**Medicare Reimbursement Challenges**

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**Financial Interest**

I acknowledge a financial interest in the subject matter of this presentation.

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**Current Issues**

Hot topics of special interest

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**CPOE**

- Computerized physician order entry (CPOE) guidelines included in Stage 2 Meaningful Use
  - CMS initial ruling: Only licensed personnel can enter orders into a medical record
    - e.g., licensed medical assistants
  - COAs, COTs, COMTs meet the criteria

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**CPOE**

- Since ophthalmologists use “scribes” in their practices, this was a big issue
- ASCRS and ASOA was able to convince CMS to change their mind
  - Ophthalmic “certified” scribes now qualify for entering CPOE in electronic health records
    - Only pertains to scribes in ophthalmology that have been certified

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**CPOE**

- ASOA joined with American College of Medical Scribe Specialists (ACMSS)
  - Non-Profit partner
  - ACMSS will offer ASOA members an ophthalmic specific certified scribe program
  - JCAHPO also has a new Scribe certification program
Dropless Cataract Surgery

- Use of intraocular or periocular injections of anti-inflammatory drugs and antibiotics at time of cataract surgery has increased
  - For example: triamcinolone and moxifloxacin with or without vancomycin
  - Referred to as "dropless cataract surgery"
- Eliminates need for post-operative antibiotic eye drops

Dropless Cataract Surgery

- According to CCI:
  - Injection of drugs during a cataract extraction or other ophthalmic procedure is not separately billable
  - Injections are part of ocular surgery and included as part of code used to report the surgical procedure

Femtosecond Revisited

- Refractive imaging component of FS laser performed on premium AC-IOL and PC-IOL cataract patients before surgery has begun is a non-covered service
  - Can bill premium IOL patients for OCT imaging
  - Fee usually included in premium IOL charge
  - Cannot charge fee for Femtosecond laser used intraoperatively (during surgery) such as:
    - Phaco incision, capsulotomy, lens fragmentation

Femtosecond Revisited

- Cannot bill patient Femtosecond OCT imaging performed on conventional IOL patients
  - CMS expects FS laser on these patients to be rare
  - Even if not charged
  - Will negate argument that only premium IOL patients need this special imaging
- LRI/CRI performed with FS laser at same time as conventional IOL surgery
  - Still billable to patient separately
    - When performed on premium IOL patients fee usually included in premium IOL charge

Allergy Testing

- CPT Code: 95004
  - Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specific number of tests
  - Used to diagnose dry eye syndrome and allergic conjunctivitis
Allergy Testing

• Medicare reimbursement includes tests as well as cost of allergenic extracts
  – Must include total number of tests performed (e.g., 30, 40) in units (Item 24G or EMC equivalent) on CMS-1500 claim form
    • Typically 50-60 scratch tests are performed for dry eye testing
  – 2015 Medicare national allowable
    • $6 - $8 per test depending on payment locality

New CCI “X” Modifiers

• New "X" modifiers developed to assist providers in correct use of unbundling codes under the CCI edits
  • Effective for dates of service on or after January 1, 2015
    – Modifier -XE: Separate Encounter
      • A service that is distinct because it occurred during a separate encounter

• CMS will still recognize -59 modifier
  – Should not be used when more appropriate modifier exists
    • CMS may begin to identify code pairs as only payable with the "X" modifiers and not the -59 modifier
    • Would result in denials if "X" modifier not used
  – CMS encourages providers to use "X" modifiers when appropriate though
Modifier -50

- When procedures or services are performed on both eyes at the same session physicians should:
  - Append the -50 modifier on one line only
  - Bill "1" unit
  - Increase your charge
    - Commercial payers may still require -LT/-RT modifiers
  - ASCs still required to bill bilateral services on two lines
    - Using the -RT and -LT modifiers

New Patient Definition

- CMS previously edited new patient exams based solely on Tax ID # of practice
  - CMS now edits new patient exams by NPI number not just Tax ID #
    - Exam will be denied if provider saw that patient anywhere during the past 3 years regardless of where he/she worked

New Patient Definition

- If new physician joins practice and sees old patients in new practice
  - Cannot bill as a new patient exam
- Patient sent to practice for test because referring doctor does not have equipment
  - No exam conducted - just I&R of test
  - If patient returns for exam within 3 years of the test, can bill as new patient since no exam or other face-to-face service was performed by the doctor

Place of Service

- Normally POS code reflects actual setting where beneficiary receives face-to-face service
  - There are a few exceptions:
    - Inpatient
      - If inpatient seen in your office must bill place of service as hospital (21), not office
    - Outpatient or Rehab Patient
      - If patient seen in your office must bill place of service as outpatient or rehab (22), not office

Glaucoma Shunt Grafts

- Cornea tissue used for placement or revision of glaucoma aqueous shunts
  - ASCs can now bill separately for the cornea allograft tissue used for aqueous shunt codes 66180 and 66185
    - Must report code V2785 for the tissue
    - Same code as regular corneal tissue
  - May be required to fax copy of eye bank invoice when electronic claim filed

ASC Sterilization

- CMS initially stated that flash sterilization could no longer be routinely used in surgical center settings
  - There was confusion between “flash” and “short-cycle” sterilization
  - CMS has now clarified ASC sterilization guidelines
    - Short-cycle steam sterilization is permitted
    - Must follow manufacturer's directions for use
Modifiers of Special Interest

Misuse can cause denials in a post-payment audit

Modifier -24

- **Unrelated service during post-op period**
  - In other words, office visit is not related to:
    - Underlying condition for which surgery was performed, or
    - Surgical episode itself such as complications
  - Before appending modifier -24 should always ask:
    - Would patient have needed exam if the surgery had not been performed
      - If answer is yes, then modifier -24 is appropriate

- **Example:**
  - Surgery patient returns in global fee period of cataract surgery for scheduled 3-month glaucoma follow-up
  - Modifier -24 is appropriate
    - Glaucoma diagnosis unrelated to cataract surgery
    - Make sure CC does not state “here for PO exam”
    - Diagnosis must be glaucoma, not cataract
      - This is a common billing error
    - Billers can’t bill appropriately if chart not correct

- **Example:**
  - Patient presents day 89 of global fee period of cataract surgery with decreased vision in the surgical eye
  - Exam identifies PCO and YAG recommended next week
  - Modifier -24 is not appropriate
    - PCO is known complication of cataract surgery
      - If patient outside global fee period, then -57 modifier would apply

Modifier -25

- **Significant, separately identifiable service by same physician on day of minor procedure**
  - Exam is not just incidental to surgery
    - Modifier -25 indicates office visit is above and beyond usual pre- and post-operative care associated with minor procedure
  - Should be appended to office visit not minor procedure code or diagnostic test

- **Example:**
  - Cannot be used as decision for surgery like modifier -57
    - Most common misconception among doctors
  - Exam must be substantial, distinct and unique and able to stand alone
    - Take the exam for the minor surgery or injection out of the mix for a minute
    - Do you have anything left?
      - If yes, append the -25 modifier
      - If no, office visit should not be billed
### Modifier -25

- **Example:**
  - Patient presents with complaint of pain and foreign body sensation after being hit in eye with tree limb
  - Complete exam performed to determine extent of injury and cause of pain – FB removed
  - Modifier -25 is appropriate
    - If only slit lamp performed and foreign body removed without complete eye exam, office visit not billable

- **Example:**
  - Patient presents for Lucentis injection #4 in left eye
    - States vision not that great but stable
  - Surgeon recommends intravitreal injection today and FU in 2 months with OCT
    - No new complaints or medical necessity to perform exam over and above need for injection
    - Modifier -25 is not appropriate

### Modifier -57

- **Initial evaluation to determine need for major surgery**
  - 90 day global fee period
- **Use if decision is made day before or day of major surgery**
  - Not to be used for re-examination of patient after surgical decision has been made

### Documentation Issues

#### Compliance Concerns

#### Amending Medical Record

- **Paper Charts**
  - Medicare expects to see:
    - S.L.I.D.E.
      - *Single Line through error*
      - *Initials of the person making the amendment*
      - *Date the amendment is made*
      - *Entry for correction*
    - White-out/obliteration of original entry not acceptable

- **EMR**
  - **Addendums**
    - *Should be made in system where documentation was originally created*
    - *Make sure any addendums are forwarded to any place where information has been previously sent*
      - Referring doctor for example
  - **Amendments**
    - *Should be timely and bear the current date of documentation*
Amending Medical Record

– Corrections after final signature
  • Usually only one individual has ability to “unlock” a document once it has been signed
  • Corrections should be made in the system where the document was created
    – Entries should be flagged as corrections and should be carefully monitored and audited
  • Current date and time should be entered
  • Person making change should be identified
  • Reason for correction should be noted in record

Amending Medical Record

– Deletions
  • If system allows “strike-through” lines, practice should follow S.L.I.D.E guidelines
  • Some systems may not permit deletions after record is signed and considered “locked”
    – May need to see how vendor and/or malpractice provider wants you to handle deletions in EMR
    – Create practice policy for future reference
  • Total elimination of information should NEVER occur

Cloned Documentation

• Cloned Documentation big issue in EHR
  – EHR must follow same documentation requirements as paper chart
    • Progress note must accurately reflect what occurred at current visit
  – Chief complaint
    • Must be pertinent to today’s visit only
      – Can be a new or continued complaint or previously diagnosed condition
        » May be found in Plan of previous visit
    • CC also drives level of service for E&M (99) codes

Cloned Documentation

– Templates can be beneficial but can also create problems
  • Sometimes ROS and Exam templates are pulled into every exam to save time
  • If additions and/or deletions to the template are not made at every visit, the documentation begins to look the same for each patient
    – Thus the OIG’s issue with “cloned documentation”
  • According to OIG, cloned documentation does not meet medical necessity requirements for coverage

Diagnostic Tests

• Diagnostic tests have special circumstances in order to be billed
  – Chart must be clear as to who ordered the test and who performed the service
  – The ordering physician must be the treating physician and responsible for the patient’s care

What’s required for billing
## Diagnostic Tests

- Medical necessity must be clearly noted or evident in the patient chart
- All special diagnostic tests are billable with eye examinations both E&M and “92” codes
- Most ophthalmic diagnostic tests require an interpretation and report

### Interpretation & Report

- Increasing lack of compliance with Interpretation & Report requirements
  - Seems to be a particular problem in EHR systems
  - An “interpretation and report” should address the findings, relevant clinical issues, and comparative data (when available)
    - Source: Medicare Claims Processing Manual, 100-4, 13:§100

## Interpretation & Report

- At minimum MD should address:
  - What was seen or not seen but anticipated
    - Glaucoma
  - What findings suggest as to status of illness
    - Stable, worsening, improving
  - What impact the test results have on treatment
    - Continue present meds, surgery as indicated, see Plan, etc.
  - Physician must sign and date I&R

## Test Results

- All test results must be readily available
  - In some instances, photos and results of tests may not be in the paper chart or the EMR
    - Sometimes stored digitally
  - The medical record must document the location of the diagnostic test in this case
    - Disc C, dated 4/1/13, etc., or
    - Notation as to where test result can be found

## Problematic Diagnostic Tests

These tests require special attention

### Diagnostic Tests

- **A-Scan-76519 & IOLMaster-92136**
  - Submit code 76519 or 92136 (no modifiers) prior to first eye
  - Will permit payment of the technical component for both eyes and one IOL calculation
  - Prior to the second eye surgery, submit code 76519-26 or 92136-26 to receive payment for the second IOL calculation
  - Surgeon should date and initial test strip if 2nd IOL calculation performed on different date
Diagnostic Tests

- **Extended Ophthalmoscopy**
  - **Codes 92225 and 92226**
    - Limited to posterior segment disease or conditions
    - Requires separate, detailed sketch, minimal size of 3-4 inches
    - All items noted must be identified and labeled
    - Color (4-6 standard colors) is preferred
    - Non-colored drawings also
    - Drawing must be anatomically correct
    - Abnormal findings must be labeled

- **Serial Tonometry**
  - **Code - 92100**
    - Tonometry is the measurement of intraocular pressure
    - Is considered part of the ophthalmic examination unless done in a series
    - At least three separate “timed” pressure readings must be noted
    - Use extreme caution – highly visible for audit

- **Gonioscopy**
  - **Code 92020 – Separate Procedure**
  - Billable to Medicare with visual fields or other tests even though it’s a “separate procedure”
  - Not billable on same day as external photos, code 92285, if photos performed through gonio lens
  - Not billable for diagnosis of cataract only
  - Must report glaucoma, narrow angles, cupping of optic disc, etc., as primary diagnosis
  - Cataract as secondary diagnosis

- Diagnostic Tests
  - Must have documented pathology in fellow eye in order to bill extended ophthalmoscopy for that eye
  - Routine examination of eyes without signs or symptoms is not medically necessary
  - Reminder:
    - Routine ophthalmoscopy is part of a general office visit and not billable separately
    - Ophthalmoscopy must be extended as described in previous slide in order to bill codes 92225 and 92226

Questions

- Bundled with ALT/SLT if performed at same session
  - Gonio performed in office and ALT performed in ASC later that same day
  - Can append -XE modifier to gonioscopy as it was performed at a separate encounter
  - When performed merely as screening, billable only to patient
  - 3rd most frequently billed diagnostic test
  - Watch frequency to avoid audit