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Codequest Ophthalmic Coding Course

2016

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Code your way to a profitable practice with the Academy's Web-based coding resources. Use them to code precisely and reduce claim denials. Access them from your desktop, laptop, tablet or smartphone.

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- Modifiers
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Codequest Ophthalmic Coding Course
Meet our Instructors

Matthew Baugh, COT, OCS
Matt supervises all ophthalmic technicians at the John A. Moran Eye Center. He started his career in ophthalmology six years ago after receiving his Bachelors Degree from the University of Utah. Matt is currently pursuing his Masters in Health Administration. He brings his passion for patient care and clinic experience to the Academy coding team.

Elizabeth Cottle CPC, OCS
Elizabeth is an associate administrator of the Casey Eye Institute at OHSU, in Portland, Oregon, responsible for department compliance activities. She is a Certified Professional Coder (CPC) with a "specialty proficient" credential in ophthalmology by the American Association of Professional Coders (AAPC). Elizabeth has over 30 years healthcare experience, and over 20 in ophthalmology.

Jenny Edgar CPC, CPCO, OCS
Jenny is the Academy's coding specialist. Her 12 years of experience with coding and reimbursement includes certification as a compliance officer responsible for practice adherence with chart documentation and government relations. Jenny is a contributing author to YO Info, the Ophthalmic Coding Coach and the Ophthalmic Coding Series.

Jessica Schroeder, MPH, CPC, OCS
Jessica is a coding specialist at The Wilmer Eye Institute at Johns Hopkins. She completed her Master of Public Health in Health Policy and Administration in 2010 from the University of North Carolina at Chapel Hill. Jessica has been at Wilmer for four of her 12 years in the healthcare setting and is responsible for reviewing all retina visits and surgical encounters. She also trains new residents and fellows in billing and documentation workflows in Epic.

Sue Vicchrilli, COT, OCS
Sue is the director of coding and reimbursement at the Academy. Her 30 year ophthalmic background includes all aspects of coding, reimbursement, practice management, clinic and surgical assistance. Sue is the author of EyeNet's "Savvy Coder" and AAOE's "Coding Bulletin", the Ophthalmic Coding Coach, and the Ophthalmic Coding Series.

Joy Woodke, COE, OCS
Joy is practice administrator at Oregon Eye Consultants, LLC, in Eugene, Oregon, a practice specializing in anterior segment and retina. She has over 25 years of experience in ophthalmology, which includes management, accounting and ophthalmic coding and reimbursement. She is a Certified Ophthalmic Executive (COE) and has earned a Bachelor of Arts degree in Healthcare Administration. She enjoys providing an administrator's perspective to coding and reimbursement, along with the unique aspects of a retina practice. Joy also serves as the Chair of the AAOE EHR Committee.

None of the speakers, activity planners or AAOE staff have any financial disclosures to report.

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ONLINE LINK:

bit.ly/2016Codequest

Claim Your Codequest Course Online FAQs

1. **How do I claim my course credit online?**
   Type the URL in the circle into your browser. This link directs you to a webpage with instructions on obtaining the certificate required, based on the state course you attended:

   Physicians: Select "CLAIM CME" option
   Non-physicians: Select "CLAIM CEU/CERTIFICATE" option

2. **How long do I have to claim my course credit?**
   Completion of the evaluation should be within 30 days of attending this course.

3. **How do I claim AAPC credit?**
   For AAPC credit, you'll need to access their site to claim credit. You'll see an area where it asks whether or not you have an AAPC number. Select the option without the number. You will need to manually type in the information.

4. **Will you send me a copy of my course credits?**
   For Members: The Academy does not mail CME certificates. As a service to members only, the Academy maintains a cumulative record of all Academy-sponsored *AMA PRA Category1 Credits™* earned by its members for a ten-year period. An official CME Transcript is available on the Academy's Web site.

   For Non-Members: The Academy does not provide CME/CEU/CEU transcripts for non-members but, upon request, will provide verification of credits earned for a single Academy-sponsored CME activity. However, it is the responsibility of non-members to verify with their own reporting agencies (professional associations, hospitals, state licensing boards, etc.) whether Academy credits are acceptable.

5. **What is the Academy's accreditation for Codequest?**
   The American Academy of Ophthalmology is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

   The American Academy of Ophthalmology designates this live activity for a maximum of 4 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

   To provide education of the highest quality, physicians will be contacted to participate in a 3-month follow-up survey designed to measure the effectiveness of this presentation.

6. **What other course credits can be obtained other than CME?**
   JCAHPO CE Credits: Ophthalmic Allied Health Professionals receive 4 JCAHPO "A" continuing education credits for completion of this course

   COE CE Credits: The National Board of Certified Ophthalmic Executives (NBCOE) approved 4 credits hours under Category "A" continuing education credit.

   Certificate of Completion: For anyone not requiring continuing education credits, please keep and maintain a certificate of completion for this course. This will also apply to those requiring credits for **AAPC.** AAPC will grant continuing education credits to courses that have CME approval.

7. **Who do I contact if I have questions about obtaining course credit?**
   Licia Wells, Coding Coordinator, lwells@aao.org

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Financial Disclosure

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- Tour the workbook

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Coding Competency

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Coding Competency #1

- We perform several tests on new patients before they see the ophthalmologist.
  - But we only bill when pathology is found.
  - The sales rep told us this was okay.

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Coding Competency #1

- Is it appropriate to bill when we find pathology?

1. Yes
2. No

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Coding Competency #2

- I have been told there is a national coverage rule that all patients must be examined within 90 days prior to cataract surgery.

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Coding Competency #2

1. True. The patient must have an exam 90 days prior to cataract surgery.
2. False. The physician determines when an exam is medically necessary.

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Coding Competency #3

- The Advance Beneficiary Notice (ABN) applies to all traditional Part B and Medicare Advantage Plan patients.

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Coding Competency #3

1. Yes, this is a true statement.
2. No, this statement is false.

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Coding Competency #4

- Does the modifier order make any difference?

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Coding Competency #4

1. Yes. The order of the modifiers determines whether payment is made correctly.
2. No. No difference.

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Coding Competency #5

- How many diagnosis codes should be reported on each encounter?

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Coding Competency #5

1. All that have ever applied to the patient.
2. All that apply to today's visit.
3. At least 4 if coding 99204.
4. The CMS 1500 form allows for 12. Fill them up.

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Coding Competency #6

- How long do we have to keep medical records?

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Coding Competency #6

1. The law varies by state.
2. At least 7 years since last exam or if a child, at least 7 years past their 21st birthday.
3. Purge records if the bill is returned and you can't find a forwarding address.

Coding Competency #7

- How far back can a payer auditor request records?

Coding Competency #7

1. 3 years
2. 7 years
3. 10 years
4. Retirement prohibits an audit
5. There is no end . . .

Coding Competency #8

- We are non-par with an insurance company.
- Which of the following statements is true?

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Coding Competency #8

1. Provide the patient what they need to submit to their insurance.
2. Submit the claim on their behalf.

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2016 Update

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Medicare Part B Fee Schedule

- Reflects budget neutrality adjustment of -0.2% and the 0.5% update
  - Targeted cuts to retina and glaucoma procedures
  - Mis-valued code initiative
  - Must cut 1 billion in payments
  - There will not be a fix in 2016.
    - Hoping for 2017

Glaucoma Codes Impacted

- 65855 Trabeculoplasty by laser surgery
  - 2015 Office $345 / Facility $304
  - 2016 Office $279 / Facility $245

Glaucoma Codes Impacted

- 66170 Trabeculectomy ab externo in absence of previous surgery
  - 2015 Facility $1,126
  - 2016 Facility $989

Glaucoma Codes Impacted

- 66172 Trabeculectomy ab externo with scarring from previous ocular surgery or trauma
  - 2015 Facility $1,546
  - 2016 Facility $1,248

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Retina Codes Impacted

- 67107 Repair of retinal detachment; scleral bucking (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid
  - 2015 Facility $1235
  - 2016 Facility $1037

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Retina Codes Impacted

- 67108 with vitrectomy, any method including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique
  - 2015 Facility $1631
  - 2016 Facility $1323

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Retina Codes Impacted

- 67110 Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)
  - 2015 Facility $787
  - 2016 Facility $710

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Retina Codes Impacted

- 67113 Repair of complex retinal detachment
  - 2015 Facility $1772
  - 2016 Facility $1438

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Lacrimal Codes Impacted

CPT	2015 Part B Office/ Facility	2016 Part B Office/ Facility
68801	$127 / $110	$103 / $89
68810	$246 / $192	$199 / $155
68811	N/A / $211	N/A / $170 General anes.
68815	$458 / $263	$405 / $227
68816	$767 / $256	$659 / $206

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New E/M and Eye Visit* Codes

Exam Codes	2015 Part B Par	2016 Part B Par
99201	$44	$45
99202	$76	$76
92002*	$83	$82
99203	$110	$109
92004*	$151	$150
99204	$167	$167
99205	$210	$209

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Established E/M and Eye Visit* Codes

Exam Codes	2015 Part B Par	2016 Part B Par
99211	$20	$20
99212	$44	$44
99213	$74	$74
92012*	$87	$87
99214	$109	$109
92014*	$126	$126
99215	$148	$147

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New CPT Code

- 65785 Implantation of intrastromal corneal ring segment
  - Replaced Category III code 0099T
  - 90-day global period
  - Office $2,162 Facility $395

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65785 Implantation of intrastromal corneal ring segment

- CCI edits effective January 1st

65772	Corneal relaxing incision for correction of surgically induced astigmatism
65775	Corneal wedge resection for correction of surgically induced astigmatism
67500	Retrobulbar injection; medication
68200	Subconjunctival injection

- And all established patient exam codes

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New CPT Code

- The typical patient is a 27-year-old male with progressive keratoconus in both eyes who is unable to adequately see to function with glasses or contact lenses. Two small intrastromal tunnels of appropriate length are created surgically and intrastromal corneal implants are placed into each of the stromal incisions.

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Description Change

Δ 65855 Trabeculoplasty by laser surgery ~~one or more sessions (defined treatment series)~~

The change was made to align with an assigned 10-day global period and that only one laser treatment is typical during this time period.

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65855 ALT, MLT, SLT

- 65855 is not payable same day/same eye as:

65860	Severing adhesions of anterior segment, laser technique
65865	Goniosynechiae
65870	Anterior synechiae, except goniosynechiae
65875	Posterior synechiae
65880	Severing corneovitreal adhesions
92020	Gonioscopy

New: Payment Issue with 65855

- Bilateral performance.
- 65855 -50 and a 1 in the unit field.
- New CMS indicator of 2 instead of 1 for bilateral surgery.

New: Payment Issue with 65855

- Indicator of 2 means: 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure.

New: Payment Issue with 65855

- Unilateral performance:
- Claims are denied when correctly appending -RT/-LT
- Short term solution:
  - Resubmit without the eye modifiers.

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Description Change

Δ 67101 Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, ~~with or without~~ including drainage of subretinal fluid, when performed

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Description Change

Δ 67105 photocoagulation, including ~~with or without~~ drainage of subretinal fluid, when performed

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Description Change

Δ 67107 Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), ~~with or without~~ including, when performed, implant, ~~with or without~~ cryotherapy, photocoagulation, and drainage of subretinal fluid

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Description Change

Δ 67113 Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, ~~may include~~ air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens

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Description/Global Period Change

Δ 67227 Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), ~~one or more sessions~~ cryotherapy, diathermy

- 10-day global period
- Confirm with commercial payers
- 2015 Office $624 / Facility $583
- 2016 Office $296 / Facility $263

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Description/Global Period Change

Δ 67228 Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), ~~one or more sessions~~ photocoagulation

- 10-day global period
- Confirm with commercial payers
- 2015 Office $1,021 / Facility $967
- 2016 Office $348 / Facility $314

Deleted CPT Code

- 67112 Repair of retinal detachment; by scleral buckling or vitrectomy, one patient having previous ipsilateral retinal detachment repair(s) using scleral bucking or vitrectomy techniques
  - To report, use 67107, 67108, 67110, or 67113

Global Period Change

- CPT codes 65778 AMT without sutures, and 65779 sutured
  - 0-day global period for Medicare Part B and MA plans
    - Was 10-day
  - Confirm any change with commercial payers

New Category III Code

- 0402T Collagen cross-linking of cornea (including removal of the corneal epithelium and intraoperative pachymetry when performed)
  - Sunsets January 2021

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New Category III Code

- Do not submit 0402T with:

65435	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)
66990	Use of ophthalmic endoscope
76514	Pachymetry
92018/92019	EUA
92071	Bandage contact lens fitting

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Description Change Category III Code

Δ 0308T Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis

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Deleted Category III Code

- 0123T Fistulization of sclera for glaucoma, through ciliary body
  - Report unlisted code 66999 if the procedure is performed

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New HCPCS Code

- Effective January 1, 2016, submit J7313 Injection, fluocinolone acetonide, intravitreal implant for ILUVIEN.
  - Put 19 in the unit field
  - Not all payers may recognize the new code immediately. Best to obtain prior approval from non-Medicare payers.

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New HCPCS Code

- ILUVIEN
  - Indicated for the treatment of diabetic macular edema
  - Box 19 information: ILUVIEN, NDC 68611019002 Injection, fluocinolone acetonide intravitreal implant 0.01mg
  - Associated with CPT code 67028 Intravitreal injection

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New: Coding for Avastin

- First Coast, Noridian and WPS have already switched to J7999 effective January 1st.
- Maybe coming soon to other MACs.
  - What to do with cross-over claims for secondary payers who don't recognize the HCPCS code?

Place of Service Codes

- POS 19 New
  - Off Campus-Outpatient Hospital
- POS 22
  - On Campus-Outpatient Hospital
- This action was taken to simplify claims processing for coordination of benefits between Medicare and Medicaid as Medicaid requires greater clarification.

Sequestration Update

- Congress has extended the 2% sequestration indefinitely to help pay for the debt limit bill.

2016 Update

Questions?

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ICD-10 Related Denials

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Regarding the Launch of ICD-10

- The morning of October 1, 2015, with regards to ICD-10 transition, I felt

1. Confident
2. Almost confident
3. ALOL : Actually laughed out loud
4. V92.10XA: Drowning/submersion

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ICD-10 Information Update

- Excludes1 edits won't be denied.
  - You can now code two conditions together even if one or both conditions is listed in an Excludes1 note, *as long as the two are not related*, according to interim guidance from the National Center for Health Statistics (NCHS) released October 19, 2015.

ICD-10 Information Update

- ICD-10 has rules that are not required for payment by the payer.
  - Code first underlying disease
  - Excludes1 edits
  - Injury and trauma "how" codes may only be required by Workers Comp – who doesn't have to convert to ICD-10!
  - Look at LCDs or Ophthalmic Coding Coach for ICD-10 to CPT code linkage

October 1, 2016 Possible Updates

- E11.37- Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment
  - E11.371 Right eye
  - E11.372 Left eye
  - E11.373 Bilateral

October 1, 2016 Possible Updates

- H40.11 Primary open-angle glaucoma
  - New code H40.111 Primary open-angle glaucoma, right eye
  - New code H40.112 Primary open-angle glaucoma, left eye
  - New code H40.113 Primary open-angle glaucoma, bilateral

October 1, 2016 Possible Updates

- H53.04- Amblyopia, suspect
  - H53.041 Right eye
  - H53.042 Left eye
  - H53.043 Bilateral

ICD-10 Related Denials

- See Appendix
  - EyeNet Savvy Coder January 2016

Cataract/Anterior Segment

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66982 Complex Cataract Surgery

- In 2015 ophthalmologists received comparative billing reports on complex cataract surgery.
  - "Outlier"
  - "Significant outlier"

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66982 Complex Cataract Surgery

CGS
NGS
Novitas

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66982 Complex Cataract Surgery

- The diagnosis of floppy iris syndrome is enough to qualify the patient for complex cataract surgery.

1. True
2. False

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66982 Complex Cataract surgery

Four questions

Miotic pupil with use of special instruments?	Additional support for IOL? Capsular ring? Intraocular sutures?	Kids Must have IOL	Mature cataract with dye

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66982 Complex Cataract Surgery

- The CPT code has nothing to do with the surgeon's perception of the "degree of difficulty."

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66982 Complex Cataract Surgery

- Pseudoexfoliation syndrome, which is known to predispose to weaker lens zonules and thus an increased risk for loss of capsular support for an IOL, would not be sufficient if the zonular support ended up being adequate and no special tools were employed.

66982 Complex Cataract Surgery

- The need for suturing in place a posterior IOL to address inadequate capsular support or the need for capsular tension rings would allow for the complex cataract code.

66982 Complex Cataract Surgery

- Typically known preoperatively.
- Operative report should specify why case qualifies as complex.
- Facility billing should match surgeons.
- What percent of your cataract cases are complex?
  - Up to 10 percent

Code this Case

- History:
  - Cataract extraction plus IOL in the right eye October 1, 2015
  - Cataract extraction plus IOL in the left eye October 10, 2015
  - Office visit November 10th patient complains "cataract has grown back in the right eye"
  - YAG capsulotomy is scheduled: H26.491

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Criteria for YAG

Cahaba	20/30 plus additional criteria.
CGS	20/50 or 20/40 if all criteria is met
First Coast	20/30 and/or contract sensitivity testing or glare testing resulting in a decreased visual acuity by two lines.

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Criteria for YAG

- Is the exam billable with modifier -24?

1. Yes
2. No

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Criteria for YAG

- What modifiers should be appended to the YAG?

1. Modifiers -58 -RT
2. Modifiers -78 -RT
3. Modifiers -79 -RT

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2nd Eye Cataract Surgery

- When the second eye surgery is performed within the global period of the first eye – what is billable?
  - Biometry
  - Out-of-pocket fees associated with premium (toric/astigmatic) lens
  - Exam?
    - OIG report findings

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Cataract/Anterior Segment

Questions?

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Retina

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Coding Bilateral Injections

- Medicare Part B

67028 -50	**1 unit**

- Other payers vary

67028 -RT 67028 -LT	**1 unit for each line**
67028 -RT 67028 -50	1 unit for each line

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Coding Bilateral Units

- Medicare Part B

JXXXX	**Double the units**

- Other payers vary

JXXXX -RT JXXXX -LT	**Units for each line**
JXXXX JXXXX	2 lines without modifiers -RT or -LT

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Bilateral Injections

Questions?

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Cornea

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Corneal Burn

- Who is the payer?
  - Workers Compensation
    - Get the incident report file!
- Emergency Department Visit
  - 99281-99285, POS 23
  - T54.91XA Corrosive substance, accidental
  - T26.61XA Corrosion of cornea and conjunctival sac, right eye

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New: Prepayment review

- Medicare is currently conducting a pre-payment review of 99285 Emergency department level 5 exam via CERT process.

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Corneal Burn

- Follow-up in office submitted as:
- 99213 exam
- 92071 for fitting of bandage contact lens.
- V2599 for supply of bandage lens
- ICD-10 is subsequent "D"

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Corneal Burn

- A: Initial encounter. Use this when the physician actively treats the condition during the initial encounter (e.g., surgical treatment, ED encounter, evaluation by new physician).

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Corneal Burn

- D: Subsequent encounter. Use this for encounters after the physician performs the initial treatment, but the patient continues to receive care during the healing or recovery phase (e.g., cast change/removal, medication adjustment).

Corneal Burn

- Follow-up 2 days later with placement of PROKERA, CPT code 65778

Office	ASC
$1,411	$72
Includes supply of PROKERA	ASC absorbs cost of PROKERA

Corneal Burn

- Is the exam performed the same day as placement of PROKERA billable?

1. Yes
2. No

Corneal Burn

- Should any long-term effect of the corneal burn such as an ulcer or corneal degeneration be submitted with "S" as sequela for ICD-10?

1. Yes, required for payment.
2. No, not required for payment.

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Corneal Tissue

- ASC/Hospital Out-Patient Department
- HCPCS code V2785 for corneal transplant tissue
  - ASC: Bill paper claims with Eye Bank invoice
  - Hospital: Bills charges for tissue

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Cornea

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Retina

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Case Scenario

- "For our office, a typical claim the day of an injection is":
  - 92014 Comprehensive Eye visit code
  - 67028 Intravitreal injection
  - JXXXX Drug
  - 92134 Retina OCT
  - 92235 Fluorescein angiography
  - Occasionally 92226 Subsequent ophthalmoscopy

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Cased Scenario Issues

1. Fact or fiction?
   - Are all retinal exams comprehensive?

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Case Scenario Issues

2. Is the exam significantly, separately identifiable from the injection?
   - If yes, append modifier -25.
   - If no, while medically necessary, if the *established patient exam* is performed solely to confirm the need to inject, then it is not separately billable.

Case Scenario Issues

3. F/As are always accompanied by fundus photos.
   - Is it a potential red flag to have billed the OCT instead of the funds photography?

Case Scenario Issues

4. Is an F/A medically necessary with every injection?

Case Scenario Issues

5. Extended and subsequent ophthalmoscopies are bundled with injections since July 2014.
   - If both are billed, only the lower of the two allowables might be paid.
   - Extended: $28
   - Subsequent: $25
   - Injection: $104

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Glaucoma

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iStent

- Commercial payers
  - Precertification vs. preauthorization
  - Does the patient's plan cover 0191T?
  - If yes, what is the allowable?
  - If yes, what is the global period?

iStent

- What about additional iStents placed during the initial surgery?
  - Neither the insurance, or the patient can be billed for +0376T each additional device insertion for Medicare Part B.
  - Patient's responsibility when the commercial plan doesn't cover iStent.

iStent

- Typical covered diagnosis codes
  - See appendix

Injections During Global Period

- An injection of Kenalog, Avastin, 5FU, etc., is administered in the exam lane during the global period. Which statement is true?

1. Part of postop
2. Billable with modifier -58
3. Only billable if unrelated to the major surgery.

Case Scenario

- An exam, CPT code 99213 (why not 92012?)
- SCODI CPT code 92133,
- Visual field CPT code 92183,
- Pachymetry CPT code 76514
  - are performed on the same day.
- Payment for this Medicare Part B patient will be:

Case Scenario

1. 100% of the allowable for the exam and VF and SCODI and 20% reduction of the technical component of the pachymetry.
2. 100% of the exam and VF and 20% reduction of the technical component of the SCODI and pachymetry.

New UHC policy

- UHC has also adopted the multiple procedure reduction rule for the MA and commercial plans.

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Glaucoma

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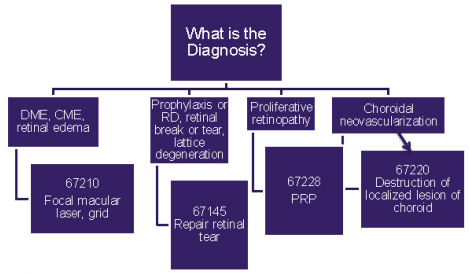
Diode Lasers



Retina

Questions?

Oculofacial

Oculofacial

- Sty vs. Chalazion vs. Hordeolum vs. Sebaceous Cyst of Eyelid
  - See Appendix

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Modifier -59 Separate Procedure

- Tendency for some practices to append modifier -59 when it is not needed.
- Remember the primary purpose of modifier -59 is to unbundle CCI edits.
- Appending modifiers unnecessarily triggers audits!

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CCI Edits effective April 1, 2009

Column 1	Column 2
67901, 67902, and 67904	15822 and 15823
67903, 67906 and 67908	15822
15823	67903, 67906 and 67908

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Medically Unlikely Edits

CPT	Description	Frequency
11440	Excision, other benign lesion, 0.5 cm or less	4
11441	0.6 – 1.0 cm	3
11640	Malignant lesion, 0.5 cm or less	2
11641	0.6 – 1.0 cm	2

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Oculofacial

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Retina

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Type 1 Diabetes E10

Without mention of complication	E10.9
With mild non-prolif, with macular edema	E10.321
With mild non prolif, without macular edema	E10.329
With moderate non-prolif, with macular edema	E10.331
With moderate non-prolif, without macular edema	E10.339
With severe non-prolif, with macular edema	E10.341
With severe non-prolif, without macular edema	E10.349
With prolif retinopathy, with macular edema	E10.351
With prolif retinopathy, without macular edema	E10.359

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Type 1 Challenge

- FA/FP are ordered on a patient with type 1 diabetes.
- Diagnosis:
  - Right eye: Mild retinopathy, no edema
  - Left eye: Proliferative retinopathy, with edema

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Type 1 Challenge

- OD:
- OS:

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Type 2 Diabetes E11

Without mention of complication	E11.9
With mild non-prolif, with macular edema	E11.321
With mild non prolif, without macular edema	E11.329
With moderate non-prolif, with macular edema	E11.331
With moderate non-prolif, without macular edema	E11.339
With severe non-prolif, with macular edema	E11.341
With severe non-prolif, without macular edema	E11.349
With prolif retinopathy, with macular edema	E11.351
With prolif retinopathy, without macular edema	E11.359

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Type 2 Challenge

- A genetically predisposed, recently diagnosed type 2, 50-year-old patient is referred by the comprehensive ophthalmologist to retinal specialist.

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Type 2 Challenge

- Findings:
  - Right eye: Non-proliferative mild retinopathy with macular edema
  - Left eye: Proliferative retinopathy, w/o macular edema

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Type 2 Challenge

- OD:
- OS:

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Retinal Tests

- Pathology is in both eyes.
- The physician orders bilateral
  - FA
  - ICG
  - OCT
  - FP
- What is billable?

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Retinal Tests

1. All four tests when medically necessary
2. ICG, FA, OCT
3. FA, FP
4. ICG and FP

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New: Prepayment review for ICG

- OH, IN, IL, KY, WI, MN and MI
- AdvanceMed (ZPIC)
  - Hopefully practices are following LCD language.

New: Prepayment review for ICG

- FCSO and CGS have policies for ICG.
  - May be a valuable diagnostic adjunct to fluorescein angiography in the evaluation of the following conditions:
    - Retinal neovascularization, Choroid neovascularization, Serous detachment of retinal pigment epithelium, Hemorrhagic detachment of retinal pigment epithelium, Retinal hemorrhage

New: Prepayment review for ICG

- CGS (L34175):
  - Considered medically necessary no more than 9 times per eye in 365 days.
  - FA performed within 30 days of ICG will be denied as not medically necessary, unless there is documentation in the patient's medical record of co-existing diseases such as AMD or diabetes.

New: Prepayment review for ICG

- FCSO (L33911):
  - Generally, only one ICG is medically necessary prior to and following a course of treatment. Services in excess of this standard of care must be reflected in the patients' medical records to support the medical necessity of more frequent testing.

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Peds/Strabismus

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Case Scenario

- 12-year old patient
  - XT with history of ET surgery
  - Commercial payer
  - Exam 99214 or 92014 depending on the payer allowable
  - Interim visit before surgery for additional measurements.
    - CPT code 92060 Sensorimotor exam

Case Scenario

67312 -LT	Strabismus surgery, recession or resection procedure; two horizontal muscles
+67335 -LT	Adjustable suture
+67332 -LT	Scarring of extraocular muscles, prior ocular injury or surgery

Case Scenario

- What would be appropriate payment?

1. 100% of surgery and 50% for each add-on code
2. 100% of surgery and 100% for each add-on code

Peds/Strabismus

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Case 1

- Medicare Part B established patient 10-days postop from cataract extraction with IOL.
  - C/O right eye +4 pain, ↓ vision, photophobia x 2 days
  - Problem focused history
  - Comprehensive exam
  - MDM: Purulent endophthalmitis

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Case 1

- Same day, surgeon performs:

67015	Vitreous tap	$591	Not bundled with 67028 or 65800
67028	Injection	$104	Bundled with both 67015 and 65800
65800	Paracentesis	$94	Not bundled with 67015 or 67028
JXXXX	Drug		Facility bills

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Case 1

- Endophthalmitis

Bleb associated H59.4-	Gonorrheal A54.39
Parasitic H44.12-	Purulent H44.00-

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Case 1

- What level of exam?
- Which surgical code(s)?
- Modifiers?
- ICD-10?

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Case 1

- What if patient is not treated by cataract surgeon but by retinal surgeon
  - Inside the office
  - Outside the office

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Case 2

- New patient, with commercial insurance, glued their left eye shut while helping son with model car.
- Comprehensive history
- Expanded problem focused exam
- MDM: Low

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Case 2

- Does cutting the lids apart qualify as CPT code 67710 Severing of tarsorrhaphy?
  - If substantial – yes
  - $227 office/$99 facility
  - 10-day global period

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Case 2

- ICD-10 options?
  - S00.202A Unspecified injury to eyelid
  - Z accident code?
  - H01.8 Other specified inflammations of eyelid?

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Case 2

- Consider looking for list of typically covered diagnosis codes linked to surgical codes.
  - Ophthalmic Coding Coach
    - Bums, corrosions of eyelids T26.51XA

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Case 2

- Exam?
- Surgery?
- ICD-10?
- Modifiers?

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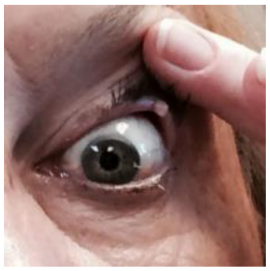
Case 3

- Patient with commercial insurance complains of:
  - Family history of glaucoma
  - Lesion on LUL growing in size, rubbing on eye
- Ophthalmologist completes comprehensive exam.
  - Refers to oculofacial for lesion removal



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Case 3

- Two days later oculofacial MD examines lesion and removes it in office surgical suite same day.
  - New patient exam
  - Comprehensive history
  - Visual acuity and
  - Lesion only examined
  - MDM?

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Case 3

67961	Excision and repair, lid margin, tarsus, conjunctiva, canthus, full thickness up to ¼ lid margin	90-days	Office $596 Facility $465

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Case 3

- ICD-10 options:
  - Code from the Table of Neoplasms?
  - Wait for pathology report?
  - Code from covered diagnoses linked to surgical code?

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Case 3

- Exam?
- Test?
- Surgery?
- ICD-10?
- Modifier(s)?

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Case 4

- Patient presents with a right eye:
  - Conjunctival laceration
  - Corneal abrasion, and
  - Debris under the conjunctiva
    - Due to "stomping on a stick while camping with her grandkids."

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Case 4

- She was seen in the ED and ended up in surgery for the conjunctival (not corneal) laceration and removal of debris.
- Exam
  - ED or office E/M or Eye visit codes?

Case 4 Surgical Options/Location

CPT	Description	Allowable	Global
65270	W/wo non-perforating laceration sclera, direct closure	O $272 F $144	10
65272	By mobilization and rearrangement, w/o hospitalization	O $513 F $358	90
65273	By mobilization and rearrangement, w/hospitalization	F $388	90

Case 4

- ICD-10: Do you code:
- Conjunctival laceration, S05.01XA
  - Injury of conjunctiva and corneal abrasion without foreign body, right eye, initial encounter?
    - No ICD-10 codes with foreign body

Case 4

- ICD-10: Do you code:
  - Due to stomping on a stick while camping with grandkids
    - Only stick injuries are needle stick injuries

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Case 4

- ICD-10: Do you code:
  - Diagnosis associated with laceration repair
    - S05.31XA Ocular laceration without prolapse or loss of intraocular tissue, initial encounter.

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Case 4

- Exam
- Surgery
- ICD-10

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2016 PQRS/VBM Reporting

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2016 Penalties

- How we report in 2016 impacts 2018 payments for:
  - Medicare Part B,
  - Medicare as a Secondary Payer, and
  - Railroad Medicare.

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2016 Penalties

- Penalties depend on the size of the physician practice
  - No PQRS or unsuccessful participation?
  - 4% penalty for less than 10 physicians
  - 6% penalty for 10 or more physicians
    - Note: if more than 50% of the qualifying providers fail, practice may be subject to VBM penalty.

New PQRS Reporting Option

- Diabetic Retinopathy Measures Group
  - Report all 7 measures on 20 cases. Of the 20, at least 11 patients must have Medicare Part B insurance. The remaining patients may have Medicare Advantage or commercial insurance.
  - **Ages 18-75**
  - IRIS Registry reporting
    - See Appendix

Diabetic Retinopathy Measures Group

1. **Measure 1** Diabetes: Hemoglobin A1c Poor Control
2. **Measure 18** Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
3. **Measure 19** Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
4. **Measure 117** Diabetes: Eye Exam
5. **Measure 130** Documentation of Current Medications in the Medical Record
6. **Measure 226** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
7. **Measure 317** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Reporting Options

- Simultaneously report MU and PQRS via vendor or IRIS Registry
- Group reporting option
  - ACO affiliation?
- Diabetic Retinopathy Measures Group
- Cataracts Measures Group
- Nine individual measures cross three quality domains with at least one cross cutting measures
- QCDR

AMA compares penalty risks for 2019

MIPS factors	2019 scoring
Quality management	50% of score
MU	25% of score
Resource use	10% of score
Clinical improvement activities	15% of score
Total penalty risk	Max of -4%
Bonus potential	Max of 4% plus potential for 10% for high performers

AMA compares penalty risks for 2019

Prior Law	2019 Adjustment
PQRS	-2%
MU	-5%
VBM	-4% or more*
Total penalty risk	-11 or more*
Bonus potential (VBM only)	Unknown (budget neutral)

***VBM was in effect for 3 years before MACRA passed, and penalty risk was increased in each of these years. There were no ceilings or floors on penalties and bonuses; only a budget neutrality requirement.**

2016 Measure Changes

- www.aao.org/pqrs

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PQRS

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Fred Rogers

- The thing I remember best about successful people I've met all through the years is their obvious delight in what they're doing.
- They just love what they are doing and they love it in front of others.

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Quick Links

• Allied Health Toolkit	www.aao.org/toolkit
• Codequest	www.aao.org/codequest
• Coding Products	www.aao.org/codingproducts
• Coding Resources	www.aao.org/coding
• Consultant Directory	www.aao.org/consultant
• DMEPOS	www.aao.org/dme
• EHR	www.aao.org/ehr
• Events	www.aao.org/aaoeevents
• EyeNet Archive	www.aao.org/publications
• ICD-10-CM	www.aao.org/icd10
• Listservs	www.aao.org/listservs
• Membership	www.aao.org/joinaaoe
• OCS Exam	www.aao.org/ocs
• Online Products	www.aao.org/myonlineproducts
• PECOS	www.aao.org/pecos
• PQRS	www.aao.org/pqrs
• Webinars	www.aao.org/aaoeevents

MODIFIERS QUICK REFERENCE GUIDE

CPT MODIFIERS	TIPS
-24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	Management of a problem unrelated to the surgery or in the unoperated eye. Generally requires a different diagnosis code from the surgical diagnosis code.
-25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	The CPT narrative associated with this CPT modifier has changed, effective for dates of service on or after January 1, 2008. This modifier may be used to indicate that an established patient E/M service or Eye visit code, performed on the same day as minor surgery (0 or 10 global days) and which is performed by the surgeon, is significant and separately identifiable from the usual work associated with the surgery. This modifier should not be submitted with E/M codes that are explicitly for new patients only: CPT codes 92002, 92004, 99201 through 99205, 99281 through 99285, and 99341 through 99345. These codes are "new patient" codes and are automatically excluded from the global surgery package, meaning that they are reimbursed separately from surgical procedures.
-26 Professional Component	To be used when the physician component of a testing service is reported separately.
-50 Bilateral Procedure	Bilateral procedures performed during the same session.
-51 Multiple Procedures	Modifier being phased out. Many carriers no longer require this modifier. Multiple procedures performed during the same session. Modifier is appended to 2nd and beyond procedures. This modifier should not be submitted with designated "add-on" codes. Medicare Part B may add -51 on the RA indicating the multiple test reduction was made.
-52 Reduced Services	Less work than the CPT descriptor describes is performed. Rarely used.
-53 Discontinued Procedure	Due to a variety of circumstances, the physician may elect to terminate a service or procedure before its completion.
-54 Surgical Care Only	Physician performs the surgery and no postoperative care.
-55 Postoperative Management Only	Only postoperative care is provided. Modifier is attached to the surgical code.
-56 Preoperative Management Only	This modifier is not valid for Medicare Part B claims. Reimburse as a percentage of the preoperative global fee for the procedure.
-57 Decision for Surgery, Major Procedure	This modifier may be used to indicate that the E/M or Eye visit code service performed on the same day or the day before a major surgery (90 global days) is the office visit to determine the need for surgery. This modifier should not be submitted with E/M or Eye visit codes that are explicitly for "new patients only."
-58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	Three definitions for use: Performance of a procedure was determined preoperatively More extensive than the original procedure For therapy following a diagnostic surgical procedure
-59 Distinct Procedural Service	The primary purpose of this modifier is to unbundle CCI edits when appropriate.
-62 Two Surgeons	Two surgeons work together as primary surgeons performing distinct parts of a procedure. Each surgeon should report his/her distinct operative work by adding modifier to the procedure performed.
-76 Repeat Procedure or Service by Same Physician	Service repeated on the same day as the original procedure. Rarely used.
-77 Repeat Procedure by Another Physician	Basic procedure or service performed by another physician that needs to be repeated on the same day as the original procedure. Rarely used.

Figure 10 Modifiers Quick Reference Guide *(continued on the next page)*

MODIFIERS QUICK REFERENCE GUIDE *(continued)*

CPT MODIFIERS	TIPS
-78 Unplanned Return to Operating/Procedure Room by the Same Physician for Related Procedure During the Postoperative Period	Office based surgeries as well as hospital and ASC based procedures are now payable even when performed during the global period of another procedure.
-79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period	Return to the operating room for an unrelated surgery during the postop of the original surgery.
-80 Assistant Surgeon	Surgical assistant
-82 Assistant Surgeon (when qualified resident surgeon not available)	Unavailability of qualified resident
LEVEL II HCPCS MODIFIERS	**DESCRIPTION**
-AI	Principal Physician of Record
-E1	Left upper lid
-E2	Left lower lid
-E3	Right upper lid
-E4	Right lower lid
-EY	Not ordered by a physician (DME)
-GA	An Advance Beneficiary Notice (ABN) or waiver of liability is on file
-GC	This service has been performed in part by a resident under the direction of a teaching physician.
-GW	Unrelated to hospice care
-GY	Deny the claim
-GZ	No ABN on file
-JW	Drug wastage
-KX	Documentation to support medical necessity (DME)
-LT	Left side
-PA	Surgery wrong body part
-PB	Surgery wrong patient
-PC	Wrong surgery on patient
-RT	Right side
-Q0	Investigational clinical service provided in a clinical research study
-Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study
-Q5	Service furnished by a substitute physician under a reciprocal billing arrangement
-Q6	Services furnished by a locum tenens physician under a reciprocal billing arrangement
-TC	Technical component
-XE	Separate Encounter, A service that is distinct because it occurred during a separate encounter. See modifier -59 for additional details.
-XP	Separate Practitioner, A service that is distinct because it was performed by a different practitioner.
-XS	Separate Structure, a service that is distinct because it was performed on a separate organ/structure.
-XU	Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service

Figure 10 Modifiers Quick Reference Guide

Patient Medical Record Number/ID #: _____ Practice: _____
Survey Date: _____ Operating Physician: _____

Pre-Cataract Surgery - Visual Functioning Index (VF-8R) Patient Questionnaire

Do you have difficulty, even with glasses with the following activities?

1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
2. Reading a newspaper or book?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
3. Seeing steps, stairs or curbs?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
4. Reading traffic signs, street signs or store signs?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
6. Writing checks or filling out forms?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
7. Playing games such as bingo, dominos, card games or mahjong?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
8. Watching television?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	

Guidelines for Billing Medicare Beneficiaries When Using the Femtosecond Laser

The allowable Medicare reimbursement for cataract surgery does not change according to the surgical methods used. For example, the reimbursement is the same whether a cystotome or femtosecond (FS) laser makes the capsulotomy. Providers may not "balance bill" a Medicare patient or his or her secondary insurer for any additional fees to perform covered components of cataract surgery with an FS laser.

Medicare Part B permits patients to be billed for additional services used specifically to implant premium refractive IOLs (presbyopia-correcting and toric) for medically-necessary cataract. The surgeon and facility may charge the patient for premium refractive IOLs (presbyopia-correcting and toric) and the associated incremental professional and technical services. The patient, however, must be informed about, and consent to, the additional out-of pocket-costs in advance.

Refractive Lens Exchange

A refractive lens exchange is not medically necessary and therefore is not covered under Medicare Part B. The surgeon and the facility may bill the patient. Tiered pricing is allowed (e.g., additional fee for premium refractive IOL; additional fee to use the FS laser for lens removal steps), subject to properly documented informed consent.

Medically-Necessary Cataract Extraction with a Conventional IOL (No astigmatic keratotomy)

Medicare Part B covers the cataract surgery and the implantation of a conventional IOL without regard to the technology used. A surgeon may use the FS laser for the cataract surgery, but neither the surgeon nor the facility may obtain additional reimbursement from either Medicare or the patient over and above the Medicare-allowable amount.

Medically-Necessary Cataract Extraction with a Premium Refractive IOL (No astigmatic keratotomy)

Neither the surgeon nor the facility should use the differential charge allowed for implantation of a premium refractive IOL to recover all or a portion of the costs of using the FS laser for cataract surgical steps. As set forth above, Medicare Part B covers the cataract surgery and the implantation of a conventional lens without regard to the technology used. Patient-shared pricing with one cost for a premium IOL, and a higher cost for the additional use of the FS laser to perform the cataract surgical steps, should not be offered. This would amount to charging the patient to use the FS laser to perform covered components of the procedure.

Medically-Necessary Cataract Surgery Plus Astigmatic Keratotomy Performed for Refractive Indications

Medicare will cover medically-necessary cataract surgery, but not concurrent correction of astigmatism performed for refractive indications. Medicare patients may be charged a fee for performing astigmatic keratotomy, assuming that they were informed about, and consented to, the non-covered charges in advance. Because astigmatic keratotomy for refractive indications is a non-covered service, a higher fee can be charged for performing it using the FS laser, instead of with a metal or diamond blade. As with premium IOLs, however, the patient should not be charged an additional amount to concurrently perform the cataract surgical steps with the FS laser. While most astigmatism treatment is not covered, Medicare does cover the treatment of large degrees of astigmatism that were the result of previous ocular surgery. Local coverage determinations may apply. In this situation, neither the surgeon nor the facility may obtain

additional reimbursement from either Medicare or the patient over and above the Medicare allowable amount.

Additional Considerations

Advertising: Promotional claims must be consistent with the best available clinical evidence and should not be deceptive or misleading to patients.

Transparency: Patient-shared pricing should be discussed openly with the patient. Increased charges should be explained and documented.

Note: The guidelines presented in this advisory represent the best effort of AAO and ASCRS, as of January 2012, to determine when Medicare and its beneficiaries can be billed for using the femtosecond laser during cataract surgery. They are subject to modification based on any new regulations issued by the Centers for Medicare and Medicaid Services or its contractors. The organizations suggest that ophthalmologists seek additional guidance directly from their Medicare carriers for coverage determinations under Medicare Part C or through commercial carriers.

Clarifications from CMS:
Dropless Cataract Surgery Billing

No Separate Billing for Dropless Cataract Surgery

CMS has provided clear guidance to carriers that periocular injections of combined anti-inflammatory drugs and antibiotics (commonly referred to as “dropless” cataract surgery) are never separately payable. Injections are a part of the ocular surgery and are included in the CPT codes used to report the surgical procedure. CMS also warns that physicians or facilities cannot circumvent packaged payments in the HOPD or ASC by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

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Pre-Certification vs Pre-Authorization: What Is the Difference?

Pre-Certification
Pre-certification (also known as Pre-Determination) is the process of verifying that a patient's insurance plan will cover a scheduled procedure (CPT) for the patient's medical conditions (ICD). Even though an insurance company may have a published policy for a procedure, it does not mean that the patient's plan will cover, as it may be excluded from an individual or employer benefits.
One you have verified that the patient's plan covers a procedure then ask what is the medical coverage criteria or policy.

Pre-Authorization
Pre-authorization is the process of obtaining approval in advance from a managed care plan for a scheduled procedure, usually via an assigned authorization number or written letter. Please note that most insurance companies no longer grant retroactive authorizations, so unless an emergent situation exists, start the process as soon as possible. The insurance company may also want medical review before approving.

Please also note that neither of these processes guarantees payment. Payment is based first on the patient's eligibility. Eligibility can be dependent upon enrollment in employer plan, payment of premiums, enough hours worked, or end of employment. It often follows a calendar month, so a surgery pre-authorized this month, may not be effective next month for a procedure scheduled that next month.

The Typical Covered ICD-10 Codes for iStent

Category III code 0191T Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork; initial insertion

ICD-10 diagnosis codes that are typically covered:

H40.051	Ocular hypertension, right eye
H40.052	Ocular hypertension, left eye
H40.053	Ocular hypertension, bilateral
H40.11X1	Primary open-angle glaucoma, mild stage
H40.11X2	Primary open-angle glaucoma, moderate stage
H40.11X3	Primary open-angle glaucoma, severe stage
H40.11X4	Primary open-angle glaucoma, indeterminate stage
H40.1211	Low-tension glaucoma, right eye, mild stage
H40.1212	Low-tension glaucoma, right eye, moderate stage
H40.1213	Low-tension glaucoma, right eye, severe stage
H40.1214	Low-tension glaucoma, right eye, indeteminate stage
H40.1221	Low-tension glaucoma, left eye, mild stage
H40.1222	Low-tension glaucoma, left eye, moderate stage
H40.1223	Low-tension glaucoma, left eye, severe stage
H40.1224	Low-tension glaucoma, left eye, indeterminate stage
H40.1231	Low-tension glaucoma, bilateral, mild stage
H40.1232	Low-tension glaucoma, bilateral, moderate stage
H40.1233	Low-tension glaucoma, bilateral, severe stage
H40.1234	Low-tension glaucoma, bilateral, indetermined stage
H40.1311	Pigmentary glaucoma, right eye, mild stage
H40.1312	Pigmentary glaucoma, right eye, moderate stage
H40.1313	Pigmentary glaucoma, right eye, severe stage
H40.1314	Pigmentary glaucoma, right eye, indeterminate stage
H40.1321	Pigmentary glaucoma, left eye, mild stage
H40.1322	Pigmentary glaucoma, left eye, moderate stage
H40.1323	Pigmentary glaucoma, left eye, severe stage
H40.1324	Pigmentary glaucoma, left eye, indeterminate stage
H40.1331	Pigmentary glaucoma, bilateral, mild stage
H40.1332	Pigmentary glaucoma, bilateral, moderate stage
H40.1333	Pigmentary glaucoma, bilateral, severe stage
H40.1334	Pigmentary glaucoma, bilateral, indeterminate stage
H40.211	Acute angle-closure glaucoma, right eye (attack, crisis)
H40.212	Acute angle-closure glaucoma, left eye (attack, crisis)
H40.213	Acute angle-closure glaucoma, bilateral (attack, crisis)
H40.2211	Chronic angle-closure glaucoma, right eye, mild stage
H40.2212	Chronic angle-closure glaucoma, right eye, moderate stage
H40.2213	Chronic angle-closure glaucoma, right eye, severe stage
H40.2214	Chronic angle-closure glaucoma, right eye, indeterminate stage
H40.2221	Chronic angle-closure glaucoma, left eye, mild stage
H40.2222	Chronic angle-closure glaucoma, left eye, moderate stage
H40.2223	Chronic angle-closure glaucoma, left eye, severe stage
H40.2224	Chronic angle-closure glaucoma, left eye, indeterminate stage

H40.2231	Chronic angle-closure glaucoma, bilateral, mild stage
H40.2232	Chronic angle-closure glaucoma, bilateral, moderate stage
H40.2233	Chronic angle-closure glaucoma, bilateral, severe stage
H40.2234	Chronic angle-closure glaucoma, bilateral, indeterminate stage
H40.31X1	Glaucoma secondary to eye trauma, right eye, mild stage
H40.31X2	Glaucoma secondary to eye trauma, right eye, moderate stage
H40.31X3	Glaucoma secondary to eye trauma, right eye, severe stage
H40.31X4	Glaucoma secondary to eye trauma, right eye, indeterminate stage
H40.89	Other specified glaucoma
Q15.0	Congenital glaucoma (Axenfeld's anomaly, Buphthalmos)

Table of Common Drugs

Updated – January 2016

HCPCS office	HCPCS facility	Description	Units
J9035, J3490, J3590, Q9977 or J7999	C9257	Avastin®	1 unit ofc 5 units fac
J0585	J0585	Injection, onabotulinumtoxinA, 1 unit. Use this code for Botox, Botox cosmetic	As needed
J0586	J0586	Injection, abobotulinumtoxinA, 5 units. Use this code for Dysport	As needed
J0587	J0587	Injection, rimabotulinumtoxinB, 100 units. Use this code for Myobloc	As needed
J0588	J0588	Injection, incobotulinumtoxinA, 1 unit. Use this code for Xeomin	As needed
J0713	J0713	Ceftazidime	As needed
J0702	J0702	Celestone	As needed
J1100	J1100	Dexamethasone	As needed
J0178	J0178	EYLEA™	2 units
J9190	J9190	5-FU	As needed
No J code for ophthalmic use Healon			
J7316	C9298	Jetrea®	4 units
J2778	J2778	Lucentis®	3 units DME 5 units Wet AMD, RVO
J2503	J2503	Macugen	As needed
J9250/J9260	J9250/J9260	Methotrexate(MTX)	As needed
J7312	J7312	Ozurdex	7 units
J3301	J3301	Triamcinalone (Kenalog)	4 units
J3300	J3300	Triesence	40 units
J3370	J3370	Vancomycin	As needed
J3396	J3396	Verteporfin (Visudyne)	150 units
J7313	J7313	fluocinolone acetonide (Iluvien)	19 units
Subject to Change – www.aao.org/coding			

Note: Use ABN (Part B only) for off-label use (eg. 5 units of Lucentis for DME)

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New 2016 PQRS Diabetic Retinopathy Measures Group

Ophthalmologists have a new way to successfully report PQRS in 2016. The Academy proposed a new measures group focusing on diabetes and CMS accepted the request. Similar to the Cataracts Measures Group, these measures must be reported by a qualified registry, such as IRIS® Registry. The 7 measures below must be reported on 20 patients, 11 of which must have traditional Medicare Part B insurance. Visit www.aao.org/pqrs for details.

PQRS #1
Diabetes: Hemoglobin A1c Poor Control: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.

PQRS #18
Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy: Percentage of patients aged 18 and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.

PQRS #19
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

PQRS #117
Diabetes Eye Exam: Percentage of patients 18-75 years of age with a diagnosis of diabetes who had a retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement period.

PQRS #130
Documentation of Current Medications in the Medical Record: Percentage of visits for patients aged 18 years and older for which the EP attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

PQRS #226
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

PQRS #317
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented: Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.

Nine Measures via IRIS Registry or Claims Reporting for 2016

Through IRIS® Registry or via claims based reporting, a physician must select 9 measures across 3 quality domains and at least 1 cross cutting measure; If not reporting via EHR, or the Cataracts Measures or Diabetic Retinopathy Measures Group.

Quality Domain Effective Clinical Care	
Measure 1 Cross Cutting	Diabetes Hemoglobin A1c Poor Control Note: Can be reported via claims or DRMG, but not individually through IRIS Registry
Measure 12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
Measure 14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination
Measure 117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
Measure 140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
Measure 191	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
Measure 236 Cross Cutting	Controlling High Blood Pressure
Measure 384	Adult Primary Rhegmatogenous Retinal Detachment No Return to the Operating Room Within 90 Days of Surgery
Measure 385	Adult Primary Rhegmatogenous Retinal Detachment Surgery Visual Acuity Improvement Within 90 Days of Surgery
Measure 389	Cataract Surgery: Difference Between Planned and Final Refraction

Quality Domain Community / Population Health	
Measure 110 Cross Cutting	Preventive Care and Screening: Influenza Immunization
Measure 111 Cross Cutting	Pneumonia Vaccination Status for Older Adults
Measure 226 Cross Cutting	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Measure 317 Cross Cutting	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented Note: Can be reported via claims or DRMG, but not individually through IRIS Registry
Measure 402 Cross Cutting	Tobacco Use and Help with Quitting Among Adolescents

Quality Domain Patient Safety	
Measure 130 Cross Cutting	Documentation of Current Medications in the Medical Record
Measure 192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
Measure 238	Use of High-Risk Medications in the Elderly
Measure 388	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule requiring unplanned vitrectomy)

Quality Domain Communication/ Care Coordination	
Measure 19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care
Measure 131 Cross Cutting	Pain Assessment and Follow-Up
Measure 137	Melanoma: Continuity of Care – Recall System
Measure 138	Melanoma: Coordination of Care
Measure 141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% or Documentation of a Plan of Care
Measure 265	Biopsy Follow-Up Note: Can only be reported via IRIS Registry, not via claims
Measure 397	Melanoma Reporting Note: Can only be reported via IRIS Registry, not via claims

Quality Domain Efficiency and Cost Reduction	
Measure 224	Overutilization of Imaging Studies in Melanoma

Quality Domain Person and Caregiver-Centered Experience and Outcomes	
Measure 303	Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery Reporting
Measure 304	Patient Satisfaction within 90 Days Following Cataract Surgery

For details about each measure, visit www.aao.org/pqrs

For details about IRIS Registry, visit www.aao.org/irisregistry

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5 Reasons to Participate in IRIS® Registry

Successfully streamline quality reporting and enhance patient care

The American Academy of Ophthalmology IRIS® Registry (Intelligent Research in Sight) is the nation's first EHR-based comprehensive eye disease and condition registry.

Here are the top five reasons you should participate.

1. Improve patient care

Ophthalmologists with IRIS Registry-integrated electronic health record systems can benchmark their performance, patient outcomes and care processes against practice colleagues or national averages.

Measure performance on up to 26 quality-improvement measures, plus 15 electronic clinical quality measures used for meaningful use and the Physician Quality Reporting System.

2. Support clinical discovery

As the largest ophthalmic clinical data registry in the world, IRIS Registry will enhance clinical knowledge and advance scientific discoveries.

By participating, you support data analyses that further our understanding about the natural history of disease, risk factors for disease development, factors affecting treatment outcome and practice patterns.

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3. Simplify federal quality reporting with or without an EHR system

IRIS Registry lessens the burden to participate in PQRS and meaningful use. Providers who don't successfully participate in PQRS for 2016 face a 2 percent penalty for 2018, plus additional value-based modifier penalties. Those who don't attest to meaningful use in 2016 face a 4 percent penalty for 2018.

- Practices that integrate an EHR system with IRIS Registry to report for 2016 PQRS can report clinical quality measures for meaningful use and satisfy Measure Option 3: Specialized Registry Reporting for Public Health Objective 10. IRIS Registry already integrates with 42 EHR systems.
- Practices without an EHR system can use the IRIS Registry web portal to report the PQRS Cataracts Measures Group, Diabetic Retinopathy Measures Group or individual measures. The measures groups allow physicians to satisfy PQRS by reporting on a minimum of 20 patients.
- IRIS Registry may also satisfy hospital requirements to participate in a quality improvement program.

4. Satisfy future CMS payment programs

Beginning in 2017, providers face future penalties and bonuses under the Merit-Based Incentive Payment System, which replaces PQRS, meaningful use and the value-based modifier. MIPS will measure physician performance on both quality and cost. The Academy is advocating for participation in the IRIS Registry to be an option for taking part in MIPS.

5. Participate for free

All U.S. Academy members in good standing can participate in IRIS Registry fee free. Join a community of quality with more than 13,000 of your ophthalmologist colleagues and their practice staff by signing up for IRIS Registry.

For more information, visit

- aao.org/irisregistry
- aao.org/pqrs
- aao.org/ehr

Upcoming participation deadlines

- June 1 - Deadline to submit signed agreements to participate in IRIS Registry via an EHR system for 2016 reporting
- August 1 - Deadline to submit signed agreements to report the Cataracts Measures Group via IRIS Registry web portal for 2016 PQRS reporting
- October 31 – Deadline to submit signed agreements to report the Diabetic Retinopathy Measures Group or individual measures via IRIS Registry web portal for 2016 PQRS reporting

Smoking and Eye Disease

Smoking and eye disease

Smoking tobacco (cigarettes, cigars or pipes) can cause lung disease, heart disease, cancer, and many other serious health problems. But did you know that smoking can also harm your eyes?

Eye Words to Know

Retina: Layer of nerve cells lining the back wall inside the eye. This layer senses light and sends signals to the brain so you can see.

Macula: Small but important area in the center of the retina. You need the macula to clearly see details of objects in front of you.

Lens: Clear part of the eye behind the colored iris. It helps to focus light on the retina (back of the eye) so you can see.

Optic nerve: A nerve at the back of your eye that connects to your brain. The optic nerve sends light signals to your brain so you can see.

Here are some eye problems that are made worse by smoking:

Dry eye. This is when your eyes do not have enough—or the right kind of—tears. Smoking with dry eye will make your eyes more likely to feel scratchy, sting, burn or be red.

Cataracts. If you smoke you are at increased risk for getting cataracts. A cataract is clouding of your eye's naturally clear lens. It causes blurry vision and makes colors look dull, faded or yellowish. Cataracts are removed in surgery.

Age-related macular degeneration (AMD). This disease happens when a part of the retina called the macula is damaged. You lose your central vision and cannot see fine details. But your peripheral (side) vision stays normal. Sometimes medicine or surgery can help certain people with AMD from getting worse. But there is no cure. Studies show that smokers and ex-smokers are more likely to get AMD than people who never smoked.

Diabetic retinopathy. Smokers who also have diabetes risk getting diabetic retinopathy. Diabetic retinopathy is when blood vessels in the eye are damaged. It causes blurry or distorted vision and possibly blindness. Treatment includes medication or surgery.

Optic nerve problems. People who smoke risk having optic nerve problems. The optic nerve connects the eye to the brain. Damage to this nerve can lead to blindness.

Uveitis. Smoking can lead to a disease that affects part of the eye called the uvea. This is the middle layer of the eye wall. Uveitis is when this layer becomes inflamed (red and swollen). This disease causes a red eye, pain and vision problems.

Graves' disease. This is a disease of the body's thyroid gland. One of the symptoms of Graves' disease is bulging eyes. Smokers who have Graves' disease risk having their eye condition get worse. They can also lose vision.

Pregnant? Smoking can harm your baby's eyes.

If you smoke while pregnant, your baby is 5 times more likely to get bacterial meningitis as a child. This is when tissues around the brain swell. Meningitis can cause eye infection(s) and other vision problems.

Also, smoking during pregnancy increases your risk for giving birth too early. Premature birth can lead to a serious eye problem called "retinopathy of prematurity." The baby may have permanent vision loss or blindness.

Summary

Smoking tobacco (cigarettes, cigars or pipes) can make eye problems worse. Glaucoma, cataracts, macular degeneration and dry eye are some of these problems.

Also, a baby's eyes can be affected if the mother smokes during pregnancy.

Quitting smoking can help save your vision.

To learn more about smoking and eye health, scan this code with your smartphone or visit **http://bit.ly/smokingandeyedisease**.

COMPLIMENTS OF:

Content last reviewed 09/15

El tabaquismo y las enfermedades oculares

El tabaquismo y las enfermedades oculares

El tabaquismo (los cigarrillos, los puros/cigarros o las pipas) puede causar enfermedad pulmonar, enfermedad cardíaca, cáncer y muchos otros problemas graves de salud. ¿Pero sabía que el tabaquismo también puede dañar los ojos?

Estos son algunos problemas oculares que empeoran con el tabaquismo:

Ojo seco. Se produce cuando los ojos no tienen suficientes lágrimas o no cuentan con el tipo adecuado de lágrimas. Si padece de ojos secos y fuma, será más propenso a sentir los ojos ásperos, a sentir picazón o ardor en los ojos, o a tener los ojos rojos.

Vocabulario útil relacionado con los ojos

Retina: capa de células nerviosas que recubren la pared posterior en el interior del ojo. Esta capa detecta la luz y envía señales al cerebro para que usted pueda ver.

Mácula: zona pequeña pero importante en el centro de la retina. La mácula es necesaria para ver con claridad los detalles de objetos frente a usted.

Cristalino: parte transparente del ojo detrás del iris de color. Ayuda a enfocar la luz sobre la retina (parte trasera del ojo) para que pueda ver.

Nervio óptico: un nervio en la parte trasera del ojo que se conecta con el cerebro. El nervio óptico envía señales de luz al cerebro para permitirnos ver.

Cataratas. Si fuma, correrá un mayor riesgo de padecer cataratas. Una catarata es cuando el cristalino del ojo se opaca, el cual naturalmente debe ser transparente. Puede causar vista borrosa y hacer que los colores se vean opacos, desteñidos o amarillentos. Las cataratas se pueden quitar mediante una cirugía.

Degeneración macular relacionada con la edad (DMRE). Esta enfermedad se produce cuando una parte de la retina llamada mácula se daña. Se pierde la visión central y no se pueden ver los detalles precisos. Sin embargo, la visión periférica (lateral) funciona normalmente. En ocasiones, los medicamentos o una cirugía pueden ayudar a algunas personas a evitar que la DMRE empeore. Sin embargo, no existe cura. Los estudios demuestran que los fumadores y ex fumadores tienen más probabilidades de desarrollar DMRE que las personas que nunca fumaron.

Retinopatía diabética. Los fumadores que también sufren de diabetes corren el riesgo de padecer retinopatía diabética. La retinopatía diabética ocurre cuando se dañan los vasos sanguíneos de la retina. Causa visión borrosa o distorsionada, y posiblemente puede provocar ceguera. El tratamiento incluye medicamentos o cirugía.

Problemas en el nervio óptico. Las personas que fuman corren el riesgo de tener problemas en el nervio óptico. El nervio óptico conecta el ojo con el cerebro. El daño en este nervio puede provocar ceguera.

Uveítis. El tabaquismo puede causar una enfermedad que afecta la parte del ojo llamada úvea. La úvea es la capa intermedia de la pared ocular. La uveítis ocurre cuando esta capa se inflama (se hincha y tiene color rojizo). Esta enfermedad provoca ojos rojos, dolor y problemas de visión.

Enfermedad de Graves. Es una enfermedad de la glándula tiroidea del cuerpo. Uno de los síntomas de la enfermedad de Graves es la presencia de ojos protuberantes. Los fumadores que padecen enfermedad de Graves corren el riesgo de que el estado de los ojos empeore. Además, pueden perder la visión.

¿Está embarazada? El tabaquismo puede dañar los ojos del bebé.

Si fuma mientras está embarazada, su hijo es 5 veces más propenso a padecer meningitis bacteriana durante su niñez. La meningitis bacteriana se produce cuando se hinchan los tejidos que cubren el cerebro. La meningitis puede causar infección(es) ocular(es) y otros problemas de visión.

Además, fumar durante el embarazo aumenta el riesgo de parto prematuro. El parto prematuro puede causar un problema ocular grave llamado "retinopatía de la prematuridad." El bebé podría tener pérdida de visión permanente o ceguera.

Resumen

El tabaquismo (los cigarrillos, los cigarros/puros o las pipas) puede empeorar los problemas oculares. *El gl*aucoma, las cataratas, la degeneración macular y el ojo seco son algunos de estos problemas.

Además, es posible que los ojos de los bebés se vean afectados si la madre fuma durante el embarazo.

Dejar de fumar puede ayudarlo a salvar su visión.

Para más información sobre fumar y la salud ocular, escanee este código con su smartphone o visite **http://bit.ly/_tabaquismo**.

CORTESÍA DE:

Revisado 09/15

Coding Competency Questions from 2015 Codequest

A. There are several practices in our call group. One physician sees another physician's surgical patient during the global period. The physician on call should:

1. Code the appropriate level of new patient E/M or Eye code
2. Code the appropriate level of established patient E/M or Eye code
3. No claim submitted as this is postop

B. It is appropriate to unbundle 92133 SCODI and 92134 Retina OCT as long as you have 2 separate diagnosis codes.

1. True
2. False CPT description says no. CCI mutually exclusive edit.

C. The retina specialist refers a patient to the glaucoma specialist in the same office. The glaucoma specialist bills the commercial payer patient as:

1. The appropriate level of consult code
2. A new patient E/M or Eye code
3. An established patient E/M or Eye code

D. The 2015 CMS fee schedule will be published:

1. December 2014
2. January 2015
3. April 2015

E. A patient, who is in the hospital, is seen in your office for an exam. Which of the following statements is true?

1. Place of service is office
2. Place of service is hospital
3. The patient is responsible for payment of this non-covered exam

F. 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.
   - This is a big MAC and OIG issue

G. 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 (if medically necessary) but only needs new paperwork if/when the rules change or if the patient is "new" again.

H. Discontinued surgical procedures have a global period.

1. True
2. False

I. A Medicare Advantage Plan patient is schedule for bilateral blepharoplasty. You should obtain an ABN and append modifier -GA to the surgery just as you would Medicare Part B patient.

1. True
2. False
   - Medicare Part B prohibits MA plans from using ABNs

J. What isn't paid by Medicare Part B while the patient is in a SNF?

- The technical component of any test
- Any drug injected
- Postop cataract glasses

K. 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.

L. Practices who do not report at least 3 PQRS measures in 2014 are subject to:

1. 0.5% payment adjustment in 2016
2. 1% payment adjustment in 2016
3. 2% payment adjustment in 2016

M. You hire a new physician in your practice. Best to check with the OIG first.

1. True
2. False

- 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.

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Ask the Coding Experts Top 10

Ask the Coding Experts is a new online resource for trusted responses to your coding questions. Each month you can find these new answers online at aao.org/coding.

Top 10 for October 2015

Q. When submitting injury claim exams do we need to report where and how the injury occurred in addition to the injury itself?

A. Probably not. Unless a particular payer required it with ICD-9 E codes, it will not be required in ICD-10 despite what the ICD-10 book instructions indicate. Remember, too, that Workers' Compensation does not even have to transition to ICD-10. And the largest payer, CMS, stated the use of external cause codes in ICD-10 will not be mandatory. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1518.pdfExam added 10/11/15

Q. What is the best diagnosis code to use when a patient is sent to our practice because they have diabetes, but no ophthalmic disease progression is diagnosed?

A, Submit either E10.9 Type 1 diabetes without complications or E11.9 Type 2 diabetes without complications. There is no direct cross walk from ICD-9 to ICD-10 for the 250.0 family of codes.

Q. Should we be reporting insulin use Z79.4 for our patients with diabetes?

A. Probably not. If the payer didn't require this additional information in ICD-9, it should not be a requirement for ICD-10 reporting. Some physicians choose to report insulin use as it may indicate a higher level of risk to the payer.

Q. How should we code exams for patients on high-risk medications in ICD-10?

A. When no pathology is found, code the systemic disease such as L93.0 Lupus or M06.09 Rheumatoid arthritis. ICD-10's Z79.899 Other long term (current) drug therapy should be linked to any tests performed and may be added to the exam for supporting documentation.

Q. Blepharitis is reported by lid, not by eye, so must I report all four lids for payment on my exam?

A. No. Report at least one lid for payment. Only four diagnoses can be reported per CPT code. When a patient has glaucoma as well as blepharitis, reporting all four lids doesn't provide enough room to report the higher risk glaucoma diagnosis.

Q. How can I indicate to the payer that that the cataract surgery was complex?

A. The best way is to choose the appropriate ICD-10 code. The options listed in Medicare administrative contractor local coverage detereminations are:

- Use H21.261-H21.263, H21.269, H21.29, H21.561-H21.563, H21.569 if the operative note indicates the use of an endocapsular ring to partially occlude the pupil.
- Use H21.271-H21.273, H21.279, H26.211-H26.213, H26.219, H26.221-H26.223, H26.229 if the operative note indicates micro iris hooks were inserted through four separate corneal incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, or sector iridotomy with suture repair of iris sphincter.
- Use H21.221-H21.223, or H21.229 if the operative note indicates permanent intraocular suture or a capsular support ring was employed to place the IOL in a stable position.
- Use H21.531-H21.533, or H21.539 if the operative note indicates a capsular support ring was employed or an endocapsular support ring was used to partially occlude the pupil.
- Use E08.36, E09.36, E10.36, E11.36, E13.36, H21.81, H21.89, H21.9, H22, H25.031-H25.033, H25.039, H25.041-H25.043, H25.049, H25.10-H25.13, H25.89, H25.9, H26.001-H26.003, H26.009, H26.041-H26.043, H26.049, H26.051-H26.053, H26.059, H26.011-H26.013, H26.019, H26.031-H26.033, H26.039, H26.061-H26.063, H26.069, H26.09, H26.101-H26.103, H26.109, H26.121-H26.123, H26.129, H26.30-H26.33, H26.8, H28, Q13.0, or Q13.2 if the operative note indicates the use of micro iris hooks inserted through four separate corneal incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, the IOL implant was supported by using permanent intraocular sutures or a capsular support ring, or an endocapsular ring was used to partially occlude the pupil.
- Use H25.011-H25.013, H25.019, H25.811-H25.813, H25.819, H25.89 if the operative note indicates the use of micro iris hooks inserted through four separate corneal incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, the IOL implant was supported by using permanent intraocular sutures or a capsular support ring, or an endocapsular ring was used to partially occlude the pupil.
- Or, when Trypan Blue or isocyanine green is employed to enhance visualization:
- Use H25.89 if the operative note indicates dye was used to stain the anterior capsule.
- Use H25.20, H25.21, H25.22, or H25.23 with H40.89, phacolytic glaucoma or dye staining of the anterior capsule.
- Use H26.111-H26.113, H26.119, H26.131-H26.133, H26.139, if the operative note indicates the use of micro iris hooks inserted through four separate corneal incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, the IOL implant was supported by using permanent intraocular suture or a capsular support ring was employed.
- Use H26.20 if the operative note indicates the use of micro iris hooks inserted through four separate corneal incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, IOL implant was supported by using permanent intraocular sutures, a capsular support ring was employed, or a primary posterior capsulorrhexis was performed.
- Use H28 if the operative note or postoperative records indicate an extraordinary amount of work was involved in the preoperative or postoperative care.
- Use H27.10, H27.111-H27.113, H27.119, H27.121-H27.123, H27.129, H27.131-H27.133, H27.139, Q12.1, Q12.2, Q12.4, or Q12.8 if the operative note indicates the IOL was supported by using permanent intraocular sutures or a capsular support ring was employed.

- Use H57.00-H57.04, H57.051-H57.053, H57.059, H57.09 or H57.9 if the operative note indicates the use of micro iris hooks inserted through four separate incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, or an artificial prosthetic iris was placed in the eye.
- Use Q13.1 if the operative note indicates the IOL was supported in the eye by using permanent intraocular sutures, a capsular support ring was employed or an endocapsular ring was used to partially occlude the pupil.

Q. Are modifiers -RT and -LT still required for CPT codes or is the laterality of ICD-10 sufficient?

A. Continue to use modifiers -RT and -LT on CPT codes. Not every ICD-10 code has laterality. Some diagnoses have just one code. When both the CPT and the diagnosis code require laterality, be sure to link right eye to right eye and left eye to left eye.

Q. The patient is diagnosed with bilateral age-related nuclear cataracts. It's determined that cataract surgery will be performed in the right eye and an A-scan is performed the same day. How should the ICD-10 codes should be linked?

A. Submit the appropriate level of E/M or Eye visit code linked with either H25.13 Bilateral age-related nuclear cataracts, or 2 diagnoses H25.11 Right eye and H25.12 Left eye. Link H25.11 Right eye to the A-scan 76519 or 92136.

Q. What diagnosis codes should be reported? All that apply to the patient or all that apply to today's visit?

A. The primary diagnosis should relate to the chief complaint. Only those diagnosis codes that pertain to the exam should be reported. While it is possible to report up to 12 diagnosis codes, it is certainly not required for payment.

Q. My pediatric ophthalmologist heard claims will be denied because two diagnosis codes are considered mutually exclusive. I could not find any information regarding this on these two diagnosis codes--H50.2 and H52.0. Have you seen or heard of any issues when billing with these two diagnosis codes?

A. ICD-10 code H50.02 Monocular esotropia with A pattern and H52.0 Hypermetropia do not have an Excludes1 edit, which means both can be reported on the same patient same eye same eye.

Top 10 for November 2015

Q. I've heard varying opinions regarding when to use the required A vs. D in the seventh position for ICD-10 when caring for patients with injury or trauma.

A. Report an A for the initial encounter. Use this when the physician actively treats the condition during the initial encounter (e.g., ED encounter, evaluation by new physician). Report a D: Subsequent encounter after the

physician performs the initial treatment, but the patient continues to receive care during the healing or recovery phase.

Q. I will be performing either CPT code 66986 IOL exchange or possibly CPT code 66985 Piggyback IOL on a patient that is having negative dysphotopsia which is defined as a visual complaint after cataract surgery described by the patient as a persistent dark temporal crescent. The postoperative phenomenon was originally described by Davision, who likened this temporal darkness to "horseblinders". My problem is figuring out the ICD-10 code or codes for these procedures.

A. Either T85.21X- Breakdown (mechanical) of intraocular lens or T85.29X- Other mechanical complication of intraocular lens is appropriate for either procedure. Both require a final seventh character of encounter status.

Q. When would it be appropriate to use Z01.01 (routine eye exam with abnormal findings) instead of Z01.00 (routine eye exam without abnormal findings); would that include refractive disorders such as myopia?

A. The answer depends upon the patient's vision plan coverage. While some payers may recognize routine eye exam with abnormal findings to be a covered diagnosis, other plans may not and require only Z01.00 for vision exam coverage.

Q. What is the appropriate code for a neoplasm of uncertain behavior of the eyelid?

A. D49.2 Neoplasm of unspecified behavior of bone, soft tissue and skin.

Q. What is the ICD-10 code for superior limbic keratoconjunctivitis?

A. As there is no specific ICD-10 code. The best choice may be H16.29- Other keratoconjunctivitis

H16.291 right eye, H16.292 left eye, H16.293 bilateral

Q. What is the ICD-10 code for cystoid macular edema? All we can locate is cystoid macular edema following cataract surgery (H59.03-).

A. Best to use:
Cystoid macular degeneration, right eye H35.351
Cystoid macular degeneration, left eye H35.352
Cystoid macular degeneration, bilateral H35.353

Q. I was wondering what the best code for straight macular edema with no diabetes?

A. According to the ICD-10 for Ophthalmology book it is H35.81 Retinal edema. There is no laterality with this diagnosis.

Q. ICD-9 code 363.20 Posterior uveitis crosswalks to what ICD-10 code?

A. Report H30.89-. This is an "other specified" code and better choice than unspecified. This code also requires laterality in the 6th character position.

Q. Is there an ICD-10 code for status post vitrectomy surgery? Of the ones I have looked at, none pertain to retina.

A. There is not a unique code for this specific post procedural diagnosis. Best to use Z98.89 Other specified postprocedural states. Depending upon the payer, Z codes provide supporting documentation but may not be primary payable diagnoses.

Q. Where do I find the staging definitions for glaucoma?

A. The ICD-10-CM Quick Reference Guide for Glaucoma includes that information.
http://www.aao.org/glaucoma_reference_guide

Report Card for ICD-10 Launch: Practices Get an A, Payers a C

How well has ophthalmology handled the transition to ICD-10? Looking back, it appears that ophthalmology practices scored an A for preparedness. Payers, however, haven't done so well thus far.

Payer Problems

Problems with ICD-10 codes that had no ICD-9 equivalent. Payers were focused on converting ICD-9 codes into ICD-10 codes and sometimes overlooked those diagnoses in ICD-10 that had no precursors in ICD-9. For instance, there is a family of ICD-10 codes for diabetes with diagnoses that had not been represented in ICD-9 at all—and many payers failed to link those codes to CPT code 92134, which is used for scanning computerized ophthalmic diagnostic imaging (SCODI) of the retina. Consequently, practices were denied payment when they used those ICD-10 codes to justify their use of retinal SCODI. Some practices successfully explained the new code set to payers during a phone review. And in some states, carrier advisory committees (CAC) contacted payers about these omissions. In many states, the payer automatically corrected the claim without asking practices to go through the resubmission process.

Insisting on more specificity than CMS requires. In July, CMS stated that, during the first year of ICD-10, payment would be made if a code was submitted from the right code family, even if it wasn't the precise code that the regulations appeared to require. The goal of this was to provide practices with a margin of error while they get up to speed. However, CMS initially denied several codes from the cataract family, stating they were "investigational." Again, phone reviews and contact from CAC representatives reversed these denials.

Denying medical claims. One payer inappropriately denied thousands of medical claims in which practices had reported refractive or routine diagnoses. Once this was brought to the payer's attention, the payer made a mass correction of those denied claims.

Applying the wrong coverage policies. At least one Medicare Advantage plan failed to recognize glaucoma diagnosis codes for CPT code 92133, which is used for SCODI of the optic nerve. An investigation revealed they had based their denial on a national coverage policy for photodynamic therapy (CPT code 67221)!

5 Tips for ICD-10

The following tips will assist you in finding the correct ICD-10 code and will also help you to make your case when claims are incorrectly denied.

Use ICD-9 to buttress your arguments. For each CPT code, keep electronic or paper copies of the list of diagnoses that were covered under ICD-9. During phone reviews, you can use those earlier coverage policies to support your efforts in securing payment under ICD-10.

Continue using CPT codes to report laterality. Even though many ICD-10 codes indicate laterality, you should still append modifiers –RT and –LT on all CPT codes. When the ICD-10 code also has laterality (or "liderality"), link the right-sided ICD-10 code(s) to the right-sided CPT code and the left-sided ICD-10 code(s) to the left-sided CPT code.

Example: A patient is diagnosed with bilateral cataracts, and the right eye is scheduled for surgery. For the exam CPT code, report the bilateral cataract diagnosis; for the A-scan CPT code (either 76519 or 92136), report the diagnosis code for the right eye.

Refer to *Ophthalmic Coding Coach.* If your payer hasn't published a coverage policy for a CPT code, the most efficient source of information is the *Ophthalmic Coding Coach* (available both as a book and online), which lists the diagnosis codes that payers typically cover for that CPT code.

Review the top 10 questions. Each month, you can read answers to the top 10 ICD-10 and CPT questions that were emailed to icd10@aao.org and coding@aao.org. Learn from these at www.aao.org/practice-management/coding/ask-the-coding-experts.

Sign up for E-Talk. When members of the American Academy of Ophthalmic Executives (AAOE) are stumped by a problem, they can use the E-Talk listserv. This option for crowdsourcing advice has proved invaluable during the transition to ICD-10. •

BY SUE VICCHRILLI, COT, OCS, ACADEMY DIRECTOR OF CODING AND REIMBURSEMENT

Oculofacial Coding

Stye/Chalazion

CPT Code	Office/ Facility
67800 Excision of chalazion; single	$129 / $105
67801 Excision of chalazion; multiple, same lid	$165 / $136
67805 Excision of chalazion; multiple, different lids	$205 / $168
67808 Excision of chalazion; under general anesthesia and/or requiring hospitalization, single or multiple	NA / $374
11900 Injection, intralesional; up to and including seven lesions	$56 / $32 (will be reduced by 50%)

ICD-10 Diagnosis Codes

H00.11 Chalazion right upper eyelid (meibomian (gland) cyst)

H00.12 Chalazion right lower eyelid (meibomian (gland) cyst)

H00.14 Chalazion left upper eyelid (meibomian (gland) cyst)

H00.15 Chalazion left lower eyelid (meibomian (gland) cyst)

Hordeolum

CPT Code	Office/ Facility
67840 Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	$279 / $161
11900 Injection, intralesional; up to and including seven lesions	$56/ $32 (will be reduced by 50%)

ICD-10 Diagnosis Codes:

H00.011 Hordeolum externum right upper eyelid

H00.012 Hordeolum externum right lower eyelid

H00.014 Hordeolum externum left upper eyelid

H00.015 Hordeolum externum left lower eyelid

H00.021 Hordeolum internum right upper eyelid

H00.022 Hordeolum internum right lower eyelid

H00.024 Hordeolum internum left upper eyelid

H00.025 Hordeolum internum left lower eyelid

Sebaceous Cyst

CPT Code	Office/ Facility
67700 Blepharotomy, drainage of abscess, eyelid	$272 / $118

ICD-10 Diagnosis Codes:

H02.821 Cysts of right upper eyelid (Sebaceous cyst of eyelid)

H02.822 Cysts of right lower eyelid (Sebaceous cyst of eyelid)

H02.824 Cysts of left upper eyelid (Sebaceous cyst of eyelid)

H02.825 Cysts of left lower eyelid (Sebaceous cyst of eyelid)

Palmetto List of Items for Lucentis Probe

- Beneficiary name and date of service on all documentation
- Beneficiary weight used to calculate dose given
- Name and amount of drug administered
- Signed physician/provider order for the drug
- Stage of treatment for accurate dose administration
- Calculation for the drug (i.e. first dose or subsequent dosing)
- Documentation of administration of the medication
- Documentation legible and complete (including signature(s))
- Abbreviation key (if applicable)
- Relevant history and prior treatment, if needed, to support medical necessity of administration and amount of drug used in administration, which may include documentation (i.e. peer-reviewed medical literature) supporting any off-label use as applicable
- Initial patient history and physical or initial consultation related to the treatment

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ZPICs Request for Documentation

1. Patient information, copy of Medicare card and photo ID
2. Patient consent forms
3. Advance Beneficiary Notices
4. Patient billing statements
5. Patient superbills/encounter forms
6. Any and all drug invoices
7. Legible patient logs
8. Pre-treatment/initial treatment plan including history and physical
9. Plan of care including the drug dosage, frequency and expected duration of treatment
10. Legible medication administration records
11. Documentation of any drug wastage
12. Exams, photos (color) interpretation and legible results
13. Progress and office notes, initial and most recent (legible)
14. Any and all diagnostic tests – legible interpretation and results
15. Legible physician orders
16. Legible physician referral notes and consultation reports
17. Legible operative reports
18. Laboratory/pathology reports/results
19. Radiology reports and results
20. Signatures/credentials of all professionals, non-professionals providing services
21. Office addresses, telephone numbers and office hours for all locations
22. The name and telephone number of a contact person in your office
23. The beneficiary signature on the Medicare claim form authorizing release of this information

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The Ophthalmic Scribe Certification (OSC®) Examination

Academy members can help ensure that scribes comply with meaningful use rule

Allied health personnel employed by ophthalmologists now can become certified online to perform computerized physician order entry duties in compliance with Medicare meaningful use requirements **(**http://tinyurl.com/olebs5n**).**

The Ophthalmic Scribe Certification (OSC®) examination is now being offered to these personnel through the Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO®) in partnership with the Academy.

Upon successful completion, scribes are certified for three years and may be compliant with the Centers for Medicare & Medicaid's meaningful use requirements. The new scribe certification can also be a pathway for the allied health personnel seeking a career in the eye care profession.

In January 2015, CMS clarified that certified ophthalmic scribes are permitted to enter electronic medication, laboratory or radiology orders into electronic health record systems to satisfy the EHR Meaningful Use Program's Computerized Provider Order Entry (CPOE) measures in Stage I and Stage II.

According to a CMS FAQ **(http://tinyurl.com/oqlx26f)**, if a staff member "is appropriately credentialed and performs similar assistive services as a medical assistant but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, he or she can use the CPOE function of CEHRT [Certified EHR Technology] and have it count towards the measure." Physicians utilizing scribes for CPOE must provide a comparison document illustrating that the duties the scribes perform are similar to those that a medical assistant performs. This documentation could help physicians avoid failing audits. The Academy and JCAHPO are offering a form for the documentation **(http://tinyurl.com/qzr7p6).**

Ophthalmic scribes who are employed by an Academy member or member of the American Academy of Ophthalmic Executives (AAOE) are eligible to apply for the online examination at a discounted rate of $20 if they are certified as an ophthalmic assistant, technician or medical technologist under JCAHPO. The application fee for non-certified candidates is $40.

The exam is available on JCAHPO's EyeCareCE website at www.eyecarece.org.

The 125-item, open-book exam tests knowledge of creating and maintaining patient medical records and orders under the supervision of an ophthalmologist. The examination content covers history taking, ophthalmic patient services and education, ophthalmic terminology, medical ethics and legal issues as well as medical notes and records.

While the Academy is pleased that this scribe certification method has been made available through JCAHPO, the Academy will continue its previous efforts to push CMS to allow the use of non-certified staff to satisfy the requirements of this measure.