

MANAGED CARE ORGANIZATIONS REVIEW FOR OPTOMETRY:
BLUE CROSS BLUE SHIELD OF MICHIGAN

by

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ABSTRACT

Background: This research study is designed to analyze the Blue Cross Blue Shield of Michigan (BCBSM) health care program. Specifically, the study will break down the characteristics that all managed care organizations obtain and how they relate to the profession of optometry as well as the overall health care system. The study is geared toward young optometrists interested in the business aspect of managed care issues in the profession of optometry. I hope this research will improve the knowledge and judgement needed to offer specific managed care plans in an optometry practice. *Methods:* In order to evaluate managed care organizations, BCBSM was chosen to be researched individually in order to correlate their specific characteristics to managed care organizations as a whole. The research was acquired from the sources listed on the references page. *Results:* BCBSM possesses many characteristics of a successful managed care organization. The organization has a long history of experience and success, along with a reliable administrative and management department. On the contrary, I feel that the program lacks appropriate benefits for eye care service based on reimbursement and follow-up care. *Conclusions:* In order to properly evaluate a managed care program, several areas should be researched thoroughly. The managed care program should meet the optometrist's practice goals and financial goals. The management structure and administrative leadership of the managed care organization should also be considered in the evaluation, as well as the reimbursement and payment schedules.

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Introduction

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Introduction:

How do I chose which managed care organization is best for my optometry practice?

Which aspects of a managed care organization do I need to evaluate? As a future optometrist with a strong will to own my own practice, I wanted to research about managed care organizations due to the large impact that they have on an optometric practice financially.

Methods:

In order to evaluate managed care organizations, Blue Cross Blue Shield of Michigan (BCBSM) was chosen to be researched individually in order to correlate their specific characteristics to managed care organizations as a whole. Although BCBSM is a popular managed care organization in Michigan, the principles applied to evaluating this specific company can be applied in evaluating other managed care organizations. The following research has been acquired from several sources listed on the references page.

Research/Results:*Legal Status of BCBSM:*

Third-party reimbursement occurs when someone other than the patient pays directly for the services provided; the patient pays indirectly in forms of premiums, taxes, and benefits. There are various types of health care plans including health maintenance organizations (HMO) and preferred provider organizations (PPO). A HMO offers a "per member per month" system in which the member is covered for all services. A PPO operates under negotiated fee schedules; patients may use other providers than those

listed on the provider panel but at an additional cost. In order to receive a payment from a PPO, the following series of events must occur: the provider bills the PPO, the PPO bills the employer, the employer pays the PPO, and then the PPO pays the provider.

BCBSM provides its members PPO health care coverage and is a non-profit organization.

History of BCBSM:

BCBSM first opened for business in 1939 with three employees at an office in Detroit. The company was started by hospital officials and began with \$15,000 in capital. It was officially named BCBSM in 1975 when Michigan Blue Shield joined with Blue Cross. The purpose of the business was to offer prepaid health coverage to residents in Michigan. This prepaid health care originally developed during the depression when most people did not have enough money to pay for health care services. Therefore hospitals were going bankrupt due to unpaid hospital bills, and hospitals lacked patients due to the extreme cost of healthcare. Later in 1939, BCBSM grew and developed offices in Flint, Saginaw, Pontiac, Grand Rapids, Kalamazoo, and Marquette. Over the years, BCBSM has expanded their coverage from hospital and physician coverage to dental, vision, hearing, and prescription drug services. Today, BCBSM pays \$4.7 billion per year in health care benefits. They employ 8,300 people who process over 80 million claims and 7 million inquiries yearly.

BCBSM is contracted by many companies including the "Big Three" of Michigan: General Motors (GM), Ford Motor Company, and Chrysler Corporation. Other groups contracted with BCBSM include: Catherine McAuley, Comerica, House of

Representatives, Kmart, Mazda, Michigan Conference of Teamsters Welfare Fund, Michigan Dental Association, Michigan Education Special Services Association (MESSA), Michigan Public School Employee Retirement System (MPERS), and State of Michigan.

BCBSM has been a member of the Better Business Bureau since November 1948. Based on the Better Business Bureau files, BCBSM has a satisfactory record. In order to have a satisfactory record, a company must be in business for at least 12 months and address issues referred to it by the Bureau in an appropriate manner. Also, the company must be absent from a pattern of complaints and law enforcement action involving its conduct. Very few complaints were processed by the Better Business Bureau in the past and the complaints were typical credit and billing issues that would be expected with an insurance company.

BCBSM has been involved in many different community service programs. In January 2005, BCBSM announced a \$1 million grant program directed toward helping free clinics in Michigan, therefore making it easier for the uninsured to receive healthcare. BCBSM is also involved in working with other organizations to help find ways for the uninsured to receive healthcare. The company is a founding member of Michigan's Access to Health Care Coalition, which was formed in 1999 to develop strategies to improve health care coverage for the uninsured.

Management/Administration of BSBSM:

BCBSM is an independent nonprofit company controlled by a board of directors composed of community-based public and subscribing members. BCBSM is different from regular insurance companies in that they do not generate profit or pay dividends; the company must be competitive with commercial insurance companies, yet generate enough money to cover administrative costs and benefits for their subscribers. There is no fee to become a provider of BCBSM, however one must abide by contract rules and accept the fee schedule as payment in full.

BCBSM benefits can be determined by the provider using a computerized telephone information service. This program tells the provider if the patient is covered by BCBSM, which services are covered, the date services were last received, and the date available services will next be payable. The following information is needed from the patient to obtain the eligibility information: contract number, subscriber's first and last name, patient's birth year, and patient's first name. This telephone operation makes it convenient for the provider to obtain service information about a patient without the hassle of talking to a representative.

Payment for all services is based on medical necessity, which is determined by physicians on behalf of BCBSM. The standard of care determined by these physicians is based on the necessity of tests essential in diagnosis and management for the patient. The guidelines are reviewed frequently during each year due to the frequently changing structure of healthcare.

Participating providers are responsible for submitting claims within 24 months of performing covered services unless the patient's policy specifies differently. Patient's financial and medical records must be kept on file for at least three years after providing services, and these records must be available to BCBSM upon request. Providers must collect all co pays and provide care in accordance with standards recognized by the professional community.

BCBSM provides two different ways to file claims: paper claims and electronic claims. All claims must be submitted on a specific form, CMS-1500. Within this form, the provider will have to list specific procedural codes and explanation codes to explain the services provided. Routine vision exams are designated by procedural codes, which differ between new and established patients. A new patient is defined as a patient who has not been seen in your clinic within the past three years.

Reimbursement for vision exams is based on BCBSM maximum payment levels and the provider's charge to the patient. To determine the maximum payment level, BCBSM reviews the charges of vision care providers throughout the state; the maximum payment corresponds to 85% of the total charges for a particular service. BCBSM has the right to consider other factors to arrive at a reasonable increase in the maximum payment level; the level of payment is reviewed periodically.

Disagreements between providers and BCBSM are resolved by contacting the provider inquiry and field service department. If conflict is still not resolved, an appeal by the provider can be made. The appeals process is divided into three parts: the written complaint, the informal conference, and the independent third-party determination. If not satisfied by the inquiry and field service department, a written letter stating the complaint can be mailed to BCBSM. Within 30 days, BCBSM will respond with a written letter addressing the complaint and explaining the reasons for their decision. If the provider is still dissatisfied, a request for an informal conference can be made. The purpose of the conference is to discuss the disagreement and explore possible solutions. Within 10 days following the conference, BCBSM will send a written proposed resolution to the conflict. If the proposed resolution is still not satisfactory, an independent third-party determination can be requested. One of three forums can be chosen depending on the conflict: binding arbitration, insurance commissioner review, or judicial review. Providers who choose binding arbitration to resolve non-policy related issues must agree to abide by the commercial arbitration rules of the American Arbitration Association. Secondly, providers may choose an insurance commissioner review to resolve both policy and non-policy related issues. If either party is dissatisfied by the Insurance Bureau's decision, they can request to have the matter contested under the Michigan Administrative Procedures Act. Lastly, providers may choose to have the policy or non-policy issue resolved in the appropriate state or federal court.

The "Record" is BCBSM's official periodical communication that serves to update providers with company benefits, billing, administrative procedures, claims,

documentation rules, and other essential information needed as a provider. The "Record" is sent out periodically with these updates.

Optometric Services:

Vision exams performed by licensed physicians and optometrists are covered under the BCBSM vision program. Exams must include the following elements:

1. Patient History
2. External examination of the eye
3. Subjective Refraction
4. Visual Acuity Testing (one or both eyes)
5. Biomicroscopic Evaluation
6. Ophthalmoscopic Examination
7. Intra-ocular Pressure Measurement
8. Dilation of Pupils (if medically necessary)
9. Summary of Findings

If an optometrist recommends a second vision exam by an ophthalmologist, it must be done within 60 days for the service to be covered by BCBSM.

Exam services are contract dependent. For specific information on exam benefits and services for participating providers, see Addendums I-V. By signing an agreement to participate in BCBSM, the provider agrees to accept allowance for vision services as payment in full. Patients may not be billed for the difference between BCBSM fees and

the provider's usual and customary fees. Patients may be billed for co payments, deductibles, and services not covered under BCBSM.

Non-participating providers may also provide exam services to patients. For specific information on exam benefits for non-participating providers, see Addendum VI-X.

Non-participating providers are reimbursed at a lower rate and payment is sent to the subscriber instead of the provider.

A contact lens suitability exam includes the following elements:

1. Biomicroscopic examination
2. Lid evaluation
3. Ophthalmoscopy
4. Tear test
5. Pupil evaluation
6. Fluorescein evaluation
7. Cornea evaluation
8. Lens tolerance tests

This examination determines whether a patient can wear contact lenses. If contact lenses are dispensed, this suitability exam does not need to be reported on a claim form.

However if contact lenses are not dispensed, BCBSM will cover this extra service to the patient if the appropriate procedural code is reported on the claim form.

Contact lenses are considered therapeutic or cosmetic. They are therapeutic when they provide the only means to correct the patient's vision to 20/70 in the better eye, or they provide the only effective treatment for keratoconus, irregular astigmatism, or irregular corneal curvature. Contact lenses are covered by BCBSM depending on the specific type of plan; for coverage information on contact lenses, see Addendum I-X.

Medical treatment, surgical treatment, vision therapy, and low vision services are not covered under the BCBSM vision program. Medical treatment and surgical treatment may however be covered by the BCBSM medical program. The patient is responsible for the additional costs of non-covered services. A selection of frames and lenses are also available as covered by the BCBSM vision program.

Medical Services:

Payment for all medical services is based on medical necessity, which means that the following guidelines need to be met:

1. The service is accepted as necessary and appropriate to the patient's condition.
2. The service is not mainly completed for the convenience of the patient's physician.
3. In case of diagnostic testing, the tests are essential in the diagnosis and/or management of the patient's condition.

Optometrists will commonly encounter medical visits. Medical care is defined by evaluation and management services for the diagnosis and treatment of any disease, illness, or injury. Appropriate coding for these services helps facilitate communication between BCBSM and the provider; good communication speeds reimbursement and avoids frustration. In order to code a patient visit (procedural code), an examination must be completed and documented in three main categories: history, examination, and decision-making. Under each of these categories, there are four specific options in which the patient may qualify (Addendum XI). Depending on whether the patient is new or established, the combination of specific choices between history, examination, and decision-making will determine the examination code for the patient (Addendum XII). Reimbursement fees are generally higher for new patients.

A second type of service that optometrists may encounter will be medical consultations. A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician. A written report back to the requesting physician is required. In order to be reimbursed for this service, the same requirements as medical coding must be met: history, examination, and decision-making (Addendum XI). Depending on whether the patient is new or established, the combination of specific choices between history, examination, and decision-making will determine the examination code for the patient (Addendum XII).

Typically, three additional codes are used in medical billing along with procedural codes: diagnostic codes, materials codes, and pharmaceutical codes. Current copies of these codes can be found in the following books that are produced periodically: CPT-4 for procedural codes, ICD-9-CM for diagnostic codes, HCPCS for material codes, and AHFS for pharmaceutical codes. These specific books should be kept current; therefore it is important to purchase new books frequently to keep up on any changes in coding.

Diagnostic coding is a very important part of the billing process. Along with correctly using a procedural code, a diagnostic code must be used and be related to the procedural code. The highest specificity of code should always be used and multiple diagnostic codes may be used if the patient has multiple problems.

Listed below are a few additional rules that should be used during medical billing:

1. Only the doctor can assign codes.
2. The reason for the visit (chief complaint) determines coverage validity.
3. A new patient is one who has not been seen by the physician or his partners for at least three years.
4. All forms must have the physician's signature or initials and date showing the document was reviewed.
5. All documents must have the patient's name.
6. Abbreviations are permitted as long as there is a list in the office with the definitions; also records must be legible.
7. "Negative" or "Abnormal" can be used on the record, but any abnormal findings must be documented.

8. Alterations can be made by putting a single line through the erroneous entry and initial with date.
9. Payment does not always mean the claim was filed correctly.

BCBSM generally does not reimburse physicians for the following services: drugs, materials, supplies, treatment/services before effective date of coverage, services not directly related to diagnosis/treatment of the patient's condition, examinations/procedures in connection with research, services covered by Medicare if applicable, or services not personally performed by the physician.

BCBSM works with other groups of health care insurers in order to share the cost of medical services; this is called coordination of benefits. The plan that has the first obligation to pay for services is the primary plan. The plan that is required to pay for services after the primary plan is called the secondary plan. The secondary plan takes into account services covered by the primary plan. If the patient is the policyholder, his or her policy should be billed first. If the patient is a dependent, the policy of the parent whose birthday falls earlier in the year should be billed first. Coordination of benefits usually does not apply if the additional health insurance is Medicare; this is named Medicare supplemental coverage. Coordination of benefits only applies when the patient has two supplemental policies; otherwise the Medicare supplemental claims follow a different policy. Coordination of benefits does not make the secondary carrier responsible for costs incurred when the patient fails to comply with the guidelines set forth by the primary insurance carrier.

Common Managed Care Terms:

1. Coordination of Benefits (COB): a program for determining which health insurer pays for services first when a subscriber is covered by more than one health care plan.
2. Coinsurance/Co pay: the percentage of approved expenses paid by the patient for services. It is usually paid after a deductible is satisfied.
3. Contract Number: this is usually the patient's social security number.
4. Deductible: the amount that must be paid by a subscriber before an insurer begins to pay for medical services.
5. Dependent: a person (usually a spouse or child) covered by another person's health care plan.
6. Eligibility: term used stating if person is covered or not covered by their insurer.
7. Exclusions: specific health care services not covered by the plan.
8. Member: a person enrolled under a specific health care program.
9. Modifier: a two-character code used to report information that cannot be reported by use of a procedural code only.
10. Preauthorization: program that allows a provider to check a person's specific coverage under his or her health care plan.
11. Premium: the amount paid by a group/individual for health care insurance.

12. Primary Carrier: the insurer responsible for paying the full benefit amount allowed by its contract. If a person has more than one health care plan, the primary carrier pays first.
13. Sanction: the percentage of a provider's charges a subscriber may be required to pay when certain program requirements are not met.
14. Secondary Carrier: the insurer responsible for any part of a benefit not covered by a primary carrier.
15. Stop Loss: the limit on a subscriber's co payment. Once this amount has been met, the subscriber is no longer responsible for co payments.
16. Subscriber: a person enrolled in a health care program.
17. Subscriber Liability: the portion of costs a subscriber pays for health care services. This could include co payments and deductibles.
18. Supplemental Coverage: coverage that pays for services not completely covered by Medicare. It can also cover Medicare co payments and deductibles.

Discussion/Conclusions:

Managed care organizations should be researched thoroughly before being incorporated into an optometric practice. Depending on the practice, some managed care plans could be beneficial, while others may decrease financial growth of the practice. Before evaluating the managed care organization, the optometric practice should first evaluate itself in deciding on a particular managed care organization. Specifically, the practice should establish goals, evaluate the patient demographics, and review financial status.

Practice goals and patient demographics are very important in evaluating whether or not a managed care organization is beneficial. For example, a particular practice is involved in mostly medical-related optometry, and the optometrist treats and manages mostly ocular disease in an abundantly populated area of elders. This particular practice may benefit from a managed care organization that offers medical services as a benefit to its subscribers and appropriate reimbursement to its providers. In this case, the managed care organization may be an appropriate match based on the practice goals for the medically based, optometry practice located in an elderly populated area. On the contrary, a practice that specializes in contact lenses located in a predominantly young to middle-aged area that does not perform many medical services may not benefit from this same managed care program due to the difference in practice goals and patient demographics.

Financial status of the practice is another aspect that must be analyzed before choosing a managed care organization. For example, a new practice in town that is struggling to get patients into the office for exams may benefit from a managed care program that has a lower reimbursement rate for eye exams than the practice's usual and customary fee. However, a practice that is thriving and has a waiting list in order to get an appointment will not benefit from a managed care organization that reimburses for eye exams at a lower amount. Financially, this practice would lose money if exam slots were taken up by low reimbursable eye exams instead of the patients paying the practice's usual and customary fee for the eye exam. Along with being a provider for a managed care

organization, additional billing may be necessary. An additional financial obligation that the practice must consider is whether or not more employees need to be hired in order to organize the billing and reimbursement requirements necessary to be a provider.

After evaluating the optometric practice and establishing goals, an appropriate managed care organization can be chosen. Several areas of the managed care organization should be evaluated as in my research of BCBSM.

The history of a managed care organization can be a good indication of whether or not a practice would be interested in being a provider. Experience and reputation are important for any business. Fellow colleagues that are providers or have been providers in the past can give input to whether the organization was beneficial to their practice. Important information about the managed care organization can be found at the Better Business Bureau. Research could be provided detailing complaints and praises by members and providers. A managed care organization involved in any optometry practice should have a good reputation for health care, specifically optometry.

The enrollment of the managed care organization is another aspect that should be considered before incorporating the plan into the practice. It is important to research how many people in the area are members and which major companies in the working district are involved with the managed care organization. If not many members are living in the same area as the practice; it is not worthwhile to be a provider of the managed care organization. If the majority of the patients in the practice are members of the managed

care organization, it is often necessary that the optometrist be a provider. There is not “good will” in managed care; patients will usually receive eye care from where their insurance covers the expenses. Also, it is important to know if there are any other providers affiliated with the managed care organization. It is probably beneficial if there have been other vision care providers within the managed care organization; therefore the managed care organization would have experience in the vision care field. A managed care organization that represents other health care fields can be beneficial too. This ensures dedication and experience as a whole health care system from the managed care organization.

The financial stability of the managed care organization can play an important role in assessing the reputation of the organization. The organization needs to be financially stable in order to reimburse providers for their services. If the organization employs an efficient staff and participates in some community service projects, one can be assured that finances are under control. If reimbursement is taking a longer period of time and employees are being laid off, one should question how long the managed care organization would be providing healthcare to the members.

The management structure of the managed care organization is very important from a provider standpoint. Usually the organization will have a “Board of Directors” that makes the final decisions for the managed care organization. It is important to know who has input in defining the standard of care for optometry; is there input from any eye care professional? Also, it is important that the committee periodically review the standard of

care due to the changing nature of health care. Some of the most important decisions from a provider standpoint are the definition of standard of care for the patient. The managed care organization would be reimbursing the provider for his or her services, therefore it is important to know specifically what aspects of the exam must be covered.

A contract from the managed care program is an important document that links the provider to the organization. It is important to know the specific guidelines within the contract. Managed care organizations should comply with all state laws and regulations. Also, one should make sure that malpractice insurance would cover any liability assumed through contracted patients. Some managed care organizations require a fee to belong; this is important to know before signing a contract. The contract should be evaluated to see if being a provider would affect referral patterns. One may be restricted to working with panel providers only. Lastly, one should know the termination policy for the contract; sometimes fees can be applicable for early termination.

The eye care benefits offered by the managed care organization should be evaluated. The eligibility for patients and reimbursement schedules should be evaluated to determine if the practice agrees with the policies. It is important to know which services require prior authorization and how long it takes to achieve the authorization. Medical eye care benefits should also be evaluated. It is important to know how to handle patients who come to the practice for both types of services. One should know which services can be performed on the same day and how to properly bill for the services.

Payment is a very important part of determining validity of managed care organizations. The managed care organization should have a set fee amount for their reimbursement. One should know how often the payment schedule changes and how the provider is notified of the change. One should make sure which services are covered so extra services can be billed to the patient. Members receiving services may be required to make a co payment or deductible; the provider should know how and when to collect these fees. The provider should research the time period in which payment to the provider is issued. One should know in what format payment is made and if there is interest accumulated on late payments.

Access to the managed care organization is critical in obtaining enrollees for the plan. It is important to know if patients are free to choose which provider on the panel they can go to for care or if they are forced to go to a specific provider for care. The managed care organization may be able to advertise the optometric practice as a carrier of the plan, therefore bringing patients to the practice. It is also important to know how to access updated information about changes of the managed care organization so that the practice would not become dated in their practice patterns.

Overall, there are many small details of managed care organizations that should be evaluated before incorporating the program into an optometric practice. The contract should be valid and the managed care organization should fit the practice goals in order for successful practice within managed care. The provider should be comfortable with

his or her practice patterns through the managed care organization, and the reimbursement should be fair.

After analyzing several different aspects of BCBSM, I believe that this specific organization possesses many characteristics of a successful managed care organization. The program has a long history of experience and success. The administrative and management of BCBSM appears to be strong and reliable. The medical services that BCBSM provides for its members are appropriate; billing and reimbursement services are also adequate for providers. Both consumers and providers are grateful to the service in healthcare that BCBSM provides.

On the contrary, I feel as a future optometrist that the program lacks benefits for eye care service to both the provider and member. I had a hard time receiving exact reimbursement rates for a comprehensive eye exam, but from past experience, it appears that the reimbursement rate is significantly lower than private practitioners' usual and customary fee. Although great for the BCBSM member, optometrists may not be able to afford to provide their services for such a low reimbursement. Also, I feel that contact lens reimbursement does not benefit the member or provider. In several of the participating provider plans, a contact lens exam whether cosmetic or therapeutic are covered every two years (Addendum I-V). Therefore, the patient is only getting care provided every two years while wearing a medical device on the eye. Because most practitioners follow their contact lens patients 1-2 times per year, the patient is either forced to pay for the care himself or herself during the time period that the insurance does

not cover, or the patient only comes to the office every two years. This puts the provider in an uncomfortable situation; the optometrist must change his or her standard of care procedures for contact lens care to comply with insurance coverage or charge the patient as necessary for the contact lens service. Depending on the patient and his or her financial status, this situation may or may not be complicated.

Eye care services provided by BCBSM are still somewhat advantageous for provider reimbursement if the patient wears cosmetic contact lenses because the patient must pay the balance of the provider's usual and customary fee in all the participating provider plans (Addendum I-V). Cosmetic contact lens wearers under those specific contracts are not losing much money due to the large span of time between coverage because they are paying for most of their contact lens services themselves anyway.

However, it is my opinion that health care, specifically vision coverage, is optional. Some patients have fantastic vision coverage based on their managed care organization and others have very minimal vision coverage. We as optometrists should not find it necessary to give patients with lesser vision coverage reduced rates for our services. We should charge our usual and customary fees as necessary to all patients, regardless of vision coverage because it is our legal obligation. Managed care organizations are in charge of developing reduced reimbursement rates, and it is the optometrists' job to decide on whether or not to accept their coverage plan in our office. Our usual and customary fees should never be below a managed care organizations reimbursement amount because managed care is a discounted service.

Addendum I:

Category I – AMC

<u>Benefit</u>	<u>Limitation</u>	<u>Reimbursement</u>	<u>Co-pay</u>
1. Exam	12 months	100% of BCBSM approved amount	0
2. Contact Lens (therapeutic)	24 months	\$200 (including vision exam fee)	balance of provider \$
3. Contact Lens (cosmetic)	24 months	\$100 (including vision exam fee)	balance of provider \$

Note:

Payment for contact lens exams include the standard vision exam, however the patient must pay the balance of the provider's usual and customary fees.

Addendum III:

Category III – VC-1

<u>Benefit</u>	<u>Limitation</u>	<u>Reimbursement</u>	<u>Co-pay</u>
1. Exam	24 months	80% of BCBSM approved amount	20% of approved amount
2. Contact Lens (therapeutic)	24 months	80% of BCBSM approved amount (includes cost & dispensing fee)	20% of approved amount
3. Contact Lens (cosmetic)	24 months	\$35	balance of provider \$

Note:

Payments for the therapeutic contact lens exam includes the standard vision exam, contact lens suitability exam, and dispensing. The patient has a copay of 20 % of the BCBSM approved amount.

Addendum IV:

Category IV – U-80

<u>Benefit</u>	<u>Limitation</u>	<u>Reimbursement</u>	<u>Co-pay</u>
1. Exam	24 months	100% of BCBSM approved amount	0
2. Contact Lens (therapeutic)	24 months	100% of BCBSM approved amount (includes cost & dispensing fee)	0
3. Contact Lens (cosmetic)	24 months	\$35	balance of provider \$

Note:

Payments for the therapeutic contact lens exam includes the standard vision exam, contact lens suitability exam, and dispensing. The patient does not have a co pay under this specific plan.

Addendum V:

State of Michigan Groups 81814-81828

<u>Benefit</u>	<u>Limitation</u>	<u>Reimbursement</u>	<u>Co-pay</u>
1. Exam	12 months	balance of BCBSM approved amount	\$5
2. Contact Lens (therapeutic)	24 months	100% of BCBSM approved amount (includes cost & dispensing fee)	0
3. Contact Lens (cosmetic)	24 months	\$90	balance of provider \$

Note:

Payments for the therapeutic contact lens exam includes the standard vision exam, contact lens suitability exam, and dispensing. The patient has a \$5 co pay under this specific plan. The balance of BCBSM approved amount is contract specific. The contact lens examination can be covered every 12 months if there is a change in prescription.

Addendum VI:

State of Michigan Groups 81814-81828 (non-participating providers)

<u>Benefit</u>	<u>Limitation</u>	<u>Reimbursement</u>	<u>Co-pay</u>
1. Exam	12 months	75% of average participating provider payment	\$5
2. Contact Lens (therapeutic)	24 months	Up to \$96 (includes cost & dispensing fee)	balance of provider \$
3. Contact Lens (cosmetic)	24 months	For groups other than 81826: up to \$40 For group 81826: up to \$35	balance of provider \$

Note:

Payments for the therapeutic contact lens exam includes the standard vision exam, contact lens suitability exam, and dispensing. The patient has a \$5 co pay under this specific plan. Also, the contact lens exam will be covered every 12 months if there is a prescription change. This fee schedule is for non-participating providers; therefore, the reimbursement amount is decreased as compared to participating providers.

Addendum VII:

Non-participating providers: AMC

<u>Benefit</u>	<u>Limitation</u>	<u>Reimbursement</u>	<u>Co-pay</u>
1. Exam	12 months	Approved benefit amount or provider charge, whichever is less	0
2. Contact Lens	Not a benefit	Approved benefit amount or provider charge, whichever is less	

Note:

If provider charge is less than approved benefit amount, you will get paid the lesser amount. There is no co pay in this plan. This fee schedule is for non-participating providers; therefore, the reimbursement amount is decreased as compared to participating providers.

Addendum VIII:

Non-participating providers: A-80

<u>Benefit</u>	<u>Limitation</u>	<u>Reimbursement</u>	<u>Co-pay</u>
1. Exam	24 months	75% of BCBSM approved benefit	\$5
2. Contact Lens (therapeutic)	24 months	Approved benefit amount or your charge, whichever is less	0
3. Contact Lens (cosmetic)	24 months	\$35	0

Note:

If provider charge is less than approved benefit amount for the contact lens exam, you will get paid the lesser amount. Payments for the therapeutic contact lens exam includes the standard vision exam, contact lens suitability exam, and dispensing. There is a \$5 co pay for this specific plan. This fee schedule is for non-participating providers; therefore, the reimbursement amount is decreased as compared to participating providers.

Addendum IX:

Non-participating providers: VC-1

<u>Benefit</u>	<u>Limitation</u>	<u>Reimbursement</u>	<u>Co-pay</u>
1. Exam	24 months	60% of BCBSM approved benefit	0
2. Contact Lens (therapeutic)	24 months	50% of your charge or 75% of average par payment, whichever is less	0
3. Contact Lens (cosmetic)	24 months	\$35	0

Note:

Payments for the therapeutic contact lens exam includes the standard vision exam, contact lens suitability exam, and dispensing. There is not any co pay in this plan. The provider may be getting a smaller reimbursement amount if his or her fees are less than BCBSM approved benefit amount. This fee schedule is for non-participating providers; therefore, the reimbursement amount is decreased as compared to participating providers.

Addendum X:

Non-participating providers: U-80

<u>Benefit</u>	<u>Limitation</u>	<u>Reimbursement</u>	<u>Co-pay</u>
1. Exam	24 months	100% of BCBSM approved benefit	0
2. Contact Lens (therapeutic)	24 months	Approved benefit amount or your charge, whichever is less	0
3. Contact Lens (cosmetic)	24 months	\$35	0

Note:

Payments for the therapeutic contact lens exam includes the standard vision exam, contact lens suitability exam, and dispensing. There is not any co pay for this specific plan. The provider may be getting a smaller reimbursement amount if his or her fees are less than BCBSM approved benefit amount.

Addendum XI: Medical Coding Requirements

History:

- | | |
|--|--|
| <p>1. Problem Focused
*chief complaint
*1-3 elements of HPI</p> | <p>2. Expanded Problem Focused
*chief complaint
*1-3 elements of HPI
*ocular review of systems</p> |
| <p>3. Detailed
*chief complaint
*4 or more elements of HPI or status of at least 3 chronic or inactive conditions
*ocular review of systems and 1-8 additional systems
*1 specific item from past or family social history</p> | <p>4. Comprehensive
*chief complaint
*4 or more elements of HPI or the status of at least 3 chronic or inactive conditions
*ocular review of systems and 9 additional systems
*complete review of past, family, and social history</p> |

Examination:

- | | |
|---|---|
| <p>1. Problem Focused
*1-5 elements of eye exam</p> | <p>2. Expanded Problem Focused
*6 elements of eye exam</p> |
| <p>3. Detailed
*9 elements of eye exam</p> | <p>4. Comprehensive
*all elements of eye exam plus mental status documented</p> |

Decision Making:

1. Straightforward
*minimal number of diagnoses or management options, minimal amount or complexity of data to be reviewed, minimal risk of complications and/or morbidity.
2. Low Complexity
*limited number of diagnoses or management options, limited amount or complexity of data to be reviewed, limited risk of complications and/or morbidity.
3. Moderate Complexity
*multiple number of diagnoses or management options, moderate amount or complexity of data to be reviewed, moderate risk of complications and/or morbidity.
4. High Complexity
*extensive number of diagnoses or management options, extensive amount or complexity of data to be reviewed, high risk of complications and/or morbidity.

Addendum XI continued: Explanation of Specific Elements

1. Chief Complaint: the specific reason the patient is visiting the office
 - a. avoid terms like routine, simple, or uncomplicated
 - b. make short and concise
 - c. history, exam, and decision are all arrived on chief complaint

2. HPI: history of present illness
 - a. chronological description of the development of the patient's present illness from the first sign/symptom or from the previous encounter to the present
 - b. elements include: location, quality, severity, duration, timing, context, modifying factors, and associated signs/symptoms

3. Review of Systems: inventory of the body systems obtained through a series of questions seeking to identify signs/symptoms in which the patient has experienced.
 - a. positive and negative responses should be marked individually per system
 - b. there are 14 different systems: constitutional, ocular, ears/nose/throat/mouth, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, integumentary, neurological, psychiatric, endocrine, blood/lymphatic, and allergic/immunologic
 - c. checklist may be used for subsequent visits

4. Past, Family, and/or Social History:
 - a. Past history includes the patient's past experiences with illnesses, operations, injuries, treatments, or medications
 - b. Family history includes a review of medical events in patient's family, including diseases which may be hereditary or place the patient at risk
 - c. Social history includes age appropriate review of past and present activities (marital status, employment, tobacco or alcohol use, etc..)

5. Examination Elements:
 - a. Visual Acuity, Visual Field, Ocular Motility, Conjunctiva, Adnexa, Pupils/Irides, Cornea/Tears, Anterior Chamber, Lens, Intraocular Pressure, Optic Disc/Nerve Fiber Layer, and Posterior Segment
 - b. Mental status includes: Orient and Mood.

Addendum XII: New Patient vs. Established Patient Coding

New Patient (must meet 3 of 3 in order to bill the specific code level):

<u>Code</u>	<u>99201</u>	<u>99202</u>	<u>99203</u>	<u>99204</u>	<u>99205</u>
History	1	2	3	4	4
Exam	1	2	3	4	4
Decision	1	1	2	3	4

Established Patient (must meet 2 of 3 in order to bill the specific code level):

<u>Code</u>	<u>99211</u>	<u>99212</u>	<u>99213</u>	<u>99214</u>	<u>99215</u>
History	physician	1	2	3	4
Exam	supervision	1	2	3	4
Decision	only	1	2	3	4

Consult Patient (must meet 3 of 3 in order to bill the specific code level):

<u>Code</u>	<u>99241/71</u>	<u>99242/72</u>	<u>99243/73</u>	<u>99244/74</u>	<u>99245/75</u>
History	1	2	3	4	4
Exam	1	2	3	4	4
Decision	1	1	2	3	4

Note: All follow-up visits in the consultant's office that are initiated by the physician consult must be reported using office visit codes for established patients (99211-99215).

Numbers in charts correspond to numbered categories in Addendum XI

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