Basics of Medical versus Vision Coding

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DISCLAIMER

- This lecture and the concepts within apply to CPT and Medicare/Medicaid guidelines that are currently applicable, but are susceptible to change over time.
- The examples in no way mandate a manner in which you should practice medicine nor is it the only way in which one could bill for it. That is an individual physician’s decision.
- Any fees presented in these examples in no manner mandate or even suggest fees you should consider for services rendered. This is also an individual physician’s decision.

Wellness Care vs. Medical Care
THE Cornerstone Issue

These are INDEPENDENT examinations – have nothing to do with each other
Can include some of the same procedures, but they have different findings and documentation

Eye Care

- We provide wellness care & medical care.
- The decision to bill wellness or medical is not solely based on why the patient is there or what their insurance coverage is.
- It is determined over the entire course of the exam.

Medical Care

- Reimbursed on cognitive thinking and the subsequent documentation of the...

Medical Care

- Reimbursed on cognitive thinking and the subsequent documentation of the...

SYMPTOMS AND THE ASSOCIATED DIAGNOSIS
Medical Care

Advantages:
- Higher reimbursement
- Patient may pay less – esp with Medicare
- Validation/Patient expectation

Disadvantages:
- Get on panel
- Wait for reimbursement
- Unique rules – sometimes difficult to know them
- Fear of being audited

Things to Remember...

- Any time a patient presents to your office, you have to rule out a medical problem before determining it’s a wellness exam.
- Some medical insurances cover routine eye care which usually reimburses higher!
- Let’s look at some key differences between wellness vs medical care.

Wellness Care vs. Medical Care

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There are five payors of eye care:
1. Patient
2. Vision Insurance
3. Medical Insurance
4. Medicare
5. Medicaid

Payors Patient:
- No rules apply!!!
- Can bill wellness or medical care
- Reimbursement is solely based on what you’re willing to charge
- Paid today

Payors Vision Insurance:
1. Few rules that govern the exam
2. Doesn’t require a medical complaint
3. Can use as a gateway to medical care
4. Carries with it some amount of patient expectation though

Payors Medical Insurance:
1. Some rules apply for covered benefits
2. Doesn’t require a medical complaint, only a medical problem
3. Must have a medical diagnosis to justify the exam and/or procedures
4. May have allowances for routine eye care INCLUDING materials

Payors Medicare only:
1. Lots of rules apply for covered benefits
2. **Must have a medical complaint**
3. Must have a medical diagnosis to justify the medical complaint to bill a medical exam and/or procedures
4. Never covers routine vision exam or refraction

What is a Medical Complaint?
1. **Medical symptom** or
2. **Physician directed** follow-up based on a prior condition diagnosed or
3. History of eye problem diagnosed before you and **state in record that patient wants condition evaluated** or
4. Few systemic problems – diabetes, high risk medication use, headache
What is a Medical Symptom?

- Almost anything other than blurred vision and sometimes that too
- NOT a routine eye exam or yearly checkup or other such wording
- Commonly overlooked symptoms:
  - Floaters, glare, difficulty with night driving, growths on eyes, fluctuating vision, itchy eyes, burning eyes, watery eyes

### Payors

**Medicaid**

1. Follows most rules that apply to Medicare covered benefits but has some unique rules too
2. Has allowances for medical care and routine eye care including materials
3. **Medical billing doesn’t require a medical complaint, only a medical problem**
4. Can now bill for a separate refraction!

### Unique Payor Rules

- Only way to find some of these rules out is to look it up, bill and see, or give up.
  - Medicare/Medicaid have LCDs.
  - Blue Cross Blue Shield does not pay for corneal topography for any diagnosis.
  - VSP uses 92000 codes for wellness exams

### Local Coverage Determination (LCD)

- Determined by the carrier (Trailblazer) and change often
- Typically limited to Medicare and Medicaid (although others may mimic)
- You MUST know and follow these limiting diagnosis rules or get denied

### LCD Examples

- "WOULD NOT EXPECT" to perform scanning laser at the same visit with visual fields, fundus photography, B-scan or extended ophthalmoscopy
- CANNOT perform more than one retinal or external photo at a given examination
- Photos cannot just document existence of a condition…must be used in the diagnostic and treatment decision making process
- Repeat fundus photos only used to document change or progression
Websites for your Favorites List

- **www.cms.hhs.gov**
  (Medicare)
- **http://www.cms.hhs.gov/NationalMedicareYouTrain**
  (Learning Center)
- **www.trailblazerhealth.com**
  (Carrier)
- **www.pgba.com**
  (Palmetto)

(commercial payors usually have informational websites too)

Numbers Involved

- **CPT – Current Procedural Terminology**
  - What procedures you did
- **ICD 9 – International Classification of Diseases, version 9**
  - What diseases you found

CPT Codes

- **99000**  Evaluation/Management Services
- **92000**  General Ophthalmological Services
- **92000**  Diagnostic Tests
- **80000**  Laboratory Tests
- **70000**  Radiology Tests
- **60000**  Surgical Procedures

CPT Examination Codes

- Evaluation and Management Codes:
  - New Pt: 99201, 99202, 99203, 99204, 99205
  - Established Pt: 99211, 99212, 99213, 99214, 99215
- Ophthalmological Codes:
  - New Pt: 92002, 92004
  - Established Pt: 92012, 92014
- 4th digit differentiates if it’s a new or established pt
- 5th digit differentiates the level of the exam

ICD 9 Codes

- Dry Eye Syndrome 375.15
- Cataract 366.16
- Type 2 Diabetes 250.00
- Floaters 379.24

References:

- ICD 9 CM, 2008 office ed. ©2007. PMIC.
- EHR, EyeCOR
- http://icd9cm.chrisendres.com/

Coding and Billing

- Code to highest level of specificity
  - “best fit”
- Use eye codes, not systemic
  - few exceptions – headache, diabetes, etc
- Use the 5 digit version of the code
- Only code what justifies the procedures
  - If you diagnosis it, then you must treat it; but you **don’t have to code for it!**
Coding and Billing
- There are many ways/styles of billing the exact same patient encounter
- No one way is right/wrong or appropriate for every given patient encounter
- Legal to use different styles based on the patient encounter

Styles of Billing
- Manage patient expectations
- Manage office efficiency
- Reimbursed for vision care
- Reimbursed for medical care

General Tips
- Find out medical benefits before the exam
  - Specialist copay or Coinsurance
  - Procedural copay (if there is one)
  - Deductible
    - How much they have met
  - Routine eye care allowance
- If Medicare patient, get a medical symptom!

Case Examples
- For medical exams, 92000 codes are the only examples used here
- For vision exams, S0620 code is used
- Example HCFAs used here only site the medical billing

Case #1
- 48yo diabetic female presents with a gradual decrease in her distance and near vision with her progressive lenses. She reports good control of her diabetes, but does notice her vision changes depending on her control. She has both vision and medical insurance.

Medical symptom?
Medical Record
- Refraction: -2.00DS with 20/20 OU
- SLE findings: unremarkable OU
- DFE findings: unremarkable OU, (-)DR
- Diagnoses:
  - Diabetes with ophthalmic manifestations (250.50)
  - Myopia (367.10)

Billing Scenario #1
- Bill a wellness vision exam (S0620) using myopia (367.10) to vision insurance
- Collect vision insurance copay
  - Managed patient expectations
  - Not reimbursed for medical care

Billing Scenario #2
- Bill a comprehensive medical exam (92004) using diabetes with ophthalmic manifestations (250.50) to medical insurance
  - Collect the medical insurance copay or monies going toward deductible
  - Reimbursed for medical care
  - Not reimbursed for vision care
  - Patient may question why vision insurance isn’t being used and bill is higher

Billing Scenario #3
- Bill a wellness vision exam (S0620) on initial visit to vision insurance
  - Collect vision insurance copay
- Bill an intermediate medical exam (92012) on follow-up visit using diabetes with ophthalmic manifestations (250.50) to medical insurance
- Bill extended ophthalmoscopy (92225-RT/LT) using diabetes with ophthalmic manifestations (250.50) to medical insurance
  - Collect medical insurance copay or monies going toward deductible
  - Reimbursed for all care delivered
  - Took 2 visits = more time
  - Patient might not come back for 2nd exam
Case #2

- 67yo male presents with a decrease in his distance and near vision with his progressive lenses. He also complains of an inability to drive in the dark due to his bad night vision. He has Medicare only.

Medical symptom?

Medical Record

- Refraction: +2.00DS with 20/30 OD, OS
- SLE findings: 2+ NS cataracts OU
- DFE findings: unremarkable OU

Diagnoses:
- Cataracts, nuclear sclerosis (366.16)
- Hyperopia (367.10)

Billing Scenario #1

- Bill a wellness vision exam (S0620) using hyperopia (367.00) to patient
  - Collect UCR from patient

✔ Managed patient expectations
✔ Got paid today

🇺🇸 Not reimbursed for medical care and there was even decreased vision
🇺🇸 Might have been able to save patient money by using his Medicare and you could had higher reimbursement

Billing Scenario #2

- Bill a comprehensive medical exam (92004) using nuclear sclerosis cataracts (366.16) to Medicare
  - Collect the appropriate monies based on unnet Medicare deductible
- Bill a refraction (92015) using hyperopia (367.00) to the patient
  - Collect UCR from patient

✔ Reimbursed for medical and vision care in one visit
✔ May have saved the patient money depending on Medicare deductible status

🇺🇸 Patient may question why using Medicare, but maybe the conversation is easy due to the decreased vision aspect
🇺🇸 Patient may also question why he has to pay for the refraction
Case #3

- 29yo male presents with complaints of occasional flashes ever since a car accident last week. No other real vision complaints that affect him daily. He has vision and medical insurance.

Medical symptom?

Medical Record
- Refraction: -0.25DS with 20/20 OD, OS
- SLE findings: unremarkable OU
- DFE findings: unremarkable OU, (-)RDs

Diagnoses:
- Photopsia (368.15)
- Myopia (367.10)
- Plan: RTC 1wk for f/u

Billing Scenario #1
- Bill a wellness vision exam (S0620) using myopia (367.10) to vision insurance
- Collect vision insurance copay

- Managed patient expectations
- Not reimbursed for medical care and there is a real liability for a detachment

Billing Scenario #2
- Bill a comprehensive medical exam (92004) using photopsia (368.15) to medical insurance
- Collect the medical insurance copay or monies going toward deductible
- Choose not to bill refraction since patient didn’t really need glasses nor the potential extended ophthalmoscopy

- Reimbursed for the medical care and higher reimbursement
- Patient may question why you’re not using vision insurance, but maybe the conversation is easy due to the potential detachment issue
- Could have billed extended ophthalmoscopy for higher reimbursement
Billing Scenario #3

- Bill a comprehensive medical exam (92004) using photopsia (368.15) to medical insurance
- Bill extended ophthalmoscopy (92225-RT/LT) using photopsia (368.15) to medical insurance
- Collect the medical insurance copay or monies going toward deductible

Case #3 – Return Visit

- Same patient returns 1wk later because you wanted to follow-up on the continued flashes. He has not seen any flashes since his last visit.

Medical Record

- Vision: 20/25 OU
- SLE findings: unremarkable OU
- DFE findings: unremarkable OU, (-)RDs
- Diagnoses:
  - Photopsia (368.15)

Medical symptom?
Billing Scenario #1

- No charge visit – didn’t bill patient
- Made patient happy without a bill
- Didn’t get reimbursed for continued medical care

Billing Scenario #2

- Bill an intermediate medical exam (92012) using photopsia (368.15) to medical insurance
- Collect the medical insurance copay or monies going toward deductible
- Still chose not to bill extended ophthalmoscopy

Billing Scenario #3

- Bill an intermediate medical exam (92012) using photopsia (368.15) to medical insurance
- Bill subsequent extended ophthalmoscopy (92226-RT/LT) using photopsia (368.15) to medical insurance
- Collect the medical insurance copay or monies going toward deductible

Billing Scenario #3

- Reimbursed for all the medical care and highest reimbursement
- Patient may question why they have to pay again for the same problem
Case #4

- 52yo female presents with dry eye complaints. It's been on-going for years without much help from artificial tear use. Also feels like her vision has been affected by her dry eyes. She has both vision and medical insurance.

Medical Record

- Refraction: +2.50DS with 20/25 OU
- SLE findings: 2+ diffuse SPK OU, 1+ diffuse conjunctival hyperemia OU
- DFE findings: unremarkable OU

- Diagnoses:
  - Dry Eye (375.15) causing decreased vision
- Plan: RTC 2wk for follow-up

Billing Scenario #1

- Bill a wellness vision exam (S0620) using myopia (367.10) to vision insurance
- Collect vision insurance copay

✓ Managed patient expectations

😊 Not reimbursed for medical care of dry eyes and there was decreased vision

Billing Scenario #2

- Bill a comprehensive medical exam (92004) using dry eye (375.15) to medical insurance
- Collect the medical insurance copay or monies going toward deductible
- Waive the refraction fee

✓ Got reimbursed for the medical care delivered and waived the refraction fee to make life easier

😊 Patient may question why their vision insurance isn’t being used and they have a higher copay
Case #4 – Return Visit

• Same patient returns 2wks later with improved symptoms, but still feeling like eyes are dry.

Medical symptom?

Billing Scenario #1

• Since you billed the medical exam initially, bill a wellness vision exam (S0620) using hyperopia (367.10) to vision insurance
  • Collect the vision insurance copay

✓ Patient understands that initially something was wrong, but now that everything is okay is getting to use vision insurance and pay less

 |_| Not reimbursed for medical care of dry eyes

Billing Scenario #2

• Bill an intermediate medical exam (92012) using dry eye (375.15) to medical insurance
  • Decide not to collect the medical insurance copay...CANNOT DO THIS!!
  • Must collect the medical insurance copay or monies going toward deductible

Billing Scenario #3

• Bill an intermediate medical exam (92012) using dry eye (375.15) to medical insurance
• Bill for punctal plugs (68761-E2,E4)
  • Collect the medical insurance copay or monies going toward deductible

✓ Get higher reimbursement and will help maintain patient’s eye health for longer period of time with plugs

 |_| Patient might have a problem with the costs involved in the medical care of dry eyes
How to Collect from Medicare

- Know Medicare’s fee schedule
- Cannot charge Medicare more for covered service than private pay patient

How to Charge:
- 2011 Annual Deductible ($162) then,
- Medicare pays 80% of covered services
- Patient pays 20% of covered services and 100% for any non-covered service

Example Charges

<table>
<thead>
<tr>
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<td>92004 (exam)</td>
<td>$149</td>
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<tr>
<td>92225-RT (ext ophthal)</td>
<td>$30</td>
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<td>92225-LT (ext ophthal)</td>
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<tr>
<td>92015 (refraction)</td>
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Total = $234

What are the covered services under Medicare?

Covered Services Total = $209
Non-Covered Services Total = $25

Annual Deductible Met – No

- Covered Services:
  - Patient Pays:
    - 20% of $209 = $41.80
  - Medicare Pays:
    - 80% of $209 = $167.20
- Non-covered Services:
  - Patient Pays:
    - $25 + $171.40 = $196.40

Annual Deductible Met – Yes

- Covered Services:
  - Patient Pays:
    - 20% of $209 = $41.80
  - Medicare Pays:
    - 80% of $209 = $167.20
- Non-covered Services:
  - Patient Pays:
    - $25 + $41.80 = $66.80

Thank you

Questions?