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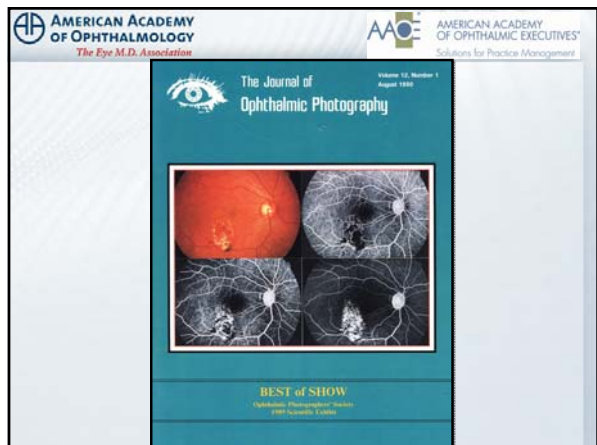
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Financial Disclosure

Kim M. Ross, OCS, CPC
Academy Coding Specialist

I have the following financial interest or relationships to disclose:

- Employee – American Academy of Ophthalmology



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Ophthalmic Photographers' Society 1989 SCIENTIFIC EXHIBIT

STEREO SLIDE DIVISION

First Place Winners:

<i>External Photography</i>	John L. Johnson, FOPS
<i>Fluorescein Angiography</i>	Jay Foreman, CRA
<i>Fundus Photography</i>	Kim M. Ross
<i>Gonioscopy</i>	Csaba L. Martonyi, COPRA
<i>Monochromatic Photography</i>	Mary Nauertz Richie
<i>Slit Lamp Photography</i>	Michael Stanley

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Testing Services

For each service, you will need to know whether it:

- requires a written order with interpretation and report
- requires general, direct or personal supervision
- is billable unilaterally (per eye) or bilaterally (per test)
- has a technical (-TC) or professional (-26) component
- has a published list of covered diagnoses
- is bundled with other procedures performed during the same office visit



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You also need to know if:


- Your state Medicare carrier has a Local Coverage Determination (LCD) policy. The LCD will also provide a list of covered diagnosis codes.
 - Third-party payers other than Medicare have their own requirements.
- There are frequency edits for utilization. The number of times a procedure for a given diagnosis can be billed within a calendar year is rarely published. State Medicare carriers may have LCDs that provide frequency information.



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Testing Services

- What documentation should be in the chart when tests are performed?



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Documentation must include:

- A written order. Any test not performed by the physician must have a written order in the medical record.
 - should specify which test and designated eye(s), OD, OS or OU.
 - this may be documented in a previous date of service.



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Testing Services

Documentation must include:

- A statement of medical necessity – an explanation of why the test(s) should be performed should be clearly stated in the medical record.



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Documentation must include:

- The written interpretation or report of medical findings.
 - Exactly what the report must state has not been specified.
 - There is no word limit or word minimum.
 - It should reflect the physicians' thoughts on the findings of the test.


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Documentation tips:

1. Comment on what was seen or what was not seen that was expected or anticipated.
2. Comment on the status of the condition. Is it improved or worsening?

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Documentation tips:

- Make a notation of any findings that reveal a need for change in treatment or what impact if any does the test have on the patient's treatment regimen.

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Levels of Supervision

- For Medicare

General	Physician presence not required
Direct	Physician must be on site
Personal	Physician must be in the room

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- For non-Medicare payers only direct supervision is recognized.

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Testing Services

CPT Code	Uni Bi	Description	\$ TC	\$ 26	\$ Total 2011/10
92025	*	Topography	\$16	\$19	\$35 / \$33
92132	*	SCODI, anterior segment	\$15	\$21	\$36 / 0187T
92133	*	SCODI, posterior segment; optic nerve	\$15	\$30	\$45 / \$45
92134	*	SCODI, posterior segment; retina	\$15	\$30	\$45 / \$45
92136	* / * *	IOLMaster	\$52	\$30	\$83 / \$78
76519		Ascan w/IOL calculations	\$48	\$30	\$78 / \$74
92235	**	Fluorescein angiography	\$85	\$45	\$131 / \$122
92240	**	ICG – Indocyanine-green angiography	\$178	\$61	\$239 / \$225
92250	*	Fundus photography	\$51	\$23	\$74 / \$69
92285	*	External photography	\$24	\$4	\$28 / \$41
92286	*	Specular endothelial microscopy and cell count	\$84	\$35	\$119 / \$113

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National Correct Coding Initiative – NCCI

The NCCI determines which special testing services are bundled when performed on the same day/same eye/same session.

- Updated quarterly – currently version 17.3 effective Oct 1, 2011.


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NCCI




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National Correct Coding Initiative – NCCI

- An indicator of “1” means the codes may be unbundled.
- An indicator of “0” means the codes are mutually exclusive and can never be unbundled.




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National Correct Coding Initiative – NCCI

Column1/Column 2 Edits				
(Jan. 1, 2011)				
Column 1	Column 2	Effective Date	Deletion Date *no data	Modifier 0=not allowed 1=allowed 9=not applicable
92133	92132, 99211	20110101	*	1
92133	92134, 92227	20110101	*	0
92134	92132, 99211	20110101	*	1
92134	92227	20110101	*	0
92136	99211	20030401	*	1
76519	99211	20030701	*	1




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National Correct Coding Initiative – NCCI

Mutually Exclusive Edits				
Column 1	Column 2	Effective Date	Deletion Date *no data	Modifier 0=not allowed 1=allowed 9=not applicable
92133	92250	20110101	*	1
92133	92250	20110101	*	1
92135	92250	20000605	20101231	1
92136	76519	20050101	*	0



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Testing Services

All testing services, even refraction, are bundled with the technician CPT code 99211.

- Result of OIG investigation
- If appropriate, unbundle by appending modifier -25 to 99211.



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Testing Services

In order for ophthalmic personnel to bill 99211:

- The physician must be on site during the exam.
- A written order must be in the chart documenting in detail the service(s) that are to be performed.



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National Correct Coding Initiative – NCCI

- Ophthalmic Coding Coach
- Coding Bulletin
- Under coding and reimbursement at www.aao.org/coding

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Ophthalmic Coding Cooch

Enter Code and Press Search:

Code Family: **92134 - 92134**

CPT CODE

92134 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina

DESCRIPTION

Laser (optical) Coherence Tomography is a non-invasive, non-contact imaging technique. It is also known as laser scanning tomography, optic nerve head imaging, optic nerve disc analysis, confocal scanning laser tomography, and electro-optic fundus

CHANGES

- New code in 2011.
- 92135 has been deleted.
- This change was driven by the dramatic increase in the number of times former CPT code 92135 was performed.

CC CODES

CODE **RVC** **OP** **FFAC** **RED** **PP** **ASST** **UNI/B**

92134 **1** **3** **3** **1** **3** **1** **3**

CCI CODES

CCI **92134** : **92132**, **92131** Mutually Exclusive: **92227**, **92250**

HCPCS MODIFIERS

-TC Technical component

LINKED CODES

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Coding Bulletin

This e-mail is a service offered to you as an AAOE member.

Your Resources for Coding & Billing Information

New Monthly CPT, ICD-9 Academy Coding Executive

AAOE Coding Specialist

Coding Bulletin
September 2011

In This Issue

- What's New... What's in a Name? - Defining and Using Determinations
- ICD-9 Final Updates Address Glaucoma Diagnosis Coding
- CPT Process for Handling a Provider's Allegation of Fraud

AAOE Coding Specialist

Coding & Reimbursement

Information you need to appropriately address all aspects of coding and reimbursement essential for practice income as well as adherence with federal regulations.

Resources & Links

- AAOE Program of the 2012 Annual Meeting: October 10-12, 2012
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Testing Services

- If the testing services are bundled in CCI, eliminate the lower paying of the procedures.
 - Example: FA – (92235), ICG – (92240), fundus photos – (92250) and OCT – (92134).

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Testing Services

Column1/Column 2 Edits and Mutually Exclusive CCI Edits
92235 36000, 36200, 36215, 36216, 36217, 36218, 36245, 36246, 36247, 36248, 36410, 76000, 76001, 77001, 77002, 90760, 90765, 90772, 90774, 90775, 92230, 93000, 93005, 93010, 93040, 93041, 93042, 96376, +96379, 99211
92240 36000, 36410, 90760, 90765, 90772, 90774, 90775, 92230, 92250, 93000, 93005, 93010, 93040, 93041, 93042, 96376, +96379, 99211
92250 99211 Mutually Exclusive: 92227
92134 92132, 99211 Mutually Exclusive: 92227 , 92250

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Testing Services

Payment:

- For tests with unilateral payment, (paid per eye) submit either:
 - 92XXX-50 or
 - 92XXX-RT and 92XXX-LT

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Testing Services

Payment:

- Just make sure that payment is 100% of the allowable per eye and that payment for the second eye is not reduced by 50%.

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Testing Services

CPT CODE	ALLOWABLE	UNI / BI
92240 – ICG	\$239	Unilateral – per eye
92235 – FA	\$131	Unilateral – per eye
92250 – Fundus	\$74	Bilateral – per test
92134 – SCODI	\$45	Bilateral – per test

Pathology in both eyes:
92240-50
92235-50

Pathology in one eye:
92240-RT or LT
92235-RT or LT

Should you submit for fundus photos 92250 or SCODI – 92134?

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A/B MAC Jurisdictions

Medicare Administrator Contractors (MAC)

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Local Carrier Determination Policies – LCDs

<http://medicare.fcso.com>

- **L29064 B-Scan**
- L29088 Botulinum Toxins
- L29095 Cataract Extraction
- **L29122 Computerized Corneal Topography**
- L29131 Destruction of Malignant Skin Lesions
- L29170 Excision of Malignant Skin Lesions
- **L29172 External Ocular Photography**
- **L29177 Fluorescein Angiography**
- **L29179 Fundus Photography**
- L29181 Ganciclovir and Cidofovir
- **L29197 Indocyanine-Green Angiography**
- L29959 Intravitreal Bevacizumab (Avastin®)
- L29207 Iridotomy by Laser Surgery
- L29210 Lacrimal Punctal Plugs
- L29211 Laser Trabeculoplasty
- L29216 Macugen (pegaptanib sodium injection)
- L29288 Noncovered Services
- **L29238 Ocular Corneal Pachymetry**
- L29239 Ocular Photodynamic Therapy (OPT) with Verteporfin
- **L29241 Ophthalmological Diagnostic Services - 92284/86/87**
- **L29242 Ophthalmoscopy**
- **L29244 Optical Coherence Biometry - 92136**
- L29266 Ranibizumab (Lucentis™)
- L29269 Retisert (fluocinolone acetonide intravitreal implant)
- **L29276 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)**
- L29301 Upper Eyelid & Brow Surgical Proc.
- **L29308 Visual Field Examinations**
- L29311 Yag Laser Capsulotomy

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Local Carrier Determination Policies – LCDs

<https://www.noridianmedicare.com>

- **L24280 Botulinum Toxin Types A and B**
- **L24473 Non-Covered Services**
- **L24361 Skin Lesion Removal (Includes AK/Excludes MOHS)**

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92025 Corneal topography

- Inherently bilateral – bill once when testing both eyes.
– Bill 92025 only – no modifier(s)

Note: Do not submit a claim for cornea transplant patients once the decision for surgery has been made until the end of the postop. This will help maintain the value of the surgical codes.

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Local Carrier Determination Policies – LCDs

Computerized Corneal Topography – 92025

Indications and Limitations of Coverage and/or Medical Necessity
FCSO Medicare will consider Computerized Corneal Topography medically necessary under any of the following conditions:

- pre-operatively for evaluation of irregular astigmatism prior to cataract surgery
- monocular diplopia
- bullous keratopathy
- post surgical or post traumatic astigmatism, measuring at a minimum of 3.5 diopters;
- post penetrating keratoplasty surgery;
- post surgical or post traumatic irregular astigmatism;
- corneal dystrophy;
- complications of transplanted cornea;
- post traumatic corneal scarring;
- keratoconus; and/or
- pterygium and/or corneal ectasia that cause visual impairment.



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76519 – A-scan IOL calculation
92136 – IOL Master

For Medicare patients

- Unique in that these codes have a global technical component and a professional component for each eye.



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76519 – A-scan IOL calculation
92136 – IOL Master

For Medicare patients

- Measurement is performed on both eyes and surgery is scheduled on the right eye:
 - 76519-RT or 92136-RT
 - Payment is for the global technical component and the professional component of the right eye.



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76519 – A-scan IOL calculation
92136 – IOL Master

For Medicare patients

- Two months later cataract surgery is performed on the left eye
 - 76519-26-LT or 92136-26-LT
 - Payment is for the professional component of the left eye.



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76519 – A-scan IOL calculation
92136 – IOL Master

For Medicare patients

- Surgery on the left eye was performed by another physician. You are performing surgery on the right eye.
 - 76519-TC-RT or 92136-TC-RT and
 - 76519-26-RT or 92136-26-RT



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76519 – A-scan IOL calculation
92136 – IOL Master

For Medicare patients

- Payment is for ½ the technical component and the professional component of the right eye.
 - 92135 - \$53 = \$27
 - 76519 - \$48 = \$24


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76519 – A-scan IOL calculation
92136 – IOL Master

For Non-Medicare patients

- Generally TC/26 are not recognized by these payers.
 - Submit 76519-eye modifier or 92136-eye modifier.

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Local Carrier Determination Policies – LCDs

Optical Coherence Biometry – 76519 or 92136

Indications and Limitations of Coverage and/or Medical Necessity
Medicare will consider the performance of OCB medically reasonable and necessary if performed preoperatively by the operating surgeon or his/her designee for the purpose of determining intraocular lens power in a patient undergoing cataract surgery. Generally, it is expected that the provider that is performing the cataract surgery will perform OCB.

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Local Carrier Determination Policies – LCDs

Optical Coherence Biometry – 76519 or 92136

Original Determination Effective Date - For services performed on or after 07/16/2011 (WPS)

Utilization Guidelines

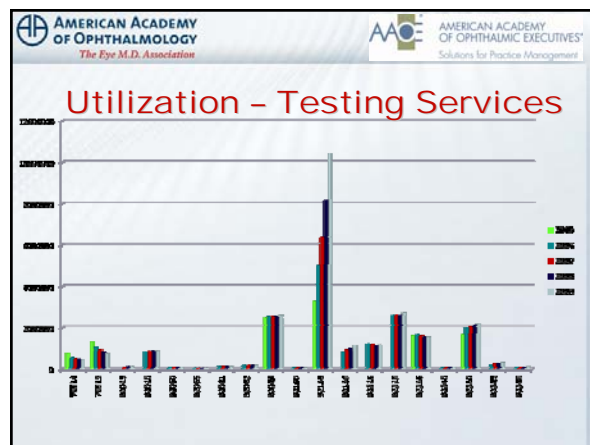
1. Ophthalmic biometry using A-scans (76519) and optical coherence biometry (92136) for the same patient should not be billed by the same provider/physician/group during a 12-month period. Claims for either of these services in excess of these parameters will not be considered medically necessary.
2. The technical portion of either 76519 or 92136 and the respective interpretations for the same patient should not be billed more than once during a 12 month period by the same provider/physician/group unless there is a significant change in vision. Claims in excess of these parameters will not be considered medically necessary

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CPT Changes – Testing Services

- Driven by the dramatic increase in the number of these procedures being performed each year, CMS is charged to review codes with the highest rate of growth for work value.



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CPT Changes – Testing Services


- CPT code 92135 was caught in this screen.


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CPT Changes – Testing Services


- The division into optic nerve and retina was caused by the distinct different uses for the service to aid clinicians in reporting different services.



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CPT Changes – Testing Services


- The CPT Editorial Board during its review would not continue the unilateral designation, feeling that claims data suggested that the service was being done bilaterally in the majority of cases.



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CPT Changes – Testing Services


- This meant that Medicare and beneficiaries were paying for overlapping practice expense and malpractice values.



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CPT Changes – Testing Services

- 92135 Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report **was deleted and replaced with three new codes.**



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CPT Changes – Testing Services

- 92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral

Note: This replaced Category III code 0187T for cornea.



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- 92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

Note: For glaucoma


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CPT Changes – Testing Services

- 92134 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina

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CPT Changes – Testing Services

- CPT states: ➤Do not report 92133 and 92134 at the same patient encounter◀
- This edit is also found in CCI edit effective – January 1, 2011.

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CPT Changes – Testing Services

CPT Code	Medicare allowable	CCI Edits	Supervision
92132	\$36	N/A	Doesn't apply
92133	\$45	92132, 99211 Mutually exclusive 92134, 92227, 92250	Doesn't apply
92134	\$45	92132, 99211 Mutually exclusive 92227, 92250	Doesn't apply

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CPT Changes – Testing Services

- Although mutually exclusive, CCI has assigned an indicator of "1" instead of "0" which means there may be medical indications where it is appropriate to unbundle the two codes by appending modifier -59 to 92250 Fundus photography.

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CPT Changes – Testing Services

- Best to watch for your Medicare or commercial payer coverage policy.
 - Cigna Government Services
 - First Coast Service Options
 - Highmark Medicare Services
 - National Government Services
 - National Heritage Insurance Company
 - Wisconsin Physician Services

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Utilization Frequency


Glaucoma	It is expected that only two tests per year would be required to manage the patient who has glaucoma or is suspected of having glaucoma.
Retina	<p>It is expected that only one test every 2 months would be required to manage the patient whose primary ophthalmological condition is related to a retinal disease.</p> <p>However, for those patients who are undergoing active treatment for macular degeneration or diabetic retinopathy one test every month may be appropriate for the management of their disease.</p>


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92235 Fluorescein angiography


- 100% of the allowable per eye when medical necessity exists. Do not bill for the eye that does not have pathology.
- Cost of the dye is not separately payable.



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92235 Fluorescein angiography

- 92235-50
– Or –
- 92235-RT and
92235-LT



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Local Carrier Determination Policies – LCDs

Fluorescein Angiography – 92235
Indications and Limitations of Coverage and/or Medical Necessity


- Eyes with the nonexudative form of macular degeneration should have regular ophthalmic examinations, including fluorescein angiography performed every 6-12 months since the exudative stage may develop suddenly at any time even before patients demonstrate symptomatic visual problems.
- The Fluorescein angiography and fundus photography are normally performed together. These studies should be performed no greater than 72 hours prior to laser therapy for ARMD because abnormal blood vessels grow at rapid rates making the studies older than 72 hours inadequate to guide laser treatment.



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92250 Fundus photography

- Bilateral procedure (bill once when testing both eyes)
- Submit 92250 only – no modifier(s) required



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Fundus Photography – 92250
Limitations of Coverage and/or Medical Necessity


-digital imaging systems for the detection and evaluation of diabetic retinopathy used to acquire retinal images through a dilated pupil with remote interpretation do not meet Medicare's reasonableness and necessity criteria for fundus photography.
- Fundus photography is not a covered service when used to document the absence of pathology (i.e., a normal or healthy fundus or screening) or when the physician elects to incorporate it as a routine procedure. Routine fundus photography for purposes other than documentation, monitoring and treatment of a pathological process falls outside the standard of care as a medical necessity and is thereby not a covered service.



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92285 External ocular photography

- Bilateral procedure (bill once when testing both eyes)
- Unfortunately many payers do not pay for preoperative photos for upper lid procedures even though they are required documentation.
 - Submit 92285 only – no modifier(s) required



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Local Carrier Determination Policies – LCDs


External Ocular Photography – 92285
Indications and Limitations of Coverage and/or Medical Necessity

- This procedure may be indicated when photo-documentation is required to track the progression or lack of progression of an eye condition, or to document the progression of a particular course of treatment. While many conditions of the eye could be photographed, this procedure should not be used to simply document the existence of a condition in order to enhance the medical record.



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92286


Specular Microscopy

- Inherently bilateral (bill once when testing both eyes)
- General supervision
- Endothelial cell count



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Testing Services

- The following testing services are considered components, not countable elements in E&M documentation, or an E&M or Eye code service and are not payable separately.



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Testing Services

Services not payable separately:

Accommodation convergences	Color vision screening (Ishihara or pseudo-isochromatic test plates)	External examination	Potential acuity measurement (PAM)
Amsler grid		Glare testing	Schirmer tear test
Basic sensorimotor evaluation	Comparison of gross visual fields	Gross visual fields	
Binocular function	Dilation of the pupils	Keratometry (K-readings)	



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Testing Services

– Skilled nursing facility

- Difference between nursing home and SNF
 - SNFs receive payment to rehabilitate the patient (21 day stay-maximum).
- The technical component of all special testing services should be submitted to the SNF and the professional component to Part B Medicare.



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Healthcare Reform



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Federal health care


- AAO involved with constant interaction with Federal, state and local agencies to develop coverage and payment policies to meet the needs of patients and society.
- More demands from government for evidenced based care lead to AAO development of PPPs in 1985.



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Factors stimulating PPACA


- Run away costs-technology biggest driver
- Health care spending causes decreases in disposable personal income.
- 43 million uninsured
- Perceived poor quality and safety
- No Comparative Effectiveness Research (CER)
- Disparities of care



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Current status: non-Medicare


- From 1996 to 2002, employer sponsored premium increased 85%. In 2008, avg. premium was \$12,846 (1/3 out of pocket)
- In 2006, less than 5% of insurance plans were "classic indemnity plans"-more out of pocket costs
- **Out of pocket costs for family of four was \$16,900 in '09 and rising to \$18,000 in '10**
- Projected to rise to \$36,000 in '19
- Only 25% of American families had incomes >\$100k and wages stagnant



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Current status-Medicare: pre-ACA

- Medicare Part A bankrupt in 2019
- Part B costs exploding; paid for with current tax revenues and under funding pressure during a recession, a crumbling infrastructure and a few wars
- **Patient premiums have doubled since 2001**


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Current status-Medicare: pre-ACA


- We were unable to pay for patients under the current system.
- There was universal agreement that no attempt to cover the uninsured was possible without payment reform to "bend the cost curve".
- Payment reform should entail a change from reimbursement based on the volume of services billed to the value of services provided.



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Quality pre ACA

- Despite explosive growth in health care spending, American receive only 55% of recommended care.


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Post PPACA

- Payment reform
- Quality/value
- Work force pressures
- CER
- Population health




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Post PPACA

- Health disparities
- Patient centeredness
- Payment reform-value based purchasing




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Payment reform

- Value based purchasing-move from volume based to value based payment.
- PQRI, "e" rx, MOC bonus, HIT adoption
- Bundling
- Accountable care organizations (ACOs)-care integration
- Value modifier



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Value Based Purchasing-HIT

VBP	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18
PQRS	2	2	1	.5		(.5)	(.5)	(1)	(1.5)	(2)
"E"RX	2	2	1	1(1)	.5 (1.5)	(2)	(2)			
EHR			*	*	*	*	(1)	(2)	(3)	(3--5)
MOC	0	0	.5	.5	.5	.5	(.5)	(.5)	(.5)	(.5)
Total	4	4	2.5	2-- (1)	1-- (1.5)	.5-- (2.5)	(3)	(3.5)	(5)	(5.5-7)

*Beginning in 2011, physicians can earn up to \$44,000 for adoption of EHR/MU




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Bundling

- CMS will bundle all services for an episode of care, eg joint replacement: imaging, consults, surgical fee, facility charges, devices, readmissions, rehabilitation and nursing care for 90 days.
- A lump sum paid to hospital or integrated group.
- Saving shared between payers and providers




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Bundling

- Theoretically, all glaucoma/AMD/DR services (drugs, devices, testing, surgeon's and facility fees, etc.) for a "typical" patient incurred over a year will be bundled and paid in installments.
- Starts in 2013
- Use more generics and order fewer tests - more revenue.
- Bundle payments adjusted for quality and efficiency
- Big problems with risk adjustment.



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Accountable Care Organizations (ACOs)-model for care integration

- Assume total care of Medicare beneficiaries.
- Primary care panel with minimum of 5,000.
- MD paid on FFS directly by CMS unless MD is hospital employed
- Shared savings with risk vs risk
- Impact on spending?
- Anti-trust concerns?
- Role of ophthalmology?
- Operational in 2014
- Organized by hospital and large MD IPOs



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ACOs and Ophthalmologists

- ACOs must provide all services to Medicare beneficiaries.
- Patients will have access to ophthalmologists of their choice and docs will be paid directly by Medicare their usual FFS fees.
- We are not attractive to hospitals-merci bien
- DO NOT SIGN AN EXCLUSIVE CONTRACT!**



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Value-Based Modifier

- CMS will issue resource use reports by 2012
- Public reporting** of quality performance in 2013
- CMS mandated to pay doctors differentially on the basis of their quality and efficiency of care**
- Modifier Applied to Payments for MDs providing high cost services with resource variation in 2015
- All MDs by 2017 and budget neutral
- % bonus/penalty unknown at this time-probably 10%



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Value Modifier

- Powerful tool to reduce variation!
- What happens with regression to mean?
- Do you move the curve to the L?
- How do we protect patients and ensure they are receiving appropriate care?
- There is a need to develop appropriate use/resource use criteria to protect patients and docs.**



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Summary

- Over the next decade, the pressure of constrained resources during a period of expanding health care access, increasing demands for improved quality, and patient centeredness in a more diverse population with known disparities of care, will lead to a growing interdependence of society and medicine. We will be working in teams to meet the work force demands of a more culturally diverse and expanded patient base. Ophthalmology must be prepared to meet these demands or they will be fulfilled by others.



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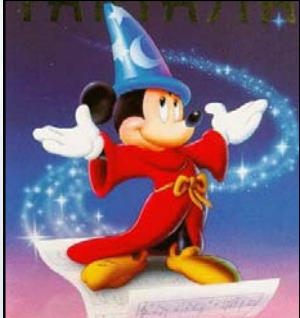
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Questions





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