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Optometry Coding & Billing Alert

Benchmarking: Majority of Optometrists' Ophthalmic Codes Nationwide Are Level 4

Use this carrier's data to compare your billings to other optometrists across the country.

Ever wonder whether your ophthalmic service billing patterns are "normal?" Now's the chance to find out.

Part B MAC Palmetto GBA published a Comparative Billing Report (CBR) in November to illustrate the benchmarks and trends that the payer has seen among optometry practices. Palmetto launched the analysis "because the OIG has found inappropriate billing and over-utilization of optometry services," the CBR report said in its "Frequently Asked Questions" section. "According to an OIG report, physicians increased their billing of the two highest level E/M services by 17 percent from 2001 to 2010 for CPT® codes 99214 and 99215."

In addition, optometry billing trends have been in the news, particularly after one Oklahoma optometrist billed Medicare for 68 hours of work for a single date of service far longer than the 24 hours available in a day and certainly exceeding the typical eight to 12-hour day that most optometrists work.

Background: CBRs are tools that the government uses to offer insight into billing and coding trends among practices. CMS partners with its contractor eGlobalTech to produce the reports, which you can find at www.cbrinfo.net. You can use the data from CBRs to see where you stand when it comes to the frequency of billing certain services, codes, or modifiers.

Here's What Auditors Reviewed

This CBR reviewed the claims data of about 6,000 optometry specialists to evaluate their use of E/M codes (99201-99215), ophthalmological services (92002-92014), visual field exams (92081-92083), and scanning diagnostic imaging (92133-92134).

What auditors found: The following were the top issues that auditors discovered among optometry claims, said Palmetto GBA's **Cyndi Wellborn, RN,** during a webinar explaining the CBR report's findings:

- Lack of orders for diagnostic testing
- Missing examining physician's signature
- Standing orders
- Medical necessity
- Cloned records
- Over/inappropriate use of modifiers 59 and 25
- Diagnostic tests without interpretation and report

Here's What the Report Revealed

During the review period of April 1, 2014 to March 31, 2015, optometrists' top-billed codes based on allowed amount were as follows, Wellborn said:

- 92014 Ophthalmological services: medical examination and evaluation, with initiation or continuation of

diagnostic and treatment program; comprehensive, established patient, 1 or more visits
- 92004 – Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
- 92012 – Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
- 99213 – Office or other outpatient visit for the evaluation and management of an established patient...

"Extended visual fields (92083) was the most commonly-billed visual field code," she added.

Remember: Medicare does not cover eye refraction services, Wellborn said, "but if the patient requires a Medicare denial to submit to a secondary insurer, for example, HCPCS modifier GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit...) must be appended to 92015 (Determination of refractive state)."

In addition, she urged practices to keep in mind that the chief complaint determines whether the eye examination is routine or medical in nature. "Medicare does not pay for routine eye exams."

Find Your Numbers

Among claims that Palmetto reviewed for optometrists (identified by specialty code 41), average minutes per visit for new patients was 36.40 and for established patients was 17.40 minutes, said Palmetto's **Craig DeFelice** during the webinar.

Why this matters: "Since higher level CPT® codes have higher typical minutes, then a higher average minutes per visit indicates that you are generally billing either higher level CPT® codes than your peers, or you are billing for more services per visit," Palmetto said in its webinar Q&A. "If your average minutes per visit is significantly higher than your peers, please ensure that you have provided the appropriate documentation to support your level of service."

Likewise, if you look at your billing trends for established ophthalmic exam codes 92012 to 92014, physicians nationally reported 92014 74 percent of the time – if you reported 92014 more frequently than this, you are on the higher side, according to Palmetto's data.

Check This SCODI Stat

In some cases, you may face a coding edit for a situation that can be bypassed in specific situations. For example, "Scanning computerized ophthalmic diagnostic imaging (SCODI) is not considered medically necessary when performed to provide additional confirmatory information regarding a dx or treatment which has already been determined," Wellborn said. However, she added, the physician is not precluded from reporting the following services along with SCODI if the documentation justifies the procedures:

- 92250 – Fundus photography with interpretation and report
- 92225 – Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report; initial
- 92226 – Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report; subsequent
- 76512 – Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)

"The reason for SCODI in addition to one of the above procedures must be clearly stated in the record," she added. Although the use of SCODI and visual field tests on the same day or within short intervals of one another can occasionally be billed together, if patients have advanced glaucomatous damage, SCODI is not typically medically necessary. Therefore, the CBR team sought to evaluate how often SCODI and visual field testing are reported together and whether they were appropriate.

Among glaucoma patients, 37 percent of beneficiaries nationwide were billed for both a visual field exam and a SCODI study within 90 days of one another, DeFelice said so if you report a higher percentage, you are above the national average.

Check Your Numbers

The practices that Palmetto reviewed as part of the CBR received personalized reports indicating whether they billed optometry services more or less frequently than other optometrists in their states, but if you weren't part of the sample, that doesn't mean you'll never know where you stand.

If you'd like to compare your usage to the average, run a calculation of your frequency of 92014 and average minutes per visit, then check out Palmetto's results to find out where you stand in relation to the other optometry providers in your state.

Here's how: "Most practice management systems should be able to generate frequency of usage of different CPT® codes," says **Vinod Gidwani,** founder of Currence Physician Solutions in Skokie, Ill. "These reports maybe subtitled CPT® code productivity by doctor, facility, etc."

Once you run your reports, use the data that you glean from them to plug numbers into the average benchmarking calculations and you're on your way to creating a system-wide benchmarking program for your optometry practice.

Don't panic: If your percentage of specific code usage is higher than the average, it doesn't necessarily mean you're billing incorrectly, but you should take a look at your documentation to ensure that it meets requirements. "Billing differently from your peers is not any indication of wrongdoing," DeFelice said during the webinar.

Resource: To read more about the CBR for optometrists, visit www.cbrinfo.net/cbr201510.html.