Health Care Reimbursement: Something Old, Something New, Something Rotten Makes Us Blue…STILL

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Financial Disclosures Joe DeLoach, OD, FAAO

I Have Received Honoraria From or Served as a Consultant for: (Partial Listing)

- Vision Source
- Alcon
- Carl Zeiss Meditec
- Optos
- Diopsys
- Kowa
- Optovue
- AllDocs
- OfficeMate
- Marco
- TSO
- NVision
- Cleinman Partners
- Vision Trends
- Konan
- Essilor of America
- Today's Vision
- Pearle Vision / SNAPP
- Vision West
- AACO
- UHCO, NOVA, RSO, UAB, Berkeley, *and other colleges*

Over half the state optometric associations in the United States

Practice Compliance Solutions – President and CEO
Former Clinical Professor – University of Houston College of Optometry

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ADDITIONAL DISCLAIMERS

I am a consultant and contract auditor for CMS and several major medical payers.

Policies presented/discussed are specific to your state and predominantly based on Medicare, CPT and Federal Fraud and Abuse guidelines. Individual payer policies are unique, regional and sometimes not clearly published.

Any fees presented in this presentation are the average North Texas Medicare allowable fees. Fees presented are in no way designed to state any acceptable fee or suggest to any provider they charge certain fees

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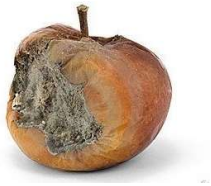
Let's start in reverse….

What's Rotten?



We covered some of this back in 2018. Fortunately, or unfortunately, the facts on medical reimbursement are much like facts on ethics courses….***some things just don't change!***

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The Bipolar World of Coding *"Experts"*

Practice Centric Care	**Patient** Centric Care
MAXIMIZE your revenue	Do what's right for the patient and the money will follow
Do what puts the most money in the bank	Use common sense
MAXIMUM use of examinations, testing and technology	Medically necessary use of examinations, testing and technology
Twist the system in an attempt to get around the rules	95% of rules are pretty clear – just follow them
RESULT	**RESULT**
Indefensible care – often "worthless" per CMS	Defensible, medically necessary care
Massive audit exposure	Minimal audit exposure
Doctors getting severely hurt	Make as much or more money just doing what's right
Sleepless nights	Sleep like a baby

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So there are tons of coding "experts" out there…remind us if we should consider listing to you…

- Recognized national authority / lecturer for 25 years *(big deal)*
- Chairman emeritus of Texas Optometric Association Third Party Committee *(so what)*
- Consultant to industry - *OPTOS, others (probably important)*
- Run a company that provide RCM management *(could be important)*
- Consultant to Medicare *(hmmmm….)*
- Serve on Medicare Carrier Advisory Committee for 20 years *(likely important)*
- Contract auditor for Medicare and medical payers ***(IMPORTANT)***

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Why the focus on fraud and abuse?
Latest really bad data…

- 2019 Medicare fraud and abuse - $60 BILLION
- 2019 Medicaid fraud and abuse - $140 BILLION
- 2019 total fraud and abuse (RAND Study) - >**$290 BILLION**
- ***But surely optometry is not a problem….***
  - **2016 CERT study puts us at #10**
  - **2020 we got better - #32**
  - **But in DME claims – we are #1**

Down $5 billion from three years ago…woohoo!!

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What did CERT say?

Both cases….main issue is lack of documented medical necessity

THINGS THAT APPLY TO US

THIS EXCLUDES THE CROOKS…**THIS RELATES TO AVERAGE OPTOMETRY BILLING!**

SERVICE	PERCENT IMPROPER PAYMENT	MAIN REASON
Diagnostic Testing	16.3%	Insufficient documentation
Minor Procedures	12.8%	Insufficient documentation
New Office Visits	12.7%	Incorrect coding
Established Office Visits	6.6%	Incorrect coding

Both cases….main issue over-coding

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And that DME thing…#1? *WHY?*

? Do you know the rules regarding provision of ophthalmic good under Medicare/Mediaid?

? Do you know you have a checklist of things you must have in your office if a DME inspector shows up **(and in 2021 CMS has an outside contractor doing that very thing!)**?

? Do you know your warranty obligations under DME?

? Do you know what your patient has to sign when you dispense DME ophthalmic goods to them?

Didn't think so…*you should talk to your compliance company*

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Why are optometrists messing up?

Poor/no understanding of the two core concepts of medical billing

1. Reason for the visit
2. Medical necessity

Greed *(there, I said it)*

1. **Too much time on blogs - #1 source of coding mis-information**
2. Too much time trying to "get around" the rules

BIG ISSUE: WE SIMPLY WEREN'T TAUGHT THE DIFFERENCE BETWEEN WELLNESS CARE AND MEDICAL CARE!

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Sources of our sadly earned reputation

- Our education
- "Experts"
  - Podium Experts – "I'm an expert because *(I'm on **the** committee; I read a lot; I'm entertaining)*"
  - Company Experts – "I'm an expert because *(Our medical director endorses this; I can make you money)*"
  - Blog Experts – "We're ALL experts ***because we say so***"
- Creative billing – ***"We're getting paid!"***
- Crooks *(more on that later…)*

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Who Conducts Audits In Our World of Optometry

In order of activity, *not severity or fairness…*

1. Medicare *(focus on fraud – typically fair, severity based on "crookedness")*
2. VSP *(rarely fair and very severe – hear about California????)*
3. Aetna *(looking for anything – King of payment policies)*
4. BCBS *(fair is a four letter word)*
5. EyeMed *(pretty fair and not too severe – unless…)*
6. On the horizon…**Medicaid**

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The Four Reasons You WILL Be Audited

? You stood out

? Someone doesn't like you

? It's your turn

? You're a crook

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There's new crooks in town…Per CMS

Actions now considered as FRAUD

(amended February 2017*)

1. Upcoding claims *(in our case, Level 4/5 EM codes and overuse of Comprehensive Ophthalmologic codes 92004/14 – more later)*
2. Waving copays
3. Waving deductibles

* www.gpo.gov/fdsys/pkg/FR-2017-01-12/pdf/2016-31390.pdf

The "outliers" in our profession make us all look bad

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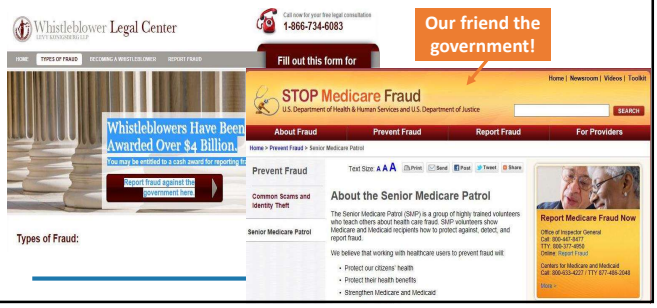
How about this – Everyone wants to help



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Sources of Coding *Truth*!

www.cms.gov (Medicare)

www.noridianmedicare.com
Jurisdiction F *(that's you)* Carrier

www.*whoever-medicalpayor*.com

CPT and ICD-10 Manuals

www.CodeSAFEPLUS.com

www.practicecompliancessolutions.com

And a handful of folks crying out in the wilderness – Chris Wolfe, Clarke Newman, John Rumpakis, me…

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Real Definition of Reimbursement

"Reimbursement is the money you keep when the auditor leaves"

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Ever read what you sign?

"In submitting this claim for payment from federal funds, I certify that 1)the information on this form is true, accurate and complete 2)I have familiarized myself with all laws, regulations and program instructions available from the Medicare contractor 3)I have provided or can provide sufficient information required to allow the government to make an informed eligibility and payment decision 4) this claim complies with all Medicare program instructions and…"

lists all five Federal F/A laws most of you can't name!

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So what are they???

- False Claims Act *(granddaddy of them all)*
- Anti-Kickback Statute
  - And 2019 - the Eliminating Kickbacks in Recovery Act (EKRA)
- Self Referral Law
- Exclusion Statute
- Civil Monetary Penalties Law

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But first….the most important concepts to understand

The PILLARS OF REIMBURSEMENT

- Reason for the visit
- Medical Necessity

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What Is The Reason for the Visit - RFV

- Simple concept…it is why THE PATIENT is seeking care from you TODAY *(not what care YOU want to deliver)*

Understanding this concept is fundamental to the whole process of medical reimbursement

- Do not address the reason for the visit, an auditor can/will deny the entire encounter as not medically necessary
- **It doesn't matter what YOU want to do, the only reimbursable care is that which answers the RFV!**

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LIKELY MORE COMMON EXAMPLE OF MEDICAL REIMBURSEMENT THAT MAY OR MAY NOT BE!

68 y/o, female, new patient presents for routine examination. Only complaint is she is having more trouble seeing her bible. You find her PAL to be measured low - pushes them up vision is perfect. The rest of the examination is completely normal except her pressure is 26mmHg OU. You run OCT, VF, pachymetry and corneal hysteresis and file with Medicare with diagnosis ocular hypertension.

Is this office visit reimbursable?
Are the diagnostic tests reimbursable?

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NO!!! PROVE THAT? NO PROBLEM…

The Medicare Carriers Manual, Part 3 §2320 reads

"The coverage of services rendered by a physician is dependent on the ***purpose of the examination rather than on the ultimate diagnosis of the patient's condition****… when a beneficiary goes to his/her physician for an eye examination* ***with no medical finding specific to the reason for the visit****,* ***the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathologic condition****."*

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Per CPT, what can qualify as a medical reason for the visit

1. Symptoms
2. Direction
   1. From the patient
   2. From another health provider
   3. From the attending physician

AND WORDS MATTER!!!

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Summary - Reason For the Visit

Unless dictated by the patient's payor or unless you have to fulfill some mindless requirements of your state law or vision plan, you perform a symptom oriented exam just like the rest of the medical world does

It's SO SIMPLE…how does the rest of the health care world do it???

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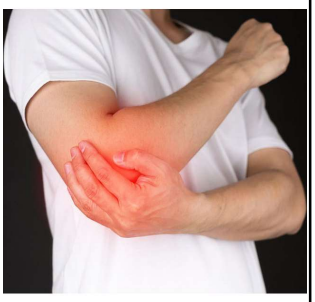
This is so simple!

"Doc…my elbow hurts!"



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Medical Necessity

- Medical necessity is the ONLY justification for reimbursement for services rendered
- Specifically it dictates whether actions or testing are "necessary" in the patient's care
- Medical necessity by law can ultimately be **determined** only by the attending physician, but operationally is often **dictated** by payor payment policy

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Medical Necessity - Several Definitions

The easiest for me to understand

Will the results of this examination or testing influence or dictate my diagnosis and/or treatment of the patient?

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Medical Necessity vs Payment Policy

Payor Payment Policy Based On

- Preferred Practice Patterns
- Established standards of care
- Scope of licensure
- Opinions / bias of payment determination panel
- Intangibles / unknowns / cost **(big and getting bigger)**

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Essential concept in medical reimbursement

Medical necessity ≠ Insurance benefits

If medically necessary – SOMEONE pays!

(because the rules say so, no Joe)

MDs never have a problem with this concept. ODs don't seem to have a problem with that concept when it comes to upselling products in the optical the patient has to pay for out of pocket (ouch!)

Why is medical care different?

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Bottom line…

If you fully understand the **TECHNICAL** and **ETHICAL** concepts behind **reason for the visit** and **medical necessity**…

You are about 95% home free on everything related to medical reimbursement

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So…

Myths, Legends, Truth and Lies in Optometry Medical Reimbursement

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#1 - Upcoding EM

Let's start with just the facts…

SERVICE CODE		CMS AVERAGES	OPTOMETRY AVERAGES
Level 2 E/M	New /Established	20% / 9%	2% / 5%
Level 3 E/M	New /Established	44% / 57%	38% / 48%
Level 4 E/M	New /Established	25% / 28%	**56% / 39%**
Level 5 E/M	New /Established	8% / 3%	4% / **8%**

These percentages will change a little bit under the new EM system

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THE CARE DICTATES THE CODE

What the LAW says:

The individual patient presentation or what you have them returning for determines everything that you do with them, and therefore determines the services performed and the subsequent coding of those services.

THIS IS THE WAY IT WORKS

1. Why is the patient here
2. What do I do to answer that need
3. What code(s) represent the care I delivered

NOT THE OTHER WAY AROUND!!!

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Historically Why Over-Estimation? *PERTINENT*

1. Over-estimation of history – because not pertinent
2. *Over-estimation of examination – because not pertinent*
3. *Over-estimation of medical decision making based on #1, #2 and overall misunderstanding of EM system*

NOW ONLY THIS COUNTS!

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DID ALL THIS REALLY CHANGE?

Yes it did!

But do YOU understand it?

As a gift to Utah, PCS is giving you access to the PCS explanation and instructions on the EM code changes. Whether you think you understand them or not, PLEASE take advantage of this information which we know to be correct.

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Changes in E/M coding system

- Determination of code level based TOTALLY on the complexity of medical decision making
- Rules for new patient same as an established patient
- This will likely result in the following expected % changes
  - **Level 2 – down, est. 15%**
  - **Level 3 – somewhat down, est. 35%**
  - **Level 4 – UP, est. 40%**
  - **Level 5 – somewhat up, est. 12%**
- ***Estimated minimum 18% raise using E/M vs Ophthalmologic codes***
- Definition of time changed, but unless you are doing low vision or vision rehab, billing based on time will cost you money

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What else? All the codes have new definitions…and every one of them requires a "medically appropriate history and examination"….*MEANS WHAT?*

For services to be adjudicated as reimbursable…you must pass two tests:

MEDICAL NECESSITY

Medically appropriate history/examination

COMPLETE REQUIREMENTS OF CPT DEFINITION

You MUST understand the new system of medical decision making

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MEANS WHAT???

Basic tenet of reimbursement DOES NOT CHANGE

1. The ONLY services you are legally allowed to be reimbursed for are those **BASED ON THE REASON FOR THE VISIT**
2. Medical decision making is defined by the **medically necessary services provided based on the reason for the visit**

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EASY guide to new E/M system in just four slides

(Put them on your exam wall…in no time you will be an expert!)

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Summary Level 2

MUST MEET TWO OF THREE

CPT Code	MDM Level	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity
99202/12	**Straightforward**	**Minimal** 1 self-limiting or minor problem	**Minimal to none**	**Minimal risk** of morbidity from additional testing or treatment

OBVIOUS CONCLUSION: Under the new system, it takes very little to meet the requirements of a Level 2 service

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Summary Level 3

MUST MEET TWO OF THREE

CPT Code	MDM Level	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity
99203/13	**Low**	**Low** 2 or more self-limiting or minor problems **-or-** 1 stable chronic illness **-or-** 1 acute, uncomplicated illness or injury	**Limited (must meet 1)** Category One Order and review of tests you ordered and reviewed, **or** Additional external documents analyzed Category Two Assessment by Independent Historian	**Low risk** of morbidity from additional testing or treatment

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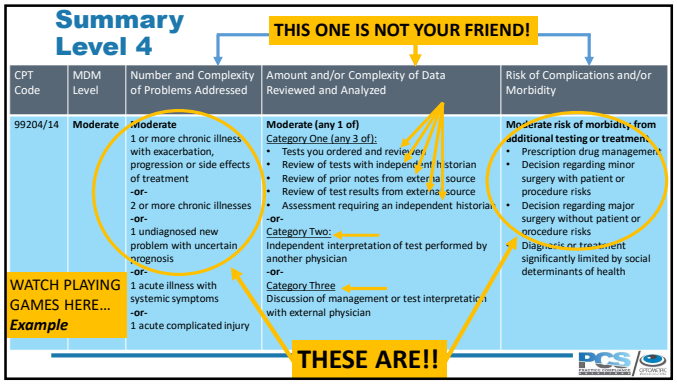

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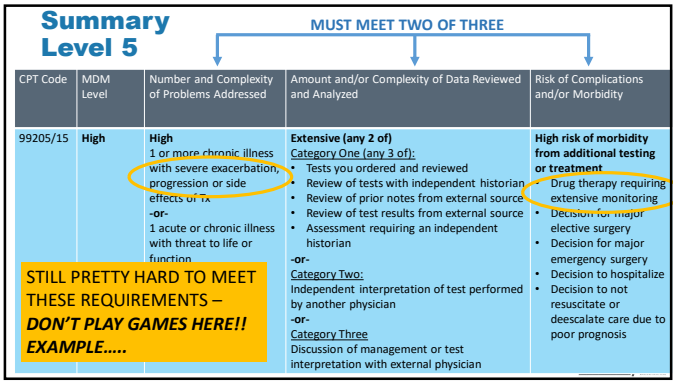

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BIG POINT

- Your "coding assistant" in your EMR was highly questionable prior to January 1, 2021
- You may officially consider them **USELESS** at this point
- At current level of technology, **there is NO WAY your EMR can determine medical decision making and now, that is ALL that matters in code level determination**

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#2 – Overuse of Comprehensive Ophthalmologic Code

More of just the facts…

SERVICE CODE	CMS AVERAGES	OPTOMETRY AVERAGES	PCS AUDIT AVERAGES
92004 / 14	56%	81%	92%
92002 / 12	44%	19%	8%

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Why? *PERTINENT*

- Refer back to explanations of **reason for the visit** and medical necessity
- Again – appropriate medical care is not what you WANT to do it is what you NEED to do based on the reason for the visit

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You're kidding right – you're not saying a patient states their only concern is a "bump" on their eyelid and all I do is diagnose and treat the eyelid problem – not a comprehensive history, refraction, cover tests, ductions, screening visual fields, dilated internal, and give them three glasses prescriptions?

Actually, that is EXACTLY what the core principles of medical reimbursement say!

And talk to a health care attorney about the "liability fantasy" perpetuated by optometry

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Remember experts? What did recent Optometry Management article just say?

Patient presents for a routine examination with symptoms of allergic conjunctivitis – which service code do you use?

WRONG answer
- 92004 as a MEDICAL visit

RIGHT answer
- **POSSIBLE** answer #1 - 92004 as a WELLNESS visit
- **POSSIBLE** answer #2 – 92002 or 99202/3 as a MEDICAL visit

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Other "myths" about comprehensive eye exams

First and foremost, they are not medically necessary and NOT medical.

- Optometry creations for medical care
  - Comprehensive eye examination
  - Comprehensive medical eye examination
  - Eye health evaluation
  - Diabetic eye examination
- But my patient expects one
- I'm bound legally to do one
- I'm bound ethically to do one

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Ophthalmologic vs Evaluation and Management Codes

This is actually VERY simple!

1. You can ALWAYS use an evaluation and management code – conduct a problem oriented examination based on the reason for the visit and add up what you did
2. You can ONLY use an ophthalmologic code when your service meets the definition and description of the code based on the reason for the visit – means what?

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When can I use 92002 / 92012

*Ophthalmological services: **medical examination** and evaluation with initiation of diagnostic and treatment program; intermediate*

Requires:

The evaluation of a new or existing condition *complicated with a new diagnostic or management problem not necessarily related to the reason for the visit (?)*

- A medical history
- General medical observation
- Examination of external eye and adnexa

NEW: *And other services are indicated – may include the use of mydriasis or cycloplegia*

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When can I use 92004 / 14?

*Ophthalmological services: **medical examination** ar initiation of diagnostic and treatment program; con visits. Requires:*

- General evaluation of the complete visual system
- A medical history
- General medical observation
- Examination of external eye and adnexa
- Ophthalmoscopic examination (***usually*** includes dilation)
- Gross visual fields
- Basic sensorimotor exam
- Always includes initiation of diagnostic and treatment programs

BIG POINT

Dilation does **NOT** equate with a comprehensive code

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Here's the point usually missed…

THE REASON FOR THE VISIT ***must justify***:

1. Medical evaluation
2. History
3. General medical observation
4. External and internal examination
5. Gross visual fields
6. Basic sensorimotor (binocular) assessment
7. Diagnosis and treatment plan

REMEMBER?

Allergic conjunctivitis??????

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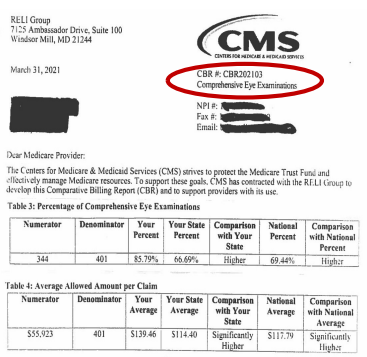
RELI Group
7125 Ambassador Drive, Suite 100
Windsor Mill, MD 21244

March 31, 2021

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CBR #: CBR202103
Comprehensive Eye Examinations

NPI #: [redacted]
Fax #: [redacted]
Email: [redacted]

Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with the RELI Group to develop this Comparative Billing Report (CBR) and to support providers with its use.

Table 3: Percentage of Comprehensive Eye Examinations

Numerator	Denominator	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
344	401	85.79%	66.69%	Higher	69.44%	Higher

Table 4: Average Allowed Amount per Claim

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
$55,923	401	$139.46	$114.40	Significantly Higher	$117.79	Significantly Higher

Think they're kidding???

CMS = BIG BROTHER

States ***"not an audit but does not prevent payer from further investigation of outlying providers"***

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#3 – Medically Unnecessary Diagnostic Testing

Wait just one minute….now you're saying I can't run pachymetry, fundus photos, OCT, VF and ERGs on my glaucoma patients every six months?

No….*you can do whatever you want.* ***You just can't bill a medical payer for it!***

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Excessive Testing – Just a few examples to make you think

- The American College of Physicians estimates excessive testing costs the health care between $250 BILLION every year (2012 and getting worse)
- The American Cancer Society's past director Dr. Brawley said the $10 stool test has been shown to save lives equally, but **in the United States**, the $3,000 colonoscopy is mostly commonly used. ***"Everyone is getting the expensive test, even though the cheaper test is as good. But the cheaper test involves handling shi… and no one can make money off of it,"***
- Closer to home…

  In the United States, despite the barrage of increase technology, the overall incidence of blindness from glaucoma has not changed in over two decades

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One of the biggest misunderstandings in optometry – "Confirmatory Testing"

Per CMS:

Medical record documentation must clearly indicate rationale which supports the medical necessity for performing ***each*** *test. Documentation should also reflect how the test results were used in the patient's plan of care.*

"It would not be considered medically reasonable and necessary to perform any diagnostic procedure simply to provide additional confirmatory information for a diagnosis or treatment which has already been determined." (my emphasis added)

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Just two examples – while too many are trying to run unnecessary tests on glaucoma and AMD patients to make more money – they leave this RECOMMENDED care on the table!

WHAT IS THE STANDARD OF CARE FOR FREQUENCY OF MONITORING A PATIENT WITH ALLERGIC CONJUNCTIVITIS?

According to the National Institute on Asthma, Allergy and Immunology – once every six months

PLAQUENIL IS NOT THE ONLY HIGH RISK MEDICATION IN EYE CARE

Patients taking ANY of the following medications should be monitored for potential ocular side effects: Thorazine, Nolvadex, Flomax, All corticosteroids, Aredia, Fosamax, Boniva, Zometa, Actonel, Topamax, Viagra etal, Accutane, Cordone, Zyrtec, Myambutol, Fluoroquinolones

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Just the facts…

Medicine is NOT menu driven care. A particular disease or diagnosis does NOT support an exhaustive list of diagnostic tests just because you have the instrument.

Biggest problem in optometry – significant over testing for glaucoma. Sorry, a patient with a family history of glaucoma does not routinely need a scanning laser, fundus photo, visual field, pachymetry, gonioscopy, anterior segment OCT, color vision test, VEP, and ERG – much less all repeated six months later.

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So How Do I Decide If I Will Keep My Testing Money After an Audit?

In general, this is how an audit will come down:

- ✓ Is the need for the test related to the reason for the visit or incidental finding related to exam for the reason for the visit?
- ✓ Is the data usable?
- ✓ Does the outcome of the test directly contribute to the care of the patient?
- ✓ Need for the test stand alone against other known data (not confirmatory)?
- ✓ Is there a more simple or less expensive alternative test?
- ✓ Was the need for the test clear (explicit or ordered)?
- ✓ Was an interpretation and report documented?
- ✓ If a payment policy exists, was if followed?

(NOTE: If there wasn't one – all the other seven still apply!)

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#4a – Mis-Use of Modifiers. -59 in particular

-59 Modifier

- Ten years running still the most audited modifier in healthcare
- ALMOST never an application in primary eye care – some rare applications for complex retinal disease
- ***NEVER applicable to bill fundus photos and scanning lasers during the same encounter in glaucoma***

(You may have heard there is an acceptable diagnosis list…there was…that is gone…replaced by a national edit against the two codes)

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Can they make it any more clear?

*Fundus photography and posterior segment SCODI performed on the same eye on the same day are mutually exclusive of one another **(National Correct Coding Initiative [NCCI] Policy Manual for Medicare Services)**. The provider is not precluded from performing both on the same eye on the same day when each service is necessary to evaluate and treat the patient. The medical record should clearly document the medical necessity of each service. **Frequent reporting of these services together will likely trigger focused medical review**.*

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=35038

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#4b – Mis-Use of Modifiers. -25 in particular

-25 Modifier

- The second most abused and actively audited modifier. Two problems:
- Certain "coding experts" are teaching to add the -25 modifier to all office visits to "bypass" the rules. That is called fraud. Three important words in healthcare reimbursement start with the letter "F" – fraud, felony, you are f….
- Providers do not understand that the office visit is included in the fee for a surgical procedure with only one exception – has been since 2007

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The OIG feels abuse of the -25 is a NATIONAL HEALTH CARE CONCERN and says…

"We (*NOT you…my edit*) will determine whether providers used modifier –25 appropriately. ***In general, a provider should not bill evaluation and management codes on the same day as a procedure or other service unless the evaluation and management service is unrelated to such procedure or service."***

CLEAR ENOUGH?

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Two common blog solutions…that do NOT hold up in an audit

Patient presents - pain after getting something in eye….needs corneal foreign body removal. Bill 65222 with NO office visit for about $60 bucks. ***Not fair…..***

CREATIVE SOLUTION #1: 99203 pays about $119 bucks…bill that instead of surgical code!

NO NO NO…you just broke CPT rules. You must bill the code that MOST ACCURATELY represents the service provided.

CREATIVE SOLUTION #2: Bill the office visit with diagnosis of corneal pain and FB removal with diagnosis of foreign body. NO NO NO – what does CMS say?

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

https://www.cms.gov/medicare/coding/icd10/downloads/2018-icd-10-cm-coding-guidelines.pdf

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Still not convinced? JUST IN!

Massachusetts Eye and Ear just got nailed for **$2.6 MILLION** for violations of False Claim Act

What did they violate?

IMPROPER USE OF THE -25 MODIFIER

Did someone just hear the mic drop??

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#4c – Mis-Use of Modifiers. -52 in particular

-52 Modifier

- Hard to swallow, but simple concept. Cannot get paid 100% of fee for 50% of the work
- Only significant application is to photos
- It's not that you did or didn't photo both eyes – ***was it medically necessary to photo both eyes?***

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#5 – Bulk Claims – aka - Panel Testing

- ZPIC now given the authority to evaluate manpower and time against volume of claims and workload within the claim
- ZPIC made this a 2017/18 audit target

2018 CMS per patient revenue - national ave. $108.47

Want examples of why optometry is in trouble?

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#6 – Major Medical Payers Love Vision Therapy Claims

No so much…..

See position paper written by AOA

Its not a matter of whether or not it's valuable…it's a matter of **DO THEY PAY FOR IT**!

UNLESS YOU HAVE IN WRITING THAT EVERY CPT CODE YOU WANT TO SUBMIT IS CONSIDERED A COVERED EXPENSE UNDER THE PATIENT'S PLAN…..MAKE THE PATIENT PAY

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#7 – Photography is fun…photo EVERYTHING

Biggest issues

- Cannot document the absence of disease *(a few exceptions)*
- Cannot document absence of change *(no exceptions)*
- Screening vs medically necessary photos
- Photos substituting for ophthalmoscopy

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#8 – Not Making Vision Plan Happy – Part 1

Exam Requirements

- Read the history requirements, they are extensive
- Read the examination requirements, they are extensive
- Read the dilation requirements
- While you're at it, read what the agreement says about compliance issues

And understand they are ruthless, relentless and unforgiving. Let's talk about their new law…

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#8 – Not Making Vision Plan Happy – Part 2

Contact Lens Requirements

1. History must include the lenses worn, how they are worn, solutions used
2. Examination must document the fitting characteristics of the lenses (NOTE: Simply documenting WHAT trial lenses were used is not sufficient – need to note the fit)
3. Findings must include K's and SOR (mandate of VSP)
4. Assessment must state how the patient is doing with the lenses
5. The plan must state what you are doing going forward, even if that is no change

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But Joe….what about all those rules?

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First…

- Payment policies are REGIONAL – information from your coding expert in Florida may not apply to Montana.
- This applies to major medical AND Medicare
- This does not apply to vision plans – their rules are:
  - National *(except when made up on the spot)*
  - Spelled out in the provider agreement *(except when made up on the spot)*
  - Ruthlessly applied

Strongly recommend use of a program that can help you keep up with all the rules and guidelines

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And Medicare – that's Noridian for you

Few points about Noridian

1. They are one of the least active in medical policy specific to eye care (2 policies)
   1. Blepharoplasty – L36286
   2. Cataract surgery – L37027
2. They are not very active in the audit market

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BUT….

New CMS Statement: The audits will resume in full force despite ANY pandemic crisis

AND

When a Medicare auditor conducts an audit of your records, they can use the published Noridian LCDs…

BUT THEY CAN ALSO USE ANY PUBLISHED POLICY FROM ANY OTHER CARRIER – especially if Noridian does not have a policy specific to the issue in question

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What's HOT in the eye care LCD market across the country

- Electrodiagnostic testing
- Scanning computerized ophthalmic diagnostic imaging
- Cataract surgery
- Provider qualification statements *(watch for this!!!!!)*

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Things major medical sometimes have medical policy to support

- ✓ SCODI (common)
- ✓ Visual fields
- ✓ Electrodiagnostics (NOT for glaucoma – a sad story)
- ✓ Punctal plugs (some dry eye tx in general)
- ✓ Photography

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Things major medical commonly have policy on NOT paying

- × Vision care / glasses
- × Vision therapy *(be very careful!)*
- × Anterior segment OCT *(changing – and you're lucky here)*
- × Macular pigment testing
- × Any ocular genetic testing
- × Pachymetry (new)

MAJOR MEDICAL PAYMENT POLICIES ARE OFTEN MORE ABOUT WHAT THEY **WILL NOT** PAY FOR THAN WHAT THEY **WILL** PAY FOR

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Most important advice on this matter…

Whenever possible, keep vision care and medical care separate

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THANK YOU!

Any questions… maybe at the bar or email me

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