Office of Billing Compliance
2014 Professional Coding, Billing and Documentation Program

Department of Optometry

Prepared by:
Medical Compliance Services, Miller School of Medicine/University of Miami and Compliance Concepts, Inc.
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What is a Compliance Program?

7 Elements of an Effective Compliance Program

- A centralized process to promote honest, ethical behavior in the day-to-day operations of an organization, which will allow the organization to identify, correct, and prevent illegal conduct.
- It is a system of: FIND – FIX – PREVENT

The University of Miami implemented the Billing Compliance Plan on November 12, 1996. The components of the Compliance Plan are:

1. Policies and Procedures
2. Having a Compliance Officer and Compliance Committees
3. Effective Training and Education
4. Effective Lines of Communication (1-877-415-4357 or 305-243-5842)
5. Disciplinary Guidelines
6. Auditing and Monitoring
7. Detect Non-Compliance Issues and Develop Corrective Action Plans
The Government

- In order to address fraud and abuse in the Healthcare Field, the government has on-going reviews and investigations nationally to detect any actual or perceived waste and abuse.

- The Government does believe that the majority of Healthcare providers deliver quality care and submit accurate claims. However, the amount of money in the healthcare system, makes it a prime target for fraud and abuse.

Centers for Medicare and Medicaid Services (CMS) Estimates > $50 Billion In “Payment Errors” Annually in Healthcare

OIG reported that in FY 2013 that $5.8 billion was recovered from auditing providers
Health Care Laws

There are five important health care laws that have a significant impact on how we conduct business:

- False Claims Act
- Health Care Fraud Statute
- Anti-Kickback Statute
- Stark Law
- Sunshine Act
  - Requires manufacturers of drugs, medical devices and biologicals that participate in U.S. federal health care programs to report certain payments and items of value >$10 given to physicians and teaching hospitals.
What is a False Claim?

- A false claim is the knowing submission of a false or fraudulent claim for payment or approval or the use of a false record that is material to a false claim.

OR

- Reckless disregard of the truth or an attempt to remain ignorant of billing requirements are also considered violations of the False Claims Act.
How do you create a False Claim?

One method is to submit a claim form to the government.

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<tr>
<td>24. A. DATE(S) OF SERVICE</td>
<td>B. PLACE OF SERVICE</td>
<td>C. EMERGENCY</td>
<td>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</td>
<td>E. DIAGNOSIS/POINTER</td>
<td>F. $ CHARGES</td>
<td>G. DAYS OR UNITS</td>
<td>H. DSM5/Family/Plan</td>
<td>I. QUAL.</td>
<td>J. RENDERING PROVIDER ID. #</td>
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This certification forms the basis for a false claim.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)
Medical Necessity
Elective Procedures Alert

When applicable for all prior procedures should be documented:

- List all failed:
  - Therapies in the patients history or operative report
  - Medication trials
  - Prior surgeries, interventions or procedures

Document worsening conditions as evidenced by abnormal test results or decline in functional abilities or why this elective procedure is the best option for the patient if other, lower cost options are available.

Criteria which establishes medical necessity guidelines have been established for many procedures and diagnostic studies.

**DOCUMENT! DOCUMENT!**
Audits are being conducted for all payer types based on the medical necessity of procedures and E/M levels. Procedure are often linked to diagnosis codes and the E/M audits are generally expressed in two ways in conjunction with the needs of the patient:

- Frequency of services (how often the patients are being seen) and,
- Intensity of service (level of CPT code billed).
Annually the OIG publishes its "targets" for the upcoming year. Included is:

**Cutting and Pasting Documentation in the EMR**

REMEMBER: More volume is not always better in the medical record, especially in the EMR with potential for cutting/pasting, copy forward, pre-defined templates and pre-defined E/M fields. Ensure the billed code is reflective of the service provided on the DOS.
Practitioner reimbursement will likely be tied to outcomes soon.

Some experts say that the CMS penalties for not participating in the Physician Quality Reporting System (PQRS) signal that the pay-for-performance trend is not fading away and will likely will be adopted by private payers.

“I think we’re slowly transitioning out of fee-for-service and into a system that rewards for quality while controlling cost,” says Miranda Franco, government affairs representative for the Medical Group Management Association. “The intent of CMS is to have physicians moving toward capturing quality data and improving metrics on [them].”
Optometrists can select either the “eye codes” or E/M visit codes for their services.

**Choosing Correct Codes**

- Most Optometrists prefer using the Eye Codes, believing they are easier to use and more audit-proof. That is not necessarily so. If you use only eye codes, not only are you punishing yourself financially, but you also may be found to be upcoding or downcoding under audit. For example, the intermediate eye code for established patients (CPT code 92012) is not always suitable for coding frequent follow-ups such as follow-up examination for corneal abrasion. (The correct code for healing corneal abrasion often usually is E/M code 99212).

- The Center for Medicare and Medicaid Services (CMS) wants you to code correctly — to neither upcode nor downcode.

- Typically eye codes are billed in the OP setting for visits related to “routine” eye follow-ups or complaints.

- E/M codes are usually billed for consultations and IP services.
Ophthalmology Codes

- **S0620** Routine ophthalmological examination including refraction; new patient (not a Medicare Code)
- **S0621** Routine ophthalmological examination including refraction; established patient (not a Medicare Code)
- **92002** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
- **92004** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
- **92012** Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
- **92014** Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
S Code Documentation

- S0620-1 are defined ‘routine ophthalmological examination, includes refraction’. These are HCPCS codes, not CPT, and as a result, most continue use the 99xxx or 92xxx visit codes, combined with 92015, refraction, to report their eye care visits.

- The word 'routine' in the definition indicates that the visit had no medical reason/Chief Complaint/presenting problem. Doctors who choose to use the S codes would use them whenever there was no medical reason for the visit, whether the patient has insurance to cover the visit or not. This is further complicated because most of the vision plans that cover the 'non medical visits' don't accept the use of the S code.

- An advantage in the S codes is that offices can establish fees for their 99xxx and 92xxx office visits as if they are always used for medical cases, reserving the S codes; in most cases with a lower fee; for the visits without a medical reason.
General Ophthalmologic Services:
New 92002-04 & Established 92012-14
13 elements of an ophthalmologic exam including:

- Test visual acuity (does not include determination of refractive error)
- Ocular mobility (required for comprehensive level)
- Intraocular pressure
- Retina (vitreous, macula, periphery, and vessels)
- Optic disc
- Gross visual fields (required for comprehensive level)
- Eyelids and adnexa (required for intermediate level)
- Pupils
- Iris
- Conjunctiva
- Cornea
- Anterior chamber
- Lens

Illustration by Art Studio and Gallery of Rudolf Stalder
Comprehensive Examination 92004-92014

- Includes 9 or more elements and:

  - History, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination.
  - It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry.
  - It always includes initiation of diagnostic and treatment programs.
Intermediate Examination 92002-92012

Includes 3 -8 elements and-

• Intermediate history
• General medical observations
• External ocular and adnexal examination
• If less than 3 elements are provided, then the service must be billed with an E/M code.

• ICD-9 Codes that Support Medical Necessity
  • In addition to the general documentation requirements and the specified number of elements necessary to report a particular level of service, the "reasonable and necessary" requirements for billing Medicare must also be met. Therefore, certain ICD-9 codes may not justify the "reasonable and necessary" criteria for reporting a particular level of service.
Intermediate and comprehensive ophthalmological services constitute integrated services in which medical decision making cannot be separated from the examining techniques used. Ophthalmological codes are appropriate for services to new or established patients when the level of service includes several basic routine optometric/ophthalmologic examination techniques, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, tonometry, and basic sensorimotor examination, that are integrated with and cannot be separated from the diagnostic evaluation.
Intermediate and Comprehensive

- Itemization of service components such as slit lamp examination, keratometry, routine ophthalmoscopy, retinoscopy, tonometry or motor evaluation is not applicable.
Included, Not Billed Separately

- Amsler Grid Test, Maddox Test
- Brightness Acuity Test
- Corneal Sensation
- Exophthalmometry
- General Medical Observation
- Glare Test
- History
- Keratometry
- Laser Interferometry
- Potential Acuity Meter (PAM)
- Schirmer's Test
- Slit Lamp Tear Film Adequacy
- Transillumination
Routine Eye Examinations

- Medicare does not cover routine eye examinations or refractions

For “statutory exclusions” (services never covered by Medicare) Advanced Beneficiary Notice (ABN) is not necessary

HOWEVER

- For patients with secondary insurance that may cover these services, a claim can be submitted to Medicare to obtain a formal “denial” of reimbursement
  - Explain Medicare coverage policy to the patient
  - Explain that patient has the choice of having the service
  - Indicate how much the patient will be financially responsible for
  - Append appropriate modifier (GY) if you need to obtain a denial from Medicare to process secondary insurance claim
Extended Services

- 92225 - Ophthalmoscopy, extended, with retinal drawing, with interpretation and report
- 92226 - subsequent
An extended ophthalmoscopy is appropriate when one of the following criteria are met:

A serious retinal condition exists or is suspected based on a routine ophthalmoscopy that requires further detailed studies such as:

- detailed study of a pre-retinal membrane;
- macular hole;
- clinically significant macular edema;
- 360° scleral depression;
- study of a retinal tear;
- detachment;
- uncontrolled glaucoma (in some instances where detailed drawings of the optic nerve and changes need to be documented);

- suspected retinal tear with sudden onset symptomatic floaters or vitreous hemorrhage; and,
- suspected wet age-related macular degeneration or central serous retinopathy
- proliferative diabetic retinopathy
- intraocular foreign body
- retinal vascular occlusion
- posterior vitreous detachment

Documentation supporting the medical necessity, including retinal drawings, should be legible, maintained in the patient’s medical record, and must be available to the carrier upon request. An extensive scaled drawing must accurately represent normal, abnormal and common findings such as; lattice degeneration, hypertensive vascular changes, proliferative diabetic retinopathy, as well as retinal detachments, holes, tears or tumors. Additionally, documentation specific to the method of examination (e.g., lens, instrument used) should be maintained in the medical record.
Contact Lenses

- Proper coding for contact lens exams?
  - Patient comes in for routine eye exam and CL fit, code 92004/14 and 92310. If a refraction was done also bill 92015.
    - 92310 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
  - First follow-up exam after the contact lenses are dispensed is included in the 92310, as its definition includes "medical supervision of adaptation".
  - Patient presents for a routine eye exam, doesn't want CL's at that visit, but decides a month down the road they now want CL's.
    - Code 92310 for the fitting and supervision of adaptation.
    - If medically necessary for a specific patient a limited examination to be sure no eye changes have occurred.
May report E/M or Ophthalmalogy codes
Bill the appropriate code for the level/type of service provided
Documentation must support the procedure code that is billed and must meet the requirements of the procedure code and medical policy
What is the definition of "new patient" for billing E/M services?

- "New patient" is a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., Procedure) from the same physician or another physician in the same group practice (same group NPI# and physician specialty) within the previous three years.
- An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.
- In 2012, the AMA CPT instructions for billing new patient visits include physicians in the same specialty and subspecialty. However, for Medicare E/M services the same specialty is determined by the physician's or practitioner's primary specialty enrollment in Medicare.
E/M Key Components

History (HX)- Subjective information
Examination (PE)- Objective information
Medical Decision Making (MDM)- Linked to medical necessity

The billable service is determined by the combination of these 3 key components with MDM often linked to medical necessity. For new patients all 3 components must be met or exceeded and established patient visits 2 of 3 are required to be met or exceeded. Often when downcoded for medical necessity it is determined that documented History and Exam exceeded what was necessary for the visit.
Elements of an E/M History

- The extent of information gathered for history is dependent upon clinical judgment and nature of the presenting problem. Documentation of the patient’s history includes some or all of the following elements:

  - **Chief Complaint (CC)**
    - WHY IS THE PATIENT BEING SEEN TODAY
  - **History of Present Illness (HPI),**
  - **Review of Systems (ROS),**
  - **Past Family, Social History (PFSH).**
History of Present Illness (HPI) A KEY to Support Medical Necessity to
in addition to MDM

- HPI is chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present or the status of chronic conditions being treated at this visit.
  - The HPI must be performed and documented by the billing provider for New Patients in order to be counted towards the New Patient level of service billed.

- Focus upon present illness!

- HPI drivers:
  - Extent of PFSH, ROS and physical exam performed
  - Medical necessity for amount work performed and documented & Medical necessity for E & M assignment
HPI

- Status of chronic conditions being managed at visit
  - Just listing the chronic conditions is a medical history
  - Their status must be addressed for HPI coding
    OR

- Documentation of the HPI applicable elements relative to the diagnosis or signs/symptoms being managed at visit
  - Location
  - Quality
  - Severity
  - Duration
  - Timing
  - Context
  - Modifying factors
  - Associated signs and symptoms
Review of Systems (ROS)

- 1 ROS documented = Pertinent
- 2-9 ROS documented = Extended
- 10 + = Complete (or documentation of pertinent positive and negative ROS and a notation “all others negative”. This would indicate all 14 ROS were performed and would be complete.)

Record positives and pertinent negatives. Never note the system(s) related to the presenting problem as "negative". When using "negative" notation, always identify which systems were queried and found to be negative.
Past, Family, and/or Social History

- **Past history:** the patient’s past experience with illnesses, surgeries, & treatments
- **Family history:** a review of medical events in the patient’s family, such as hereditary diseases, that may place a patient at risk
- **Social history:** age appropriate review of past and current activities

Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services.

Don't use the term "non-contributory"
### Scoring E/M History

**CHIEF COMPLAINT:**

| HPI (history of present illness) elements: (Extended also includes status of 3 or > chronic conditions) |
|---|---|---|---|---|
| Location | Severity | Timing | Modifying Factors | Brief (1-3) | Extended 4 or more |
| Quality | □ Duration | □ Context | □ Associated signs and symptoms | | |

**ROS (Review of systems):**

- □ Constitutional (wt loss, etc)
- □ Ears, nose, mouth, throat
- □ GI
- □ Integumentary (skin, breast)
- □ Endo

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<tr>
<th>None</th>
<th>Pertinent to problem (1 system)</th>
<th>Extended (2-9 systems)</th>
<th>** Complete</th>
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- Eyes: Card/vasc
- GU
- Neuro
- □ Hem/Lymph

- Resp: □ MS
- Psych
- □ All/immuno
- □ All others negative

**PFSH (past medical, family, social history) areas:**

- Past history (the patient’s past experiences with illness, operations, injuries and treatments)
- Family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk)
- Social history (an age appropriate review of past and current activities)

* Complete PFSH:
**10 or more systems, or some systems with statement all others neg.

2 hx areas: a) Estab pts. Office (outpt) care; domiciliary care; home care
b) Emergency dept c) Subsequent nursing facility

3 hx areas: a) New pts. Office (outpt) care; domiciliary care; home care
b) Consultations c) Initial hospital care d) Hospital observation
e) Comprehensive nursing facility assessments

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<tr>
<th>PROBLEM FOCUSED (PF)</th>
<th>EXP. PROB. FOCUSED (EPF)</th>
<th>DETAILED (D)</th>
<th>COMPREHENSIVE (C)</th>
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<tr>
<td>None</td>
<td>Pertinent (1 history area)</td>
<td>* Complete (2 or 3 history areas)</td>
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EXAMINATION

- 4 TYPES OF EXAMS
  - Problem focused (PF)
  - Expanded problem focused (EPF)
  - Detailed (D)
  - Comprehensive (C)

A cataract is an opacity of the normally clear lens which may develop as a result of aging, metabolic disorders, trauma or heredity.
EYE 1997 Examination

Test visual acuity (Does not include determination of refractive error)
- Gross visual field testing by confrontation
- Test ocular motility including primary gaze alignment
- Inspection of bulbar and palpebral conjunctivae

Examination of ocular adnexae including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes
- Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology
- Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film
- Slit lamp examination of the anterior chambers including depth, cells, and flare
- Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus

Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)

Ophthalmoscopic examination through dilated pupils (unless contraindicated) of:
- Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer

Posterior segments including retina and vessels (eg, exudates and hemorrhages)

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**Neurological/Psychiatric**

Brief assessment of mental status including:
- Orientation to time, place and person
- Mood and affect (eg, depression, anxiety, agitation)
1997 Eye Physical Exam Definitions

**Problem Focused (PF)**
- ‘97=Specialty and GMS: 1-5 elements identified by bullet.

**Expanded Problem Focused (EPF)**
- ‘97=Specialty and GMS: At least 6 elements identified by bullet.

**Detailed (D)**
- ‘97=Specialty: At least 12 elements identified by bullet (9 for eye and psyc)  
  GNS= At least 2 bullets from each of 6 areas or at least 12 in 2 or more areas.

**Comprehensive (C)**
- ‘97=Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area.
Medical Decision Making

DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE!!

Exchange of clinically reasonable and necessary information and the use of this information in the clinical management of the patient

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<th>Step 1:</th>
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<td>• Number of possible diagnosis and/or the number of management options.</td>
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<th>Step 2:</th>
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<tr>
<td>• Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.</td>
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<th>Step 3:</th>
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<td>• The risk of significant complications, morbidity, and/or mortality with the patient’s problem(s), diagnostic procedure(s), and/or possible management options.</td>
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Note: The 2 most complex elements out of 3 will determine the overall level of MDM
### Number of Diagnosis or Treatment Options – Identify Each That Effects Patient Care For The DOS

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<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
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<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max=2</td>
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<td>Est. Problem (to examiner) stable, improved</td>
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<tr>
<td>Est. Problem (to examiner) worsening</td>
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<tr>
<td>New problem (to examiner); no additional workup planned</td>
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<td>New prob. (To examiner); additional workup planned</td>
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<td><strong>Total</strong></td>
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### MDM Step 2

#### Amount and/or Complexity of Data Reviewed - Total the points

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<th>REVIEWED DATA</th>
<th>Points</th>
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<tr>
<td>Review and/or order of clinical lab tests</td>
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<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
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<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
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<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
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<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
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<tr>
<td>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</td>
<td>2</td>
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<td>Independent visualization of image, tracing or specimen itself (not simply review of report).</td>
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<td><strong>Total</strong></td>
<td><strong>40</strong></td>
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MDM Step 3: Risk

- The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.
  - DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

- Risk is assessed based on the risk to the patient between present visit and the NEXT time the patient will be seen by billing provider or risk for planned intervention.
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<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
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<tbody>
<tr>
<td><strong>Min</strong></td>
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<tr>
<td>One self-limited / minor problem</td>
<td>Labs requiring venipuncture</td>
<td>Rest Elastic bandages</td>
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<td>CXR  EKG/ECG  UA</td>
<td>Gargles  Superficial dressing</td>
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<td><strong>Low</strong></td>
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<td>2 or more self-limited/minor problems</td>
<td>Physiologic tests not under stress (PFT)</td>
<td>OTC meds</td>
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<tr>
<td>1 stable chronic illness (controlled HTN)</td>
<td>Non-CV imaging studies</td>
<td>Minor surgery w/ no identified risk factors</td>
</tr>
<tr>
<td>Acute uncomplicated illness / injury (simple sprain)</td>
<td>Superficial enemas</td>
<td>PT, OT</td>
</tr>
<tr>
<td></td>
<td>Labs requiring arterial puncture</td>
<td>IV fluids w/out additives</td>
</tr>
<tr>
<td></td>
<td>Skin biopsies</td>
<td></td>
</tr>
<tr>
<td><strong>Mod</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 &gt; chronic illness, mod. Exacerbation, progression or side effects of treatment</td>
<td>Physiologic tests under stress (stress test)</td>
<td>Prescription meds</td>
</tr>
<tr>
<td>2 or more chronic illnesses</td>
<td>Diagnostic endoscopies w/out risk factors</td>
<td>Minor surgery w/ identified risk factors</td>
</tr>
<tr>
<td>Undiagnosed new problem w/ uncertain prognosis</td>
<td>Deep incisional biopsies</td>
<td>Elective major surgery w/out risk factors</td>
</tr>
<tr>
<td>Acute illness w/ systemic symptoms (colitis)</td>
<td>CV imaging w/ contrast, no risk factors (angiogram, cardiac cath)</td>
<td>Therapeutic nuclear medicine</td>
</tr>
<tr>
<td>Acute complicated injury</td>
<td>Obtain fluid from body cavity (lumbar puncture)</td>
<td>IV fluids w/ additives</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 &gt; chronic illness, severe exacerbation, progression or side effects of treatment</td>
<td>CV imaging w/ contrast, w/ risk factors</td>
<td>Elective major surgery w/ risk factors</td>
</tr>
<tr>
<td>Acute or chronic illnesses that may pose threat to life or bodily function (acute MI)</td>
<td>Cardiac electrophysiological tests</td>
<td>Emergency surgery</td>
</tr>
<tr>
<td>Abrupt change in neurologic status (TIA, seizure)</td>
<td>Diagnostic endoscopies w/ risk factors</td>
<td>Parenteral controlled substances</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drug therapy monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DNR</td>
</tr>
</tbody>
</table>
Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2\textsuperscript{nd} circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid.

### Final Result for Complexity

<table>
<thead>
<tr>
<th></th>
<th>Number diagnoses or treatment options</th>
<th>( \leq 1 ) Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>( \geq 4 ) Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Highest Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>C</td>
<td>Amount and complexity of data</td>
<td>( \leq 1 ) Minimal or low</td>
<td>2 Limited</td>
<td>3 Multiple</td>
<td>( \geq 4 ) Extensive</td>
</tr>
</tbody>
</table>

| Type of decision making | STRAIGHT-FORWARD | LOW COMPLEX. | MODERATE COMPLEX. | HIGH COMPLEX. |
USING DIFFERENT LEVELS OF CARE

99233 *  
(PATIENT ADMITTED

99231 *  
(PATIENT DISCHARGED

99232 *  
(PATIENT HAS DEVELOPED MINOR COMPL.)

99233 *  
(PATIENT IS UNSTABLE)
Using Time to Code

Time shall be considered for coding an E/M level when greater than 50% of total Teaching Physician visit time is Counseling / Coordinating Care –

Total time must be Face-to-face for OP and floor time / face-to-face for IP
What Is Counseling / Coordinating Care (CCC)?

A Discussion of:

- Diagnostic results, impressions, and/or recommended studies
- Prognosis
- Risks and benefits of management
- Instructions for treatment and/or follow-up
- Importance of compliance

Required Documentation:

- Total time of the encounter
- The amount of time dedicated to counseling / coordination of care
- The nature of counseling/coordination of care

John Doe MR# 11122234
D.O.S. 9/15/014
Patient counseled regarding health risk, contraceptives, exercise, and usage of medication.
Counseling Time: 20min.
Total Encounter Time: 30min.
National ‘12 CMS Data For Speciality E/M

Optometry

99211: 1%
99212: 19%
99213: 49%
99214: 29%
99215: 1%

National Dist.
# Top Procedure Codes Billed in 2013

## Top 4 Procedure Non-eye Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>92083</td>
<td>VISUAL FIELD EXAM, EXTENDED</td>
<td>17%</td>
</tr>
<tr>
<td>92133</td>
<td>COMPUTERIZED OPHTHALMIC IMAGING OPTIC NERVE</td>
<td>7%</td>
</tr>
<tr>
<td>92015</td>
<td>REFRACTION</td>
<td>5%</td>
</tr>
<tr>
<td>92020</td>
<td>SPECIAL EYE EVAL, GONISCOPY</td>
<td>3%</td>
</tr>
</tbody>
</table>

## Top 5 E&M Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>OFFICE/OUTPT VISIT, EST</td>
<td>50%</td>
</tr>
<tr>
<td>99203</td>
<td>OFFICE/OUTPT VISIT, NEW</td>
<td>34%</td>
</tr>
<tr>
<td>99212</td>
<td>OFFICE/OUTPT VISIT, EST</td>
<td>12%</td>
</tr>
<tr>
<td>99204</td>
<td>OFFICE/OUTPT VISIT, NEW</td>
<td>4%</td>
</tr>
<tr>
<td>99205</td>
<td>OFFICE/OUTPT VISIT, NEW</td>
<td>2%</td>
</tr>
</tbody>
</table>

Total: 100.0%
Guidelines for Teaching Physicians, Interns, Residents and Fellows

For Billing Services, All Types of Services Involving a Teaching Physician (TP) Requires Attestations In EHR or Paper Charts
Evaluation and Management (E/M)

E/M IP or OP: TP must personally document at least the following:

- That s/he performed the service or was physically present during the key or critical portions of the service when performed by the resident; AND
- The participation of the teaching physician in the management of the patient.

Example: ‘I saw and examined the patient and agree with the resident’s note...’

Time Based E/M Services: The TP must be present and document for the period of time for which the claim is made. Examples:

- Critical Care Hospital Discharge (>30 minutes) or
- E/M codes where more than 50% of the TP time spent counseling or coordinating care
Unacceptable TP Documentation

- Assessed and Agree
- Reviewed and Agree
- Co-signed Note
- Patient seen and examined and I agree with the note
- As documented by resident, I agree with the history, exam and assessment/plan
RADIOLOGY AND OTHER DIAGNOSTIC TESTS

General Rule: The Teaching Physician may bill for the interpretation of diagnostic Radiology and other diagnostic tests if the interpretation is performed or reviewed by the Teaching Physician with modifier 26 in the hospital setting.

Teaching Physician Documentation Requirements:
Teaching Physician prepares and documents the interpretation report.
OR
Resident prepares and documents the interpretation report.
The Teaching Physician must document/dictate: “I personally reviewed the film/recording/specimen/images and the resident’s findings and agree with the final report.”

A countersignature by the Teaching Physician to the resident’s interpretation is not sufficient documentation.
Working With NP's and PA's (NPP's)

The NP or PA MUST BE AN EMPLOYEE OF THE PRACTICE AND CANNOT BE A HOSPITAL EMPLOYEE TO UTILIZE ANY OF THEIR DOCUMENTATION FOR PHYSICIAN BILLING AS SHARED

- Shared visit with an NPP may be billed under the physician's name only if:
  - The physician provides a face-to-face portion of the visit and
  - The physician personally documents in the patient's record the portion of the E/M encounter with the patient they provided.

- If the physician does not personally perform or personally and contemporaneously document their face-to-face portion of the E/M encounter with the patient, then the E/M encounter may only be billed under the PA/ARNP's name and provider number.

- Procedures must be billed under the performing provider & not the supervisor. They cannot be “shared”
Scribed Notes: Medicare Bulletin

- Record entries made by a "scribe" should be made upon dictation by the physician. A scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently or obtain any information independently except to ROS and PFSH. They cannot obtain the HPI, any portion of the PE or MDM.

- The scribe must note "written by xxxx, acting as scribe for Dr. yyyyy." Then, Dr. yyyyy should sign, indicating that the note accurately reflects work and decisions made by him/her.

- It is inappropriate for an employee of the physician to round at one time and make entries in the record, and then for the physician to see the patient at a later time and note "agree with above...".

- AAMC does not support someone “dictating” as a scribe by an NPP, as scribing is over the shoulder immediate documenter with no services personally performed by the scribe. In this case, the physician should be dictating their own visit. Scribes can do EMRs under their own password.
“Orders” Are Required For Any Procedure With a TC / -26 Modifier

An Optometrist Can Be The Ordering & Treating Physician

- The CPT descriptions of documentation requirements for many ophthalmic diagnostic tests include the phrase, ". . with interpretation and report." Once the appropriate individual has performed the test, you must document your interpretation of the results somewhere in the medical records. This doesn't have to be anything elaborate.
- It may merely be a brief phrase indicating if a test is "normal," "stable from a previous test" or "mild superior arcuate defect."
Diagnostic Interpretation Requirements

- All services billed for interpretation must include an order (even as a notation in the encounter note for the DOS) and distinct report for payment purposes.
- For Medicare, the Interpretation and Report needs the Three C’s to be addressed:
  - Clinical Findings,
  - Comparative Data and
  - Clinical Management.
- There must be a written report that becomes part of the patient’s medical record and this should be as complete as possible.
2014 CPT Code Changes

Special Ophthalmological Services

- **92100** Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)
  - (For monitoring of intraocular pressure for 24 hours or longer, use 0329T)
  - (Ocular blood flow measurements are reported with 0198T. Single-episode tonometry is a component of general ophthalmological service or E/M service)
2014 CPT Code Changes

92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
- (For specular microscopy and endothelial cell analysis, use 92286)
- (For tear film imaging, use 0330T)

92136 Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation
- (For tear film imaging, use 0330T)

- **Rationale:** Parenthetical notes have been added below codes 92132 and 92136 to instruct the use of 0330T for tear film imaging.
2014 CPT Code Changes

• **Rationale**
  • In support of the addition of new Category III code 0329T for 24-hour intraocular pressure monitoring, a parenthetical note was added after code 92100 to instruct the use of code 0329T when a monitoring device is fitted to the patient for continuous monitoring during a 24-hour period. Code 92100 represents a service that involves measurements taken at defined intervals during the course of a one-day patient session at one location utilizing a standard tonometer to assess the resistance of an applied force required to deform the natural corneal shape.
OTHER SPECIALIZED SERVICES

- External ocular photography with interpretation and report for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereo-photography)
  - (For tear film imaging, use 0330T)

- **Rationale:** In support of the addition of new Category III code 0330T for digital interferometry of the lipid layer of the tear film of the eye, a parenthetical note was added after code 92285 to instruct the use of code 0330T for tear film imaging.
Modifier Reminders

**Modifier 25**: Significant, Separately Identifiable E/M by the Same Physician/Group on the Day of a minor Procedure: on the day a procedure the patient's condition required a significant, separately identifiable E/M service above and beyond the usual care associated with the procedure that was performed.

*Usually an E&M service is included in the exam performed just prior to and during joint injections and/or EMGs. If the E&M service is a separate and identifiable service, the medical record must document medical necessity and modifier 25.*

**Modifier 59**: Distinct Procedural Service: Under certain circumstances, indicate that a procedure or service was independent from the services performed on the same day.
ICD-10 and Clinical Documentation

- Increased specificity of the ICD-10 codes requires more detailed clinical documentation to code some diagnoses to the highest level of specificity.
  - Coding and documentation go hand in hand
    - ICD-10 based on complete and accurate documentation, even where it comes to right and left or episode of care.
    - ICD-10 should impact documentation as physicians are required to support medical necessity using appropriate diagnosis code—this is not an easy situation.
  - Will not change the way a physician practices medicine
HIPAA
Final Reminders for All Staff, Residents, Fellows or Students

- **Health Insurance Portability and Accountability Act – HIPAA**
  - Protect the **privacy** of a patient’s personal health information
  - Access information for business purposes only and only the records you need to complete your work.
  - Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  - **PHI is protected even after a patient’s death!!!**
- **Never share your password with anyone and no one use someone else’s password for any reason, ever –even if instructed to do so.**
  - If asked to share a password, report immediately.
Any Questions
Available Resources at University of Miami, UHealth and the Miller School of Medicine

- If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  - Gemma Romillo, Assistant Vice President of Clinical Billing Compliance and HIPAA Privacy; or
  - Iliana De La Cruz, RMC, Director Office of Billing Compliance
    - Phone: (305) 243-5842
    - Officeofbillingcompliance@med.miami.edu

- Also available is The University’s fraud and compliance hotline via the web at www.canewatch.ethicspoint.com or toll-free at 877-415-4357 (24 hours a day, seven days a week).
- Office of billing Compliance website: www.obc.med.miami.edu