

Ophthalmology Coding Compliance Plan Table Of Contents

1. Coding Compliance Program at OPHTHALMOLOGY CLINIC.....	2
I. Policy Statement.....	2
II. Code of Conduct.....	2
III. Methods of Distribution.....	2
IV. Coding Compliance Plan..... Corporate Compliance Plan.....	3
2. Coding Compliance Officer (CCO):.....	4
I. Responsibilities:.....	4
II. Ophthalmology Clinic Coding Compliance.....	4
3. Training and Education.....	5
4. Implementation and Scope (Process).....	8
I. Coding Process.....	8
II. Periodic Documentation and Coding Audits.....	8
III. Minimum Documentation Requirements.....	8
IV. Coding/Provider.....	8
V. Internal Audits.....	9
VI. Identification Coding Compliance Responsibilities.....	9
VII. The Coding Compliance Officer should determine how codes.....	9
VIII. Periodic Review of Personnel Records for Compliance.....	9
IX. Review a sample of coded material and verify that.....	10
X. Compliance Is A Required Component Of Performance Evaluation.....	10
XI. Data Mine historical ICD-9 and CPT© codes for problems.....	10
5. Audit/Review of Coding.....	11
I. Formal Auditing and Monitoring.....	11
II. Lines of Communication.....	14
6. Corrective Procedures.....	15
I. Disciplinary Actions.....	16
7. Correction of Identified Problems.....	17
Appendix 1.....	18
Ophthalmology Coding Guidelines.....	18
Procedures Paid as <i>Bilateral</i> (Code = 2).....	24
92015 Refraction.....	25
Appendix 2.....	26
Appendix 2.....	28
I. Outpatient Coding.....	29
II. E & M Coding.....	30
III. Surgical Coding.....	30
Appendix 3.....	32
I. Coding Resources.....	32
Appendix 4.....	33
I. Coding Compliance Plan Recommended Issues.....	33
Appendix 5 – Illegal Medical Acronyms.....	34
Appendix 6 Coding Compliance Plan Flowchart.....	35
Appendix 7 Coding Training Plan Flowchart.....	36

1. Coding Compliance Program at OPHTHALMOLOGY CLINIC

I. Policy Statement

Employees must be cognizant of all applicable federal and state laws and regulations that apply to and impact upon Ophthalmology Clinic's documentation, coding, billing and competitive practices, as well as the day to day activities of Ophthalmology Clinic and its employees and agents. Each employee who is materially involved in any of Ophthalmology Clinic's documentation, coding, billing or competitive practices has an obligation to familiarize himself or herself with all such applicable laws and regulations and to comply with the requirements thereof. Where any question or uncertainty regarding these requirements exists, it is incumbent upon, and the obligation of, each employee to seek guidance from the Coding Compliance Officer or the attorney for Ophthalmology Clinic.

II. Code of Conduct

Ophthalmology Clinic has a policy of maintaining the highest level of professional and ethical standards in the conduct of its business. Ophthalmology Clinic places the highest importance upon its reputation for honesty, integrity and high ethical standards. This Policy Statement is a reaffirmation of the importance of the highest level of ethical conduct and standards.

These standards can only be achieved and sustained through the actions and conduct of all personnel of Ophthalmology Clinic. Each and every employee, including management employees of Ophthalmology Clinic, is obligated to conduct himself/herself in a manner to ensure the maintenance of these standards. Such actions and conduct will be important factors in evaluating an employee's judgment and competence, and an important element in the evaluation of an employee for raises and for promotion. Employees who ignore or disregard the principles of this Policy will be subject to appropriate disciplinary actions.

III. Methods of Distribution

All applicable OPHTHALMOLOGY CLINIC employees shall receive a copy of the Coding Compliance Plan and conduct themselves accordingly. This plan will be available and updated on a continual basis on a server on the Ophthalmology Clinic Intranet. Updates to the Coding Compliance Plan will be e-mailed to all appropriate employees.

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IV. Coding Compliance Plan versus a Corporate Compliance Plan

This Coding Compliance Plan should be considered a component of an overall Corporate Compliance Plan, which should include but not be limited to the following:

- I. HIPAA (Health Insurance Portability and Accountability Act of 1996) Guidelines
- II. OSHA (Occupational Safety & Health Administration) Guidelines
- III. CLIA (Clinical Laboratory Improvement Act/Amendment) Guidelines
- IV. EMTALA (Emergency Medical Treatment and Active Labor Act)
- V. Stark II laws (ban on physician self-referrals)
- VI. Other regulatory and governmental compliance guidelines that may apply to Ophthalmology Clinic.

Note: There is overlap between HIPAA compliance, Medical Records compliance and the coding and documentation compliance. An example would be requiring the provider's signature on all progress notes and operative reports. Open lines of communication should be established between these three compliance entities.

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2. Coding Compliance Officer (CCO):

I. Responsibilities:

The Coding Compliance Officer is responsible for developing the coding compliance policies and standards, overseeing and monitoring the compliance activities, and achieving and maintaining coding compliance. Responsibilities and duties of the CCO include:

- A. Assure that up-to-date, comprehensive internal policies and procedures for coding and billing are developed and maintained.
- B. Responsible for assuring consistent coding practices throughout Ophthalmology Clinic departments.
- C. Responsible for ensuring appropriate ongoing education for all coding employees including coding compliance issues.
- D. Responsible for regularly updating education for all coding employees as standards change.
- E. Responsible for monitoring the documentation supporting the medical necessity of services provided by the clinics.
- F. Assure that all coding personnel are informed of issues pertaining to Medicare medical necessity guidelines.
- G. Responsible for monitoring that the clinics maintain such as [Physician Acknowledgement Forms](#).
- H. Thoroughly analyze coding consultants' recommendations before implementing them.
- I. Periodically compare Clinic's evaluation and management code usage with others in the same specialty and region (Utilization Review Analysis).
- J. Participate in the annual management reviews as a member of the [Reimbursement Committee Meeting](#).
- K. Periodically examine organizational data from the past several years to determine inconsistencies.
- L. Ensure that all records required either by Federal or State law or by the compliance plan are created and maintained.
- M. Assure that evaluations of managers and supervisors include a component requiring the promotion and adherence to coding compliance.
- N. Maintain the confidentiality of any person reporting potential areas of concern and assure that no reprimanding acts shall be taken.
- O. Responsible for initialing corrective action to improve compliance processes
- P. Establish minimum competency education requirements for all coders.

II. Ophthalmology Clinic Coding Compliance Team

CFO / Corporate Compliance Officer
Coding Compliance Officer
Medical Director
Attorney
Coder Supervisor
Director of Medical Records
Physician Specialist's Team

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3. Training and Education

Obtain the Coding Department's education and training schedule for the current year.

- I. In order to create and maintain a culture of compliance, Ophthalmology Clinic shall provide initial and continuing education for both its physicians and employees on all matters set forth in the Coding Compliance Plan. Participation in the educational programs set forth in the Coding Compliance Plan shall be a condition of employment with Ophthalmology Clinic and all new employees will be trained within sixty (60) days of beginning employment. New billing and coding employees will receive direct supervision from an experienced employee until their initial training has been completed. The OIG recommends a minimum of one hour annually for basic training in compliance areas. Additional training shall be provided for specialty fields concerning compliance and billing.
- II. **Training Methods:** Ophthalmology Clinic will use a variety of methods to train and educate its employees including in-person training sessions, distribution of newsletters, posting information on bulletin boards, and online training via the Internet. In establishing educational objectives for current and future employees, Ophthalmology Clinic will determine: (1) Who needs training—both in coding and billing and compliance; (2) The type of training that best suits Ophthalmology Clinic's needs (e.g., seminars, in-service training, self-study or other programs); and (3) When the education is needed and how much each person should receive.
- III. **Coding Compliance Training:** Training will be provided on both an initial and recurrent basis. This will include information on the compliance program itself and applicable statutes and regulations. The educational programs provided by Ophthalmology Clinic should include:
 - a. An overview of this Plan with specific instruction on the disclosure and reporting mechanisms for infractions.
 - b. An overview of state and federal laws relating to billing practices, including submitting a claim for physician services when rendered by a non-physician (under "incident to" supervision and physical presence requirement); signing a form for a physician without a physician's authorization; altering medical records after the fact; and proper documentation of services rendered.
 - c. Training regarding the role of each employee and the consequences of violating the policies; and:
 - d. (g) Training regarding key risk areas including OIG guidance and areas of particular OIG interest.
- IV. **Coding and Billing Training.** Individuals who are directly involved with billing, coding or other aspects of the Federal health care programs will receive extensive training specific to their responsibilities. Ophthalmology Clinic will ensure that updated ICD-9, HCPCS and CPT® manuals (in addition to the carrier bulletins construing those sources) are available to those employees involved in the billing process. Continuous updates on current billing policies will also be readily available.

As appropriate for the individual the coding and documentation training will include:

- a. Coding requirements;
- b. Claim development and submission processes;
- c. Marketing practices that reflect current legal and program standards;
- d. The ramifications of submitting a claim for physician services when rendered by a non-physician;
- e. Signing a form for the physician without the physician's authorization;
- f. The ramifications of altering medical records;
- g. Proper documentation (coding and billing);
- h. How to report misconduct;
- i. Proper billing standards and procedures, and submission of accurate bills for services or items rendered to ensure program benefits;
- j. The personal obligation of each person involved in the billing process to ensure claims are properly and accurately submitted;
- k. The legal sanctions for submitting deliberately false or reckless billings; and informing physicians that they cannot receive payment or any type of incentive to induce referrals and that claims should not be submitted for physician services when those services are rendered by a non-physician (unless they follow the applicable Federal health care program requirements).

V. **Documentation.** The Coding Compliance Officer shall maintain documentation of all educational activities, including a record of dates, times, attendance, and agenda for all professional and compliance training sessions in which Ophthalmology Clinic personnel (both coders and providers) participate.

VI. **Compliance Reference Materials.** The Coding Compliance Officer shall maintain a library of regulatory and compliance-related information and training manuals. This information includes coding references, carrier newsletters, Medicare manuals, federal regulations, CMS interpretations, and materials published by the American Medical Association, Specialty medical associations and other relevant professional societies. The Coding Compliance Officer is also responsible for regularly disseminating new compliance information to Ophthalmology Clinic physicians and employees.

VII. Outline and document all employee education pertaining to coding, documentation and compliance:

- a. Training for Providers
- b. Training for Coding Staff
- c. Training for Medical Specialties
- d. Training for New Employees (provider coding and billing)
- e. Training Regarding Coding and Documentation Compliance

IX. Obtain a list of all employees with coding responsibilities, select a sample, and perform the following:

- a. Trace back to written documentation that the employee has attended compliance education and training.
- b. Review Compliance training material and verify that the material emphasizes the Organization Commitment to:
 - a. Comply with all laws, regulations and guidelines of Federal and State programs.
 - b. Covers the coding compliance policies.
 - c. Reinforces the fact that strict compliance with the law and coding policies is a condition of employment.
 - d. Informs employees that failure to comply with the law and the Coding policies may result in disciplinary action, including termination.
 - e. Inform employees that appropriate disciplinary actions include and including termination for failure to report a potential violation by another employee, supervisor or outside contractor or provider.
 - f. Review coding errors for the current year. Verify that the clinics has reviewed its practice covering the errors and taken appropriate action if needed and made employees aware of any potential problems.
 - g. Based on Federal and State law and the compliance policies and procedures, select a sample or records and verify that records are created and maintained in accordance with Federal and State law and by the compliance policies and procedures.

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4. Implementation and Scope (Processes)

I. Coding Process Controls

Process controls shall be instituted to establish responsibility and accountability among departments. Quality controls and feedback mechanisms shall be developed to help identify coding and documentation problems and correct them in a timely manner. This is an ongoing and iterative process.

II. Periodic Documentation and Coding Audits

Audits should be conducted to ensure the accuracy of clinical documentation on coding assignments. Audits should be scientifically designed to provide a fair assessment of coding practice and should encompass both hospital and outpatient (clinic) professional services. The Outpatient Reimbursement Coordinator shall be responsible for designing and conducting these audits.

III. Minimum Documentation Requirements

Minimum documentation requirements will be established for all proposed documentation.

Examples include:

All progress notes/operative reports will be signed and dated.

Personal, Family, Social History must be updated annually as a master document in the medical record. Each encounter should refer back to this document and the provider should notate that he/she asked the patient if there were any relevant changes to PFSH and document them accordingly.

All progress notes coded for Evaluation and Management Services will have at least 2 Review of Systems documented and reviewed by the Physician. Note that negative or normal elements count toward the total.

Providers should not copy Review of Systems, Exam or Consultation or Coordination of Care notes from one date of service to another. Any counseling or discussion with the patient should be personalized for each individual visit.

For all procedures requiring an interpretation and report, an interpretation and report must be documented in the medical record. Failure to include the proper documentation will result in disciplinary action.

IV. Coding/Provider Feedback

Feedback concerning proper documentation and coding should be documented and provided to each physician on a periodic basis. This information shall be stored in both narrative and summary form for retrieval by the Coding Compliance Office on an as-needed basis.

V. Internal Audits

The Outpatient Reimbursement Coordinator will perform regular, periodic compliance audits of the "coding processes". These audits will be designated to monitor compliance with the coding compliance policies, compliance plan, and all applicable Federal and State law.

Coding Compliance audits will be conducted in accordance with the following pre-established audit procedures:

- a) Review the Coding Compliance Plan's written policies and procedures for completeness. Verify the following issues are adequately addressed:
 - i) Coding practice.
 - ii) Medical record retention (EMR).
 - iii) Educating and training personnel regarding compliance.
 - iv) Coding Compliance Officer responsibilities.
 - v) Disciplinary action with respect to compliance adherence.
 - vi) Corrective actions (Training).
 - vii) Performance evaluation of compliance.
 - viii) Minimum coding education requirements for all coding personnel.
 - ix) Methods established for documenting continuous improvement.

VI. Identification Coding Compliance Responsibilities:

- i. Departmental Managers
- ii. Providers
- iii. Coding department
- iv. Billing department
- v. Outsourced Coding (surgical procedures)

VII. The Coding Compliance Officer should determine how coders:

- i) Determine the code selection made.
- ii) Their understanding of accurate coding versus "up coding"
- iii) Who they call for coding assistance.
- iv) Who reviews their coding assignments.

VIII. Periodic Review of Personnel Records on Compliance.

Select, at least once per year, a sample of employees who have coding responsibilities and obtain their Human Resources records. Review the records for the following:

- a. Level of coding education.
- b. Level of continuing education in coding.
- c. Verify forms signed by employee stating they understand the organizations coding policies and procedures.
- d. Verify job description and evaluation includes that employees are accountable for the quality of their work.

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IX. Review a sample of coded material and verify that:

- a. Coding is standardized throughout the organization.
- b. Codes are supported by medical necessity and the appropriate documentation is present to support a code.
- c. All procedures, tests, and services, have an appropriate order in the medical record.
- d. The code applied is the most appropriate and specific code.
- e. Billing has occurred for appropriately coded material and no billing has occurred for inappropriately coded material.
- f. Corrective action has been taken and documented when inappropriate coding has occurred.
- g. Review plan for ongoing monitoring of the coding process.

X. Compliance is A Required Component Of Performance Evaluation.

Verify that the promotion of and adherence to compliance is an element in evaluating the performance of Managers and Supervisors.

Work with Human Resources and ensure that all job descriptions include a phrase requiring strict adherence to all Compliance Guidelines.

XI. Data Mine historical ICD-9 and CPT© codes for problems

Every six months obtain a list of the top 50 ICD-9 and CPT© codes reported by Ophthalmology Clinic.

Analyze high-dollar, complex surgical or diagnostic procedures for documentation and coding accuracy.

Analyze the ICD-9 codes for unspecified codes. See the Appendix for a list of specific Examples

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5. Audit/Review of Coding

Auditing, Monitoring and Internal Reporting and Disclosure

In order to detect noncompliance with the Coding Compliance Plan, Ophthalmology Clinic shall use a system of periodic monitoring and auditing of the business activities of Ophthalmology Clinic. Further, all Ophthalmology Clinic personnel shall be required to report incidents of violations of this Plan and shall be subject to disciplinary action for failure to report any such incident.

I. Formal Auditing and Monitoring

The Coding Compliance Officer shall be responsible for the coordination of formal audits. Audits may be performed by an independent auditor with expertise in federal and state health care statutes, regulations, and policies. The auditor shall be independent of Ophthalmology Clinic's physicians and management and have broad access to records and personnel. In the event Ophthalmology Clinic uses a Third Party Billing Company; Ophthalmology Clinic shall require the Third Party Company to participate in any audit.

- (a) **Initial Audit.** Shortly after this Plan is established, Ophthalmology Clinic shall conduct a comprehensive initial audit of 1) all of Ophthalmology Clinic's business arrangements and agreements with third parties and 2) its claims submission process. The initial audit is undertaken at the request of and under the supervision of legal counsel. The purpose of the initial audit is to initially identify and subsequently correct any existing problems in Ophthalmology Clinic's business arrangements and billing, coding, and claims submission process. Any information that is identified shall be referred to the Coding Compliance Officer who shall in turn consult with legal counsel for appropriate investigation and action.
- (b) **Baseline Audit.** This initial audit shall establish a baseline against which to measure progress. Included in this baseline audit should be an examination of the claim development and submission process, from patient intake through claim submission and payment, and identify elements within this process that may contribute to non-compliance or that may need to be the focus for improving execution. This audit should establish a methodology for examining records and this methodology should serve as a basis for future audits. It should be conducted based on claims submitted during the initial three (3) months after the implementation of the education and training program so as to give Ophthalmology Clinic a benchmark against which to measure future compliance effectiveness.

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- (c) **Periodic Audits.** On a periodic basis as determined by the Coding Compliance Officer, but no less than once a year, Ophthalmology Clinic shall conduct random audits to ensure claims processing accuracy and Plan compliance. A randomly selected number of medical records should be reviewed to ensure that the coding was performed accurately. A minimum of two to five medical records per payer, or five to ten medical records per physician should be reviewed. If problems are identified, focused review should be conducted on a more frequent basis through the informal audit process. When audit results reveal areas needing additional information or education of employees and physicians, these areas will be incorporated into the training and educational system.

Periodic audits should include the following:

- i. A valid sample of Ophthalmology Clinic's top ten denials, or Ophthalmology Clinic's top ten services rendered;
- ii. A review of Ophthalmology Clinic's internal coding using specific ICD-9 codes, as some ICD-9 codes are too general for "reasonable and necessary" purposes;
- iii. A check for duplicate charges;
- iv. Confirmation that all numbers are written and signed by a physician;
- v. A check for reasonable and necessary services performed; confirmation that all tests ordered by the physician(s) were actually performed and documented and that only those tests were billed; and a review of assigned codes and modifiers to the claims.

- (d) **Claims Submission Audit.** Bills and medical records will be reviewed for compliance with applicable coding, billing and documentation requirements. The person in charge of billing compliance and a medically trained person (e.g., registered nurse or a physician) should be involved in these audits. Ophthalmology Clinic will determine whether to review the claims retrospectively or concurrently with the claims submission. The formal audit referred to above should be used as a baseline so that Ophthalmology Clinic can evaluate its progress in reducing or eliminating potential areas of vulnerability. These self-audits will be used to determine whether:

- i. Bills are accurately coded and accurately reflect the services provided;
- ii. Services or items provided are reasonable and necessary;
- iii. Any incentive for unnecessary services exist; and
- iv. Medical records contain sufficient documentation to support the charge.
- v. Ophthalmology Clinic will determine if a successful billing compliance program is appropriate action when Ophthalmology Clinic identifies a problem in its internal audit.
- vi. Proposed action will be taken in accordance with OPTHALMOLOGY CLINIC's compliance plan program below.

- (e) **Disclosure of Audit Results.** The Coding Compliance Officer shall report to the Board of Directors of Ophthalmology Clinic the results of any audit. The Coding Compliance Officer, in consultation with legal counsel, shall determine whether corrective action is necessary. Legal counsel will advise on matters of attorney/client privilege, disclosure, and whether Ophthalmology Clinic has any affirmative duties to report the violations and/or make restitution to health care payor.

(f) **Documentation.** All efforts to comply with applicable statutes and regulations shall be documented, including the fact that an audit has taken place and a description of the nature and results of the audit. Any inquiries Ophthalmology Clinic makes of third party payors or Medicare carriers regarding the claim submission process shall be documented if Ophthalmology Clinic intends to rely on the guidance provided by any such third party payor or Medicare carrier.

(g) **Informal Audits and Monitoring.** Ophthalmology Clinic will develop an ongoing evaluation process to ensure a successful evaluation program. The Coding Compliance Officer will periodically review the policies and procedures to see if they are current and complete. If they are ineffective or outdated, the Coding Compliance Officer will update them and ensure, where appropriate, that changes in the Ophthalmology Clinic or Government regulations are reflected in them.

(h) **Audit Report**

An annual audit report will be issued at the end of each compliance audit, which will be submitted to the Compliance Committee. The audit reports will identify areas where corrective actions may be needed. The Audit will perform follow-up audits to monitor corrective actions submitted by the committee have been implemented and are functioning as intended.

The Form of the Annual Audit Report shall include both actual count and percentages for each of the following:

- Up-Coded Progress Notes
- Down-Coded Progress Notes
- ROS incorrect
- Exam incorrect
- Signature not on form
- Cloned Note
- ICD-9 problem
- Modifier problem
- Progress Note Correct

Other Items of Interest:

- Dilation not performed for a Comprehensive Eye Exam
- External Ocular Adnexal Exam not performed (Intermediate or Comprehensive Eye Exam)
- Psych/Neuro element missing for Comprehensive E & M Exam.
- History and Exam are not warranted by the Nature of the Presenting Problem (Medical Decision Making)

Outliers or those that are over a 50% error rate will be highlighted in red.

II. Lines of Communication.

An open line of communication is essential to proper implementation of an effective compliance program. The Coding Compliance Officer is charged with the responsibility of ensuring that a clear "open door" policy between physicians, Ophthalmology Clinic employees and the compliance office is established. The Coding Compliance Officer will utilize a number of communication techniques to continually update staff on compliance information. This will include the use of an OPTHALMOLOGY CLINIC Intranet Bulletin Board(s) available to all Ophthalmology Clinic employees.

1. To ensure effective communication Ophthalmology Clinic will:
 - (a) Require that employees report conduct that a reasonable person would, in good faith, believe to be fraudulent or erroneous;
 - (b) Have an anonymous drop box for reporting fraudulent or erroneous conduct;
 - (c) Ensure that staff are aware that policies and procedures require staff to report fraudulent or erroneous conduct, failure to do so is a violation of the compliance program;
 - (d) Have a simple and readily accessible procedure developed by the Coding Compliance Officer to process reports of fraudulent or erroneous conduct;
 - (e) Have a process that maintains the confidentiality of the persons involved in the alleged fraudulent or erroneous conduct and the person making the allegation; and
 - (f) Ensure that there will be no retribution for reporting conduct that a reasonable person acting in good faith would have believed to be fraudulent or erroneous.
2. All Practice physicians and personnel are required to report incidents of material billing errors, violations of this Plan, unethical conduct, or incidents of potential fraud and abuse to the Coding Compliance Officer.
 - (a) Such reports may be made to the Coding Compliance Officer in person or anonymously in writing through a drop box. Reports shall be treated as confidential to the extent reasonably possible. There shall be no retaliation against anyone who submits a good faith report of noncompliance.
 - (b) Reports may be made on an anonymous basis. Any reported matters that suggest substantial violations of compliance policies, regulations, or statutes shall be documented and investigated promptly.
 - (c) Each report, regardless of the source, shall be assigned a control number, and a record shall be made containing the following data: (1) the date the report was made; (2) the person who received the report; (3) the allegations; (4) the actions taken in response; and (5) the name of the person making the report, if not made anonymously. The report shall be in the form attached hereto as Exhibit XX.

(d) The Coding Compliance Officer shall inform the Board of Directors of any reported incidents, and provide the Board of Directors with the record of the report.

(e) The Coding Compliance Officer shall maintain all discovered or reported information in the strictest confidence and shall not disclose to any person or entity, other than Ophthalmology Clinic's Board of Directors, any such information unless otherwise directed by the Board of Directors.

3. **Employee Certification.** All employees and independent contractors engaged by Ophthalmology Clinic, shall be required, on an annual basis, to certify, on a signed and dated form, whether they are aware of any violation or potential violations of this Plan, and if so, shall provide detailed information about these possible violations on the form. The form shall state (1) that confidentiality shall be maintained as best possible, and (2) that the employee has the right to meet personally with the Coding Compliance Officer in place of completing the certification form. The certification shall be in the form attached hereto in the Appendices.

4. **Exit Interviews.** Any employee or any independent contractor, who leaves Ophthalmology Clinic's employ, whether voluntarily or involuntarily, shall be requested to participate in an exit interview with the Coding Compliance Officer. The Coding Compliance Officer shall ask the departing employee whether he or she is aware of any violations of this Plan. The Coding Compliance Officer shall document the exit interview contents thoroughly on a report, the form of which is attached hereto in the Appendices.

5. **Feedback**

The key component of the Compliance plan is ensuring that feedback is provided to all relevant parties following audits, corrective action is taken and follow-up is performed within a period of time (quarterly or annually)

This iterative, feedback loop is a principal component of the coding compliance plan. Once errors are found, proper education must be provided and then followed up with another audit to determine the effectiveness of the training.

6. **Corrective Procedures**

These include the following:

- I. A periodic (annual) review and update of the Coding Compliance Plan.
- II. Time-Line for Remedy of any compliance infractions.
- III. Outline and documentation of all Provider compliance education.
- IV. Outline and documentation of all Coder compliance education.
- V. Outline and documentation of all new employee compliance education.
- VI. List of Disciplinary Procedures (outlined below)

Following documented documentation and coding feedback or training, the provider will be responsible to adhere to the policies and procedures as set forth in this document. Failure to comply with these policies will result in Disciplinary actions.

I. Disciplinary Actions

Following appropriate and documented coding and documentation education training, repeated infractions of OPHTHALMOLOGY CLINIC Coding Compliance policies and procedures will result in the following, in order:

- a. Warning (oral)
- b. Reprimand (written)
- c. Probation
- d. Demotion
- e. Suspension without pay
- f. Referral to counseling
- g. Withholding of a promotion or salary increase.
- h. Termination
- i. Restitution for damages.
- j. Referral for criminal prosecution.

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7. Correction of Identified Problems

All infractions of this Coding Compliance Plan will be investigated and appropriate corrective action will be implemented.

This will include but not be limited to:

- I. Reviewing any coding, documentation or billing errors with the Compliance Plan Team, the provider and coding and billing staff.
- II. Providing proper education and training.
- III. Implementing a future audit or review of the problem within 3, 6, 9 or 12 months to determine if the problem has been corrected.
- IV. Implementing corrective action as outlined in Section 6. Above.

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Appendix 1

Ophthalmology Coding Guidelines

Review the Following:

Is the Chief Complaint accurate and specific?
HPI Documentation (3 – 4 elements) – train all doctors on the eight HPI Elements.
Doctors must document HPI (Medicare Guideline)

CPT© Concepts

- Surgical Package
- Separate Procedures
- Check any unlisted codes every year and document

Review of all appropriate MODS

- MODS 22, 23, 24, 25, 26, 32
- MODS 50, 51, 52, 54, 55, 56, 58
- MODS 73, 74, 78, 80, 81, 90
- Doctors Trained on (Requirements)

HCPCS

- V Codes
- S Codes – When is it appropriate to use S Codes?
- Injections
- Anatomical Modifiers

Reporting and documenting Evaluation and Management Encounters

- New Versus Established Patient
- Levels of service
- Key Components
- History
- Chief Complaint
- HPI
- Exam

- Levels of Exam

- Medical Decision Making (MDM)

- Levels of MDM

- Confirm Training of all Doctors on E & M Fundamentals: _____

Reporting and documenting Eye Exam Encounters

- Intermediate Exam – Required Components
- Comprehensive Exam – Required Components
- Confirm Training for all doctors on the difference between an Intermediate and Comprehensive Exam (what are the required elements)

E & M Audit Form

Eye Exam Audit Form

Medical Decision Making Table

- Confirm Training on MDM

Personal, Family and Social History Form

Unilateral versus Bilateral Documentation

Document which Procedures are Unilateral/Bilateral – Concept does not Apply – meaning they are neither an anatomical modifier or MOD-50 should be used)

Know which procedures have a zero, 10 or 90 day global period.

Review of Specific Procedures and codes:

Review of Specific Diagnostic Procedures Billed separately (from the 920xx Eye Exam Encounters)

- Gonioscopy - 92020

- Fluorescein Angiography – 92235

Indocyanine Green Angiography (IGA) 99240
Serial Tonometry (92100-92130)

Refraction (code 92015)

Fundus Photography (92250)

Sensorimotor Exam (92060)

Visual Field Exams 9208x

Ophthalmoscopy Extended (92221 & 92226)

OCT, GDX HRT 92135

External Ocular Photo 92285

Spectra - 92286

Corneal Pachymetry - 76514

Ophthalmic Echography and Biomicroscopy (92216 - 92219)

Optical Coherence Tomography (OCT) 92136

Botox - 64612

Avastin Injections

Photodynamic Therapy (PDT)

Substitute Procedures (92018, 92019)

Utilization Patterns for common procedures

Summary

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Simple Repairs and Foreign Body removal

Glaucoma Procedure Codes

Cataract Procedure Codes

Retinal Detachment Procedure Codes

ICD-9 Diagnostic Coding

Overview ICD-9

Main Terms and Subterms

Cross References - See Also, See Also, See Category

Instructional Notes

Hypertension Table

Specific 5th Digit Codes

Instructional Notes

Includes

Excludes

See Also, See Additional Codes

Case Study - Exudative senile macular degeneration

Coding for suspected conditions

Coding Diabetes

Diabetes Case Study

Neoplasms

Late Effects

V Codes

E Codes - Injuries

Injury Case Study

Adverse Affects

Adverse Affects Case Study

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How are NCCI Edits handled? Software Manual / CMS Website Lookup / LCD?

Rejections versus Denials / EOBs

Monthly / Quarterly list of top ten Rejections / Denials

Review of PQRI codes

Are you billing the DME-MAC for post-cataract glasses and contact lenses? Are you reporting prosthetic eyes to the DME-MAC?

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DMERC billing training

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1	The following ICD-9 codes should not be listed on your Fee Ticket or ICD-9 cheat sheet as "Unspecified Only"			
2	List them with a box or star for the 5th digit and instruct the provider to write in the specific condition.			
3	Eye Conditions in ICD-9 (Disorders of the eye and Adnexa (360 - 379))			
4	Category	Avoid	5th Digit Options	
5	360.5x		7 codes	Retained (old) intraocular Foreign Body, Magnetic
6		360.50		Retained (old) intraocular Foreign Body, Magnetic, Unspecified
7				
8	360.6x	360.60	7 codes	Retained (old) intraocular Foreign Body, nonmagnetic
9			7 codes	Retained (old) intraocular Foreign Body, nonmagnetic, Unspecified
10				
11	362.0x			
12				Note: these are all manifestation codes, code Diabetes 250.xx first.
13	362.07			Diabetic macular edema
14				Per ICD-9 guidelines, code 362.07 is only coded with another code from category 362.0x
15				Therefore three codes may always be reported with code 362.07
16	362.2x		3 codes	Retinopathy of Prematurity
17		362.20		Retinopathy of Prematurity, Unspecified
18	369.xx			Impairment Codes 369.0x to 369.7x - LOTS of 5th digit options
19	371.5x		3 codes	Hereditary corneal dystrophies
20		371.50		Corneal dystrophy, unspecified
21	372.0x		3 codes	Acute conjunctivitis
22		372.00		Acute conjunctivitis, unspecified
23	374.0x	374.00	6 codes	Entropion and trichiasis of eyelid
24	374.1x	374.10	5 codes	Ectropion
25	374.2x	374.20	4 codes	Lagophthalmos
26	374.3x	374.30	4 codes	Ptosis of eyelid
28	Primary Code		2nd Code	Two Codes Required
29	362.11	<= AND =>	401.xx - 405.xx	Hypertensive retinopathy [always add the appropriate hypertension type code]
30	362.55	<= AND =>	E code for drug	Toxic maculopathy
31				
32	370.31	<= AND =>	017.3	Phlyctenular keratoconjunctivitis (use add'l code for assoc. tuberculosis)
33				
34	370.32	<= AND =>	372.13	Limbar and corneal involvement in vernal conjunctivitis
35	370.44	<= AND =>	372.13	Keratitis or keratoconjunctivitis in exanthema (code first underlying condition)
36	370.8	<= AND =>	372.13	Other forms of keratitis (code also underlying condition as below)
37			376.21	Acanthamoebic keratitis
38			376.22	Fungal keratitis
39	371.05	<= AND =>	017.3	Phthical cornea (code first tuberculosis)
40	372.15	<= AND =>	125.0-125.9 or 085.5	Parasitic conjunctivitis (code first underlying disease as filariasis (125.0-125.9) or mucocutaneous leishmaniasis (085.5))
41	372.31	<= AND =>	695.3	Rosacea conjunctivitis
42	372.33	<= AND =>	695.10 - 695.19 or 099.3	Conjunctivitis in mucocutaneous disease (code 1st underlying disease)
43	376.2x			Endocrine exophthalmos (code first underlying disease (122.3, 122.6, 122.9))

The following lists are derived from the 2009 Medicare PRRVU data file, or **National Physician Fee Schedule Relative Value File**

This file contains information on services covered by the Medicare Physician Fee Schedule (MPFS). For more than 10,000 physician services, the file contains the associated relative value units, a fee schedule status indicator, and a non-payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.)

92326	XXX	Replacement of contact lens
99201	XXX	Office/outpatient visit, new
99202	XXX	Office/outpatient visit, new
99203	XXX	Office/outpatient visit, new
99204	XXX	Office/outpatient visit, new
99205	XXX	Office/outpatient visit, new
99206	XXX	Office/outpatient visit, new
99207	XXX	Office/outpatient visit, new
99208	XXX	Office/outpatient visit, new
99209	XXX	Office/outpatient visit, new
99210	XXX	Office/outpatient visit, new
99211	XXX	Office/outpatient visit, new
99212	XXX	Office/outpatient visit, est
99213	XXX	Office/outpatient visit, est
99214	XXX	Office/outpatient visit, est
99215	XXX	Office/outpatient visit, est
99216	XXX	Office consultation
99217	XXX	Office consultation
99218	XXX	Office consultation
99219	XXX	Office consultation
99220	XXX	Office consultation
99221	XXX	Office consultation
99222	XXX	Office consultation
99223	XXX	Office consultation
99224	XXX	Office consultation
99225	XXX	Office consultation

150% Payment Adjustment for Bilateral Surgery Code = 3)

Equal Payment Adjustment for bilateral Procedure Codes (ET apply (RAD/DIAG Tx) (bilateral Surgery Code = 3)

HCPCS	Global	Days	Description
G9041	XXX		Low vision rehab occupationa
G9042	XXX		Low vision rehab orient/mobi
G9043	XXX		Low vision rehab orient/mobi
G9044	XXX		Low vision rehab orient/mobi
0099T	XXX		Implant corneal ring
0100T	XXX		Prosth retina receive
0187T	XXX		Ophthalmic procedure anterior
10120	010		Remove foreign body
10121	010		Remove foreign body
11100	000		Biopsy, skin lesion
11101	ZZZ		Biopsy, skin add-on
11200	010		Removal of skin tags
11201	ZZZ		Remove skin tags add-on
65757	ZZZ		Prep corneal endo allograft
66990	ZZZ		Ophthalmic endoscope add-on
67221	000		Ocular photodynamic ther
67225	ZZZ		Eye photodynamic ther add-on
67320	ZZZ		Revise eye muscle(s) add-on
67331	ZZZ		Eye surgery follow-up add-on
67332	ZZZ		Rerevise eye muscle add-on
67334	ZZZ		Revise eye muscle w/suture
67335	ZZZ		Eye suture during surgery
67340	ZZZ		Revise eye muscle add-on
67800	010		Remove eyelid lesion
67801	010		Remove eyelid lesion
67805	010		Remove eyelid lesion
67808	090		Remove eyelid lesion(s)
69990	ZZZ		Microsurgery add-on
70200	XXX		X-ray exam of eye sockets
92018	XXX		New eye exam & treatment
92019	XXX		Eye exam & treatment
92025	XXX		Corneal topography
92311	XXX		Contact lens fitting
92313	XXX		Contact lens fitting
92315	XXX		Prescription of contact lens
92317	XXX		Prescription of contact lens
92325	XXX		Modification of contact lens

HCPCS	Description
70030	X-ray eye for foreign body
70130	Visual exam of eye sockets
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76519	Echo exam of eye
76529	Echo exam of eye
92070	Fitting of contact lens
92135	Ophth dx imaging post seg
92136	Ophthalmic biometry
92225	Special eye exam, initial
92226	Special eye exam, subsequent
92230	Eye exam with photos
92235	Eye exam with photos
92240	Log angiography

Unilateral Procedural Codes (MOD-50

Applies) (Code = 1)

Global Days

HCPCS	PPRRVU09	Description	010	68110	Remove eyelid lining lesion
000	65805	Drainage of eye	090	66600	Remove iris and lesion
000	65210	Remove foreign body from eye	090	66165	Glaucoma surgery
000	65220	Remove foreign body from eye	090	66500	Incision of iris
000	65222	Remove foreign body from eye	090	66550	Follow-up surgery of eye
000	68200	Treat eyelid by injection	090	66225	Repair/graft eye lesion
000	68100	Biopsy of eyelid lining	090	66220	Repair eye lesion
000	68040	Treatment of eyelid lesion	090	66185	Revise eye shunt
000	65410	Biopsy of cornea	090	66305	Incision of iris
000	65430	Corneal smear	090	66180	Implant eye shunt
000	65205	Remove foreign body from eye	090	65920	Remove implant of eye
000	67875	Closure of eyelid	090	66170	Glaucoma surgery
000	65800	Drainage of eye	090	66670	Removal of iris
000	67820	Revise eyelashes	090	66670	Glaucoma surgery
000	67810	Biopsy of eyelid	090	66670	Glaucoma surgery
000	67515	Inject/treat eye socket	090	66130	Glaucoma surgery
000	67505	Inject/treat eye socket	090	66130	Remove eye lesion
000	67500	Inject/treat eye socket	090	65135	Insert ocular implant
000	67415	Aspiration, orbital contents	090	66900	Remove blood clot from eye
000	67346	Biopsy, eye muscle	090	66130	Incision of eye
000	67028	Injection eye drug	090	65850	Myopia, secondary cataract
000	65435	Curette/treat cornea	090	65920	Cataract surg w/iol, 1 stage
000	68525	Biopsy of tear sac	090	66983	Cataract surg w/iol, 1 stage
000	68510	Biopsy of tear gland	090	66982	Cataract surgery, complex
000	68850	Injection for tear sac stricture	090	66940	Extraction of lens
010	67938	Remove eyelid foreign body	090	66930	Extraction of lens
010	67930	Repair eyelid wound	090	66920	Extraction of lens
010	68760	Close tear duct opening	090	65130	Insert ocular implant
010	67850	Treat eyelid lesion	090	66852	Removal of lens material
010	67840	Remove eyelid lesion	090	66850	Removal of lens material
010	68761	Close tear duct opening	090	66840	Removal of lens material
010	67830	Revise eyelashes	090	66830	Removal of lens lesion
010	67825	Revise eyelashes	090	66605	Removal of iris
010	68801	Dilate tear duct opening	090	66821	After cataract laser surgery
010	67700	Drainage of eyelid abscess	090	66625	Removal of iris
010	65270	Repair of eye wound	090	66770	Removal of inner eye lesion
010	67345	Destroy nerve of eye muscle	090	66762	Revision of iris
010	67710	Incision of eyelid	090	66761	Revision of iris
010	68810	Probe nasolacrimal duct	090	66740	Destruction, ciliary body
010	68811	Probe nasolacrimal duct	090	67200	Destruction, ciliary body
010	68815	Probe nasolacrimal duct	090	67110	Ciliary endoscopic ablation
010	65855	Laser surgery of eye	090	67100	Ciliary transleral therapy
010	68816	Probe nl duct w/balloon	090	67000	Destruction, ciliary body
010	66020	Injection treatment of eye	090	66882	Repair iris & ciliary body
010	66030	Injection treatment of eye	090	66680	Repair iris & ciliary body
010	68840	Explore/irrigate tear duct	090	66635	Removal of iris
010	67715	Incision of eyelid for	090	65870	Incise inner eye adhesions
010	68705	Revise tear duct opening	090	66825	Reposition intraocular lens
010	68135	Remove eyelid lining lesion	090	66620	Removal of eye lesion
010	68530	Clearance of tear duct	090	65140	Attach ocular implant
010	68115	Remove eyelid lining lesion	090	65756	Corneal trnspl, endothelial
010	68371	Harvest eye tissue, alograft	090	65755	Corneal transplant
010	68440	Incise tear duct opening	090	65750	Corneal transplant
010	68020	Incise/drain eyelid lining	090	65730	Corneal transplant
010	68420	Incise/drain tear sac	090	65710	Corneal transplant
010	68400	Incise/drain tear gland	090	65600	Revision of cornea
			090	65450	Treatment of corneal lesion
			090	65436	Curette/treat cornea
			090	65101	Removal of eye
			090	65772	Correction of astigmatism

090	65426	Removal of eye lesion	090	67835	Revise eyelashes
090	65775	Correction of astigmatism	090	67110	Repair detached retina
090	65105	Remove eye/attach implant	090	67560	Revise eye socket implant
090	65110	Removal of eye	090	67911	Revise eyelid defect
090	65400	Removal of eye lesion	090	68335	Revise/graft eyelid lining
090	65290	Repair of eye socket wound	090	68770	Close tear system fistula
090	65286	Repair of eye wound	090	68750	Create tear duct drain
090	65285	Repair of eye wound	090	68745	Create tear duct drain
090	65280	Repair of eye wound	090	68720	Create tear sac drain
090	65275	Repair of eye wound	090	68700	Repair tear ducts
090	65273	Repair of eye wound	090	68550	Remove tear gland lesion
090	65272	Repair of eye wound	090	68540	Remove tear gland lesion
090	65103	Remove eye/insert implant	090	68530	Removal of tear sac
090	65125	Revise ocular implant	090	68525	Partial removal, tear gland
090	65880	Incise inner eye adhesions	090	68520	Removal of tear gland
090	65810	Drainage of eye	090	68502	Revise eyelid lining
090	65875	Incise inner eye adhesions	090	67950	Revision of eyelid
090	65865	Incise inner eye adhesions	090	68340	Separate eyelid adhesions
090	65860	Incise inner eye adhesions	090	67940	Revision of eyelid
090	65150	Revise ocular implant	090	67930	Revise eyelid lining
090	65155	Reinsert ocular implant	090	67920	Revise/graft eyelid lining
090	65175	Removal of ocular implant	090	67910	Revise/graft eyelid lining
090	65850	Incision of eye	090	68325	Revise/graft eyelid lining
090	65820	Relieve inner eye pressure	090	68320	Revise/graft eyelid lining
090	65770	Revise cornea with implant	090	68130	Remove eyelid lining lesion
090	65782	Ocular reconstr, transplant	090	67975	Reconstruction of eyelid
090	65900	Remove eye lesion	090	67974	Reconstruction of eyelid
090	65114	Remove eye/revise socket	090	67973	Reconstruction of eyelid
090	65235	Remove foreign body from eye	090	67971	Reconstruction of eyelid
090	65093	Revise eye with implant	090	67550	Insert eye socket implant
090	65260	Remove foreign body from eye	090	68360	Revise eyelid lining
090	65112	Remove eye/revise socket	090	67042	Vit for macular hole
090	65265	Remove foreign body from eye	090	67145	Treatment of retina
090	66985	Insert lens prosthesis	090	67570	Decompress optic nerve
090	67113	Repair retinal detach, cplx	090	67121	Remove eye implant material
090	65781	Ocular reconstr, transplant	090	67120	Remove eye implant material
090	65780	Ocular reconstr, transplant	090	67115	Release encircling material
090	65815	Drainage of eye	090	67112	Repair detached retina
090	67908	Repair eyelid defect	090	65091	Revise eye
090	67935	Repair eyelid wound	090	67108	Repair detached retina
090	67924	Repair eyelid defect	090	67107	Repair detached retina
090	67923	Repair eyelid defect	090	67105	Repair detached retina
090	67922	Repair eyelid defect	090	67450	Explore/biopsy eye socket
090	67921	Repair eyelid defect	090	67043	Vit for membrane dissect
090	67917	Repair eyelid defect	090	67208	Treatment of retinal lesion
090	67916	Repair eyelid defect	090	67041	Vit for macular pucker
090	67915	Repair eyelid defect	090	67040	Laser treatment of retina
090	67914	Repair eyelid defect	090	67039	Laser treatment of retina
090	67912	Correction eyelid wound	090	67036	Removal of inner eye fluid
090	66986	Exchange lens prosthesis	090	67031	Laser surgery, eye strands
090	67909	Revise eyelid defect	090	67030	Release inner eye strands
090	67966	Revision of eyelid	090	67027	Implant eye drug system
090	67906	Repair eyelid defect	090	67025	Replace eye fluid
090	67904	Repair eyelid defect	090	67015	Release of eye fluid
090	67903	Repair eyelid defect	090	67010	Partial removal of eye fluid
090	67902	Repair eyelid defect	090	67005	Partial removal of eye fluid
090	67901	Repair eyelid defect	090	67101	Repair detached retina
090	67900	Repair brow defect	090	67316	Revise two eye muscles
090	67882	Revision of eyelid	090	67445	Explr/decompress eye socket
090	67880	Revision of eyelid	090	67440	Explore/drain eye socket

090	67430	Explore/treat eye socket	92312	Contact lens fitting
090	67420	Explore/treat eye socket	92316	Prescription of contact lens
090	67414	Explr/decompress eye socket		
090	67413	Explore/treat eye socket		
090	67412	Explore/treat eye socket		
090	67405	Explore/drain eye socket		
090	67400	Explore/biopsy eye socket		
090	67141	Treatment of retina		
090	67318	Revise eye muscle(s)		
090	67210	Treatment of retinal lesion		
090	67250	Reinforce eye wall		
090	67218	Treatment of choroid lesion		
090	67220	Treatment of choroid lesion		
090	67227	Treatment of retinal lesion		
090	67228	Treatment of retinal lesion		
090	67343	Release eye tissue		
090	67229	Tr retinal les preterm inf		
090	67314	Revise eye muscle		
090	67255	Reinforce/globe		
090	67311	Revise eye muscle		
090	67312	Revise two eye muscle		
YYY	67999	Revision of eyelid		
YYY	68399	Eyelid lining surgery		
YYY	67399	Eye muscle surgery procedure		
YYY	67599	Orbit surgery procedure		
YYY	67299	Eye surgery procedure		
YYY	66999	Eye surgery procedure		
YYY	68899	Tear duct system surgery		

EYE

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Procedures Paid as *Bilateral* (Code = 2)

HCPCS	Description
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
92002	Eye exam, new patient
92004	Eye exam, new patient, Comp
92012	Eye exam established pat
92014	Eye exam & treatment
92020	Special eye evaluation
92060	Special eye evaluation
92065	Orthoptic/pleoptic training
92081	Visual field examination(s)
92082	Visual field examination(s)
92083	Visual field examination(s)
92100	Serial tonometry exam(s)
92120	Tonography & eye evaluation
92130	Water provocation tonography
92136	Ophthalmic biometry
92140	Glaucoma provocative tests
92250	Eye exam with photostereography
92260	Ophthalmoscopy/dynamometry
92265	Eye muscle evaluation
92270	Electro-oculography
92275	Electroretinography
92283	Color vision examination
92284	Dark adaptation eye exam
92285	Eye photography
92286	Internal eye photography
92287	Internal eye photography

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Bilateral Concept does not apply

Bilateral Code = 9

No Anatomical Modifier allowed or necessary

HCPCS Description

- 00140 Anesth, procedures on eye
- 00142 Anesth, lens surgery
- 00144 Anesth, corneal transplant
- 00145 Anesth, vitreoretinal surg
- 00147 Anesth, iridectomy
- 00148 Anesth, eye exam
- 65760 Revision of cornea
- 65765 Revision of cornea
- 65767 Corneal tissue transplant
- 65771 Radial keratotomy

- 92355 Special spectacles fitting
- 92358 Eye prosthesis service
- 92371 Repair & adjust spectacles
- 92531 Spontaneous nystagmus study
- 92532 Intentional nystagmus test
- 99000 Specimen handling
- 99001 Specimen handling
- 99002 Device handling
- 99024 Postop follow-up visit
- 99050 Medical services after hrs
- 99051 Med serv, eve/weekend/holiday
- 99052 Office emergency care
- 99053 Special supplies
- 99054 Written educational materials
- 99055 Group health education
- A4262 Temporary tear duct plug (not payable to Medicare)
- A4263 Permanent tear duct plug (not payable to Medicare)

92015 Refraction

- 92352 Special spectacles fitting
- 92353 Special spectacles fitting
- 92354 Special spectacles fitting

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Appendix 2

1. Follow all coding principles outlined below.

1.1 Use all codes necessary to completely code all diseases and procedures, including underlying diseases.

1.4 E codes are used whenever appropriate to identify external codes.

1.5 J, Q, A and W HCPCS codes are required for Outpatient Services.

2. Consult the following sources to identify all diagnoses and procedures requiring coding and to increase the accuracy and specificity of coding.

2.2 Progress Notes-Scan to detect complications and/or secondary diagnoses for which the patient was treated and/or procedures performed.

2.3 History and Physical-scan to identify any additional conditions; such as history of cancer or a family history of eye disease. These conditions should be coded.

2.5 Consultation -scan to detect additional diagnoses or complications for which the patient was treated that may impact eyecare.

2.6 Operative Reports-scan to identify additional procedures requiring coding.

2.7 Pathology Reports-review to confirm or obtain more detail.

2.8 GDX, Fundus Photos and laboratory-use reports as guides to identify diagnoses (e.g. retinal damage) or more detail (e.g., type of ARMD or glaucoma).

2.9 Physician's Orders-scan to detect treatment for unlisted diagnoses-the administration of insulin, antibiotics, sulfonamides may indicate treatment of diabetes, respiratory or urinary infections which should be confirmed by checking other medical record forms.

3. Exercise discretion in coding diagnostic conditions not identified on the provider's progress notes.

3.1 Query physician on the deficiency report if the coding question influences coding assignment.

3.2 Review all alcohol/drug abuse cases to confirm prior to coding.

4. Process special diagnostic coding situations as follows:

4.1 V codes are used to identify encounters for reasons other than illness or injury. V codes are used as principal diagnoses for routine eyecare (V72.0) – in the absence of any sign, symptom or physician recommended return visit, (V80.1) screening for glaucoma, (V80.2) screening for other eye conditions, (V58.69) Long term use of other medications – High Risk Medications, Chemotherapy, (V58.0), (V67.51) Following completed treatment with high risk medications, NEC. Avoid the use of V codes as the principal diagnosis where a diagnosis of a condition can be made.

4.2 V codes are used in outpatient coding when a person who is not currently ill obtains health services for a specific purpose, such as, to act as a donor, or when a circumstance influences the persons health status but is not in itself a current illness or injury. Patients receiving preoperative evaluations receive a code from category V72.8.

4.3 Avoid using codes that lack specificity. These vague codes should not be used if it is possible to obtain the information required to assign a more specific code.

Ophthalmology Clinic Coding Compliance Plan

4.4 Signs and symptoms are coded when a specific diagnosis cannot be made or when the etiology of a sign or symptom is unknown. Do not code symptoms if the etiology is known and the symptom is usually present with a specific disease process.

4.5 Outpatient coding requires that diagnoses documented as "probable, suspected, questionable, rule out or working", should not be coded. Code the condition for that visit, i.e., signs or symptoms or abnormal test results. The statement "Rule out Orbital Fracture" cannot be coded. Code signs, symptoms presented. Be sure to ask your provider if unclear how to code Rule-Outs.

4.6 Chronic conditions may be coded as many times as the patient receives treatment.

4.7 Code abnormal laboratory tests only when noted on the face sheet by the attending physician.

5. Code all services and procedures performed in the hospital from the time of admission to the time of discharge.

5.1 Be certain procedures were actually performed, not just ordered or consents obtained.

5.2 Code procedures clearly documented in the record but not indicated on the face sheet or in the discharge summary. Note codes for such procedures in pencil on the face sheet.

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Appendix 2

Essentials Of Accurate Coding

1. Identify all main terms or procedures included in the diagnostic/procedural statements(s).
2. Locate each main term/procedure in the Alphabetical Index. A main term may be followed by a series of terms in parentheses. The presence or absence of these parenthetical terms in the diagnosis has no effect upon the selection of the code listed for the main term.
3. Refer to any sub-terms indented under the main term. These sub-terms for individual line entries and describe essential differences by site, etiology or clinical type.
4. Follow cross-reference instructions if the needed code is not located under the first main entry consulted.
5. Verify code selected from the Index in the Tabular List.
6. Read and be guided by any instructional terms in the Tabular List.
7. Fourth and fifth digit sub-classification codes must be used where provided.
8. Continue coding diagnostic and procedural statements until all of the component elements are fully identified. This instruction applies even when no "use" statement appears.
9. Use both codes when a specific condition is stated as both acute (or sub-acute) and chronic and the Alphabetic Index provides unique codes at the third, fourth, or fifth digit level.
10. The term hypertensive means "due to", but the presence of words such as "and or with hypertension" does not imply causality.
11. If the cause of a sign or symptom is specified in the diagnosis, code the cause but do not assign a code for the sign or symptom.
12. When coding outpatient services, do not code diagnoses documented as "probable, suspected, questionable, rule out or working diagnosis". Code the condition necessitating that visit, such as signs or symptoms, abnormal test, or other reasons.
13. Do not confuse V codes, which provide for classifying the reason for visit with procedure codes documenting the performance of a procedure.
14. V codes are found in the Alphabetic Index under references such as Admission, Examination, History of, Problem, Observation, Status, Screening, Aftercare, etc.
15. When an endoscopic approach is utilized to accomplish another procedure (such as biopsy, excision of lesion or removal of foreign body), assign codes for both the endoscopy and the procedure unless the code books contain instructions to the contrary or the code identifies the endoscopic approach.
16. Surgical procedures, which were started but not completed, are to be coded as far as the procedure went:
 - A. Assign a code for exploratory procedure if a cavity or space was entered.
 - B. Assign a code for incision if the site was opened but the cavity was not entered.
 - C. Use an appropriate modifier for terminated or reduced procedures.
17. No procedure code is assigned if an incision was not made. Code canceled surgeries to V64.1, V64.2 and V64.3.

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18. Consult the Alphabetical Index first to code neoplasms in order to determine whether a specific histological type of neoplasm has been assigned a specific code.

19. Do not assign the code for primary malignancy or unspecified site if the primary site of the malignancy is no longer present. Instead, identify the previous primary site by assigning the appropriate code in category (e.g., V10.84) "Personal history of malignant neoplasm of the eye."

20. Cancer "metastatic from" a site should be interpreted as primary of that site and cancer described as "metastatic to" a site should be interpreted as secondary of that site.

21. Diagnostic statements expressed in terms of a malignant neoplasm with "spread to..." or "extension to..." are to be coded as primary site with metastases.

22. If no site is stated in the diagnosis but the morphologic type is identified as metastatic, code as primary site unknown and also assign the code for secondary neoplasm or unspecified site.

23. Code only the most severe degree of burn when different degrees of burns occur at the same site.

24. Assign separate codes for multiple injuries unless the coding books contain instructions to the contrary or sufficient information is not available to assign separate codes.

25. Poisoning by drugs includes drugs given in error, suicide and homicide, adverse effects of medicines taken in combination with alcohol, or taking a prescribed drug in combination with self prescribed drugs.

26. Adverse reactions to correct substances properly administered include: allergic reaction, hypersensitivity, intoxication, etc. The poisoning codes 960-979 are never used to identify adverse reactions to correct substances properly administered.

27. Complications of medical and surgical care are located in the Alphabetical; Index under Complication or the name of the condition.

28. The causes or residual illnesses or injuries are located in the Alphabetical Index under Late Effect.

29. When the late effect of an illness or injury is coded in the main classification, the E code assignment must also be one for late effect.

I. Outpatient Coding

1. The appropriate code(s) must be used to identify diagnoses, symptoms, conditions, problems, complaints or any other reason for the visit. List first the chief diagnosis, condition or other reason for the visit. List additional codes to describe any coexisting condition.

2. Do not code diagnoses documented as "probable, suspected, questionable, rule out" or working diagnosis". Code the condition(s) for that visit, such as signs or symptoms.

Discharge diagnosis stated as operative procedure in medical record documentation (e.g., operative report, pathology report, and/or discharge summary) does not indicate why the procedure was performed, consult the physician for clarification and request he document the diagnosis.

Late effect-the code for the residual (the current condition) is sequenced before the late effect code. If a specific residual cannot be identified after thorough review of the record, consult the physician.

Ophthalmology Clinic Coding Compliance Plan

Multiple injuries-the most severe injury is the principal diagnosis.

Poisoning to drug-the poisoning code is sequenced before the manifestation and E codes.

Principal procedure- a therapeutic procedure should be designated as the principal procedure when both a diagnostic and a therapeutic procedure were performed in relation to the principal diagnosis; regardless of which procedure was performed first. Unrelated diagnostic or therapeutic procedures may be listed as the principal procedure if not procedures were performed that relate to the principal diagnosis.

Rule out, Ruled out and R/O:

For outpatient coding, do not code rule out, working, suspected or questionable diagnosis. Instead code the condition, sign or symptoms, or other reason for the visit.

Code V codes for screenings when appropriate. If no appropriate V code is found, code the sign or symptoms.

Symptom, signs and abnormal test results-these may be used if no underlying cause has been diagnosed.

Two or more diagnoses of equal importance-if medical record documentation does not indicate otherwise, the principal diagnosis is the one for which a definitive surgical or nonsurgical procedure was performed.

II. E & M Coding

Always document at least three characteristics of the History of Present Illness. These include: Location Quality Severity Duration Timing Context Modifying Factors and Associated Signs/Symptoms.

Except for a level 1 visit, never leave the Review of Systems blank. Always document, at the very least, 2 ROS systems for every visit.

Every provider should have a copy of the 1997 Medicare Ophthalmology specific Exam requirements.

III. Surgical Coding

For Foreign body *(FB) removal the provider should always document (as appropriate):

1. Location of the FB
2. Depth of the FB (superficial, embedded, perforating)
3. Removal approach
4. Removal Method (magnetic, forceps, laser, fulguration, cryotherapy)
5. Whether a Slit Lamp was Used (6522x)
6. When removing neoplasms, it must be confirmed whether they are benign, malignant, a cutaneous vascular proliferative lesion (think port-wine stain birthmark) or a skin tag. Each requires a different CPT© code.
7. Whether hospitalization was required (CPT© 6527x for a Laceration of the Conjunctiva)
8. If Uveal Tissue was involved (Choroid, Ciliary body, and Iris) Laceration of the Cornea

For a surgical team be sure to document the extent of the assistant surgeon's involvement.

III. Surgical Coding

For all **preoperative progress notes** document the following:

Preoperative Diagnosis:

Procedure Planned:

Type of Anesthesia Planned:

Laboratory Data: Electrolytes, BUN, creatinine, CBC, PT/PTT, UA, EKG, Chest X-ray; type and screen for blood or cross match if indicated; liver function tests, ABG.

Any Risk Factors: Cardiovascular, pulmonary, hepatic, renal, coagulopathic, nutritional risk factors.

Consent: Document explanation to patient of risk and benefits of procedure, and document patient's informed consent or guardian's consent and understanding of procedure.

Allergies:

Major Medical Problems:

Current Medications:

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The **Surgical Operative Note** should include at minimum the following:

Date of the Procedure:

Preoperative Diagnosis:

Postoperative Diagnosis:

Procedure:

Names of Surgeon and Assistant:

Anesthesia:

Estimated Blood Loss (EBL):

Fluids and Blood Products Administered During Procedure:

Specimens: Pathology specimens, cultures, blood samples.

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The **Post Surgical Progress Note** should include at minimum the following:

Subjective: Mental status & patient's subjective condition; pain control.

Vital Signs: Temperature, blood pressure, pulse, respirations.

Physical Exam: Chest and lungs; inspection of wound and surgical dressings; conditions of drains; characteristics and volume of output of drains.

Labs:

Assessment/Impression:

Plan:

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Appendix 3

I. Coding Resources.

1. Medicare (Add our Jurisdiction Here) Guidelines
2. Local Medical Review Policies
3. Ophthalmology/Optometry Coding Alert publications. Ophthalmology Pink Sheets.
4. Ophthalmology Specific Coding Manuals (Ingenix, PMIC, AAOE)
5. AMA CPT© Assistant (on CD-ROM)
6. AHA Coding Clinic
7. OIG Compliance Plan
8. Associations (AAO)

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Appendix 4.

I. Coding Compliance Plan Recommended Forms

These Forms are located in a separate document.

1. OPHTHALMOLOGY CLINIC Coding Personnel Internal Education Form
2. Provider Evaluation and Management Audit Evaluation Form
3. Coding Compliance Incident Report Form
4. Ophthalmology Clinic Exit Interview Report Form
5. Annual Employee Coding Certification Form
6. Confidentiality Agreement Form
7. Third Party Company Letter Agreement Form

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Appendix 5 – Illegal Medical Acronyms

Abbreviation	Description
0.5	signifies 05
1.0 (trailing zero)	signifies 1
3d	for three days
A/A	albuterol and atrovent
ARA-A	vidarabine
AZA	azathioprine
AZT	zidovudine
CPZ	compazine
HCT	hydrocortisone
IU	international unit
ms	morphine sulfate, magnesium sulfate
MTX	methotrexate
Nitro and "Pit" stemmed names	pitocin
Q.D., Q.O.D.	every day, every other day
q.n.	every night
q.o.d.	every other day
TAC	triamcinolone
TIW	three times a week
TTP	Tender To Palpation
U	unit
ZNSO4	zinc sulfate

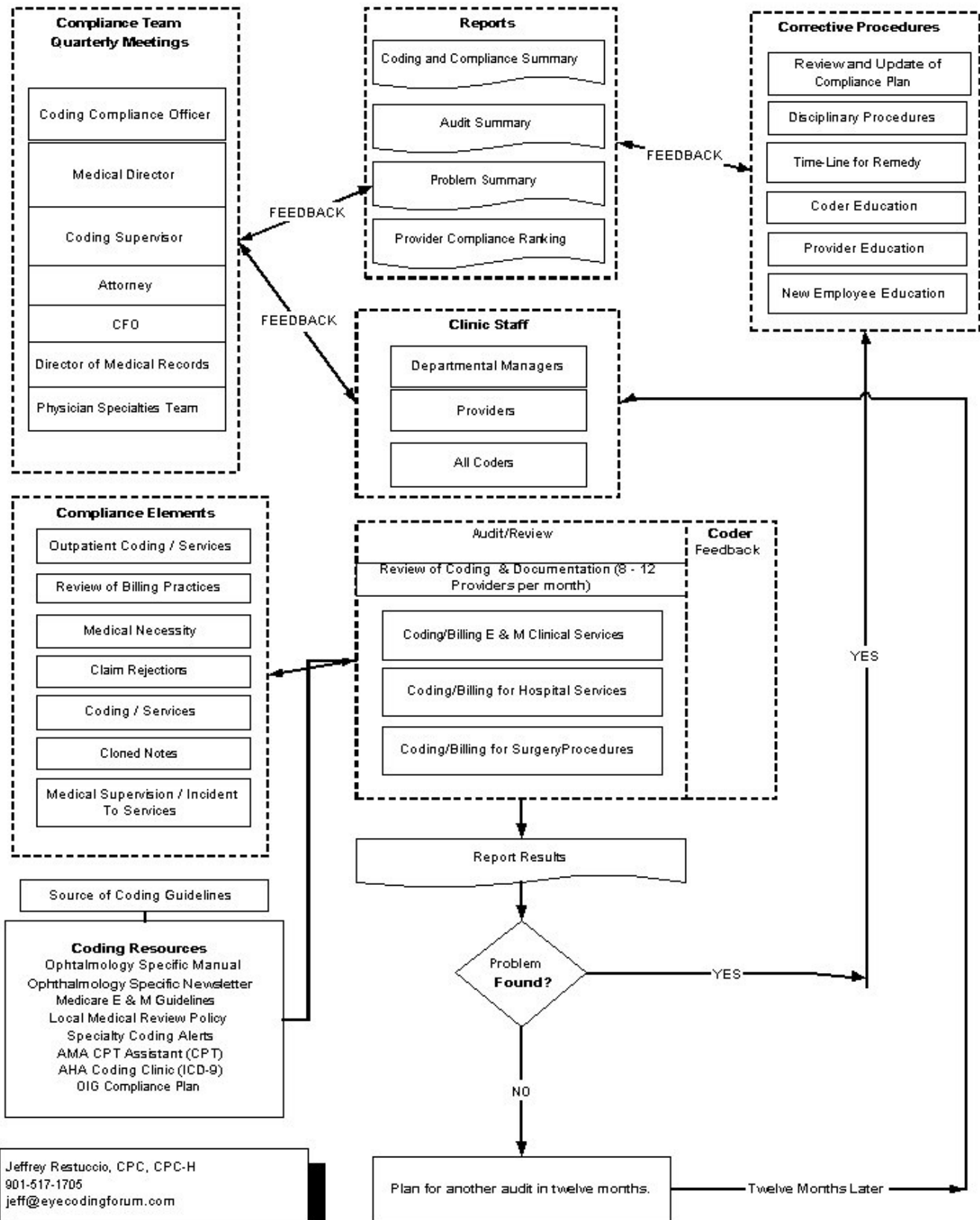
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EyeCoding Compliance Plan Flowchart



Ophthalmology Clinic Coding Compliance Plan

Coding, Documentation and Compliance Training for Eyecare

