Insurance, Vision Therapy and Neuro-Optometric Rehabilitation

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COVD Chapter 10 - AOA Document

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New AOA Document

ReApproved 1-29-2019

Vision Therapy and NeuroRehabilitation: Optometric Considerations in Third Party Reimbursement

Why Are We Here?

- Vision Therapy Coding Confusing
- Over $200,000 recoupment in past year
- Nearly $500,000 Audit Currently in Northeast
- OIG Investigation in Southwest

Coding Basics - Don’t Fall Asleep
CPT Procedure Codes
- What You Do

ICD-10 Diagnosis Codes
- What You Find

HCPCS Codes
- What You Supplied

Modifiers
- What's Different

RT/LT - Right Side/Left Side
GA - Wavier of Liability on File
GY - Statutorily excluded procedure
GW - Service unrelated to term condition
GO - Occupational therapy service

Convergence Insufficiency H51.11
Convergence Excess H51.012
Esotropia - H50.011 RET/H50.011 LET
Saccadic Dysfunction H55.81
Pursuit Dysfunction H55.89

Binocular Dysfunction H53.30
Accommodative Insufficiency - H52.523
Developmental Delay Motor - F83
Developmental Delay Language F80.9

92000 Series Ophthalmological Services
99000 Series Evaluation and Management (E/M) Services
96000 Central Nervous System Assessment/Tests
97000 Rehabilitation Codes

Fundamental difference: medical vs. well vision care vs. therapy exams

Chief complaint and detail needed varies
Medical decision making varies
Risk varies – morbidity/mortality
Examination more or less detailed

92000 Series Codes - General Ophthalmologic
Ophthalmological services: medical examination and evaluation, with initiation of diagnostic and treatment program

New Patient (3 year rule)
- 92002 Intermediate examination
- 92004 Comprehensive examination (1 or more visits)
Established Patient
- 92012 Intermediate examination
- 92014 Comprehensive examination (1 or more visits)
92000 Exam Requirements
- History
- Exam components
  - Defined in CPT but not entirely clear
  - Less clearly defined than 99000 codes
  - LOC: Local Carrier Determination (none now)
- Medical decision making

92000 Codes
Special Ophthalmologic Services
Describe services in which a special evaluation of part of the visual system is made, which goes beyond the services, or in which special treatment is given.

Special ophthalmological services may be reported in addition to the general ophthalmological services or evaluation and management services.

92000 Series Codes
- Refraction
- Gonioscopy
- External Ocular Photography*
- Sensorimotor Evaluation*
- Visual Fields*
- Extended Ophthalmoscopy*
- Not a Routine BIO
- Fundus Photography*
- Scanning Laser Technology*
- Color Vision Examination

Hemianopia
- Causes of Hemianopia
  Stroke
  Trauma
  Tumor
  Brain Surgery

Stroke is the most common cause

According to the CDC—every year, there are almost 800,000 people who have a stroke in the US—that means every 40 sec someone is having a stroke

Hemianopia
- The comprehensive eye exam should include:
  - Detailed medical and ocular history especially surrounding the time of VF loss
  - VA testing—show entire chart not just letter
  - EOM/Head Position—move target into VF loss
  - VF testing—check for macular sparing
  - DFE—rule out Retinal Detachment

Hemianopia
- Hemianopia with Macular Sparing-Occlusive Cerebrovascular disease is the most common cause of HH with Macular Sparing (ncbi.nlm.nih.gov)
- Definition: VF loss with the area of central vision present even on the HH side
- Cause—unknown but one hypothesis is may be the dual blood supply to the visual cortex and only one branch was occluded
Hemianopia

- Prism Treatment
- Fresnel prisms - usually used first, if successful use ground in prism for Yoked, or cut Fresnel prism for Sectoral
- Yoked prisms - base to the side of the VF loss
- Sectoral prisms - usually on temporal part of lens and base to the side of VF loss

99000 Codes - Evaluation and Management (E/M) Services

For eye care services, E/M codes identify physician services that cannot be accurately described by 92000 codes

Examination Elements Single System Eye

- Visual acuity
- Confrontation fields
- EOM/alignment
- Conjunctiva
- Adnexa/lacrimal
- Pupils/iris
- IOP
- SLE – cornea/tears
- SLE – ant chamber
- SLE – lens
- DFE – optic nerve
- DFE – posterior seg
- Orientation
- Mood/affect

Consultation Requirements

- Written Referral
- Written Report
- History-Detailed to Complex
- Examination-Detailed to Complex
- Decision Making Component – Initiation of Treatment
- Time Component

Time Documentation

- Time Needs to be on Examination Form
- Counseling/Coordination of Care Needs to be at least 50% of the time spent with patient to utilize
- But E&M already have C/C built in

CMS Policy 2011
- Cigna
- Aetna
- United Healthcare
- Humana

NO MCR ADVANTAGE
**Time to go?**

- Increased Evaluation and Management Level
- Prolonged Service Codes

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**Prolonged Service Codes**

- **99354**
  - Prolonged physician service in the office or other outpatient setting requiring direct (face to face) patient contact beyond the usual service each additional 30 minutes
  - List separately in addition to code for service of other outpatient Evaluation and management Service

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**Prolonged Service Code**

- **99355**
  - Prolonged physician service in the office or other outpatient setting requiring direct (face to face) patient contact beyond the usual service each additional 30 minutes

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**Prolonged Service Code**

- **99358**
  - Prolonged non-face to face
  - Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; each additional 30 minutes

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**Prolonged Service Codes**

- **99359**
  - Prolonged non-face to face
  - Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; each additional 30 minutes

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**Care Plan Oversight Services**

- **99367**
  - Medical team conference with interdiscplinary team of health care professionals, patient and/or family
  - Not present, 30 minutes or more; participation by physician
Visual Orientation/Visual Acuity
- Infants respond to face patterns
- Young children - lights/finger puppets
- Preferential Looking, Lea Chart, Snellen Chart

Pediatric Examination

**HISTORY**
- Purpose of the examination
- Family history and previous eye care
- Prenatal, perinatal, postnatal events
  - Maternal care during pregnancy
  - Term of pregnancy
  - Birthweight: < 5 lb & 8 oz is low
  - Apgar score: > 7 (resist/tone/etc)

**STATISTICS**
- Children under 18 years of age > 26% of US population
- Population underserved for eye and vision care
  - <31% between 6-16 have yearly exams
  - <14% below age 6 have exams

**Recommendations for Exam Frequency**
- 6 months of age: AOA, AAOPhtls, AAP
- 3 years of age
- Before 1st grade
- Every 1-2 years thereafter
  - More frequently if at risk
  - At risk includes prematurity, developmental delay, strabismus, amblyopia

**Vision Disorders in Children**
- Hyperopia: 24.8%
- Astigmatism: 22.5%
- Myopia: 18.4%
- Vergence: 14.3%
- Accommodative: 5.3%
- Strab/Amblyopia: 3.1%
- Retinal Disease: 1.8%
**Visual Acuity Methods**
- Preferential Looking: Teller Acuity Cards
- Face-Dot Test (Richman): Paddles
- Picture Cards
  - LEA apple/house/square/circle
  - Broken Wheel (Richman)
  - Tumbling E
  - Allen Symbols (AO) apple/house/umbrella

**Normal Acuity Development**
- >20/400 birth
- >20/200 3 mos
- >20/100 6 mos
- >20/50 1 yr
- >20/25 9 yrs
- Visual impairment 20/70 or worse in better seeing eye with best correction
- Legally Blind 20/200 or worse in better seeing eye with best correction

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**Testing Methods**
- Forced Choice

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**The Face Dot Test**

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**Landolt C**
- Broken Wheel Test

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**LEA Symbols**
Ocular Motility

- Fixation (blow the light out)
- Pursuits (follow the racecar)
- Nystagmus in primary gaze?
- Nystagmus null point
- Versions-full excursions

Binocular Vision Testing

- Hirschberg corneal light reflexes
- Stereopsis
  - Random dot “E” preferable
- Worth 4 Dot
- Supplemental tests
  - Bruckner test
  - Photorefraction

Eye Movements

- Crossover category between visual efficiency and visual processing
  - Performance tests
    - DEM: Developmental Eye Movement Test
    - TOSWR: Test of Silent Word Reading Fluency
  - Objective Eye Movement Recordings
    - Visagraph/Readalyzer
    - RightEye

Convergence Insufficiency
Convergence Excess

Convergence Testing

- Near Point of Convergence
- Prism Bar Vergence Ranges
- In Phoropter Ranges
**Focusing Problems Accommodative Facility**

- Chalkboard needs to be clear.
- With visual attention directed in the distance.
- Near point is blurry.

**Accommodative Testing**

- +/- Flippers
- Push Up Test

**Accommodation & Vergence**

- Insights from the CITT and CISS particularly with regard to reading.
  - www.aoa.org/documents/PLRG-CI-Card.pdf
- Look at the number of questions in the CISS that pertain to reading.

**Accommodation & Vergence**

- The relationship of CI to attention.
  - 3x greater incidence of ADHD among patients with CI when compared with the incidence of ADHD in the general population, and 3x greater incidence of CI in the ADHD population.

**Side note**

- All these measurements can be used as BASELINE TESTING INFORMATION needed if your patient ever experiences TBI or mTBI (aka CONCUSSION).
- Even if your practice is not focused on Concussion – your comprehensive eye exam already has BASELINE MEASUREMENTS which would be helpful in managing or participating in a concussion case.

**Special Ophthalmological Services**

- 92060
- Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure).
Q. What is a “basic” sensorimotor exam?

- CPT lists basic sensorimotor exam as a required exam element of a comprehensive eye exam (920-4);
- It is an incidental component and not separately reimbursed.
- A quantitative sensorimotor examination, utilizing prisms to measure ocular deviation, is a more extensive exam and may be separately billable.

What is a “basic” sensorimotor exam?

- A basic sensorimotor exam evaluates ocular range of motion to determine if the eyes move together in the various cardinal positions of gaze (12:00, 3:00, 6:00 etc).
- This exam element is commonly noted as ocular motility, or extraocular muscles (EOM), in the chart note. A normal range of motion is often noted as “full” or “within normal limits.”

What is a sensorimotor exam?

- Fundamentally, this test requires the clinician to assess both eyes (i.e., bilateral); it should not be billed per eye. Pertinent diagnoses include but are not limited to: diplopia, exotropia, esotropia, hypertropia and paralytic strabismus.

What is a sensorimotor exam?

- The American Association for Pediatric Ophthalmology and Strabismus (AAPOS) issued a position statement in 1999.
- "Sensorimotor eye exam includes measurement of ocular alignment in more than one field of gaze at distance and/or near, and inclusion of at least one appropriate sensory test in patients who are able to respond.”
- Measuring only primary gaze at distance would not satisfy the requirements. You should include ocular alignment measurements in more than one field of gaze.
**What is a sensorimotor exam?**
- The assessment of sensory function is complementary to the evaluation of the motor function as the term "sensorimotor" implies. It is no less important and an essential part of the service.
- Sensory function testing include Worth 4 dot, Maddox rod, and Bagolini lenses.
- Motor function includes Cover Test, etc.

**How is the sensorimotor exam documented in the patient's medical record?**
- An order for the test should be noted in the chart.
- Test results for motor function are typically documented in a "tic-tac-toe" format to represent different fields of gaze. Results of the sensory function test are noted, too.
- Examiners note what type of stereopsis test was used and the score that the patient received.
- A positive stereo test on a nonverbal patient might be represented by the patient's attempt to touch or pick up the fly's wings. Results of a Worth 4 dot often note which lights were seen.
- An interpretation of the test results and the effect on the patient's condition and course of treatment satisfy the interpretation requirements.

**How is the sensorimotor exam documented in the patient's medical record?**
- Take care that the notations for the test are clearly identifiable and distinct from the office visit notes (e.g., stamp, boxed entry, separate page, etc.).
- Repeated testing is indicated when medically necessary for new symptoms, disease progression, new findings, unreliable prior results or a change in the treatment plan. In general, additional testing is warranted when the information garnered from the eye exam is insufficient to adequately assess the patient's disease.

**Effect of Lenses**

**Refraction-92015**
- Determination of refractive state
- Statutorily not covered by Medicare but is included in many medical plans
- RVU $38.09
- Consider Modifiers

**Refraction 92015**
- If a Non-Covered Service
- Patient Responsibility
- ABN Not Required but Useful
- GY Modifier
- GA Modifier
- 22 Modifier
- Multilevel Refraction Codes 92015
- Phoropter
- Trial Frame
- Cycloplegia
Developmental Disorders
- Cerebral Palsy: motor disorder with high prevalence of refractive error & strabismus
- Down Syndrome: cognitive disorder with high prevalence of refractive error & strabismus
- PDD: Pervasive Developmental Disorder
  - Autistic spectrum
  - May be high functioning (Asperger’s)
  - Poor eye contact/social/emotional

AOA Clinical Practice Guidelines
- http://aoa.org/x4816.xml
  - CPG 20: Care of the Patient with Learning Related Vision Problems
  - The full clinical practice guidelines
- http://aoa.org/x6388.xml
  - QRG 20: Care of the Patient with Learning Related Vision Problems
  - A quick reference guide

Rationale
- Optometry has a long history of caring for learning based vision problems
- Doctors of Optometry function as members of a multidisciplinary team of health care practitioners and special education professionals in the comprehensive care of individuals with learning problems

Epidemiology
- 15-20% of individuals with learning disabilities have problems with visual efficiency
- At least 20% of individuals with learning disabilities are thought to have a prominent visual processing deficit

Two Broad Categories
- Visual efficiency
  - Visual acuity, refractive profile, accommodation, vergence, motility
- Visual information processing
  - Brain based components of visual perception and cognition and their integration with motor, auditory, language and attention systems

Visual Efficiency
- Visual acuity
  - Understanding how amblyopia can serve as a developmental model of learning disabilities
  - The concept of crowding reflected in what happens to print and children progress through elementary school years
Visual Information Processing
- General Considerations in Evaluation
- Quantitative vs. qualitative assessment
- Standardized testing
- Quiet environment
- Observational insights
- Attention to the task
- Cognitive style
- Motor overflow
- Frustration tolerance

Visual Spatial Orientation
- Bilateral Integration
  - Body knowledge and control
    - Standing balance eyes open vs. eyes closed
    - chalkboard circles
  - Laterality/Directionality
    - Feget L/R awareness
    - Gardner Reversal Frequency
    - Jordan L/R reversal

Visual Analysis Skills
- TVPS-4: Test of Visual Perceptual Skills, 3rd edition
- Visual memory
- Visual sequential memory
- Visual discrimination
- Form constancy
- Spatial relations
- Figure-ground
- Visual closure

Vision & Learning Problems
- >5% of children have LD
- >75% LD children have RD
- >15% of LD children have problems in visual efficiency (oculomotor)
- >20% of LD children have problems in visual processing (perceptual)

Ocular Health - Anterior
- Red reflex (check for leukocoria)
- Pupils (check: anisocoria/lens anomalies)
- miosis at birth normal size at 6 months
- Cornea (check for clarity)
- Dystrophopterygostatization
- Conjunctiva
- bulb (Bacterial?/purpural/Allergic?)
- Lids (check for ptosis)
- Lens: cataract - congenital v. acquired
- IOP avg: 15mm (adult like by age 10)

Ocular Health - Posterior
- ROP (Retinopathy of Prematurity)
- Low birthweight exacerbated by O2
- Neonatal ICUs saving more preemies
- Ocular albinism
- Congenital (+/- in cases of nystagmus)
- Optic nerve
- Atrophy (genetic, endocrine, diabetes, CP)
Central Nervous System Assessments/Tests (eg, Neuro-Cognitive, Mental Status)

96101

Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg. MMPI, Rorschach, WAIS), per hour of the psychologist’s or physician’s time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report.

Central Nervous System Assessments/Tests (eg, Neuro-Cognitive, Mental Status) Tests

96110

Developmental testing; limited (eg. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report

96113 - DELETED 2019

Extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

Central Nervous System Assessments/Tests (eg, Neuro-Cognitive, Mental Status) Tests

96112 (NEW 2019)

Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

Central Nervous System Assessments/Tests (eg, Neuro-Cognitive, Mental Status) Tests

96113 (NEW 2019)

Developmental test administration; additional 30 minutes (List separately in addition to code for primary procedure)
What is Code for VT?

92065
AMA (CPT®) coding perspective
- reported for each individual training session provided by the physician.
- physician prescribes exercises to correct ocular problems (e.g., ocular motor misalignment).
- physician trains the patient to perform therapeutic exercises to correct the misalignment.
- no specific time allotted to the procedure by CPT®.

92065 Supervision Guidelines-CMS Level 1
General supervision means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

92499
Unlisted ophthalmological service or procedure—Physicians may use this code to report services that have not been given a more specific code by CPT®. However, insurers are likely to reject claims for services reported with 92499 and/or request further clarification and supporting documentation relative to the services provided.

99199
Unlisted Procedure, Service or Report
Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
Concussion

Most Common Vision Problems:
- Binocular Vision Disorders
- Convergence Insufficiency
- Accommodative Insufficiency
- Eye Movement Disorders
- Glare and Balance Issues

Concussion

The comprehensive eye exam should include:
- Detailed medical and ocular history especially surrounding the time of the concussion
- VA testing
- Pupil testing
- EOM testing

Concussion

Additional testing should include:
- Accommodative testing
- Binocular Vision testing
- Refraction
- Visual Field testing
- Dilated Fundus Exam

Concussion

Rehabilitation Team:
- Optometrist
- Occupational Therapists
- Speech & Language Pathologists
- Physical Therapists
- Ophthalmologists
- Other Physicians

Concussion

Optometric Management includes:
- Treatment of ocular injury
- Treatment of visual dysfunction (lenses, prisms, filters, etc)
- Offering Vision Therapy, Low Vision Services, etc.

Central Nervous System Assessments/Tests (eg, Neuro-Cognitive, Mental Status)

96116 updated 2019 wording

Neurobehavioral status examination (clinical assessment of thinking, reasoning and judgment, (eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities)), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
Central Nervous System Assessments/Tests (e.g., Neuro-Cognitive, Mental Status)

- 96125
- Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of qualified health care professional’s time; both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

Required Documentation for Rehabilitation

- Physician Prescription for Rehabilitation
- Initial Evaluation and Plan of Care
- Daily Progress Notes
- Monthly Progress Notes
- Discharge Summary

Duration and Frequency of Visits

- Estimated Length of Session
  - 30 Minutes usual (up to 2 hours)
- Estimated Frequency of Treatment
  - 2 times per week usual (can be less)

Physical Medicine and Rehabilitation Codes for Vision Therapy

- Documentation for provision of vision therapy should be identified in the indications section of the chart. Once they are established, an INDIVIDUAL REHABILITATION PLAN (IRP) must be entered into the patient’s record. Minimum documentation requirements in the IRP and sessions executing the plan

Physical Medicine and Rehabilitation Codes for Vision Therapy - Documentation

1. Patient's perceptions of visual function and measures of health related quality of life (HRQOL).
2. During execution of the treatment plan, the progress should be documented.

3. Specific goals based upon answers the patient has provided to questions about concerns; for example “to increase reading speed to 100 words per minute”.

4. A description of the method which will be employed to achieve each goal should be in the treatment plan.
Physical Medicine and Rehabilitation Codes for Vision Therapy

5. Quantitative measurements of current performance measurements at each session should be compared to baseline performance measurements. A treatment plan may call for achieving goals in a sequential manner.

6. Sufficient time between visits is necessary for the patient to apply vision training to their activities of daily living. The vision specialist can assess the patient’s improvement following practice by the patient with techniques to maximize performance. This may require periods of at least two (2) to five (5) days between visits.

Physical Medicine and Rehabilitation Codes for Vision Therapy

7. When there is no progress in a quantitative measurement of performance on two occasions following the maximal measure of performance, subsequent treatment for that goal will be considered maintenance and will be considered by most insurers to be a non-covered benefit, payable by the patient.

8. A written progress report of each session is a required element of E&M service, and should identify changes in goals, therapy schedules, or treatment plan.

Did you get that?

Physical Medicine and Rehabilitation Codes for Vision Therapy

9. Each session using a service whose definition includes specific time requirements, either therapeutic procedures or prolonged services, must have the face-to-face time between the patient and physician or licensed practitioner documented in the medical record. Units are calculated as described in prolonged services. In the case of therapeutic services, 97530, 90575, and 97533 a minimum of 15 minutes of face-to-face time for each unit of service must be billed. If less than 15 minutes of therapeutic procedure time is involved no therapeutic service may be billed. If less than 30 minutes of a therapeutic service code face-to-face time is recorded only one unit may be billed. Three units of therapeutic service require 45 to 60 minutes of face-to-face time.

Third Party Reimbursement

Insurance Pays for Functional Activities as they Relate to Activities of Daily Living.

Physical Medicine and Rehabilitation Codes for Vision Therapy

CPT® Defines Rehabilitation as “A manner of effecting change through the application of clinical skills &/or services that attempt to improve function.”
**Physical Medicine Codes**
- State Board Limitations
- Third Party Limitations: WPS Medicare (xray/labs/DMEPOS)
- CMS Approved Codes for Rehab
  - 97112: Neuromuscular Reeducation
  - 97530: Functional Performance Therapy
  - 97532: Cognitive Skills Therapy
  - 97127: Development of cognitive skills
  - 97533: Sensory Processing Therapy

**97XXX Supervision CMS**
- The physician or therapist is required to have direct (one on one) patient contact. This does not usually allow for “incident to” billing. Furthermore, documentation guidelines are very specific and fairly complex.

**Therapeutic procedures**
- In order for therapeutic activities to be covered, all of the following requirements must be met:
  - The patient has a condition for which therapeutic activities can reasonably be expected to restore or improve functioning and
  - The patient's condition is such that he/she is unable to perform therapeutic activities except under the direct supervision of a clinician
  - There is a clear correlation between the type of exercise performed and the patient's underlying functional deficit(s) for which the therapeutic activities were prescribed.

**Therapeutic Procedure-97110**
- Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

**Neuromuscular Re-education 97112**
- This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception.
- Eccentric Fixation Training

**Gait Training-97116**
- Therapeutic Activity-gait training (includes stair climbing)
**Group Therapy-97150**

- Therapeutic procedure(s), group (2 or more individuals)
  - (Report 97530 for each member of group)
- (Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist)

**Functional Performance 97530**

- This procedure involves the use of functional activities to improve functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance, or coordination. They require the skills of a clinician and are designed to address a specific functional need of the patient.

**Cognitive skills therapy-97532**

- This code describes interventions used to enhance cognitive skills (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one on one) patient contact.

**Cognitive skills therapy-97157**

- Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one on one) patient contact.

**Cognitive skills therapy-G0515**

- Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes

**Sensory integrative therapy 97533**

- This activity focuses on sensory integrative techniques to enhance sensory processing and to promote adaptive responses to environmental demands, with direct (one-on-one) patient contact by the clinician.
**CMS-Modifier GO**
- Services delivered under an outpatient occupational therapy plan of care
- GO therapy modifiers are required to be appended to therapy services
- Contractors shall ensure that there is at least one claim-level referring provider identified

**Therapy Thresholds**
- Section 415(c) requires financial limitations to all outpatient rehabilitation services.
- No payment for over the threshold
- Existed since 1999
- $2040 for 2019
- Occupational Therapy
- Physical Therapy/Speech Language Therapy Combined

**CMS-Modifier KX**
- Provider attests that the services are
- Reasonable and Necessary
- Documented medical necessity in the record

**In 2019-No Limits**
- Therapy caps repealed by the 2018 federal budget
- Still need to submit a KX modifier on claims
- Attestation of medical necessity
- Denied for noncompliance

**DON’T GO THERE?**
**Special Otorhinolaryngologic Services**
- Vestibular Function Tests, with Observation and Eval by Physician, w/o Electrical Recording
- 90651 Spontaneous nystagmus, including gaze
- 90654 Positional nystagmus test
- 90654 Optokinetic nystagmus test

**DON’T GO HERE EITHER?**
<table>
<thead>
<tr>
<th>Vestibular Function Tests, with Recording (e.g., ENG, PENC), and Medical Diagnostic</th>
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<tbody>
<tr>
<td>90541 Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording</td>
</tr>
<tr>
<td>90568 Positional nystagmus test, minimum of 4 positions, with recording (California Post Rotary Nystagmus)</td>
</tr>
<tr>
<td>90564 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording</td>
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<tr>
<td>90555 Oscillating tracking test, with recording</td>
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</tbody>
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2/10/19
Strike Three

A9270-HCPCS “Non-Covered Item or Service”
CMS 2001 Policy
| Only for use on bills submitted by DMEPOS supplier

REMEMBER-
Just because you got paid

SHOW ME THE
MONEY!!!!!!!