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

Health Care in 2011

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.

Medicare Definition in Texas

- Patient History
- Visual Acuity
- Objective Refraction
- Subjective Refraction
- Tonometry
- Gross Visual Fields
- Basic Sensorimotor Examination
- 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.

Medicolegal Nature of Eye Care

- **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.

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
  1. Clinical indications
  2. Documentation requirements
  3. Coding guidelines
  4. 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 exam, new patient
- CPT Code 92014 – Comprehensive eye exam, established patient
- CPT Code 92002 – Intermediate eye exam, new patient
- CPT Code 92012 – Intermediate eye exam, established patient

1st Eye Care Practice Statistics

![Vision Care Exams](Type|Quantity)
- VSP: 3,008
- Block Vision: 389
- Superior Vision: 341
- Medicaid: 246
- Eye Med: 229

![Medical Eye Exams](Type|Quantity)
- Comprehensive: 1,727
- Intermediate: 2,830
- Evaluation & Mgmt: 97

Joe’s Last Words

- Quote from Barton McCann, M.D., M.P.H.
  He is the Senior Health Care Officer for Health Care Financing Administration. (As told by Dr. McCann and heard by Joe DeLoach, O.D. at the National Carrier Advisory Committee Member Meeting in Baltimore, Maryland, October 2007)
  
  “I have no explanation why an optometrist or ophthalmologist would ever use an E/M code under any condition.”
CPT Codebook: Service Components

- Patient History
- General Medical Observation
- Gross Visual Fields
- Basic Sensorimotor Examination
- External Examination
- Adnexal Examination
- External Ocular Examination with Biomicroscopy
- Ophthalmoscopy
- Initiation of a Diagnostic and Treatment Program

CPT Codebook: Clinical Indications

- Comprehensive services may be indicated for the diagnosis and/or treatment of a patient with symptoms indicating possible disease of the complete visual system such as glaucoma, cataract, macular degeneration or retinopathy.
- Intermediate services may be indicated when a patient requires an evaluation of a new or existing condition complicated with a new diagnostic or management problem.
- Intermediate services may be indicated when a patient’s condition is failing to change as expected and/or worsening.

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.
  1. Chief Complaint
  2. History of Present Illness
  3. Past, Family and/or Social History
  4. Review of Systems

General Medical Observation

- The CPT Codebook provides no documentation guidelines for performing a general medical observation. In general, this is the act of watching the patient carefully and attentively in an attempt to identify the presence of ocular or systemic conditions that may exist without symptoms.
- Common observations include as assessment of the patient’s general appearance, mobility limitations or compensatory adaptations such as a head tilt secondary to a binocular vision disorder.

General Medical Observation

- General appearance encompasses the following areas of interest:
  1. Development
  2. Nutrition
  3. Body habitus (describing a person’s physique)
  4. Deformities
  5. Attention to grooming
- Documentation requirements for this service component of the medical eye examination include a written description of what is seen or noticed by the optometrist.
**Gross Visual Fields**

- The CPT Codebook provides no documentation guidelines for examining the visual field.
- The most common method of fulfilling this documentation requirement is the confrontation visual field test.
- For a comprehensive examination, it would generally be considered that all four quadrants of the visual field would be evaluated.
- Other methods of examining gross visual fields include using a tangent screen, an automated perimeter, or instruments that utilize frequency doubling technology.

**Basic Sensorimotor Examination**

- The motor system has three main functions.
  1. First, it enlarges the field of view by transforming the field of vision into the field of fixation.
  2. Second, it brings objects of attention onto the fovea and keeps them there.
  3. Third, it positions the two eyes in such a way that they are at all times properly aligned, ensuring and maintaining binocular vision.

**Basic Sensorimotor Examination**

- The examination involves assessing the following ocular functions:
  1. Ocular Motility
  2. Accommodation
  3. Binocular Vision Function
- The results of the basic sensorimotor examination allows the eye doctor to evaluate the different components of the sensorimotor system and to determine how they interact with each other.
- You can do as much or as little as you like.

**External Examination**

- The CPT Codebook provides no documentation guidelines for performing an external examination.
- In a general sense, the external examination is an inspection of the external ocular and facial areas.
- The inspection should be performed in a well-lighted room with particular attention to the skin and eyelids.
- This is a face-to-face inspection, not biomicroscopy.
- In addition to inspection, it may be necessary to examine the skin and subcutaneous tissue by palpation.

**Adnexal Examination**

- Eyelids (e.g., ptosis)
- Extraocular Muscles
- Orbits
- Preauricular Lymph Nodes
- Lacrimal Apparatus
  1. A network of anatomical structures, appendages, ducts, and glands that secrete tears and then drain them from the surface of the eye.
  2. The drainage system includes the punctum, the lacrimal canaliculus, the lacrimal sac and the duct.

**External Ocular Examination**

- Eyelids
t- Cornea
t- Eyelashes
t- Sclera
t- Tear Film
t- Anterior Chamber
t- Palpebral Conjunctiva
t- Iris
t- Bulbar Conjunctiva
t- Lens
Ophthalmoscopy

- The CPT Codebook does not specify the type of ophthalmoscopy (direct or indirect) that is used during the examination and also does not specify that the examination be performed through a dilated pupil.
- In general, an ophthalmoscopic examination includes visualization of the retina and the optic disc.
  1. Vitreous
  2. Macula
  3. Vessels
  4. Retinal periphery

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

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.
- PQRI – Claim-based reporting program with incentive payments for reporting data on quality measures (2% of annual Medicare payments).
- E-Prescribing – Claim-based reporting program with incentive payments for reporting data using a qualified E-Prescribing System (2% of payments).

“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
- AOA says 4% optometric utilization in 2010

Medicare Physician Quality Reporting Initiative

- PQRI 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 PQRI 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.

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, 2013.
- 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*

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

Version 5010 Compliance Date

- These electronic health care transactions include functions like claims, eligibility inquiries, and remittance advices.
- Unlike the current Version 4010/4010A1, Version 5010 accommodates the ICD-10 codes and must be in place before the ICD-10 implementation date.

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 clearinghouses, 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, 2013 compliance date.

We Are Done!