Plans for Coding in the Coming Year
John W. Lahr, O.D., FAAO

What’s New
- CPT definition updates
- Multiple Procedure Payment Reductions
- DMEPOS Fee

Diagnosis Codes-International Classification of Diseases (ICD)
- Use most detailed and specific code(s) possible for each submission
- List all pertinent diagnosis for each patient for most claims
- Some medical plans reject refractive diagnosis
- Some vision plans reject medical diagnosis
- Avoid xxx.9 codes (garbage codes) whenever possible
  List primary diagnosis first and others after

ICD-10
Implementation moved back to October 1, 2014
Details and changes
Managing the transition

V-Diagnosis Codes
V42.5-Corneal transplant
V43.1-Pseudophakia
V58.69-Encounter-long-term (current use) of other (high risk) medications
V65.5-Person with feared complaint in whom no diagnosis was made
V67.51-Follow-up exam following completed treatment with high risk medication

Diabetes Codes
250.0x and 250.5x
Diabetes retinopathy required on line following 250.5x

Why All the Interest in ICD Codes
- Outside the US, providers list 6-10 ICD codes per encounter
- ICD codes, per definition, are to report what is observed as well as obtained via history, medications, etc.
- There are 3.6x more eye exams per year than physical examinations
- ICD reporting allows early identification of high-risk health care conditions

Why Submit ICD Codes
- Many plans are adding this to requirements in Provider Manuals-Continued participation in plans
- Opportunity to allow your patients to have improved overall health
- With changing models of deliver, Eye Care Professionals can be leaders in change to complete ICD reporting
- Pay for performance is coming in all areas of health care and impacting overall health can be powerful

Eye Exam Codes
920x4-Comprehensive
CPT 2013 Definition: “… describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmological 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.”

920x2-Intermediate
CPT 2013 Definition: “… describes an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily related to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated: may include the use of mydriasis for ophthalmoscopy.”

S-Codes
New HCPCS Codes-How to Use
Medicare and other Federal Payers do not recognize S-codes
May be useful for private payers or self-pay patients when no other option available
- S0620-Routine comprehensive ophthalmological exam including refraction-new patient
- S0621-Routine comprehensive ophthalmological exam including refraction-established patient

Evaluation/Management Codes
99xxx-Site of Service Specific
Levels of Service
Generally 3 to 5 levels per site

Seven Components:
Three key components
- History
- Examination
- Medical decision-making
Three contributory components
- Counseling (Not always needed)
- Coordination of care (Not always needed)
- Nature of presenting problem
- Time

History
4-levels
Body Organ Systems
History of Present Illness (HPI)

Examination
Problem Focused-1-5 elements of exam documented
Expanded Problem Focused-6 elements of exam documented
Detailed-9 elements of exam documented
Comprehensive-all elements of exam documented

Documentation of Exam Elements
- Visual acuity
- Pupils and iris
- Bulbar and palpebral Conjunctiva
- Slit lamp exam cornea
- Slit lamp exam-AC
- Optic nerve
- Neurological (Time/Place/Person)
- Confrontation VF
- Adnexa
- Extra-ocular muscles
- Slit lamp exam-lens
- IOP
- Posterior segment
- Psychiatric: (Depression/Anxiety/Agitation)
Medical Decision Making
Complexity of Data
- Diagnostic tests ordered, scheduled, planned or performed
- Review of diagnostic tests
- Obtain previous records or extended history
- Relevant findings from previous records or extended history
- Communications with other physician(s)
- Independent interpretation of previous tests, images or studies

Medical Decision Making
- Minimal
- Low
- Moderate
- High

Documentation Guidelines
Obtain a copy of the proposed guidelines and stay in touch

CMS E/M Services Guidelines

E/M Coding and Billing for Medical Follow-up Visits

Consultation Codes and Guidelines

Special Ophthalmological Services
- Interpretation and Report

Resources
- AOA-Codes for Optometry-800-365-2219
- www.cms.gov