THE BIG DEBATE: MEDICAL VERSUS VISION EYE CODING

by

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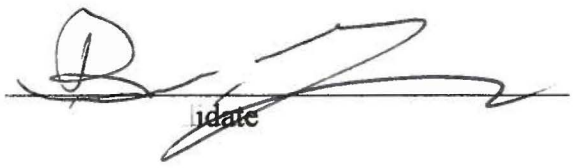

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ABSTRACT

BACKGROUND: Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted to improve the efficiency and effectiveness of the health care system. To improve efficiency HIPAA required the Human Health Service (HHS) to adopt national standards for electronic health care. The HHS developed Healthcare Common Procedure Coding System (HCPCS) to aid providers for a more efficient claims processing. HCPCS are divided into two levels. Level I HCPCS are comprised of Current Procedural Terminology (CPT®) codes. CPT® codes are maintained by the American Medical Association (AMA) and are used to bill medical insurance companies. Level II HCPCS codes are used for codes not covered under CPT® codes. PURPOSE: Many vision insurance companies require optometrist to go above and beyond the definition in CPT® codebook for medical eye exams. Vision carriers are also using medical eye codes when the diagnosis is refractive in nature. METHOD: To investigate and determine if vision companies are breaking any laws by rewriting the definition of CPT® codes and by their use of medical eye codes.

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Introduction

Four years ago, I started optometry school. I was ignorant to the idea of billing and coding. We spent a whole semester trying to understand eye coding. Trying to differentiate medical versus vision and different evaluation and management levels was not an easy task. To further complicate students and I suspect most physicians, some vision carriers force providers, by contract, to perform more examination elements not described in the Current Procedural Terminology (CPT®) manual. There are four CPT® eye codes in particular interest to the optometrist. These are the eye codes most commonly used:

92002 (Ophthalmological services): Medical examination and evaluation with initiation of diagnostic treatment program; intermediate, new patient.

92004 (Ophthalmological services): Medical examination and evaluation with initiation of diagnostic treatment program; comprehensive, new patient, one or more visits.

92012 (Ophthalmological services): Medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient.

92014 (Ophthalmological services): Medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits.

Listed above are the codes and their **description**. Earlier in the CPT® manual there is an actual **definition** for comprehensive and intermediate exams. CPT® defines a comprehensive exam as:

". . . includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs."

And CPT®'s definition for intermediate exam:

". . . an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated; may include the use of mydriasis for ophthalmoscopy."

Since CPT® is covered under Health Insurance Portability and Accountability Act (HIPAA), I suspected certain carriers are violating HIPAA by contractually rewriting CPT®'s definition of intermediate and comprehensive exams. Is my suspicion only a suspicion, or are carriers really violating HIPAA?

HIPAA, CPT, & Standards

HIPAA became law in 1996; it was a bipartisan effort to provide portability and reduce administrative costs. There are five titles within HIPAA, three of them yet to be defined. The first title is portability. Portability allows beneficiaries who left employment in a group health insurance to transfer coverage so there would be no lapse in coverage. Title II is called Administrative Simplification, which contains three subcategories: electronic data interchange, privacy, and security. The purpose of

Administrative Simplification is to establish federal regulation and standards for electronic exchange to reduce waste, fraud, and abuses in health care.

A component of Administrative Simplifications called "Health Insurance Reform: Standards for Electronic Transactions," are standards composed of code sets maintained by various entities. The Department of Health and Human Services (HHS) maintains International Classification of Diseases Ninth Revision (ICD-9-CM) Volumes 1, 2, and 3, NDC, and Health Care Financing Administration Common Procedure Coding System (HCPCS). American Dental Association maintains Current Dental Terminology (CDT), and the American Medical Associations (AMA) maintains CPT®.

The CPT® codebook contains much more than just a code set, there are also numerous definitions, conventions, and guidelines. Although HIPAA requires any electronic transaction to use the code sets found in CPT®, there is confusion among providers, carriers, and even auditors on what HIPAA covers.

On August 17th, 2000, a Final Rule for Standards for Electronic Transactions was released. There were many regulations adopted with the final rule. One specific section addressed by the HHS was the elimination for local codes. HHS stated "national codes are only designed to identify an item or service; ...**codes are not established to carry health plan specific information**...such information must be used elsewhere and cannot be embedded in the national codes." Later on in the final rule HHS stated, "when the HIPAA code set standards become effective, these health plans will have to receive and process all standard codes, **without regard to local policies regarding reimbursement for certain conditions or procedures, coverage policies, or need for certain types of information that are part of a standard transaction.**"

Still confused? Michael Miscoe, a current member of the Legal Advisory Board of the American Academy of Professional Coders, explains, "HHS points out the code and description alone are included in the code set. Health plan specific information regarding how and when the code is to be used is not and cannot be included within the code."[1] The American Medical Association (AMA) also describes the HHS not accepting CPT definitions, guidelines, or conventions into HIPAA.[2] Clearly stated by Miscoe and the AMA, HIPAA only covers the code set and description within CPT®. If physicians and carriers are required to only follow code sets and descriptions within CPT, you may ask yourself "what else is required?"

Physicians need to follow certain standards for reimbursements and surviving audits. Miscoe describes two types of standards, persuasive and controlling.[1] Controlling standards are standards you are required to follow. Controlling standards come about by laws or contracts. Besides HIPAA, physicians mostly deal with contracts. Once you sign a contract, you have just signed a type of controlling standard. In courts, controlling standards always trump persuasive standards.

Persuasive standards exist when there are no controlling standards. An example of a persuasive standard is the text incorporated in the CPT® manual other than the code and descriptions. The text is a persuasive standard that may be followed when there is no controlling standard. Many physicians rely on persuasive standards for a basis to select a code, but I emphasize persuasive standards do not need to be followed. Even auditors cannot and should not rely on persuasive standards.

Medical versus Vision

Previously, I've described why carriers are not violating HIPAA due to HIPAA only covering descriptions and not definitions. There is a fundamental question I haven't addressed though, "why are vision insurance companies using medical eye codes?"

I've asked myself many times "is it medical or refractive?" What really is the difference between "refractive" and "medical" codes? The answer…Medicare determined not to accept "refractive" codes because they are not "medical" in nature. I would argue differently.

In the ICD-9 codebook you will find myopia in the disease section not too far away from glaucoma. Is myopia not a disease and medical in nature? Myopia requires a prescription just like glaucoma drops. Even in CPT under ophthalmologic diagnostic and treatment services spectacles are listed as a type of treatment, along with medications, laboratory, and radiological services.

Medicare has led the way for other insurance companies to follow. Most carriers determine what is medical and what is refractive based on Medicare. Even though the government runs Medicare, Medicare is not the law. There are no controlling standards under HIPAA determining myopia is not medical in nature.

Many optometrists bill "refractive" codes with a HCPCS S-codes (S0620 and S0621). S-codes were made to help private insurers report drugs, services, and supplies when no national codes exist. But national codes due exist, the medical eye codes. S-codes should only be used when you cannot meet the requirements of the intermediate and comprehensive exam descriptions. I caution you to read the contracts you have signed because you may be required to use s-codes or evaluation and management codes for a "refractive" diagnosis.

Conclusion

Carriers are not violating HIPAA. HIPAA only covers the codes and their description within CPT® and nothing more. Even copyright laws are not being broken because anyone can interpret the description of a CPT® code and make their own definition of how to interpret the description of the code. Laws change once a physician signs a contract; they are forced to follow the contractual agreement. The contract can require providers to code a certain way, and I can only emphasize the importance reading each contract and following the binding law you have signed.

A recent white paper by the AMA pushes for the CPT guidelines, definitions, and conventions named into HIPAA. AMA argues physicians are losing 14 percent of their total revenue to obtain accurate payment. HIPAA was designed to standardize electronic transactions and health care in general. Is it really standardized though? HHS commented on the Final Rule for Standards for Electronic Transactions in 2000,

> "While operational guidelines or instructions are not included in the concept of a maximum defined data set, we agree that standardization of these code set guidelines is highly desirable and beneficial. We reviewed the available guidelines to determine which should be adopted as implementation specifications and have found that there are also many current practical barriers to achieving such standardization."

Even HHS believes code set guidelines are desirable and beneficial, but they just don't think they are practical. AMA again argues the CPT editorial panel uses the same rigorous standards for code sets and their descriptions as they do for the

guidelines, definitions, and conventions. There is a push for standardization, but until HHS adopts code set guidelines, definitions, and conventions for CPT, physicians must differentiate controlling and persuasive standards.

Physicians do have one choice many are not utilizing. There are no standards requiring eye care physicians to not code "refractive" ICD-9 codes as medical. Myopia can be a natural process making our vision abnormal. Just like myopia, a cataract can be a natural process making our vision abnormal. Medicare will reimburse one but not the other. If Medicare decides to stop reimbursements for cataracts, are you going to start billing cataract patients with S-codes? As a profession we need to value our services that increase the quality of life for our patients.

What does my future look like? I see notebooks of contracts containing different controlling standards by each carrier requiring different exam elements. Ralph Waldo Emerson once said, "There are many things of which a wise man might wish to be ignorant." Four years ago being ignorant was so blissful. Now with the added responsibility of becoming an eye care physician, my ignorance is only unlawful. Following laws can be confusing and eye coding is no different. The future of coding is a dull gray sky, not knowing if the sun will shine or a big storm will emerge. Right now standing in this unknown future of health care one can cut back on the confusion by determining "refractive" codes are medical in nature, and only with the passing of the clouds we will hopefully find true standardization.

REFERENCES

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