Modern Optometric Staff

- Ask the right questions, take the right actions
- Follow HIPPA guidelines
- Federal government — Medicare audits
- Vision plan audits
- Obtain informed consent
  - Contact lens wear
  - Minor surgical procedures
  - Waiver of liability if no polycarbonate lenses

The HIPPA Act of 1996

- Result of law is to establish national standards for electronic health care transactions
- Result of law is to establish national identifiers for covered entities:
  - Health plans
  - Health care clearinghouses
  - Health care providers who transmit any health information in electronic form in connection with a transaction defined in the law

“I’m From The Government”

- A 44-year-old woman presents for an eye examination
- When called from the reception area, the patient and a man come forward together to begin the examination process
- The staff member obtains the initial patient history and performs some of the other service components of the eye examination
- Patient is placed in the exam room to await the arrival of the optometrist

“And I’m Here To Help”

- Optometrist enters the room and greets the two people
- He/she continues the examination process by reviewing the initial patient history
- STOP – STOP – STOP
- You are breaking the law
- Someone has to do it – ask permission

Definitions of Eye Examinations

- Optometry School definition
- Federal Government definition
- State Government definition
- Medicare definition*
- Other Payor definition
- Medicolegal definition
- Current Procedural Terminology definition
### Optometry School Definition
- Patient history
- Visual acuity
- Tonometry
- General medical observation
- Gross visual fields
- Basic sensorimotor examination
- External examination
- External ocular examination with biomicroscopy
- Ophthalmoscopy
- Initiation of diagnosis and treatment program
- Refraction

### Federal Government Definition
- A patient is a person who has had an eye examination
- An eye examination is the process of determining the "refractive condition" of a person’s eye or the presence of any visual anomaly by the use of objective or subjective means
- A prescription is the written specification for lenses for eyeglasses which are derived from an eye examination, including all of the information specified by state law, if any, necessary to obtain lenses for eyeglasses

### Texas Definition of Eye Examination
- The Texas Administrative Code describes a “Spectacle Examination” and lists the documentation requirements of the procedure
- These documentation requirements only apply to patients receiving an initial, signed prescription for ophthalmic lenses
- Patient history
- Visual acuity
- Objective refraction
- Subjective refraction
- Tonometry
- Gross visual fields
- Basic sensorimotor exam
- Ophthalmoscopy
- External ocular exam with biomicroscopy

### Medicolegal Definition
- **Helling vs. Carey.**
  - A young woman sues her ophthalmologist for failure to diagnose glaucoma over a 10-year period
  - The M.D. argues that standard-of-care is to measure IOP only in older patients
  - Judge’s decision created the new standard-of-care, measuring IOP on every patient regardless of age
- **Keir vs. United States.**
  - Evaluated on a military base for a “routine exam”
  - Less than a year later, pupil turned white and diagnosed with retinoblastoma
  - Judge determined that the eye doctor should have performed BIO - result is new dilation standard

### Medicolegal Nature of Eye Care
- All eye examinations are medical eye examinations
- Optometrists are held to the same medico-legal standard of care as ophthalmologists when it comes to diagnosing eye disease
- Many eye diseases present at various stages of their natural history without clinical symptoms
- Relying on the patient to self-diagnose is not the best way to deliver medical eye care
- Most malpractice claims are for failure to make a proper diagnosis

### Coverage Decision-Making
- For patients with Medicare, the coverage of an eye examination is dependent upon the purpose of the examination
- If the purpose of the visit is for correction of refractive errors, the examination is not payable
- The patient must have a complaint or symptoms of an eye disease or eye injury to create medical necessity when using Medicare insurance
- For patients with vision insurance and medical insurance, the final decision-making involves professional judgment of the optometrist regarding the intensity of the eye disease
Reporting Medical Services

- International Classification of Disease - (ICD-9)
- Medicare
  - Clinical indications
  - Documentation requirements
  - Coding guidelines
  - Utilization guidelines
- Individual Payor Guidelines
  - "Whoever is paying is the one that makes the rules"

Current Procedural Terminology

- Current Procedural Terminology (CPT) has designated four specific procedure codes that are used for Medical Eye Examinations and they are called General Ophthalmological Services
- General Ophthalmological Services can be provided in two levels of intensity
  1. Intermediate services
  2. Comprehensive services
- The intensity of an eye examination is a function of medical necessity

Determining Medical Necessity

- According to Medicare, services should be for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member
- Services furnished at the most appropriate level that can be provided safely and effectively to the patient (expressed in frequency and intensity)
- A service that is reasonable and medically necessary meets, but does not exceed the patient's medical need

Medical Decision-Making

- The intensity of an eye examination is defined by the number and type of service components that are performed during the examination
- The decisions regarding examination intensity are based upon the following:
  1. The clinical judgment of the eye doctor
  2. The patient’s history
  3. The nature of the presenting problem

General Ophthalmological Services

- CPT Code 92004
  - Comprehensive eye examination, New patient
- CPT Code 92014
  - Comprehensive eye examination, Established patient
- CPT Code 92002
  - Intermediate eye examination, New patient
- CPT Code 92012
  - Intermediate eye examination, Established patient

Medicare and Modifiers

- 25 - Modifier
  - This code is appended to an eye examination when it is performed on the same day as a minor surgical procedure
- 24 - Modifier
  - This code is appended to an eye examination when it is performed during the postoperative period of a previously performed minor surgical procedure
### CPT Codebook: Service Components

1. Patient history
2. General medical observation
3. Gross visual fields
4. Basic sensorimotor examination
5. External examination
6. Adnexal examination
7. External ocular examination with biomicroscopy
8. Ophthalmoscopy
9. Initiation of a diagnostic and treatment program

### Comprehensive Exam

1. Patient history
2. General medical observation
3. Gross visual fields
4. Basic sensorimotor examination
5. External examination
6. Ophthalmoscopy
7. Initiation of diagnostic and treatment program

### Intermediate Exam

1. Patient history
2. General medical observation
3. Adnexal examination
4. External ocular exam with biomicroscopy
5. Initiation of diagnostic and treatment program

### Patient History

- The CPT Codebook provides no documentation guidelines for performing a patient history.
- The level of patient history that is documented is dependent on the clinical judgment of the eye doctor and the nature of the presenting problem.
  - Chief Complaint
  - History of Present Illness
  - Past, Family and/or Social History
  - Review of Systems

### Chief Complaint

- A concise statement (usually in the patient’s words) describing the symptoms, problem, condition, diagnosis, and/or other factors that are the reason for the examination.

### Chief Complaint

- For medical insurance and Medicare, the reason for the visit determines the coverage.
- The chief complaint is more important than the final diagnosis.
- The reason for the visit must be either a medical sign or symptom or ongoing care for an existing medical condition.
- “Needs new glasses” will not create the medical necessity to perform a medical eye examination.

- Optometrists have the right and obligation to follow a patient with a chronic disease.
- Medical eye examinations for patients with chronic eye and systemic disease are covered as long as they are reasonable and medically necessary.
- Many conditions may not produce symptoms to report as a “chief complaint”:
  - Glaucoma
  - Diabetic retinopathy
  - Retinal hole or tear
Chief Complaint

Examples of Chief Complaints

- Glaucoma: 4 month follow-up
- Diabetic Retinopathy: 6 month follow-up
- Dry Eye Syndrome: 1 month follow-up
- Cataract: 1 year re-evaluation
- Keratitis: 2 week follow-up
- Eye Pain
- Blurred Vision

History of Present Illness

- A chronological description of the chief complaint since the initial clinical signs or symptoms or since the last examination
- This information describes how the patient has been affected, what they have observed, or how the chief complaint has been treated
- There are eight (8) elements of the History of Present Illness

History of Present Illness

- **SYMPTOMS** – a subjective indication of a disease or a change in condition as perceived by the patient
- **LOCATION** – right eye, left eye, both eyes, upper eyelid, lower eyelid, etc.

History of Present Illness

- **QUALITY** – characteristics or attributes of the condition (i.e. “sharp pain, dull ache, throbbing pain,” etc.)
- **SEVERITY** – mild / moderate / severe
- **DURATION** – length of time that the condition has been present

History of Present Illness

- **TIMING** – getting better; getting worse; or staying the same
- **CONTEXT** – the circumstances in which the present illness occurs (i.e., “in the morning” or “when I bend over” or “when I put my contact lens on,” etc.)

History of Present Illness

- **MODIFIERS** – conditions that affect the present illness: what makes it better and/or what makes it worse (i.e., Tylenol, ice pack, dark room, etc.)
Personal, Family, & Social History

The personal, family, and social history is intended to explore personal medical history, family medical history, and social habits or behaviors that may have an impact on the examination findings or suspected findings.

Review of Systems

The review of systems is a systematic medical history of all the major organ systems of the body.

There are fourteen systems that can be evaluated.

Optometrists have been trained to consider the ocular interactions with these organ systems and to evaluate the effect of any treatment plan on these other systems.

Review of Systems

- Constitutional
- Eyes
- Ears, Nose, Throat
- Respiratory
- Cardiovascular
- Gastrointestinal
- Genitourinary
- Blood/Lymphatic
- Musculoskeletal
- Skin
- Endocrine
- Allergic/Immunology
- Neurological
- Psychiatric

PFS History & Review of Systems

A review of systems and/or a personal medical, family, and social history obtained during an previous examination does not need to be re-recorded if you provide evidence that you reviewed and updated the previous information.

It is necessary to note the date and location of the earlier medical history.

Initiation of Diagnostic and Treatment Program

According to the CPT Codebook, at the conclusion of the medical eye examination, one or more of the following actions must be taken to justify the reporting of General Ophthalmological Services:

- The prescription of medication, ophthalmic lenses, and/or other therapy
- Arranging for special ophthalmological diagnostic or treatment services
- Arranging consultations
- Ordering laboratory or radiological studies

Health Care in 2013
Electronic Medical Records (EMR)

- Within a few years, EMR will be required to participate in the delivery of medical eye care in this country
- HITECH Act Stimulus Package – incentive payments for using “certified” EMR technology
- PQRS – Claim-based reporting program with incentive payments for reporting data on quality measures
- E-Prescribing – Claim-based reporting program with incentive payments for reporting data using a qualified E-Prescribing System

The HITECH ACT

- 2009 Economic Stimulus Bill
- Federal government to develop national health information technology standards by 2010
- Law includes incentive payments for doctors to use “certified” electronic health records (EHR)
- Doctors must show “meaningful use” of health information technology
- Medicare payments will be eventually reduced for doctors that do not adopt a health information technology system

“Meaningful Use”

- Improving quality, safety, efficiency and reducing health disparities
- Engage patients and their families in their health care
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections for personal health information

Medicare Physician Quality Reporting

- PQRS was created as part of the Tax Relief and Healthcare Act of 2006
- The basis of the initiative is the reporting of evidence-based quality measures
- The hope is that PQRS will result in improved patient care
- Optometrists must report on at least three measures for 80% of the applicable cases in which the measure is reportable
- The anticipated goal is that Centers for Medicare & Medicaid Services (CMS) will move to a true “pay-for-performance” system in the future

PQRS Reporting Example

- Glaucoma or glaucoma suspect (365.01, 365.10, 365.11, 365.12, or 365.15)
- All medical eye examinations
- CPT II Code 2027F – This measure applies to patients 18 years and older diagnosed with primary open-angle glaucoma who have had an optic nerve evaluation at least once within the past 12 months
- Please note that you may be required to report this measure more than once within the 12-month reporting period

PQRS Claim Submission

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Examples of CPT II Code Descriptors

- **Measure 12** - (2027F)
  - Primary open-angle glaucoma: optic nerve evaluation
- **Measure 14** - (2019F)
  - Age-related macular degeneration: dilated exam
- **Measure 18** - (201F)
  - Diabetic retinopathy: +/- macular edema; severity
- **Measure 19** - (5010F)
  - Diabetic retinopathy: communication with physician managing ongoing diabetes care

ICD-9 to ICD-10 Transition

- ICD-9 adopted as official codes to report diagnoses in the year 2000 under the 1996 HIPPA Act
- ICD-10 will be adopted as official codes to report diagnoses on October 1, 2014
- **No delays – No grace period**
- Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPPA) must make the transition, not just those who submit Medicare or Medicaid claims
- If you are not ready – your claims will not get paid

ICD-9 vs. ICD-10

- **ICD-9 System:** 3 - 5 alpha and numeric digits
  - Digit 1 is alpha (E or V) or numeric
  - Digits 2 - 5 are numeric

- **ICD-10 System:** 3 - 7 alpha and numeric digits
  - Digit 1 is alpha
  - Digit 2 is numeric
  - Digits 3 - 7 are alpha or numeric
  *alpha digits are not case sensitive

ICD-9 vs. ICD-10

- **ICD-9 System:** Mechanical complication of other vascular device, implant and graft – 1 code (996.1)
- **ICD-10 System:** Mechanical complication of other vascular grafts – 156 codes, including:
  - T82.310 – Breakdown of aortic graft
  - T82.311 – Breakdown of carotid arterial graft
  - T82.312 – Breakdown of femoral artery graft
  - T82.318 – Breakdown of other vascular grafts
  - T82.319 – Breakdown of unspecified vascular grafts
  - T82.320 – Displacement of aortic graft
  - T82.321 – Displacement of carotid arterial graft

Changes to Work Flow & Business Processes

- Clinical documentation
- Encounter forms/superbills
- Practice management system
- Electronic health record system
- Contracts
- Public health and quality reporting protocols
Preparing for ICD-10 Transition

- Is your practice management vendor ready to accommodate both Version 5010 and ICD-10 codes
- What updates are they planning
- When will they have them ready for install
- Are these upgrades included in my contract
- If you are in the process of making a practice management or electronic medical records system purchase, ask if it is Version 5010 and ICD-10 ready

Implementation Plans

- Discuss implementation plans with all your clearing-houses, billing services, and payors to ensure a smooth transition
- Ask about their plans for Version 5010 and ICD-10 compliance and when they will be ready to test their systems for both transitions
- Ask payors if ICD-10 will affect your contracts
- Since ICD-10 codes are more specific than ICD-9 codes (17,000 vs. 155,000), payors may modify the terms of contracts, payment schedules, or reimbursement

ICD-10 Transition Budget

- Expenses for system changes
- Software upgrades
- Resource materials
- Reprinting of manuals, superbills, and other materials
- Staff training and testing time
- Coding professionals recommend that staff training take place approximately six months prior to the October 1, 2014 compliance date

Eye Health Management Program

- The VSP program focuses on early detection and aids in the treatment and coordination of care for eye and related health conditions.
  - Promotes and quantifies optometry’s role in health care
  - Helps facilitate medical care for your patients
  - Helps your practice earn more money
- By reporting chronic health conditions to VSP, they will reimburse the practice for the additional education and services provided to patients
  - $5 for reporting diabetes and/or diabetic retinopathy
  - $2 for reporting hypertension and/or high cholesterol

We Are Done!