AAO Coding Update
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AAO Coding Executive

2014 S.E. Eye Annual Regional Meeting: July 24-26, 2014
Financial Disclosure

- Sue Vicchrilli, COT, OCS
  - Has no financial interests or relationships relative to this live activity to disclose.
Overview

- While the **physician** is ultimately responsible, it takes a team of **experts** to correctly
  - Schedule the appointment,
  - Document and code the encounter,
  - Preauthorize,
  - Collect copayments, deductible,
  - Submit the claim,
  - Process the remittance advice
  - Monthly statements/work collections
Best Practice - Technicians

Technicians must be proficient in knowing the following in addition to your technical skills:

- Guidelines for E/M and Eye codes
  - The importance of the chief complaint
  - Does the CC identify what the physician needs to know and have a minimum of 4 elements to the HPI?
  - Established patients – the status of 3 chronic or inactive conditions
Best Practice - Technicians

• Are exams performed the same day as tests/minor/major surgery payable?

• Key words not to write:
  ◦ Preop
  ◦ Postop
  ◦ Routine – unless a vision exam

• ROS
  ◦ New patient a minimum of 10 systems
  ◦ Established patient as medically necessary
  ◦ Any system with a positive answer has details of what the patient is doing presently to care for that problem
Best Practice - Technicians

• PFSH
  ◦ All three on new patients
    – Including children
  ◦ As medically necessary for established patients

• Testing services
  ◦ Which are unilateral vs. bilateral
  ◦ Written order for delegation
  ◦ Interpretation and report
Best Practice - Technicians

- Surgeries
  - Payable per lid, eye, lesion?
  - CCI edits for same day surgery
- Modifiers
  - Exams
  - Tests
  - Surgery
    - Procedures performed in the global period
Best Practice - Technicians

- Advance Beneficiary Notice (ABN)
  - Part B patients only
  - Append modifier –GA to claim
    - Alerts Medicare Part B that signed ABN is in your office
  - Frequency of test
  - Covered diagnosis
  - Oculoplastic procedures
PECOS

All physicians who enrolled with Medicare Part B prior to March 25, 2011, will be required to revalidate their Medicare enrollment.

Physicians have 60 days from the date of the revalidation notice to submit their complete enrollment information.

You will receive a revalidation letter through the mail when it is your turn.
Best Practice - Administrators

- PECOS
- Be proactive and re-enroll now.
- Delay?
  - No payment!
  - Lengthy re-enrollment process
  - Pediatric ophthalmologists who do not submit a claim to Medicare Part B within a calendar year are automatically dropped from Part B participation.
Best Practice - Administrators

- Adding a “licensed professional” to the practice?
  - Verify status with OIG!
Best Practice - Administrators

- Adding a “licensed professional” to the practice?
  - Verify status with OIG!
    - XXX institution entered into a settlement agreement with the Office of Inspector General (OIG) for the Department of Health and Human Services, effective July 8, 2014. The $197,839.94 settlement resolves allegations that XXX employed three individuals who were excluded from participating in any Federal health care programs.
Best Practice - Administrators

- Do you have protocol for staff to follow when the requests for records arrives?
- Who is responsible in the event the audit has a negative outcome?
  - Individual physician?
  - Practice?
Best Practice - Administrators

- Are prepared for an audit
- Medicare Administrative Contractor (MAC)
- Comprehensive Error Rate Testing (CERT)
- Zone Program Integrity Contractors (ZPIC)
- Office of Inspector General (OIG)
- Quality Improvement Organization (QIO)
- Recovery Audit (RA)
  - Important to note: RAs will not review claims previously examined by another audit entity.
Best Practice - Administrators

- Are prepared for an audit
  - Medicare Advantage Plans
  - HEDIS
Best Practice - Administrators

- Are prepared for an audit
  - Written protocol in place
  - Receive weekly emails from payer listservs
  - Familiarize everyone in the practice with Local Coverage Determination (LCD) rules.
Best Practice - Administrators

- Alabama/Tennessee – Cahaba
  - Drugs/biologicals
  - Botulinum toxins
  - Blepharoplasty
  - Cataract
  - Benign lesions
  - YAG
Best Practice - Administrators

- Louisiana/Mississippi – Novitas
  - Cataract/complex cataract
  - Comanagement
  - iStent
  - Punctal plugs
  - Benign skin lesions
  - SCODI
  - Blepharoplasty
Best Practice - Administrators

- All others –
  - Under Coding Tools
  - www.aao.org/coding
# PQRS Incentives and Penalties

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Best Practice - Administrators

- January 1, 2014
  - CMS 1500 Form
    - List ordering physician rather than referring physician
    - #1 error currently resulting in denied claims
Best Practice - Physicians

- All the above!
  - Don’t guess when it comes to coding
  - Take ownership
Best Practice - Physicians

• Be mindful of remittance advice to patients:
  ◦ “Payment is included in another service received on the same day”
  ◦ “You should not be billed for this service”
  ◦ This is an adjustment to a previously processed claim”
  ◦ You should have been told that Medicare may not cover this service and are not responsible for payment”
First Things First

- Before physicians greet the patient
- Identify the payer!
  - There is very little standardization among payers.
  - Five categories
Who are the Payers?

1. Medicare Part B
   a. Disability, black lung
   b. Age 65
   c. If employed or spouse employed, commercial payer is primary and Medicare Part B becomes secondary payer
2. Commercial payers:
   - Aetna, BCBS, CIGNA, Humana, United Healthcare, etc.
     - Carve outs for each plan
3. Medicare Advantage Plans (MA):
   - Alternative to Medicare Part B
   - Not a supplemental insurance
   - Not administered by Part B
   - Follow some of Part B rules and some rules of the commercial plan administering the insurance
Who are the Payers?

4. Affordable Care Act (ACT)
   • Under commercial plan until renewal
   • Verify coverage at each visit!
Who are the Payers?

5. Medicaid
   - Welfare recipient
   - While a federal program, funded on a state level
   - Different rules/coverage
   - Verify coverage at each visit
Questions ?
Coding Jeopardy
Question 1

- We received a RA letter alleging we incorrectly billed a new patient exam.
  - Two years previously, at the request of a plastic surgeon, we performed a visual field test (92081) on a patient because the plastic surgeon didn’t own the visual field equipment.
Question 1

1. There was no face-to-face encounter with the patient so billing a new patient exam is right.

2. As a physician of the practice submitted a bill for the visual field, the patient is now considered an established patient of the practice.
Answer 1

1. There was no face-to-face encounter with the patient so billing a new patient exam is right.

2. As a physician of the practice submitted a bill for the visual field, the patient is now considered an established patient of the practice.
Question 2

How often do we need to have the patient fill out _new_ paperwork for the ROS and PFSH?

1. Annually

2. Can be referenced at each exam but only needs new paperwork if/when the rules change or if the patient is “new” again.
How often do we need to have the patient fill out new paperwork for the ROS and PFSH?

1. Annually
2. Can be referenced at each exam but only needs new paperwork if/when the rules change or if the patient is “new” again.
Question 3

- For Medicare Part B patients who undergo bilateral surgery, claims should be submitted as:
  1. Two lines with modifiers -RT/ -LT
  2. One line with modifier -50 and 2 in the unit field
  3. One line with modifier -50 and 1 in the unit field
Answer 3

- For Medicare Part B patients who undergo bilateral surgery, claims should be submitted as:

1. Two lines with modifiers -RT/ -LT
2. One line with modifier -50 and 2 in the unit field
3. One line with modifier -50 and 1 in the unit field (According to MUEs Apr ’13)
Question 4

- During the global period of vitrectomy (CPT code 67036), an unplanned paracentesis of the anterior chamber was performed (CPT code 65800) in the office dedicated procedure room.

1. Append modifier -58
2. Append modifier -78
3. Append modifier -79
4. Unless performed in an ASC, not separately billable
During the global period of vitrectomy (CPT code 67036), an unplanned paracentesis of the anterior chamber was performed (CPT code 65800) in the office dedicated procedure room.

1. Append modifier -58
2. **Append modifier -78**
3. Append modifier -79
4. Unless performed in an ASC, not separately billable
Within the global period of a iridotomy/iridectomy on the right eye, a trabeculectomy is performed on the same eye.

What is the appropriate modifier(s) to append to the trabeculectomy?

1. Modifier -58 -RT
2. Modifier -59 -RT
3. Modifier -78 -RT
Question 5

- Within the global period of a iridotomy/iridectomy on the right eye, a trabeculectomy is performed on the same eye.
- What is the appropriate modifier(s) to append to the trabeculectomy?

1. Modifier -58 -RT (Lesser to greater concept)
2. Modifier -59 -RT
3. Modifier -78 -RT
During the global period laser suture lysis is performed. Correct coding:

1. No charge
2. CPT code 65222 for corneal foreign body removal
3. CPT code 66250 for wound repair
4. CPT code 66250-78 for wound repair
Answer 6

- During the global period laser suture lysis is performed. Correct coding:
  1. No charge

- Suture removal, no matter the technique, is not separately billable within the global period. Outside the global period or if you were not the surgeon, it is part of the examination billed.
Question 7

- When a retina OCT (CPT code 92134) and glaucoma OCT (CPT code 92133) are performed the same day:
  1. Both are billable and payable
  2. Both are payable when appending modifier -59 to 92133
  3. Only one should be billed due to mutually exclusive CCI edits
Answer 7

- When a retina OCT (CPT code 92134) and glaucoma OCT (CPT code 92133) are performed the same day:

1. Both are billable and payable
2. Both are payable when appending modifier -59 to 92133
3. Only one should be billed due to mutually exclusive CCI edits
The documentation of each patient encounter should **not** include:

1. The reason for the encounter, relevant history, physician examination findings
2. Information from the previous exam brought forward
3. Assessment, clinical impression and diagnosis
4. Plan of care
The documentation of each patient encounter should **not** include:

1. The reason for the encounter, relevant history, physician examination findings
2. Information from the previous exam brought forward

Copy forward or copy paste is not appropriate and places practices in an area of vulnerability in an audit. It is one of the areas the OIG continues to investigate.
Question 9

- Patient underwent pneumatic retinopexy (CPT code 67110). One day postop physician performed repair of retinal detachment; photocoagulation (CPT code 67105).

1. As 67105 is bundled in CCI with 67110 it is not separately billable
2. 67105 is billable by appending modifier -58
3. 67105 is billable by appending modifier -78
1. As 67105 is bundled in CCI with 67110 it is not separately billable

2. 67105 is billable by appending modifier -58

3. 67105 is billable by appending modifier -78

- Modifier -58 following the lesser to greater rule.
Question 10

Which of the following is true regarding subsequent ophthalmoscopy?

1. Payment is for drawing a change in pathology that is drawn and labeled.
2. A covered diagnosis is all that is required.
3. The drawing must be in color.
4. Payment is made whether there is change or not, as long a picture is drawn.
Which of the following is true regarding subsequent ophthalmoscopy?

1. Payment is for drawing a change in pathology that is drawn and labeled.

Of all testing services performed by physicians, subsequent ophthalmoscopy is billed most often.
Question 11

- When a YAG capsulotomy is performed during the postoperative period of cataract surgery on the same eye, in the physician’s office, the correct coding is:
  1. CPT code 66821-78-eye modifier
  2. CPT code 66821-58-eye modifier
  3. CPT code 66821-79-eye modifier
  4. No separate billing as the procedure is not performed in a hospital or ASC
When a YAG capsulotomy is performed during the postoperative period of cataract surgery on the same eye, in the physician’s office, the correct coding is:

1. CPT code 66821-78-eye modifier
2. CPT code 66821-58-eye modifier
3. CPT code 66821-79-eye modifier
4. No separate billing as the procedure is not performed in a hospital or ASC
Question 12

- Retina OCT (CPT code 92134) is performed in one eye. Correct claim submission is:
  1. 92134-RT
  2. 92134-52
  3. 92134-50
  4. 92134
Retina OCT (CPT code 92134) is performed in one eye. Correct claim submission is:

1. 92134-RT
2. 92134-52
3. 92134-50
4. 92134
Question 13

- Physician performed CPT code 65855 SLT on the left eye and then two weeks later on the right eye. Correct coding for the second laser procedure on the Medicare Part B patient is:

1. 65855-78-RT
2. 65855-RT
3. 65855-58-RT
4. 65855-79-RT
Physician performed CPT code 65855 SLT on the left eye and then two weeks later on the right eye. Correct coding for the second laser procedure on the Medicare Part B patient is:

1. 65855-78-RT
2. 65855-RT (Medicare Part B – 10 day global period)
3. 65855-58-RT
4. 65855-79-RT
Question 14

Which of the following should be coded as CPT code 66982 complex cataract surgery?

1. Piggy-back IOL
2. Vitrectomy at the time of cataract surgery
3. Use of Healon 5
4. None of the above
Answer 14

Which of the following should be coded as CPT code 66982 complex cataract surgery?

1. Piggy-back IOL
2. Vitrectomy at the time of cataract surgery
3. Use of Healon 5
4. None of the above
Question 15

- Multiple chalazia are excised.
  - RUL, LUL, LLL

- Correct claim submission should be:
  1. 67800 with 3 in until field
  2. 67801-E3, 67801-E1, 67901-E2
  3. 67805
Multiple chalazia are excised.

- RUL, LUL, LLL

Correct claim submission should be:

1. 67800 with 3 in until field
2. 67801-E3, 67801-E1, 67901-E2
3. 67805 multiple, different lids
Due to complications during the surgery, cataract extraction without implant (CPT code 66850) was performed on the right eye.

An IOL was implanted one month later. What is the correct surgical code and modifier?

1. Secondary IOL 66985-58-RT
2. Secondary IOL 66985-78-RT
3. IOL exchange 66986-78-RT
4. IOL exchange 66986-79-RT
Answer 16

Answer:

1. Secondary IOL 66985-58-RT
   - As the initial complication happened during the first surgery, it necessitated a planned IOL implant later.
   - If modifier -78 was your choice, it’s okay too, but payment would be reduced 20%.
A patient returns during two weeks after a focal laser (CPT code 67210) of the right eye for additional laser because the eye is still bleeding.

Which of the following statements is true?

1. Submit 67210 -RT only as the global period is 10 days
2. Submit 67210 -76 -RT
3. No additional charge
4. Submit 67210 -78 -RT
A patient returns during two weeks after a focal laser (CPT code 67210) of the right eye for additional laser because the eye is still bleeding.

Which of the following statements is true?

1. Submit 67210 -RT only as the global period is 10 days
2. Submit 67210 -76 -RT
3. No additional charge (CPT descriptor for this 90-day postop surgery, states, one or more sessions)
Within the 90-day global period of CPT code 67210 Destruction of localized lesion of retina, the doctor determines the need for a Kenalog injection. Which of the following statements is true?

1. The injection is part of the global period.
2. The injection is billable with modifier -78 if performed in the ASC.
3. The injection is billable with modifier -58 no matter where the service is performed.
4. If the diagnosis is the same, the injection is not billable.
Within the 90-day global period of CPT code 67210 Destruction of localized lesion of retina, the doctor determines the need for a Kenalog injection. Which of the following statements is true?

1. The injection is part of the global period.
2. The injection is billable with modifier -78 if performed in the ASC.
3. The injection is billable with modifier -58 no matter where the service is performed.

This is one of the three indications for modifier -58.
The Medicare Part B patient had an LPI (CPT code 66761) on the right eye. Two weeks later undergoes a pupilloplasty for plateau iris. Which of the following statements is true?

1. Submit CPT code 66680
2. Submit CPT code 66680-58-RT
3. Submit CPT code 66680-78-RT
4. Submit CPT code 66680-79-RT
Answer 19

Answer:

1. Submit CPT code 66680
   - The original surgical procedure, CPT code 66761 has a ten-day global period for Medicare Part B.
   - For commercial plans that have a 90-day global period, modifier -58-RT would be appropriate. This follows the lesser to greater definition of modifier -58.
Question 20

- I saw a patient who had surgery by another doctor less than one week ago. The patient is having complications from their surgery and came to see me since the surgeon is located far away. How should I be billing these encounters?

1. Surgical code with modifier -55
2. Appropriate level of E/M or Eye code with modifier -24
3. Appropriate level of E/M or Eye code without a modifier
4. No charge if you are the physician taking call for the other physician
Answer:  

3. Appropriate level of E/M or Eye code without a modifier  
   - No comanagement agreement. Patient initiated the exam on their own.
Question 21

- Patient complains of eye irritation in both eyes. It has become progressively worse over the last three months. Bright lights and computer work make it worse. Artificial tears provide no relief. Which of the following is true about this chief complaint and elements to the HPI?

1. The chief complaint is brief
2. The chief complaint is extended
3. The chief complaint along with the results of a Schirmer test result or corneal decompensation should be documented prior to insertion of punctal plugs.
4. Both B and C
Answer 21

Answer:

4. Both B and C

- Prior to inserting punctal plugs, documentation of patient complaint, medical findings and that other methods of relief have not been successful are required.
Question 22

- Following cataract surgery in the left eye, the surgeon removed fluid from the anterior chamber to relieve increased IOP. How should this be coded?
  1. No charge as this is postoperative care
  2. CPT code 65805-LT for the paracentesis
  3. CPT code 65805-58-LT
  4. CPT code 65805-78-LT
Answer 22

Answer:

4. CPT code 65805-78-LT
   - This is an unplanned return to procedure room/facility within the global period.
Initial visit for an 18-year-old female with a two day history of acute conjunctivitis. Extensive history of possible exposures, prior normal ocular history, and medication use is obtained, is a clinical example of which level of E/M code?

1. 99201
2. 99202
3. 99203
4. 99204
Initial visit for an 18-year-old female with a two day history of acute conjunctivitis. Extensive history of possible exposures, prior normal ocular history, and medication use is obtained, is a clinical example of which level of E/M code?

1. 99201
2. 99202
3. 99203
4. 99204
Question 24

For the convenience of the patient, a YAG capsulotomy is performed on the left eye the same day as cataract surgery on the right eye. Correct coding is:

1. CPT code 66984-RT Cataract and 66821-LT YAG
2. CPT code 66984-RT Cataract and 66821-59 - LT YAG
3. CPT code 66984-RT Cataract and 66821-79 - LT YAG
4. No charge for the YAG as 66821 is bundled with 66984 in CCI
Answer 24

Answer:

2. CPT code 66984-RT Cataract and 66821-59-LT YAG

- YAG is bundled with cataract surgery in CCI. It is appropriate to unbundled with modifier -59. Modifier -79 indicating an unrelated procedure is insufficient to break a CCI edit.
Question 25

Which of the following statements is true concerning ophthalmic tests?

1. The interpretation and report must be dictated.
2. A physician of the practice must be on site when tests are performed according to CMS.
3. Tests are payable within the global period of a surgery when medically indicated.
4. Payment is inherently bilateral for all tests.
Answer:

3. Tests are payable within the global period of a surgery when medically indicated.

- Whether related or unrelated to the surgery, tests performed during the global period are payable when performed within the global period of a corneal transplant.
Question 26

- This CPT code is bundled with all testing services:
  1. 99211 Established patient level 1 exam
  2. 99215 Established patient level 5 exam
  3. 92250 Fundus photography
  4. 92015 Refraction
Answer 26

- This CPT code is bundled with all testing services:
  1. 99211 Established patient level 1 exam – known as the tech code
  2. 99215 Established patient level 5 exam
  3. 92250 Fundus photography
  4. 92015 Refraction
Office visit for a 68-year-old male, established patient with the sudden onset of multiple flashes and floater in the right eye due to a posterior vitreous detachment.

1. 99212
2. 99213
3. 99214
4. 99215
Answer:  
3. 99214

- However, depending on the payer’s fee schedule, many practices may choose 92014 when the Eye code has a higher allowable.
An exam, gonioscopy (CPT code 92020), Pachymetry (CPT code 76514), and a visual field (CPT code 92083) are performed on the same day on a Medicare Part B patient. Correct coding is:

1. Exam, modifier -25, 92020, 76514, and 92083
2. Exam, 92020 and 92083 only due to CCI edits
3. Exam, 92020 and 76514 only due to CCI edits
4. Exam, 92020, 76514-GA, and 92083
Answer 28

Answer:

4. Exam, 92020, 76514-GA, and 92083

- The exam and all three tests are payable as they are not subject to CCI edits. Modifier – GA is appended to pachymetry as Medicare Part B allows payment once per patient per (not per provider) for the diagnosis of glaucoma.
Question 29

- Which level of exam, unless contraindicated, requires dilation according to CPT?
  1. 99203
  2. 99204, 99205
  3. 99214
  4. 92014
Answer 29

Answer:

2. 99204

- E/M new patient level 4. According to CPT comprehensive eye exam, “often includes, as indicated; examination with cycloplegia or mydriasis”.

- For a new non-dilated patient, best to indicate why dilation wasn’t performed.
Question 30

When coding for multiple procedures performed in the same surgical session, which of the following statements is true?

1. The procedure with the highest charge should be listed first.
2. The procedure with highest allowable should be listed first.
3. When a procedure is performed on both eyes, both eyes are paid at 100% of the allowable.
4. Third and fourth procedures are paid at 25% of the allowable.
Answer:  
2. The procedure with highest allowable should be listed first.  
   - This may vary by payer. It is best to have the fee schedules for at least your five top payers.
Questions?
Thank you ...
Financial Disclosure

- Sue Vicchrilli, COT, OCS
  - Has no financial interests or relationships relative to this live activity to disclose.
Overview

- Penalties, sequestration, impending payment reduction
- The business of ophthalmology has never been as important or as challenging as it is now!
Overview

- Administrators – save the day!
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**Stephen Covey**
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Stephen Covey

Willing

Able
Abuse

- To use wrongly or improperly; misuse. An error.
Fraud

- Wrongful or criminal deception intended to result in financial or personal gain
Modifier -25

- Significantly, separately identifiable E/M (Eye code too) service the same day as a minor surgical procedure (0 or 10 days)
  - Does not apply to exams and tests the same day
  - Does not apply to new patient exams
Modifier -25

Bottom line:

- While medically necessary, if the established patient exam is performed solely to confirm the need to perform the minor surgical procedure, it is not separately billable.
Modifier -25

- When separately billable?
  - A separate complaint or reason for the exam
  - While not required, two separate diagnosis codes help
  - Medical necessity to evaluate the other eye
Correct Coding Initiative - CCI

- CMS developed NCCI or CCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Medicare Part B claims.
- Commercial payers have their version too.
CCI Edits

- The CCI contains two tables of edits.
- The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for a number of reasons.
## CCI Edits

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## CCI Edits

### Mutually Exclusive Edits

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</tr>
<tr>
<td>92136</td>
<td>76519</td>
<td>20050101</td>
<td>0</td>
</tr>
</tbody>
</table>
CCI Edits

- Remember to check every code combination.
# CCI Edits

## Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVUs</th>
<th>Bundled with</th>
</tr>
</thead>
<tbody>
<tr>
<td>67040</td>
<td>Vitrectomy with endolaser panretinal photocoagulation</td>
<td>43.09</td>
<td>67121 Indicator of 1</td>
</tr>
<tr>
<td>67121</td>
<td>Removal of intraocular implanted material</td>
<td>28.09</td>
<td>Not bundled with 67040 Indicator of 1</td>
</tr>
</tbody>
</table>
CCI Edits

- CPT code 67040 Vitrectomy has a higher RVU than CPT code 67121 Removal of implanted material, so we billed it as secondary procedure with modifier -59.
- Medicare is denying 67040 stating it is bundled with 67121.
CCI Edits

- Updated quarterly beginning January 1st
- Found in the Ophthalmic Coding Coach
- Coding Bulletin
- Under Coding Tools

http://www.aao.org/coding
CCI Edits

- When is it appropriate to unbundle?
  - A different session, procedure or surgery, site, organ system, a separate incision or excision and/or a separate injury.
  - Modifier -59
**Premium IOLs**

- Medicare Part B published guidelines where physicians can bill patients out-of-pocket for premium IOLs (must be on CMS approved list)
  - Presbyopia
  - Astigmatism
Premium IOLs

- No need for ABN
- Develop patient information that details exactly what patients are paying for
- Co-management
- ASC
Premium IOLs

- Caution regarding balance billing when IOL isn’t a premium IOL
  - Inappropriate use of ABN
Advance Beneficiary Notice

- Advance Beneficiary Notice (ABN)
  - Part B patients only
  - Append modifier –GA to claim
    - Alerts Medicare Part B that signed ABN is in your office
  - Frequency of test
  - Covered diagnosis
  - Oculoplastic procedures

- Never needed for non-covered services
Claim Denial Processes

- Status of A/R?
- Training of staff who process remittance advice?
- Written protocol for denied claims?
- List of causes of denial?
- Corrective action taken?
- Holding staff responsible?
Claim Denial Processes

- With transition to ICD-10 and the expectation of more denials . .
  - Current A/R and policies and procedures must be perfected!
Go Directly to Jail
Go Directly to Jail

- “How are other practices passing the 2% sequestration to patients?”
- “We have to do your injection on another day because we won’t get paid for the exam if we do both today.”
- “Because we can’t charge for a surgical tray, we bump up the level of exam we bill the same day as a procedure.”
Questions?