



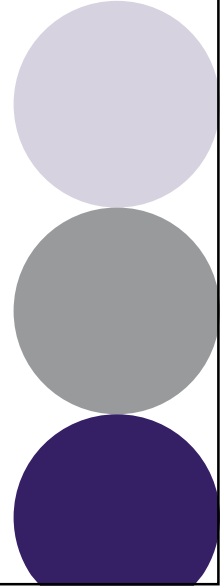
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Coding Updates & Tips for The Exceptional Technician

OAO Ophthalmic Technology Meeting
Friday, March 11, 2022

Presented by:
Joy Woodke, COE, OCS, OCSR



Financial Disclosure

- Joy Woodke, COE, OCS, OCSR

- I have no financial interests or relationships to disclose.



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Course Agenda



What is new in 2022?



Coding Tips:

E/M vs. Eye Visit Codes
Diagnostic Testing Services
Fundamentals of Coding



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What's New in 2022?



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Deleted Category III Code

- Deletion of codes
 - 0191T Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork; initial insertion
 - And
 - +0376T each additional device insertion



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New Category III Code

- New Category III code
 - 0671T Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more
 - iStent, iStent *inject*, Hydrus
 - Coverage, payment to be determined
 - Sunsets Jan. 2027
 - Not yet approved by FDA as a stand-alone procedure



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New CPT Code

- New Level 1 code
 - 66989 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more
 - Complex cataract + iStent, iStent *inject*, Hydrus
 - 2022 typical allowable: \$856.50



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New CPT Code

- New Level 1 code
 - 66991 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more
 - Cataract + iStent, iStent *inject*, Hydrus
 - 2022 typical allowable \$683.47



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Change in CPT Code Description

* ▲ 99211 Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional

- Can be reported for telemedicine
- Code still must meet incident-to requirements
- Continues to be bundled with all testing services



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Change in CPT Code Description

▲ 67141 Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy

- 10-day global period from 90-day global period
- Monitor change for commercial payers
- Modifier -25 vs. -57
- 2022 allowable: \$272.70 (office), \$216.98 (facility)



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Change in CPT Code Description

▲ 67145 Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; photocoagulation

- 10-day global period from 90-day global period
- Although the 1 or more session language was removed, payers would not expect additional treatment billed in the global period
- Monitor global period change for commercial payers
- Modifier -25 vs. -57
- 2022 allowable: \$244.32 (office), \$216.98 (facility)



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Other 2022 CPT Code Changes

- Impacting other subspecialties
- *Amblyopia, Strabismus, Lacrimal Implant, Orthoptic Training, Anterior Segment Implant, Posterior Chamber Injection*
 - Revalued strabismus codes (67311-67340)
 - Deleted codes: 0290T, 0191T, +0376T, 0356T
 - Change in descriptor: 92065
 - New codes: 0671T, 66989, 66991, 68841, 0660T, 0661T, 0699T, 0687T, 0688T, 0704T, 0705T, 0706T
 - Join us for Virtual Multi-State Codequest, March 29 for more details!



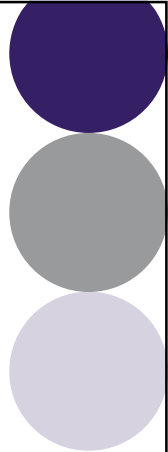
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Coding Tips

For the Exceptional Technician



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Coding Tip

- Recognize the documentation guidelines for E/M and Eye visit codes and how to choose the appropriate level of code.



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2021 E/M Documentation Guidelines



Medically relevant history and examination



E/M code selection based on:

Medical Decision Making, or
Total Physician Time



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“Medically Relevant” History & Exam

- As determined by your physician
- Not restricted by 1997 E/M guidelines
 - 4 HPI elements, 10 ROS body systems, oriented to time/place, mood & affect
- What should be included in the chief complaint?
- Does that patient have to be dilated?
- Make sure and document history elements related to MIPS quality measures
 - e.g. tobacco use, medication reconciliation



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“Medically Relevant” History & Exam

- Document based on presenting illness or condition.
- Not restricted by elements
- Communicate with your physician what he/she considers relevant
- Technician workup may be different
 - What exam elements are medically relevant?



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“Medically Relevant” History

- Example: Flashes & Floaters
- 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? Have diabetes?



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“Medically Relevant” History

- Example: NPDR patient here for 6 month follow-up
- Any changes or worsening in vision?
- Any bleeds in either eye?
- Status of blood sugar/A1c?



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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 result(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

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Eye Visit Codes

Documentation requirements remain the same

Comprehensive codes: 92004, 92014

Intermediate codes: 92002, 92012



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E/M vs Comprehensive Eye Visit Codes

	E/M Office and Other Outpatient Encounters	Eye Visit Code Comprehensive Exam Components
	CPT codes 99202-99215	CPT codes 92004, 92014
History	Medically relevant	<ul style="list-style-type: none"> History (not defined) General medical observation (not defined) Chief Complaint
Exam	Medically relevant Dilate as medically necessary	Exam: recommended 12 elements, often includes dilation
Medical Decision Making	Number and Complexity of Problems Addressed at the Encounter , Amount and/or Complexity of Data to be Reviewed and Analyzed , Risk of Complications and/or Morbidity or Mortality of Patient Management (2 of 3)	Initiation or continuation of diagnostic and treatment programs



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E/M vs Comprehensive Eye Visit Codes

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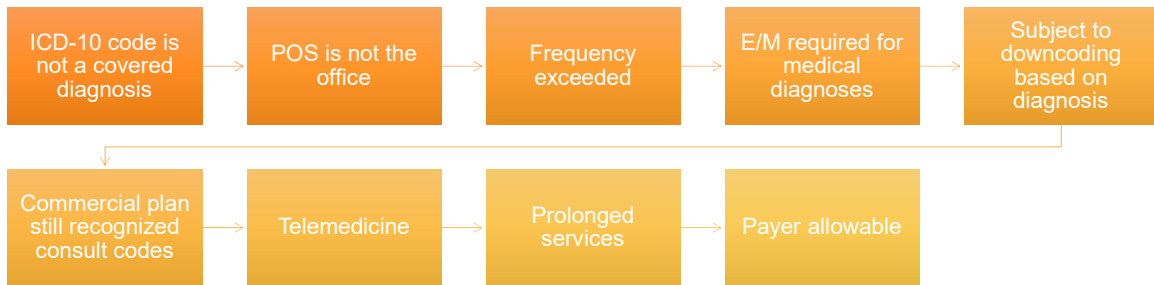
Coding Tip

- Understand the scenarios when to bill an E/M or an Eye visit code.



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Scenarios When You Should Not Submit an Eye Visit Code



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2022 Noridian Fee Schedule: Portland

E/M New	Office	wRVU
99202	\$ 75.76	.93
99203	\$115.65	1.60
99204	\$172.18	2.60
99205	\$227.56	3.50
Eye New	Office	wRVU
92002	\$ 91.09	.88
92004	\$158.00	1.82

E/M Est	Office	wRVU
99212	\$ 58.79	.70
99213	\$ 94.18	1.3
99214	\$133.03	1.92
99215	\$186.79	2.80
Eye Est	Office	wRVU
92012	\$ 94.34	.92
92014	\$133.55	1.42



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Case Studies: New Patients

Clinical Scenario	Medical Decision Making	E/M Code: Noridian: OR 01	Eye Code: Noridian: OR 01
Cataract	New glasses Rx Return 1 year	99203 \$116	92004 \$158
Glaucoma suspect	Gonioscopy/VF/SCODI/Refraction Return 1 year	99203 \$116	92004 \$158
Plaquenil No maculopathy	VF/Refraction Return as recommend by referring MD	99203 \$116	92004 \$158
Cataract	Cataract worsening, impact on daily living, patient desires surgery	99204 \$172	92004 \$158
Mac on RD	Macula on retinal detachment, schedule surgery today High	99205 -57 \$228	92004 -57 \$158



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Case Studies: Established Patients

Clinical Scenario	Work Performed	E/M Code	Eye Code
Glaucoma quarterly evaluation	VF/Refraction Glaucoma stable, no change in medication	99213 \$94	92012 \$94
Glaucoma quarterly evaluation	VF/Refraction Medication change or surgery Return 4 months	99214 \$133	92014 \$133
Acute angle closure attack	Drop therapy begins, 3 rounds, start Diamox, needs laser PI today	99215 \$187	92014 \$133



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Diagnostic Testing Services



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Coding Tip

- Know the required documentation requirements for testing services.



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Diagnostic Testing Services








- Delegated testing services require physician order
- The physician must examine the new patient to determine medical necessity
- Standing orders or screening tests are not covered by insurance payers
- Test interpretation required



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Written or Electronic Physician Order

-  Date of service
-  Name of the test(s)
-  Medical necessity reflected in the chart note
-  Medically necessary diagnosis
-  Eye(s) being tested
-  Interpretation/report
-  Physician legible or secure electronic signature



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Diagnostic Testing Services

Tests that can be delegated are comprised of:

- Technical component (-TC)
- Professional component (-26)

Interpretation and report

- An interpretation and report is completed for each test performed and per eye by the physician
- There are no published documentation requirements for the interpretation and report. The required documentation could include; diagnosis, findings and the impact on the treatment plan.

Copy of the diagnostic test should easily accessible.



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Coding Tip

- Recognize CCI bundles for testing services and understand when appropriate to unbundle.



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Test Your Knowledge

- During an encounter today, medically necessary testing was performed which included:
- 92202 EO, posterior pole
- 92133 Optic nerve OCT
- 92250 Fundus photos



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Test Your Knowledge


- Code this case:
- A. Exam + 92202 + 92133
- B. Exam + 92202 only due to CCI bundles
- C. Exam + 92202 + 92133 -59 + 92250 -59
- D. Exam + 92202 + 92250



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Retina Testing Services NCCI 28.0 Effective 1/1/2022	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
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*Retina Testing Services, CCI bundles,
 January 1, 2022, Version 28.0*

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Test Your Knowledge

- Modifiers Matter – and can be unnecessary too!
 - Appending -59 modifier just in case, will
 - Cause denials!
 - Attract unnecessary audits!
 - Verify CCI bundles prior to claim submission
 - Use an internal quick resource
 - aao.org/coding link to CMS CCI files
 - Academy Coding Coach or Retina Coding: Complete Reference Guide
 - aao.org/store



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-59 Modifier: What You Need to Know

- 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

Column 1	Column 2	Date of Bundle	Date of Deletion	Indicator
92134	92250	20110101	*	1
92133	92134	20110101	*	0



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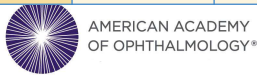
Test Your Knowledge

- When can I unbundle 92133 Optic nerve OCT and 92134 Retina OCT?
 1. Never as they are mutually exclusive
 2. When you have two different diagnoses
 3. When the payer states it is appropriate in writing



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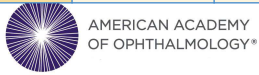
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Fundamentals of Coding

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Coding Tip

- Master the definitions and appropriate uses for modifiers.



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Test Your Knowledge

- 65 year old male is seen for sudden floaters in the left eye. The patient is 1 month status-post cataract surgery in the right eye.
- Diagnosis: Posterior vitreous detachment, left eye
- Plan: Symptoms of RD discussed, return to office in one month.



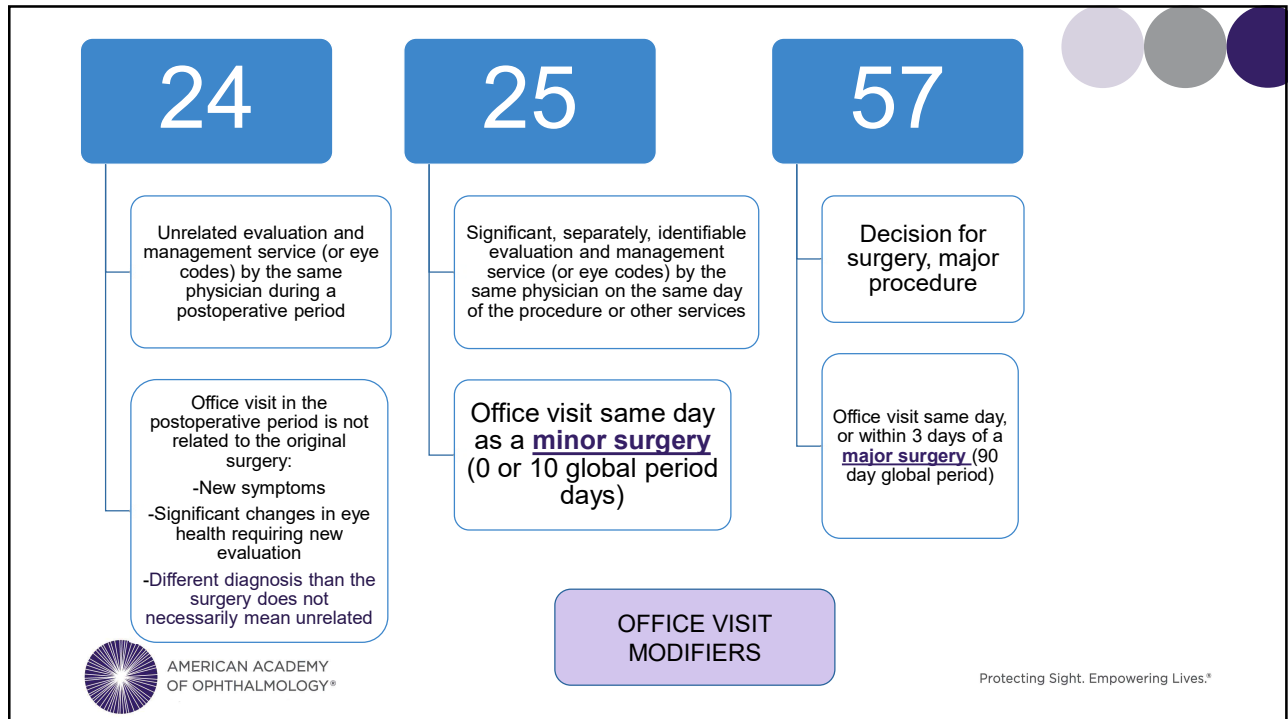
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Test Your Knowledge

- The office visit today should be coded as:
 - A. 9XXXX -24
 - B. 9XXXX -79
 - C. No charge, it is postop
 - D. 9XXXX -25



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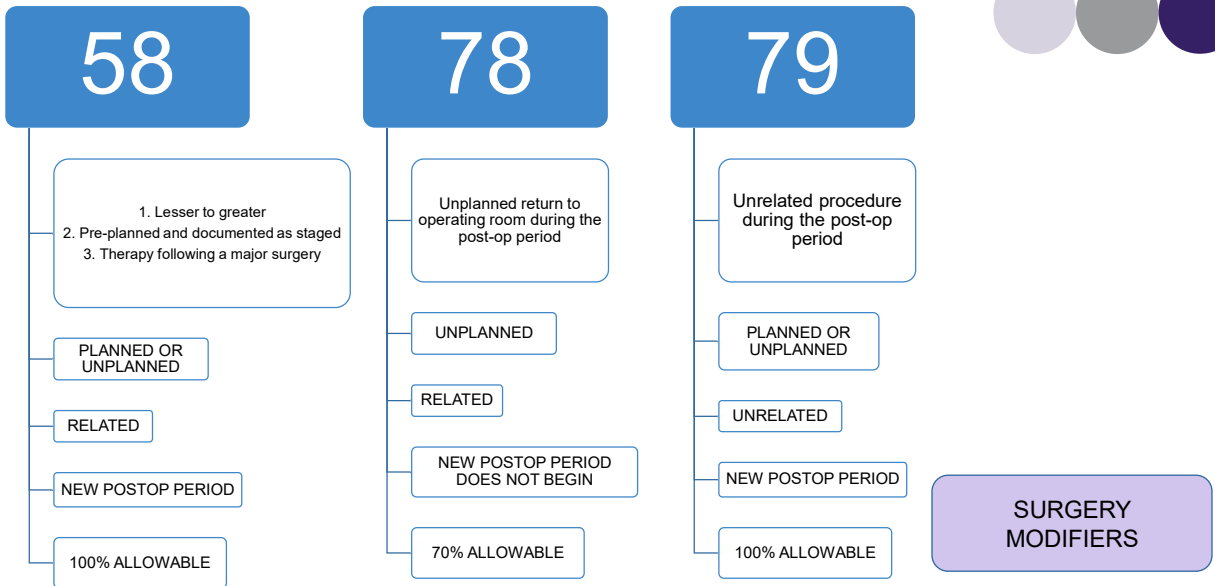
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Test Your Knowledge

- Cataract surgery in the left eye is performed. During the 90-day global period, a YAG capsulotomy is performed in the right eye.
 - What modifier should be used?
- 79
 - 58
 - 59
 - 78



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Coding Tip

- Understand how the global period impacts correct coding.



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Global Periods

The global periods vary *by surgery* and by *insurance carrier*

- Medicare's 10-day global period = 90-day global period for some commercial or Medicaid insurance carriers

Minor Surgery

- 0-10 day global

Major Surgery

- 90 day global



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Impact of Global Period

Identify	Identify appropriate modifier to use during postop period
Choose	Choose the correct modifier for the same day office visit
Know	Know when the postop ends, and bill office visits
Avoid	Avoid denials!



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Test Your Knowledge

- 3 weeks s/p PRP (67228) in the left eye, the same patient is seen for a retinal tear in the right eye
- Correct coding:
 - A. Exam only
 - B. Exam, -24 modifier
 - C. Exam, -79 modifier
 - D. No charge, post-op



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2022 Laser Global Periods

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	10 or 90-day global
67210	90-days	-57 modifier	90-day global
66761	10-days	-25 modifier	10 or 90-day global
66821	90-days	-57 modifier	90-day global

*CPT code 67145, global period change effective 1/1/2022



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Coding Tip

- Confirm the ICD-10-CM to CPT code link is appropriate.



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ICD-10-CM Link to CPT

- Diagnosis link matters
 - Confirms medical necessity
 - Identifies laterality
 - Some circumstances, justifies unbundling services
 - Avoids denials



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ICD-10-CM

- ICD-10-CM link to CPT
- Identified on the CMS-1500 or electronic equivalent
 - Box 24E
- Essential to avoid claim denials

24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (From A.L. to service line item (SLI))										ICD-10-CM
A. I.		B. I.		C. I.		D. I.		E. I.		
E. I.		F. I.		G. I.		H. I.		I. I.		
J. I.		K. I.		L. I.		M. I.		N. I.		
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. PROCEDURES, SERVICES, OR SUPPLIES		D. PROCESSES, SERVICES, OR SUPPLIES		E. DIAGNOSIS		
From	To	BRFFS	EMS	CDL	OPS	I	NONRES	DIAGNOSIS	POINTER	
MM	DD	YY	MM	DD	YY					



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ICD-10-CM

POAG AMD

A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C.	D. PROCEDURE, SERVICE, OR SUPPLY	E. DIAGNOSIS			
From	To	Office	EMG	Other	Pointer			
MM	DD	YY	MM	DD	YY			
10	05	20	10	05	20	11	99214	A, B
10	05	20	10	05	20	11	92083	B
Visual Field								

- What is wrong with this claim?
- Will this claim be denied?
- How can this be avoided?



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ICD-10 Link: Multiple Testing Services

- 92004-25, comprehensive exam → • E11.3513, H43.12
- 92134, PS OCT → • E11.3513, PDR w edema OU
- 76512-LT, B-scan → • H43.12, Vitreous hemorrhage
- 67028-LT → • E11.3512, PDR w edema OS
- J7999 → • E11.3512, PDR w edema OS



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Coding Tip

- Recognize ICD-10-CM Excludes1 edits and the impact on claim denials.



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Test Your Knowledge

- H10.11 Acute atopic conjunctivitis, right eye and
- H16.221 Keratoconjunctivitis sicca, right eye
- Are submitted with an E/M code to a commercial payer.
- **The claim is denied due to diagnosis code link. Why?**
 1. There is an Excludes1 edit with the two ICD-10 codes.
 2. If I submitted with an Eye visit code the claim would have been paid.



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ICD-10-CM

- Excludes1 note
 - Diagnosis code combinations that are not payable in the same eye.
 - Two conditions that cannot occur together, such as a congenital form versus an acquired form of the same condition



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Join Me For Codequest!

- Oregon Academy of Ophthalmology has partnered with the Academy for the Virtual Multi-State Codequest
- Tuesday, March 29, 8:00 am PST
- Live or recording available



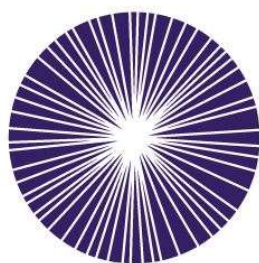
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Academy Coding Resources

- Become a member of American Academy of Ophthalmic Executives (AAO), the practice management division of the Academy. aao.org/aaoe
- Coding resources – aao.org/coding
- Study & pass the Ophthalmic Coding Specialist (OCS) or Ophthalmic Coding Specialist Retina (OCSR) Exam – aao.org/ocs
- Academy coding products - aao.org/store



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