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Coding Audit Success Toolkit



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CODING AUDIT SUCCESS TOOLKIT

THE REALITY OF THIRD-PARTY PAYER AUDITS

With the volume of audit types, the reality is that every ophthalmologist will be audited at some time during their career. It's not a matter of if, but when. Being the subject of an audit is stressful and time-consuming for physicians and staff. However, you can protect your practice by preparing for when that request for records arrives.

The purpose of this toolkit and ongoing resources on the Academy's website aao.org/audits is to educate you to the variety and types of audits and identify target areas so that your documentation is consistently in compliance with the payer requirements.

To assist you in proactively navigating the inevitable audit, this toolkit will cover the following topics:

- Coding Compliance Goals
- CMS Mandated Training
- Best Practice Tips
- Audit Triggers
- Competency Question and Answers
- How to Build Your Own Audit Toolkit

This toolkit contains helpful checklists and guidelines for your everyday use (see pages 8-51).

Additional information and ongoing updates are available at aao.org/audits as an Academy and AAOE membership benefit. These resources contain:

- A list of each audit type:
 - CERT
 - RA
 - SMRC
 - TPE
 - UPIC/ZPIC
- Each of the audit target areas such as:
 - New or established patient exams
 - Cataract surgery

- Extended ophthalmoscopy
- Scanning computerized ophthalmic diagnostic imaging

All payers conduct audits. Why?

Here is one anonymous carrier medical director's response:

1. Because they can. As a physician, you are a contractor generally not independent.
2. Because they should. There is fiduciary responsibility to patients, taxpayers, stockholders and employers to control cost and limit fraud. It is driven more and more by insurance competitors rolling out proposals on how they will save the purchaser more money than current vendor.

Who gets audited?

Everyone who accepts money from a third-party payer gets audited. The list that follows highlights scenarios for those who commonly undergo audits.

- With comparative billing reports, you could be an outlier compared to your peers by state or by region. Note: Unique taxonomy identifying you as a specialist isn't factored into the data—yet.
- Creative coding might put the whole practice at risk, unlike investments where one can diversify. Is the increase in income worth the risk of an audit or worse? Avoid the “hot” idea to bill patients out of pocket for dropleless cataract surgery, or laser assisted cataract surgery with a standard, not premium IOL.
- Past audit failures often lead to additional future audits.
- With random audits, it may just be bad luck.

Is there any way to avoid an audit?

The only way to avoid an audit is to opt out of all insurance plans. Of course, this may opt you out of receiving any patients too when they are unable to use their insurance at all.

Fraud/abuse—what is the difference?

Fraud is intentional and illegal and includes any of the following:

- Knowingly submitting, or causing submissions of, false claims or making misrepresentations of fact to obtain a Federal health care payment for which no entitlement would otherwise exist
- Knowingly soliciting, receiving, offering and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal health care programs
- Making prohibited referrals for certain designated health services
- Billing Medicare for appointments the patient failed to keep
- Knowingly billing for services at a level of complexity higher than services actually provided or documented in the file
- Knowingly billing for services not furnished, supplies not provided or both, including falsifying records to show delivery of such items
- Paying for referrals of Federal health care program beneficiaries

Learn more about Medicare fraud and abuse in the MLN booklet provided by CMS: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud_and_Abuse.pdf

Abuse examples:

- Mistakes such as incorrect coding
- Inefficiencies such as ordering excessive tests

CODING COMPLIANCE

To ensure your practice is prepared for an audit, you must be coding compliant. To maximize the impact and minimize the time away from patient care, coding compliance should focus on the following steps.

- Educate physicians and staff in coding regularly
- Know each payer's unique rules
- Create checklists to increase compliance to the payer rules
- Document so well that no outside source can recoup monies
- Submit clean claims
- Rework and resubmit denied claims within 24 hours
- Keep a list of denial reasons and share with all who need to know to stop perpetuating the errors

The result will be that you appropriately maximize reimbursement.

Who are the key players?

The list that follows highlights the key players in your practice and helpful tips for each to maintain coding compliance.

- Physicians
 - Take ultimate responsibility for documentation, CPT and diagnosis code selection
- Technicians
 - Obtain a history to make the physician and payer proud
 - Don't copy forward
 - Understand medicine to appropriately link CPT and ICD-10 codes
 - Know testing services documentation and billing requirements
 - Identify minor surgery as a 0- or 10-day global period; major surgery as 60- or 90-day global period depending on the payer
 - Know payer preoperative requirements
 - Know modifier application
- Scribes
 - MUST know requirements for E/M and Eye visit codes
 - Don't copy forward
 - Know testing services documentation and billing requirements
 - Identify minor surgery as a 0- or 10-day global period; major surgery as 60- or 90-day global period depending on the payer
 - Know payer preoperative requirements
 - Know modifier application
- Billers/Coders
 - Never change CPT or ICD-10 code without physician approval
 - Ask questions when unsure about surgery being performed
 - Provide monthly list of claim denial reasons so that mistakes are corrected, not perpetuated
- Administrators
 - Have internal chart audits performed the way the payers do
 - Never let an outside source review records that have already been submitted for payment
 - Conduct your own audits internally
 - Obtain and convey confidence in your own knowledge

- Monitor possible coding violations; take corrective action and re-teach at every level
- Develop protocol to implement when request for records arrives

CMS MANDATED COMPLIANCE

CMS has mandated that Fraud, Waste, and Abuse (FWA) plus general compliance training be performed on an annual basis.

Both Medicare Parts C and D may have their own training guidelines, and initiation of and attesting to completion may be a condition of your contract.

Note: All new hires should have training within their first 90 days. The annual training can be completed any time between January 1–December 31 of any given contract year.

CMS has provided several options for compliance training which provide certification of fulfilling the requirement. Both FWA and general compliance training is available in either web-based training, or through downloadable documents which can be incorporated into existing practice documents.

Note: While not all staff is required to have training, those with decision-making roles, claims processors and management should be well-versed in conditions of practice compliance.

As part of your training, read:

- Medicare Managed Care Manual: Compliance Program Guidelines and
- Prescription Drug Benefit Manual: Compliance Program Guidelines

made available by CMS at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf>

Additional resources

- MLN fraud and abuse products available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-Products.pdf>
- MAC webinar participation available from each MAC website listed at aao.org/practice-management/coding/updates-resources

BEST PRACTICE TIPS

1. Do not apply one payer's rules or perceived rules to all payers
 - a. Support physicians by updating them immediately with payer guideline changes
 - b. Participate with free payer listservs
2. Share weekly updates with all who need to know

3. Preauthorize, predetermine, precertify as necessary
 - a. May need to research based on patient insurance
 - b. Use practice management software for efficient processes
 - c. While preauthorization, etc., does not guarantee payment, you are guaranteed no payment without it
4. Verify patient insurance prior to examinations, including the type of service the patient is requesting
 - a. Electronic eligibility check
 - b. Programs such as Eylea4you, vendor eligibility online
 - c. Rate yourself where you are right now
5. Research and report reasons for claim denials to eliminate repetitive errors
 - a. Top reasons practices have denials
 - b. Understanding why denials take place
 - c. Injury report for WC claims—payment denied without this report
 - d. Communicate to staff and physicians to eliminate persistent errors
6. Have policies and procedures in place to verify correct claim submission and any resubmissions
 - a. Compliance plan
 - b. Resubmit claims within 48 hours as payment is already delayed
 - c. Weekly track corrected claims until payment is received
7. Keep physicians informed of AR standing
 - a. Accountability
 - b. Checks and balances
 - c. Practice dashboard
8. Use Academy tools and resources to appropriately bill
 - a. Accountability
 - b. Do not guess (research before claim submission)
 - c. Just because it is paid, doesn't mean it was paid correctly—always chance of recoupment when policy is not verified by payer
 - d. Discuss policy for those commercial payers that do not have written policy
 - e. Everyone has an opinion, but are they following policy—always go to a trusted source

9. Collect deductibles, copayment at time of service
10. Do not change CPT codes without physician approval
11. Obtain ABN only when necessary on Medicare Part B patients only
 - a. When you are not sure either by diagnosis or frequency if the service is covered
 - b. Anything oculofacial that could be deemed cosmetic
12. Confirm where patient is “living while they heal”
 - a. SNF impacts billing
 - b. Has patient recently been hospitalized or receiving physical therapy?
 - c. Hospice care
3. Billing inherently bilateral tests
 - a. One eye to the payer
 - b. ABN and bill the other eye to patient
4. Modifier -59 explosion
 - a. Unbundling injections at time of surgery
 - b. Unbundling fundus photo and SCODI or OCT
5. Excessive use and abuse of ABN
6. Injecting Avastin and billing for Lucentis
7. Ignoring 28-day rule in anti-VEGF drugs
8. Improper out-of-pocket expenses to patient for premium IOLs
 - a. Billing for laser assisted cataract surgery
 - b. Billing for monovision or blending vision
 - c. Billing for use of ORA with a standard IOL
9. Billing assistant surgeon to patients when not a covered benefit
10. Billing place of service office when procedure took place in facility for higher site-of-service differential payment
11. Billing modifier -25 with every established patient and all minor procedures
 - a. While medically necessary, if the established patient exam is performed solely to confirm the need for the minor procedure, the exam is not separately payable for the minor procedure.

AUDIT TRIGGERS

1. Billing under any other National Physician Identifier (NPI) but your own, even if the physician signs off on your charts
2. Charging patients extra fees which are in violation of your contract with the payer and have ethical ramifications
 - a. Late fees
 - b. Cancellation fees
 - c. Charging for paperwork
 - d. Routine refill fees

COMPETENCY QUESTIONS AND ANSWERS

Protect your practice by knowing and implementing the answers to these questions.

General Questions

Q. How long do we have to keep medical records?

A. The law varies by state. Check with your state medical association. Typically, records should be maintained for seven years since the last exam date for an audit. For children, it is typically seven years after their 21st birthday.

Q. How far back can a payer auditor request records?

A. There is no limit on time frame. Recovery audits can only go back three years. Other audits typically request records for the past 18 months, but they can go back much further if they choose to do so.

Q. We are non-par with an insurance company. Can we provide the patient what they need to submit to their insurance?

A. Submit the claim on their behalf. The patient should be notified you are non-par before making an appointment. Explain that payment is due at the time of service and if their insurance plan has an allowable for off-plan coverage, the check will come to them.

Q. True or False? The Advance Beneficiary Notice (ABN) applies to all traditional Part B and Medicare Advantage Plan patients.

A. This statement is false. In fact, if you forget and append modifier -GA to any MA claim, there may be no payment from the MA plan or the patient.

Q. There are several practices in our call group. One physician sees another physician's surgical patient during the global period. Should the on-call physician submit a claim?

A. The on-call physician should not submit a claim as this is postop. The on-call physician acts as the operating physician.

Q. What isn't paid by Medicare Part B while the patient is in a skilled nursing facility (SNF)?

A. The technical component of any test, any drug injected and postop cataract glasses.

Q. True or False? You hire a new physician in your practice. It's best to check with the Office of Inspector General (OIG) first.

A. True. If legal action has been taken against a physician, no payments can be made to them by Medicare.

Diagnosis Question

Q. How many diagnosis codes should be reported on each encounter?

A. Only those that pertain to today's visit should be reported. While your EHR may require the status of all previous diagnoses, those should not convert to today's exam if they don't apply.

Examination Questions

Q. The retina specialist refers a patient to the glaucoma specialist in the same office. What does the glaucoma specialist bill the commercial payer patient as?

A. An established patient E/M or Eye code.

Q. A patient, who is in the hospital, is seen in your office for an exam. Which of the following statements is true?

1. Place of service is office.
2. Place of service is hospital.
3. The patient is responsible for payment of this non-covered exam.

The place of service is hospital. You can't have an outpatient exam while the patient is inpatient of record. When a patient is admitted to the hospital, coding is the same whether the patient is examined in the hospital or in the office. An inpatient of record can't have an outpatient exam.

CPT codes 99251, 99252, 99253, 99254, 99255

POS 21

Whether new or established, the CPT codes are the same.

This family of codes also qualifies for telemedicine.

- Append modifier -95
- POS 2

If during the global period, your patient is admitted to the hospital and postop visits are performed at that location.

- Not separately billable
- Still postop care

Q. Copy forward/copy paste is a time-saving feature of our EHR, yet I've heard that it is an area of vulnerability in an audit. Is this true?

A. Yes. According to carrier medical directors and auditors, payment is made from the work performed at each patient encounter. This doesn't include information from the previous exam brought forward. Doing so also may overinflate the level of exam billed as only system pertaining to the exam should be reviewed and only elements that pertain to the chief complaint should

be performed. For this reason, often auditors will request consecutive encounters to see if copy forward/copy paste has been done.

Q. How often do we need to have the patient fill out new paperwork for the ROS and PFSH?

A. Paperwork can be referenced at each exam (if medically necessary) but new paperwork is only needed if/when the rules change or if the patient is “new” again.

Modifier Questions

Q. Does the modifier order make any difference?

A. Yes. The order of the modifiers determines whether payment is made correctly. CPT modifiers should go first, followed by modifiers -RT or -LT.

Q. True or False? Discontinued surgical procedures have a global period.

A. False.

Surgery Question

Q. I have been told there is a national coverage rule that all patients must be examined within 90 days prior to cataract surgery. Is this true?

A. False. The physician determines when an exam is medically necessary. Unless there is a payer policy that publishes this requirement, it is physician's decision. OIG investigation revealed “too many exams with the sole diagnosis of cataract.”

Testing Services Questions

Q. We perform several tests on new patients before they see the ophthalmologist; however, we only bill when pathology is found. The sales rep told us this was okay. Is it appropriate to bill when we find pathology?

A. No. These are considered standing orders or screening tests. The patient is responsible for payment or they are no charge.

Q. Is it appropriate to unbundle 92133 Glaucoma OCT and 92134 Retina OCT as long as you have two separate diagnosis codes?

A. It is not appropriate to unbundle according to the CPT description. It is also a CCI mutually exclusive edit.

Q. True or False? Regarding subsequent ophthalmoscopy, payment is made whether there is change or not, as long as a picture is drawn.

A. False. Payment is for drawing a change in pathology that is drawn and labeled.

BUILD YOUR OWN AUDIT TOOLKIT

A year from now you may wish you had started today.

—Karen Lamb

Tips:

- Proactive preparation will serve you well and help you sleep at night.
- Focus your attention on target areas. Don't waste your time with non-essential areas.
- Once the payer has published the information on their website, they have fulfilled their obligation to inform you of any updates and changes.
- Be prepared! Ignorance only works once.
- Don't appeal what you know can't be sustained. Take the hit early to cut costs.
- Most audits are not about who is right and who is wrong, but whether you followed the rules.
 - When the rule is wrong, fight it out in a different venue.
- Consultant opinions don't make it payer policy.
- Conduct your own internal chart audits. No one is more vested than you are. If you absolutely must have an outside source review your records, give them chart notes that have yet to be submitted to the payer. This will help avoid whistle-blowing cases which are plentiful in ophthalmology.

Step-by-Step Process to Follow When the Request for Records Arrives

How you conduct yourself is crucial.

Real-life scenario 1: Staff opens the mail and finds an audit request for 40 charts. In their effort to be helpful, they compile what they perceive the appropriate documentation is, submit it without telling the physician and hope for the best. The audit results are not favorable, and a substantial refund is requested. Now they need to plan for an appeal or a refund and must tell the physician. If the refund is not made within the allotted time frame, future payments will be withheld until the recoupment is paid in full. It's a challenge to post a payment to a patient's account when there is not actually funds for deposit. Worse yet, the next several claims received by the payer are from the ophthalmologist's partner and funds are withheld from their payment.

Real-life scenario 2: A request for 30 records is received. Rather than put their best foot forward and make sure all documentation requested is submitted, the practice administrator determines that they will send in records, knowing they can always appeal. While appealing denied claims is always an

option—it is a costly one. Review the request and compile the documentation accompanied by a cover letter with further explanation and set the tone of the audit.

It's not a matter of if but when that request for records arrives from a third-party payer. Having written protocols in place will help ease your angst. Consider this written protocol. Customize to your practice.

1. Do not toss the envelope. It shows the postmark date. The letter inside may be a date much earlier than when you received the request.
2. Determine the type of audit or investigation. Visit aao.org/audits for details and updates.
CERT: Comprehensive Error Rate Testing
OIG: Office of Inspector General investigation
RA: Recovery Audit (RA) or Recovery Audit Contractor (RAC)
SMRC: Supplemental Medical Review Contractor
TPE: Targeted, Probe and Educate
UPIC: Unified Program Integrity Contractor or
ZPIC: Zone Program Integrity Contractor
3. Identify due date for records. Respond within the time limits provided, or immediately request an extension. Request and document written confirmation of new due date.
4. Identify if there is a common theme, such as:
A particular level of E/M or Eye visit code
A consistent modifier
A particular testing service
A high-volume surgery
Is it a single date of service versus a series of encounters?
5. Copy the right date of service requested.
6. For paper charts, is the physician signature present and is it identifiable? If not, immediately prepare a signature log typing the names of all who document in the medical record and identify their title, i.e., MD, DO, OD, technician, scribe, receptionist, etc. For EHR, provide documentation that the physician signature is

“secure” and no one has or uses the physician password. Most audits also request EHR signature protocol. Without an identifiable, secure, physician signature, the auditors do not have to complete the actual audit. They can just deny payment.

7. Provide a list of abbreviations used.
8. If the payer has a Local Coverage Determination on a test or surgery performed, quote chapter and verse from that LCD. Be sure to use the LCD in place at the time the test or surgery took place.
9. If testing services are part of the audit, make sure there is a written order that identifies by name what test, which eye(s) and the medical necessity for the test. These should be obvious in the medical record. Provide the interpretation and report as soon as possible. If the delegated test falls under direct supervision, make sure the payer is aware a physician of the practice was on site during the test.
10. If an E/M or Eye visit code, audit internally before so that you know the best case, worst case scenario.
11. Physicians should have the opportunity to review all records before they leave the office. With paper charts, if the handwriting can't be easily read, take the time to dictate (not embellish) it. Include the actual chart note plus the dictation. Only that which can be read can be audited. With EHR, make sure all fields populate. For example, if documentation shows only those body systems that have a problem and not those that are normal, you won't receive credit for 10 or more systems reviewed.
12. The Academy is here for you. Email our experts at coding@aao.org.

CHECKLISTS

Having a checklist that meets the payers' documentation requirements is the only way to consistently maintain compliance. Before the physician closes the chart with their signature, make sure each bullet in the relevant checklist has been documented and adhered to.

Checklist: Anti-VEGF Drug Treatment

- ☐ Obtain preauthorization from commercial payers if required.
- ☐ Confirm there are 28 days between injections in the same eye.
- ☐ Record surgical order which includes the drug name, dosage and indication (diagnosis) with physician signature.
- ☐ Assess visual acuity.
- ☐ Record chief complaint and elements to the HPI.
- ☐ For new patients, document why the specific drug was chosen.
- ☐ For established patients, document at each visit:
 - ☐ Why you are keeping the patient on the drug; and
 - ☐ How the patient is responding to the drug.
- ☐ For established patients, document why you are changing the drug if a change is made.
- ☐ Document how much drug was injected.
- ☐ Document how much drug was wasted. If less than one unit, state language similar to “residual medication discarded.”
- ☐ Ensure diagnosis is a covered benefit by the particular payer.
 - ☐ If it’s not a covered diagnosis, the patient is responsible for the injection and drug costs.
- ☐ Obtain documentation that the patient desires surgery.
- ☐ Obtain informed consent if it’s the first injection or there is a change in medication or eye.
- ☐ Maintain legible medication administration records.

Note:

- Adhere to each payer policy. For Medicare’s local coverage determination visit aao.org/lcds.
 - For example, the LCD for First Coast states, “Macugen (pegaptanib sodium injection) may be considered medically necessary for the treatment of the following indications: Neovascular (wet) age-related macular degeneration (AMD). Macugen 0.3 mg should be administered once every 6 weeks by intravitreal injection (45 days).”
- Never share a vial between both eyes. Correct billing is one eye per vial.

Checklist: Blepharoplasty

Chief complaint

- ☐ Document patient's unique functional (not cosmetic) chief complaint, including any of the following:
 - ☐ Not cloned from patient to patient
 - ☐ Primary gaze and/or down gaze (eg, reading position)
 - ☐ Looking through eyelashes
 - ☐ Seeing upper lid skin

Document the following when applicable

- ☐ Blepharochalasis
- ☐ Dermatochalasis
- ☐ Horizontal eyelid laxity
- ☐ Pseudoptosis
- ☐ Patient complaints and relevant medical history (eg, failure to respond to botulinum toxin therapy, botulinum toxin therapy is contraindicated, etc.)

Ptosis

- ☐ When applicable, document brow ptosis: drooping of the eyebrows to such an extent that excess tissue is pushed into the upper eyelid. It is recognized that in some instances the brow ptosis may contribute to significant superior visual field loss. It may coexist with clinically significant dermatochalasis and/or lid ptosis.

Other requirements

- ☐ Obtain ABN and append modifier -GA to surgical code.
- ☐ Obtain signed operative report.

Note:

- Testing requirements vary by payer, including Medicare contractors.
- Not all payers require visual fields and photos. Some only fields. Some only photos (see the following table Checklists Per Carrier). When fields and/or photos are not required documentation, and you perform the tests anyway, do not submit a claim to the payer.
- Bill one unit of service for visual fields and/or photographs, even if multiple studies are performed.
- Visual fields and/or photographs must be identified with the beneficiary's name and the date.
- Visual fields 92081 or 92082 and photographs 92285, are bundled with blepharoplasty surgery when performed the same day of surgery.
- If using a cell phone for photos, make sure you are HIPAA compliant.
- If not recorded in the chart, photos should be readily available if documentation is requested.
- CCI edits bundle functional blepharoplasty and functional ptosis.

Medicare Carrier Part B	Checklists Per Carrier – as of August 2018
CIGNA Government Services Kentucky/Ohio	<p>Visual fields, taped and untaped, must demonstrate:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Significant loss of superior visual field and potential correction of the visual field by the proposed procedure(s); <input type="checkbox"/> A minimum 12-degree or 30-percent loss of upper field of vision with upper lid skin and/or upper lid margin in repose and elevated (by taping of the lid) to demonstrate potential correction. <p>Note: Visual field studies are not required for ectropion, entropion.</p> <p>Photographs</p> <ul style="list-style-type: none"> <input type="checkbox"/> Photographs may be used to demonstrate eyelid abnormalities necessitating the procedure (s) but are not required or paid.
First Coast Service Options Florida, Puerto Rico, Virgin Islands	<p>Visual Fields, taped and untaped, must demonstrate:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Either a Goldmann Perimeter (III 4-E test object) or a programmable automated perimeter (equivalent to a screening field with a single intensity strategy using a 10 dB stimulus) to test a superior (vertical) extent of 50-60 degrees above fixation with targets presented at a minimum 4 degree vertical separation starting at 24 degrees above fixation while using no wider than a 10-degree horizontal separation; <input type="checkbox"/> Visual field interpretation should demonstrate a minimum 12-degree or 30-percent loss of upper field of vision with upper skin and/or upper lid margin taped and untaped to demonstrate potential correction by the proposed procedure; <input type="checkbox"/> If patient is unable to perform visual field testing, documentation must support evidence of the medical condition which prevents the performance of the test. Examples of medical conditions which may prevent performance of the visual field testing may include severe tremors, macular degeneration, physical deformities that prevent sitting up straight at the perimeter and glaucoma. <p>Photographs</p> <ul style="list-style-type: none"> <input type="checkbox"/> Prints or slides must be frontal, canthus-to-canthus with the head perpendicular to the plane of the camera (not tilted) to demonstrate a skin rash or position of the true lid margin or the pseudo -lid margin. <input type="checkbox"/> Oblique photos are only needed to demonstrate redundant skin on the upper eyelashes when this is the only indication for surgery.
National Government Services JK- Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont J6- Illinois, Minnesota and Wisconsin	<p>Visual fields taped and untaped required, must demonstrate:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A significant loss of superior visual field and potential correction of the visual field by the proposed procedures(s). A minimum 12-degree or 30-percent loss of upper field of vision with upper lid skin and/or upper lid margin in repose and elevated (by taping of the lid) to demonstrate potential correction by the proposed procedure or procedures is required. <input type="checkbox"/> Tangent screen visual field, Goldmann Perimeter (III 4-E test object), or a programmable automated perimeter, equivalent to a screening field with a single intensity strategy using a 10dB stimulus, to test a superior (vertical) extent of 50-60 degrees above fixation with targets presented at a minimum four-degree vertical separation starting at zero (0) degrees above fixation while using no wider than a 10-degree horizontal separation.

	<p>Note: Visual fields are not required when the reason for the lid surgery is entropion or ectropion.</p> <p>Photographs</p> <ul style="list-style-type: none"> <input type="checkbox"/> Prints, not slides, must be frontal and canthus-to-canthus with the head perpendicular to the plane of the camera (ie, not tilted) in order to demonstrate the position of the true lid margin or the “false lid margin” in the case of pseudoptosis caused by severe dermatochalasis. <input type="checkbox"/> The photographs must be of sufficient clarity to show a light reflex on the cornea or the relationship of the eyelid to the cornea or pupil (except in cases where the lid margin obscures the corneal light reflex or a digital camera is used and there is no light reflex). Photographs for the purpose of justifying an eyelid procedure(s) and/or brow ptosis procedures due to superior visual field loss must demonstrate that the upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex. <input type="checkbox"/> Blepharoplasty must portray both eyelids in the frontal (straight-ahead) position demonstrating: <ul style="list-style-type: none"> <input type="checkbox"/> Upper eyelid skin resting on the eyelashes or over the eyelid margin; or, <input type="checkbox"/> Excessive dermatochalasis pushing the eyelid margin down to an abnormally low position; or, <input type="checkbox"/> One of the above in cases of the induction of visually compromising dermatochalasis after ptosis repair in patients having a large dehiscence of the levator aponeurosis. <input type="checkbox"/> In addition, an operative note documenting the skin excess after the ptosis has been repaired, and that blepharoplasty is indicated for its repair, is also required. <input type="checkbox"/> Blepharoptosis repair must portray both eyelids in the frontal (straight-ahead) position demonstrating: <ul style="list-style-type: none"> <input type="checkbox"/> True lid ptosis; the upper eyelid position with respect to a prosthesis in an anophthalmic socket or to the globe in congenital or acquired microphthalmos or in enophthalmos. <input type="checkbox"/> Blepharoptosis repair and blepharoplasty must portray both eyelids in the frontal (straight-ahead) position demonstrating: <ul style="list-style-type: none"> <input type="checkbox"/> Presence of true lid ptosis when excessive skin is elevated by taping or is otherwise retracted, especially if it lies below the position of the true eyelid margin. <input type="checkbox"/> Oblique or lateral photographs may be required to demonstrate redundant skin on the eyelashes. <input type="checkbox"/> Brow ptosis (performed singly or in combination with other procedures) must be frontal demonstrating: <ul style="list-style-type: none"> <input type="checkbox"/> Drooping of brows below the superior orbital rim; and, <input type="checkbox"/> Improvement of blepharoptosis and/or dermatochalasis by elevation of the brows.
<p>Noridian Healthcare Solutions</p> <p>JE- California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands</p> <p>JF- Alaska, Arizona, Idaho, Montana, North</p>	<p>Photographs for Blepharoptosis</p> <ul style="list-style-type: none"> <input type="checkbox"/> A margin reflex distance (MRD sometimes referred to as MRD1) of 2.0 mm or less. The MRD is a measurement from the corneal light reflex to the upper eyelid margin (NOT any overhanging skin that may be present causing pseudoptosis) with the brows relaxed, and <input type="checkbox"/> If applicable, the presence of Herring's effect (related to equal innervation to both upper eyelids) defending bilateral surgery when only the more ptotic eye clearly meets the MRD criteria (ie, if lifting the more ptotic lid with tape or by instillation of phenylephrine drops into the superior fornix causes the less ptotic lid to drop downward and meet the strict criteria, the less ptotic lid is also a candidate for surgical correction. <input type="checkbox"/> If an anatomic abnormality of the eye (such as an eccentric or elongated pupil) makes the MRD either difficult to establish or meaningless for this

Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	<p>purpose, it is expected the surgeon will include a statement outlining their rationale that an equivalent standard has been met.</p> <p>Upper Blepharoplasty and/or Brow Ptosis Repair:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Redundant eyelid tissue hanging over the eyelid margin resulting in pseudoptosis where the “pseudo” margin produces a central “pseudo-MRD” of 2.0 mm or less, or <input type="checkbox"/> Redundant eyelid tissue predominantly medially or laterally that clearly obscures the line of sight in corresponding gaze. <input type="checkbox"/> The patient’s head and the camera must be in parallel planes, not tilted so as not to distort the appearance of any relevant finding (eg, a downward head tilt might artificially reduce the apparent measurement of a MRD). Unless medial/lateral gaze is required to demonstrate a specific deficit, photos should be with gaze in the primary position, looking straight ahead. Oblique photos are only necessary if needed to better demonstrate a finding not clearly shown by other requested photos. Digital or film photographs are acceptable and may be submitted electronically where possible. <input type="checkbox"/> Photographs of both eyelids in the frontal (straight-ahead) position should demonstrate the MRD outlined in Section A. If the eyelid obstructs the pupil, there is a clear-cut indication for surgery. (For reference, the colored part of the eye is about 11 mm in diameter, so the distance between the light reflex and the lid would need to be about one fifth that distance or less for the MRD to be 2.0 mm or less.) <input type="checkbox"/> In the special case of documenting the need for bilateral surgery because of Herring’s law, two photos are needed: <ul style="list-style-type: none"> <input type="checkbox"/> One showing both eyes of the patient at rest demonstrating the above MRD criterion in the more ptotic eye; and <input type="checkbox"/> Another showing both eyes of the patient with the more ptotic eyelid raised to a height restoring a normal visual field, resulting in increased ptosis (meeting the above MRD standard) in the less ptotic eye. <input type="checkbox"/> Photographs of the affected eyelid(s) in both frontal (straight ahead) and lateral (from the side) positions demonstrate the physical signs in Section A. Oblique photos are only necessary if needed to better demonstrate a finding not clearly shown by frontal and lateral photos. For Brow Ptosis Repair (CPT 67900): <ul style="list-style-type: none"> <input type="checkbox"/> One frontal (straight ahead) photograph should document drooping of a brow or brows and the appropriate other criteria in Section A. If the goal of the procedure is improvement of dermatochalasis, a second photograph should document such improvement by manual elevation of brow(s). If a single frontal photograph that includes the brow(s) would render other structures too small to evaluate, additional (overlapping to the degree possible) photos should be taken of needed structures to ensure all required criteria can be reasonably demonstrated and evaluated. Documents must be identified with the beneficiary’s name and the date.
Novitas Solutions, Inc.	<p>Lower lid blepharoplasty (CPT 15820 and 15821) is considered as medically necessary when documentation reveals:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Excessive eyelid skin resting on the patient’s eyeglasses (when applicable) and interferes with vision, or causes physical discomfort and/or skin irritation;

<p>JL- Pennsylvania, New Jersey, Maryland, Delaware and the District of Columbia</p> <p>JH- Texas, Oklahoma, Colorado, New Mexico, Arkansas, Louisiana, Mississippi</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Glasses rest upon the lower eyelid tissues and cause lower eyelid ectropion as a result of the weight of the glasses and weight of the tissues; <input type="checkbox"/> Significant lower eyelid edema, causing signs and symptoms. <input type="checkbox"/> Photographs must document the above, and such photographs must include a good quality frontal photograph, with the gaze in primary position, looking straight ahead, as well as lateral photographs. When applicable, the photographs must demonstrate the eyeglasses on the skin. <p>Upper Eyelid Blepharoplasty (CPT 15822 and 15823) is considered medically necessary when:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Clinical notes, rather than formal visual field testing, support a decrease in peripheral vision and/or upper field vision; and <input type="checkbox"/> Photographs document obvious dermatochalasis, ptosis, or brow ptosis; and such photographs must be good quality frontal photographs, with the gaze in primary position, looking straight ahead. The photos must demonstrate a distance of 2 mm or less from the central corneal reflex to the upper eyelid margin or skin that overhangs the eyelid margin (pseudoptosis), or <input type="checkbox"/> Symptomatic skin rests on the upper eyelashes that cause a decrease in peripheral vision and/or upper field of vision, and photographs document the skin on the eyelashes. <p>Repair of Brow Ptosis (CPT 67900) and Blepharoptosis (CPT 67901 and 67902) are considered medically necessary for the following functional indications:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Clinical notes, rather than formal visual field testing, support a decrease in peripheral vision and/or upper field vision, from eyebrow ptosis; or <input type="checkbox"/> Brow malposition that would prevent adequate correction of dermatochalasis, blepharochalasis or blepharoptosis; and <input type="checkbox"/> Photographs document obvious dermatochalasis, ptosis or brow ptosis. <p>Ptosis Repair (CPT 67901, 67902, 67903, 67904, 67906, and 67908) is considered medically necessary when:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Clinical notes, rather than formal visual field testing, support a decrease in peripheral vision and/or upper field vision; and <input type="checkbox"/> Pre-operative photographs reveal the ptotic lid covering one-fourth of the pupil, or no greater than 2 mm above the midline of the pupil (MRD1).
<p>Palmetto GBA</p>	<p>Photographs:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Color photographs are required to support upper eyelid surgery as medically necessary. <input type="checkbox"/> The “physical signs” documented: <ul style="list-style-type: none"> <input type="checkbox"/> Redundant eyelid tissue touching the eyelashes or hanging over the eyelid margin resulting in pseudoptosis where the “pseudo” margin produces a central “pseudo-MRD” of 2.0 mm or less; or <input type="checkbox"/> Redundant eyelid tissue predominantly medially or laterally clearly obscures the line of sight in corresponding gaze; and/or erythema, edema, crusting, etc. of redundant eyelid tissue; <input type="checkbox"/> Sufficient size and detail as to make those structures easily recognizable. <input type="checkbox"/> The patient’s head must be parallel to the camera and not tilted, so as not to distort the appearance of any relevant finding (eg, a downward head tilt might artificially reduce the apparent measurement of a MRD). <input type="checkbox"/> Digital or film photographs are acceptable.

	<p>For Upper Blepharoplasty:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Photographs of both eyelids in both frontal (straight ahead) and lateral (from the side) positions demonstrate the physical signs. <p>For Brow Ptosis Repair</p> <ul style="list-style-type: none"> <input type="checkbox"/> One frontal (straight ahead) photograph should document drooping of a brow or brows and the appropriate other criteria. <input type="checkbox"/> If the goal of the procedure is improvement of blepharochalasis, a second photograph should document such improvement by manual elevation of brow(s). If a single frontal photograph that includes the brow(s) would render other structures too small to evaluate, additional (overlapping to the degree possible) photos should be taken of needed structures to ensure all required criteria can be reasonably demonstrated and evaluated. <p>For Prosthetic-Related</p> <ul style="list-style-type: none"> <input type="checkbox"/> In the case of prosthetic difficulties associated with an anophthalmic, microphthalmic or enophthalmic socket, photographic documentation demonstrating abnormalities as they relate to the abnormal upper and/lower eyelid position related to prosthesis wear are required.
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Reconstructive blepharoplasty

- When blepharoplasty is performed to correct visual impairment caused by drooping of the eyelids (ptosis); repair defects caused by trauma or tumor-ablative surgery (ectropion/entropion corneal exposure); treat periorbital sequelae of thyroid disease and nerve palsy; or relieve the painful symptoms of blepharospasm, the procedure should be considered reconstructive. This may involve rearrangement or excision of the structures with the eyelids and/or tissues of the cheek, forehead and nasal areas. Occasionally a graft of skin or other distant tissues is transplanted to replace deficient eyelid components.
- Repair of anatomical or pathological defects, including those caused by disease (including thyroid dysfunction and cranial nerve palsies), trauma or tumor-ablative surgery. Surgery is performed to reconstruct the normal structure of the eyelid, using local or distant tissue. Reconstruction may be necessary to protect the eye and/or improve visual function.
- Post-traumatic defects of the eyelid
 - Post-surgical defects after excision of neoplasm(s)
 - Lagophthalmos
 - Congenital lagophthalmos
 - Congenital ectropion, entropion
 - Congenital ptosis
 - Lid retraction or lag (due to horizontal lower eyelid laxity without ectropion or entropion, causing exposure keratopathy and/or epiphora; due to horizontal upper eyelid laxity, causing floppy eyelid syndrome; or due to orbital thyroid disease)
 - Chronic symptomatic dermatitis of pretarsal skin caused by redundant upper eyelid skin
- Prosthetic difficulties associated with an anophthalmic, microphthalmic, or enophthalmic socket, subjective complaints, examination findings (signs), and failure of prosthesis modification (when indicated) must be documented, along with photographic documentation demonstrating the

contribution of one of the above-mentioned orbital and/or globe abnormalities as they relate to the abnormal upper and/or lower eyelid position and intolerance of prosthesis wear.

- Blepharospasm is characterized by severe squinting, secondary to uncontrollable spasms the peri-ocular facial muscles. Occasionally, it can be debilitating. If other treatments have failed or are contraindicated, a blepharoplasty combined with limited myectomy may be necessary. Patient complaints and relevant medical history (eg, failure to respond to botulinum toxin therapy, botulinum toxin therapy is contraindicated, etc.) must be documented and available upon request.

Cosmetic blepharoplasty

- No ABN is required.
- Document that patient acknowledges surgery is not covered by insurance.
- If the patient insists upon claim submission, append modifier -GY to 15822 for Medicare beneficiary claim.
- Diagnosis codes considered cosmetic:

Z41.1 Encounter for cosmetic procedure
 L11.8 Other specified acantholytic disorders
 L11.9 Acantholytic disorder, unspecified
 L57.2 Cutis rhomboidalis nuchae
 L57.4 Cutis laxa senilis
 L66.4 Folliculitis ulerythematosa reticulata
 L85.8 Other specified epidermal thickening
 L87.1 Reactive perforating collagenosis
 L87.8 Other transepidermal elimination disorders
 L90.3 Atrophoderma of Pasini and Pierini
 L90.4 Acrodermatitis chronica atrophicans
 L90.8 Other atrophic disorders of skin
 L91.8 Other hypertrophic disorders of the skin
 L92.2 Granuloma faciale [eosinophilic granuloma of skin]
 L94.8 Other specified localized connective tissue disorders
 L98.5 Mucinosis of the skin
 L98.6 Other infiltrative disorders of the skin and subcutaneous tissue
 L99 Other disorders of skin and subcutaneous tissue in diseases classified elsewhere

Checklist: Botox Injections

64612: Chemodenervation of muscles by facial nerve

Documentation requirements

- ☐ Support for the medical necessity of the botulinum toxin injections
- ☐ Type of botulinum toxin used
- ☐ A covered diagnosis (however, when a form of botulinum toxin is used for an indication that is not a listed indication in the AHFS, a physician statement in the medical record stating the reason(s) why the unapproved form was used is also required)
- ☐ Strength of the toxin
 - Use J0585 Injection, onabotulinumtoxinA, 1 unit for Botox, Botox cosmetic
 - Use J0586 Injection, abobotulinumtoxinA, 5 units for Dysport
 - Use J0587 Injection, rimabotulinumtoxinB, 100 units for Myobloc
 - Use J0588 Injection, incobotulinumtoxinA, 1 unit for Xeomin
- ☐ Dosage(s), site(s) and frequency of injection
- ☐ Description of effectiveness of this treatment

Frequency edits / utilization guidelines

- CGS: It is generally not considered medically necessary to give botulinum toxin injections for spastic or excess muscular contraction conditions more frequent than every 90 days.
- First Coast: It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.
- NGS: Dose and frequency should be in accordance with the FDA label. When services are performed in excess of established parameters, they may be subject to review for medical necessity.
- Palmetto GBA: Chemodenervation treatment has a variable lasting beneficial effect from twelve to sixteen weeks, following which the procedure may need to be repeated. It is appropriate to inject the lowest clinically effective dose at the greatest feasible interval that results in the desired clinical result.
- WPS: NA
- Noridian: None

Note:

- When a patient presents with complaints of eye muscle spasms and twitches, consider the following for reimbursement before you schedule treatment:
 - Make a notation that the patient has been unresponsive to conventional methods (such as medications and physical therapy) for controlling or treating spastic conditions.
- CGS: Botulinum toxin injection therapy is accepted first line treatment for patients with blepharospasm and/or hemifacial spasm. If the upper and lower lid of the same eye and/or adjacent facial muscles, or brow are injected at the same surgery, the procedure is considered to be unilateral. Bilateral procedures will only be considered when both eyes or both sides of the face are injected.
- Payment policy allows for only one injection code per side of the body regardless of the number of needle passes made into the site.
 - Proper documentation of complex or multiple injection sites can support and warrant additional reimbursement with some commercial payers while others pay one amount regardless of the number of injections.
- WPS: Botulinum toxin type A incobotulinumtoxinA for blepharospasm, ONLY if there is a history of the beneficiary having previous history of receiving J0585 onabotulinumtoxinA.

CCI edits

G0463, 12011, 12013, 12014, 12015, 12016, 12017, 12018, 12051, 12052, 12053, 12054, 12055, 12056, 12057, 13150, 13151, 13152, 13153, 92012, 92014, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99291, 99292, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99374, 99375, 99377, 99378

Mutually Exclusive:

G0453, 0333T, 95865, 95866, 95907, 95908, 95909, 95910, 95911, 95912, 95913, 95940, 99149, 99150, 99155, 99156, 99157, 99446, 99447, 99448, 99449, 99495, 99496

Modifier usage

- When billing an established patient office visit the same day, make sure the criteria for modifier -25 is met.
- Medicare will reimburse the unused portion of these drugs only when vials are not split between patients. Use modifier -JW to code for drug wastage on a separate line of the claim form. The documentation must show in the patient's medical record the exact dosage of the drug given, exact amount and reason for unavoidable wastage and the exact amount of the discarded portion of the drug.
- Scheduling of more than one patient is encouraged to prevent wastage of botulinum toxins. If a vial is split between two patients, the billing in these instances must be for the exact amount of botulinum toxin used on each individual patient. Medicare would not expect to see billing for the full fee amount for botulinum toxin on each beneficiary when the vial is split between two or more patients.
- Bilateral procedures will only be considered when both eyes, or both sides of the face, are injected. In this case, submit the procedure with a -50 modifier. For an ASC, the appropriate site modifier (-RT and/or -LT) should be appended to indicate if the service was performed unilaterally or bilaterally. Bilateral services must be reported on separate lines using an -RT and -LT modifier (-50 modifier should not be used).
- Medicare will allow payment for one injection per site regardless of the number of injections made into the site. A site is defined as one eye (including all muscles surrounding the eye including both upper and lower lids) or one side of the face.

64615: Chemodenervation of facial muscles

Documentation requirements

- ☐ Support for the medical necessity of the botulinum toxin injections
- ☐ Type of Botulinum toxin used
- ☐ A covered diagnosis (however, when a form of botulinum toxin is used for an indication that is not a listed indication in the AHFS, a physician statement in the medical record stating the reason(s) why the unapproved form was used is also required)
- ☐ Strength of the toxin
 - Use J0585 Injection, onabotulinumtoxinA, 1 unit for Botox, Botox cosmetic
 - Use J0586 Injection, abobotulinumtoxinA, 5 units for Dysport
 - Use J0587 Injection, rimabotulinumtoxinB, 100 units for Myobloc
 - Use J0588 Injection, incobotulinumtoxinA, 1 unit for Xeomin
- ☐ Dosage(s), site(s) and frequency of injection

Frequency edits / utilization guidelines

- Dose and frequency should be in accordance with the FDA label. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Headache/migraine

- First Coast: when Botox (onabotulinumtoxin A) is used for the FDA approved indication of prophylaxis of headaches in adult patients with chronic migraine (> 15 days per month with headache lasting 4 hours a day or longer), the documentation must support these specific symptom parameters.
- CGS: Coverage will only be allowed for those patients with chronic daily headaches (headache disorders occurring greater than 15 days a month - in many cases daily with a duration of four or more hours - for a period of at least 3 months) who have significant disability due to the headaches, and have been refractory to standard and usual conventional therapy. The etiology of the chronic daily headache may be chronic tension-type headache or chronic migraine (CM). CM is characterized by headache on > 15 days per month, of which at least 8 headache days per month meet criteria for migraine without aura or respond to migraine-specific treatment. For continuing botulinum toxin therapy the patients must demonstrate a significant decrease in the number and frequency of headaches and an improvement in function upon receiving botulinum toxin.
- WPS: Migraine headaches are described as an intense pulsing or throbbing pain in one area of the head. The headaches are often accompanied by nausea, vomiting, and sensitivity to light and sound. Migraine usually begins with intermittent headache attacks 14 days or fewer each month (episodic migraine), but some patients go on to develop the more disabling chronic migraine. To treat chronic migraines, botulinum toxin is given approximately every 12 weeks as multiple injections around the head and neck to try to dull future headache symptoms. Botulinum toxin has not been shown to work for the treatment of migraine headaches that occur 14 days or less per month, or for other forms of headache.
- Noridian: Botulinum toxin is covered for prophylaxis of headaches in adult patients with chronic migraine (≥ 15 days per month with headache lasting 4 hours a day or longer).
- NGS: CM is characterized by headache on > 15 days per month, of which at least 8 headache days per month meet criteria for migraine without aura or respond to migraine-specific treatment. For continuing botulinum toxin therapy, the patients must demonstrate a significant decrease in the number and frequency of headaches and an improvement in function upon receiving botulinum toxin.

- Palmetto GBA: Onabotulinumtoxin A (BOTOX®), is the only botulinum toxin product that is FDA-approved for the prophylaxis of headaches in adult patients with chronic migraine (≥ 15 days per month with headache lasting 4 hours a day or longer). For intractable headaches at least one of the following must be met:
 - Failed trials of at least three preventive pharmacologic migraine therapies (e.g. beta-blockers, anticonvulsants, antidepressants) with or without concomitant behavioral and physical therapies, after titration to maximal tolerated doses or have medical contraindications to common therapies or who cannot tolerate common preventative therapies; or
 - Experience chronic daily headaches or recurrent headaches at least twice per month causing disability lasting three or more days per month; or
 - Standard abortive medication is required more than twice per week, or is contraindicated, ineffective or not tolerated.

Modifiers

- When billing an established patient office visit the same day, make sure the criteria for modifier -25 is met.
- Vial for medical Botox is 100mg. The average dose is 15-50 units. Be sure to append modifier -JW to wastage of additional units so that the sum is 100 units.

CCI edits

G0463, 0333T, 12011, 12013, 12014, 12015, 12016, 12017, 12018, 12051, 12052, 12053, 12054, 12055, 12056, 12057, 13150, 13151, 13152, 13153, 64642, 64643, 64644, 64645, 64646, 92012, 92014, 95865, 95866, 95907, 95908, 95909, 95910, 95911, 95912, 95913, 95940, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99291, 99292, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99374, 99375, 99377, 99378

Mutually Exclusive: G0453, 64612, 64613, 64614, 64616, 99149, 99150, 99155, 99156, 99157, 99446, 99447, 99448, 99449, 99495, 99496

Checklist: Cataract Surgery

Documentation Requirements

- ☐ Chief complaint and impact on activities of daily living unique to each patient
- ☐ Best corrected visual acuity (only CIGNA and First Coast have visual acuity requirements)
- ☐ Other preoperative ophthalmologic studies should be reserved for special situations such as:
 - ☐ Glare testing for patients with cataracts who complain of glare, yet measure good Snellen acuity when tested in an office circumstance
 - ☐ B-scan for patients with dense cataracts which preclude visualization of the posterior segment of the eye including the vitreous or retina
 - ☐ Corneal topography for patients where significant astigmatism is present (eg, per basement membrane dystrophy or Salzmann's nodular degeneration), or for cataract surgery in an eye which has previously undergone corneal surgery, such as pterygium excision or refractive keratectomy
- ☐ Patient desires to proceed with cataract surgery.

Visual Acuity Requirements

CIGNA Government Services Kentucky, Ohio	<input type="checkbox"/> The patient has a best corrected visual acuity of 20/50 or worse at distant or near; or additional testing shows one of the following: <ul style="list-style-type: none"> • Consensual light testing decreases visual acuity by two lines, or • Glare testing decreases visual acuity by two lines
First Coast Florida, Puerto Rico, Virgin Islands	<input type="checkbox"/> Visual disability with Snellen acuity worse than 20/40 with impairment of ability to carry out needed or desired activities. The ocular exam should confirm that the best correctable visual acuity in the affected eye is worse than 20/40 and that the cataract is responsible for this. <input type="checkbox"/> For patients with a Snellen acuity of 20/40 or better, the indicators are the same as for patients with Snellen acuity of worse than 20/40. In addition, documentation must support a visual impairment such as fluctuation of visual function because of glare or reduced contrast sensitivity, which can be supported with the use of (but not limited to) procedures such as glare testing, brightness acuity testing (BAT), or contrast sensitivity testing; complaints of monocular diplopia or polyopia; or visual disparity existing between the two eyes (anisometropia).
Novitas JL- Pennsylvania, New Jersey, Maryland, Delaware and the District of Columbia JH- Texas, Oklahoma, Colorado, New Mexico, Arkansas, Louisiana, Mississippi	<input type="checkbox"/> The patient has undergone a <u>formal measure</u> that documents the patient's inability to function satisfactorily due to visual impairment while performing various Activities of Daily Living. The questionnaire must be maintained in the patient's medical records and be available upon request. <input type="checkbox"/> Confirm the maximum appropriate interval between the preoperative examination and the date of surgery is three months. <input type="checkbox"/> Confirm the patient has been educated by the surgeon about the risks and benefits of cataract surgery and the alternative to surgery and has provided informed consent.

Note:

When the only diagnosis is cataract(s), Medicare does not cover testing other than one comprehensive eye examination (or a combination of brief/intermediate examinations not to exceed the charge of a comprehensive examination) plus an appropriate ultrasound scan.

When modifiers -RT and -LT are appended to 66984 and there is laterality in the ICD-10 code, do not report a bilateral diagnosis.

Other indications for surgery

- Monocular diplopia due to a cataract in the affected eye
- Worsening angle closure due to increase in size of the crystalline lens
- A significant cataract in a patient who will be undergoing concurrent surgery in the same eye, such as a trabeculectomy or a corneal transplant when the surgeon deems that the decreased morbidity of single stage surgery is of significant benefit over surgery on separate dates

Checklist: Complex Cataract Surgery

In addition to the documentation for cataract surgery, one of the following criteria must be met to qualify as complex surgery:

- ☐ A miotic pupil that will not dilate sufficiently to allow adequate visualization of the lens in the posterior chamber of the eye and that requires the insertion of four iris retractors through four additional incisions, or
- ☐ Beehler expansion device, a Malyugin ring to expand a miotic pupil, a sector iridectomy with subsequent suture repair of iris sphincter, or sphincterotomies created with scissors, intraocular sutures, or
- ☐ Pediatric cataract surgery, which may be more difficult intraoperatively because of an anterior capsule that is more difficult to tear, cortex that is more difficult to remove and the need for a primary posterior capsulotomy or capsulorrhexis. Furthermore, there is additional postoperative work associated with pediatric cataract surgery, or
- ☐ Mature cataract requiring dye for visualization of capsulorrhexis

Note:

The use of dye for the mature cataract may not be an indication for complex cataract surgery for all commercial payers.

The best way to indicate to the payer that the cataract surgery was complex is to choose the appropriate ICD-10 code. The options listed in Medicare administrative contractor local coverage determinations are:

- Use H21.261-H21.263, H21.269, H21.29, H21.561-H21.563, H21.569 if the operative note indicates the use of an endocapsular ring to partially occlude the pupil.
- Use H21.271-H21.273, H21.279, H26.211-H26.213, H26.219, H26.221-H26.223, H26.229 if the operative note indicates micro iris hooks were inserted through four separate corneal incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, or sector iridotomy with suture repair of iris sphincter.
- Use H21.221-H21.223, or H21.229 if the operative note indicates permanent intraocular suture or a capsular support ring was employed to place the IOL in a stable position.
- Use H21.531-H21.533, or H21.539 if the operative note indicates a capsular support ring was employed or an endocapsular support ring was used to partially occlude the pupil.
- Use E08.36, E09.36, E10.36, E11.36, E13.36, H21.81, H21.89, H21.9, H22, H25.031-H25.033, H25.039, H25.041-H25.043, H25.049, H25.10-H25.13, H25.89, H25.9, H26.001-H26.003, H26.009, H26.041-H26.043, H26.049, H26.051-H26.053, H26.059, H26.011-H26.013, H26.019, H26.031-H26.033, H26.039, H26.061-H26.063, H26.069, H26.09, H26.101-H26.103, H26.109, H26.121-H26.123, H26.129, H26.30-H26.33, H26.8, H28, Q13.0, or Q13.2 if the operative note indicates the use of micro iris hooks inserted through four separate corneal incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, the IOL implant was supported by using permanent intraocular sutures or a capsular support ring, or an endocapsular ring was used to partially occlude the pupil.
- Use H25.011-H25.013, H25.019, H25.811-H25.813, H25.819, H25.89 if the operative note indicates the use of micro iris hooks inserted through four separate corneal incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, the IOL implant was supported by using permanent intraocular sutures or a capsular support ring, or an endocapsular ring was used to partially occlude the pupil.
- Or, when Trypan Blue or isocyanine green is employed to enhance visualization:
 - Use H25.89 if the operative note indicates dye was used to stain the anterior capsule.
- Use H25.20, H25.21, H25.22, or H25.23 with H40.89, phacolytic glaucoma or dye staining of the anterior capsule.

- Use H26.111-H26.113, H26.119, H26.131-H26.133, H26.139, if the operative note indicates the use of micro iris hooks inserted through four separate corneal incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, the IOL implant was supported by using permanent intraocular suture or a capsular support ring was employed.
- Use H26.20 if the operative note indicates the use of micro iris hooks inserted through four separate corneal incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, IOL implant was supported by using permanent intraocular sutures, a capsular support ring was employed, or a primary posterior capsulorrhexis was performed.
- Use H28 if the operative note or postoperative records indicate an extraordinary amount of work was involved in the preoperative or postoperative care.
- Use H27.10, H27.111-H27.113, H27.119, H27.121-H27.123, H27.129, H27.131-H27.133, H27.139, Q12.1, Q12.2, Q12.4, or Q12.8 if the operative note indicates the IOL was supported by using permanent intraocular sutures or a capsular support ring was employed.
- Use H57.00-H57.04, H57.051-H57.053, H57.059, H57.09 or H57.9 if the operative note indicates the use of micro iris hooks inserted through four separate incisions, Beehler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, or an artificial prosthetic iris was placed in the eye.
- Use Q13.1 if the operative note indicates the IOL was supported in the eye by using permanent intraocular sutures, a capsular support ring was employed or an endocapsular ring was used to partially occlude the pupil.

Checklist: ICD-10 Linkage Documentation

☐ **Link the appropriate diagnosis code.**

When coding for ophthalmic services, link the ICD-10 code to the CPT code that accurately reflects the diagnosis of the exam, test or surgery provided. Review of the medical records would indicate the appropriate diagnosis per service and the claim accurately reflects this correlation.

Case study – Examination billed today for a patient with:

- Lattice degeneration, left eye (H35.412)
- Nonexudative macular degeneration, intermediate, left eye (H35.3122)
- Horseshoe tear of retina, right eye (H33.311)
- Examination and laser to repair the retinal tear is performed
- Correct coding reflects the appropriate diagnosis pointer

99XXX or 92XXX -57 H33.311, H35.3122, H35.412
67145 -RT H33.311

☐ **File insurance claim.**

Complete CMS-1500 paper claim or Electronic Data Interface (EDI) transaction 837P electronic claim with:

- ☐ Diagnosis codes listed in box 21 (up to 12) coded to the highest level of specificity for the date of service, however up to four can be linked to individual service,
- ☐ ICD-10 codes listed in order of priority,
- ☐ The diagnosis code pointer (A-L) entered in box 24 E from box 21 that links to the procedure code in 24D.
 - For example, the above would be listed as:

Box 21

A - H33.311, B - H35.3122, C- H35.412

Box 24

Box 24 D - 99XXX or 92XXX -57

Box 24 E - A, B, C

Box 24 D - 67145 -RT

Box 24 E - A

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												ICD Ind.		22. RE PC			
A. _____			B. _____			C. _____			D. _____			23. PF					
E. _____			F. _____			G. _____			H. _____								
I. _____			J. _____			K. _____			L. _____								
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		S.	
From MM DD YY To MM DD YY						SERVICE				CPT/HCPCS MODIFIER							
1																	
2																	

☐ **Use insurance policies as a reference.**

It is the responsibility of the provider to code to the highest level specified in ICD-10. Review the Medicare Administrative Contractors (MAC) Local Coverage Determination (LCD) and National Coverage Determination (NCD) or other commercial insurance policies, as

applicable. These policies provide guidance for insurance coverage, documentation requirements and approved ICD-10 codes for an ophthalmic service.

- ☐ **Record chart notes supporting medical necessity per insurance policies.**
A review of the patient's medical records reveals documentation of the medical necessity for the services provided and reflects the context of a changing clinical picture.
It is inappropriate to bill rule-out diagnoses. When a diagnosis is not made, best to use the sign or symptom for which the patient presented.
- ☐ **Obtain physician signature.**
 - ☐ Ensure the physician signature is legible on paper chart records.
 - ☐ Create a signature log to provide during an audit. The log should include initials and signature and credentials of all who may document in the chart.
 - ☐ For EHR, the electronic physician signature is secure. Ensure the practice has an electronic signature policy to provide in the event of an audit.
- ☐ **Chart notes have the correct beneficiary name and date of birth.**
- ☐ **Prepare abbreviation list.**
The practice has an approved abbreviation list readily available for all audits.

Checklist: Lesion Removal

Chief complaint must be functional in nature. If cosmetic, do not submit a claim to the payer.

Indications

The lesion has one or more of the following characteristics:

- ☐ Bleeding
- ☐ Persistent or intense itching
- ☐ Pain
- ☐ The lesion has physical evidence of inflammation (purulence, oozing, edema, erythema, etc.)
- ☐ The lesion obstructs an orifice or clinically restricts vision
- ☐ There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on lesional appearance, such as increased rate of growth and/or color changes
- ☐ The lesion is in an anatomical region subject to recurrent physical trauma and there is documentation that such trauma has in fact occurred

Wart destruction will be covered if it falls under one of the conditions of the first five bullets above. In addition, because warts are a viral infection of the skin, wart destruction will be covered when any one of the following clinical circumstances is present:

- Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesional virus shedding
- Warts of recent origin in immunosuppressed patients

Documentation requirements

- ☐ Superficial or depth - determines integumentary vs. eye and ocular adnexa section of CPT
 - ☐ Size before excision measured in cm
 - ☐ Location
 - ☐ Number of lesions removed
 - ☐ Technique used for excision
 - ☐ Whether or not specimen was sent to pathology
-
- ☐ Obtain an ABN and append modifier -GA for Medicare Part B patients.
 - ☐ The patient has provided informed consent.
 - ☐ The patient wishes to proceed with surgery.

Note:

New patient exams are separately billable.

While medically necessary, if the established patient exam was performed solely to confirm the need for the lesion removal, then the exam is not separately billable.

Checklist: Level of Exam Documentation

- ☐ **Use insurance policies as a reference.**
Review the Medicare Administrative Contractors (MAC) Local Coverage Determination (LCD) and National Coverage Determination (NCD) or other commercial insurance policies, as applicable. These policies provide guidance for insurance coverage and documentation requirements.
 - ☐ **Record chart notes supporting medical necessity per insurance policies.**
A review of the patient's medical records reveals documentation of the medical necessity for the services and exam elements provided.
 - ☐ **Determine appropriate level of Eye visit code.**
 - ☐ Eye visit codes, intermediate (92002 and 92012)
 - ☐ Chief complaint
 - ☐ History
 - ☐ General medical observation
 - ☐ Visual acuity
 - ☐ External ocular exam
 - ☐ Adnexal exam
 - ☐ May include use of mydriasis or ophthalmoscopy
 - ☐ Eye visit codes, comprehensive (92004 and 92014)
 - ☐ Chief complaint
 - ☐ History
 - ☐ General medical observation
 - ☐ Evaluation of the complete visual system
 - ☐ Visual acuity
 - ☐ External ocular exam
 - ☐ Gross visual fields
 - ☐ Basic sensorimotor exam
 - ☐ Tonometry
 - ☐ Fundus exam (dilation as medically indicated)
 - ☐ All 12 elements of the exam performed through dilated pupils unless contraindicated
 - ☐ **Determine appropriate level of E/M Code per the 1997 Audit Guidelines for single organ system.**
 - ☐ Use the Academy resource: *E/M Internal Chart Auditor for Ophthalmology*.
 - ☐ **Documentation Requirements for CPT Codes 99201, 99202, 99213, 99214, 99204 and 99205:**
 - ☐ History - the chief complaint and pertinent elements to the history of the present illness is completed, along with the past, family and social history and pertinent review of systems.
 - ☐ Examination elements are medically necessary and documented as performed.
 - ☐ Medical risk and decision making is clearly recorded and meets the level of service billed.
- 99201, new patient, level 1 or 99212, established patient, level 2**
History is **problem focused**, exam is **problem focused** and medical decision making is of **straight forward** risk

99202, new patient, level 2

History is **expanded**, exam is **expanded** and medical decision making is of **straight forward** risk

99213, established patient, level 3

History is **expanded**, exam is **expanded** and medical decision making is of **low** risk

99203, new patient, level 3

History is **detailed**, exam is **detailed** and medical decision making is of **low** risk

99214, established patient, level 4

History is **detailed**, exam is **detailed** and medical decision making is of **moderate** risk

99204, new patient, level 4

History is **comprehensive**, exam is **comprehensive** and medical decision making is of **moderate** risk

99205, new patient, level 5 or 99215, established patient, level 5

History is **comprehensive**, exam is **comprehensive** and medical decision making is of **high** risk

☐ **File insurance claim.**

Complete CMS-1500 paper claim or Electronic Data Interface (EDI) transaction 837P electronic claim with:

- ☐ Appropriate level of exam that is billed,
- ☐ Diagnosis codes accurately linked to the office visit, and
- ☐ Any necessary modifiers that are used.

☐ **Obtain physician signature.**

- ☐ Ensure the physician signature is legible on paper chart records.
- ☐ Create a signature log to provide during an audit. The log should include initials and signature and credentials of all who may document in the chart.
- ☐ For EHR, the electronic physician signature is secure. Ensure the practice has an electronic signature policy to provide in the event of an audit.

☐ **Chart notes have the correct beneficiary name and date of birth.**

☐ **Prepare abbreviation list.**

The practice has an approved abbreviation list readily available for all audits. When possible, use industry standard abbreviations.

Frequency

- The frequency of the office visit is based on the medical necessity.
- Medicare has no frequency edits for medically necessary E/M or Eye codes billed.
- Commercial or Medicaid products may limit Eye codes to be billed annually and with a vision diagnosis.

Note:

Reference these Academy resources to determine the level of Eye visit code and E/M code:

1-Hour Coding Course: Eye Visit Code Documentation Guidelines

1-Hour Coding Course: E/M Documentation Guidelines for All Subspecialties

Checklist: Medical Chart Review Standards

The following managed care plan audit guidelines, developed by the National Committee for Quality Assurance to review medical records, are used by numerous plans.

- ☐ If paper records, are all documents properly secured to chart?
- ☐ Do all pages contain the correct patient ID?
- ☐ Is documentation legible? If not, take the time to dictate. Auditors can only audit that which they can read.
- ☐ Is the physician identified with their signature on each date of service?
- ☐ Are all entries dated, including the year?
- ☐ Is all clinical staff assisting identified in each chart entry?
- ☐ Are the entries written in a consistent, organized format? There should be no subjective or personal remarks about the patient, family or other caregivers noted in the chart.
- ☐ Are all record entries legible?
- ☐ Are errors made in documentation clearly labeled as an error with the standard of policy utilized? There should be no omissions, erasures, white-out or missing pages.
- ☐ Are allergies and adverse reactions to medications prominently displayed on all medical charts?
- ☐ Are lab and other studies ordered and documented as appropriate? Is there a physician order and test results (interpretation and report) documented?
- ☐ Are any prescriptions and refills documented?
- ☐ How do you differentiate patients with the same name?
- ☐ Are reported diagnoses consistent with findings?
- ☐ Are plans of action or treatment consistent with the diagnosis or diagnoses?
- ☐ Is the surgical consent form signed, witnessed and dated (if applicable) with the correct eye(s) noted?
- ☐ Is there a date noted for a return visit or other follow-up plan for each encounter?
- ☐ Are problems from previous visits addressed?
- ☐ Do consultant summaries, lab and imaging study results reflect the physician's review?
- ☐ Are all telephone calls regarding patient care documented?
- ☐ Check to ensure only approved abbreviation(s) are used in documentation.
- ☐ Is the physician signature legible or is the EHR signature secure?

Checklist: Medical Necessity

Medical necessity according to insurance carriers:

- Patient services are determined by the treating physician and based on their preferred practice patterns, training, peer review journals and experience. Ophthalmologists use their best judgment to determine the appropriate diagnosis and treatment for each patient. Generally, these services are considered medically necessary by the medical community and peers.
- Insurance carriers, however, may consider some services not medically necessary, even when the physician considers it the best treatment for their patient. Examples may include:
 - Treatment not approved by the FDA
 - New and emerging technology (Category III codes)
 - Experimental services
 - Excessive frequency based on administrative policy
 - Screenings
 - Routine examinations

☐ **Use insurance policies as a reference to determine medical necessity.**

Review the Medicare Administrative Contractors (MAC) Local Coverage Determination (LCD) and National Coverage Determination (NCD) or other commercial insurance policies, as applicable. These policies provide guidance for insurance coverage and documentation requirements.

Practices should be signed up for payer listservs and bulletins, as once this information has been disseminated they feel you should be informed.

If policies are unable to be found online, consider reaching out to provider or contract representatives for assistance.

☐ **Record chart notes supporting medical necessity per insurance policies.**

A review of the patient's medical records reveals documentation of the medical necessity for the services provided and reflects the context of a changing clinical picture.

☐ **Complete preauthorization and predetermination appropriate.**

Preauthorization (PA) is a process to determine the medical necessity for treatment as required by insurance carriers for certain covered services. If the PA is required and not completed, the claim will be denied. Many insurance carriers will not allow retroactive requests for PAs. Even when obtained, a PA is not a guarantee of payment.

Predetermination is a voluntary request to review a service, prior to treatment, to determine the medical necessity and possible approval based on policies. This process would not replace the PA process if required.

☐ **Use Advance Beneficiary Notice of Noncoverage (ABN) appropriately.**

For Medicare Part B beneficiaries only, an ABN is used when:

- You believe Medicare will not pay for an item or service;
- Medicare usually covers a service but is expected to deny because in this case it may not be medically necessary for this beneficiary;
- Experimental and investigational as determined by Medicare;
- Not indicated for the diagnosis and/or treatment per policy;

- Services are always denied for medical necessity;
- When a service exceeds the frequency limits based on Medicare policy.

ABN should NOT be used when:

- The liability shifts to the beneficiary for exclusions under Medically Unlikely Edits (MUEs);
- The patient is charged for a component of a service when Medicare pays for the full service through a bundled payment;
- Payment transfers to the beneficiary for a Medicare-covered service;
- Patients have insurance coverage under a Medicare Advantage Plan (MA), commercial plan or Medicaid. These insurance carriers may have their own waiver of liability form. If not, an internal practice waiver of liability may be used to disclose non-covered services under these plans.

☐ **Frequency**

- Bill the frequency of the medically necessary test based on the insurance policies guidelines.

☐ **File insurance claim.**

Complete CMS-1500 paper claim or Electronic Data Interface (EDI) transaction 837P electronic claim with:

- ☐ Appropriate CPT code that is billed,
- ☐ ICD-10 codes accurately linked to the appropriate service, and
- ☐ Any necessary modifiers that are used.
- ☐ If an ABN is completed, append the -GA modifier to CPT code. When Medicare should deny the services billed, use a -GY modifier.

☐ **Obtain physician signature.**

- ☐ Ensure the physician signature is legible on paper chart records.
- ☐ Create a signature log to provide during an audit. The log should include initials and signature and credentials of all who may document in the chart.
- ☐ For EHR, the electronic physician signature is secure. Ensure the practice has an electronic signature policy to provide it in the event of an audit.

☐ **Chart notes have the correct beneficiary name and date of birth.**

☐ **Prepare abbreviation list.**

The practice has an approved abbreviation list readily available for all audits.

Checklist: Punctal Occlusion

Documentation requirements

- ☐ Chief complaint of chronic dry eye syndrome includes the following symptoms: foreign body sensation, itching, excessive mucus secretion, dryness, burning, photosensitivity, redness, and pain.
- ☐ Document other methods that have been tried and failed, such as trial period of synthetic tears.

Indications

- Superficial punctate keratopathy
- Corneal erosions or ulceration
- Filamentary keratitis
- Corneal scarring
- Conjunctival findings, such as from the keratoconjunctivitis associated with Sjogren's syndrome
- Dry eye symptoms (eg, blurred vision, reflex tearing, mucous precipitation) not adequately relieved by artificial tears

Note:

Separate reimbursement for tear production measurement (Schirmer test), tear break-up time (TBUT), dye disappearance testing (sodium fluorescein), Jones dye testing or saccharine testing is not separately billable and considered part of the E/M or Eye visit code.

Replacement of silicone punctal plugs or other long-lasting plugs (4-6 months) is generally not medically necessary more frequently than every 6 months unless they spontaneously and/or inadvertently come out. In this case a single replacement will be allowed. If punctal plugs do not stay in place because of anatomical reasons, other forms of punctal occlusion should be considered.

Supply of plugs

For Medicare Part B cost of plugs is built into payment.

For commercial payers, consider:

A4262 Temporary tear duct plug, or

A4263 Permanent tear duct plug.

Checklist: Testing Services

Corneal Pachymetry

Documentation requirements

- ☐ Obtain physician order.
Written or electronic physician order for each test includes:
 - ☐ Date of service
 - ☐ Medically necessary diagnosis
 - ☐ Eye(s) being tested
 - ☐ Physician signature
- ☐ Indicate RT, LT, OU.
- ☐ Obtain ABN for Medicare Part B patient and append modifier -GA to 76514.
- ☐ Ensure physician initials test.
- ☐ Ensure physician provides interpretation and report. This should be documented in the same location for each patient, each physician in the practice so that it is easily found.

Indications should be one of the following:

- The amount of endothelial trauma sustained during surgery
- Assessment of the health of the cornea pre-operatively in Fuch's dystrophy
- Post ocular trauma
- Assessment of corneal thickness or (in suspected glaucoma) following the diagnosis of increased intraocular pressure prior to the initiation of a treatment regimen for glaucoma

When there is a question of corneal disease supported by diagnosis, then pachymetry may be performed at the same time as endothelial cell count.

Frequency

- Once per lifetime, for glaucoma, unless there has been interval corneal trauma or surgery

Limitations

- Not covered in preparation for surgery to reshape the cornea of the eye for the purpose of correcting visual problems (refractive surgery), such as myopia (nearsightedness) and hyperopia (farsightedness)

Checklist: Testing Services

Corneal Topography 92025

Documentation requirements

- ☐ Obtain physician order.
Written or electronic physician order for each test includes:
 - ☐ Date of service
 - ☐ Medically necessary diagnosis
 - ☐ Eye(s) being tested
 - ☐ Physician signature
- ☐ Indicate RT, LT, OU.
- ☐ Legible documentation must show medical necessity for testing.
- ☐ The ordering physician must document the order in the chart, or it should be easily inferred, including the test, the eye and the reason. The physician should document the interpretation and include a signature.
- ☐ Ensure physician initials test.
- ☐ Ensure physician provides interpretation and report. This should be documented in the same location for each patient, each physician in the practice so that it is easily found.

Note:

- Screening for any condition is not medically reasonable and necessary and should not be submitted to the payer. The patient would be responsible and should be notified prior to testing.
- Medicare states supervision rules do not apply.
- Corneal topography is not used for manual keratometry, which is part of a single system Evaluation and Management or ophthalmological service.
- May be used for Orb scan.
- CGS states: Corneal topography should not be reported with or during the postoperative period for corneal procedures, eg, 65710, 65730, 65750, 65755, 65756, 65757 and 65770.
- May be used for pre-operative cataract patients with irregular astigmatism.
- Follow-up testing is not typically covered.
- Both CGS and FCSO have LCD policies on 92025. Coverage indications include:
 - Preoperative evaluation of irregular astigmatism for intraocular lens power determination with cataract surgery
 - Monocular diplopia
 - Post-surgical or post-traumatic astigmatism, measuring at a minimum of 3.5 diopters
 - Post-penetrating keratoplasty surgery
 - Post-surgical or post-traumatic irregular astigmatism
 - Complications of transplanted cornea
 - Post-traumatic corneal scarring
 - Pterygium and/or corneal ectasia that cause visual impairment
- Unique coverage for FCSO includes:
 - Bullous keratopathy
 - Corneal dystrophy
 - Complications of transplanted cornea
 - Keratoconus
- Unique coverage for CGS includes:
 - Diagnosis of early keratoconus
 - Suspected irregular astigmatism based on retinoscopic streak or conventional keratometry
 - Certain corneal dystrophies

CCI edits

92025 is bundled with the following CPT codes:

65760 Keratomileusis
65765 Keratophakia
65767 Epikeratoplasty
65771 Radial keratotomy

Checklist: Testing Services

Extended Ophthalmoscopy (EO) Documentation

Documentation is not for a routine direct and/or indirect ophthalmoscopy

- ☐ Include routine ophthalmoscopy in the appropriate level of office visit coded.

Retinal drawing

The definition of EO is a more extensive examination that requires a detailed and labeled drawing that cannot be documented in any other way. Although it may be preferred, a color drawing for EO is not a documentation requirement for most payers.

- ☐ Provide a drawing that is clearly identified, labeled and appropriately represents the retinal pathology is required.
- ☐ Document that the diagnostic technique used is completed (360-degree scleral depression, fundus contact lens, or a 90D lens).

Completing the retinal drawing directly from the OCT findings is not appropriate.

An EO performed during the global period of a related surgery is non-covered.

Interpretation and report

- ☐ Complete an interpretation and report for the EO.
 - There are no published documentation requirements for the interpretation and report.

Insurance claim

Complete CMS-1500 paper claim or Electronic Data Interface (EDI) transaction 837P electronic claim completed with:

- ☐ 92225 or 92226 with appropriate diagnosis linkage and modifiers.
- ☐ Append the appropriate modifier. Most payers recognize -RT and -LT modifiers when billing for the bilateral EO. Some payers may require the -50 modifier.
- ☐ EO is bundled the same day as retinal procedures.
- ☐ 92225 and 92226 have a bilateral indicator of 3, which would pay 100% allowable per eye.

Physician signature

- ☐ Ensure the physician signature is legible on paper chart records.
- ☐ Create a signature log to provide during an audit. The log should include initials and signature and credentials of all who may document in the chart.
- ☐ For EHR, the electronic physician signature is secure. Ensure the practice has an electronic signature policy to provide in the event of an audit.

Other requirements

- ☐ Chart notes have the correct beneficiary name and date of birth.
- ☐ Prepare abbreviation list.
The practice has an approved abbreviation list readily available for all audits.

Chart notes supporting medical necessity per insurance policies

Medicare MACs with local coverage determinations (LCDs) include: Palmetto, NGS, CGS and First Coast.

- Review the patient's medical records for EO documentation of the medical necessity, including the pathology per eye if billed bilaterally.
- Confirm that an EO of the fellow eye without pathology was not billed to insurance as this would not be considered medically necessary.

The documentation and billing of the initial and subsequent EO meets the coding definitions

- EO initial (92225) documents the initial extended ophthalmoscopy or a new event (diagnosis).
- EO subsequent (92226) is used when following a chronic condition, after the initial extended ophthalmoscopy, with progression of the disease.

Checklist: Testing Services

Fluorescein Angiography (FA) / Fundus Photography (FP) Documentation

- ❑ **Use insurance policies as a reference.**
Review the Medicare Administrative Contractors (MAC) Local Coverage Determination (LCD) and National Coverage Determination (NCD) or other commercial insurance policies, as applicable. These policies provide guidance for insurance coverage and documentation requirements.
- ❑ **Record chart notes supporting medical necessity per insurance policies.**
A review of the patient's medical records provides documentation of the medical necessity for the diagnostic test billed including the pathology per eye and reflects the context of a changing clinical picture.
 - Diagnostic testing performed for screening purposes would not be deemed medically necessary.
 - Medicare MACs with local coverage determinations for FA include: CGS, First Coast and Palmetto.
 - Medicare MACs with local coverage determinations for FP include: CGS, First Coast, NGS and Palmetto.
 - When reviewing documentation for insurance payers without policies, the Academy Coding Coach can be used as a guideline for medically necessary diagnoses.
 - Fluorescein Angiography is used to identify by fluorescence the leaking from damaged vessels and make it useful in the diagnosis of chorioretinal vascular disorders, especially relating to choroidal neovascularization, noninfective vasculitis and age-related macular degeneration.
 - Fundus photography is covered when used to diagnose abnormalities of the retina. The photos may be necessary to follow the progress of a disease or to plan treatment.
- ❑ **Obtain physician order.**
Written or electronic physician order for each test includes:
 - ❑ Date of service
 - ❑ Medically necessary diagnosis
 - ❑ Eye(s) being tested
 - ❑ Physician signature
- ❑ **Medical records include the following.**
 - ❑ A copy of the photography for each diagnostic test (digital or photographic)
 - ❑ Record of whether the pupil was dilated and the medication that was used
 - ❑ Relevant examination, history and diagnostic testing related to the medical necessity
- ❑ **Complete interpretation and report for each test performed per eye.**
 - FA and FP reports are not combined.
 - There are no published documentation requirements for the interpretation and report.
The required documentation could include:
 - Clinical findings – *summary of pertinent findings*
 - Comparative data – *better, worse or same*
 - Clinical management – *how test effected management*
- ❑ **Frequency of the medically necessary test should be billed based on the insurance policies guidelines.**
 - Some MACs have published LCDs with the following frequency requirements:
 - FA should not be billed more than 9 times per year.
 - FP is usually not medically necessary more than 1-2 times per year.
 - FA should not bill within 30 days of billing for Indocyanine Green Angiography (ICG).

- The frequency for performing FA or FP is based on indication.
- FA is used to document recurrent leakage for patients with dry AMD every 6-12 months.
- **File insurance claim.**
Complete CMS-1500 paper claim or Electronic Data Interface (EDI) transaction 837P electronic claim completed with the following:
 - FA (92235) and FP (92250) are billed with appropriate diagnosis linkage supporting the medical necessity.
 - FP (92250) is bundled the same day as Optical Coherence Tomography (OCT), 92132, 92133, and 92134.
 - 92235 and 92250 have a bilateral indicator of 2 and are considered inherently bilateral. It is inappropriate to use -RT, -LT or -50 modifiers.
- **Obtain physician signature.**
 - Ensure the physician signature is legible on paper chart records
 - Create a signature log to provide during an audit. The log should include initials and signature and credentials of all who may document in the chart.
 - For EHR, the electronic physician signature is secure. Ensure the practice has an electronic signature policy to provides in the event of an audit.
- **Chart notes have the correct beneficiary name and date of birth.**
- **Prepare abbreviation list.**
The practice has an approved abbreviation list readily available for all audits.

CCI edits

92250: Mutually exclusive with 92227

Checklist: Testing Services

Fluorescein Angiography (FA) / Indocyanine Green Angiography (ICG) Documentation

- **Use insurance policies as a reference.**
Review the Medicare Administrative Contractors (MAC) Local Coverage Determination (LCD) and National Coverage Determination (NCD) or other commercial insurance policies, as applicable. These policies provide guidance for insurance coverage and documentation requirements.
- **Record chart notes supporting medical necessity per insurance policies.**
A review of the patient's medical records provides documentation of the medical necessity for the diagnostic test billed including the pathology per eye and reflects the context of a changing clinical picture.
 - Diagnostic testing performed for screening purposes would not be deemed medically necessary.
 - Medicare MACs with local coverage determinations (LCDs) for FA and ICG include: CGS, First Coast and Palmetto.
 - When reviewing documentation for insurance payers without policies, the Academy Coding Coach can be used as a guideline for medically necessary diagnoses.
 - Fluorescein Angiography is used to identify by fluorescence the leaking from damaged vessels and make it useful in the diagnosis of chorioretinal vascular disorders, especially relating to choroidal neovascularization, noninfective vasculitis and age-related macular degeneration.
 - Indocyanine Green Angiography (ICG) is effective when used in the diagnosis and treatment of ill-defined choroidal neovascularization (ie, associated with age-related macular degeneration)
 - ICG can be most useful in the evaluation of the following conditions:
 1. Retinal neovascularization
 2. Choroid neovascularization
 3. Serous detachment of retinal pigment epithelium
 4. Hemorrhagic detachment of retinal pigment epithelium
 5. Retinal hemorrhage
- **Obtain physician order.**
Written or electronic physician order for each test includes:
 - Date of service
 - Medically necessary diagnosis
 - Eye(s) being tested
 - Physician signature
- **Medical records include the following.**
 - A copy of the photography for each diagnostic test (digital or photographic)
 - Record of whether the pupil was dilated and the medication that was used
 - Relevant examination, history and diagnostic testing related to the medical necessity
- **Complete interpretation and report for each test performed and per eye.**
 - There are no published documentation requirements for the interpretation and report. The required documentation could include:
 - Clinical findings – *summary of pertinent findings*
 - Comparative data – *better, worse or same*
 - Clinical management – *how test effected management*
- **Frequency of the medically necessary test should be billed based on the insurance policies guidelines.**
 - Some MACs have published LCDs with the following frequency requirements:

- FA / ICG should not be billed more than 9 times per year.
- FA should not be billed within 30 days of billing for ICG.
- ☐ **File insurance claim.**

Complete CMS-1500 paper claim or Electronic Data Interface (EDI) transaction 837P electronic claim completed with the following.

 - ☐ FA and ICG performed the same day (92242) should be billed with the appropriate diagnosis linkage supporting the medical necessity.
 - ☐ FA (92235) and ICG (92240) should only be billed when these tests are performed on separate days. Test should not be scheduled on different days to avoid billing with the FA and ICG combination code (92242).
 - ☐ FA and ICG (92242) are bundled the same day as Fundus Photography (92250).
 - ☐ The code 92242 has a bilateral indicator of 2 and is considered inherently bilateral. It is inappropriate to use -RT, -LT or -50 modifiers.
- ☐ **Obtain physician signature.**
 - ☐ Ensure the physician signature is legible on paper chart records.
 - ☐ Create a signature log to provide during an audit. The log should include initials and signature and credentials of all who may document in the chart.
 - ☐ For EHR, the electronic physician signature is secure. Ensure the practice has an electronic signature policy to provide in the event of an audit.
- ☐ **Chart notes have the correct beneficiary name and date of birth.**
- ☐ **Prepare abbreviation list.**

The practice has an approved abbreviation list readily available for all audits.

Checklist: Testing Services

Indocyanine Green Angiography (ICG) Documentation

- ☐ **Use insurance policies as a reference.**
Review of the Medicare Administrative Contractors (MAC) Local Coverage Determination (LCD) and National Coverage Determination (NCD) or other commercial insurance policies, as applicable. These policies provide guidance for insurance coverage and documentation requirements.
- ☐ **Record chart notes supporting medical necessity per insurance policies.**
A review of the patient's medical records provides documentation of the medical necessity for the diagnostic test billed including the pathology per eye and reflects the context of a changing clinical picture.
 - Diagnostic testing performed for screening purposes would not be deemed medically necessary.
 - Medicare MACs with local coverage determinations (LCDs) for ICG include: CGS, First Coast and Palmetto.
 - When reviewing documentation for insurance payers without policies, the Academy Coding Coach can be used as a guideline for medically necessary diagnoses.
 - Indocyanine Green Angiography (ICG) is effective when used in the diagnosis and treatment of ill-defined choroidal neovascularization (ie, associated with age-related macular degeneration).
 - ICG can be most useful in the evaluation of the following conditions:
 1. Retinal neovascularization
 2. Choroid neovascularization
 3. Serous detachment of retinal pigment epithelium
 4. Hemorrhagic detachment of retinal pigment epithelium
 5. Retinal hemorrhage
- ☐ **Obtain physician order.**
Written or electronic physician order for each test includes:
 - ☐ Date of service
 - ☐ Medically necessary diagnosis
 - ☐ Eye(s) being tested
 - ☐ Physician signature
- ☐ **Medical records include the following.**
 - ☐ A copy of the photography for each diagnostic test (digital or photographic)
 - ☐ Record of whether the pupil was dilated and the medication that was used
 - ☐ Relevant examination, history and diagnostic testing related to the medical necessity
- ☐ **Complete interpretation and report** for each test performed and per eye.
 - There are no published documentation requirements for the interpretation and report. The required documentation could include:
 - Clinical findings – *summary of pertinent findings*
 - Comparative data – *better, worse or same*
 - Clinical management – *how test effected management*
- ☐ **Frequency of the medically necessary test should be billed based on the insurance policies guidelines.**
 - Some MACs have published LCDs with the following frequency requirements:
 - ICG should not be billed more than 9 times per year.
 - ICG should not bill billed within 30 days of billing for Fluorescein Angiography (FA).

☐ **File insurance claim.**

Complete CMS-1500 paper claim or Electronic Data Interface (EDI) transaction 837P electronic claim completed with the following:

- ☐ ICG (92240) is billed with the appropriate diagnosis linkage supporting the medical necessity.
- ☐ ICG (92240) is bundled the same day as Fundus Photography (92250).
- ☐ ICG (92240) has a bilateral indicator of 2 and is considered inherently bilateral. It is inappropriate to use -RT, -LT or -50 modifiers.
- ☐ ICG performed the same day as FA would be billed with 92242.
- ☐ FA (92235) and ICG (92240) should only be billed when these tests are performed on separate days. Test should not be scheduled on different days to avoid billing with the FA and ICG combination code (92242).

☐ **Obtain physician signature.**

- ☐ Ensure the physician signature is legible on paper chart records.
- ☐ Create a signature log to provide during an audit. The log should include initials and signature and credentials of all who may document in the chart.
- ☐ For EHR, the electronic physician signature is secure. Ensure the practice has an electronic signature policy to provides in the event of an audit.

☐ **Chart notes have the correct beneficiary name and date of birth.**

☐ **Prepare abbreviation list.**

The practice has an approved abbreviation list readily available for all audits.

Checklist: Testing Services

Scanning Computerized Ophthalmic Diagnostic Imaging—92132 Anterior Segment OCT

Documentation guidelines

- ☐ Obtain physician order for anterior segment OCT.
Written or electronic physician order for each test includes:
 - ☐ Date of service
 - ☐ Medically necessary diagnosis
 - ☐ Eye(s) being tested
 - ☐ Physician signature
- ☐ Indicate RT, LT, OU.
- ☐ Indicate medical necessity in chart note.

Usage of Anterior Segment OCT

- ☐ Narrow angle, suspected narrow angle, and mixed narrow and open angle glaucoma
- ☐ Considered medically reasonable and necessary for evaluation of specified forms of glaucoma and certain disorders of the cornea, iris and ciliary body
- ☐ Determine the proper intraocular lens for a patient who has had prior refractive surgery and now requires cataract extraction.
- ☐ Evaluate iris tumor.
- ☐ Evaluate corneal edema or opacity that precludes visualization or study of the anterior chamber.
- ☐ Calculate lens power for cataract patients who have undergone prior refractive surgery.
Reimbursement will only be made for the cataract codes as long as additional documentation is available in the patient record of the prior refractive procedure. Reimbursement will not be made in addition to A-scan or IOL master.
- ☐ Evaluate and plan treatment for patients with diseases affecting the cornea, iris, lens and other anterior segment structures.
- ☐ Provide additional information during the planning and follow-up for corneal, iris, cataract, glaucoma and other anterior segment surgeries.

Frequency edits

- 1-2 exams per year will be considered medically appropriate.

Palmetto	<ul style="list-style-type: none"> • No more than two tests are medically appropriate for patients with a diagnosis of angle closure suspect, narrow angles, angle closure, and mixed mechanism glaucoma without a significant change in clinical status. • Only one test is appropriate per three years in patients with all forms of open angle glaucoma including glaucoma suspect, ocular hypertension, secondary glaucoma, and congenital glaucoma.
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Note:

- When medically necessary, this test is payable during the global postoperative period whether related or unrelated to the surgery.
- Physician provides initial exam.
- Physician provides interpretation and report.

Bundled with 99211, 92133, 92134

Checklist: Testing Services

Scanning Computerized Ophthalmic Diagnostic Imaging—92133 Optic Nerve OCT

Documentation guidelines

- ☐ Obtain physician order for optic nerve OCT.
Written or electronic physician order for each test includes:
 - ☐ Date of service
 - ☐ Medically necessary diagnosis
 - ☐ Eye(s) being tested
 - ☐ Physician signature
- ☐ Indicate RT, LT, OU.
- ☐ Indicate medical necessity in chart note.
- ☐ Ensure physician initials test.
- ☐ Ensure physician provides interpretation and report.

Frequency edits

First Coast WPS	Only two tests are medically appropriate for patients with glaucoma or who are suspect.
CGS NGS	Once per year with mild stage, one to two times including visual field testing for patients with moderate stage. May not be medically necessary for patients with advanced stage; instead visual field may be more appropriate with no more than four in a year.

Note:

- WPS, CGS, FCSO: Physician will need to show medical necessity for additional testing when performed the same day.
- WPS: It is not necessary for patients with advanced optic nerve damage.
- Medical record must include the test results, comparison with prior tests when applicable, computer analysis of the data, and appropriate data storage for future comparison in follow-up exams.
- If bilateral studies are performed, the documentation maintained by the provider must demonstrate medical need for the performance of the test for each eye.
- When medically necessary this test is payable during the global postoperative period whether related or unrelated to the surgery.

CCI edits

- Fundus photography is bundled together. However, there are a limited number of clinical conditions where both techniques are medically reasonable and necessary on the ipsilateral eye. In these situations, you may report both codes by appending modifier -59 to CPT code 92250.
- CPT code 92133 Optic nerve OCT and Retina OCT are mutually exclusive of each other.
- Only one test can be submitted when performed at the same visit.

Diagnoses

- A few Medicare contractors removed from coverage H40.001-.003 Preglaucoma unspecified, due to the lack of specificity. Report one of the other glaucoma suspect qualifiers.

Checklist: Testing Services

Scanning Computerized Ophthalmic Diagnostic Imaging—92134 Retina

Documentation guidelines

- ☐ Obtain physician order for retina OCT.
Written or electronic physician order for each test includes:
 - ☐ Date of service
 - ☐ Medically necessary diagnosis
 - ☐ Eye(s) being tested
 - ☐ Physician signature
- ☐ Indicate RT, LT, OU.
- ☐ Indicate medical necessity in chart note.
- ☐ Legible documentation must show medical necessity for testing.
- ☐ The ordering physician must document the order in the chart, or it should be easily inferred, including the test, the eye and the reason. The interpretation should be documented by the physician and include a signature.
- ☐ Medicare states general supervision rules apply. Not all commercial payers follow these supervision rules. For those that don't they generally only allow for direct supervision, where a physician of the practice must be present in the suite. Confirm with your payer's guidelines.

Frequency edits

- One exam every two months is medically appropriate when the primary diagnosis of retinal disease is not undergoing active treatment.
- One exam per month is medically appropriate to manage retinal disease with active treatment management. These diagnoses include: wet AMD, choroidal neovascularization, macular edema, diabetic retinopathy (proliferative and nonproliferative), branch retinal vein occlusion, central retinal vein occlusion and cystoid macular edema.

Novitas and FSCO	With the development of treat and extend protocols for patients with wet AMD treated with antiangiogenic drugs, it is expected that SCODI (unilateral or bilateral) will be used for therapeutic decision making and utilized at maximum of monthly with subsequent less frequency based on the patient treatment protocol and patient response as documented in the medical record.
FSCO	Currently does not allow for 92134 to be submitted less than 31 days as they are denying claims due to frequency.

High risk medication

- When treatment is for CQ and/ or HCQ, the test is medically appropriate for a baseline examination.
 - Novitas states: patients should receive a baseline examination within the first year of treatment and as an annual follow-up after five years of treatment. For higher-risk patients, annual testing may begin immediately (without a 5-year delay).
 - Palmetto states: Current recommendations for monitoring patients taking chloroquine or hydroxychloroquine who are on a dose <5 mg/kg real weight who lack other major risk factors are recommended to undergo screening beginning at the 5th year of exposure and annually thereafter. The presence of major risk factors or a dosage exceeding 5 mg/kg real weight may necessitate earlier and more frequent screening intervals.

- WPS states: Clinical evidence has shown that long-term use of chloroquine (CQ) and/or hydroxychloroquine (HCQ) can lead to irreversible retinal toxicity. Therefore, these two medications are deemed high risk, and scanning optical coherence tomography may be indicated to provide a baseline prior to starting the medication and as an annual follow-up.

Note:

- Clinical evidence has shown that long term use of chloroquine (CQ) and/or hydroxychloroquine (HCO) can lead to irreversible retinal toxicity. Therefore, these two medications are deemed high risk, and as a result some payers will allow payment with Z79.899 Long-term use (current) use of other medications and Z09 Following completed treatment with high risk medication, as covered diagnosis codes.
- Screening for any condition is not medically reasonable and necessary and should not be submitted to the payer. The patient would be responsible and should be notified prior to testing.
- When medically necessary this test is payable during the global postoperative period whether related or unrelated to the surgery.

CCI edits

- Fundus photography and Retina OCT are bundled together in that a physician would use one technique or the other to evaluate fundus disease. However, there are a limited number of clinical conditions where both techniques are medically reasonable and necessary on the ipsilateral eye. In these situations, you may report both codes by appending modifier -59 to CPT code 92250.
- CPT code 92133 Optic nerve OCT and Retina OCT are mutually exclusive of each other. Therefore, only one test can be submitted when performed at the same visit.

Modifier usage

- This code includes a technical component (-TC) and professional component (-26). When the test is ordered by the physician who also provides the interpretation, bill the test as a global. No need to separate out each component to bill. The interpretation should be documented as soon as possible after the test has been performed.

ICD-10 codes

- Use Z03.89 when testing is necessary prior to CQ and HCQ therapy.
 - This code is inherently bilateral; therefore, no eye modifier should be appended.
 - This code includes a technical component (-TC) and professional component (-26). When the test is ordered by the physician who also provides the interpretation, bill the test as a global. No need to separate out each component to bill. The interpretation should be documented as soon as possible after the test has been performed.
- When reporting ICD-10 code Z79.899, the medical record must reflect the medication administered as well as the underlying condition for which it was given.

Checklists: Testing Services

Visual Fields

Documentation Guidelines

- ☐ Documented order for exact name of visual field
- ☐ Indicate RT, LT, OU.
- ☐ Ensure physician initials test.
- ☐ Ensure physician provides interpretation and report. This should be documented in the same location for each patient, each physician in the practice so that it is easily found.

Indications must be one of the following:

1. The patient has a disorder of the eyelid(s) potentially affecting the visual field(s).
2. The patient has a visual field defect detected on gross visual field testing (eg, confrontational testing).
3. The patient has a documented diagnosis of glaucoma. It should be noted that the progression of, and effects of treatment on glaucoma can be monitored only through periodic visual field testing. The frequency of such examinations is dependent on changes in intraocular pressure (IOP), retinal damage and changes at the optic disc.
4. The patient is suspected of having glaucoma; signs include increased intraocular pressure, asymmetric IOP measurements, notching or thinning of the neuroretinal rim, splinter hemorrhages and asymmetric appearance of the discs.
5. The patient has a documented disorder of the optic nerve, the retina or the neurologic visual pathway.
6. The patient has a recent intracranial hemorrhage, an intracranial mass or a recent increased intracranial pressure measurement (with or without visual symptoms).
7. The patient has a recent occlusion / stenosis of cerebral or precerebral arteries.
8. The patient has a history of a cerebral aneurysm, pituitary or occipital tumor potentially affecting the visual fields.
9. The patient is being evaluated for buphthalmos, congenital anomalies of the posterior segment or congenital ptosis.
10. The patient has a disorder of the orbit potentially affecting the visual field.
11. The patient has sustained a significant eye injury.
12. The patient has unexplained visual loss.
13. The patient has a pale or swollen optic nerve on a recent examination.
14. The patient is having new functional limitations which may be due to visual field loss (eg, reports by family of patient bumping into objects). (change to eg,)
15. The patient is taking a medication with a high risk of affecting the visual system (eg, Plaquenil).
16. The patient is being evaluated for macular degeneration or has experienced central vision loss (< 20/70). (Repeated examinations for diagnosis of macular degeneration or central vision loss are not medically necessary unless changes in vision are documented, or to evaluate the results of a surgical intervention).

Note

Taped and un-taped visual field testing is considered one unit of service for MUE (medically unlikely edits) purposes.

Modifier usage

- This code includes a technical component (-TC) and professional component (-26). When the test is ordered by the physician who also provides the interpretation, bill the test as a global. No need to separate out each component to bill. The interpretation should be documented as soon as possible after the test has been performed.

CCI mutually exclusive edits

92081: 92082, 92083

92082: 92083

Checklist: YAG Laser Capsulotomy

Documentation Requirements

- ☐ Ensure physician provided informed consent.
- ☐ Ensure patient desires to proceed with surgery.

Indications

- ☐ The patient has decreased ability to carry out activities of daily living including (but not limited to) reading, watching television, driving, or meeting occupational or vocational expectations;
- ☐ The patient has determined that they are no longer able to function adequately with the current level of visual function; and
- ☐ Other eye disease(s), including but not limited to macular degeneration or diabetic retinopathy, has (have) been excluded as the primary cause of visual functional disability, except for the instance in which significant visual debility, in the judgement of the treating physician, is deemed secondary to ACO or PCO and laser treatment would provide the patient with improved functionality; and
- ☐ Physician concurrence with significant patient-defined improvement in visual function can be expected as a result of capsulotomy; and
- ☐ The patient has been educated about the risks and benefits of capsulotomy and the alternative(s) to surgery (eg, the avoidance of glare, use of optimal eyeglasses prescription, etc.); and
- ☐ The patient has undergone an appropriate preoperative ophthalmologic evaluation.

Visual Acuity Requirements

Only the following MACS have visual acuity requirements. All others only require:

- Patient complaint of decreased vision
- Impact on lifestyle
- Physician findings

CGS	The patient has a best-corrected visual acuity of 20/50 or worse at distance or near; or additional testing shows one of the following: Consensual light testing decreases visual acuity by two lines, or Glare testing decreases visual acuity by two lines; and the patient no longer is able to function adequately with the current level of visual function
Palmetto	Visual loss and/or symptom of glare (visual acuity 20/30 or worse under Snellen conditions, using contrast sensitivity, or simulated glare testing); Symptoms of decreased contrast; Amount of posterior capsular opacification or; Other possible causes of decreased vision following cataract surgery.

FCSO	<p>The patient complains of symptoms such as blurred vision, visual distortion and/or glare resulting in reduced ability or inability to carry out activities of daily living due to decreased visual acuity or an increase in glare, particularly under bright light conditions, and/or conditions of night driving.</p> <p>The eye examination confirms the diagnosis of posterior capsular opacification and excludes other ocular causes of functional impairment by one of the following methods:</p> <ul style="list-style-type: none"> • The eye examination should demonstrate decreased light transmission (visual acuity $\leq 20/30$ or $\leq 20/25$ if the procedure is performed to assist in the diagnosis and treatment of retinal detachment) after other causes of loss of acuity have been ruled out, or • Additional testing must demonstrate 1) contrast sensitivity testing resulting in a decreased visual acuity by two (2) lines or 2) a decrease of two (2) lines of visual acuity in the glare tester.
	<p>This procedure should not be routinely scheduled after cataract surgery and rarely would it be expected to see this procedure performed within four months following cataract surgery. However, if a patient develops a posterior capsular opacification within four months following cataract surgery, Yag laser capsulotomy will be considered medically reasonable and necessary when the documentation demonstrates the following: the patient is experiencing symptoms of blurred vision, visual distortion, and/or glare with associated functional impairments; decreased light transmission (visual acuity $< 20/30$; and/or contrast sensitivity testing or glare testing resulting in a decreased visual acuity by two (2) lines.</p> <p>Generally, the Yag laser capsulotomy is expected to be performed only once per eye per lifetime of a beneficiary.</p>

VIOLATIONS

Prevent, detect and remedy violations. A compliance program should be reflective of your practice. A compliance program sitting on your shelf or unopened on your computer does not make the practice compliant.

Examples of non-compliance:

- “How are other practices passing the 2 percent sequestration to patients?”
- “We have to do your injection on another day because we won’t get paid for the exam if we do both today.”
- “Because we can’t charge for a surgical tray, we bump up the level of exam we bill the same day as a procedure.”
- “I haven’t looked at CCI edits in years.”
- “I often change the CPT and/or ICD-10 code as I know best how each exam should be billed. Informing the physician would just slow us down.”
- “I know that fundus photography and retina OCT are bundled, so I bill the fundus photography as it has the highest allowable.”
- “We have a super-tech that closes out all the EHR exams.”

Report of Suspected Violation(s)

Name:

Position:

Description of possible violation:

ADDITIONAL RESOURCES

Scribe Documentation Requirements

Payers recognize an increasing trend in physician use of scribes to assist with medical record documentation. Here’s what you need to know to be in compliance.

The scribe’s responsibility is to record the physician’s dictated notes during the visit or in other words, enter the information on the physician’s behalf. Scribes should never to record any independent notes, only those specifically dictated by the physician. All documentation must be approved by the physician. Physicians may amend the scribe’s entry or add an addendum.

Well-educated scribes should also know the payer requirements for history, exam and medical decision making, order of delegated tests and preoperative requirements. The scribe may be responsible to assure every item on the relevant checklist is documented as medically necessary before the physician signs the record.

Compliance: “Acting as scribe for Dr. _____” must be documented.

SAVVY CODER

CODING & REIMBURSEMENT

OIG: “Medicare Paid \$22 Million in 2012 for Potentially Inappropriate Ophthalmology Claims”

BY SUE VICCHIRILLI, COT, CCS
ACADEMY DIRECTOR OF CODING AND REIMBURSEMENT

Late last year, the Office of Inspector General (OIG) published a study on ophthalmology billing. Based on 2012 claims data, the report focused on three conditions—wet age-related macular degeneration (AMD; \$2.2 billion in 2012), cataract (\$3.5 billion), and glaucoma (\$1.3 billion).

Some context. The report found payments totaling \$22 million that perhaps shouldn't have been paid. (That amount is much less than 1 percent of the total amount that Medicare paid for the three conditions in the study.) And when those potentially improper payments are broken down by provider, the study found that 74 percent of providers received no such payments and 16 percent received less than \$1,000.

Why were claims deemed potentially inappropriate? In some cases, national requirements dictate when a service is covered; in others, the bodies that administer Medicare regionally—the Medicare Administrative Contractors (MACs)—can each establish their own local requirements. In 2012, \$14 million was paid for services that didn't meet national requirements, and \$8 million was paid for services that didn't meet local coverage determinations (LCDs). But the study didn't look at medical records to see if practices had documented any valid exceptions to those requirements.

Wet AMD

Payments for wet AMD-related services were classed as potentially inappropriate when claims for the following codes didn't meet LCD requirements.

- CPT code 92235 *Fluorescein angiography*—some LCDs set an annual limit for this service.
- CPT code 92250 *Fundus photography*—under some MAC LCDs, this is not allowed more than two times per eye per year.
- CPT codes 92235 *Fluorescein angiography* and 92240 *Indocyanine-green angiography*—some LCDs state that these are not allowed within 30 days of one another on the same eye, unless performed on the same day or unless the patient has a second diagnosis in addition to wet AMD. Furthermore, the second diagnosis cannot be diabetic retinopathy. Combined frequency edits are not to exceed nine times per eye per year.
- CPT codes 92133 *Posterior segment imaging* (glaucoma) and 92134 *Posterior segment imaging* (retina)—not allowed on the same day for the same eye by any payer.
- CPT code 92134 *Posterior segment imaging* (retina)—not allowed more than once a month.
- CPT codes 92225 *Extended ophthalmoscopy* and 92226 *Subsequent ophthalmoscopy*—under some LCDs, the combined frequency edits for these two codes are 12 times per eye per year.

- HCPCS code J2778 *Lucentis* is not allowed more often than every 28 days, per the label instructions.

Cataract

Two national coverage requirements for cataract weren't always met.

- Medicare will not routinely cover more than one comprehensive eye examination and scan for patients whose only diagnosis is cataract. However, in 2012, such claims were paid more than 52,000 times.
- Medicare will not cover cataract surgery for an eye that has already undergone that procedure. In 2012, such claims were paid 10,560 times.

Glaucoma

A national requirement states that Medicare covers glaucoma screenings once every 12 months for patients at high risk for glaucoma. But the report noted that 5,055 payments were made for screening tests performed less than 12 months after the previous one.

What Next?

CMS may instruct MACs to take further action to recoup any inappropriate payments from practices.

For links to MAC websites and their LCDs, go to www.aao.org/coding and select “Coding Updates and Resources.”

Read the complete OIG report at <http://oig.hhs.gov/oei/reports/oei-04-12-00281.asp>. ■

EYE NET 53

Figure 1 EyeNet, March 2015

CODING & REIMBURSEMENT SAVVY CODER

Put on Your Audit Armor, Part 1

It's not a matter of *if* but *when* a third-party payer sends you a request for records. And when that day arrives, having a written protocol in place will help to ease your angst. Here's how to get started.

Be Audit Ready: Create Written Protocol

Use the protocol below as a starting point, and customize it to fit your practice.

You receive a request for records. What do you do next?

1. Do not toss the envelope. It shows the postmark date. The letter inside may be dated much earlier than the date when you received the request.

2. Determine the type of audit or investigation. The government has assigned auditing duties to several types of organization, each with its own type of audit. These include the following:

- **CERT:** Comprehensive Error Rate Testing
- **OIG:** Office of Inspector General investigation
- **RA and RAC:** Recovery Audit (RA) and Recovery Audit Contractor (RAC)
- **SMRC:** Supplemental Medical Review Contractor
- **TPE:** Targeted Probe and Educate
- **ZPIC:** Zone Program Integrity Contractor

The mechanics of the audit may vary, depending on which type of audit is performed.

Two Real-Life Scenarios

Scenario 1: The dutiful but ill-informed staff member. A staff member opens the mail and finds an audit request for 40 charts. In an effort to be helpful, he compiles what he perceives to be the appropriate documentation. He submits it without telling the physician.

The audit results are not favorable, and a substantial refund is requested. Now the employee needs to plan for an appeal or a refund and must tell the physician. If the refund is not made within the allotted time frame, future payments will be withheld until the recoupment is paid in full. This can have some awkward repercussions. Suppose, for instance, the physician's partner submits the next few claims to this payer. It will be the partner who is impacted when the payer withholds payment for those claims. Patients may also be affected, as the practice won't be able to post a payment to a patient's account if actual funds aren't available for deposit.

Scenario 2: Kicking the can down the road. A request for 30 records is received. Rather than putting her best foot forward and making sure all the documentation that the auditor requested is submitted, the practice administrator determines that the practice will just send in records and hope for the best, knowing that the practice can always appeal. While appealing denied claims is always an option, it is a costly one. Best practice is to review the request and carefully compile the documentation. When you send the documentation, include a cover letter that can provide further explanation and can help set the tone for the audit.

3. Identify the due date for sending records. Respond within the time limits provided, or immediately request an extension. Make sure you document written confirmation of new due date.

4. Look for the common theme. Does the auditor seem to be zeroing in on a particular level of E&M or Eye visit code? A consistent modifier? A particular testing service? A high-

volume surgery? Is it a single date of service versus a series of encounters?

5. Note the date of service requested. Make sure that you are gathering documentation for the correct date of service.

6. Check the records for signatures. For paper charts, is the physician signature present and identifiable? If signatures are illegible, immediately prepare a signature log. Include the names of all who document in the medical record and identify their title (i.e., MD, DO, OD, technician, scribe, receptionist,

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Figure 2 EyeNet, January 2018

etc.). If the signature is missing from the medical documentation, it is acceptable for the author of the medical record entry to add a signed attestation that he or she had entered the original information into the record.

If you use electronic health records (EHRs), provide documentation that the physician signature is “secure” and nobody else has or uses the physician password. Most audits also request EHR signature protocol. Without an identifiable, secure physician signature, the auditors do not have to complete the actual audit—they can just deny payment.

6. Provide a list of abbreviations used. Don’t assume that the auditor will understand the abbreviations used in your records.

7. Check whether LCD(s) apply. If the payer has a Local Coverage Determination (LCD) on a test or surgery performed, quote chapter and verse from that LCD. Be sure to use the LCD that was in place at the time the test or surgery took place.

8. Make sure tests are fully documented. If testing services are part of the audit, make sure there is a written order that identifies by name what test and which eye(s). Furthermore, the medical necessity for the test should be obvious in the medical record; the physician should provide the interpretation and report as soon as possible; and if the delegated test falls under direct supervision, make sure the payer is aware that one of the practice’s physicians was on site during the test.

9. Self-audit. If the auditor is looking at E&M or Eye visit codes, audit internally before submitting the documentation, so you can gauge your worst-case scenario. Next, you can estimate how much money the auditor might seek to recoup and plan accordingly.

10. Make sure that a physician reviews the documentation. Physicians should have the opportunity to review all records before that documentation is sent to the auditor.

With paper charts, if the handwriting is not readily legible, physicians should take the time to dictate (not embellish) the notes. Include the actual chart note plus the dictation. After all,

only that which can be read can be audited.

With EHR, check whether all fields are populated. For example, if documentation shows only those body systems that have a problem and not those that are normal, you won’t receive credit for reviewing 10 or more systems. Work with the vendor to make sure all fields show when the record is printed.

11. Remember that the Academy is here for you. Email coding@aao.org.

CODING & REIMBURSEMENT
SAVVY CODER

Put on Your Audit Armor, Part 2: Create Payer-Specific Checklists

The best way to audit-proof your practice is to adhere to payer-specific checklists. This month's Savvy Coder gets you started on a checklist for cataract surgery.

Note: According to a 2014 Office of Inspector General report, when the only diagnosis is cataract(s), Medicare does not cover testing other than one comprehensive eye examination (or a combination of brief/intermediate examinations not to exceed the charge of a comprehensive examination) plus an appropriate ultrasound scan.

Know Your MAC's Policies

Under Medicare Part B, the United States is divided into several jurisdictions, with a Medicare Administrative Contractor (MAC) assigned to each one. These MACs can develop their own coverage policies, known as Local Coverage Determinations (LCDs).

Important! Go to aao.org/lcds, read the LCDs that affect your state, and incorporate their requirements into your payer-specific checklists.

Medicare Cataract Surgery

Make sure that your payer-specific checklist addresses the issues below, and advise physicians not to close out a chart until *all* of the checklist's requirements have been met.

Ensure that you have documented:

- the patient's chief complaint;
- the impact that decreased vision

has on activities of daily living (ADL) unique (never cloned) to each patient;

- best-corrected visual acuity (note that most MACs don't have a visual acuity requirement—the exceptions are CIGNA for Kentucky and Ohio, which requires "20/50 or worse," and First Coast for Florida and Puerto Rico, which requires "worse than 20/40.");
- physical findings of the cataract;
- that the patient has been educated by the surgeon about the risks and benefits of surgery and the alternative to surgery, and has provided informed consent; and
- that the patient desires surgery.

Verify the diagnosis code. Also, be sure the surgery code is linked to a covered ICD-10 code.

Check the indication(s) for lens removal. These may include the following:

- Monocular diplopia due to a cataract in the affected eye.
- Worsening angle closure due to increase in size of the crystalline lens.
- A significant cataract in a patient who will be undergoing concurrent surgery in the same eye, such as a trabeculectomy or a corneal transplant when the surgeon deems that the decreased morbidity of single-stage surgery is of significant benefit compared with surgery on separate dates.
- Intolerable anisometropia or aniseikonia uncorrectable with glasses or contact lenses that exists as a result of lens extraction in the first eye (despite

satisfactorily corrected monocular visual acuity).

Your MAC might cover lens removal in the following situations:

- when an unimpeded view of the fundus is mandatory for proper management of patients with diseases of the posterior segment of the eye(s).
- during vitrectomy procedures if it is determined that the lens interferes with vitreoretinal dissection at the far periphery and excision of the vitreous base, as in cases of proliferative vitreoretinopathy, complicated retinal detachments, and severe proliferative diabetic retinopathy.

Unique to Novitas. If your MAC is Novitas, your documentation must also show the following:

- The patient has undergone the Pre-Cataract Surgery Visual Functioning Index (VF-8R) questionnaire. The questionnaire must be maintained in the patient's medical records and be available upon request. (VF-8R is available at aao.org/practice-management/coding/updates-resources.)
- The date of surgery wasn't more than 3 months (the maximum appropriate interval) after the preoperative examination.

Is Novitas your MAC? Novitas is the MAC for the District of Columbia and for the following states: Arkansas, Colorado, Delaware, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, or Texas.

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MORE ONLINE. For more resources, see this article at aao.org/eyenet.

For Web

Further Resources

You receive a request for records: Do you have a protocol to guide your response? If not, read “Put on Your Audit Armor, Part 1” (Savvy Coder, January 2018) for guidance on creating a written protocol.

aao.org/eyenet/article/put-on-your-audit-armor-2?january-2018

Make sure your documentation is sound. Read “How to Document the Need for Cataract Surgery” (Savvy Coder, July 2017).

aao.org/eyenet/article/how-to-document-the-need-for-cataract-surgery

Available Sept. 21: Buy the Audit Toolkit (product #: 0120444V). Learn 1) what prompts payers to conduct audits, 2) the definitions of each type of audits, 3) the audit focus for each audit type, and 4) when you need to call your lawyer. The Audit Toolkit will launch on Sept. 21, and will be available for sale at aao.org/store.

aao.org/ shortcut URLtktktktk

Coming soon: Buy the Audit Toolkit Workbook. If you found September’s Savvy Coder helpful for your compliance, you should consider purchasing this workbook, which will be available for sale in early October at aao.org/store. For each type of audit, you’ll have a checklist for each item that is likely to be targeted. If you are attending AAO 2018, visit the Resource Center to review this and the Academy’s other coding products.

Figure 3 EyeNet, September 2018 (continued)

Stay on the Leading Edge with Coding and Practice Management Solutions

NEW - Coding Audit Success Toolkit (#0120444V)

Stay compliant with payer requirements and proactively navigate the audit process using this all-new comprehensive toolkit. Includes valuable checklists and helpful guidelines you can use every day. Visit aao.org/audit-toolkit.

NEW - Business of Retina: Strategically Grow Your Retina Practice (#0121003V)

This all-new handbook uncovers the key secrets for growing a modern retina practice and provides real-life case studies to guide your implementation strategy. Visit aao.org/business-of-retina.

NEW - Private Consultations: Coding and Practice Management

Ensure your practice's success with patient documentation, claim submissions, clinic efficiency, financial management and more with personal guidance and practical solutions from Academy experts. Visit aao.org/consultation-services.

Coding Coach: Complete Ophthalmic Online Reference (#CODNGMULTI)

Save time searching multiple sources with this web-based tool, the most comprehensive and up-to-date in all of ophthalmology. Easily search by CPT code or keywords. Save up to 40% when you subscribe for multiple users. Visit aao.org/codingtools.

Attend the American Academy of Ophthalmology Codequest Event in a City Near You

In just four hours, Academy coding experts guide you through all the significant updates, plus quality reporting changes, new payer policies, audit triggers and more. Register at aao.org/codequest.

Join the American Academy of Ophthalmic Executives (AAOE)

Join AAOE, the practice management affiliate of the American Academy of Ophthalmology, and get access to a host of benefits that can help you effectively manage every part of your practice. Visit aao.org/member-services/join.

More Coding and Practice Management Solutions

The Lean Practice: A Step-by-Step Guide to Running a Profitable Practice (#0121002V)

The Academy's transformative lean management program — designed specifically for ophthalmology — offers the most complete set of tools to help your practice compete and thrive. Visit aao.org/leantools.

Improve Your Business with 60-Minute Practice Management Webinars

Get expert instruction about the coding and business topics you care about most. Save up to 40% when you order multiple webinars in a single transaction. Register at aao.org/webinar.

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ICD-10-CM for Ophthalmology: Complete Online Reference (#ICDMULTI)

Identify ophthalmic-specific codes easily and accurately with this web-based tool. Search by keywords or code. Save up to 40% when you subscribe for multiple users. Visit aao.org/codingtools.



About the American Academy of Ophthalmic Executives

The American Academy of Ophthalmic Executives (AAOE), an affiliate of the American Academy of Ophthalmology, is the leading membership organization for ophthalmic practice management serving thousands of members. AAOE's mission is to facilitate the business success of ophthalmic practices through accurate and up-to-date coding and practice management resources. Visit aao.org/aaoe.