Providing Retina Services in a General Ophthalmology Practice

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Financial Disclosure

Warren Laurita – Speaker for Regeneron and Allergan

Financial Disclosure

Mary Pat Johnson is a consultant for Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

Need vs Desire

A. Need -
   1. Is there a lack of retina services in the community
   2. Is there significant patient volume
      a. 2 to 5 new patients per half day
      b. 15 to 20 established patients per half day

B. Desire –
   1. Provide total ophthalmic care
   2. One stop care - marketing

Types of Arrangements

A. Rental
   Pre-established rent
   1. Includes
      a. Space
      b. Equipment
      c. Some Staff
   2. Functions as a Retina Group Office – retina bills

B. Leased Employee
   Physician is leased to General Group
   1. Payment is made to Retina Practice
      a. Flat Fee
      b. Percentage
   2. May or may not include leased staff
   3. Functions as general with retina service – general bills

C. Hired Physician (part time)
   Physician becomes employee of General Practice – general bills

Types of Arrangements

A. Governmental Regulations
   1. Fair Market Value
   2. The contract must be for a minimum of one year
   3. The contract cannot be ‘evergreen’
      a. The contract must be reviewed / negotiated annually
      b. The fair market value must be re-determined annually
Space

A. Appropriate space must be available on a consistent basis
   1. Waiting room and sub waiting room
   2. Work-up rooms
   3. Exam rooms
   4. Procedure / injection rooms
B. Space requirements varies from general
   1. Sub waiting
   2. Injection rooms
C. Variation in patient flow
   1. Bottlenecks
      a. Fluorescein Angiography
      b. Injections
   2. Typical age of patients
      a. Respond slower
      b. Longer responses
      c. Move slower

Equipment and Supplies

A. Equipment
   1. Slit lamps
   2. Camera
      a. Fluorescein Angiography
      b. Fundus Photos
   3. OCT
   4. Laser
      a. Argon
      b. PDT
   5. Indirect
   6. Refrigerator
B. Supplies
   1. Fluorescein
   2. Intracocular drugs for injection
      a. Avastin
      b. Lucentis
      c. Eylea

Equipment and Supplies – cont..

A. Drug inventory System
   1. Ordering of Drugs
      a. Receiving and refrigerating
      b. Logging into system
   2. Tracking utilization
      a. Patient
      b. Drug
      a. Eye
      b. Lot number
   3. Payments
      a. Match payments received to each drug
      b. Tracking payment of Invoices
B. Electronic Medical Records System
   1. Retina Physician must learn new EMR system (leased or employed)
   2. Retina staff must learn new EMR system (leased)

Staff

Reception
Typically provided by General Practice
   1. Always present to make appointments
   2. Require proper training for scheduling retina patients
      a. Proper spacing for new and established patients
      b. Direct injection patients
      c. Patients receiving procedures
   3. Providing training
      a. When
      b. Where
      c. By whom
   4. Benefit Investigation for Injectable
      a. Prior authorization requirements
      b. Drug co-pay and deductibles
   5. Confirmation of patients

Technicians
   1. Work-up technicians typically provided by general practice
      a. Require training to perform retina work-ups
         i. When
         ii. Where
         iii. By whom
   2. Followers (Scribes) if from general
      a. Must be trained for following in retina
         i. When
         ii. Where
         iii. By whom
      b. Must learn all retina terminology
      c. Must learn injection preparation and assistance
   3. Followers (Scribes) if from retina
      a. Must learn general EMR
      b. Must adopt to environment
Staff cont..
A. Work Place Culture
1. Who is in charge?
2. Pace of work
3. Responsibilities
4. Expectations
   a. By general staff (retina staff if present)
   b. By retina physician

B. Staff Cooperation
1. With retina physician
2. With retina group staff (if present)
3. General physicians with retina physician

Goals and Expectations
A. General Practice
1. Provide retina care
   a. Better service to patients
   b. Better marketing position
2. Utilize vacant space
   a. Use office space when vacant (i.e. in surgery)
   b. Offset cost
3. Generate additional revenue

B. Retina Practice
1. Expand patient catchment area
2. Maximize available treatment time
3. Protect referral base

Thank You
for your attention
Coding and Billing for Retina Services

Mary Pat Johnson, COMT, COE, CPC, CPMA
Senior Consultant
Corcoran Consulting Group

Objectives
- Practice patterns
- Exam Coding
- Documenting Tests
- Procedure Billing Challenges
  - Intravitreal injections

Office Visits
Medicare Utilization Patterns Ophthalmology (18)

<table>
<thead>
<tr>
<th>CPT</th>
<th>New Patients</th>
<th>λ</th>
<th>CPT</th>
<th>Established Patients</th>
<th>λ</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>Level 5 E/M</td>
<td>2%</td>
<td>99215</td>
<td>Level 5 E/M</td>
<td>1%</td>
</tr>
<tr>
<td>99204</td>
<td>Level 4 E/M</td>
<td>29%</td>
<td>99214</td>
<td>Level 4 E/M Comprehensive Eye</td>
<td>54%*</td>
</tr>
<tr>
<td>92003</td>
<td>Level 3 E/M Comprehensive Eye</td>
<td>62%*</td>
<td>99213</td>
<td>Level 3 E/M Intermediate Eye</td>
<td>42%*</td>
</tr>
<tr>
<td>99202</td>
<td>Level 2 E/M Intermediate Eye</td>
<td>6%*</td>
<td>99212</td>
<td>Level 2 E/M</td>
<td>3%</td>
</tr>
<tr>
<td>99201</td>
<td>Level 1 E/M</td>
<td>&lt;1%</td>
<td>99211</td>
<td>Level 1 E/M</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

*Combined utilization of E/M and eye codes
Source: CMS data 2014, 18 - Ophthalmology

CHIEF COMPLAINT (CC)
The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s words.

The medical record should clearly reflect the chief complaint.

Source: 1997 Evaluation and Management (E/M) Guidelines
Office Visit
Diabetic Retinopathy

CC: Pt here for retina check
Hx: No changes

Dx: BDR OU
Exam: CE, DFE

Tx: Return to PCP to check
BS; RTO 6-9 mo or sooner
if VA↓

Claim = Not a covered service
Patient Pay

Office Visit
Diabetic Retinopathy

CC: Pt here for retina check
Hx: No changes

Dx: BDR OU
Exam: CE, DFE

Tx: Return to PCP to check
BS; RTO 6-9 mo or sooner
if VA↓

EMR hiccups

• 65 year old male presented for evaluation of existing condition, GLAUCOMA in both eyes for several years. The timing is described as all the time. Quality is fixed. Relief is experienced from using drops as directed. Patient described the following signs and symptoms: none currently to report.

• 66 year old male complains of blur at near in both eyes. The timing is described as all the time. Quality is unchanging. Context is reported without glasses.

Target for Scrutiny
E/M: Potentially Inappropriate Payments

“We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported.”

Source: HHS OIG FY 2013 Work Plan

E/M Pre-Payment Review

• J1 Part B Service Specific Complex Pre-Payment Review Notice for CPT Code 99204: E/M Initial Office Visit Services for Provider Specialties 01, 04, 08, 18, 25, 48 and 66 in Northern California and Southern California

• J1 Part B Service Specific Complex Pre-Payment Review Notice for CPT Code 99204: E/M Initial Office Visit Services for Provider Specialty Codes 11 and 18 in Nevada, Hawaii and the Islands

Source: http://www.palmettogba.com
E/M Coding

• 99204 New Patient Level 4 E/M Code
  • Comprehensive history
  • Comprehensive examination
  • Medical decision making of moderate complexity
  • 3 of 3 components required

Source: CPT Manual

• 99205 New Patient Level 5 E/M Code
  • Comprehensive history
  • Comprehensive examination
  • Medical decision making of high complexity
  • 3 of 3 components required

Source: CPT Manual

E/M vs Eye Codes

E/M Codes
- Complicated
- 2+ pages needed
- 5 levels of service
- Wide range
- Universal
- Used ~ 30%

Eye Codes
- Simple definitions
- Easy documentation
- 2 levels of service
- Higher reimbursement
- Not universal
- Used ~ 70%

Common Ophthalmic Tests

Medicare Utilization Patterns (18 - Ophthalmology)

<table>
<thead>
<tr>
<th>CPT</th>
<th>Procedure</th>
<th>A</th>
<th>CPT</th>
<th>Procedure</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>92134</td>
<td>Scanning Laser (retina)</td>
<td>23%</td>
<td>92250</td>
<td>Fundus Photo</td>
<td>8%</td>
</tr>
<tr>
<td>9222x</td>
<td>Ext Ophthalmoscopy</td>
<td>16%</td>
<td>92235</td>
<td>Fluorescein</td>
<td>6%</td>
</tr>
<tr>
<td>9208x</td>
<td>Perimetry</td>
<td>11%</td>
<td>92020</td>
<td>Gonioscopy</td>
<td>3%</td>
</tr>
<tr>
<td>---</td>
<td>Biometry (A or OCB)</td>
<td>8%</td>
<td>95004</td>
<td>Allergy testing</td>
<td>2%</td>
</tr>
<tr>
<td>92133</td>
<td>Scanning Laser (optic nerve)</td>
<td>8%</td>
<td>76514</td>
<td>Pachymetry</td>
<td>2%</td>
</tr>
</tbody>
</table>

Frequency is per 100 office visits (%) on Medicare beneficiaries
Source: CMS data (2014), 18 – Ophthalmology

Diagnostic Tests

• Physician's order
  • Date of service
  • Reliability of test
  • Patient cooperation
  • Findings
  • Assessment
  • Impact on treatment
  • Physician's signature

Test Interpretation

• What does it show?
  • Increased edema RT macula from last OCT
• What does it mean?
  • Worsening edema/wet AMD
• What are you going to do about it?
  • Avastin injection
Interpretation & Report

“Carriers generally distinguish between an ‘interpretation and report’ of an x-ray or an EKG procedure and a ‘review’ of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete written report similar to that which would be prepared by a specialist in the field does not meet the conditions for separate payment of the service. This is because the review is already included in the … E/M payment.”

Source: CMS MCPM Chapter 13, §100

Interpretation & Report

“For example, a notation in the medical records saying ‘fx tibia’ or ‘EKG-normal’ would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An ‘interpretation and report’ should address the findings, relevant clinical issues, and comparative data (when available).”

Source: CMS MCPM Chapter 13, §100

Top 10 Ophthalmic Procedures

<table>
<thead>
<tr>
<th>Rank</th>
<th>CPT</th>
<th>Procedure</th>
<th>Rank</th>
<th>CPT</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>67028</td>
<td>Intravitreal Injection</td>
<td>6</td>
<td>66982</td>
<td>Complex Cataract</td>
</tr>
<tr>
<td>2</td>
<td>66984</td>
<td>Cataract w/IOL</td>
<td>7</td>
<td>65855</td>
<td>Lx Trabeculoplasty</td>
</tr>
<tr>
<td>3</td>
<td>66821</td>
<td>YAG Capsulotomy</td>
<td>8</td>
<td>15823</td>
<td>Blepharoplasty</td>
</tr>
<tr>
<td>4</td>
<td>68761</td>
<td>Punctum plug</td>
<td>9</td>
<td>66761</td>
<td>Laser PI</td>
</tr>
<tr>
<td>5</td>
<td>67820</td>
<td>Epilation</td>
<td>10</td>
<td>67210</td>
<td>Focal Laser</td>
</tr>
</tbody>
</table>

Source: CMS data 2014, 18 - Ophthalmology

Minor vs. Major Surgery

Minor procedure
• Post-operative period of 0 or 10 days

Major Procedure
• Post-operative period of 90 days

Source: Medicare Claims Processing Manual, Chapter 12, §40.1E

Minor Procedure

• Included in surgery package
• Same day exam usually bundled
• Significant Evaluation and Management Service
• Append exam with modifier 25

Source: Medicare Claims Processing Manual, Chapter 12, §40.1C

Modifier 25 vs. Modifier 57

“Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery”

If evaluation and management services occur on the day of surgery, the physician bills using modifier “-57”, not “-25”. The “-57” modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.”

Source: Medicare Claims Processing Manual, Chapter 12, §40.2A4
**Modifier 25**

“Significant Evaluation and Management Service on the Day of a Procedure”

It is used to report a significantly, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed.”

Source: Medicare Claims Processing Manual, Chapter 12, § 40.2.A8

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**Nov 2012 AAO Coding Bulletin**

“A frequently asked question is: Isn’t modifier -25 associated with minor procedures in the same way that modifier -57 is associated with a decision for a major surgery? The answer is no. Modifier -25 does not indicate it is the visit to determine the need for a minor surgery.”

“If the need for the intravitreal injection has been established at an earlier visit and the patient is in the office solely to be injected, an E&M or Eye code service should not be billed.”

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**Modifier -25**

- Use modifier -25
- Decision for surgery
- Only one reason for exam
- Two or more problems
- OD vs. OS
- Anterior vs. posterior seg
- Eye vs. systemic dx
- Multiple eye conditions
- Don’t use modifier -25

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**Drug Overfill**

Can we use a single vial of Lucentis for bilateral injections?

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**Aflibercept (Eylea)**

First Coast Service Options – FL Medicare (3/21/12)

Payment for Eylea® is for the entire content of the single-use vial, which is labeled as providing a 2 mg dose of aflibercept. Each vial should only be used for the treatment of a single eye. If the contralateral eye requires treatment, a new vial must be used and the sterile field, syringe, gloves, drapes, eyelid speculum, filter, and injection needles must be changed before Eylea® is administered to the other eye. After injection, any unused product must be discarded.

Source: http://medicare.fcso.com/Coverage_News/232489.asp

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**Discarded Drugs and Biologicals**

Recent Questions:

- The vial contains more drug than necessary to treat a single patient. What about the overfill?
- Is each dose including the overfill, if used for another patient (s), also reimbursable at $1,961?
**Discarded Drugs and Biologicals**

"The CMS encourages physicians, hospitals and other providers and suppliers to care for and administer to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner. When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label."

*Source: MCPM 17 §40 Discarded Drugs and Biologicals*

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**Managing Overfill**

"Any excess product (that is, overfill) is provided without charge to the provider. In accordance with our current policy as explained above, providers may not bill Medicare for overfill harvested from single use containers, including overfill amounts pooled from more than one container, because that overfill does not represent a cost to the provider. Claims for drugs and biologicals that do not represent a cost to the provider are not reimbursable, and providers who submit such claims may be subject to scrutiny and follow up action by CMS, its contractors, and OIG."


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**Summary**

- Adding a subspecialist can impact many aspects of the practice
  - Staffing levels and training
  - Patient scheduling
  - Allocating space
  - New services and medications
  - Change in billing patterns
- Prepare in advance

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**Additional Assistance**

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Mobile application: Corcoran 24/7