Optometric Protocols: Case by Case

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Current Challenges
- Access to patients
- Increasing overhead costs and decreased reimbursement rates
- Third party denials
- Importance of correct coding
- Changing third party environment (HSA’s vs. HMO vs. PPO)
- Working harder for less

Do You Delegate?
- Utilize paraoptometric technicians
- Why Delegate?
  - Increased efficiency
  - Increased profitability
- What tests/jobs can be delegated?
- What should not be delegated?

The Office of the Future
- Efficient
  - Delegate effectively
- Service centric
- Patient centric
  - Medical necessity
- Highly modernized & automated
  - Electronic Medical Records (EMR) and Practice Management Systems (PMS)

Establish Protocols
- Patient work ups
- Additional testing
- Progress checks
- Follow up schedules

Optometric Practices Sources of Revenue

- Contact Lenses: 36%
- Medical Eye Care: 17%
- Prescription Eyewear: 48%
- Other: 2%

Changing third party environment (HSA’s vs. HMO vs. PPO)
**Cross Training Your Staff**

- Front desk
- Technician
- Scribe
- Optician

**Doctor’s Role in Efficiency**

- Time doesn’t make a better doctor
- Do only things that a doctor needs to do
- One pass system
- Importance of scripting
- Never answer questions twice
- Always say Thank You!

**Staff Training**

- Monthly, quarterly, yearly?????
- Where can we improve??
- AOA Paraoptometric Section

**How Do You Implement?**

1st – Decide where you are going to...
2nd – Discuss at Staff Meeting (get buy-in)
3rd – Put a Plan in Place
4th – Execute the Plan

**Staff Meetings**

- Daily huddles
- How are things going within the practice?
- Opportunity to get feedback from the staff
- What’s new in the practice?

**Evidence Based Medicine**

- Be an Investigator...
- What is the best way to treat this condition?
- i.e. RFV or Chief Complaint (cc):
  - If Refractive – generally refractive carrier is responsible (VSP, Vision Plus, etc.)
  - If Medical – generally medical carrier is responsible (UHC, Medical Mutual, etc.)
The RFV / Chief Compliant

- “It should detail the primary reason(s) the patient scheduled the examination. Ideally, it should be recorded in the patient’s own words. The chief complaint also suggests what tests you’ll need to perform and the possible CPT codes to use for the encounter.”

- Note: this could also be “Doctor driven” – tests ordered at completion of last visit.

Medical Necessity

- Definition – “Services or supplies that are proper and needed for the diagnosis and treatment of the patient’s medical condition . . . and aren’t mainly for the convenience of the patient or the physician.”

- www.medicare.gov

Remember...

- Medicare does not intend to pay for:
  - Routine Services
  - Screening for medical conditions

The Medical Model

- Look at your “Business Model”

- Vision Care vs. Medical Care

- Efficiency will be key:
  - Multiple Exam Lanes
  - Instrumentation / Diagnostic equipment
  - Staffing / Scribe
  - Revamp Record Keeping and Billing Systems (e-Rx)
  - Disease Protocols
  - Full-scope Optometry

Medical Necessity

- Ocular surface disease
- Cataract comanagement
- LASIK comanagement
- Glaucoma
- Retina
- Red eyes
- Urgent / Emergency eye care
- On-call services

Implement the Medical Model
Physician Patient Encounter

- Jim, 47yo NP
- IDDM – VSP, UHC
- Poor control
- BS > 200
- Does not check
- Wants new glasses
- (+) Diabetic Ret
- IOP's 23mmHg OU

Establishing the Medical Model

- Patient Forms
- Insurance panels
- Patient questionnaires
- Testing protocols
- Know the treatment algorithms
- Patient education
- Importance of follow up

Physician Patient Encounter

- Jim, 47yo NP IDDM
- Is there a Right or Wrong??

Patient Education

What you told me...

The tests revealed...

I recommend...

Diabetes Protocol

- Billed Vision / Medical for Exam
  - Ordered testing for Diabetic Retinopathy and POAG Suspect
  - Maybe Fundus Photos (92250) to Medical on same day

- Returned 4 wks later for:
  - Office visit / DFE (99—)
  - 24-2 Threshold VF (92083)
  - GDx / OCT (92133)

- Ordered close monitoring – RTC in 6 months for Office visit / DFE, Retinal Photos and Repeat TVF's
**Fundus Photography 92250**
- Fundus photography with interpretation and report
- Bilateral
- MPPR applies

**NP 64 YOAAF – Concerned about Glaucoma / Strong Family history**
- What is your protocol?
- What testing is most important?
- What is your threshold for diagnosis?
- When do you see the patient back?

**Invest in Technology**
- So what should I buy?
  - Does it improve patient care?
  - Does it improve efficiency?
  - Will I get reimbursed for it?
- Consider Contribution Margin
  - Gross Revenue – Variable Costs
  - Gross Revenue

**Glucoma Coding and Billing**
- Ability to practice both primary and medical eye care for your patients
- Practice building opportunity
- “But I don’t see many glaucoma patients”

**Case Example: Glaucoma**

**Glucoma Protocol**
- Do you have a protocol in place?
- Which tests?
- Maximize each patient encounter
**Glaucoma Coding and Billing**

- Office visit plus orders for:
  - 76514  Pachymetry
  - 92083  Extended visual fields
  - 92250  Fundus photos
  - 92135  Optical Coherence Tomography
  - 92020  Gonioscopy
  - 92100  Serial Tonometry

**Allergy Protocol**

- Again, depends on severity...
- Possibly set an appointment just prior to their “allergy season”
- If year round, monitor on a more regular basis:
  - Especially if need corticosteroids at times

**Glaucoma Protocol**

- It on severity depends...
- Order Glaucoma Work-Up:
  - Office Visit, 99 — (IOP’s)
  - 92083 (TVF)
  - 92135 (GDx / OCT)
- Follow-Up in 6 months:
  - Office Visit, 99 — (IOP’s, DFE)
  - 92250 (Fundus Photos)
  - 92020 (Gonioscopy)

**Case Example EP:**

**Susan, 44yo IT Manager, EP**

- Pt here to update CL Rx – vision seems stable, good compliance with monthly soft multifocal CL’s.
- Does get some dryness at the end of the day and occasional tearing OU.
- Ocular / Medical history is negative.
- (+) Family history of glaucoma

**Case Example: Billy, 15 year old, NP**

- Presents with complaints of “burning, itching and redness”; going on for the past 4 weeks, on/off, has not used any eye drops
- Wears glasses full-time, thinks vision has progressively worsened, is considering contact lenses this time.
- Has seasonal ocular allergies – taking Zyrtec
Dry Eye Coding and Billing
- Typical dry eye patient seen at least 5 times during the 1st year and most will have punctal occlusion
- Patients pleased to have a problem addressed that has been overlooked in the past

Don’t Take it Lightly...
- Many eye care professionals have taken a passive approach to ocular surface disease treatment and management
- Studies show that patients expect a focused approach in a similar pattern to other eye diseases
- Patients are leaving practices that do not take ocular surface disease seriously

Dry Eye Protocol
- Initial Exam: KEY = Patient Education – ocular surface disease, chronic problem
  - 375.15 (Dry Eye Syndrome)
  - 370.21 (Keratitis, Superficial Punctate)
  - 370.33 (Keratoconjunctivitis sicca)
  - Reschedule Dry Eye Workup (99xxx)
- VA’s, Slit Lamp with NaFl and Wratten filter (TBUT, Tear prism), Anterior seg photography, Schirmer

Dry Eye Management
- Increased knowledge of ocular surface disease has given us new treatment options
- Outstanding practice building opportunity
- Can result in patient satisfaction, referrals, and practice profitability

Dry Eye Protocol
- Initiate supportive therapy
- Reschedule Progress Check (99xxx) 6-8 wks later:
  - Decide where to go to next
  - Punctal Plugs, Cyclosporine A, Omega-3
Examination Flow – Order Dry Eye Workup

- Clinical history
- Symptom questionnaire
- Tear film break up time
- Ocular surface staining
  - Nall / Lissamine Green
- Schirmer / Red Thread Test
- Lid and meibomian morphology
- MG Expression
- Tear meniscus
- Tear film osmolarity**

Tear Osmolarity 83861

- Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity
- For offices with CLIA Waiver Certificates, Medicare requires the use of a QW modifier when submitting claims.
- When billing for two eyes, code 83861 twice, on two lines, using the RT and LT modifiers

InflammaDry

85% Sensitivity
94% Specificity

Don’t Forget - Punctal Plugs

Punctal Occlusion 68761*

- Closure of the lacrimal punctum; by plug, each
- Global period: 10 days
- Modifiers
  - E1 Left upper
  - E2 Left lower
  - E3 Right upper
  - E4 Right lower
- Supply codes included in procedure code
- MPPR applies
Frequently Asked Questions on Occlusion

- Does Medicare cover plugs?
- What if the plug falls out?
- May we charge for an exam on the same day as the procedure?

Dry Eye Coding and Billing

- Initial NP/EP examination
  - NP $ xxx - xx
- Initial Dx of OSD
- 4-6 wk visit and plugs
  - Level II/III $ xx / xx
  - Level II/III $ xx / xx
- 4 wk follow-up
  - Plugs $ xxx
- 2 month follow-up
  - Level II $ xx
- 4 month follow-up
  - Level II $ xx
  - Level II $ xx
  - Total $ xxx - xxx

Advanced Beneficiary Notice

Importance of the Follow Up Examinations

- Address any unanswered concerns
- Review additional lab/ancillary testing
- Determine if condition is improving/worsening
- Need of modification/additional treatment
- Increased patient compliance
- Malpractice issues

Necessary Documentation

- Not used as initial treatment for dry eyes
- Informed consent
- Operative report
  - Drops used
  - Puncta occluded
  - Brand
  - Size
  - Lot number
- Post-operative instructions

Practice Pearls

- Actively diagnose evaporative and aqueous deficient dry eye
- Develop your protocols for each disease state and its severity respectively
- Prescribe! Prescribe! Prescribe!
- Education patients on acute/chronic nature of disease
Thank You!

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