CODING DISCREPANCIES IN OPTOMETRY

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This paper is submitted in partial fulfillment of the
requirements for the degree of

Doctor of Optometry

Ferris State University
Michigan College of Optometry

May, 2012

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Has been approved

May, 2012

Ferris State University
Doctor of Optometry Senior Paper
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ABSTRACT

Background: The purpose of this study is to analyze coding patterns across the state of Michigan. Is there is a general consensus on how to code, or are there are a lot of discrepancies between optometrists? The design of this study is to have a "paper patient" case that each doctor will read and then code. The patient case will not be based on a real patient and the case will be completely fictitious. The case will give extensive information about the exam and at the end of the case the optometrist will be asked to code the case as if it was an actual patient that presented to the office *Methods:* The sample size will be 500 optometrists from the state of Michigan. The case will be sent via email to optometrists in the Michigan Optometric Association database. The email will contain a consent form and a link to the "paper patient" case. The exam elements and results will be detailed and the optometrists will be asked how to code the case. One week was given to fill out a response to the case. *Results*: 45.3% of the optometrists who participated coded the case correctly. In addition, optometrists in a group-practice coded correctly the most often at 52.6%

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INTRODUCTION

Optometrists provide a service to their patients and must be compensated accordingly. Therefore, billing and coding is an essential component in any optometric practice. Rules and regulations are perpetually changing and correctly coding an examination is not always straightforward. There are many different philosophies in publications, magazines, and on the internet regarding coding. Coding an examination properly should not be subjective, yet two different optometrists may bill the same examination quite differently.

In the United States, each year health insurers process over five billion claims for payment. Standardized coding systems are crucial in order to ensure that these claims are processed in an organized and uniform manner. The Healthcare Common Procedure Coding System (HCPSC) is one of the standard code sets used for this purpose. It is separated into two subsystems, level I and level II. Level I is made up of the Current Procedural Terminology (CPT-4), which is a numeric coding system maintained by the American Medical Association (AMA).[1] The CPT is a uniform language of detailed terms and established codes for accounting medical procedures and services used to report services on claims for public and private health plans.[2] The CPT codes are published and updated annually. Level II is a standardized coding system that is used to identify products, supplies, and services that are not included in the CPT codes. Examples include ambulance services, prosthetics, and orthotics, among others. Level II codes are designated by a single alphabetical letter followed by four numeric digits, whereas level I codes consist of five numeric digits.[1] Optometrists commonly use both levels of the

HCPSC. The CPT codes are further divided into two categories depending on if the patient one is coding for is either new or established.

For the purpose of this research, the primary focus will be on codes commonly used in optometry. These CPT codes include general ophthalmological service codes, evaluation and management codes, and routine ophthalmological examination codes (or S-codes). The general ophthalmological service codes include 92002, 92012, 92004, and 92014. The first two codes listed are considered intermediate codes for a new and established patient and the latter two codes are considered comprehensive codes for a new and established patient. The patient is considered new if they have not received services from any doctor of the same specialty in a specific practice or group in the last three years. This holds true for evaluation and management codes and S-codes as well. One may choose to use these codes if certain requirements are met. The requirements for the intermediate codes include taking patient history, a general medical observation, external ocular/adnexal examination, other diagnostic procedures as indicated, and the initiation or continuation of a diagnostic or treatment program. The requirements for the comprehensive codes include a general evaluation of the complete visual system, patient history, general medical observation, external examination, ophthalmoscopic evaluation, gross visual fields, basic sensorimotor examination, and the initiation or continuation of a diagnostic or treatment program. The code for refraction, 92015, is not included in the general ophthalmologic service code and needs to be coded separately if performed. The evaluation and management codes include 99201 (level 1), 99202 (level 2), 99203 (level 3), 99204 (level 4), 99205 (level 5), 99211 (level 1), 99212 (level 2), 99213 (level 3), 99214 (level 4), and 99215 (level 5). If the code begins with 9920- it is used for a new

patient, and if it begins with 9921- it is used for an established patient. Determining which code level is most appropriate depends on the level of detail of the history and examination for each specific patient. Certain elements of the exam are counted and placed into one of four groups depending on the number of elements included. These groups include problem focused, expanded problem focused, detailed, and comprehensive. Also included in determining the appropriate code is the level of medical decision making (MDM), which is also placed into one of four groups including straightforward, low complexity, moderate complexity, and high complexity. To determine the most appropriate code for a new patient three requirements must be met. For level one these include a problem focused history, a problem focused exam, and straightforward MDM. Level two requirements include an expanded problem focused history, an expanded problem focused exam, and straightforward MDM. Level three requirements include both detailed history and exam, and low complexity MDM. To meet the level four requirements one must have a comprehensive history and exam, and moderate complexity MDM. A level five is appropriate when there has been a comprehensive history and exam with high complexity MDM. For established patients, two of the three key components must be met. A level one is met when the presenting problems are minimal and typically a nurse or doctor supervises the services. Level two components include both a problem focused history and exam, and straightforward MDM. Level three components include both an expanded problem focused history and exam, and low complexity MDM. Level four components include both a detailed history and exam, and moderate complexity MDM. A level five is appropriate with a comprehensive history and exam, and high complexity MDM. An optometrist may

choose to use the S-codes for a patient when there is no medical diagnoses for the presenting chief complaint. The S0620 code is considered a routine ophthalmological examination, including refraction, for a new patient, and the S0621 code is a routine ophthalmological examination, including refraction, for an established patient.[3]

The American Optometric Association (AOA) realizes all of the discrepancies in optometric coding and each year puts out the AOA's comprehensive coding and billing manual for optometric practices. The AOA's Clinical & Practice Advancement Group offers webinars, publications, journals, and many other resources for optometric coding.[4] There are also many private companies that offer coding assistance in exchange for a fee.

Currently, there is not a continuing educational (CE) requirement for billing and coding for Michigan optometrists. Any CE relating to coding or billing would fall under the general Practice Management category, where there is no specific requirement.[2]

The goal of this study is to analyze the different ways optometrists code the same examination. Is there a general consensus on how to code, or are there are many discrepancies between optometrists? The results will be analyzed and it will be calculated what percentage of optometrists coded correctly, and what percentage coded incorrectly.

METHODS

The design of the study was to have a "paper patient" case that each doctor was to read and then code. The patient case was not based on any real patient and the case was completely fictitious. The case gave extensive information about the exam and at the end of the case the optometrist was asked to code the case as if it was an actual patient who came into their office. The case gave information regarding past history of the patient, chief complaint, history of present illness, review of systems, personal/family/social history, exam elements performed, additional testing, diagnoses, and plan. After the information was provided regarding the case, questions followed for the optometrist to answer. There were a total of four questions. Question one asked the specific codes the optometrist would use to bill the case, and question two was an open-ended question for the optometrist to explain their reasoning for their coding decision. Question three asked the optometrist what mode of practice they were in. The last question was asking who does the coding for the office, and if it was not the doctor what was the title of the staff member who does the coding. (See Appendix A)

The paper patient case was put into the format of a survey using the website Questionpro which is partnered with Ferris State University and allows students to securely perform anonymous research. [3] An email was sent out to the optometrists asking them to take part in our research project. (See Appendix B) Participation in the survey was completely voluntary and no incentives were given for participating. If they decided to participate in the survey they clicked a link that led them directly to the case and survey questions on the Questionpro website.

The sample size was 500 optometrists from the state of Michigan. The 500 optometrists were chosen at random from the Michigan Optometric Association member database. An email was sent out, along with a letter of informed consent to 500 optometrists. Choosing a random sample of optometrists would allow results from a variety of types of practice settings. In addition, we did not focus on one region of Michigan but sent out the case to optometrists all over the state chosen at random. All participant identities were kept anonymous and will never be included in any part of the study. We gave the optometrists one week to reply to our survey. A reminder was sent out to all the optometrists five days after the initial email was sent.

The data and results were able to be viewed through the Questionpro website. The identity of the optometrist was kept anonymous through the Questionpro survey format. All data was analyzed by the administrators of the survey. Each open-ended question was read and analyzed individually and contributed to the final data.

RESULTS

Out of 500 surveys sent out to Michigan Optometric Association Optometrists, 79 were fully completed. Therefore, the rate of return for the survey was 15.8%. There were 4 surveys that were not filled out correctly and were therefore discarded leaving a total of 75 completed surveys. There were a total of ten different codes used to bill the examination. Four of the ten codes were for additional testing.

The code that was used most often was 92014, with 54.7% of respondents using this code. The next most used code for the examination was 99214 which was used 24.0% of the time. The 99215 code was used 9.3% of the time and the 99213 code was also used 9.3% of the time. The three other codes were only used by one out of the seventy one optometrists and they were an S-code and 92004. (Table 1)

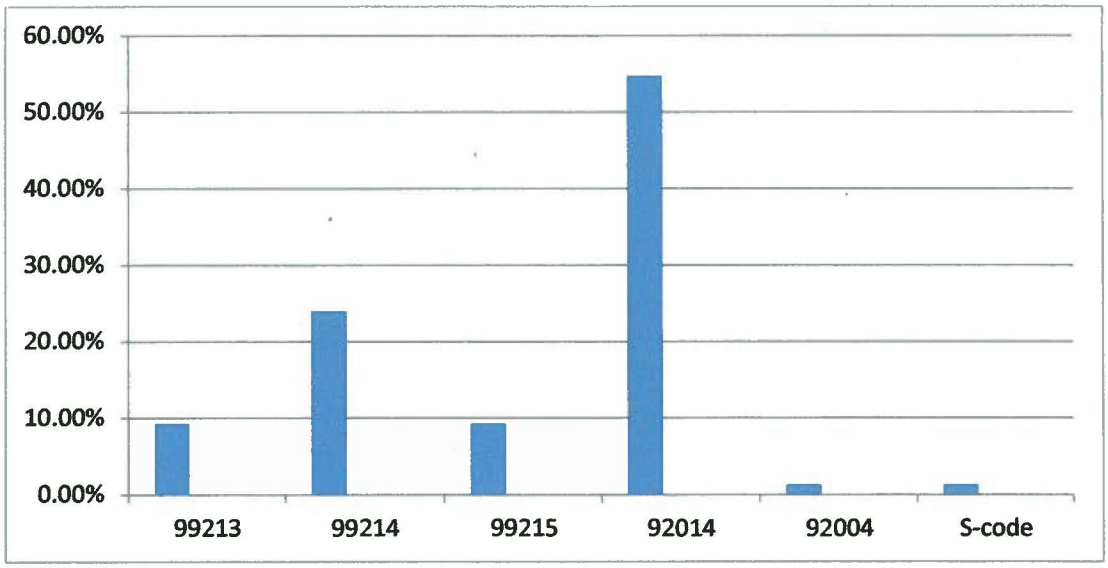

Table 1

The four codes that were used for additional testing were 92285 (external photos), 92225 (extended ophthalmoscopy), 92250 (fundus photos), and 92015 (refraction). 76.0% of respondents added the refraction code to their billing and 76.0% added the code for fundus photos. Only one respondent used the 92285 code and only one respondent used the 92225 code.

To code the case completely correctly, the optometrist must code the exam correctly, and remember to code for any additional procedures or testing. Either the 92014 code or the 99215 are correct ways to code the examination and then the code for 92015 (refraction) and 92250 (fundus photos) must also be coded because they were performed during the examination. 36% of respondents coded the case correctly using 92014, 92015, and 92250. In addition, 9.3%% of respondents coded the case correctly using 99215, 92015, and 92250. Therefore a total of 45.3% of respondents coded the case properly. That leaves 54.7% of optometrists who did not code the case correctly.

The results can also be broken down by what mode of practice the optometrist works. Out of all the respondents to the survey, 50.6% of the respondents work in a group practice setting, 20% work as a solo-practitioner, 9.3% work in an OD/MD practice, and 4% work in a corporate or commercial setting. The other 16% of optometrists were in a variety of settings such as academia, government, or non-profit organizations.

Most of the optometrists who participated in the survey work in a group practice setting. Out of these 38 optometrists, half of them coded the case using the ophthalmologic code 92014. The other half of practitioners in a group practice used the E/M codes to level out the examination. 29% of group practice optometrists used a 99214 code, 10.5% used a 99215 code, and 7.9% used a 99213 code. There was also one

optometrist who coded the examination by using an S-code for a vision exam. 81.6% of group-practice optometrists coded a 92015(refraction) and 88.6% coded for the fundus photos using a 92250 code. Even though group-practice optometrists made up just half of the participants in the study, they made up a larger percentage of optometrists who coded the case correctly. 67.7% of respondents who coded the case by one of the two correct ways worked in a group practice setting. In addition, the 99215 (level 5) code which is has the highest reimbursement, was used most by optometrists in a group practice. Only 7 of the 75 optometrists who participated in the study used the 99215 (level 5) code and four of them were from a group practice.

Solo-practitioners were also a large part of the survey at 20% of all respondents. Out of these fifteen optometrists, 60% of them coded the case using the 92014 code, 20% used the 99213 code, and 20% used the 99214 code. Also, 60% of solo-practitioners remembered to code a 99215 (refraction) and 75% coded for the fundus photos taken using a 92250 code. . Another pertinent statistic is that out of the 9.3% of respondents who coded the case using a 99215 (level 5); none of them were a solo-practitioner.

Optometrists who work with an ophthalmologist made up 9.3% of respondents. Out of these seven optometrists, five of them coded the exam with the 92014 code, one used the 92004 (comprehensive ophthalmologic exam for a new patient), and one used a 99214 (level 4) code. Five of the seven optometrists coded for a refraction and five of them coded for the fundus photos taken.

It is important to note that optometrists in a group practice coded the case correctly more often than optometrists in other modes of practice. 52.6% of optometrists in a group practice setting code the case correctly remembering to code for the

examination, fundus photos, and refraction. To code correctly they also had to use either the 99215 (level 5) code of the 92014 (ophthalmologic code). Optometrists who were in a solo-practice coded incorrectly 73.3% of cases. Doctors working with an ophthalmologists coded incorrectly in 71.4% of cases.

Practice Setting	Percent of optometrists in that setting that coded correctly
Solo-Practice	26.7%
Group Practice	52.6%
OD/MD	28.6%

Table 2

Another pertinent result was the fact that almost all optometrists do their own coding. Over 93% of optometrists do the coding themselves. The other 7% of optometrists either used their electronic medical records to assist them in coding, or a staff member.

DISCUSSION

The correct ways to code the case was based on the laws by The Health Insurance Portability and Accountability Act (HIPPA) that requires a standard medical code data set that specifies the usage of ICD-9 and ICD-10 codes, CPT codes, and S codes. There are essentially two ways to code this case properly since optometrists may use either the E/M codes or CPT Medical Eye Exam codes to report services.[5] One way would be coding the general ophthalmological service code. The patient is an established patient since the patient has been examined in the past three years. The exam coding is based on the chief complaint, which in this case is a medical eye exam since the patient is presenting to the office for a diabetic eye examination. The requirements for this code include complete system evaluation, history, medical observation, external and opthalmoscopic examinations, gross visual fields, and basic sensorimotor examination. In addition the patient must be dilated and an internal evaluation must be performed. It always includes initiation of diagnosis and treatment.[5] The refraction or the fundus photos count as treatment. Using this method, the proper code would be 92014 which is the Comprehensive Ophthalmological Service Code for an established patient.

The other correct way to code this case example is by using an Evaluation and Management (E/M) code. The three important components to define level of service for E/M services are history, examination, and medical decision making.[5]

The history in this case is Comprehensive since there is a chief complaint, an extended history of present illness (HPI), a complete review of systems, and a complete personal/family/social history. The components of the HPI were the fact that the patient

was a diabetic, it was Type II diabetes, he was diagnosed 4 years earlier, his blood sugar was controlled, and his vision was stable and had not changed. All fourteen possible systems to review were addressed in the examination; therefore a complete review of systems was done. A complete personal/family/social history was done since at least two areas were reviewed.

The examination was a comprehensive exam since all fourteen elements were performed. The number of elements needed depends on the doctor's clinical judgment of the chief complaint. In this case, it is justifiable that all fourteen exam elements should be performed for a diabetic evaluation. It is important to note that for the exam elements evaluating the posterior segment and optic disc, the patient must be dilated unless contraindicated. The patient in this case was in dilated using 1.0% Tropicamide.

The medical decision making for the case involves the level of complexity of establishing a diagnosis and/or selecting a management option. The number of points for diagnosis and treatment options is 2, because the diabetes is an established problem that is worsening. The number of points for amount and/or complexity of data to be reviewed is 1, because fundus photos were taken which is in the medicine section of CPT 9000s. The level of risk is moderate since there is one chronic illness with a mild exacerbation. Therefore the overall level of medical decision making would be a 2, which is Low.

The coding for the exam will be based on the comprehensive history, the comprehensive examination, and the low level of medical decision making. Since the patient is an established patient, only 2 of 3 of the components must be satisfied to bill at a certain level. Therefore since the history and examination were comprehensive, the exam should be billed at a level 5.

Both the 92014 code or the 99215 code are correct ways to code the case. However, the 99215 code does have a higher reimbursement. For example, using Medicare reimbursement for the state of Michigan, besides the Detroit area, a Level 5 99215 code has a reimbursement of $135.35 and the ophthalmologic service code has a reimbursement of $114.81. [1]

When the optometrists were asked how they made their coding decision, a wide variety of answers were given. Most of the optometrists who coded the case correctly used specific rules, such as exam elements and type of history, to make their coding decision. Many of the practitioners, who incorrectly coded the case, said their coding decision was based on how much complexity they felt the case had. In addition, many optometrists said that they used the 92014 code instead of leveling the case using the E/M codes because it takes less time. Using the E/M codes also has more requirements than the ophthalmologic service codes.[5]

The results showed the optometrists in a group-practice setting were twice as likely to code the case correctly as other optometrists. One reason for this result could be because when more than one doctor works in a practice, there needs to be rules and a basis for coding. Multiple doctors working with the same staff and patients need to be on the same page with coding, so there needs to be a consensus on how to code examinations. If one doctor is working in a solo-practice, they do not need to converse with another doctor on coding decisions and can base all coding on own understanding of coding.

Another important result was that no solo-practitioners coded the case using 99215 (Level 5). This could be because solo-practitioners often perform less medical

exams than in a group-practice setting, or because they are less comfortable coding the 99215 (Level 5). Optometrists often are tentative when it comes to this code for fear of being audited.[6] As long as the requirements are met to code a 99215 (Level5), there is no reason why optometrists should not utilize it.

With all the rules and regulations regarding coding, it seems that optometrists are still confused on how to code properly. 54.7% of optometrists who participated in the study did not code the case correctly. Doctors need to code from the facts of the case and not use perception of how much work they did. Knowledge of billing and coding is an essential aspect of optometry that can have severe consequences if not done correctly. Coding needs to be taken seriously and put as a top priority. In 2010 alone, 284 different types of medical doctors were prosecuted against for inaccurate coding. [6] Doctors may not think they are doing anything wrong by "under-coding" on an examination, but under-coding is as inaccurate and wrong as over-coding.

APPENDIX A

A forty nine year old male patient presents to your office for his yearly diabetic eye exam. He has been examined by you one time previously two years prior. At that visit, there was no retinopathy found in either eye and only reading glasses were prescribed. All other ocular history is unremarkable.

Chief Complaint: Diabetic Exam

HPI: Patient is a type II diabetic with controlled blood sugar. He was diagnosed with diabetes 4 years ago. Reports good vision with no changes noticed.

Review of systems

Constitutional/general health: denies

Ear/nose/throat: denies

Cardiovascular: Hypertension

Pulmonary: Asthma

Endocrine: Type II Diabetes

Dermatological: denies

Gastrointestinal: denies

Genitourinary: denies

Musculoskeletal: denies

Neurologic: denies

Psychiatric: Depression

Immunologic: denies

Hematologic: denies

Eyes: Presbyopia

Personal/Family/Social History

Type II Diabetes Mellitus, previous alcoholic, denies smoking.

Father has macular degeneration, brother has diabetes.

Exam Elements Performed (patient was dilated using 1% Tropicamide)

Visual Acuity (refraction was performed)

IOP	Mood/Affect
Adnexa/Lacrimal	EOM/Cover test
Lens	Cornea
Confrontation Fields	Optic Disk
Pupils/Irises	Conjunctiva
Anterior Chamber	Posterior Segment

Orientation

Additional Testing: Fundus Photos

Diagnoses:

1.	Diabetes Mellitus Type II controlled with retinopathy	250.50
2.	Mild Nonproliferative Diabetic Retinopathy OU	362.04
3.	Presbyopia	367.40
4.	Myopia	367.1

Plan:

Patient to return in 6 months for dilated fundus exam to monitor retinopathy. Patient education on condition and importance of good blood sugar control. New glasses ordered with updated prescription.

Questions

1. What code (include diagnosis) would you use to bill this patient? If multiple codes (include diagnosis for each code) are used, list all of them here.
2. Please provide a brief explanation of how you came to your coding decision
3. What type of practice setting are you in?

A. Solo Practice B. Group Practice C. OD/MD D. Commercial E. Other

4. Who does the coding for your examinations?

(if it is a staff member please state their title)

APPENDIX B

Hello Doctor,

We are students from the upcoming graduating class from the Michigan College of Optometry. Our senior project is on coding and billing for optometric examinations and procedures. Dr. Roger Kamen, a coding expert, is our supervising doctor for the project. We need your help to make this project successful! Please take a few moments of your time to participate in our project. Our project consists of a patient case and then a few questions regarding how you would code the patient examination. If you choose to participate, please fill out the survey within the next week.

Reading the case and answering the questions should only take 5 minutes.

All responses will remain confidential and secure.

Please click on this link to complete the survey:

<SURVEY_LINK>

Please contact Kate Vanderhoof at vanderhoof2012@gmail.com, or Emilie Mathiak at emathiak@gmail.com

Thank You

Kate Vanderhoof and Emilie Mathiak

Michigan College of Optometry Class of 2012

For any complaints or problems with the content of this survey please contact

C. Meinholdt, Ph.D.

Chair, Institutional Review Board

Ferris State University

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