

OPTOMETRY CODING & BILLING ALERT

Your essential guide to Coding • Billing • Clean claims • Efficient collections • Compliance • HIPAA

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Safeguard E/M Code Selection With Ironclad ROS, Exam Notes

▶ *These 7 steps will ensure your 99204 history, examination levels meet documentation guidelines*

Your E/M documentation probably won't stand up to an audit unless you improve your documentation habits.

Most optometrists who use E/M codes are not recording the review of systems (ROS) the right way, says experienced auditor **Jeffrey P. Restuccio, CPC, CPC-H, MBA**, principal owner of www.Ritecode.com. This problem, however, is understandable and correctable.

1. Change Your Format

Sure, not passing an audit is a scary proposition. And it's not that you purposely upcode or don't have documentation that supports the E/M code level you selected. Your office is probably just not set up for that, says Restuccio, who is a national speaker on coding and documentation. "Optometry school trained you to take notes using an eye format," he says.

Better way: Collect the system information you need using a general medical exam form. Have areas where you can record findings on the systems you review, such as the integumentary system, the respiratory system, etc.

2. Get a Grip on ROS Numbers

You've got to be familiar with the ROS number that correlates to each history element. Otherwise, you could assign an E/M code that your documentation can't support.

Example: "To report 99204, you have to have recorded pertinent findings of 10 systems," Restuccio says. If documentation supports reviewing fewer than 10 of the 14 systems, your E/M coding won't pass the 1997 guidelines for a complete ROS (at least 10 systems reviewed), he says.

The documentation guidelines require you to record the patient's positive responses and pertinent negatives. Here's how many systems you need to document for each element of ROS:

- problem-pertinent — 1 (documentation about the system related to the problem)

- extended — 2-9
- complete — 10.

3. Tie ROS Into History and E/M Level

If you look in the CPT manual, 99204 requires a comprehensive history, a comprehensive examination and moderate-complexity medical decision-making. So how does a complete ROS come into play?

The types of history that CPT lists for each E/M service level have three elements: history of present illness (HPI); ROS; and past, family and social history (PFSH). To qualify for a given type of history, you have to meet all three elements in the following table:

HPI	ROS	PFSH	Type of History
Brief	N/A	N/A	Problem-focused
Brief	Problem-pertinent	N/A	Expanded problem-focused
Extended	Extended	Pertinent	Detailed
Extended	Complete	Complete	Comprehensive

Impact: Code 99204 requires a comprehensive history. The documentation guidelines indicate that you need a complete ROS to have a comprehensive history. So unless you document 10 systems, your documentation won't support 99204.

Now let's look at what an extended ROS could equate

to. Code 99203 requires a detailed history, a detailed examination and low-complexity medical decision-making. You can't have a detailed history without an extended ROS. Therefore, to support a level-three new patient visit (99203), you need to document findings of two to nine systems.

4. Make Your Finding Count

You don't need to write a book to deserve credit for a positive response or a pertinent negative. In the applicable system area, just mark "normal" or "negative," Restuccio says.

Example: A patient with eye problems is also experiencing headaches. So you ask questions about the patient's neck, such as if she's having any neck pain. She says "no." For the series of questions, you mark "negative" for the musculoskeletal system.

After putting the positive and the pertinent negatives in the ROS, you can still get credit for any remaining systems. Doctors should specifically state "all others are negative" in their notes, says **Jim Collins, CPC, CHCC**, president of Compliant MD Inc. "That way, instead of having to document out every single one of the review-of-systems elements, the doctor can just say those brief words and get full credit for it."

Caution: Use "all others are negative" only when you asked the patient about all the review-of-systems elements.

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Don't use the phrase like a rubber stamp that you slap on notes for every visit, Collins says.

Also, make sure medical necessity guides the systems you count. Medicare warns carriers that even if the physician generates a complete note not to consider [when selecting an E/M level] information that has no relevance to the patient's condition, said **Bill Dacey, MHA, MBA, CPC**, in the AAPC 2007 presentation "E/M Auditing: Regulations vs. Reality."

5. Check Your Exam Type

To prevent your documentation from also falling short on the office visit's examination portion, pay attention to the systems you need for each type of examination. You can keep your levels straight with this handy rule from Collins: "The required level of history is always going to match the required level of exam."

For instance, 99203 requires a detailed level of history and exam, 99205 requires a comprehensive history and exam, and 99242 (*Office consultation for a new or established patient ...*) requires an expanded problem-focused history and an expanded problem-focused exam.

Using the 1997 documentation guidelines for the single-organ-system eye examination, you need to perform and document the following number of

elements identified by a bullet to obtain the given examination level:

- problem-focused: 1-5 elements
- expanded problem-focused: 6-8 elements
- detailed: 9-13 elements
- comprehensive: all 14 elements (12 specific to eye, two for neurology/psychiatry).

6. Capture the 'Gimmes'

Don't overlook giving yourself credit for the two bulleted elements in the neurological/psychiatric system. "Most optometrists perform these elements," which Restuccio dubs the "gimmes," "as part of the eye exam," he says.

Clever: Think of the "gimmes" as "O x 3," Restuccio says. The "O" stands for the guideline system element of "Orientation to time, place and person."

Qualifying statements you probably make but may forget to mark toward the examination level include "dizzy," or notes about the patient's general appearance.

The other neurology/psychiatry element is for "Mood and affect." Give yourself credit for this bullet if you document any description of the patient's mood and affect, such as "agitated," "depressed" or "anxious," Restuccio says. Positive or "normal" adjectives include "charming," "in a good mood," or "relaxed."

Take-away: Because an eye exam usually includes noting a patient's orientation, mood and affect — provided you document these assessments — you should almost always mark the neurological/psychiatric system bullets as performed for the examination level, Restuccio says.

7. Opt for an Eye Code

"The 99000 codes are more detailed and require more documentation than the 92000 eye codes," says **David Gibson, OD, FAAO**, practicing optometrist in Lubbock, Texas. Sometimes the 99000 codes more appropriately describe an encounter, and sometimes the 92000 codes are a better choice.

Solution: To determine if the 99000 codes are truly the best for your case, "consider the payment schedule for each code set and the complexity of the patient," Gibson says. □

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Boost 92135 Pay With These Insider Secrets

► Experts answer your top SLGT coding questions

If you're using scanning laser glaucoma testing (SLGT) for early detection of eye disease, you've probably found that getting proper reimbursement for this newer technology is a challenge.

Take a look at these expert answers to ensure you're up to speed on how to avoid the common SLGT coding and billing pitfalls.

Question: Should I report all SLGTs the same?

Answer: There are several technologies that you may use to get diagnostic images through SLGTs. The trick is that you should not base your coding on the type of SLGT you use.

CPT has one code to describe all of the SLGTs: 92135. "This CPT code is defined as 'scanning computerized ophthalmic diagnostic imaging (e.g., scanning laser) with interpretation and report,' so you would use this for any scanning laser testing," says **Krystin Keller, CPC**, insurance specialist and billing manager at Five Points Eye Care in Athens, Ga., and consultant with Forché Consulting Group.

Question: How should I code if I only interpret the SLGT results?

Answer: CMS divides the relative value units (RVUs) for 92135 into a technical component and a professional component. Therefore, you'll need to append a modifier, depending on which portion of the test you perform.

How it works: If you perform only the test (technical component) and do not read the results, you should report 92135-TC (*Technical component*). If another office performs the technical component, however, and you do the interpretation and report, append modifier 26 (*Professional component*) to 92135.

"In private practice, this would really only come into play if you did not have the equipment and you sent your patient over to a different office that does have the actual equipment to do the test and then your patient returns to you to continue treatment," Keller says.

If you see patients in a skilled nursing facility (SNF), you would also separate the professional and technical components and bill only for the technical component. The SNF would bill for the professional component, and you would receive payment for the professional services directly from the SNF.

In dollars: In Medicare's 2007 fee schedule, the total unadjusted RVUs for 92135 are 1.16. Multiplying that by the conversion factor of 37.8975 means that an optometrist performing both the technical and professional components would earn about \$44.

The technical component alone is worth 0.66 RVUs, so if you only performed the technical component, you would receive about \$25 for the service. You would earn 0.5 RVUs for just the professional portion — about \$19 for that service.

Question: Can I report two codes if I perform SLGT on each eye?

Answer: Medicare considers 92135 to be inherently unilateral, Keller says, meaning that the RVUs in the fee schedule represent the work done on only one eye. If you perform an SLGT on only one eye, report one unit of 92135 and append the alphabetic modifier RT (*Right side*) or LT (*Left side*) to indicate which eye you tested.

Carriers differ on how you should report a scanning laser test on both eyes. Medicare and many private carriers look for 92135 reported on two lines of the billing form, each with a "1" in the units field and with the LT and RT modifiers appended. On the other hand, some carriers may want you to report one unit of 92135 with modifier 50 (*Bilateral procedure*) appended. □

You Be the Expert

Nursing Home Patient: Eye or E/M Code?

Question: *I visited a patient who was in a nursing home. Should I use an eye exam code or a nursing facility service E/M code?*

Hawaii Subscriber

Answer: Test yourself. Determine how you would handle this situation. Answer on page 79. □

BUILD A BETTER BUSINESS

Streamline your collections system and get money due you faster with these tips on completing claim forms and charging for services. *Optometrists*: Clip and give this monthly section to your biller.

Tap Into New Database for All of Your NPI Needs

► ***A phone call isn't necessary to locate referral/consult number***

Save yourself a phone call by going online for national provider identifier (NPI) information using a query-only database from CMS: the NPI Registry.

You can search the National Plan and Provider Enumeration System (NPPES) database (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) by query using information such as a provider's name or NPI number. You'll get a list of all NPPES records that meet the criteria you enter in the query. Once you select the record or records you wish to view, the NPI Registry displays the available information for that record.

The database includes real-time NPPES information, according to Empire Medicare's Web site. That means you'll have quick access to Freedom of Information Act (FOIA) disclosable data for newly enumerated providers, as well as updates and changes to enumerated providers' FOIA-disclosable data as soon as it's available in the NPPES system.

Obtain Omitted Info by Going Online

Getting NPIs for referring physicians has been very time-consuming, says **Rebecca Marthaller, CMRS**, owner of Lower Columbia Medical Billing in Longview, Wash. "I know of many billing offices that are looking forward to this database."

"I think this a step forward that we need," says **Shannon Smith, CRTT, CPC, CMSCS**, director of coding and reimbursement for DoctorsManagement in Knoxville, Tenn. "One of the biggest provider complaints regarding NPI has been that they have not been published thus far — meaning when you received a referral/consult in which the NPI number is needed for the claim form, you would have to obtain this information from the practice even if it meant an additional phone call. Before the UPIN, we were able to look up that information."

Important: Not all of your providers' information in the database will be publicly available, said CMS' **Jim**

Bossenmeyer during a recent open-door forum. Social Security numbers, dates of birth, countries of birth and other sensitive data won't be in the public database.

Verify Your Number or Risk Rejections

"Be sure your legacy numbers are on file at the NPPES Web site," says **David Gibson, OD, FAAO**, practicing optometrist in Lubbock, Texas. Between Sept. 3 and Oct. 29, 2007, all Part B carriers and DME MACS will begin to turn on edits to validate the NPI/legacy pairs submitted on claims. If the pair is not found on the Medicare NPI crosswalk, the claim will reject. For details, see <http://gatewayedi.cmail4.com/l/239352/1446str/www.gatewayedi.com>. □

Billing Question

Set 1 Fee for Post-Op Refractive Surgery

Question: *How should I report a photorefractive keratotomy (PRK) follow-up exam to Medicare? Another facility performed the surgery, so this is the first time the optometrist saw the patient.*

Illinois Subscriber

Answer: Medicare will not cover PRK. Therefore, you do not need to file a claim for follow-up care with the carrier. Exception: If the patient requests that you submit a claim or you need to obtain a denial for a secondary insurance, report 66999-GY (*Unlisted procedure, anterior segment of eye; Item or service statutorily excluded or does not meet the definition of any Medicare benefit*) with a description in Item 19 of the CMS-1500 form. Otherwise, submitting non-covered services to Medicare is not necessary, and the patient is responsible for payment of the service.

Instead: Use an internal code for PRK follow-up. Collect payment directly from the patient or the surgical center. Make this easier by billing post-op refractive surgery patients on a per-case basis for "x" number of months. Using a single charge, rather than a per-visit charge, cuts down on how many bills you send out — and try to collect on. □

READER QUESTIONS

Is Routine Reporting of 92002, V72.0 OK?

Question: *Our office has been coding exams (routine exams) as 92002 and V72.0 when we don't see anything wrong. Would this raise any red flags?*

Texas Subscriber

Answer: No. You may use the general ophthalmological services code 92002 (*Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient*) with V72.0 (*Special investigations and examinations; examination of eyes and vision*). The V code indicates that the patient presented for a routine vision exam or a preventive service. Listing no additional diagnosis tells the insurer that you did not detect or treat the patient for any condition or problem.

Coverage: If a patient has a medical-only insurance policy, the plan will not cover a claim for 92002 with V72.0. But BCBS of Texas will pay this combination for beneficiaries who have a routine vision rider on their health insurance policies.

You might, however, raise a red flag — or trigger a denial — if you code a routine eye exam, in which you found no problem, with an E/M code, such as 99212 (*Office or other outpatient visit for the evaluation and management of an established patient ...*). The office visit codes are for problem-oriented visits. Many insurers have system edits in place that will reject a well code (such as V72.0) with a problem-related code (for instance, 99201-99215).

Check 92025 LCD Before Appealing

Question: *Blue Cross and Blue Shield of North Carolina (BCBSNC), United Healthcare (UHC) and Medicare are denying 92025 as not medically necessary. What can we do to obtain payment for corneal topography using the new code?*

North Carolina Subscriber

Answer: A spring medical policy put an end to payment for corneal topography (92025, *Computerized corneal topography, unilateral or bilateral, with interpretation and report*) from BCBSNC. “Computer-assisted

corneal topography is not covered,” states BCBSNC’s medical policy update, effective April 9, 2007. The insurer considers the procedure investigational in detecting or monitoring diseases of the cornea.

Topography has seemingly more interpretations than any other code in eyecare. Check UHC and your carrier’s covered diagnoses for 92025. For instance, TrailBlazer (Medicare Part B Washington, D.C./Delaware, Maryland, Texas, Virginia, IHS service areas) “will not pay for corneal topography when billed with a routine diagnosis or when being done for routine screening purposes,” according to an Aug. 31, 2007, FAQ published in the carrier’s newsletter. The carrier considers 367.22 (*Irregular astigmatism*) to be routine but has allowed 367.20 (*Astigmatism, unspecified*) and 743.41 (*Anomalies of corneal size and shape*).

Other policies allow several ICD-9 codes to represent medical necessity for 92025. Cigna Part B for Tennessee allows:

- 367.22* — *Irregular astigmatism*
- 371.00 — *Corneal opacity, unspecified*
- 371.23 — *Bullous keratopathy*
- 371.50 — *Hereditary corneal dystrophy, unspecified*
- 371.52 — *Other anterior corneal dystrophies*
- 371.57 — *Endothelial corneal dystrophy*
- 371.60 — *Keratoconus, unspecified*
- 371.61 — *Keratoconus, stable condition*

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- 371.62 — *Keratoconus, acute hydrops*
- 372.40 — *Pterygium, unspecified*
- 996.51 — *Mechanical complication of prosthetic corneal graft*
- V42.5 — *Cornea replaced by transplant*
- V45.61* — *Cataract extraction status*
- V45.69* — *Other states following surgery of eye and adnexa.*

Notes: *367.22 must be accompanied by V45.61 or V45.69.

*V45.61 must be accompanied by 367.22.

*V45.69 must be accompanied by 367.22.

Best practice: If you need the information that topography provides, order the test and take care of your patient, regardless of payment.

When an insurer, such as BCBSNC, does not cover the test, alert your state optometric association. It and the state ophthalmological association (remember, ophthalmologists aren't getting paid either) should set up a meeting with the state insurance commissioner and/or the insurance company to present patient benefits of topography and examples of how and where it is already accepted.

Success: Aetna in Texas denied coverage of topography with any diagnosis as "experimental technology." After the state optometry and ophthalmology associations educated the insurer, Aetna modified its policy.



Count Prescriptions as Part of E/M

Question: *Is there a code I can use for writing a prescription? If so, may I report it in addition to an E/M service or when a patient calls in and I simply write a prescription for the patient to pick up at the front desk?*

New Jersey Subscriber

Answer: There is no CPT code that you should report when you write a prescription for a patient. CPT specifically includes writing prescriptions as part of an E/M service. You should consider prescription writing as part of the cost of seeing patients.

Coding solution: If you or a technician sees the patient, you should report the appropriate E/M code — for example, an established patient code (99211-99215, *Office or other outpatient visit for the evaluation and management of an established patient ...*).

But you must meet incident-to guidelines to report 99211 (*Office or other outpatient visit for the evaluation and management of an established patient, that may not*

(Continued on next page)

You Be the Expert

Nursing Home Patient: Eye or E/M Code?

Answer: You're on the right track that you can report only one of these codes, not both. The Correct Coding Initiative (CCI) bundles eye exam codes 92002-92014 (*Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program ...*) into 99307-99310 (*Subsequent nursing facility care, per day, for the evaluation and management of a patient ...*), 99324-99328 (*Domiciliary or rest home visit for the evaluation and management of a new patient ...*) and 99334-99337 (*Domiciliary or rest home visit for the evaluation and management of an established patient ...*). These bundles have a modifier indicator of "0," meaning you cannot report the bundled codes separately under any circumstances.

Best bet: Experts recommend coding an intermediate eye exam (92002 for new patients or 92012 for established patients) for routine visits because you'll need less documentation to substantiate this code. To report a subsequent nursing facility care code (99307-99310), you would need to meet CPT's requirement to review the medical record and the results of diagnostic studies, as well as changes in the patient's status.

If, however, you are seeing the patient for a medical problem (such as glaucoma) or are evaluating a more far-reaching systemic disease process — and can meet the documentation requirements for history, examination and medical decision-making — you may report an E/M code.

Select the E/M code based on the type of facility. The nursing-facility codes (99307-99310) are for services provided within a facility in which 24-hour medical services are available. Domiciliary, rest home and custodial-care codes (99324-99337) are for nursing homes that provide room and board, as well as personal assistance. You should use domiciliary codes only when the nursing facility does not provide medical assistance to its residents. □

require the presence of a physician), which means there must be a plan of care with medical necessity for the technician to see the patient. There must also be documentation to support the visit, and you must be immediately available in the office suite.

But if the only reason the patient is coming into your office is to pick up a prescription and you do not see her, you shouldn't report an E/M service. Note, however, that this service, if documented, may accrue to the medical decision-making of a subsequent E/M service.

Diagnosis option: There is a diagnosis code, V68.1 (*Issue of repeat prescriptions*), which might be appropriate for you to report.

□

Get the Scoop on 92020, 92060 and 92100

Question: Some CPT code descriptions include the phrase "separate procedure." What does this mean and how does it affect coding?

Florida Subscriber

Answer: The phrase "separate procedure" designates codes that are "commonly carried out as an integral component of a total service," according to CPT. You should not report such a code in addition to the code for the total procedure or service for which it is considered an integral component.

Ophthalmic tests designated as a "separate procedure" include:

- 92020 for gonioscopy
- 92060 for quantitative sensorimotor exam
- 92100 for serial tonometry.

— *Answers to You Be the Coder, Reader Questions and Building a Better Business reviewed by David Gibson, OD, FAAO, practicing optometrist in Lubbock, Texas.* □

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