AMERICAN ACADEMY
OF OPHTHALMOLOGY®
Protecting Sight. Empowering Lives.

The Evolving Retina Practice: How to Lead Post-COVID (MC02)

Nov. 12, 2021 | 9:00 a.m. to 12:00 p.m.

Ernest N. Morial Convention Center | New Orleans, LA

American Academy of Ophthalmic Executives® (AAOE®)

AMERICAN ACADEMY OF OPHTHALMOLOGY®

AAOE® Program of 2021

November 12-15, 2021 | New Orleans, LA
Ernest N. Morial Convention Center

Master Class (MCO2)

The Evolving Retina Practice: How to Lead Post-COVID

Senior Instructor:
Joy Woodke, COE, OCS, OCSR,
Academy Coding & Practice Management Executive

Co-instructors:
Jessica Schroeder, MPH, CPC, OCS
Ankoor Shah, MD, Retina Consultants of Texas,
Academy Health Policy Committee Member

AAOE 2021 | Master Class Presenters

Joy Woodke, COE, OCS, OCSR

Academy Coding & Practice Management Executive

Joy Woodke is the Academy's coding and practice management executive. Her 30+ years of experience in ophthalmology includes all aspects of practice management, accounting, coding and billing. Joy is the author of The Profitable Retina Practice series, a contributing author of the Academy coding product line, and recipient of the Academy's Secretariat and Achievement Awards.

Jessica Schroeder, MPH, CPC, OCS

Practice Administrator — Cape Fear Retinal Associates, PC

Jessica Schroeder is the practice administrator at Cape Fear Retinal Associates, PC in Wilmington, NC. She joined the practice in 2018 after working nine years at The Wilmer Eye Institute at Johns Hopkins in all facets of the billing department as well as the Epic trainer for new providers and technicians. Jessica has served as an Academy volunteer and assisted in Codequest instruction.

Ankoor R. Shah, MD

Retina Consultants of Texas, Academy Health Policy Committee Member

Dr. Ankoor R. Shah is a board-certified medical and surgical retina specialist with Retina Consultants of Texas. Dr. Shah has authored over 100 peer-reviewed scientific papers, book chapters, and presentations at national meetings. In addition to his medical and surgical research interests, he has an additional interest in the advocacy and the business of retina. He has been involved nationally as the coding/compliance committee co-chair of Retina Consultants of America, a member of the Practice Management Committee of the ASRS, and a RUC Advisor and Health Policy Committee member for the AAO.

AMERICAN ACADEMY
OF OPHTHALMOLOGY®

POWERPOINT SLIDES

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

The Evolving Retina Practice: How to Lead Post-COVID

AAOE Annual Meeting
New Orleans
Friday, November 12, 2021

Financial Disclosure

- Ankoor Shah, MD
  - Retina Specialist, Retina Consultants of Texas
- Novartis – Consultant, Honoraria; Ocular Therapeutix, Consultant, Honoraria

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Financial Disclosure

- Joy Woodke, COE, OCS, OCSR
  - Academy Coding & Practice Management Executive
- Jessica Schroeder, MPH, CPC, OCS
  - Practice Administrator, Cape Fear Retinal Associates, PC
- I have no financial interests or relationships to disclose.

Weather Each Storm

- Pandemic
- Payment cuts
- Staff shortages
- Disasters
- Cybersecurity hacks
- The next new retina challenge...

Evolving Culture

- Stable foundation
- Core values
- Vision of the future
- Culture of change
- Foster growth
- Proactive approach

Course Agenda

On the Horizon

- Ankoor Shah, MD

Operational Management in an Evolving World

- Jessica Schroeder

Protect Revenue with Expert Knowledge

- Joy Woodke, COE, OCS, OCSR

Panel Discussions

- Q & A
- Audience Polls
- Rapid Fire Topics

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

On the Horizon

Ankoor Shah, MD

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Retina Practice Landscape

Rise of Private Equity and Consolidation

Consolidation in Healthcare

Participants

- Hospitals/Ambulatory Surgery Centers
- Insurers
- Providers

Providers

- Hospital-based consolidation
- Private Equity:
  - Vertical Integration (eg Retina Practices + Referring HCP [Ophthalamology/Optometrist])
  - Horizontal Integration (eg Retina Practices + Local/National Retina Practices)

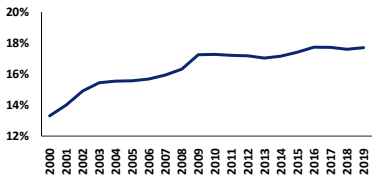
Why Consolidation in Healthcare?

Macro drivers	Key takeaways	Relevant data

1 Large, growing, resilient market

- Healthcare among largest sectors of US economy – $3.8tn in 2019, or ~18% of GDP
- US healthcare spending has continued to grow significantly in recent years outpacing broader GDP growth
- Highly defensive sector historically, with continued growth / stability throughout recessionary periods

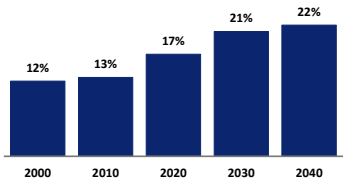
Health expenditures as a % of US GDP



2 Strong underlying demand fundamentals

- Aging population drives increased healthcare utilization
  - Population of Americans over 65, which account for a disproportionate share of healthcare spend, is expected to surpass those 18 and younger by 2030
  - Prevalence of chronic conditions, including retinal disease, increases with age
- Increased commercial insurance coverage further strains HC system capacity – ~40mm newly insured Americans in the last decade

Age 65+ share of US population



Source Market research, US Bureau of Economic Analysis

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Why Consolidation in Healthcare?

Macro drivers	Key takeaways	Relevant data

3 Robust macros supporting PE deal activity

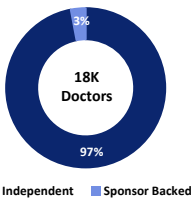
- Private equity dry powder is at an all-time high reaching $2.9tn in 2020
- Private equity funds took in over $514bn in the first half of 2021, 70% more than the same period in 2020
- Fundraising environment remains strong with Carlyle currently raising largest-ever PE pool of $27bn and H&F raising $24bn in its latest fund
- Robust lending markets with interest rates near historic lows support PE buyers' ability to pay

Global PE dry powder at year end ($tn)

4 Compelling consolidation opportunity for PE

- Healthcare delivery in the US is highly fragmented with most single specialty / alternate site physician practices remaining independent
- PPM platforms offer attractive 'buy and build' opportunity for PE firms
  - Significant recent consolidation in ophthalmology, primary care, women's health, dermatology and dentistry
- Ophthalmology expected to see continued consolidation driven by:
  - High degree of fragmentation with thousands of practices likely to consolidate
  - Scale benefits for large groups (improved purchasing and payor contracting, sales & marketing efficiencies)
  - Limited exit options for aging independent practice owners

Ophthalmology



Source Market research, Forbes, Bloomberg

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Why Consolidation in Healthcare?

Macro drivers	Key takeaways	Relevant data
5 **Physician Practice Management (PPM) model offers viable alternative for physicians**	• Relief from administrative burden (accounting, marketing, HR, etc.) while maintaining clinical autonomy • Larger share of doctors seeking more predictable and flexible hours • Ability to build up patient base by leveraging corporate resources (marketing and patient retention best practices) • Student debt has grown substantially in recent years and larger platforms offer immediate income for recent graduates	**Up to ~50%** of doctors' time spent on paperwork **~175%** increase in average medical school debt taken over the past 15 years
6 **Regulatory complexity creates natural barriers to entry**	• Healthcare industry is highly regulated making it challenging for new participants to quickly enter the market / gain share • Increasingly complex regulatory / compliance requirements are a major source of frustration for independent physicians • Environment favors PE firms with longstanding track record of HC experience/ expertise and proven ability to drive successful outcomes	**~$40,000** cost practices spend per physician to comply with federal regulations **~60%** of doctors unfamiliar with Medicare payment system practices

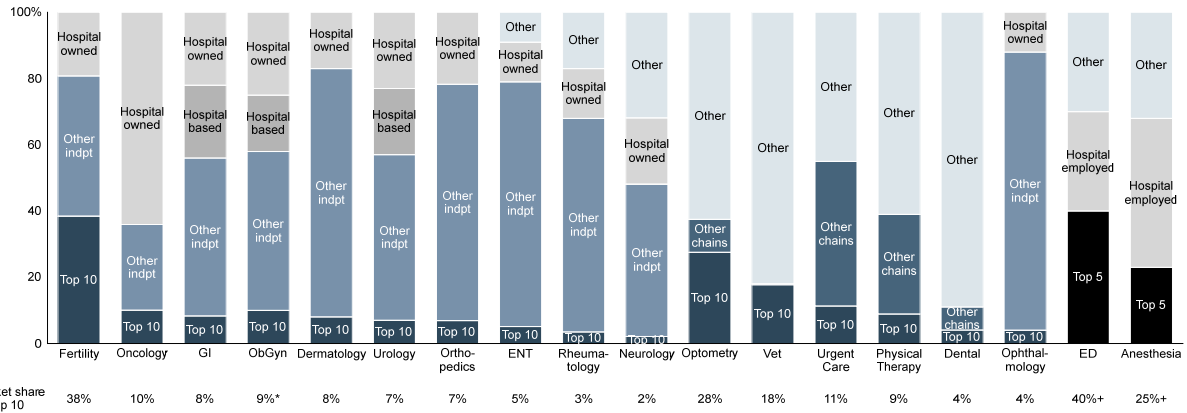
Source Market research, Forbes, Bloomberg

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Degree of consolidation varies across healthcare specialties

Share of US market (%)



Note: Retail health and inpatient PPM market share from 2019.
Source: Bain proprietary retail health database, CapIQ, Definitive Healthcare, Vision Monday, D&B, Orb Intelligence, IBIS World, Harris Williams, Company financial statements, APPA, Lit search, Bain analysis

Outpatient specialties | Retail health | Select inpatient PPMs

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Private Equity Approaches

- **Overall, scale provides the opportunity to invest in greater supporting resources such as business, legal, payor relations and compliance**

Consideration	Horizontal Integration	Vertical Integration
Focus & Strategy	• Platform made up of solely retina specialists • Inorganic growth strategy purely focused on partnering with retina-only practices and physicians • Focus on aligning incentives and creating retina-specific synergies (purchase power, recruiting, clinical trial research, etc.)	• Platform that combines retina specialists with general ophthalmologists and optometrists • Idea is to create a one-stop-shop for all eyecare needs which also allows for "in-house synergies" (referral base, business offerings / lines, etc.)
Sustainability of the Model	• Market competitive baseline compensation with opportunity for continued growth in tandem with practice growth • Partner compensation pool structured as a % of bottom-line so physicians share in the upside and downside – Compensation pool grows through both organic and inorganic growth	• Compensation structure based on top-line which factors in growth but not margin / reimbursement • Captive referral base: seek concentrated / in-house referrals – Pro: guaranteed source of referrals – Con: potential to lose other referrals
Research and Clinical Trials Focus	• Ability to focus on research and clinical trials due to alignment from all parties (physicians and sponsor) • Coordinate company-wide budget submissions and patient enrollment targets • Sustain premier quality through creating common Standard Operating Procedures	• Generally little to no emphasis in research and clinic trials
Clinical and Strategic Autonomy	• Practices maintain full operational / clinical autonomy • Physician representation on HoldCo board of directors	• Sponsor generally maintains operational control • Thesis / vision usually already in place and primarily developed by sponsor • Physicians may have minimal say in important business decisions due to "too many cooks in the kitchen" issue because of the multitude of specialties

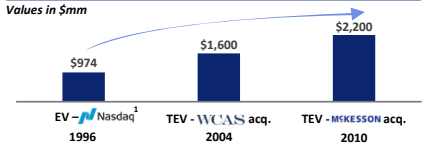
US Oncology case study

- Scaled platform with integrated physician services and drug administration/distribution

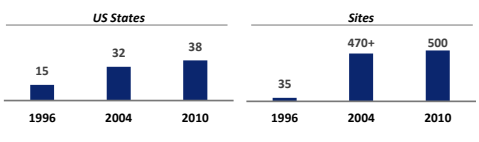
Platform established through IPO → **US Oncology's public-to-private buyout by WCAS** → **McKesson's acquisition of US Oncology**

1992 - 2004	2004 - 2010	2010+
• Welsh, Carson, Anderson & Stowe (WCAS) founding investor in 1992 • In 1995, raised ~$106mm through IPO • Focused on expanding service offerings, increasing geographic market position and improving operational efficiency • Developed core competencies in purchase, distribution and management of oncology pharmaceuticals	• In 2004, WCAS acquired the company for ~$1.6bn – As of March 2004, served approx. 15% of the US new cancer cases per year • Thesis driven by cancer care consolidation opportunity in medium-size markets and scale benefits for drug purchases • In addition, company shifted focus to emphasizing cancer drug distribution	• In 2010, McKesson acquired US Oncology for ~$2.2bn • Strategic rationale and synergies included: – Expanding clinical expertise and research, evidence-based medicine offerings and enhanced value-based reimbursement capabilities – Distribution capabilities and supply-chain expertise

Value creation



Evolution of platform



Note
1 As of Jan. 1, 1996

Challenges of Medication Administration

Prior Authorizations and Step Therapy

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Step Therapy for Medicare Advantage Plans

- Step therapy has been implemented for a number of medicare advantage plans. The increase in restrictions has been evident from just from 2020 to 2021
- No clear definition of “failure” yet though some commercial plans have tried defining with strict non-patient care focused definitions

AMERICAN ACADEMY OF OPHTHALMOLOGY®

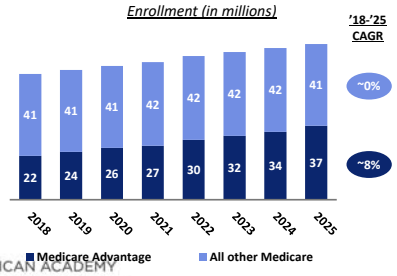
Protecting Sight. Empowering Lives.®

Medicare Advantage continues market penetration

Large and consistently growing enrollment base

Continuous growth driven by:

- Focus to contain increasing healthcare costs
- Bipartisan government support
- Flexibility from CMS for MA plan providers
- Expanded coverage from payors



Optimally positioned to take advantage of shift to value-based care

Payors and providers have found multiple routes to optimize revenue, costs, and outcomes through:

- Analytics to target ways to reduce costs
- Bonuses for quality improvements to increase physician engagement and care coordination
- Increasing use of risk bearing arrangements to increase potential provider earnings

➡ Increasingly important for provider groups to have a constructive approach with MA plans

Clinical and Utilization Management

- Prior authorization and pre-certification are the most common form of utilization management
  - Higher frequency of PA under the prescription benefit for high cost categories i.e. oral oncology drugs
- Preferred product selection is driven by closed formularies, or differentiated member share, and is more prevalent under the prescription benefit
- Medical policy and coverage criteria development, outside of the pre-cert program, is more applicable to the Medical benefit coverage determinations

EMD Serono Specialty Digest < 10th Edition, Managed Care Strategies for Specialty Pharmaceuticals, Debbie Stern, RPh, editor, 2014

Step Therapy

Use most clinically & cost effective meds first

Can result in long-term savings if patient starts on generic/off-label drug

Commonly drives utilization of a preferred brand

Challenges with Step Therapy

- Barrier between MD and patient
- May affect patient outcomes
- Patient nonadherence
- Clinical and ethical issues

1. Commins J. Prior Authorization Hurts Patient Care, AMA Survey Finds. *HealthLeaders.* November 23, 2010. http://www.healthleadersmedia.com/physician-leaders/prior-authorization-hurts-patient-care-ama-survey-finds. Accessed November 6, 2017.
2. Mantel I. Optimizing the Anti-VEGF Treatment Strategy for Neovascular Age-Related Macular Degeneration: From Clinical Trials to Real-Life Requirements. *Translational Vision Science & Technology.* 2015;4(3):6.
3. Nayak RK, Pearson SD. The Ethics Of 'Fail First': Guidelines And Practical Scenarios For Step Therapy Coverage Policies. *Health Aff (Millwood).* 2014;33(10):1779-1785.

Retinal Coding Changes

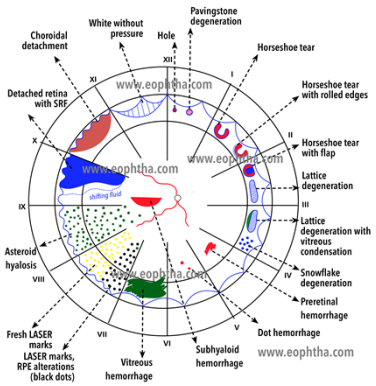
Coding Updates in 2022

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Rationale for Change

- RUC mandated a review of extended ophthalmoscopy due to increased utilization
- Eliminated existing codes (92225/92226)
- Created two new codes (92201/92202)
- Conversion from unilateral to bilateral code



AMERICAN ACADEMY OF OPHTHALMOLOGY®

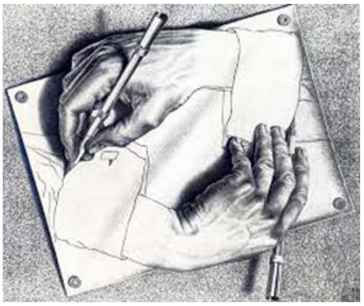
Protecting Sight. Empowering Lives.®

New CPT Guidelines

- 92201 - Ophthalmoscopy, extended; with retina drawing and scleral depression of peripheral retinal disease (eg. For retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral
- 92202 - with retina drawing of optic nerve or macular (eg. For glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral
- DO NOT Report 92201 or 92202 in conjunction with 92250

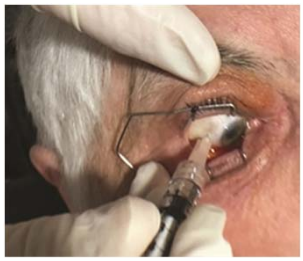
RVU Changes

- Eliminated Codes - 92225[$28.53]/92226[$26.33])
- Created Codes - 92201[$26.15]/92202[$16.58])
- However due to laterality issues both were effectively cut an additional 50%



Coding complications

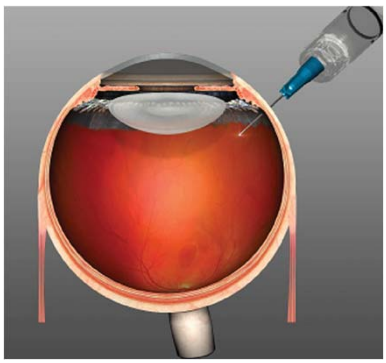
- Seeing Ms. Smith for monthly injections in the right eye, on this particular visit she's seeing new floaters on the left eye
- 67028 and 92201 conflict since laterality not reflected
- National Correct Coding Initiative (NCCI)
- 67028-RT and 92201-59
- -59 modifier when used routinely is a recurring target for CMS audits



Intravitreal injection of anti-VEGF drug. John T. Thompson, MD. Retina Image Bank, 2017; Image 27125. © American Society of Retina Specialists.

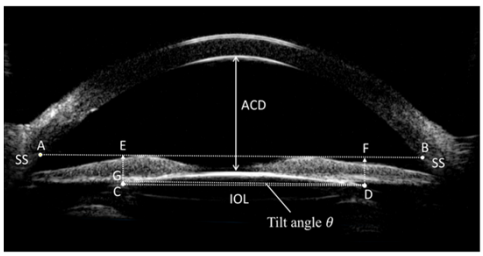
Intravitreal Injections

- Surveyed and reviewed by RUC October 2019
- New Valuations implemented this year in 2021
- Increase in reimbursement driven by increases in practice expenses to perform the procedure



Ultrasound Biomicroscopy

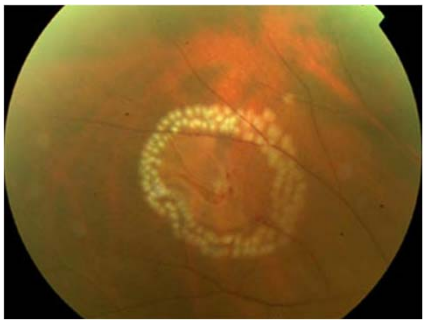
- Surveyed and reviewed by RUC January 2020
- New Valuations implemented this year in 2021
- Significant reduction of RVUs



- CPT code 76513

Retinal Lasers/Cryo for Tear

- Surveyed October 2020
- Switching from 90 to 10 day global
- Significant reduction in RVUs and subsequent reimbursement
- The post op visits included in the value of the code alone are reimbursed more than the procedure with the global period.
- CPT codes 67141 and 67145



Questions?

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Audience Poll

What are your experiences with step therapy policies?

- Limited payers with policies related to Avastin failure prior to high-cost meds
- Potentially harmful policies related to failure (e.g., uveitis)
- Denials related to step therapy and unable to find payer policy
- No payer policies related to step therapy

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Rapid Fire Retina

- Panel and audience discussion

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Operational Management in an Evolving World

Jessica Schroeder, MPH, CPC, OCS

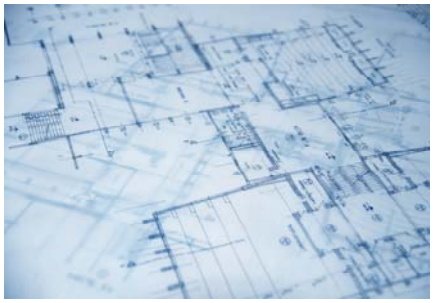
AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

COVID

Managing Change Through the Pandemic

- Space



- Repurpose current space
  - Reduction in people in building
  - More room to social distance in waiting areas
  - Review templates

Managing Change Through the Pandemic

- Staffing

- Physician teams
- Cross-training
- Efficiencies

Managing Change Through the Pandemic

- Technology

- Maximize current technology
  - Faxing through EMR
  - Phone system
- Server based vs. cloud based
  - EMR
  - Company files

Current Challenges

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Tackling the Current Environment

Staffing

Internal changes
Hiring
Interviewing

"Buyer's Market"

More opportunity for job seekers
Evaluate salaries and benefits

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Tackling the Current Environment

Internal changes

How we utilize staff

Scribes

Hiring

Personality over experience

Short term vs. long term

Interviewing

Flexibility

Video conference

Tackling the Current Environment

- Telework
  - Who in the practice has the ability to perform their job duties remotely?
  - What tools are needed?
  - Is it worth the investment in new technology to provide a remote working environment?
    - VOIP
    - EMR
    - Work stations

Tackling the Current Environment

- Telework
  - Provides a foundation to allow remote work to those in quarantine.
  - Update current processes to allow for more efficiencies.
  - Update outdated systems

Tackling the Current Environment

- Population growth
  - Increase in aging population
  - Growth in community

Tackling the Current Environment

- Hire a new physician
- Network with regional practices
- Lean practice flow
- Evaluate satellites

Tackling the Current Environment

- Payers
  - Managed care Medicaid
  - ACA plans
  - Prior Auths
- How does this affect staffing?

Tackling the Current Environment

- Patient demand for technology
  - Text-to-pay
  - Patient portal
  - Updated website
    - Patient portal
    - New patient paperwork
    - Email/Electronic messaging
  - Reminder call system

Tackling the Current Environment

- Staff Communication
  - Less face-to-face large staff meetings
    - Busy physician templates
    - COVID
  - Office messaging systems
  - Educational videos

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Questions?

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Audience Poll

What operational changes during the pandemic positively impacted your practice?

- Remote work
- Improved and effective communication
- Leadership develop in crisis response
- Workflow changes

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Rapid Fire Retina

- Panel and audience discussion

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Protect Revenue With Expert Knowledge

Joy Woodke, COE, OCS, OCSR

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Ultimate Goal

- Appropriately maximize reimbursement by producing clean claims, audit-proof documentation and developing expert level knowledge

Eliminate Guesswork

- Just because the claim was paid, doesn't make it policy
- Roll of the dice:
  - Adding modifiers, just in case
  - Sending bundled CPT codes, and let the payer sort it out
  - Applying one payer's rules to all payers
  - Trusting EHRs for comprehensive documentation

Exceptional Foundation and Grow

- Master the fundamentals of coding
- Expand knowledge as policies and documentation guidelines change
- Follow the hot topics in retina
- Monitor audit targets
- Know your resources

Fundamentals of Retina Coding

- E/M and Eye Visit Codes
- Modifiers
- Correct Coding Initiative (CCI) Bundles
- Testing Services
- Global Periods
- ICD-10 to CPT Code Link
- Intravitreal Injection Coding

Ask the Coding Experts: Top 5

1. New retinal tear in the global period of CPT code 67145?
2. Compounded drugs?
3. Why is my injection claim denied?
4. What HCPCS code should be used for Avastin?
5. When can I unbundle OCT and FP?

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Ask the Coding Experts

- A patient with a symptomatic new PVD and three retinal holes with small cuff of subretinal fluid was treated with laser, CPT 67145.
- Two weeks later, he returned with a new horseshoe retinal tear.
- Is it appropriate to bill 67145 ?
- What modifier?

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Ask the Coding Experts

- 2021 CPT code 67145 descriptor:
- Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation

- Second laser, related or unrelated?
- How should this be billed in 2022?

Ask the Coding Experts

How do I code compounded ….. ?

- Methotrexate, vancomycin, ceftazidime, dexamethosone, foscavir, etc.

Generic HCPCS code, J3490 or J7999

- CMS-1500 item 19, report medication name, dosage and invoice amount
- OIG Report, April 2014

Ask the Coding Experts

- Why is my injection claim denied?
  - ❑ Incorrect ICD-10 to CPT code link
  - ❑ NDC reported incorrectly
    - ❑ 5-4-2 format
    - ❑ Submit in item 24a or EDI loop 2410, preceded with the N4 qualifier
  - ❑ Additional information required in item 19
  - ❑ Wrong units
  - ❑ Wastage not reported
  - ❑ Sooner than 28-days
  - ❑ Missing modifier
  - ❑ Lack of prior authorization or step therapy not followed

Ask the Coding Experts

- What HCPCS should be used for Avastin?
- What is the #1 rule in coding?
  - o Who is the payer?

Avastin

MAC	LCD/ LCA*	J-Code
CIGNA Government Services	No active policy	J3490 or J3590
First Coast Service Options	A56716, L36962	J7999
National Government Services	A52370	J9035
Noridian	A53008-JE A53009-JF	J7999
Novitas	A53121	J7999
Palmetto	No active policy	J9035
WPS Government Health Administrators	No active policy	J3590

- Units: 1
  - Compounded syringe
- NDC in 5-4-2 format:
  - 50242-0060-01
- Indication per payer policy

Medicare local coverage determinations (LCD) and articles (LCA) can be found at aao.org/lcds.

Ask the Coding Experts

- When can I unbundle OCT and fundus photos?
  - CCI edits:
  - "0" indicator–mutually exclusive
  - "1" indicator–can unbundle when appropriate
- When is it appropriate to unbundle with modifier -59?
  - Separate structure, opposite eye
  - When the payer states in published policies **(e.g., First Coast, Novitas)**

Column 1	Column 2	Date of Bundle	Date of Deletion	Indicator
92134	**92250**	**20110101**	*	**1**
92133	92134	20110101	*	0
67028	92201, 92202	20200101	*	1

Ask the Coding Experts

- If both tests are performed, however only one is being submitted, bill the test that provides the most information that day.
- Not necessarily the one with the highest allowable.

CPT Codes	Total	Ophthalmology	Optometry
92250	3,333,223	1,935,603	1,363,288
92134	6,983,198	6,267,420	707,398

Targeted Retina Audits

Post-payment Service-Specific Probes	Lucentis & Eylea
Recovery Auditors	PDT
OIG Investigations	Injections Bypass modifiers, -25 and -59

Top Chart Deficiencies

- Missing physician order for delegated testing services
- Cloned charts
- No patient identifiers
- Chief compliant or reason for visit lacking
- No assessment or plan

Academy Resources

- Appendix: Coding Resources
- Retina Coding: Complete Reference Guide
- Medicare NCDs & LCDs
  - aao.org/lcds
- Codequest
  - aao.org/codequest
- Retina Practice Management & Coding Resources
  - aao.org/retinapm

Questions?

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Audience Poll

How does your practice educate your team on coding changes?

- Internal communication
- Onsite live education courses
- External courses
- Recorded training videos
- Other?

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Rapid Fire Retina

- Panel and audience discussion

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

Final Thoughts

AMERICAN ACADEMY OF OPHTHALMOLOGY®

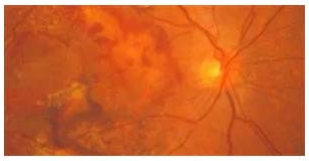
Protecting Sight. Empowering Lives.®

Academy Resources

- Retina Coding & Practice Management Resources
  - aao.org/retinapm
- 2021 E/M Documentation Guidelines
  - aao.org/em
- Private Consulting
  - Coding education, external audits
  - consulting@aao.org

Practice Management for Retina

Your trusted resource for vital coding, practice management and Merit-Based Incentive Payment System resources unique to the retina practice. Practice Management for Retina provides current and relevant information as your practice evolves over the next decade.



- Questions?
  - Email retinapm@aao.org

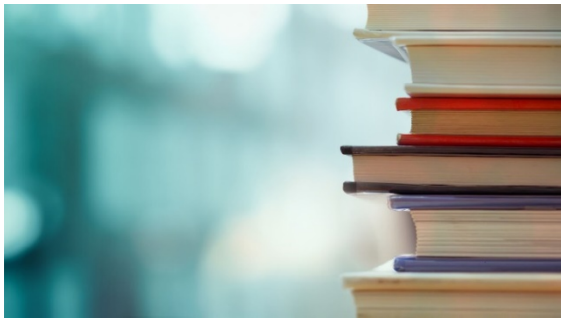
AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.

AMERICAN ACADEMY
OF OPHTHALMOLOGY®



APPENDICES

AMERICAN ACADEMY OF OPHTHALMOLOGY®

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:

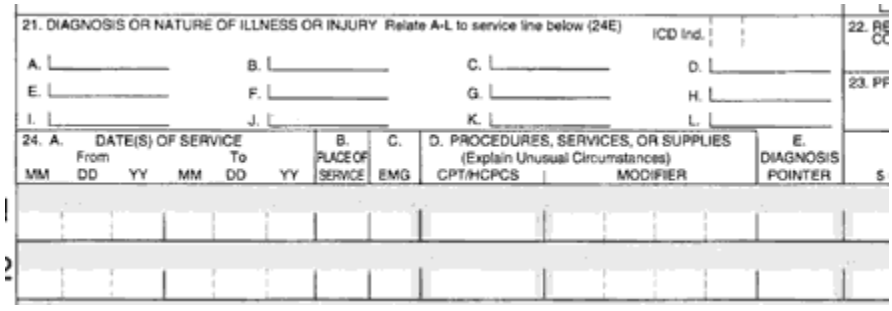
- ☐ Diagnosis codes listed in box 21 (up to 12) coded to the highest level of specificity for the date of service, however up to four can be linked to individual service,
- ☐ ICD-10 codes listed in order of priority,
- ☐ The diagnosis code pointer (A-L) entered in box 24 E from box 21 that links to the 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.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22.
23.
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER

☐ **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.

American Academy of Ophthalmic Executives®

Final Determination Table for Medical Decision Making

To arrive at the final determination for the level of exam, 2 of 3 components (problems, data and risk) must have the same level of complexity (straightforward, low, moderate or high). Otherwise, select 1 level lower from highest level.

COMPONENT	STRAIGHT-FORWARD	LOW	MODERATE	HIGH
Number and/or Complexity of Problems Addressed at the Encounter	**Minimal** 1 self-limited or minor problem	**Low** 2 self-limited or minor problems; ***Or*** 1 stable chronic illness; ***Or*** 1 acute, uncomplicated illness or injury	**Moderate** 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ***Or*** 2 or more stable chronic illnesses; ***Or*** 1 undiagnosed new problem with uncertain prognosis; ***Or*** 1 acute illness with systemic symptoms; ***Or*** 1 acute complicated injury	**High** 1 or more chronic illnesses with severe exacerbation, progression or side effects of treatment; ***Or*** 1 acute or chronic illness or injury that pose a threat to life/body function
Amount and/or Complexity of Data to be Reviewed and Analyzed	**Minimal or none**	**Limited** 1 of 2 Categories must be met Category 1: Tests and documents any combination of 2 from the following: • Review of prior external note(s) from each unique source; • Review of the results(s) of each unique test; • Ordering of each unique test; ***Or*** Category 2: Assessment requiring an independent historian(s)	**Moderate** At least 1 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) ***Or*** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported); ***Or*** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)	**Extensive** 2 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) ***Or*** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported) ***Or*** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)
Risk of Complications and/or Morbidity or Mortality of Patient Management	**Minimal** Minimal risk of morbidity from additional diagnostic testing and treatment	**Low** Low risk of morbidity from additional diagnostic testing or treatment	**Moderate** Moderate risk of morbidity from additional testing or treatment. Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health	**High** High risk of morbidity from additional diagnostic testing or treatment. Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis
Final Determination	**99202** **99212**	**99203** **99213**	**99204** **99214**	**99205** **99215**

AMERICAN ACADEMY OF OPHTHALMOLOGY®

EYE VISIT CODE CHECKLIST

Intermediate Exam Codes 92002/92012

HISTORY

- ☐ Chief complaint
- ☐ History
- ☐ General medical observation

EXAMINATION

- ☐ Three or more, but less than 12 elements of the exam medically necessary to perform.
- ☐ Visual acuity
- ☐ Gross or confrontation visual fields
- ☐ Extraocular motility
- ☐ Conjunctiva
- ☐ Ocular adnexa
- ☐ Pupil and iris
- ☐ Cornea
- ☐ Anterior chamber
- ☐ Lens
- ☐ Intraocular pressure
- ☐ Optic nerve discs
- ☐ Retina and vessels
- ☐ Dilation: As medically necessary.

INITIATION OF DIAGNOSTIC AND TREATMENT PROGRAM

Includes, but is not limited to:

- ☐ Prescription of medication, glasses or contact lenses
- ☐ Arranging for special ophthalmological diagnostic or treatment services
- ☐ Consultations
- ☐ Laboratory procedures
- ☐ Radiological services
- ☐ Recommendation or decision for or scheduling or performance of a major or minor (000, 010, or 090 day global) surgical procedure.
- ☐ Scheduling necessary follow-up of a medical problem
- ☐ Other_____

Comprehensive Exam Codes 92004/92014

HISTORY

- ☐ Chief complaint
- ☐ History
- ☐ General medical observation

EXAMINATION

All 12 elements of the exam medically necessary to perform unless unable due to age of patient or trauma.

- ☐ Visual acuity
- ☐ Gross or confrontation visual fields
- ☐ Extraocular motility
- ☐ Conjunctiva
- ☐ Ocular adnexa
- ☐ Pupil and iris
- ☐ Cornea
- ☐ Anterior chamber
- ☐ Lens
- ☐ Intraocular pressure
- ☐ Optic nerve discs
- ☐ Retina and vessels
- ☐ Dilation: As medically necessary. If not dilated, document why.

INITIATION OF DIAGNOSTIC AND TREATMENT PROGRAM

Includes, but is not limited to:

- ☐ Prescription of medication, glasses or contact lenses
- ☐ Arranging for special ophthalmological diagnostic or treatment services
- ☐ Consultations
- ☐ Laboratory procedures
- ☐ Radiological services
- ☐ Recommendation or decision for or scheduling or performance of a major or minor (000, 010, or 090 day global) surgical procedure.
- ☐ Scheduling necessary follow-up of a medical problem
- ☐ Other_____

92201 and 92202—Meet the New Codes for Extended Ophthalmoscopy

Effective Jan. 1, 2020, two ophthalmoscopy CPT codes became replaced with new codes. Here's what has changed.

Deleted: 92225 and 92226

The deleted codes were for initial (92225) and subsequent (92226) extended ophthalmoscopy, with "extended" indicating that the clinician had gone beyond a routine exam of the retina and had performed a more extensive examination of the periphery for specific conditions. For both codes, the allowable was per eye, but you couldn't bill for an eye that didn't have pathology.

In 2017, the two codes were flagged as being potentially misvalued, and it was also noted that they didn't adequately indicate what portion of the retina was being examined.

Meet Codes 92201 and 92202

The two replacement codes are defined as follows:

92201 *Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral*

92202 *with drawing of optic nerve or macula (e.g., for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral.*

Note: Examples of labeled drawings are included in *2020 CPT Professional Edition* (aao.org/store).

Payment is inherently bilateral. Unlike the old codes, payment is the same whether one or both eyes has pathology.

Allowables. The allowables vary, depending on where you practice—but regardless of your location, you will be paid less for the new codes than you were for the old ones. Using Baltimore as an example, in 2019, Medicare's payment for CPT codes 92225 and 92226 was $29.87 and $27.63 per eye, respectively. By contrast, in the same city, CPT code 92201 has an allowable of $27.21 for both eyes, and CPT code 92202's bilateral allowable is $17.21.

Modifiers. There is no need to append modifiers –RT, –LT, –50, or –52. Submit either 92201 or 92202 without a modifier.

Covered diagnoses. Which diagnosis codes (ICD-10 codes) will support the use of the two new codes? This can vary by payer, so you should check your payer's policy—but it is likely to be similar, if not the same, as the list of diagnosis codes that were covered for the two retired codes.

Payer policies. Once payers update their policies for the new codes, they will publish local coverage determinations (LCDs) on their websites and the American Academy of Ophthalmic Executives (AAOE) will post them at aao.org/lcds. (At time of press, payers had not updated their policies.)

CCI Edits for the New Codes

CMS publishes pairs of codes, known as Correct Coding Initiative (CCI) edits, that should not be billed together. Some CCI edits are known as "mutually exclusive edits," meaning they can *never* be billed together. Other CCI edits can be billed together—in a process known as "unbundling"—if certain criteria are met.

Look for the "0" or "1" indicator. CMS materials use a "0" to flag mutually exclusive edits and a "1" to indicate that a pair of codes can be unbundled.

Mutually exclusive edits. These pairs should never be billed together: 92201 and 92202; 92201 and 92250 *Fundus photography;* or 92202 and 92250.

E&M code 99211 can be unbundled. CPT code 99211—which is the E&M code for an established patient, level 1—is bundled with each of the new codes, but both of those CCI edits can be unbundled if both services are medically necessary.

Retina procedures can be unbundled. All retina procedures—both minor and major—are bundled with the new codes with an indicator of 1. This means that they can be unbundled if justified by medical necessity. For example, the patient might need extended ophthalmoscopy in one eye and surgery in the other. The codes for these procedures are as follows: 0465T, 67005, 67010, 67015, 67025, 67027, 67028, 67030, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67115, 67120, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67225, 67227, 67228, and 67229.

BY **SUE VICCHRILLI, COT, OCS, OCSR,** ACADEMY DIRECTOR OF CODING AND REIMBURSEMENT.

Improve Scheduling in Your Ophthalmology Clinic—Lessons Learned During the Pandemic

The live event "Lean Scheduling and Practice Management Tips for COVID-19" was one of four open mic events organized by the American Academy of Ophthalmic Executives (AAOE) at AAO 2020 Virtual. Some select pearls from that session are highlighted below, and if you registered for the meeting you can go online to watch the full event, which includes tips for avoiding burnout (see "Watch the Open Mics," below).

During the open mic on scheduling, oculoplastic surgeon Mark J. Lucarelli, MD, and practice manager Stephanie Collins Mangham, COA, MBA, OCSR, fielded questions from moderator Aneesh Suneja, MBA.

Improve Scheduling

What have practices been doing to avert a backup of patients during the pandemic?

Avoid starting the day with a complex case. Dr. Lucarelli avoids seeing a complex case—such as a new thyroid patient—at the start of the day, as this could turn into a prolonged visit that throws the rest of the morning's appointments off by half an hour.

Front-load the schedule with some of your "express" patients. Ms. Collins Mangham's retina practice starts the day with a series of patients who require retinal injections. Scheduling these patients "one after another, means that staff can be prepared with an all-hands-on-deck approach to get them in and out of the office ASAP," she said.

Use some of your routine patient visits as "buffers." The more complex patient visits can sometimes run long, but you can give yourself some wiggle room by intermixing them with more routine patient visits, such as the one-week post-op visit.

Don't give physicians a reason to arrive late. "Physicians not turning up on time is a chronic problem in a lot of practices," said Dr. Lucarelli. Many practices—though they may not realize it—are contributing to that problem by not having patients ready to be seen on time. "Templates have to be designed so there is somebody ready for the doctor as soon as he or she walks into office," said Mr. Suneja. Otherwise, added Dr. Lucarelli, "it is the classic scenario of wishing for one thing and incentivizing another."

Base schedules on physicians' face time with patients. "Schedules have to be based on the pace of the physician, generally speaking," said Mr. Suneja. If a doctor takes an average of 10 minutes per patient, then the scheduling should aim to have a patient ready for that doctor every 10 minutes. Work with staff in designing and refining such a schedule.

Be realistic about patient throughput. "Providers are notoriously optimistic about how many patients they can see in a given amount of time," but practices can't afford to have waiting rooms overflowing during a pandemic, said Dr. Lucarelli.

Be willing to alter the schedule. Seeing patients in the order in which they are scheduled should not be a rigid rule, said Dr. Lucarelli. Sometimes it may be more efficient to see patients out of order. However, it is important, added Ms. Collins Mangham, to communicate with patients early and set expectations. "Tell them that you are trying to care for everybody on the same day, and some days their visits may be a little longer than others."

Watch the Open Mics

The AAOE program at AAO 2020 Virtual featured 21 hours of live-streaming content (including the four open mics), plus additional on-demand recordings. If you are registered for the meeting, this content is available via the virtual meeting platform until Feb. 15, and much of it will continue to be available via the meeting archives until October 15. Learn more at aao.org/2020.

PRACTICE PEARLS FROM **ANEESH SUNEJA, MBA, MARK J. LUCARELLI, MD,** AND **STEPHANIE COLLINS MANGHAM, COA, MBA, OCSR.** EDITED BY CHRIS MCDONAGH.

Ms. Collins Mangham is CEO at Austin Retina Associates in Austin, Texas. *Financial disclosures: Regeneron: C,L.*

Dr. Lucarelli is an oculoplastic surgeon at UW Health in Madison, Wis., and is medical director of its University Station Eye Clinic. *Financial disclosures: None.*

Mr. Suneja is the lead consultant at FlowOne Lean Consulting, based in Wisconsin. *Financial disclosures: FlowOne Lean Consulting: C.*

See disclosure key, page 8.

AMERICAN ACADEMY OF OPHTHALMOLOGY®

INTRAVITREAL INJECTION
CHECKLIST/GUIDE FOR CHART DOCUMENTATION
(Update per payer guidelines, visit aao.org/lcds)

Updated: October, 2020

- Visual acuity, chief complaint and appropriate history of present illness (HPI)
- Treatment plan
  - For new patients, document why the specific medication was chosen.
  - For established patients, document response to current medication and why continuing.
  - When changing medications, document the reason.
- Diagnosis supporting medical necessity and appropriate indication for use per payer policy
- Any relevant diagnostic testing services, with interpretation and report
- Risks, benefits and alternatives discussed
- Document that the patient desires surgery
- Physician's order includes:
  - Date of service
  - Medication name anddosage
  - Diagnosis
  - Physician signature
- Interval of administration is appropriate such as 28-day rule
- Procedure record includes:
  - Diagnosis
  - Route of administration (intravitreal injection) and medication name
  - Site of injection - eye (s) treated
  - Dosage in mg and volume in ml, (e.g.., Avastin 1.25 mg@ 0.05 ml) and lotnumber
  - Single-use medications record wastage greater than 1 unit (e.g., Triesence)
  - For wastage less than 1-unit document: *"any residual medication less than one unit has been discarded."* (e.g. EYLEA)
  - Consent completed for injection, medication and eye (s) on file.
  - For initial treatment using a medication with off-label use, an informed consent with that notification is completed. (e.g. Avastin)
  - Advance Beneficiary Notice (ABN) for Medicare Part B beneficiaries or waiver of liability (all other patients) is completed, if applicable (e.g. diagnosis not indicated, exceeds frequency)
- Chart record is legible and has patient identifiers (e.g. patient name, date of birth) on all pages
- Physician signature is legible
  - Paper chart records have a signature log
  - EHR, the electronic physician signature is secure
- Abbreviations are consistent with approved list and readily available for audits
- Maintain legible medication administration and inventory records

CHECKLIST/GUIDE FOR CODING INJECTIONS

- CPT 67028, eye modifier appended (-RT or-LT)
  - Bilateral injections billed with a -50 modifier per payer guidelines. (Medicare Part B claims billed with 67028-50 on one line, fees doubled and 1 unit.)
- HCPCS J-code for medication
- Appropriate units administered (i.e., EYLEA 2 units)
- HCPCS J-code on a second line for wasted medication, if appropriate
  - -JW modifier appended
- Medically necessary ICD-10 code appropriately linked to 67028 and J-Code (s)
- On the CMS-1500 claim form **in** item
  - 24a or EDI loop 2410: 11-digit NDC code in 5-4-2 format, proceeded by "N4" qualifier
  - 19 or EDI equivalent: Description of medication and dosage per insurance guidelines (e.g. Avastin)

2022 Global Periods – Proposed Rule

CPT code	Medicare global period	Same day exam modifier	Other payers may vary
67105	10-days	-25 modifier	10 or 90-day global
67145	10-days	-25 modifier	90-day global
67210	90-days	-57 modifier	90-day global
67220	90-days	-57 modifier	90-day global
67228	10-days	-25 modifier	10 or 90-day global

Fact Sheet for Documenting the Need for Photodynamic Therapy (PDT)

Because of the pandemic, CMS suspended audits of practices on March 30, 2020, but allowed them to resume on Aug. 3, 2020. At the time, CMS said that "providers should discuss with their contractor any COVID-19-related hardships they are experiencing that could affect audit response timeliness."[1] If you are granted an extension, save the written confirmation of it.

Auditors zeroing in on PDT therapy. Retina practices across the country have reported receiving requests for documentation to support the need for photodynamic therapy (PDT).

Noncovered indications. CMS has explicitly said that PDT isn't covered for atrophic ("dry") age-related macular degeneration (AMD) or for choroidal neovascularization (CNV) lesions that are juxtafoveal or extrafoveal. Also, initial treatment isn't covered if you can't obtain fluorescein angiography (FA).

Re-treatment. Re-treatment with PDT is considered reasonable and necessary if, on reexamination, the ophthalmologist finds leakage from classic CNV on FA.

Use of either OCT or FA to assess treatment response is permitted for claims with dates of service on or after April 3, 2013.

Coding. To report PDT for CNV, you can use CPT code 67221 for the first eye and, if treating the second eye at the same session, use add-on code 67225.

Use HCPCS code J3396 to bill for Visudyne (verteporfin). The billable unit is 0.1 mg, and a 15-mg vial contains 150 billable units. Report the number of units injected and, since it is a single-use vial, use modifier –JW on a second line to report how many units were wasted.

PDT Checklist

Pretherapy checklist. Document the following *before* therapy begins:

☐ CNV membrane (CNVM) secondary to AMD

☐ CNVM under the geometric center of the foveal avascular zone

☐ Evidence of classic CNVM on FA

☐ Area of classic CNVM at least 50% of the area of the total neovascular membrane

When is PDT covered? Effective April 1, 2003, PDT may be covered for:

☐ Subfoveal occult with no classic CNV associated with AMD

☐ Subfoveal minimally classic CNV (where the area of classic CNV occupies <50% of the area of the entire lesion) associated with AMD

Important caveat: These two indications are considered reasonable and necessary only when: The lesions 1) are small (4 disc areas or less in size) at either the time of initial treatment or within three months prior to initial treatment; and 2) have shown evidence of progression within the three months prior to initial treatment.

Procedure note. Your procedure note should document the following:

☐ Diagnosis supporting medical necessity and appropriate indication for use

☐ Relevant diagnostic testing services within the policy guidelines (FA, OCT)

☐ Physician order including medication name, dosage, and signature

☐ Route of administration, site of injection

☐ Dosage in mg and volume in mL

☐ Medication wastage recorded

☐ Consent completed

☐ Legible physician signature (paper chart records should include a signature log; if electronic, the electronic signature must be secure)

Sources: National Coverage Determinations (NCDs) for ocular PDT (Document ID#: 80.2.1), verteporfin (80.3.1), and PDT (80.2) are available at www.cms.gov/medicare-coverage-database. *Academy 2021 Retina Coding: Complete Reference Guide* is available at aao.org/store.

BY **SUE VICCHRILLI, COT, OCS, OCSR,** ACADEMY DIRECTOR OF CODING AND REIMBURSEMENT, AND **JOY WOODKE, COE, OCS, OCSR,** ACADEMY CODING AND PRACTICE MANAGEMENT EXECUTIVE.

1 www.cms.gov/files/document/provider-burden-relief-faqs.pdf. Accessed Feb. 2, 2021.

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Created: March 4, 2020

Photodynamic Therapy Laser

CPT Code 67221, +67225, J3396

All the following must be present before therapy begins:

☐ Choroidal neovascularization membrane (CNVM) secondary to age-related macular degeneration

☐ CNVM under the geometric center of the foveal avascular zone

☐ Evidence of classic CNVM on fluorescein angiogram (FA)

☐ Area of classic CNVM at least 50% of the area of the total neovascular membrane

☐ Retreatment with PDT is reasonable and necessary if, on re-examination, the ophthalmologist finds leakage from classic CNV on the FA

☐ Effective for claims with dates of service on and after April 3, 2013 permit either optical coherence tomography (OCT) or FA to assess treatment response.

Effective April 1 2003, PDT may be covered for:

☐ Subfoveal occult with no classic CNV associated with AMD

☐ Subfoveal minimally classic CNV (where the area of classic CNV occupies < 50% of the area of the entire lesion) associated with AMD

These two indications are considered reasonable and necessary only when:

☐ The lesions are small (4 disk areas or less in size) at the time of initial treatment or within 3 months prior to initial treatment; and,

☐ They have shown evidence of progression with the 3 months prior to initial treatment

Non-covered indications

☐ Juxtafoveal or extrafoveal CNV lesions (lesions outside the fovea),

☐ Inability to obtain a FA

☐ Atrophic or “dry” AMD

Procedure note should include

☐ Diagnosis supporting medical necessity and appropriate indication for use

☐ Relevant diagnostic testing services within the policy guidelines (FA, OCT)

☐ Physician order including, medication name and dosage and signature

☐ Route of administration, site of injection

☐ Dosage in mg and volume in ml

☐ Medication wastage recorded

☐ Consent completed

☐ Physician signature is legible

- Paper chart records have a signature log
- Electronic health records (EHR), the electronic physician signature is secure

References:

CMS National Coverage Determination, Ocular Photodynamic Therapy (80.2.1)
CMS National Coverage Determination, Verteporfin (80.3.1)
CMS National Coverage Determination, Photodynamic Therapy (80.2)
Academy 2020 Retina Coding: Complete Reference Guide

Remote Access Policy

[Insert Practice Name]	Approval Date: _____ Revision Date/No: _____ Approval Signature: _____
Policy Name: Remote Access to [Insert Practice Name] Information Systems Policy Number: Admin - 105	Page **1** of **3**

I. Purpose

- To promote effective provision of high-quality care by expanding the range of settings in which staff members can perform their duties.
- To define requirements for connecting to **[Practice Name]** IT systems from a remote host and to assist users in following proper and secure remote access usage and practices in order to comply with applicable privacy and security requirements.

II. Definitions

O365 - a suite of applications offered by Microsoft to support Microsoft Office applications in a distributed and remote work environment.

III. Scope

This policy applies to all **[Practice Name]** employees, contractors, vendors, and agents using any computing device to remotely connect to [Practice Name]'s IT systems or network for the purposes of doing work on behalf of **[Practice Name]**, including reading or sending email and viewing intranet web resources.

IV. Procedures

- **[Practice Name]** IT will provide reliable and secure remote access to [Practice Name] IT systems and provide detailed standards and configuration information for remote access users.
- Remote access users must use only [Practice Name] IT–approved remote access methods.
- Remote access users will comply with all policies that apply to **[Practice Name]** computing practices while connected to [Practice Name] IT systems. Key points of compliance include:
    - Safe computing practices
    - Appropriate system and Internet use
    - Preventing unauthorized network access and data transfer
    - Protecting patient confidentiality and privacy
- Remote access devices are to be used only by the approved user and not by family members, friends, or other persons while any remote access sessions are in progress.
- Remote access privileges will be granted, maintained, and revoked based on continuing need.
- Remote access may be terminated without warning if **[Practice Name]** management or IT determines there is a risk to the confidentiality and/or integrity of the data or network environment.

Remote Access Methods

There are three standard methods of remote access to **[Practice Name]** IT systems:

- **Outlook Webmail** – this method utilizes a web browser to securely connect to **[Practice Name's]** O365 email server.
- **Virtual Private Network (VPN) client** – this method utilizes a VPN client to connect to **[Practice Name's]** IT systems over an encrypted virtual private network. It can provide access to all or a subset of [Practice Name] IT systems.
- **WebEx, Live Meeting, & Similar –** these methods enable the user to participate in live web-based meetings. Because they are not HIPAA compliant the user must determine, before the meeting begins, that no PHI will be presented or discussed. If PHI is presented, the user must terminate the meeting as soon as possible.

Remote Access System Requirements

Remote access users accessing **[Practice Name]** IT systems with a VPN client must configure their host as follows while connected to the **[Practice Name]** network:

- Install and maintain a current operating system set to apply all operating system updates regularly.
- Install, use, and maintain current antivirus software and definitions.
- Disable peer–to–peer software.
- Disconnect from all networks other than the user's ISP.

Remote Access Approval Process

- The individual requesting remote access completes the **[Practice Name]** Remote Access Request Form (Admin – 136 F) and submits it to the administrator.
  - As part of the application, the individual requesting remote access will supply a photograph of the intended location, demonstrating a secure work environment.
- The administrator has final approval relating to all remote access requests.
- Related paperwork is retained electronically in the user's employee file or contract file as appropriate.

Safe Computing Requirements

Remote access users accessing **[Practice Name]** IT systems much to use the following safe computing practices always in addition to all other **[Practice Name]** policies that apply to **[Practice Name]** computing practices.

- Remote access devices must always use up-to-date approved antivirus protection.
  - Antivirus protection must run in real time.
  - Antivirus library definitions must be updated at least daily.
  - Antivirus full scans must be performed at least on a weekly basis and any time the [Practice Name] administration or IT support announces a major threat risk.
- Remote access PCs must:
  - Have current, updated protection for spyware and malware.
  - Have current operating system updates and patches applied regularly.
  - Turn on web browser pop-up blocking.
- Remote access users may only use devices that follow these safe computing requirements. No other devices may be used. Public PCs and public Internet access devices are specifically prohibited.
- Passwords and/or PINs should never be written down or stored on the remote access device in

an unencrypted format.

- The remote user will adhere to standard [Practice Name] policy about password changes and strength.
- Remote access users are prohibited from personal and recreational computer use while connected remotely to **[Practice Name]** IT systems and networks. Recreational computer use includes any Internet activity such as personal email, social networks, Internet gaming, etc.
- Remote access devices should be disconnected from **[Practice Name]** IT systems and networks before being left unattended.
- Installation and use of un-trusted software should be avoided.
- Remote access devices network capabilities, such as Bluetooth, must be deactivated when in public areas.
- No PHI or **[Practice Name]** confidential or trade information may be stored locally on the remote access device or on removable media such as flash drives or CDs.
- PHI or **[Practice Name]** confidential or trade information printed on a remote access device must be handled, stored, and disposed of according to **[Practice Name]** HIPAA privacy guidelines.
- Installation or use of pirated, reverse engineered, or otherwise illegal software is strictly prohibited.
- The remote access user must take all reasonable precautions to prevent others from viewing PHI or confidential trade or operational information.

V. References / Citations [complete per practice HIPAA policies]

- **[Practice Name]** HIPAA Privacy Policy
- **[Practice Name]** HIPAA Security Policy
- Admin 109 – Passwords
- Admin 107 – Destruction of Devices Containing PHI
- Admin 110 – Physical Security of Devices Holding PHI

CREDIT STATEMENT

The Remote Access Policy was adopted from policies provided by:

- Peter D Berger, MBA, Administrator, Orion Eye Center, LLC, Redmond, Oregon.

Download a copy of this form in Word format by visiting:
https://www.aao.org/practice-management/resources/practice-forms-library/practice-forms-library-reopening-and-recovery

Remote Access Policy

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Reboot Your Practice: Post-COVID-19 Recovery Roadmap for the Ophthalmic Practice

DISCLAIMER AND LIMITATION OF LIABILITY

Practice forms have been shared by AAOE members for inclusion in *Reboot Your Practice: Post-Covid Recovery Roadmap for the Ophthalmic Practice.* These practice forms can be customized for your practice and are provided by the American Academy of Ophthalmology for informational purposes only. The Academy does not review, warrant, verify or guarantee the forms. The Academy does not provide legal or accounting services or advice. You should seek legal and/or accounting advice if appropriate to your situation. The Academy, its employees, agents and representatives are not liable to you or any other party to any extent whatsoever for errors in, or omissions from, or inclusions in the forms or for any information they contain. By using the forms you accept this Disclaimer and Limitation of Liability.

Retina Testing Services **NCCI 27.3** **Effective 10/1/2021**	**EO peripheral retinal disease 92201**	**EO posterior pole 92202**	**FA 92235**	**ICG 92240**	**FA/ICG 92242**	**FP 92250**	**Posterior Segment OCT 92134**	**Optic Nerve OCT 92133**
EO peripheral retinal disease 92201		Mutually Exclusive	Billable same day	Billable same day	Billable same day	Mutually Exclusive	Billable same day	Billable same day
EO posterior pole 92202	Mutually Exclusive		Billable same day	Billable same day	Billable same day	Mutually Exclusive	Billable same day	Billable same day
FA 92235	Billable same day	Billable same day		Mutually Exclusive	Mutually Exclusive	Billable same day	Billable same day	Billable same day
ICG 92240	Billable same day	Billable same day	Mutually Exclusive		Mutually Exclusive	Bundled	Billable same day	Billable same day
FA/ICG 92242	Billable same day	Billable same day	Mutually Exclusive	Mutually Exclusive		Bundled	Billable same day	Billable same day
FP 92250	Mutually Exclusive	Mutually Exclusive	Billable same day	Bundled	Bundled		Bundled	Bundled
Posterior Segment OCT 92134	Billable same day	Billable same day	Billable same day	Billable same day	Billable same day	Bundled		Mutually Exclusive
Optic Nerve OCT 92133	Billable same day	Billable same day	Billable same day	Billable same day	Billable same day	Bundled	Mutually Exclusive	

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Red Light, Green Light: Reviewing Prior Authorization for Intravitreal Injections

From the Academy's "The Profitable Practice: Medication Inventory Management" published in 2019

As you evaluate your prior authorization (PA) process, an important step is identifying if you have the necessary authorization on file prior to performing an intravitreal injection. Creating a protocol that provides easy access to review the approved PA is essential. Basically, outlining a red light or green light process that provides timely, clear direction is advantageous to the retina specialist and staff.

The green light could be a notification in the computer system or documentation in the chart, superbill or other patient information readily available during the encounter. This could be communication that a PA is either not required for this insurance, or that there is approval on file. For all scheduled injections, the PA could be confirmed and documented prior to the encounter.

For same day injections, there would be a time-out process to confirm the green light to inject. If identified that a PA is not on file and required, what is your next step? How do you communicate with the physician and patient?

Taking the time to check for the PA is the most important step. But with various insurance carriers and different requirements, a resource to identify these nuances promptly will provide efficiency. Developing a quick reference guide can communicate: Red light - referral and/ or prior authorization is required, please confirm approval, Yellow light - caution, confirm secondary insurance requirements, and Green light- no referral or PA required.

There are many types of resources that can be helpful in the "green light" process. The takeaway is to find a guide that is effective. As the resource is used and new insurance carrier rules are introduced, the guide is revised or improved. This continuous process will help ensure that all injections have the appropriate authorization.

Medication PA/Referral Resource

	EYLEA (2 UNITS)		LUCENTIS (5 UNITS)		TRIESENCE		OZURDEX		AVASTIN		SPECIAL INSURANCE REQUIREMENTS
	PA	REF	PA	REF	PA	REF	PA	REF	PA	REF	
HMA COMMERCIAL	CALL		CALL		CALL		CALL		CALL		Prior authorization via phone request only
USA MA PLAN	✔		✔		✔		✔				PA not required for Avastin
BB MA PLAN	✔		✔		✔		✔				Requires step therapy
MEDICARE PART B											**confirm secondary coverage if HMO and PA/REF requirements
CARE COMMERCIAL	✔	HMO	✔	HMO	✔	HMO	✔	HMO	✔	HMO	888-222-2222 REF needed for HMO plans (from PCP only)
MEDICAID HMO	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	
HMO INSURANCE	✔	HMO	✔	HMO	✔	HMO	✔	HMO	✔	HMO	REF needed for choice or medical home plans only

✔ Prior authorization is required
HMO HMO – Referral required
CALL Prior authoriztion is required, must call is request
No referral or PA required
Caution – confirm other coverage requirements

New E/M Rules for Office Visits, Part 2: How to Document the Retina Exam

On Jan. 1, 2021, new documentation criteria for the office-based evaluation and management (E/M) codes 99202-99215 go into effect with a focus on what's medically relevant. Before the turn of the year, take time to teach your technicians how to properly document patient histories under the new rules.

What is medically relevant? Last month, *EyeNet* provided examples of what should be documented when you are examining cataract, cornea, glaucoma, and pediatric patients. This month, the emphasis is on retina.

Retina Examples

Under the new rules, what elements will Eric P. Brinton, MD, expect his technicians to document? This will depend on the reason for the exam.

Flashes and floaters. If the patient was referred because of flashes and floaters, Dr. Brinton would expect the following information to be recorded in the patient's medical record:

- When did the flashes and floaters begin?
- Right, left, or both eyes?
- Over time, have the flashes and floaters become more intrusive, less intrusive, or stayed the same?
- Recent eye surgery or trauma?
- Is the patient a high myope?
- Does the patient have diabetes?

Wet AMD follow-up. For a one-month follow-up exam on a patient who received an injection in one eye, document the following:

- Has the patient noticed any improvement?
- Were there any problems following the injection, such as eye irritation?
- How committed is the patient about continuing treatment?
- Any issues or changes with the other eye?

(Note: For a checklist of payers' requirements on the day of the injection, whether the exam is billable or not, visit aao.org/retinapm and click on the "Anti-VEGF Drug Treatment" documentation checklist.)

Following the NPDR patient. When patients with nonproliferative diabetic retinopathy (NPDR) are coming in every six to nine months, the exam's documentation should include the following:

- Any changes or worsening in vision?
- Any bleeds in either eye?
- Status of blood sugar/A1c? (If the patient doesn't know, that is a red flag.)

General tips. Dr. Brinton said that training on the new documentation requirements is an opportunity to remind staff about best practices, such as:

- Examination of the eye may lead to other pertinent questions.
- Words of encouragement should be expressed to the patient with any chronic condition.

Dr. Brinton practices at the Retina Associates of Utah in Northern Utah.

What About Nonoffice Exams?

What if you leave your office to examine a patient or if a hospital inpatient is transported to your office for an exam? In those cases, at least for 2021, you must continue to fulfill the E/M criteria that were established in 1997, with your documentation including the following:

- **A chief complaint and a history of the present illness** that includes at least four of the following elements: location, context, modifying factor, duration, timing, quality, and associated signs and symptoms.
- **A review of at least 10 of the following systems** and, for any that are positive, what the patient is currently doing to treat the problem:
  - eyes (e.g., sudden loss or change in vision)
  - constitutional (e.g., fever)
  - ears, nose, mouth, throat (e.g., dry mouth)
  - gastrointestinal (e.g., hepatitis)
  - genitourinary (e.g., bladder or kidney issues)
  - integumentary (e.g., dermatitis)
  - cardiovascular (e.g., high blood pressure)
  - respiratory (e.g., asthma)
  - hematologic/lymphatic (e.g., infection)
  - psychiatric (e.g., mental and/or emotional factors)
  - neurological (e.g., stroke)
  - musculoskeletal (e.g., arthritis)
  - allergic/immunologic (e.g., hay fever)
  - endocrine (e.g., diabetes)
- **Past, family, and social history**

BY **SUE VICCHRILLI, COT, OCS, OCSR,** ACADEMY DIRECTOR, CODING AND REIMBURSEMENT, AND **ERIC P. BRINTON, MD.**