

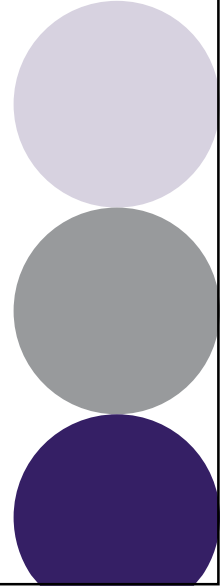


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# Poll the Audience: Coding Competency Challenge

Table Rock Regional Roundup  
Sunday, November 10, 2024



## Speaker Financial Disclosure

- Joy Woodke, COE, OCS, OCSR
  - Academy Director of Coding & Reimbursement
- Speaker has no financial relationships to disclose.
- All relevant financial relationships have been mitigated.





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# Course Agenda

 Poll the Audience!  Coding Competency Challenge

 Q&A



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# Competency #1



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## Competency #1

- How would you find the answer to this question?
- A. Google it
- B. Verify the diagnosis
- C. Look up the specific payer policy
- D. B and C
- E. All of the above

**How often can  
you bill for  
a visual field?**



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## Competency #1

### Factoring the **Why**

- Trusted source
- Why was the test ordered for the patient?
- Why is the payer important?
  - Access at [aao.org/lcds](http://aao.org/lcds)

**Ensure documentation  
is accurate**



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## Competency #2

- Commercially insured patient with bilateral primary open angle glaucoma is seen for their 6 month follow up. Their glaucoma is stable OU. They are to continue current prescription medication and return in 6 months for a full exam.
- How would you code this visit?
  - A. 99214
  - B. 99213
  - C. 99212



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## Competency #2 EHR Coding

**EHR  
suggested  
99214**

- Two or more stable illnesses
  - H40.1111 Primary open-angle glaucoma, right eye, mild stage
  - H40.1122 Primary open-angle glaucoma, left eye, moderate stage
- Minimal or no data
- Prescription drug management
- Overall MDM of moderate

Do you code based on the software recommendation?



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## Competency #2

### Factoring the **Why**

- Two separate ICD-10 codes does not always meet the definition of more than one chronic illness
- 2 of the 3 MDM components must have the same level of complexity

### Ensure documentation is accurate and coding selection appropriate

- Physician is ultimately responsible



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## Competency #2: Bonus

**EHR  
suggested  
99212**

- Problem is chronic (low), not self-limited
- What would you do?



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## Competency #3

- A practice owns transcranial doppler (TCD) testing equipment.
- The ophthalmologist orders and supervises a TCD test for diabetic retinopathy with macular edema and assumes it is a screening and noncovered by the payer.
- The ophthalmic technician performs the test.
- Prior to claim submission, the internal protocol is for the compliance team to review the encounter and select approved ICD-10 codes per the payer policy.

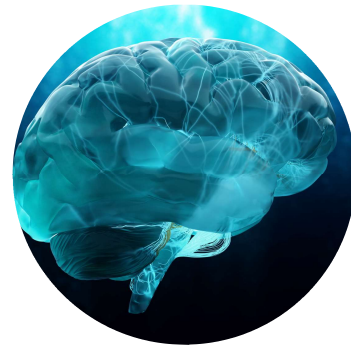


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## Competency #3

- What would you do?
  - A. Not bill the payer - screening tests are never payable even when pathology is found
  - B. Bill the payer if pathology was noted with an approved ICD-10 code
  - C. Never update the ICD-10 code without the physician's approval
  - D. A & C



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## TCD in Ophthalmic Practices

- Increased ophthalmic utilization flagged by the RUC
- **Key violations to avoid:**
  - Billing medically unnecessary tests
  - Billing for services not performed (eg interpretation)
  - Illegal kickbacks, violating AKS
- **Pitfalls**
  - Required training/licensing for supervising physician and technologists per LCDs



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**United States  
Attorney's Office  
District of Massachusetts**

**Connecticut Ophthalmologist Sentenced to Prison  
for Five-Year Health Care Fraud Scheme**

PRESS RELEASE Monday, July 29, 2024

**Eye Practice and Its Physician Owner Agree to Pay  
More Than \$460,000 to Resolve Allegations of False  
Claims and Receiving Illegal Kickbacks**

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## Competency #3

### Factoring the **Why**

- Not reasonable and necessary tests are not payable, including screenings
- Consider supervising MD and technologist certifications
- AKS and other legal considerations
  - Interpretations

**Ensure documentation,  
coding and compliance is  
accurate**



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## Competency #4

- When preparing to refer a patient to the oculofacial surgeon, the optometrist will order visual field studies, one with the upper lids in the taped position and one untaped, then provide the interpretation and report with the referral notes.
  - Is this appropriate?
- A. No
- B. Yes



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## Competency #4

### Factoring the **Why**

- Does the payer require Visual Field?
- Code of Federal Regulations: 42 CFR, Section 410.32
  - Diagnostic tests may only be ordered by the treating physician
  - Tests not ordered by the physician (or other qualified non-physician provider) who is treating the beneficiary are not reasonable and necessary

### Ensure documentation, coding and compliance is accurate

- What else to know?
- Screening Test/Standing Order
- Missing Order



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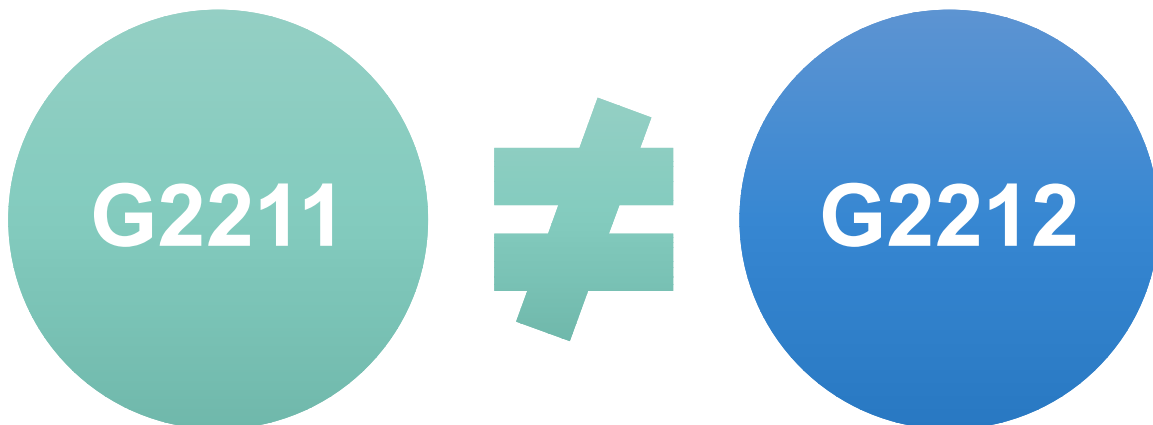
## Competency #5

- An established Medicare Part B patient was seen for a complex visit. The total physician time on the date of the encounter was documented as 56 minutes, including face to face time, coordinating care with external providers, reviewing prior chart notes and tests, and educating the caregiver.
- Code this case:
  - A. 99215 + G2212 (prolonged services)
  - B. 99215 + G2212 + G2211 (complex visit)
  - C. 99215
  - D. 99214



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## Complexity Code $\neq$ Prolonged Services

# G2211

Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition

Medicare Part B HCPCS code. Other payers may have noncoverage policies

# G2212

Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician.

Medicare Part B HCPCS code. Commercial payers require CPT code 99417



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## G2211: Competency Challenge #1

True or False?

Coding G2211 does not impact MDM and increase the level of E/M



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## G2211: Competency Challenge #2

For efficiency, we created an EHR standard macro for all complex visits

Good idea?  
Yes or No



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## G2211 Checklist

Verify payer coverage.

- Medicare Part B.
- Other payers have varied coverage.

Office/outpatient E/M visit.

- CPT codes 99202-99215.
- Do not report with Eye visit codes (92002-92014)

Modifiers 24, 25, or 53 are not billed on the same day

- Unrelated exam in global or minor procedure/same day as exam

Primary reason for the visit is a single, serious or complex condition.

- Chronic uveitis, Glaucoma, AMD, etc.
- Engaging the patient in a continuous and active collaborative plan of care.

Not an acute or time limited condition resolved with intervention

- eg, corneal abrasion, cataract, ERM, etc.

The physician is providing ongoing medical care for this condition.

- Established physician-patient relationship

Documentation supports the use of G2211.

- Collaborative care plan for each unique patient encounter including patient education, shared decision-making around therapeutic goals and commitments to achieve those goals.



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## Competency #6

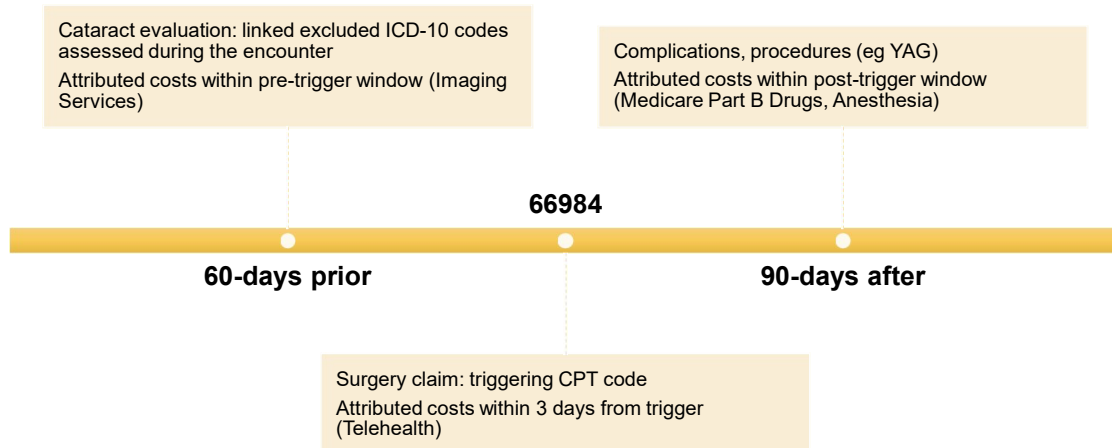
- An established patient with Band Keratopathy is scheduled for cataract surgery (CPT code 66984).
- According to the MIPS Cataract Surgery Cost Measure, this is considered an excluded diagnosis, and this episode should not impact our score.
- How should this be reported? Link the ICD-10 code to the:
  - A. Office visit code for the cataract evaluation
  - B. 66984 reported for the surgeon's claim
  - C. Both A & C



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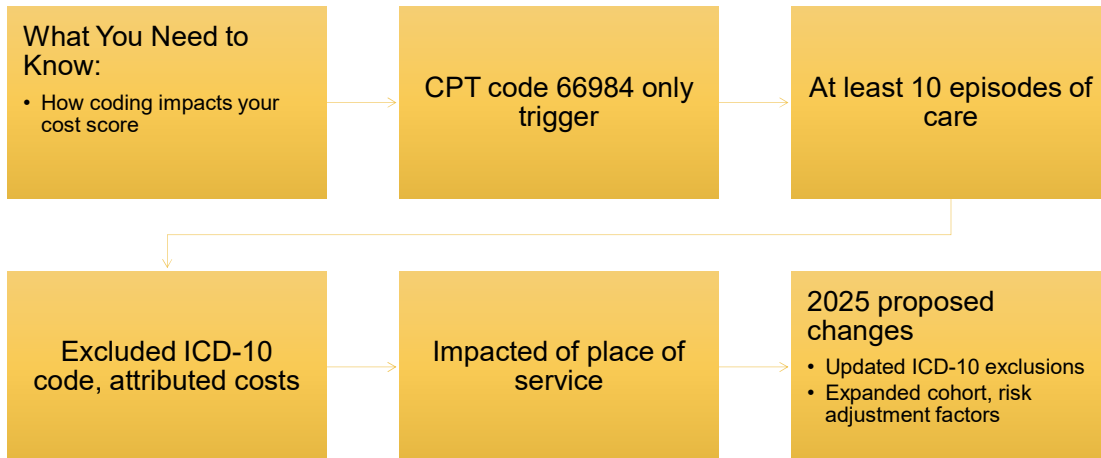
## Cataract Cost Measure



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## Cataract Cost Measure



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## Competency #7

- Corneal foreign body removal was performed during an encounter today. The documentation does not support the use of modifier –25.
- Comparing our local MAC reimbursement for CPT code 65222 (\$69.18) to the Eye visit code, 92012 (\$91.43), should we just bill the exam and not the minor surgery?

A. Yes!

B. No!



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## Competency #7

### Factoring the **Why**

- Fundamental coding rule – bill for all medically necessary services provided with appropriate CPT code.
  - Payer contracts prohibit not reporting services provided
- Exam is not billable as it does not meet the definition of modifier –25. It is then bundled.
- Could this impact the patient copay and/or experience?

### Ensure coding and compliance is correct per policy guidelines.

- Master modifiers



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### E/M and Eye visit codes

- Different documentation guidelines
- 99214 does not automatically equal 92014

### Documentation Guidelines

- E/M – medically relevant history and exam, determine level of E/M from MDM or total physician time
- Eye Visit Codes – meet history, exam elements and initiation of diagnostic & treatment program



### Consider both family of codes

- Confirm the level of E/M and Eye Visit Code
- Avoid 9 scenarios when not to use an Eye Visit Code
- Maximize reimbursement

CODING & REIMBURSEMENT  
SAVVY CODER

Simplifying Coding—5 Steps to Choosing  
the Right E/M or Eye Visit Code



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## Competency #8 – E/M vs Eye

A new patient is seen for a diabetic exam.

Medically appropriate history and comprehensive exam documented

Diagnosis: Diabetes without ocular manifestations E10.9 and dry eye syndrome H04.123

A letter was dictated to their PCP with the findings.

Recommend artificial tears and return in 1 year.



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## Competency #8 - E/M vs Eye

- Code this case:
  - A. 92002, intermediate Eye visit code
  - B. 92004, comprehensive Eye visit code
  - C. 99203, 2 stable chronic illness, risk low
  - D. 99204, 2 stable chronic illness, correspondence with PCP



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## Competency #8 - E/M vs Eye

- More to the Story: Why not moderate data?

Amount and/ or Complexity of Data to be Reviewed and Analyzed	Minimal or none	Limited	Moderate	Extensive
		1 of 2 Categories must be met Category 1: Tests and documents any combination of 2 from the following: <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source;</li> <li>• Review of the result(s) of each unique test;</li> <li>• Ordering of each unique test;</li> </ul> Or Category 2: Assessment requiring an independent historian(s)	At least 1 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source;</li> <li>• Review of the result(s) of each unique test;</li> <li>• Ordering of each unique test;</li> <li>• Assessment requiring an independent historian(s)</li> </ul> Or Category 2: Independent interpretation of tests <ul style="list-style-type: none"> <li>• Independent interpretation of a test performed by another physician/QHP (not separately reported);</li> </ul> Or Category 3: Discussion of management or test interpretation <ul style="list-style-type: none"> <li>• Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)</li> </ul>	2 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source</li> <li>• Review of the result(s) of each unique test</li> <li>• Ordering of each unique test</li> <li>• Assessment requiring an independent historian(s)</li> </ul> Or Category 2: Independent interpretation of tests <ul style="list-style-type: none"> <li>• Independent interpretation of a test performed by another physician/QHP (not separately reported);</li> </ul> Or Category 3: Discussion of management or test interpretation <ul style="list-style-type: none"> <li>• Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)</li> </ul>

- AMA clarified that to qualify, “discussion” requires two-way communication.
- What else: Any test with a CPT code current or past for which you or your practice receive(d) separate payment **does not count**.



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## Competency #8– E/M vs Eye

Problem	Data	Risk	Overall MDM	E/M Code
2 stable chronic illnesses (moderate)	None (straight-forward) Letter to PCP does not meet definition	OTC meds and return in 1 year (low)	Low	99203

History	Exam	Treatment	Eye Visit Code
Complete	12 elements of the exam medically necessary to perform  Comprehensive	Schedule follow-up and test  Initiation or continuation of diagnostic and treatment program(s) met	92004



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## Competency #8 – E/M vs Eye

- E/M vs Eye Visit Code?
  - Medicare Part B patient

E/M 99203	\$ 111.51
Eye 92004	\$ 148.46



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## Competency #8B – E/M vs Eye

What if the patient had visual complaint for OD and diagnosis was mild diabetic retinopathy with macular edema OD (E10.3211)?

OCT retina performed. Recommendation is intravitreal injection of anti-VEGF OD.

Patient wishes to think about the treatment and call back tomorrow.

How would you code this case?



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## Competency #8B - E/M vs Eye

- Code this case:
  - A. 92002, intermediate Eye visit code
  - B. 92004, comprehensive Eye visit code
  - C. 99203, 1 chronic illness with progression, risk low
  - D. 99204, 1 chronic illness with progression, prescription drug management (anti-VEGF)



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# 24

Unrelated evaluation and management service (or eye codes) by the same physician during a postoperative period

Office visit in the postoperative period is not related to the original surgery:

- New symptoms
- Significant changes in eye health requiring new evaluation
- Different diagnosis than the surgery does not necessarily mean unrelated

# 25

Significant, separately, identifiable evaluation and management service (or eye codes) by the same physician on the same day of the procedure or other services

Office visit same day as a **minor surgery** (0 or 10 global period days)

# 57

Decision for surgery, major procedure

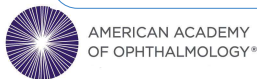
Office visit same day, or within 3 days of a **major surgery** (90 day global period)



[aao.org/coding-topics](https://aao.org/coding-topics)

**OFFICE VISIT  
MODIFIERS**

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# Name That Modifier

1. During the global period of a YAG laser capsulotomy in the left eye, the patient is seen with new flashes and floaters in the right eye. Diagnosis: Posterior vitreous detachment, right eye
2. After examination, a focal laser for macular edema is scheduled today
3. Patient is seen for a scheduled SLT laser today but complains of new symptoms in the fellow eye. Diagnosis: dry eye syndrome, ATs given

**24**

Unrelated evaluation and management service (or eye codes) by the same physician during a postoperative period

**57**

Decision for surgery, major procedure

**25**

Significant, separately identifiable evaluation and management service (or eye codes) by the same physician on the same day of the procedure or other service



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**58**

1. Lesser to greater
2. Pre-planned and documented as staged
3. Therapy following a major surgery

PLANNED OR UNPLANNED

RELATED

NEW POSTOP PERIOD

100% ALLOWABLE

**78**

Unplanned return to operating room during the post-op period

UNPLANNED

RELATED

NEW POSTOP PERIOD DOES NOT BEGIN

70% ALLOWABLE

**79**

Unrelated procedure during the post-op period

PLANNED OR UNPLANNED

UNRELATED

NEW POSTOP PERIOD

100% ALLOWABLE



[aao.org/coding-topics](https://aao.org/coding-topics)

**SURGERY MODIFIERS**

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# Name That Modifier

1. During the global period of a bilateral blepharoplasty, a YAG laser capsulotomy, left eye is performed
2. Pneumatic retinopexy was performed last month and today the patient returns to the OR for a repair of retinal detachment in the same eye
3. A patient is s/p strabismus surgery and develops an abscess. The surgeon decides to return to the OR to clean the wound.

**79** Unrelated procedure during the post-op period

**58** 1. Lesser to greater  
2. Pre-planned and documented as staged  
3. Therapy following a major surgery

**78** Unplanned return to operating room during the post-op period



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# Academy Resources

[aao.org/coding](http://aao.org/coding)

[aao.org/audits](http://aao.org/audits)

[aao.org/retinapm](http://aao.org/retinapm)

[aao.org/em](http://aao.org/em)

[aao.org/lcds](http://aao.org/lcds)

[aao.org/consulting](http://aao.org/consulting)

## Save the Date - 2025 Codequest

State	City	Date	Course Length
South Carolina	Virtual	January 10	4 hours
Arkansas	Little Rock	January 17	4 hours
California	Virtual	January 24	4 hours
Texas	Austin (Fundamentals of Ophthalmic Coding and Codequest)	January 25	6 hours

[aao.org/codequest](http://aao.org/codequest)

Ophthalmic Coding Coach 2.0 Complete Reference

Help and How-to Post Admin

Q 67504

CCI Edit Lookup

67504 is Bundled with 15523

RVU Comparison

CHECK BUNDLES	CPT Code	RVU Office	RVU Facility
<input type="checkbox"/>	15523	18.70	16.62
<input checked="" type="checkbox"/>	67504	22.12	17.69

Bundled: Codes that are not separately billable with another code on the same eye in the same operative session. These bundles have an indicator of "1".  
Exception: When the definition of modifier 59 is met bundled codes with an indicator of "1" may be paid separately.  
Mutually exclusive: Codes that can never be paid separately. These bundles have an indicator of "0".

[aao.org/store](http://aao.org/store)



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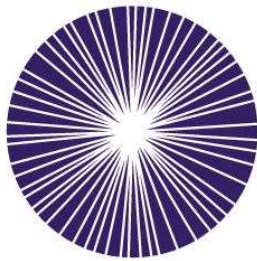
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