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

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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 Laboratories
- Carl Zeiss Meditec
- Optos
- Diopsys
- Kowa
- Optovue
- AllDocs
- OfficeMate
- Marco
- TSO
- NVision
- Cleinman Partners
- Vision Trends
- Konan
- Essilor of America
- Pearle Vision / SNAPP
- Vision West
- UHCO, NOVA, RSO, UAB, Berkley, *and other optometry schools*

Over half the state optometric associations in the United States

Optometric Business Solutions, LLC – President and CEO *(no financial interest)*
Clinical Professor – University of Houston College of Optometry *(opinions do not necessarily reflect the views of the University)*

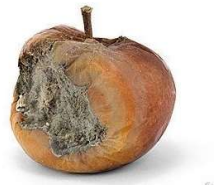
ADDITIONAL DISCLAIMERS

Policies presented or discussed in this presentation 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

Let's start in reverse….

What's Rotten?



The Bipolar World of Coding - Experts…

Practice Centric Care

MAXIMIZE your revenue
Do what puts the most money in the bank
MAXIMUM use of examinations, testing and technology
Twist the system in an attempt to get around the rules

RESULT

Indefensible care – often "worthless" per CMS
Massive audit exposure
Doctors getting severely hurt
Sleepless nights

Patient Centric Care

Do what's right for the patient and the money will follow
Use common sense
Medically necessary use of examinations, testing and technology
95% of rules are pretty clear – just follow them

RESULT

Defensible, medically necessary care
Minimal audit exposure
Make as much or more money just doing what's right
Sleep like a baby

And the fruits of our labors…

US HEALTHCARE FRAUD AND ABUSE

2016 Medicare – 41 BILLION
2016 Medicaid – **140 BILLION**

2016 RAND study – total fraud and abuse in US Healthcare

$295 BILLION

But optometrists aren't involved – RIGHT?

Bad Stats from CERT 2016

Improper service payments by provider type:

OUT OF 55 PROVIDER TYPES

#1 Chiropractors
#2 PT
#3 Psychiatrists
.
.
.
#10 **OPTOMETRISTS** *(up from #25)*

And CERT tells us why!

2016 Reasons for Optometry Overpayment

#1** Insufficient **documentation (80%)
#2 Incorrect coding (16.7%)

80% Of denials are based on inadequate medical record documentation – some stupidity, some ignorance and a LOT of mis-information

Which is why the next lecture will focus on documentation and audits!

Sources of our sadly earned reputation

- "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…)*

Where a lot of it comes from….

A lot of improper or fraudulent or stupid coding is performed because someone said they were doing it and getting paid who was told by someone else who said they were doing it and getting paid who was told by someone else they were doing it and getting paid who was told by someone who **made it up**…
and "GOT PAID"

Typical situation – February 2018

DOC: *We were just audited by Medicare and have to pay back $62,544 – said we are billing unnecessary 92004/14*

JOE: (after review of 20 charts that were audited) It looks like they let you off easily – I would consider all 20 of these encounters not medical visits

DOC: *But the patient has Medicare – we have to bill medical*

JOE: No, you CAN bill Medicare if the reason for the visit leads to a medical diagnosis

DOC: *But Dr XXXX, a coding expert, told us at XXX (meeting) to "take a stance" and always bill medical*

JOE: You should contact Dr XXXX and ask him to pay the $62,544 back to Medicare for you

Conversation 1.24.2018

DR: *Joe, BCBS is denying my claims for 92132 saying It is investigational. That's bullsh…Dr. Z is a coding expert and he said that is wrong.*
ME: *I would agree the policy stinks but that is their policy and they have every right to make it.*
DR: *That can't be right – they have an obligation to the patient.*
ME: *Actually their only obligations are to the state insurance commission and their board of directors*
DR: *Never mind…I'll call someone else.*

TWO HOUR PAUSE – CALL FROM OCT COMPANY REP

REP: *Joe, Dr X is reporting you AND Dr. Rumpakis said he can't get paid for 92132 – that's usually a submission error. If I send you the claim form can you tell me what he is doing wrong.*
ME: *Actually, BCBS published policy says they do not pay for 92132. It's not a claim error.*
REP: *PAUSE….. No shi….. What can we do about this?*
ME: ***Pray to the god of your choosing***

This is also just wrong!

Typical Email…

Dear Dr. DeLoach,

On December 17th a special interactive webinar, "[redacted]" highlighting how to get the maximum return on your Investment in your [redacted]

The ROI of Glaucoma Care - let's count the errors

1. From Jan 2017-April 2018 we screened 224 patients for glaucoma…

2. *Editor's note: You cannot charge third-party providers for anything other than threshold visual fields*

3, 4. If I had an OCT I could add $38.04 to my bottom line per patient screened.

5. An office visit (99211) is charged with my retinal photography (92250) reimbursement.

6. Per Medicare guidelines, you cannot perform visual fields and retinal photos on the same day as an OCT….

7. I perform the dilation, retinal photos, gonio (if I suspect narrow angles)

8. We typically charge $108 for photos and threshold visual fields (cash pay). The break down is $69 for threshold visual fields with an office visit; $39 photos…Medicare is paying us $58.32 for photos and $65.32 visual fields

9. I offer patients, who are covered by insurance companies whose panels we are not on, cash-discounted prices

10. I do the initial glaucoma diagnosis, and then we co-manage with an OD-friendly ophthalmologist if the patient is no longer just a suspect and has glaucoma.

REALLY???

So why believe me?

I have lectured nationally on ethical coding for 25 years (so what)

I am CourseMaster for the UHCO Professional Ethics Course - have been since it's introduction (more so what)

I served on the TOA Third Party Committee for 20 years and as their consultant "emeritus" for the past 5 years (so what again)

I direct a company that performs audit and billing services – ***we are responsible to our clients to know what works and what doesn't*** *(very important)*

I served on the Jurisdiction H CAC for a over two decades (still on it) - CACs make Medicare policy! *(more important)*

I audit for medical payors - including Medicare *(more very important!)*

Unless I say it is my opinion, I will back up anything I tell you from the "TRUTH" sources. Or don't…you decide

Sources of Coding *Truth*!

www.cms.gov (Medicare)

https://med.noridianmedicare.com/
Jurisdiction F *(that's you)* Carrier

www.*whoever-medicalpayor*.com

CPT and ICD-10 Manuals

www.CodeSAFEPLUS.com

www.practicecompliancessolutions.com

Real Definition of Reimbursement

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

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!

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

But first….the most important concepts to understand

The PILLARS OF REIMBURSEMENT

- Reason for the visit
- Medical Necessity

PILLAR ONE

REASON FOR THE VISIT

What Is The Reason for the Visit

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

If you do not address the reason for the visit, an auditor can/will deny the entire encounter as not medically necessary

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 complaint 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****."*

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!!!

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???

PILLAR TWO

MEDICAL NECESSITY

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

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?

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)**

Essential concept in medical reimbursement

Medical necessity ≠ Insurance benefits
If medically necessary – SOMEONE pays!

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 –

why is medical care different?

Making Patients Pay

- As stated, this is predominantly an issue in the mind of optometrists ***(except in the dispensary)***
- If you decide it is medically necessary, SOMEONE has to pay – and that will increasingly be the patient
- BIG POINT – **you are legally obligated to collect from the patient what they owe you**
- Same Day Discounts are fine in wellness care but regulated by the Anti-Kickback Statute in medical care (use is LIMITED only for financial need – the patient's, not yours)
- Use Advanced Beneficiary Notice (ABN)

ABNs….What Are They?

Per CMS: *The ABN allows the beneficiary to make an informed decision about whether to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay.*

SPECIAL NOTE: **Use form CMS R-131** – *THAT WAS CHANGED EFFECTIVE 6/21/2017*

ww.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf

NOTE: All Part C plans have their own ABN forms and rules

When You MUST Issue an ABN
(use – GA modifier)

When you EXPECT or KNOW Medicare may deny payment based for a service ***that normally WOULD be paid***.

Have patient select one of the three options and sign the form ***BEFORE the care is rendered.***

When You MAY Issue an ABN
(Use – GX or – GZ modifier)

When you EXPECT or KNOW Medicare will deny because Medicare NEVER pays for the service.

- Lack of medical necessity *(THEIR definition, not yours)*
- Payment policy – LCD *(Ex. visual field for a headache Dx when that Dx is not allowed under a payment policy)*
- Not a covered service *(Ex. REFRACTION)*

BUT…The patient does NOT choose an option and does NOT sign the form. Issuing an ABN in this case serves only one debated purpose but it **DOES NOT legally obligate the patient to pay for the service!**

OK – Let's Review Those Major Reasons You WILL be Audited

subtitled: Coding Issues and Myths in Optometry

ALERT – Late Entry News

Top 5 Claim Submission Errors – Novitas 2018

RANK	EOB CODE	DESCRIPTION
1	CO-16	Claim cannot be adjudicated – missing/incorrect information
2	96	Non-covered service
3	18	Duplicate claim **(REALLY??? *Main reason this happens?)***
4	109	Wrong payor **(you have to be kidding!)**
5	49	Routine exam **(#1 item cited – REFRACTION)**

#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%**

Why?

#1 - Over-estimation of history

- History details exceed medical necessity based on reason for the visit *(everyone gets comprehensive history like we are taught to do in school)*
- Review of systems not **PERTINENT** to reason for visit *(**NOTE**: 99204 and 99205 require comprehensive history – **all eleven systems pertinent to RFV** - almost impossible in eye care)*

Why?

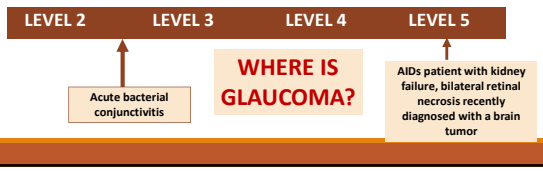
#2 Over-estimation of examination elements

- Do not understand the concept of ***"medically necessary based on the reason for the visit"***
- JUST BECAUSE YOU DID IT OR WANT TO DO IT DOESN'T MEAN IT IS REIMBURSEABLE

Why?

#3 – Over-estimation of complexity of care

- Bottom line…it is damn complicated. That's why 66% of audited EM codes are denied or down-coded (90% due to over-estimation of code level)
- Concept behind complexity of medical decision making



IS THIS ALL GETTING READY TO CHANGE?

Yes it is..maybe it is…not sure!
But does ANYONE understand it?

#2 – Overuse of Comprehensive Ophthalmologic Code

More of just the facts…

SERVICE CODE	CMS AVERAGES	OPTOMETRY AVERAGES
92004 / 14	56%	**81%**
92002 / 12	44%	19%

Why?

- 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

Here's the way it works in medicine…

In MEDICAL encounters, services are **LIMITED** based on the concept of symptom driven care *(reason for the visit)*

Optometry in general is still stuck on the concept of ***every examination is a comprehensive examination where you do the same thing every time – regardless of the RFV.***

This, along with mis-information and greed, has fundamentally led to optometry moving from 25th to 10th most improperly paid specialty

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

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

POSSIBLE answer #1 - 92004 as a WELLNESS visit

POSSIBLE answer #2 – 92002 or likely 99202 as a MEDICAL visit

Other "myths" about comprehensive eye exams

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

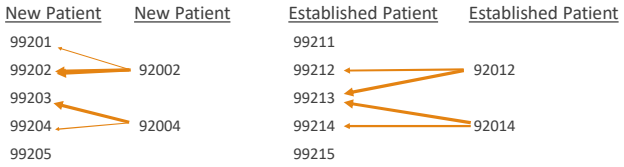
- Optometry creations for medical care
  - Comprehensive eye examination
  - Comprehensive medical eye examination
  - Eye health evaluation
  - Diabetic eye examination
- But my patient expects one
- I'm bound legally to do one
- I'm bound ethically to do one

Ophthalmologic vs Evaluation and Management Codes

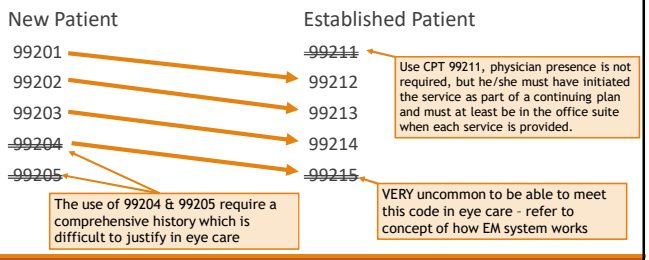
This is actually VERY simple!

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?

#1 Most Important Slide on EM Service Code Understanding the CMS Crossover Concept



#2 Most Important Slide on EM Service Code Simplifying the EM Code System



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*

When can I use 92004 / 14?

*Ophthalmological services: **medical examination** and evaluation with initiation of diagnostic and treatment program; comprehensive, one or more 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

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??????

#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!***

Excessive Testing – Just a few examples to make you think

The American College of Physicians estimates excessive testing costs the health care between $200-$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,"*** Brawley said.

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

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)

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

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.

REMEMBER – WE'RE NOW #10!!!

What if…

52 y/o AA male presents for routine eye examination. He has no complaints other than newspaper is hard to see even with his readers (Rx is six years old). Medical history is unremarkable. Ocular history includes uncle with glaucoma.

Vision corrects fine with increase add. All findings normal. CD is .7/.7 OU with VDD is 2.3 OD / 2.4 OS. IOP by NCT is 23mmHg OU.

You consider the patient a glaucoma suspect and run baseline OCT, pachymetry and visual fields – have the patient return in a week for fundus photo, gonioscopy, extended color vision and VEP. All findings are normal. You schedule a return visit in six months to repeat the OCT, visual field and VEP.

Six months in patient is fine and you have $895 in "medically necessary" care

MOVE THE CALENDAR FIVE YEARS….

Under the new **"episode based"** payment system, a diagnosis of low risk borderline glaucoma reimburses $350 for one year of care.

Does your plan of assault change?

IF you can get on the plan. WHAT?

#4 – Mis-Use of Modifiers. Three 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***

(refer to Medicare Carrier First Coast for the most common list of diagnoses that MIGHT justify both tests – HINT: ***NO*** glaucoma diagnoses listed!)

#4 – Mis-Use of Modifiers. Three 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

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?

#4 – Mis-Use of Modifiers. Three 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?***

#5 – Prolonged Service Codes (99554/5)

This one is simple…

OIG 2017 Work Report

"The necessity of the prolonged service codes is considered to be rare and unusual"

"RARE AND UNUSUAL"…look those words up

APPLICATIONS? Sure – LV services, very special complex cases

#6 – Bulk Claims

- 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

2016 CMS per patient revenue - national ave. $108.47

#7 – 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

#8 – Photography is fun…photo EVERYTHING

Biggest issues

- Cannot document the absence of disease
- Cannot document absence of change
- Screening vs medically necessary photos
- Photos substituting for ophthalmoscopy

But Joe….what about all those rules?

And Medicare – that's Noridian for you

L37027 Cataract Extraction

One of the least restrictive; not based on Snellen acuity

L36286 Blepharoplasty

Draft Policy – Non-Invasive Glaucoma Surgery

THAT'S IT FOR MEDICARE!

And major medical….

Major medical policies are different – they often state what they do NOT pay for rather than what/how they DO pay.

An they are REGIONAL in jurisdiction

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 (see point #

Things major medical commonly have policy on NOT paying

- × Vision care / glasses
- × Vision therapy
- × Anterior segment OCT (changing)
- × Macular pigment testing
- × Any ocular genetic testing
- × Pachymetry (new)

Time permitting (never is)….the age old question: Is it vision or medical?

- FIRST AND FOREMOST – the reason for the visit determines that
- The patient has a choice when there is duplicative coverage
- Personally, I don't think it is all that complicated but the answer is NOT drawing a line in the sand on this issue

EXAMPLE ONE

New patient presents with complaints of blurred vision when reading – no other symptoms. You examination reveals presbyopia and moderate dry eyes based on inferior corneal staining. The patient has VSP refractive insurance and Aetna medical insurance.

Is this encounter billed to VSP or Aetna?

Soooooooo…two answers

The reason for the visit is blurred vision…

1. One answer for the blurred vision is presbyopia – if this is the sole reason, this is a wellness encounter and you bill VSP comprehensive vision examination
2. The patient has dry eyes – ***can you say the dry eye contributes to the reason for the visit?*** If no, refer to answer #1. If yes, you MUST STATE THAT and then you CAN bill medical to Aetna – but what office visit code would be appropriate? *(HINT…could lose money doing it this way)*

EXAMPLE TWO

Your new patient presents with two complaints – their distance vision is blurred and they have a bump on their right upper eyelid that does not hurt. Your examination reveals an increase in their myopic correction and a non-pigmented papilloma. The patient has EyeMed refractive insurance and BCBS medical.

Is this encounter billed to EyeMed or BCBS?

What is the reason for the visit?

1. Blurred vision
2. Lid lesion

OPTION ONE: Bill vision examination to EyeMed; treat the papilloma for free. Bill a comprehensive vision code – for EyeMed that's 92004.

OPTION TWO: Bill vision examination to EyeMed; make the patient return to evaluate the papilloma. Comprehensive vision code to EyeMed today; likely 99212 or 92012 to BCBS on return

OPTION THREE: Treat the papilloma; make the patient return for a vision examination. Bill BCBS 92002 or an EM likely a 99202

OPTION FOUR: Perform a comprehensive vision examination and a medical evaluation of eyelid. Bill EyeMed (92004) and bill a 92002 or 99202 to EyeMed *(really? Really yes but no…)*

Geez, thanks for making this even more complicated. Oh don't worry - just getting started!

Factors to Consider In Deciding on Those Options

1. What copays exist – EyeMed and BCBS?
2. Does the patient have a deductible with BCBS? If yes, how much has been met?
3. What was the patient's expectation? Is the money worth making the patient mad?
4. If all the options are legal and ethical, which one makes YOU the most money?

Diabetes – the Consummate Example

New patient presents on the direction of her PCP due to a recent diagnosis of "pre-diabetes" (her BMI is 39 and A1C was 8.1). She says she needed an eye examination anyway because she is out of contact lenses. You examination is unremarkable. She has VSP refractive insurance and United Health Care medical insurance.

Is this a vision or medical encounter?

Hmmm….

Does duplicative coverage exist?

Is this a vision examination?

Is this a medical examination?

What would be the difference between those two examinations?

Can you handle this in two separate visits?

LAST EXAMPLE

Patience rewarded…can you over-ride the patient's direction?

Patient presents with complaints of blurred vision. BVA is OD 20/60 OS 20/30. Patient has mild diabetic retinopathy and CSME OD. Patient has VSP and BCBS.

Is this vision or medical – the patient wants you to bill VSP.

Let's review….

Remember all the legal options - remember the patient owns the policy – remember this possibly could be considered duplicative coverage. BUT…when faced with this (and other) scenario, ***my opinion only.***

Does the presenting medical condition prevent me from conducting a proper comprehensive vision examination (wellness).

NO – bill vision

YES – bill medical

Most important advice on this matter…

Whenever possible, keep vision care and medical care separate

THANK YOU!

Let's take some questions… maybe at the bar or email me

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