Understanding the New Medicare Guidelines - I

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2009 Medicare E/M Guidelines

- Compliance
  - How To Document the Medical Record
  - How To Select an E/M Codes, eye codes, “S” codes
  - How To Evaluate your Fees
  - How To Effectively Co-manage Surgical Cases
  - How To Increase Revenues
  - How To Survive an Audit
  - How To Understand HCPCS and PQRI code sets
  - How To Implement a Compliance Plan

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Other Medicare Benefits Changes

- Deductible (Part B) – $135 in 2009; thereafter increase by annual percentage increase in Part B expenditures
- Part B premium – currently uniform for all beneficiaries will vary based on income; phases in over 5 year period beginning in 2007
- Preventive benefits – beginning in 2005, all newly enrolled beneficiaries will be eligible for initial routine physical examinations, ECG, cardiovascular blood screening tests, education, counseling and referral for other preventive services and chronic care programs

2005 Coverage for Smokers

- Counseling services for Americans over 65 who want to quit smoking
- 9.3% of >65 year old smoke
- 300,000 die annually from smoking related diseases
- 10% of Medicare budget or 14.2 billion is spent on healthcare caused or complicated by smoking

2006 New HCPCS Codes

- V2788 Presbyopia-correction function of an intraocular lens
  - For reporting additional, non-covered charges associated with the insertion of the presbyopia correcting IOLs
  - Effective Jan. 1, 2006
  - Recommend ABN
Multifocal IOLs

- "Presbyopia-correcting IOLs allowed by CMS on May 3, 2005
  - ReSTOR
  - ReZoom
  - CrystaLens

2006 New CPT Codes

- Pegaptanib for AMD
  - 67028 Intravitreal injection - $196.58
  - J2503 Macugen - $1054.70
- Verteporfin for AMD
  - 67221 infusion of photodynamic agent - $301.46
  - J3396 Visudyne - $1400
- Bevacizumab for AMD
  - 67028 Intravitreal injection - $196.58
  - J9035 Avastin

2006 New ICD-9 Codes

- Must report with 250.5
- 362.03 Nonproliferative diabetic retinopathy NOS
- 362.04 Mild nonproliferative diabetic retinopathy
- 362.05 Moderate nonproliferative diabetic retinopathy
- 362.06 Severe nonproliferative diabetic retinopathy
- 362.07 Diabetic macular edema
  - Must report with ICD code for diabetic retinopathy
    - 362.01 = background diabetic retinopathy
    - 362.02 = proliferative diabetic retinopathy
    - 362.03 - 362.07
2007 New CPT Codes

- 92025  Computerized Corneal Topography, Unilateral or Bilateral, with Interpretation & Report
  - Fee $28.39
- 67346  Biopsy of Extraocular Muscle

2007 New ICD-9 Codes

- 377.43  Optic Nerve Hypoplasia
- 379.60  Inflammation (infection) of post procedural bleb; unspecified
- 379.61  Inflammation (infection) of post procedural bleb; stage 1
- 379.62  Inflammation (infection) of post procedural bleb; stage 2
- 379.63  Inflammation (infection) of post procedural bleb; stage 3

2008 New CPT Codes

- 68816  Probing of nasolacrimal duct w or w/o irrigation, with transluminal balloon catheter dilation
  - Fee $551.79
- 67041  Vitrectomy w removal of ERM
- 67042  Vitrectomy w removal of ILM for repair of DME, or macular hole
- 67043  Vitrectomy w removal of CNV
- 67113  Repair of complex RD (PVR, diabetic traction RD, ROP, tear >90 degrees) w vitrectomy and membrane peeling, includes everything
- 67229  Preterm infant (<37wks gestation, birth to one yr), photocauterization or cryopexy (ex ROP)
2008 New ICD-9 Codes
- 364.89 Other disorders of the iris and ciliary body (prolapse, NOS)
  - Excludes prolapse of iris in recent wound
- V49.85 Dual sensory impairment
  - Blindness with deafness
- V68.01 Disability examination
  - Use additional code to identify specific examination, screening, and testing performed (V72.0-V82.9)
- 364.81 Floppy eyelid syndrome*
  - Can’t use for 66982

2009 New CPT Codes
- 0198T Measurement of ocular blood flow by repetitive IOP samples, with interpretation & report
- 65756 Keratoplasty, endothelial
- 65757 Backbench preparation of corneal endothelial allograft prior to transplantation

2009 New ICD-9 Codes
- 362.2 Retinopathy of prematurity, unspecified
- 362.22 ROP stage 0
- 362.23 ROP stage 1
- 363.24 ROP stage 2
- 362.25 ROP stage 3
- 362.26 ROP stage 4
- 362.27 ROP stage 5
- 364.82 Plateau iris syndrome
- 372.34 Pingueculitis
Job Growth and Tax Relief Reconciliation Act of 2003

- Bush signed May 28, 2003
- 3rd largest tax cut in history
- Encourages businesses to increase capital spending
  - Section 179 expense limit increased to $250,000.00 for equipment put in service by 12.31.08
  - Also applies to pre-owned equipment for 2008
  - Purchased can be financed and interest expense is also deductible

Tax Relief and Health Care Act of 2006

- Set conversion factor for physician payment at same level as in 2006
  - Reverses statutory mandated 10.1% negative update for 6 months
  - “Deal” provides for
    - 0.5% fee increase
    - Extends expiring incentive payments for rural physicians
    - Extends bonus payments for quality reporting

Health Insurance Portability and Accountability Act of 1996

- President Clinton & USAG J. Reno
  - #2 priority: prosecution of health care fraud
  - $104 Million: Appropriations to HHS
  - $70 Million: OIG
  - $47 Million: FBI fraud investigation unit
  - Criminal offenses expanded
  - $10,000 fine / line item violation
  - Suspension of payment and participation from program
  - Yielded $23 return on every $1 spent in 1997
Dead Doctors Billing Scams 2000-2007
- 478,500 false claims
- 16,500 dead physicians
- $92.8 million in payments just by Medicare
- 16% made by doctors dead for more than 10 years

Qui Tam Relaters
- Amendment to False Claims Act of 1986
- Encourages private individuals to sue in the government’s behalf
- Whistleblowers - 30% of recoveries
  - $1 Billion paid since 1987 in Qui Tam actions
- Compliance Plan
  - Eliminates aggressive or conservative billing philosophies
  - Removes incentives for whistleblowers
  - Improves collections while reducing audit risks

Medicare Review Strategies - 2009
- Error rates at below 7% nationally
- E/M codes represent 75% of errors (highest for Part B)
  - 10-1 overpayment –underpayment
  - Insufficient documentation and incorrect coding
- OB/GYN specialty highest error rate nationally at 35.75%
- Diagnostic radiology specialty highest projected dollars paid incorrectly at 48 million
**Top 5 Errors by Profession - 2006**

- OB/GYN
- Neurology
- Chiropractic
- **Optometry – 11.6%**
- Nephrology

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**Medicare Review Strategies - 2008**

- E/M established codes
- Laboratory
- Hospital E/M, subsequent
- Consultation codes
- E/M new codes
- Electrocardiograms
- Chiropractic
- Rituximab
- Hospital E/M, initial

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**Medicare Review Strategies - 2008**

- ED E/M
- Modifier-Q6
  - $1 million / quarter / state
  - Highest diagnostic radiology
- Modifier-59
- Physical therapy
- Psychiatric services
- Infliximab
- Wound care
**Top 10 Procedure Codes – Optometry**

**Missouri / Jan-June 2007 / 495 Providers**

- 92014 $1,369,645
- 99214 $634,210
- 92004 $562,906
- 92012 $551,297
- 99213 $541,616
- 66984 $395,125
- 92250 $339,862
- 92083 $277,708
- 99203 $199,510
- 92135 $195,427

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**HIPAA in Bite Sized Chunks**

- **Standards for transactions** conducted electronically
- **Standards to protect privacy** of personal health information
- **Standards to protect security** of personal health information when stored electronically
- **Uniform federal identifiers** of providers, health plan, employers and individuals

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**NPI Identifier**

- **Enumerator / National Provider System / ANSI**
  - Must be used by May 23, 2007
  - Providers need to apply online at CMS website
- **Identifiers for providers, health plans, employers and individuals**
- **National Provider Identifier (NPI)**
  - 10 digit string of alphanumeric characters, includes check digit
  - Format allows 200 billion identifiers without re-using values
- **Benefits of NPI identifiers**
  - All transactions for ALL health plans
  - NPI will never change
  - Facilitates coordination of benefits
  - Facilitates tracking claims and payments
  - Facilitates identifying and prosecuting fraud
- **NPI are important in PQRI and e-prescribing**
**Code Set Adoption in HIPAA**
- CPT-4: Current Procedure Terminology
- CDT: Code on Dental Procedures and Nomenclature
- ICD-9-CM (Volume 1,2): International Classification of Diseases (Proposal to implement ICD-10)
- ICD-9-CM (Volume 3): inpatient disease codes
- NDC: National Drug Code
- HCPCS: Healthcare Common Procedure Coding System

**AOA Optometric Practice Profiles 2005**
- VSP – 21%
- Other vision plans – 8%
- Medicare – 19.1% (fastest growing share of revenues)
- Medicare HMOs – 3%
- Medicaid – 7%
- HMOs (private sector) – 8%
- Out of pocket – 35%
- Respondents - 90% self-employed, 47% solo, 24% group, 86% male, mean years in practice 24.2 years

**INTRODUCTION**
- CMS = Center for Medicare & Medicaid Services (formerly HCFA) - announced June 14, 2001
  - Center for Medicare Management - traditional fee-for-service programs
  - Center for Beneficiary Choices - provide beneficiaries with information on Medicare, MedicareSelect, Medicare+Choice, and Medigap options
  - Center for Medicaid and State Operations - focus on Medicaid and state administered services
INTRODUCTION

- CMS
- CPT
- ICD
  - www.icd9coding1.com/flashcode/userRegister.do
- Medicare
- Major Medical
- E/M Coding (99XXX)
- Eye Coding (92XXX)
- Special Ophthalmic Codes

1.800.Ingenix www.ingenixonline.com

E/M GUIDELINES

- New/Established Patient
- Chief Complaint
- History of Present Illness
- Family History
- Past History
- Social History
  - New additions level of education, sexual history, marital status/living arrangements
- Review of Systems
- Time
E/M DESCRIPTORS

- History *
- Examination *
- Medical Decision Making *
- Counseling
- Coordination of Care
- Nature of the Presenting Problem
- Time

CATEGORIES OF SERVICE

- Office Visits (E/M Codes)
  - New 99201-99205
  - Estab 99211-99215
- Office Visits (Eye Codes)
  - New 92002-92004
  - Estab 92012-92014
- Consultations (E/M Codes)
  - Office 99241-99245

E/M Coding - Consultation

- Office Consultations
  - Opinion / Advice
  - Not Referral
- Duration - short
- Continuity - expect patient back
- Documentation - required
E/M Coding - Referral

- Referral
  - Treatment or Care
- Duration - long
- Continuity - Do not expect patient back
- Documentation - not required, but courtesy
- Warning! - carefully consider the language used in the correspondence to your consulting specialists
  - avoid the term referral, unless that is what you mean!

CATEGORIES OF SERVICE

- Emergency Department Services
  - No distinction made between new and established in ED
  - Organized hospital based facility for provision of unscheduled episodic services to patients who present for immediate medical attention
  - Facility must be available 24 hours per day
  - Coding requires 3 of 3
    - 99281 (1-1-1) = $15.73
    - 99282 (2-2-2) = $26.10
    - 99283 (2-2-3) = $58.63
    - 99284 (3-3-3) = $91.55
    - 99285 (4-4-4) = $143.41

SELECTING AN E/M LEVEL

- Identify Category of Service
- Identify Extent of History Taking
- Identify Extent of Examination
- Identify Complexity of Medical Decision Making
- Review E/M Descriptors
E/M CODING - OFFICE VISITS

New Patient (3 of 3)
- 99201 - PFH / PFE / SDM / 10
- 99202 - EFH / DFE / SDM / 20
- 99203 - DH / DE / LDM / 30
- 99204 - CH / CE / MDM / 45
- 99205 - CD / CE / HDM / 60

E/M Coding - Office Visits

Established Patient (2 of 3)
- 99211 - Minimal / 5
- 99212 - PFH / PFE / SDM / 10
- 99213 - EFH / EFE / LDM / 15
- 99214 - DH / DE / MDM / 25
- 99215 - CH / CE / HDM / 40

DOCUMENTATION OF HISTORY

Problem Focused History (PFH)
- CC / 1-3 HPI

Expanded Problem Focused History (EPF)
- CC / 1-3 HPI / Ocular ROS

Detailed History (DH)
- CC / 4 HPI / Ocular ROS / ROS-2 / 1 OF 3 PFSH

Comprehensive History (CH)
- CC / 4 HPI / Ocular ROS / ROS-10 / 3 OF 3 PFSH (NEW)
- OR 2 OF 3 PFSH (ESTAB)
Eye Examination Documentation

- VA / CVF / Pupils & Iris / Adnexa
- Bulbar & Palp Conjunctiva
- EOM
- SLE: Cornea / Lens / AC
- IOP / Optic Nerve / Posterior Segment
- Neurologic: Orientation (Time / Place / Person)
- Psychiatric: Mood & Affect (Depression / Anxiety / Agitation)

DOCUMENTATION OF EXAMINATION

- Problem Focused Exam (PFE)
  - Limited Exam / 1 - 5 Elements
- Expanded Problem Focused Exam (EPF)
  - Limited Exam / 6 Elements
- Detailed Exam (DE)
  - Extended Exam / 9 Elements
- Comprehensive Exam (CE)
  - Complete Single System Exam
  - All Elements

Medical Decision Making

- Straightforward (SF)
  - # Dx / Rx Options - Min / Data - Min / Risk - Min
- Low Complexity (LC)
  - # Dx / Rx Options - Lim / Data - Lim / Risk - Low
- Moderate Complexity (MC)
  - # Dx / Rx Options - Mult / Data - Mod / Risk - Mod
- High Complexity (HC)
  - # Dx / Rx Options - Ext / Data - Ext / Risk - High
**Comprehensive Ophthalmological Service**  
92004 / 92014

- Complete system evaluation, **8 or more elements**
- Need not be performed at one session
- Integrated services where med decision making cannot be separated from examination methods
- Includes history, medical observation, external & ophthalmoscopic, gross visual fields, sensorimotor, biomicroscopy, consultations, dilation (cycloplegia), mydriasis, tonometry, initiation of diagnosis and treatment programs, prescription of medication

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**Intermediate Ophthalmological Service**  
92002 / 92012

- Evaluation of new / existing condition, complicated with a new diagnostic or management problem
- Integrated services where med decision making cannot be separated from examination methods
- Includes history, medical observation, external & adnexal, & other diagnostic procedures, biomicroscopy, mydriasis ophthalmoscopy and tonometry
**Intermediate Ophthalmological Service**

92002 / 92012

- Ophthalmological services: medical examination and evaluation, with initiation or **continuation** of diagnostic and treatment program; intermediate, established patient
- **7 or less elements**

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**2004 New HCPCS Codes**

- “S” codes are useful for some private insurers
- Medicare and other federal payers **do not** recognize them
- They are useful when CPT does not have a code to accurately describe the service (i.e. LASIK, PTK, PRK, corneal topography) or for invoicing self-pay patients.
- **They specifically describe “routine exams” including refractions** and permit a different charge

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**HCPCS “S” Codes**

- S0592 Complicated contact lens evaluation
- S0620 Routine ophthalmologic exam including refraction; new patient
- S0621 Routine ophthalmologic exam including refraction; established patient
HCPCS “S” Codes

- S0800 LASIK
- S0810 PRK
- S0812 PTK

2006 Medicare Fee Schedule
Office Visits

- 99201 $34.23-
- 99202 $60.83-
- 99203 $90.58-
- 99204 $128.26-
- 99205 $163.20-
- 92002 $66.03-
- 92004 $120.51-

- 99211 $19.96-
- 99212 $35.96-
- 99213 $49.10-
- 99214 $77.08-
- 99215 $112.36-
- 92012 $60.50-
- 92014 $89.53-

2006 Medicare Fee Schedule
Consultations

- 99241 $46.96-
- 99242 $86.00-
- 99243 $114.67-
- 99244 $162.01-
- 99245 $209.65-
Monitor Compliance with Audits

- Develop a “Documentation” team
- Monthly Assessment
  - 10 charts/Provider
- Report your Results
  - All staff, residents, students
- Acknowledge positive & negative variances
  - RETRAIN, RETRAIN...

THANK YOU!

- Primary Eyecare Network
  - 1.800.444.9230  www.primaryeye.net
- Medicare Compliance Kit
  - Health History Questionnaire
  - Examination Forms
  - E/M Worksheets
  - ICD-9 Codes
  - Interpretation/Report form
- Medicare A-Z Manual
  - Superbills / Signature on File stickers / Electronic Claims
- HIPAA Compliance Manual
- PQRI Card

Thank you
Missouri Eye Associates
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Excellence in Optometric Education