ Anterior chambers
  - ✓ Crystalline lens
  - ✓ Measurement of intraocular pressur

Examination Elements Single System

- Dilated fundus examination
- Ophthalmoscopic examination
  - ✓ Optic discs
  - ✓ Posterior segments

PLUS - Orientation to time place person

AND

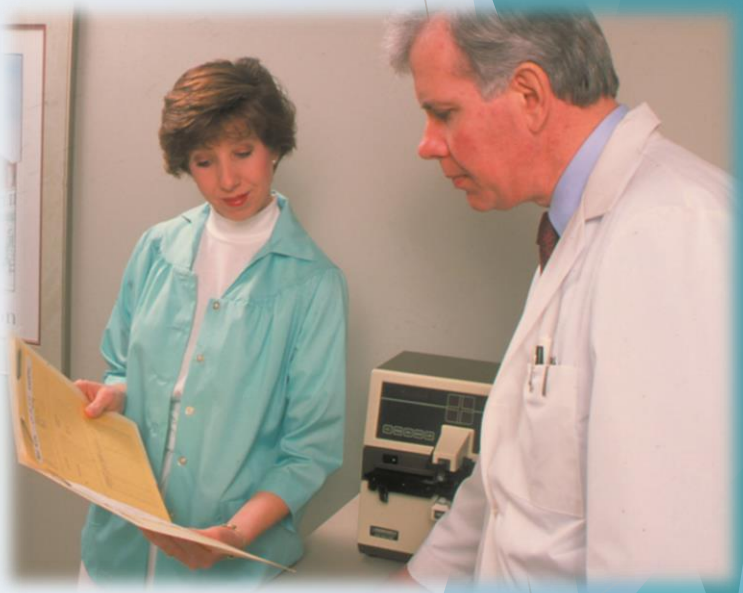
- Mood and affect

(eg, depression, anxiety, agitation)

Indirect ophthalmoscope

Examination Elements Single System

- *Problem oriented*
  - 1-5 elements
- *Expanded problem oriented*
  - 6 elements
- *Detailed*
  - 9 elements
- *Comprehensive*
  - 14 elements*
  - * all elements plus one Mood or orientation



Medical Decision Making

- Number of possible diagnoses
- Amount & complexity of medical records, diagnostic tests, other information
- Risk of significant complications, morbidity and/or mortality
- Comorbidities

Medical Decision Making

Other secondary factors to consider

- Counseling
- Coordination of care
- Nature of presenting problem
- Time

Time is key only when counseling and care coordination are the primary component

(> 50% of time spent with patient)

Medical Decision Making

Straightforward

Minimum number diagnoses
Minimal management options
Minimal risk

Low complexity

Limited number of diagnoses
Limited management options
Low risk

Medical Decision Making

Moderate Complexity

- Multiple diagnoses
- Moderate management options
- Moderate risk

High Complexity

- Extensive number diagnoses
- Extensive management options
- High risk

Medical Decision Making

The **highest** level of risk in any of the three determines **overall** risk

- Presenting problems(s)
- Diagnostic procedures
- Management options

Medical Decision Making

Document

- Findings
- Visualizations
- Plans
- Test results
- Consultations
- Old record requests

In short **DOCUMENT EVERYTHING!!**

CPT
Examples for Eye Care New Patients

99201

Initial office visit for a 10-year-old girl for determination of visual acuity as part of a summer camp physical (does not include determination of refractive error)

99203

Initial office visit for a 55-year-old female with chronic blepharitis. There is a history of use of many medications

99205

Initial office visit for a 70-year-old diabetic patient with progressive visual field loss, advanced optic disc cupping and neovascularization of retina

CPT
Examples for Eye Care Est. Patients

99213

Office visit for a 65-year-old female, established patient, with primary glaucoma for interval determination of intraocular pressure and possible adjustment of medication

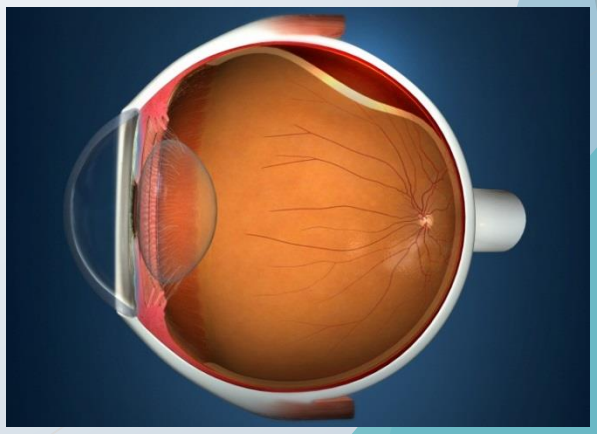
99214

Office visit for a 68-year-old male, established patient, with the sudden onset of multiple flashes and floaters in the right eye due to a posterior vitreous detachment

General Ophthalmologic Services

Example of Comprehensive Services From CPT®

The comprehensive services required for diagnosis and treatment of a patient ***with symptoms indicating possible disease of the visual system***, such as glaucoma, cataract or retinal disease, or to rule out disease of the visual system.



General Ophthalmologic Services

Examples of Intermediate Examination From CPT®

- Acute complicated condition (eg, iritis) not requiring comprehensive ophthalmological service
- Review of history
- External examination
- Ophthalmoscopy
- Biomicroscopy

General Ophthalmologic Services

Examples of Intermediate Services From CPT®

- Established patient with known cataract not requiring comprehensive ophthalmological services
- Review of interval history
- External examination
- Ophthalmoscopy
- Biomicroscopy
- Tonometry

General Ophthalmologic Services

Summary

- General ophthalmologic code set requirements is more straight forward than E&M code set requirements
- Do NOT include refraction
- Some carriers have specific definitions for intermediate and comprehensive levels apparently beyond what CPT® states

IMPORTANT: Initiation of diagnostic and treatment program seems to be the most audited item by Medicare

General Ophthalmologic Services

General Ophthalmologic examination can also includes:

None of these special tests have individual CPT codes and are included in intermediate and/or comprehensive general ophthalmologic examinations

1. Laser interferometry
2. Potential acuity meter
3. Keratometry
4. Exophthalmometry
5. Transillumination
6. Corneal sensation
7. Tear film adequacy
8. Phacometry
9. Schirmer's test
10. Slit lamp
11. History
12. General medical observation

92000 Codes
Special Ophthalmological Services

Describe services in which a special evaluation of part of the visual system is made, which goes beyond the services, or in which special treatment is given.

Special ophthalmological services may be reported in addition to the general ophthalmological services or evaluation and management services.

92000 Codes
Special Ophthalmological Services

92015 to 92499

Reported in addition to general ophthalmological services or E&M services

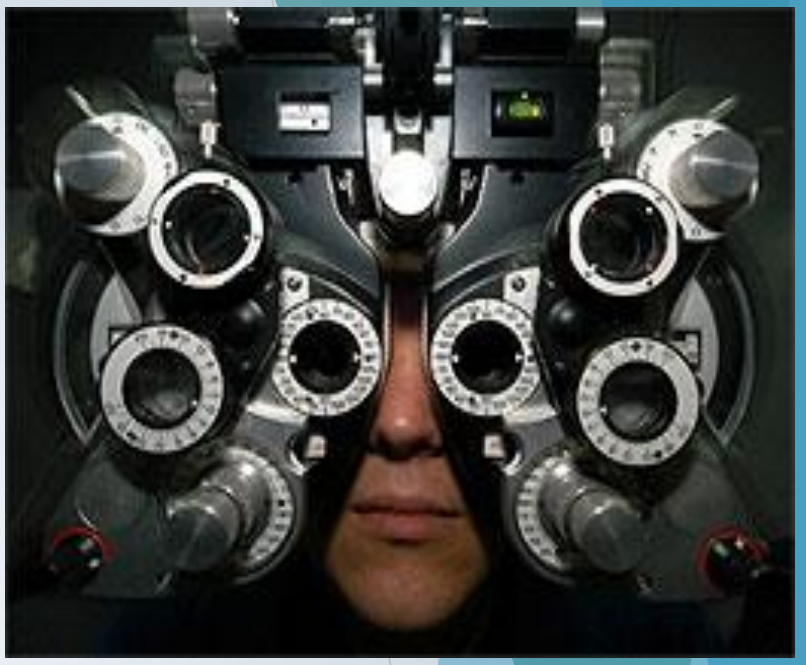
Interpretation and report by the physician or QHP is integral part of special ophthalmological services where indicated

92000 Codes
Special Ophthalmological Services

- Extended Ophthalmoscopy
  - Not a Routine BIO
- Angiography (Fluorescein / Indocyanine Green)
- Fundus Photography
- Scanning Laser Technology
- Color Vision Examination
- Gonioscopy
- External Ocular Photography
- Sensorimotor Evaluation
- Visual Fields

Effect of Lenses

Refraction-92015



- Determination of refractive state
- Statutorily not covered by Medicare
  - May file for denial
  - GY modifier may be necessary
    - service is statutorily excluded from Medicare coverage
- Consider Modifiers


How about something routine?

Other Medicare Coverage

Medicare DOES Cover - Routine:

Annual dilated exam for diabetics

Special code for glaucoma screening

G0117 with V80.1

S-Codes

- **S0620** – routine ophthalmologic examination including refraction, new patient

- **S0621** -- routine ophthalmologic examination including refraction, established patient

Routine Examination Codes?

S CODES PROBLEMS

No valuation

No further definitions

Insurers free to interpret at will

Well Vision Examinations Possible Future??

- CPT - Preventative Medicine Services
  - 99381-99397

- Used to report the preventative medicine evaluation and management of infants, children, adolescents, and adults

- Include the management of insignificant or trivial problems which do not require additional work

Preventative Medicine Codes Maybe?????

- **New Patient**
  - **99381** < 1 year old
  - **99382** 1-4 years
  - **99383** 5-11 years
  - **99384** 12-17 years
  - **99385** 18-39 years
  - **99386** 40-64 years
  - **99387** >65 years
- **Established Patient**
  - **99391** < 1 year
  - **99392** 1-4 years
  - **99393** 5-11 years
  - **99394** 12-17 years
  - **99395** 18-39 years
  - **99396** 40-64 years
  - **99397** >65 years

Well Vision Examinations
Comparison of RBRVS
New Patient

Preventative Medicine	General Ophthalmologic	
99381 to 99387		
Range: 3.10 to 4.64	92002 (Inter)	2.32
Average: 3.97	92004 (Comp)	4.22

Well Vision Examinations
Comparison of RBRVS
Established Patient

Preventative Medicine

99391 to 99397

Range: 2.87 to 3.81

Average: 3.38

General Ophthalmologic

92012 (Inter) 2.43

92014 (Comp) 3.52

Preventative Medicine Codes Maybe?????

- **Preventative Medicine codes (99381-99397)**
  - Precedent-some carriers require for child (Superior Vision)
  - Currently little general use of this approach
- **Encourage HIPAA compliance by payers**
  - Refraction not a part of any other code
- **Encourage HCPCS to delete S codes**
  - Maybe after progress with Preventative Medicine codes

SO WHAT NOW?

- How do I solve the daily dilemma of patient with Well vision coverage and a Medical problem?
- What options do I have?
- Will my patient get mad and leave my practice?
- Will the well vision plan back me up when I decide problem is medical?
- What should I do?

Well Vision Examinations

- Fundamental difference: medical vs. well vision care
  - Chief complaint and detail needed
  - Medical decision-making complex
  - Risk increased – morbidity/mortality
  - Examination more detailed
    - Anterior segment
    - Posterior segment
    - Neurological
    - Patient counseling
    - Ordered tests
    - Record review

The Problem

Medical Eye vs. Well Vision

- How to code
- How to differentiate
- How to be consistent
- How to “play by the rules”
- CPT code for Well Vision Unlikely

Well Vision Examinations

- Well vision visits vs. Medical visits
  - Many approaches around the country
  - Many with validity
  - All have unacceptable aspects

- **Key:**

  Consistency in coding regardless of payment method

Well Vision Examinations

- Why the problem?
  - Carriers (MAC) used to have LCD for 92 code
    - Can require use of 92 codes for medical claims
    - Can require use of 99 codes for medical claims
  - Private carriers inconsistent on code use
    - May include refraction in 92 codes
    - May include refraction in 99 codes
    - May require S codes for well vision, sporadic
  - No longer 99-medical and 92 well vision

Well Vision Examinations

Coding approaches across nation

- Use medical diagnosis for all examinations
- Routine coverage - refractive diagnosis

Concern:

- Diagnosis based on payment
- Creative diagnosing

Well Vision Examinations

Coding approaches across nation

- 92004/14 medical only
  - No well vision under this code
  - Concern: overcoding at times?
- 99 medical only
- 92002/12 well vision only

Concern: undercoding

  - Too many elements of exam performed

Well Vision Examinations

Coding approaches across nation

- Internally use S code for **all** well vision
  - Internal code only
  - Converted to “plan accepted code” (92 series?)
  - All routine patients –same exam=same fee concept
  - Payment method disregarded in coding
  - 92 and 99 would be used only for medical
    - Refraction separate
- **Concern:** “different” charge for same code when actually files to insurance

Medical vs Wellness

Patient with Medical Plan & well vision plan

- **Case History**
- 68 yo previous patient, not seen in 4 years
- Chief complaint: decreased vision LE
- VA : OD 20/30 OS 20/70
- Pupils: equal, no APD
- EOM: full, balanced
- Confrontation Fields: Full to Finger Counting

Medical vs Wellness

Patient with Medical Plan & well vision plan

- SL : WNL except Lens→NS + cortical opacities OU
- IOP: 18 OU
- Internal exam (volk super fundus & 20D):
  - RPE changes + drusen OU
  - Optic nerve and peripheral fundus = normal
- Amsler grid: normal OU

Diagnoses: Cataract, combined OU 366.19 (H25.813)

ARMD, OU 362.51 (H35.31)

Medical vs Wellness

Patient with Medical Plan & well vision plan

- At exam completion, fees are reviewed
- Patient announces expectation for exam to be covered by his well vision plan

- **WHAT DO YOU DO?**
- Clearly exam has medical presentation, history & exam

Medical vs Wellness

Patient with Medical Plan & well vision plan

- Many offices are faced with this dilemma
- More and more Medical Plans are adding wellness care

Options:

1. Perform well vision exam and reschedule for medical
2. Inquire upon patient arrive which plan intend to use
3. Bill Medical Carrier →exam & Bill well vision →glasses
4. Bill Medical carrier & cross file to well vision plan for copay, refraction and glasses, if allowed

Current Advice

- Doctors need to make hard decisions on how will handle BEFORE they occur
- Doctors need to thoroughly and completely TRAIN staff on policies
- Doctors need to thoroughly and completely read Well Vision Carrier policies
- Doctors need to carefully consider WHICH Well Vision Plans they will accept

Medical vs. Wellness

- **Case History-Vision Plan only**
- Complaint of itchy eyes for the past two weeks.
- Last eye examination over three years ago.
- Medical history includes hypertension (treated with Cozaar) and arthritis (treated with Plaquenil for the past year).
- VA: OD 20/20, OS 20/20 uncorrected

Medical vs Wellness

Patient with vision plan

- SL : Mild allergic conjunctivitis
- IOP: 18 OU
- Internal exam (volk super fundus & 20D):
  - Optic nerve and peripheral fundus = normal

Diagnoses: Allergic Conjunctivitis 372.14 (H10.45)

But what to do about the Plaquenil therapy and the ocular risks that occur with use?

Treat current symptoms. Explain of risks for plaquenil on ocular health and reschedule for further required baseline testing?

Medical vs Wellness

Patient with Medical Plan & well vision plan

- At exam completion, fees are reviewed
- Patient announces expectation for exam to be covered by his well vision plan

- **WHAT DO YOU DO?**
- Clearly exam has medical presentation, history & exam

Current Advice

- Doctors need to put policies in WRITING for ALL patients
- Doctors need to educate PATIENTS on what policies are in place BEFORE service
- Doctors need to educate PATIENTS on WHY policies are in place

Guiding Principles to Consider

1. The chief complaint and examination findings should ***RULE*** the examination content AND the coding

- My vision has gradually gotten worse, especially at near and no known ocular disease
  - Findings- presbyopic shift, no medical issues → Well vision examination
  - Findings – early ARMD → Medical examination

  - Examination content and technique for each similar but findings require more extensive examination, more knowledge and more risk
  - Medical examination leads to other testing, often

Guiding Principles to Consider

2. Plans accepted MAY have contract limitations on when must use well vision plans and if coordination of benefits may occur

Some plans allow Coordination of benefits (COB)

Some plans are changing their guidelines to force medical care under the well vision plan service

Some plans are rolling more medical testing under their well vision plans

Some plans are requiring the listing of medical diagnoses in addition to the refractive diagnoses applicable

PROVIDERS MUST READ AND UNDERSTAND THEIR CONTRACTS SO ARE ABIDING BY THE RULES!

Guiding Principles to Consider

3. Develop office policies and approaches to this common issue THEN stick to them!!

Avoid making rules for the rare exceptions

Ensure excellent education of staff and patients

Understand the consequences of your office policy decisions- you cannot go wrong with well thought out polices

Accept the fact that you may lose a few patients

Review your policies yearly to ensure these policies still meet the needs of your practice

Guiding Principles to Consider

4. Do apply the CPT codes and coding rules correctly and across the board

Remember waiving copays without clear case by case hardship documentation is considered fraud

Remember that waiving charges for procedures without clear case by case hardship documentation is considered fraud

Remember to develop policies that prevent fraud and abuse and uphold HIPAA rules

Resources for you

- Current Procedural Terminology Manual (CPT Book)
  - Excellent educational resource covering basics
- American Optometric Association Website

  http://www.aoa.org/coding

  Includes access to Ask the Coding Experts

  Includes access to AOA Coding Today link

See you next time….