CHAPTER

35

# Coding and Billing

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This chapter presents the basics of coding and billing. Coding requires diagnostic and procedure codes. Instructions are provided for coding Evaluation and Management (E/M) services, general ophthalmological services, S-code vision examinations, special ophthalmological services, and modifiers.

With the increased third-party coverage of medical and vision services, the practitioner has to be well versed in proper coding and billing procedures. A lack of coding and billing knowledge could result in lost revenues, increased staff time and expense, and prosecution for fraud and abuse. Coding and billing requires proper medical record documentation, and proper usage of diagnostic codes and procedure codes. The Health Insurance Portability and Accountability Act (HIPAA) requires a standard medical code data set that specifies the usage of the following:

- ICD-9-CM: diagnostic codes
- Healthcare Common Procedure Coding System (HCPCS) Level I codes: CPT-4 codes
- HCPCS Level II codes: S codes, G codes, and materials codes (see Chapter 34)
- Codes for optometry can be ordered from the American Optometric Association (AOA)

The doctor is personally responsible for ensuring proper coding procedures are being followed in his or her practice. This responsibility can not be delegated to an assistant.

## GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The following principles apply to documentation of services.

- The reason for the patient encounter is documented.
- All services provided are documented.
- The medical record clearly explains why services/procedures and/or supplies were provided.
- Patient's progress and/or results of treatment are documented.
- The medical record provides reasonable medical rationale for the services and charges billed.
- Information in the medical record supports the care provided.
- Medical record is complete, legible, and dated.
- The doctor providing services signed the medical record.
- CPT-4 and ICD-9-CM codes reported on the billing statement/ insurance claim are supported by documentation in the medical record.
- There is a medical order in the primary medical record for any additional tests or procedures (e.g., special ophthalmological procedures, radiological procedures, or surgical procedures).
- Any additional tests or procedures should be documented on a separate page.
- When a report is required, it must be clearly identified as a report.
- Any problem identified must be further defined in words or pictures.

## MEDICAL CODING

### Step 1: Reason for Visit

The reason for the visit must be medical.

### Step 2: Type of E/M Services

Identify type of E/M service provided; the most common is the office/outpatient.

- Office/Outpatient (99201-99215)
- Subsequent Hospital, Inpatient (99231-99233)
- Office/Outpatient Consultations (99241-99245)
- Inpatient Consultations (99251-99255)
- Emergency Department (99281-99285)
- Subsequent Nursing Facility Care (99307-99310)
- Rest Home, New Patient (99324-99328)
- Rest Home, Established Patient (99334-99337)
- Home Services, New Patient (99341-99343)
- Home Services, Established Patient (99347-99349)

### Step 3: New or Established Patient

Is the patient new or established for coding and billing purposes?

### New Patient

A new patient has not received any professional services (faceto-face services rendered by a physician) from any doctor of the same specialty in the practice (or group) within the past 3 years.

### Established Patient

An established patient has received professional services from doctor of same specialty in the practice (or group) within the past 3 years.

### Level of E/M Service

Seven components to define level of service for E/M services are as follows:

- History
- Examination
- Medical decision making (MDM)
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The first 3 components, history, examination, and MDM, are key components.

### Step 4: History

The 4 types of medical history (Table 35-1) are as follows:

- Problem Focused
- Expanded Problem Focused
- Detailed
- Comprehensive

The history is composed of the following 4 parts:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS)
- Past medical, family, and/or social history (PFSH)

### Chief Complaint

The CC is the reason for the examination, and it should be short and concise as it describes the symptom, problem, condition, diagnosis, physician recommended return, or factor that is the reason for the encounter. The CC goes in the #1 Diagnosis box on the insurance claim form and determines the coverage (vision or medical).

**TABLE 35-1**

**History Type Grid**

| Type of History | Key | Definition |
|---|---|---|
| Problem Focused | P | CC + Brief HPI (1-3) |
| Expanded Problem Focused | E | CC + Brief HPI + Problem Pertinent ROS (1) |
| Detailed | D | CC + Extended HPI (4+) + Extended ROS (2-9) + Pertinent PFSH (1) |
| Comprehensive | C | CC + Extended HPI (4+) + Complete ROS (10+) + Complete PFSH (2-3) |

*CC,* Chief complaint; *HPI,* history of present illness; *ROS,* review of systems; *PFSH,* past medical, family and social history.
(Courtesy Michigan College of Optometry Medicare Compliance Committee)

### History of Present Illness

The HPI is a chronological description of the development of the patient's present illness from the first sign/symptom or from the previous encounter to the present. The 8 elements possible in the HPI are as follows:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

The 2 types of HPI are as follows:

- Brief HPI has one to 3 elements.
- Extended HPI has 4 or more elements.

### Review of Systems

The ROS is an inventory of the body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. Questions for this area must be in the format of symptoms of systems. There are 14 possible systems to review, and negative or normal is an acceptable answer. The systems to review are as follows:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic

The 3 types of ROS are as follows:

- Problem pertinent: 1 system reviewed
- Extended: 2 to nine systems reviewed
- Complete: 10 plus systems reviewed

### Past Medical, Family, and/or Social History includes:

- Past medical: illnesses, operations, injuries, treatments
- Family: review of medical events in the patient's family including diseases which may be hereditary or place the patient at risk
- Social: age appropriate review of past and current activities; marital status; employment; use of tobacco, alcohol, or drugs

The 2 types of PFSH are as follows:

- Pertinent: 1 area is reviewed
- Complete: 2 areas are reviewed (established patient) or 3 areas reviewed (new patient).

### *Documentation*

- Use a history checklist for ROS and PFSH.
- Positive responses for ROS should be explained.
- May be used for subsequent visits.
- Updated by describing any new ROS and/or PFSH or note no change. Note the date of the earlier ROS and/or PFSH.
- For ROS and/or PFSH recorded by staff or patient, it is necessary to document that the doctor reviewed the information, therefore there must be a signed notation supplementing or confirming the information recorded.
- If unable to obtain history, the record should describe condition that prevents taking the history.
- The extent of history required depends on the clinical judgment of the doctor and the presenting problem(s).

*Example of Documentation:* Detailed history includes a CC, at least 4 elements of the HPI, 2 to 9 systems reviewed, and one area of the PFSH. However, a history that includes a CC, 2 elements of the HPI, 10-plus systems reviewed, and all 3 areas of the PFSH would only be an expanded problemfocused history.

## Step 5: Examination

The number of elements needed depends on the doctor's clinical judgment, presenting problem(s), and findings during the examination.

### *Examination Types*

- Problem focused: 1 to 5 elements
- Expanded problem focused: 6 to 8 elements
- Detailed: 9 to 13 elements
- Comprehensive: All 14 elements ( Box 35-1 )

*Example of Examination:* 7 examination elements documented would be an expanded problem focused examination.

## Step 6: Medical Decision-Making

The complexity of establishing a diagnosis and/or selecting a management option in MDM is measured by the following:

- Number of diagnoses/treatment options
- Amount/complexity of data
- Risk of complications and/or morbidity or mortality The 4 types of MDM are as follows:
- Straightforward
- Low complexity
- Moderate complexity
- High complexity

### *Number of Diagnoses/Treatment Options*

- Add up total points according to Table 35-2.

### Amount/Complexity of Data

- Add up total points according to Table 35-3.
- Typically very limited data for optometry.
- Amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed.
- The review of laboratory, radiology, and/or other diagnostic tests should be documented. An entry in the chart, such as "WBC elevated" is acceptable, or the review may be documented by initialing and dating the report containing the test results.
- Maximum of 1 point for each section of diagnostic test (laboratory, radiology, and medicine)

**BOX 35-1**

**Fourteen Elements for Eye Examination**

1. 1.Test visual acuity (does not include determination of refractive error)
2. Gross visual field testing by confrontation
3. Test ocular motility, including primary gaze alignment
4. Inspection of bulbar and palpebral conjunctiva
5. Examination of ocular adnexa, including lids (e.g., ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits, and preauricular lymph nodes
6. Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (e.g., anisocoria), and morphology
7. Slit lamp examination of the corneas, including epithelium, stroma, endothelium, and tear film
8. Slit lamp examination of the anterior chambers, including depth, cells, and flare
9. Slit lamp examination of the lenses, including clarity, anterior and posterior capsule, cortex, and nucleus
10. Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)

**Ophthalmoscopic Examination through Dilated Pupils (unless contraindicated)**

11. Optic discs including size, C/D ratio, appearance (e.g., atrophy, cupping, tumor elevation) and nerve fiber layer
12. Posterior segments including retina and vessels (e.g., exudates and hemorrhages)

**Brief Assessment of Mental Status (Neurologic/ Psychiatric)**

13. Orientation to time, place, and person
14. Mood and affect (e.g., depression, anxiety, or agitation)

**BOX 35-2**

**Number of Diagnosis or Treatment Options**

| Problems to Examination Physician | Number of Points |
|---|---|
| Self-limited or minor: stable, improved, or worsening | 1 (maximum of 2) |
| Established problem (to examiner/office): stable, improved | 1 |
| Established problem (to examiner/office): Worsening | 2 |
| New problem (to examiner): no additional workup planned | 3 (maximum of 1) |
| New problem (to examiner): additional workup planned | 4 |
| TOTAL | |

(Courtesy Michigan College of Optometry Medicare Compliance Committee)

**TABLE 35-3**

**Amount and/or Complexity of Data to be Reviewed**

| Data to Be Reviewed | Number of Points |
|---|---|
| Review and/or order of clinical laboratory tests | 1 |
| Review and/or order of tests in radiology section of CPT 70000s | 1 |
| Review and/or order of tests in the medicine section of CPT 90000s | 1 |
| Discussion of test results with performing physician | 1 |
| Discussion to obtain old records and/or history from someone other than patient | 1 |
| Review and summarization of old records and/ or obtaining history from someone other than patient and/or discussion of case with another health care provider | 2 |
| Independent visualization of image, tracing, or specimen itself (not simply review) | 2 |
| TOTAL | |

*CPT,* Current Procedural Terminology. (Courtesy Michigan College of Optometry Medicare Compliance Committee)

## Documentation

- The results of discussion of laboratory, radiology, and medicine diagnostic tests with the physician who performed or interpreted the study should be documented.
- A decision to obtain old records or to obtain additional history from other than patient (i.e., family, caretaker, or other source) to supplement history obtained from the patient should be documented.
- A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed. Relevant findings should be documented; do not write "old records reviewed" or "additional history obtained from family."
- Initial and date reports from other sources.
- Direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.

## Table of Risk

Pick the highest level of risk from the three categories of presenting problem, diagnostic procedures, or management options (Table 35-4). Select type of MDM using the grid in Table 35-5. To qualify for a given type of MDM, two of the three elements in Table 35-5 must be met or exceeded.

**TABLE 35-4**

**Table of Risk**

| Level of Risk | Presenting Problem | Diagnostic Procedures Ordered | Management Options Selected |
|---|---|---|---|
| Minimal (1) | • One self-limited or minor problem (e.g., subconjunctival hemorrhage) | • Tonometry<br>• PAM<br>• Contrast sensitivity test<br>• Schirmer's test<br>• Ultrasound<br>• Color vision test<br>• Visual fi eld<br>• Laboratory tests requiring venipuncture | • Rest<br>• Superfi cial dressing |
| Low (2) | • Two or more self-limited or minor problems<br>• One stable chronic illness (cataract, glaucoma)<br>• Acute uncomplicated illness or injury | • Gonioscopy<br>• Ophthalmoscopy<br>• Conjunctival culture<br>• Superfi cial needle biopsy<br>• Provocative glaucoma test<br>• MRI | • OTC drugs<br>• Minor surgery with no identifi ed risk (FB removal, trichiasis removal, insertion of punctual plugs)<br>• Occlusion<br>• Pressure patch |
| Moderate (3) | • One or more chronic illnesses with mild exacerbation<br>• Two or more stable chronic illnesses<br>• Undiagnosed new problem with uncertain prognosis (red eye)<br>• Acute illness with multiple symptoms (facial palsy with corneal exposure)<br>• Acute complicated injury | • Corneal culture<br>• IVFA<br>• Retrobulbar injection<br>• Deep needle biopsy or incisional biopsy<br>• Physiologic stress tests | • Prescription medications<br>• Minor surgery with identifi ed risk factors (corneal scraping, excision of lesion)<br>• Elective major surgery with no identifi ed risk factors |
| High (4) | • One or more chronic illnesses with severe exacerbation<br>• Acute of chronic illnesses or injuries that pose a threat to life or bodily function (e.g., trauma, endophthalmitis retinoblastoma, angle closure) | • Vitreous tap<br>• Anterior chamber tap<br>• Fine-needle biopsy: orbital, ocular | • Elective major surgery with identifi ed risk factors ,<br>• Emergency major surgery (e.g., sclera buckle, enucleation)<br>• Multiple drug therapy requiring intensive monitoring for toxicity |

*FB,* foreign body; *IVFA,* intravenous fluorescein angiography; *MRI,* magnetic resonance imaging; *OTC,* over-the-counter; *PAM, potential acuity meter.* (Courtesy Michigan College of Optometry Medicare Compliance Committee)

**TABLE 35-5**

**Medical Decision Making**

| Category | Level | | | |
|---|---|---|---|---|
| Number of diagnoses or management options | ≤1 Minimal | 2 Limited | 3 Multiple | ≥4 Extensive |
| Amount and complexity of data | ≤1 Minimal | 2 Limited | 3 Multiple | ≥4 Extensive |
| Highest risk | ≤1 Minimal | 2 Limited | 3 Multiple | ≥4 Extensive |
| Type of decision making (2 or 3 at highest level) | 1 Straightforward | 2 Low | 3 Moderate | 4 High |

(Courtesy Michigan College of Optometry Medicare Compliance Committee)

*Example of Documentation:* A 2 for number of diagnosis or management options, a 1 for amount and complexity of data, and a 3 for highest risk would be a low complexity.

## Step 7: Time as Only Key/Controlling Component

This step is used when more than one-half of the doctor/ patient (and/or family) face-to-face time is spent in counseling and/or coordination of care. Medical record must include total time doctor spent with patient (and/or family) and note that more than one-half the time was spent in counseling and/ or coordination of care. Document contents of counseling and/or coordination.

### Face-to-Face Time: New Patient

- 99201: 10 minutes
- 99202: 20 minutes
- 99203: 30 minutes
- 99204: 45 minutes
- 99205: 60 minutes

### Face-to-Face Time: Established Patient

- 99211: 5 minutes
- 99212: 10 minutes
- 99213: 15 minutes
- 99214: 25 minutes
- 99215: 40 minutes

### Face to Face Time: Consultation

- 99241: 15 minutes
- 99241: 30 minutes
- 99243: 40 minutes
- 99244: 60 minutes
- 99245: 80 minutes

*Example of Documentation:* Doctor spends 35 out of 60 minutes face-to-face time with a new patient in counseling/ coordination of care; this would be a 99205 level of service.

## Step 8: Select Evaluation and Management Code

### New Patient (Table 35-6) or Consultation (Table 35-6)

- All 3 key components met or exceeded.
- Or time, if appropriate (see Step 7).

### *Established Patient (Table 35-6)*

- 2 of 3 key components met or exceeded.
- Or time, if appropriate (see Step 7).

### *Consultation: Additional Requirements*

Consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding E/M of a specific problem is requested by another physician or other appropriate source (physician assistant or nurse practitioner). A request for the consultation and the need for consultation must be documented in the patient's medical record (in both consultant and requesting physician record). After the consultation is provided, the consultant prepares a written report of the findings, which is provided to the "requesting" physician. Medicare pays for an initial consultation regardless of treatment initiation unless transfer of care occurs. Transfer of care occurs when a physician requests that another physician take over the responsibility for managing the patient's complete care for the condition and does not expect to continue treating or caring for the patient for that condition.

A transfer of care occurs when a limited license physician refers a patient to a physician specialist for a condition that would not be within the limited license physician's scope of practice to manage/treat. The physician specialist may not bill a consultation service. Subsequent visits should be reported as established patient office visits.

*Example of Documentation:* Established patient: history detailed (D), examination detailed (D), decision straightforward (S) would be 99214 level of service.

## Step 9: General Ophthalmological Services

Optometrists may use either the E/M codes or CPT Medical Eye Exam codes to report services.

Comprehensive Ophthalmological Service: 92004/92014

- Complete system evaluation.
- It may take more than one patient encounter to complete the service.
- Includes history, medical observation, external and ophthalmoscopic examinations, gross visual fields, and basic sensorimotor examination.
- Often includes biomicroscopy examination with cycloplegia or mydriasis and tonometry.
- Always includes initiation of diagnosis and treatment programs.

**TABLE 35-6**

**Evaluation and Management (E/M) Codes: Requires All 3 Key Components Met or Exceeded for New Patient or Consultation; 2 of 3 Key Components Met or Exceeded for Established Patient**

| Key Component | E/M Codes | | | | |
|---|---|---|---|---|---|
| **NEW PATIENT** | | | | | |
| | 99201 | 99202 | 99203 | 99204 | 99205 |
| History | P | E | D | C | C |
| Examination | P | E | D | C | C |
| Decision | S | S | L | M | H |
| **CONSULTATION** | | | | | |
| | 99241 | 99242 | 99243 | 99244 | 99245 |
| History | P | E | D | C | C |
| Examination | P | E | D | C | C |
| Decision | S | S | L | M | H |
| **ESTABLISHED PATIENT** | | | | | |
| | 99211 | 99212 | 99213 | 99214 | 99215 |
| History | Physician | P | E | D | C |
| Examination | Supervision | P | E | D | C |
| Decision | Only | S | L | M | H |

P (Problem Focused), S (Straightforward), E (Expanded Problem Focused), D (Detailed), L (Low), M (Moderate) H (High), C (Comprehensive)

Intermediate Ophthalmologic Service: 92002/92012

- Evaluation of new or existing condition, complicated with a new diagnostic or management problem, not necessarily relating to the primary diagnosis.
- For new patient: with initiation of diagnostic and treatment program.
- For established patient: with initiation or continuation of diagnostic and treatment program.
- Includes history, medical observation, external and adnexal, and other diagnostic procedures as indicated.
- May include mydriasis for ophthalmoscopy.

The comprehensive and intermediate Medical Eye Exams may be further defined by carriers, for example, a few of the Medicare carriers require 8 or more examination elements to qualify for a comprehensive examination. Check your carrier Website for specific requirements.

The Medical Eye Exam code always includes initiation of diagnosis and treatment programs (as defined by CPT) and includes the following:

- The prescription of medication
- Arranging for special ophthalmological diagnostic or treatment services
- Consultations
- Laboratory procedures/radiological services
- Refractions

## Step 10: Select Code

- Office E/M
- Consultation
- Medical Eye Exam

### *S Codes (Vision Exam)*

- Level II HCPCS codes
- Use mandated by HIPAA
- S0620: Routine ophthalmological examination including refraction; new patient
- S0621: Routine ophthalmological examination including refraction; established patient
- Not payable by Medicare

### *Vision or Medical Insurance*

- CC rules, not final diagnosis, for determining coverage by vision or medical insurance.
- Patient presents for a "routine exam" and you find a medical problem. Not billable to Medicare, use S code.
- For this patient, you order a diagnostic test (e.g., visual fields and perform same day). If the medical condition supports a visual field, then the visual field is billable to Medicare.
- Patient presents with a complaint of floaters and you find nothing medically wrong (only myopia), the examination is billable to Medicare.

### *Special Ophthalmological Testing*

Special ophthalmologic services describe services that go beyond E/M level and Medical Eye Exam services and are as follows:

***Refraction (92015)***

- Billable with E/M levels and 92000s Medical Eye Exam codes
- Excluded from Medicare payment
- Other insurances may cover as benefit
- A prescription is issued

***Gonioscopy (92020)***

- Bilateral
- Requires documentation

***Topography (92025)***

- Bilateral
- Requires interpretation and separate report (Figure 35-1)

***Sensorimotor Examination (92060)***

- Quantitative measurement of ocular deviation
- Multiple measurements
- Bilateral
- Requires interpretation and separate report (Figure 35-1)

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SEPARATE INTERPRETATION REPORT

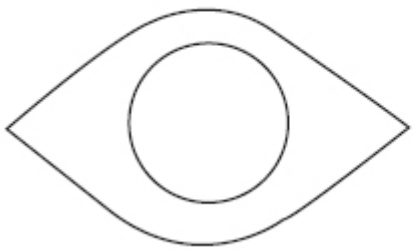
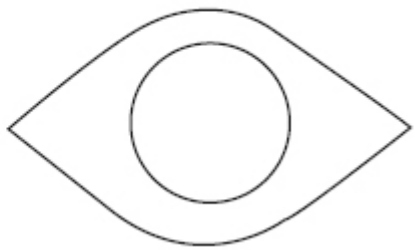
| Name: | | Date: | | Date of Birth: | |
|---|---|---|---|---|---|
| ☐ Visual fields | ☐ Extended ophthalmoscopy | ☐ A-scan/B-scan | ☐ OD | | |
| ☐ Fundus photography | ☐ Serial tonometry | ☐ Optical coherence tomography | ☐ OS | | |
| ☐ External ocular photography | ☐ Sensorimotor examination | ☐ GDx VCC | ☐ OU | | |
| ☐ Electro-oculography | ☐ Electroretinography | ☐ Fluorescein angiography | | | |
| ☐ Pachymetry | ☐ Corneal topography | ☐ Dark adaptation exam | | | |
| **Comments:** | | | | | |
| Patient reliability, understanding, cooperation, education: | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Doctor interpretation:** | | | | | |
| Test results: | | | | | |
| | | | | | |
| Implications: | | | | | |
| | | | | | |
| Impact on treatment/prognosis | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| OD  OS  | | | | | |
| RTC: | Intern signature: | Doctor signature: | | | |

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**FIGURE 35-1** Interpretation report. Courtesy Michigan College of Optometry.

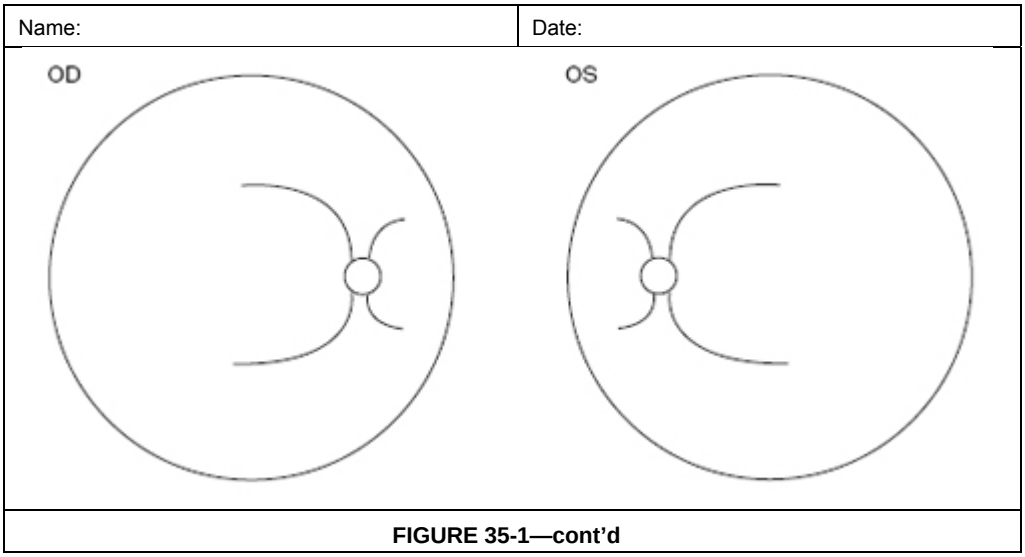


**FIGURE 35-1—cont'd**

***Therapeutic Contact Lens (92070)***

- Unilateral
- Procedure code includes the supply of the contact lens
- Can bill an E/M code along with 92070

***Visual Fields (92081)***

- Limited examination (e.g., tangent screen, autoplot, arc perimeter, single stimulus level automated test [screening], Octopus 3 or 7)
- Unilateral or bilateral
- Requires interpretation and separate report (Figure 35-1)

***Visual Fields (92082)***

- Intermediate examination (e.g., at least 2 isopters on Goldmann perimeter or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
- Unilateral or bilateral
- Requires interpretation and separate report (Figure 35-1)

***Visual Fields (92083)***

- Extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within 30 degrees; or quantitative, automated threshold perimetry; Humphrey visual field analyzer full threshold programs 30-2, 24-2, 30/60-2; Octopus program G-1, 32, or 42)
- Unilateral or bilateral
- Requires interpretation and separate report (Figure 35-1)

***Serial Tonometry (92100)***

- Bilateral
- Required documentation
- Multiple measurements over time, document times of readings (3 or more readings on same day)
- Requires interpretation and separate report (Figure 35-1)

***Scanning Laser (92135)***

- Scanning computerized ophthalmic diagnostic imaging
- Applies to glaucoma and retinal evaluations
  - Heidelberg Retinal Topography (HRT)
  - Humphrey Optical Coherence Tomography (OCT)
  - Laser Diagnostic Technology (GDX)
- Unilateral
- Requires interpretation and separate report (Figure 35-1)

***Extended Ophthalmoscopy (92225/92226)***

- Ophthalmoscopy, extended with retinal drawing
- Initial (92225) or subsequent (92226)
- Unilateral
- Use modifiers RT/LT
- Do not bill for eye that does not have pathology
- Requires interpretation and separate report (Figure 35-1)

***Fundus Photography (92250)***

- Bilateral
- Requires interpretation and separate report (Figure 35-1)

***External Ocular Photography (92285)***

- Documentation of medical progress
- Bilateral
- Requires interpretation and separate report (Figure 35-1)

## Radiology

***Corneal Pachymetry (76514)***

- Bilateral
- Enter your National Provider Identifier (NPI ) in item 17 on CMS-1500 form
- Requires interpretation and separate report (Figure 35-1)

## Modifiers

There may be times when a modifier is needed to be attached to the CPT code to specific special circumstances when submitting the code for payment. Examples when modifiers are needed include postoperative management (co-management), multiple procedures, and bilateral procedures. For a complete list of modifiers, see Appendix A of CPT-4 and HCPCS Level II modifiers.

## MEDICARE COMPLIANCE PROGRAM

It is strongly recommended that all practices (including solo practitioners) develop a Medicare Compliance Program. The program prevents, detects and corrects inappropriate and potential coding and documentation errors and assures compliance with CMS directives and documentation guidelines. The following 7-step format is suggested.

1. Development of Standards and Procedures
   - Capable of reducing chance of criminal conduct
   - Code of Conduct developed by practice administration
   - Measures to demonstrate a clear commitment to compliance
2. Appointment of Compliance Officer
   - Should have high level of authority
   - For small practice typically will be the doctor
   - Monitors/evaluates compliance program, oversees internal audits, develops educational/training programs, and enhances employee communications
3. Training Programs
   - Mandatory participation
   - Document training programs
   - Annual educational seminar for all staff and doctors on coding, documentation, and compliance issues
   - Additional seminars on as-needed basis
   - Individual training when necessary
4. Internal Audits
   - Start with baseline audit
   - Then, ongoing medical records monitoring
   - Monthly/quarterly basis
   - Additional review performed if necessary
   - Prospective (presubmission) audits
   - Retrospective (postsubmission) audits
5. Confidential Reporting System
   - Open lines of communication between compliance officer and office personnel
   - Open door policy for staff
   - Staff comfortable reporting suspected violations
6. Investigation/Enforcement of Wrongdoing
   - Ongoing evaluation of staff involved in preparation/submission of claims
   - Adequate disciplinary mechanisms
   - Warnings, reprimands, retraining, probation, demotion, dismissal, referred to law enforcement
   - Documentation of disciplinary measures
7. Corrective Actions
   - Planned course of action for compliance
   - Guidelines to eliminate problem
   - Refund collections
   - Discipline
   - Educate
   - Modify plan

## SUBMISSION OF CLAIMS

See Chapter 34 for completing the CMS-1500 for filing of insurance claims.

## CONCLUSION

Optometrists need to have a solid understanding of the coding and billing requirements because an increasing percentage of the optometrist's revenues is derived from medical services. The optometrist is the one responsible for ensuring that services are documented and coded correctly. Improper coding not only creates lost revenues but also exposes the optometrist to fraud and abuse charges.

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