# Ophthalmology Coding Compliance Plan Table Of Contents

1. Coding Compliance Program at OPHTHALMOLOGY CLINIC .................................................. 2
   I. Policy Statement .............................................................................................................. 2
   II. Code of Conduct .......................................................................................................... 2
   III. Methods of Distribution ............................................................................................. 2
   IV. Coding Compliance Plan versus Corporate Compliance Plan ................................... 3
2. Coding Compliance Officer (CCO): ................................................................................... 4
   I. Responsibilities ............................................................................................................ 4
   II. Ophthalmology Clinic Coding Compliance Team ....................................................... 4
3. Training and Education ..................................................................................................... 5
4. Implementation and Scope (Process) .................................................................................. 8
   I. Coding Process ........................................................................................................... 8
   II. Periodic Documentation and Coding Audits ................................................................. 8
   III. Minimum Documentation Requirements .................................................................... 8
   IV. Coding/Provider Feedback .......................................................................................... 8
   V. Internal Audits ............................................................................................................ 9
5. Audit/Review of Coding .................................................................................................... 9
   I. Formal Auditing and Monitoring ................................................................................. 11
   II. Lines of Communication ............................................................................................ 14
6. Corrective Procedures ...................................................................................................... 15
   I. Disciplinary Actions .................................................................................................... 16
7. Correction of Identified Problems .................................................................................... 17
8. Appendix 1 Ophthalmology Coding Guidelines ................................................................. 18
9. Procedures Paid as Bilateral (Code = 2) ........................................................................... 24
   92015 Refraction ............................................................................................................ 25
   Appendix 2 ................................................................................................................... 26
10. Appendix 2 .................................................................................................................... 28
    I. Outpatient Coding ...................................................................................................... 29
    II. E & M Coding ........................................................................................................... 30
    III. Surgical Coding ...................................................................................................... 30
11. Appendix 3 ....................................................................................................................... 32
    I. Coding Resources ...................................................................................................... 32
12. Appendix 4 ....................................................................................................................... 33
    I. Coding Compliance Plan Flowchart ......................................................................... 33
13. Appendix 5 – Illegal Medical Acronyms .......................................................................... 34
14. Appendix 6 Coding Compliance Plan Flowchart .............................................................. 35
15. Appendix 7 Coding Training Plan Flowchart .................................................................. 36
1. Coding Compliance Program at OPHTHALMOLOGY CLINIC

I. Policy Statement

Employees must be cognizant of all applicable federal and state laws and regulations that apply to and impact upon Ophthalmology Clinic’s documentation, coding, billing and competitive practices, as well as the day to day activities of Ophthalmology Clinic and its employees and agents. Each employee who is materially involved in any of Ophthalmology Clinic’s documentation, coding, billing or competitive practices has an obligation to familiarize himself or herself with all such applicable laws and regulations and to adhere in all respects to the requirements thereof. Where any question or uncertainty regarding the requirements exists, it is incumbent upon, and the obligation of, each employee to seek guidance from the Coding Compliance Officer or the attorney for Ophthalmology Clinic.

II. Code of Conduct

Ophthalmology Clinic has a policy of maintaining the highest level of professional and ethical standards in the conduct of its business. Ophthalmology Clinic places the highest importance upon its reputation for honesty, integrity and high ethical standards. This Policy Statement is a reaffirmation of the importance of the highest level of ethical conduct and standards.

These standards can only be achieved and maintained through the actions and conduct of all personnel of Ophthalmology Clinic. Each and every employee, including management employees of Ophthalmology Clinic, is obligated to conduct himself/herself in a manner to ensure the maintenance of these standards. Such actions and conduct will be important factors in evaluating an employee's judgment and competence, and an important element in the evaluation of an employee for raises and for promotion. Employees who ignore or disregard the principles of this Policy will be subject to appropriate disciplinary actions.

III. Methods of Distribution

All applicable OPHTHALMOLOGY CLINIC employees shall receive a copy of the Coding Compliance Plan and conduct themselves accordingly. This plan will be available and updated on a continual basis on a server on the Ophthalmology Clinic Intranet. Updates to the Coding Compliance Plan will be e-mailed to all appropriate employees.
IV. Coding Compliance Plan versus a Corporate Compliance Plan

This Coding Compliance Plan should be considered a component of an overall Corporate Compliance Plan, which should include but not be limited to the following:

I. HIPAA (Health Insurance Portability and Accountability Act of 1996) Guidelines
II. OSHA (Occupational Safety & Health Administration) Guidelines
III. CLIA (Clinical Laboratory Improvement Act/Amendment) Guidelines
IV. EMTALA (Emergency Medical Treatment and Active Labor Act)
V. Stark II laws (ban on physician self-referral)
VI. Other regulatory and governmental compliance guidelines that may apply to Ophthalmology Clinic.

Note: There is overlap between HIPAA compliance, Medical Records compliance and the coding and documentation compliance. An example would be requiring the provider’s signature on all progress notes and operative reports. Open lines of communication should be established between these three compliance entities.
2. Coding Compliance Officer (CCO):

I. Responsibilities:

The Coding Compliance Officer is responsible for developing the coding compliance policies and standards, overseeing and monitoring the compliance activities, and achieving and maintaining coding compliance. Responsibilities and duties of the CCO include:

A. Assure that up-to-date, comprehensive internal policies and procedures for coding and billing are developed and maintained.
B. Responsible for assuring consistent coding practices throughout Ophthalmology Clinic departments.
C. Responsible for ensuring appropriate ongoing education for all coding employees including coding compliance issues.
D. Responsible for regularly updating education for all coding employees as standards change.
E. Responsible for monitoring the documentation supporting the medical necessity of services provided by the clinics.
F. Assure that all personnel are familiar with Medicare medical necessity guidelines.
G. Responsible for monitoring that all clinics maintain signed Physician Acknowledgement Forms.
H. Thoroughly analyze coding consultants' recommendations before implementing them.
I. Periodically compare Clinic's evaluation and management code usage with others in the same specialty and region (Utilization Review Analysis).
J. Participate in the reimbursement process as a participant in the Reimbursement Committee Meeting.
K. Periodically examine organizational data over the past several years to determine inconsistencies.
L. Ensure that all records required by Federal or State law or by the compliance plan are created and maintained.
M. Assure that evaluations of managers and supervisors include a component requiring the promotion and adherence to coding compliance.
N. Maintain the confidentiality of any person reporting potential areas of concern and assure that no recriminating acts shall be taken.
O. Responsible for initiating corrective action to improve compliance processes
P. Establish minimum competency education requirements for all coders.

II. Ophthalmology Clinic Coding Compliance Team

CFO / Corporate Compliance Officer
Coding Compliance Officer
Medical Director
Attorney
Coder Supervisor
Director of Medical Records
Physician Specialties Team
3. Training and Education

Obtain the Coding Department’s education and training schedule for the current year.

I. In order to create and maintain a culture of compliance, Ophthalmology Clinic shall provide initial and continuing education for both its physicians and employees on all matters set forth in the Coding Compliance Plan. Participation in educational programs set forth in the Coding Compliance Plan shall be a condition of employment with Ophthalmology Clinic and all new employees will be trained within sixty (60) days of beginning employment. New billing and coding employees will work under the supervision of an experienced employee until their initial training has been completed. The OIG recommends a minimum of one hour annually for basic training in compliance areas. Additional training shall be provided for specialty fields such as claims development and billing.

II. **Training Methods**: Ophthalmology Clinic will use a variety of methods to train and educate its employees, including in-person sessions, distribution of newsletters, posting information on bulletin boards, and online training via the Internet. In establishing educational objectives for current and future employees, Ophthalmology Clinic will determine: (1) Who needs training—both in coding and billing and compliance; (2) The type of training that best suits Ophthalmology Clinic's needs (e.g., seminars, in-service training, self-study or other programs); and (3) When the education is needed and how much each person should receive.

III. **Coding Compliance Training**: Training will be provided on both an initial and recurrent basis. This will include information on the compliance program itself and applicable statutes and regulations. The educational programs provided by Ophthalmology Clinic should include:

a. An overview of this Plan with specific instruction on the disclosure and reporting mechanisms for infractions.

b. An overview of state and federal laws relating to billing practices, including submitting a claim for physician services when rendered by a non-physician (under "incident to" supervision and physical present requirements); signing a form for a physician without a physician's authorization; altering medical records after the fact; and proper documentation of services rendered.

c. Training regarding the role of each employee and the consequences of violating the policies; and:

d. (g) Training regarding key areas as specified in the OIG guidance and areas of particular OIG interest.

IV. **Coding and Billing Training**: Individuals who are directly involved with billing, coding or other aspects of the Federal health care programs will receive extensive training specific to their responsibilities. Ophthalmology Clinic will ensure that updated ICD-9, HCPCS and CPT© manuals (in addition to the carrier bulletins construing those sources) are available to those employees involved in the billing process. Continuous updates on current billing policies will also be readily available.
As appropriate for the individual the coding and documentation training will include:

1. Coding requirements;
2. Claim development and submission processes;
3. Marketing practices that reflect current legal and program standards;
4. The ramifications of submitting a claim for physician services when rendered by a non-physician;
5. Signing a form for the physician without the physician's authorization;
6. The ramifications of altering medical records;
7. Proper documentation of services rendered;
8. How to report misconduct;
9. Proper billing standards and procedures to submit all accurate bills for services or items rendered to Federal health care program beneficiaries;
10. The personal obligation of each person involved in the billing process to ensure claims are properly and accurately submitted;
11. The legal sanctions for submitting deliberately false or reckless billings; and informing physicians that they cannot receive payment or any type of incentive to induce referrals and that claims should not be submitted for physician services when those services are rendered by a non-physician unless they follow the applicable Federal health care program requirements.

V. Documentation. The Coding Compliance Officer shall maintain documentation of all educational activities, including record of dates, times, attendance, and agenda for all professional and compliance training sessions in which Ophthalmology Clinic personnel (both coders and providers) participate.

VI. Compliance Reference Materials. The Coding Compliance Officer shall maintain a library of regulatory and compliance-related information and training manuals. This information includes coding references, carrier newsletters, Medicare manuals, federal regulations, CMS interpretations, and materials published by the American Medical Association. Specialty medical associations and other relevant professional societies. The Coding Compliance Officer is also responsible for regularly disseminating new compliance information to Ophthalmology Clinic physicians and employees.

VII. Outline and document all employee education pertaining to coding, documentation and compliance:
1. Training for Providers
2. Training for Coding Staff
3. Training for Medical Specialties
4. Training for New Employees (provider, coding and billing)
IX. Obtain a list of all employees with coding responsibilities, select a sample, and perform the following:

   a. Trace back to written documentation that the employee has attended compliance education and training.
   b. Review Compliance training materials and verify that the material emphasizes the Organization Commitment to:
      a. Comply with all laws, regulations and guidelines of Federal and State programs.
      b. Covers the coding compliance policies.
      c. Reinforces the fact that strict compliance with the law and coding policies is a condition of employment.
      d. Informs employees that failure to comply with the law and the Coding policies may result in disciplinary action, including termination.
   e. Inform employees that appropriate disciplinary action up to and including termination for failure to report a potential violation by another employee, supervisor or outside contractor or provider.
   f. Review coding errors for the current year. Verify that the clinics has reviewed its practice covering this, has taken appropriate action if needed, and made employees aware of any potential problems.
   g. Based on Federal and State law and the compliance policies and procedures, select a sample of records and verify that the records are created and maintained in accordance with Federal and State law and by the compliance policies and procedures.
4. Implementation and Scope (Processes)

I. Coding Process Controls
Process controls shall be instituted to establish responsibility and accountability among departments. Quality controls and feedback mechanisms shall be developed to help identify coding and documentation problems and correct them in a timely manner. This is an ongoing and iterative process.

II. Periodic Documentation and Coding Audits
Audits should be conducted to ensure the accuracy of clinical documentation, coding assignments. Audits should be scientifically designed to provide reliable assessments of coding and practice and should encompass both hospital and outpatient settings for inpatient and outpatient reimbursement. The Outpatient Reimbursement Coordinator shall be responsible for designing and conducting these audits.

III. Minimum Documentation Requirements
Minimum documentation requirements will be established for all provider documentation.

Examples include:

All progress notes/operative reports will be signed and dated.

Personal, Family, Social History must be updated annually on a master document in the medical record. Each encounter should refer back to this document, and the provider should note that he/she asked the patient if there were any relevant changes to PFSH and document them accordingly.

All progress notes coded for Evaluation and Management Services will have at least 2 Review of Systems documented and reviewed by the Physician. Note that negative or normal elements count toward the total.

Providers should not copy Review of Systems, Exam or Consultation or Coordination of Care notes from one date of service to another. Any counseling or discussion with the patient should be personalized for each individual visit.

For all procedures requiring an interpretation and report, an interpretation and report must be documented in the medical record. Failure to include the proper documentation will result in disciplinary action.

IV. Coding/Provider Feedback
Feedback concerning proper documentation and coding should be documented and provided to each physician on a periodic basis. This information will be stored in both a paper and electronic form for retrieval by the Coding Compliance Officer on an as-needed basis.
V. Internal Audits
The Outpatient Reimbursement Coordinator will perform regular, periodic compliance audits of the “coding processes”. These audits will be designated to monitor compliance with the coding compliance policies, compliance plan, and all applicable Federal and State laws.

Coding Compliance audits will be conducted in accordance with the following pre-established audit procedures:

a) Review the Coding Compliance Plan's written policies and procedures for completeness. Verify the following issues are adequately addressed:
   i) Coding practices
   ii) Medical record retention
   iii) Educating and training personnel on the coding process
   iv) Coding Compliance Officer responsibilities
   v) Disciplinary action with respect to compliance adherence
   vi) Corrective actions (Training)
   vii) Performance evaluation with respect to compliance adherence
   viii) Minimum coding education requirements for all coding personnel
   ix) Method established for documenting continuing education.

VI. Identification Coding Compliance Responsibilities:
   i. Departmental Managers
   ii. Providers
   iii. Coding department
   iv. Billing department
   v. Outsourced Coding (surgical procedures)

VII. The Coding Compliance Officer should determine how coders:
   i) Determine the code selection made.
   ii) Their understanding of accurate coding versus "up coding"
   iii) Who they call for coding assistance.
   iv) Who reviews their coding assignments.

VIII. Periodic Review of Personnel Records for Compliance.
Select, at least once per year, a sample of employees who have coding responsibilities and obtain their Human Resources records. Review those records for the following:

   a. Level of coding education.
   b. Level of current continuing education on coding.
   c. Verify form signed by employee stating they understand the organization's coding policies and procedures.
   d. Verify job description and evaluation includes that employees are accountable for the quality of their work.
IX. Review a sample of coded material and verify that:

- a. Coding is standardized throughout the organization.
- b. Codes are supported by medical necessity and the appropriate documentation is present to support a code.
- c. All procedures, tests, and services have an appropriate order in the medical record.
- d. The code applied is the most appropriate and specific code.
- e. Billing has occurred for appropriately coded material and no billing has occurred for inappropriately coded material.
- f. Corrective action has been taken and documented when inappropriate coding has occurred.
- g. Review plan for ongoing monitoring of the coding process.

X. Compliance is a Required Component Of Performance Evaluation.
Verify that the promotion of and adherence to compliance is an element in evaluating the performance of Managers and Supervisors.

Work with Human Resources and ensure that all job descriptions include a phrase requiring strict adherence to all Compliance Guidelines.

XI. Data Mine historical ICD-9 and CPT codes for problems

Every six months obtain a list of the top 50 ICD-9 and CPT codes reported by Ophthalmology Clinic.

Analyze high-dollar, complex surgical or diagnostic procedures for documentation and coding accuracy.

Analyze the ICD-9 codes for unspecified codes. See the Appendix for a list of specific Examples
5. Audit/Review of Coding

Auditing, Monitoring and Internal Reporting and Disclosure

In order to detect noncompliance with the Coding Compliance Plan, Ophthalmology Clinic shall use a system of periodic monitoring and auditing of the business activities of Ophthalmology Clinic. Further, all Ophthalmology Clinic personnel shall be required to report incidents of violations of this Plan and shall be subject to disciplinary action for failure to report any such incident.

I. Formal Auditing and Monitoring

The Coding Compliance Officer shall be responsible for the coordination of formal audits. Audits may be performed by internal or external auditors with expertise in federal and state health care statutes, regulations, and policies. The auditor shall be independent of Ophthalmology Clinic's physicians and management and have broad access to records and personnel. In the event Ophthalmology Clinic uses a Third Party Billing Company; Ophthalmology Clinic shall require any Third Party Company to participate in any audit.

(a) Initial Audit. Shortly after this Plan is established, Ophthalmology Clinic shall conduct a comprehensive initial audit of 1) all of Ophthalmology Clinic's business arrangements and agreements with third parties and 2) its claims submission process. The initial audit is undertaken at the request of and under the supervision of legal counsel. The purpose of the initial audit is to initially identify and subsequently correct any existing problems in Ophthalmology Clinic's business arrangements and billing, coding, and claims submission process. Any information that is identified shall be referred to the Coding Compliance Officer who shall in turn consult with legal counsel for appropriate investigation and action.

(b) Baseline Audit. This initial audit shall establish a baseline against which to measure progress. Included in this baseline audit should be an examination of the claim development and submission process, from patient intake through claim submission and payment, and identify elements within this process that may contribute to non-compliance or that may need to be the focus for improving execution. This audit should establish a methodology for examining records and this methodology should serve as a basis for future audits. It should be conducted based on claims submitted during the initial three (3) months after the implementation of the education and training program so as to give Ophthalmology Clinic a benchmark against which to measure future compliance effectiveness.
(c) **Periodic Audits.** On a periodic basis as determined by the Coding Compliance Officer, but no less than once a year, Ophthalmology Clinic shall conduct random audits to ensure claims processing accuracy and Plan compliance. A randomly selected number of medical records should be reviewed to ensure that the coding was performed accurately. A minimum of two to five medical records per payer, or five to ten medical records per physician should be reviewed if problems are identified, focused review should be conducted more frequently through the informal audit process. When audit results reveal areas needing additional information or education of employees and physicians, these areas will be incorporated into the training and educational system. Periodic audits could include the following:

i. A valid sample of Ophthalmology Clinic's top ten denials, or Ophthalmology Clinic's top ten services provided; 
ii. A review of Ophthalmology Clinic's use of specific ICD-9 codes, as some ICD-9 codes are too general for "reasonable and necessary" purposes; 
iii. A check for medication errors are written and signed by a physician; 
iv. A check for reasonable and necessary services provided; and 
v. A review of assigned codes and modifiers to the claims.

(d) **Claims Submission Audit.** Bills and medical records will be reviewed for compliance with applicable coding, billing and documentation requirements. The person in charge of billing compliance and a medically trained person (e.g., registered nurse or a physician) should be involved in these audits. Ophthalmology Clinic will determine whether to review the claims retrospectively or concurrently with the claims submission. The formal audit referred to above should be used as a baseline so that Ophthalmology Clinic can evaluate its progress in reducing or eliminating potential areas of vulnerability. These self-audits will be used to determine whether:

i. Bills are accurately coded and accurately reflect the services provided; 
ii. Services or items provided are reasonable and necessary; 
iii. Any incentives for unnecessary services exist; and 
iv. Medical records contain sufficient documentation to support the charge. 

iv. One of the most important elements of a successful billing compliance program is appropriate action when Ophthalmology Clinic identifies a problem in its internal audit. 

v. Proposed action will be taken in accordance with OPHTHALMOLOGY CLINIC Compliance Plan Policies below.

(e) **Disclosure of Audit Results.** The Coding Compliance Officer shall report the Board of Directors of Ophthalmology Clinic the results of any audit. The Coding Compliance Officer, in consultation with legal counsel, shall determine whether corrective action is necessary. Legal counsel will advise on matters of attorney/client privilege, disclosure, and whether Ophthalmology Clinic has any affirmative duties to report the violations and/or make restitution to health care payor.
(f) **Documentation.** All efforts to comply with applicable statutes and regulations shall be documented, including the fact that an audit has taken place and a description of the nature and results of the audit. Any inquiries Ophthalmology Clinic makes of third party payors or Medicare carriers regarding the claim submission process shall be documented if Ophthalmology Clinic intends to rely on the guidance provided by any such third party payor or Medicare carrier.

(g) **Informal Audits and Monitoring.** Ophthalmology Clinic will develop an ongoing evaluation process to ensure a successful evaluation program. The Coding Compliance Officer will periodically review the policies and procedures to be sure they are current and complete. If they are ineffective or outdated, the Coding Compliance Officer will determine whether to modify them or, where appropriate, to change them. The Coding Compliance Officer will ensure, where appropriate, that changes in the CPT® codes or Government regulations are reflected in them.

(h) **Audit Report.** A written audit report will be issued at the end of each compliance audit, which will be submitted to the Corporate Compliance Committee. The audit reports will identify areas where corrective actions are needed. Each audit will perform follow-up audits to monitor corrective actions to ensure that the committee have been implemented and are functioning as intended.

The format of the annual Audit Report shall be as follows:

- **Up-Coded Progress Notes**
- **Down-Coded Progress Notes**
- **ROS incorrect**
- **Exam incorrect**
- **Signature not on form**
- **Cloned Note**
- **ICD-9 problem**
- **Modifier problem**
- **Progress Note Correct**

**Other Items of Interest:**

- Dilation not performed for a Comprehensive Eye Exam
- External Ocular Adnexal Exam not performed (Intermediate or Comprehensive Eye Exam)
- Psych/Neuro element missing for Comprehensive E & M Exam.
- History and Exam are not warranted by the Nature of the Presenting Problem (Medical Decision Making)

Outliers or those that are over a 50% error rate will be highlighted in red.
II. Lines of Communication.

An open line of communication is essential to proper implementation of an effective compliance program. The Coding Compliance Officer is charged with the responsibility of ensuring that a clear "open door" policy between physicians, Ophthalmology Clinic employees and the compliance office is established. The Coding Compliance Officer will utilize a number of communication techniques to continually update staff on compliance information. This will include the use of an OPHTHALMOLOGY CLINIC Intranet Bulletin Board(s) available to all Ophthalmology Clinic employees.

1. To ensure effective communication Ophthalmology Clinic will:
   (a) Require that employees report conduct that a reasonable person would, in good faith, believe to be fraudulent or erroneous;
   (b) Have an anonymous drop box for reporting fraudulent or erroneous conduct;
   (c) Ensure that policies require the practice and procedures require staff to report fraudulent or erroneous conduct, failure to do so is a violation of the compliance program;
   (d) Have a simple and readily accessible procedure, developed by the Coding Compliance Officer, to process reports of fraudulent or erroneous conduct;
   (e) Have a process that maintains the confidentiality of the persons involved in the alleged fraudulent or erroneous conduct and the person making the allegation; and
   (f) Ensure that there will be no retribution for reporting conduct that a reasonable person acting in good faith would have believed to be fraudulent or erroneous.

2. All Practice physicians and personnel are required to report incidents of material billing errors, violations of this Plan, unethical conduct, or incidents of potential fraud and abuse to the Coding Compliance Officer.
   (a) Such reports may be made to the Coding Compliance Officer in person or anonymously in writing through a drop box. Reports shall be treated as confidential to the extent reasonably possible. There shall be no retaliation against anyone who submits a good faith report of noncompliance.
   (b) Reports received on a confidential basis shall be investigated promptly.
   (c) Each report, regardless of the source, shall be assigned a control number, and a record shall be made containing the following data: (1) the date the report was made; (2) the person who received the report; (3) the allegations; (4) the actions taken in response; and (5) the name of the person making the report, if not made anonymously. The report shall be in the form attached hereto as Exhibit XX.
(d) The Coding Compliance Officer shall inform the Board of Directors of any reported incidents, and provide the Board of Directors with the record of the report.

(e) The Coding Compliance Officer shall maintain all discovered or reported information in the strictest confidence and shall not disclose to any person or entity, other than Ophthalmology Clinic’s Board of Directors, any such information unless otherwise directed by the Board of Directors.

3. Employee Certification. All employees and independent contractors engaged by Ophthalmology Clinic shall be required, on an annual basis, to certify, on a signed and dated form, whether they are aware of any violation of this Plan, and if so, shall provide detailed information about these possible violations on the form. The form shall state (1) that confidentiality shall be maintained as best possible, and (2) that the employee has the right to meet personally with the Coding Compliance Officer in place of completing the certification form. The certification form shall be the form attached hereto in the Appendices.

4. Exit Interviews. Any employee or independent contractor, who leaves Ophthalmology Clinic's employ, whether voluntarily or involuntarily, shall be requested to participate in an exit interview with the Coding Compliance Officer. The Coding Compliance Officer shall ask the departing employee whether he or she is aware of any violations of this Plan. The Coding Compliance Officer shall document the exit interview contents thoroughly on a report, the form of which is attached hereto in the Appendices.

5. Feedback
The key component of the Compliance plan is ensuring that feedback is provided to all relevant parties following audits, corrective action is taken and follow-up is performed within a period of time (quarterly or annually).

This iterative, feedback loop is a principal component of the coding compliance plan. Once errors are found, proper education must be provided and then followed up with another audit to determine the effectiveness of the training.

6. Corrective Procedures
These include the following:

I. A periodic (annual) review and update of the Coding Compliance Plan.
II. Time-Line for Remedy of any compliance infractions.
III. Outline and documentation of all Provider compliance education.
IV. Outline and documentation of all Coder compliance education.
V. Outline and documentation of all new employee compliance education.
VI. List of Disciplinary Procedures (outlined below)
Following documented documentation and coding feedback or training, the provider will be responsible to adhere to the policies and procedures as set forth in this document. Failure to comply with these policies will result in Disciplinary actions.

I. Disciplinary Actions

Following appropriate and documented education training, repeated infractions of OPHTHALMOLOGY CLINIC Coding Compliance policies and procedures will result in the following, in order:

a. Warning (oral)
b. Reprimand (written)
c. Probation
d. Demotion
e. Suspension without pay
f. Referral to counseling
g. Withholding a promotion or salary increase.
h. Termination
i. Restitution for damages.
j. Referral for criminal prosecution.
7. Correction of Identified Problems

All infractions of this Coding Compliance Plan will be investigated and appropriate corrective action will be implemented.

This will include but not be limited to:

I. Reviewing any coding, documentation or billing errors with the Compliance Plan Team, the provider and coding and billing staff.

II. Providing proper education and training.

III. Implementing a future audit or review of the problem within 3, 6, 9 or 12 months to determine if the problem has been corrected.

IV. Implementing corrective action as outlined in Section 6. Above.
Appendix 1

Ophthalmology Coding Guidelines

Review the Following:

Is the Chief Complaint accurate and specific?

HPI Documentation (3 – 4 elements) – train all doctors on the eight HPI elements.

Doctors must document HPI (Medicare Guideline)

CPT® Concepts
- Surgical Package
- Separate Procedures
- Check any unlisted codes every year and document

Review of all appropriate Modifiers:
- MODS 22, 23, 24, 25, 26, 32
- MODS 50, 51, 52, 54, 55, 56, 58
- MODS 73, 74, 78, 80, 81, 90

Doctors Trained on Modifiers? ___________

HCPCS
- V Codes
- S Codes – When is it appropriate to use S Codes?
- Injections
- Anatomical Modifiers

Reporting and documenting Evaluation and Management Encounters:
- New Versus Established Patients
- Levels of service
- Key Components
- History
- Chief Complaint
- HPI
- Exam
  - Levels of Exam
  - Medical Decision Making (MDM)
  - Levels of MDM
  - Confirm Training of all Doctors on E & M Fundamentals: ___________

Reporting and documenting Eye Exam Encounters
- Intermediate Exam – Required Components
- Comprehensive Exam – Required Components
  - Confirm Training for all doctors on the difference between an Intermediate and Comprehensive Exam (what are the required elements)

E & M Audit Form
Eye Exam Audit Form

Medical Decision Making Table
  - Confirm Training on MDM

Personal, Family and Social History Forms
Unilateral versus Bilateral Documentation
Document which Procedures are Unilateral, Bilateral or “Concept does not Apply” (meaning they are neither unilateral nor bilateral, and no anatomical modifier or MOD-50 should be used)

Know which procedures have a zero, 10 or 90 day global period.

Review of Specific Procedures and codes:

Review of Specific Diagnostic Procedures Billed separately (from the 920xx Eye Exam Encounters)
- Gonioscopy - 92020
- Fluorescein Angiography – 92235
Indocyanine Green Angiography (IGA) 99240
Serial Tonometry (92100-92130)
Refraction (code 92015)
Fundus Photography (92250)
Sensorimotor Exam (92060)
Visual Field Exams 9208x
Ophthalmoscopy Extended (92235 & 92226)
OCT, GDX HRT 92135
External Ocular Photo 92285
Spectra - 92286
Corneal Pachymetry – 76514
Ophthalmic Echography 92136
Optical Coherence Biometry (OCB) 92136
Botox – 64612
Avastin Injections
Photodynamic Therapy (PDT)
Substitute Procedures (92018, 92019)
Utilization Patterns for common procedures
Summary

Simple Repairs and Foreign Body removal
Glaucoma Procedure Codes
Cataract Procedure Codes
Retinal Detachment Procedure Codes

ICD-9 Diagnostic Coding
   Overview ICD-9
   Main Terms and Subterms
   Cross References – See, See Also, See Category
   Instructional Notes
   Hypertension Table
   Specific 5th Digit Codes
   Instructional Notes
   Includes
   Excludes
   See Also, See Additional Codes
Case Study - Exudative senile macular degeneration
Coding for suspected conditions
Coding Diabetes
Diabetes Case Study
Neoplasms
Late Effects
V Codes
E Codes – Injuries
Injury Case Study
Adverse Affects
Adverse Affects Case Study

Rejections versus Denials / EOBs
Monthly / Quarterly list of top ten Rejections / Denials
Review of PQRI codes

Are you billing the DME-MAC for post-cataract glasses and contact lenses? Are you reporting prosthetic eyes to the DME-MAC?

DMERC billing training
The following **ICD-9 codes** should not be listed on your Fee Ticket or ICD-9 cheat sheet as "Unspecified Only"

List them with a box or star for the 5th digit and instruct the provider to write in the specific condition.

### Eye Conditions in ICD-9 (Disorders of the eye and Adnexa (360 - 379))

<table>
<thead>
<tr>
<th>Category</th>
<th>Avoid 5th Digit Options</th>
</tr>
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<tr>
<td>360.5x</td>
<td>7 codes Retained (old) intraocular Foreign Body, Magnetic</td>
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<td>360.6x</td>
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<td>Note: these are all manifestation codes, code Diabetes 250.xx first.</td>
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<td>362.07</td>
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<tr>
<td>362.2x</td>
<td>6 codes Retinopathy of Prematurity, Unspecified</td>
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<td>362.20 Retinopathy of Prematurity, Unspecified</td>
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<tr>
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<td>372.00 Acute conjunctivitis, unspecified</td>
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<tr>
<td>372.31</td>
<td>372.33 6 codes Entropion and trichiasis of eyelid</td>
</tr>
<tr>
<td>374.0x</td>
<td>374.00 6 codes Entropion and trichiasis of eyelid</td>
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<td>374.1x</td>
<td>374.10 5 codes Ectropion</td>
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<tr>
<td>374.2x</td>
<td>374.20 4 codes Lagophthalmos</td>
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<tr>
<td>374.3x</td>
<td>374.30 4 codes Ptosis of eyelid</td>
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<tr>
<td>362.11</td>
<td>&lt;= AND =&gt; 401.xx - 405.xx Hypertensive retinopathy [ always add the appropriate hypertension type code ]</td>
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<tr>
<td>362.55</td>
<td>&lt;= AND =&gt; E code for drug, toxic maculopathy</td>
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<tr>
<td>370.31</td>
<td>&lt;= AND =&gt; 017.3 Phlyctenular keratoconjunctivitis (use add'l code for assoc. tuberculosis)</td>
</tr>
<tr>
<td>370.32</td>
<td>&lt;= AND =&gt; 372.13 Limbar and corneal involvement in vernal conjunctivitis</td>
</tr>
<tr>
<td>370.44</td>
<td>&lt;= AND =&gt; Keratitis or keratoconjunctivitis in exanthema (code first underlying condition)</td>
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<tr>
<td>370.8</td>
<td>&lt;= AND =&gt; 6.21 Acute conjunctivitis, unspecified</td>
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<tr>
<td>371.05</td>
<td>&lt;= AND =&gt; 017.3 Phthisical cornea (code first tuberculosis)</td>
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<tr>
<td>372.15</td>
<td>&lt;= AND =&gt; 125.0-125.9 or 085.5 Parasitic conjunctivitis (code first underlying disease as filariasis (125.0-125.9) or mucocutaneous leishmaniasis (085.5))</td>
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<tr>
<td>372.31</td>
<td>&lt;= AND =&gt; 695.3 Rosacea conjunctivitis</td>
</tr>
<tr>
<td>372.33</td>
<td>&lt;= AND =&gt; 695.10 - 695.19 or 099.3 Conjunctivitis in mucocutaneous disease (code 1st underlying disease)</td>
</tr>
</tbody>
</table>
| 376.2x   | <= AND => Endocrine exophthalmos (code first underlying disease (122.3, 122.6, 122.9)
The following lists are derived from the 2009 Medicare PPRRVU data file, or National Physician Fee Schedule Relative Value File. This file contains information on services covered by the Medicare Physician Fee Schedule (MPFS). For more than 10,000 physician services, the file contains the associated relative value units, a fee schedule status indicator, and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery).

### HCPCS Global Days Description

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<thead>
<tr>
<th>Code</th>
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<tbody>
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<tr>
<td>G9042</td>
<td>XXX Low vision rehab orient/mobi</td>
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<tr>
<td>G9043</td>
<td>XXX Low vision rehab orient/mobi</td>
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<tr>
<td>G9044</td>
<td>XXX Low vision rehab orient/mobi</td>
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<tr>
<td>009T</td>
<td>XXX Implant corneal ring</td>
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<tr>
<td>010T</td>
<td>XXX Prosth retina receive co</td>
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<tr>
<td>0187T</td>
<td>XXX Ophthalmic dx image anterior</td>
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<tr>
<td>10120</td>
<td>010 Remove foreign body</td>
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<tr>
<td>10121</td>
<td>010 Remove foreign body</td>
</tr>
<tr>
<td>11100</td>
<td>000 Biopsy, skin lesion</td>
</tr>
<tr>
<td>11101</td>
<td>ZZZ Biopsy, skin add-on</td>
</tr>
<tr>
<td>11200</td>
<td>010 Removal of skin tags</td>
</tr>
<tr>
<td>11201</td>
<td>ZZZ Remove skin tags add-on</td>
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<tr>
<td>65757</td>
<td>ZZZ Prep corneal endo allograft</td>
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<tr>
<td>66990</td>
<td>ZZZ Ophthalmic endoscope add-on</td>
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<tr>
<td>67221</td>
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<tr>
<td>67225</td>
<td>ZZZ Eye photodynamic ther add-on</td>
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<td>67320</td>
<td>ZZZ Revise eye muscle(add-on)</td>
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<tr>
<td>67331</td>
<td>ZZZ Eye surgery follow-up add-on</td>
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<tr>
<td>67332</td>
<td>ZZZ Rerevise eye muscle add-on</td>
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<tr>
<td>67334</td>
<td>ZZZ Revise eye muscle w/suture</td>
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<tr>
<td>67335</td>
<td>ZZZ Eye suture during surgery</td>
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<tr>
<td>67340</td>
<td>ZZZ Revise eye muscle add-on</td>
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<td>67800</td>
<td>010 Remove eyelid lesion</td>
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<tr>
<td>67805</td>
<td>010 Remove eye lesion</td>
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<tr>
<td>67808</td>
<td>090 Remove eye lesion(s)</td>
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<td>69990</td>
<td>ZZZ Microsurgery add-on</td>
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<td>70200</td>
<td>XXX X-ray exam of eye sockets</td>
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<tr>
<td>76510</td>
<td>Ophth us, b &amp; quant a</td>
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<td>XXX Corneal topography</td>
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**Unilateral Procedural Codes (MOD-50 Applies) (Code = 1)**

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<tr>
<th>Global Days</th>
<th>HCPCS PPRRV09 Description</th>
<th>010 68110 Remove eyelid lining lesion</th>
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<tr>
<td></td>
<td>66000 Remove iris and lesion</td>
<td>090 66100 Glaucoma surgery</td>
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</table>

<p>| 000 65805  | Drainage of eye                                                  | 090 66165 Follow-up surgery of eye   |
| 000 65210  | Remove foreign body from eye                                     | 090 6625 Repair/graft eye lesion     |
| 000 65220  | Remove foreign body from eye                                     | 090 6620 Repair eye lesion           |
| 000 65222  | Remove foreign body from eye                                     | 090 66185 Revise eye shunt           |
| 000 68200  | Treat eyelid by injection                                         | 090 6605 Incision of iris            |
| 000 65100  | Biopsy of eyelid lining                                           | 090 66180 Implant eye shunt          |
| 000 65430  | Corneal smear                                                    | 090 66920 Remove implant of eye      |
| 000 67875  | Closure of eyelid                                                | 090 65400 Removal of iris            |
| 000 65800  | Drainage of eye                                                  | 090 66090 Glaucoma surgery            |
| 000 67820  | Revise eyelashes                                                 | 090 66130 Remove eye lesion          |
| 000 67810  | Biopsy of eye                                                    | 090 65135 Insert ocular implant       |
| 000 67515  | Inject/treat eye socket                                           | 090 65825 Follow-up surgery of eye   |
| 000 67505  | Inject/treat eye socket                                           | 090 65800 Drainage of eye            |
| 000 67500  | Inject/treat eye socket                                           | 090 66000 Remove iris and lesion     |
| 000 67415  | Aspiration, orbital contents                                      | 090 65600 Revision of cornea         |
| 000 67346  | Biopsy, eye muscle                                               | 090 65700 Incise iris &amp; ciliary body  |
| 000 67028  | Injection eye drug                                               | 090 65750 Correction of astigmatism  |
| 000 65435  | Curette/treat cornea                                             | 090 65850 Remove iris                |
| 000 68525  | Biopsy of tear sac                                               | 090 65870 Incise inner eye adhesions  |
| 000 68510  | Biopsy of tear gland                                             | 090 66705 Incise tear duct opening   |
| 000 68850  | Injection for cornean anlysis                                     | 090 66710 Incise iris &amp; ciliary body  |
| 010 67938  | Remove eyelid foreign body                                        | 090 66715 Incision of ciliary body   |
| 010 67930  | Repair eyelid wound                                              | 090 66770 Remove of corneal lesion    |
| 010 67860  | Close tear duct opening                                           | 090 66775 Repair of corneal lesion    |
| 010 67850  | Treat eyelid lesion                                               | 090 66800 Repair of ciliary body     |
| 010 67840  | Remove eyelid lesion                                              | 090 66850 Removal of ciliary body     |
| 010 67861  | Close tear duct opening                                           | 090 66852 Removal of iris            |
| 010 67830  | Revise eyelashes                                                 | 090 68135 Insert ocular implant       |
| 010 67825  | Revise eyelashes                                                 | 090 65920 Remove implant of eye      |
| 010 68801  | Dilate tear duct opening                                          | 090 66155 Glaucoma surgery            |
| 010 67700  | Drainage of eyelid abscess                                        | 090 66160 Glaucoma surgery            |
| 010 65270  | Repair of eye wound                                              | 090 66180 Glaucoma surgery            |
| 010 65220  | Remove foreign body from eye                                     | 090 66185 Revise eye shunt           |
| 010 65410  | Biopsy of cornea                                                 | 090 66130 Remove eye lesion          |
| 010 65405  | Repair iris &amp; ciliary body                                       | 090 66160 Glaucoma surgery            |
| 010 65700  | Incision of iris                                                 | 090 66160 Glaucoma surgery            |
| 010 65750  | Corneal transplant                                               | 090 66160 Glaucoma surgery            |
| 010 65710  | Corneal transplant                                               | 090 66160 Glaucoma surgery            |
| 010 65720  | Corneal transplant                                               | 090 66160 Glaucoma surgery            |
| 010 65730  | Corneal transplant                                               | 090 66160 Glaucoma surgery            |
| 010 65740  | Corneal transplant                                               | 090 66160 Glaucoma surgery            |
| 010 65750  | Corneal transplant                                               | 090 66160 Glaucoma surgery            |
| 010 65756  | Corneal transpl, endothelial                                     | 090 66160 Glaucoma surgery            |
| 010 65816  | Probe nl duct w/balloon                                           | 090 66635 Removal of iris            |
| 010 66020  | Injection transverse lymph duct                                   | 090 66600 Revision of cornea          |
| 010 66030  | Injection treatment cataract                                       | 090 65400 Removal of iris            |
| 010 68840  | Explore/irrigate tear duct                                       | 090 65436 Curette/treat cornea        |
| 010 67715  | Incision of ciliary body                                          | 090 65700 Incise inner eye adhesions  |
| 010 67705  | Revise tear duct opening                                          | 090 65750 Corneal transplant          |
| 010 68135  | Remove eyelid lining lesion                                       | 090 65750 Corneal transplant          |
| 010 68530  | Clearance of tear duct                                           | 090 65750 Corneal transplant          |
| 010 68115  | Remove eyelid lining lesion                                       | 090 65750 Corneal transplant          |
| 010 68371  | Harvest eye tissue, alograft                                     | 090 65750 Corneal transplant          |
| 010 68440  | Incise tear duct opening                                          | 090 65750 Corneal transplant          |
| 010 68020  | Incise/drain eyelid lining                                        | 090 65750 Corneal transplant          |
| 010 68420  | Incise/drain tear sac                                             | 090 65750 Corneal transplant          |
| 010 68400  | Incise/drain tear gland                                          | 090 65750 Corneal transplant          |</p>
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<thead>
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<td>090 65775</td>
<td>Correction of astigmatism</td>
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<tr>
<td>090 65105</td>
<td>Remove eye/attach implant</td>
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<td>090 65110</td>
<td>Removal of eye</td>
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<td>090 65290</td>
<td>Repair of eye socket wound</td>
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<td>090 65093</td>
<td>Revise eye with implant</td>
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<td>Remove foreign body from eye</td>
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</tr>
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<td>Incise inner eye adhesions</td>
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<td>090 65093</td>
<td>Revise eye with implant</td>
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<td>Remove foreign body from eye</td>
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<td>Remove eye/revise socket</td>
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<td>090 67113</td>
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<td>Ocular reconstruct, transplant</td>
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<td>Revision of eyelid</td>
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<tr>
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090 67430 Explore/treat eye socket
090 67420 Explore/treat eye socket
090 67414 Explr/decompress eye socket
090 67413 Explore/treat eye socket
090 67405 Explore/drain eye socket
090 67400 Explore/biopsy eye socket
090 67141 Treatment of retina
090 67318 Revise eye muscle(s)
090 67210 Treatment of retinal lesion
090 67250 Reinforce eye wall
090 67218 Treatment of choroid lesion
090 67220 Treatment of choroid lesion
090 67227 Treatment of retinal lesion
090 67228 Treatment of retinal lesion
090 67343 Release eye tissue
090 6729 Tr retinal les preterm inf
090 67314 Revise eye muscle
090 67318 Revise eye muscle
090 67312 Revise two eye muscles
YYY 67999 Revision of eyelid
YYY 68399 Eyelid lining surgery
YYY 67399 Eye muscle surgery procedure
YYY 67599 Orbit surgery procedure
YYY 67299 Eye surgery procedure
YYY 66999 Eye surgery procedure
YYY 68899 Tear duct system surgery

Procedures Paid as Bilateral (Code = 2)

HCPCS Description
76514 Echo exam of eye, thickness
76516 Echo exam of eye
76519 Echo exam of eye
92002 Eye exam, new patient
92004 Eye exam, new patient, Comp
92012 Eye exam established pat
92014 Eye exam & treatment
92020 Special eye evaluation
92060 Special eye evaluation
92065 Orthoptic/pleoptic training
92081 Visual field examination(s)
92082 Visual field examination(s)
92083 Visual field examination(s)
92100 Serial tonometry exam(s)
92120 Tonography & eye evaluation
92130 Water provocation tonography
92136 Ophthamic biometry
92140 Glaucoma provocative tests
92250 Eye exam with photography
92260 Ophthalmoscopy/dynamometry
92265 Eye muscle evaluation
92270 Electro-oculography
92275 Electrotoretinography
92283 Color vision examination
92284 Dark adaptation eye exam
92285 Eye photography
92286 Internal eye photography
92287 Internal eye photography
**Bilateral Concept does not apply**

**Bilateral Code = 9**

No Anatomical Modifier allowed or necessary

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<th>CPT Code</th>
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<td>00142 Anesth, lens surgery</td>
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<tr>
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Appendix 2

1. Follow all coding principles outlined below.

1.1 Use all codes necessary to completely code all diseases and procedures, including underlying diseases.

1.4 E codes are used whenever appropriate to identify external codes.

1.5 J, Q, A and W HCPCS codes are required for Outpatient Services.

2. Consult the following sources to identify all diagnoses and procedures requiring coding and to increase the accuracy and specificity of coding.

2.2 Progress Notes-Scan to detect complications and/or secondary diagnoses for which the patient was treated and/or procedures performed.

2.3 History and Physical-scan to identify any additional conditions; such as history of cancer or a family history of eye disease. These conditions should be coded.

2.5 Consultation -scan to detect additional diagnoses or complications for which the patient was treated that may impact eyecare.

2.6 Operative Reports-scan to identify additional procedures requiring coding.

2.7 Pathology Reports-review to confirm or obtain more detail.

2.8 GDX, Fundus Photos and laboratory-use reports as guides to identify diagnoses (e.g. retinal damage) or more detail (e.g., type of ARMD or glaucoma).

2.9 Physician's Orders-scan to detect treatment for unlisted diagnoses-the administration of insulin, antibiotics, sulfonamides may indicate treatment of diabetes, respiratory or urinary infections which should be confirmed by checking other medical record forms.

3. Exercise discretion in coding diagnostic conditions not identified on the provider’s progress notes.

3.1 Query physician on the deficiency report if the coding question influences coding assignment.

3.2 Review all alcohol/drug abuse cases to confirm prior to coding.

4. Process special diagnostic coding situations as follows:

4.1 V codes are used to identify encounters for reasons other than illness or injury. V codes are used as principal diagnoses for routine eyecare (V72.0) – in the absence of any sign, symptom or physician recommended return visit, (V80.1) screening for glaucoma, (V80.2) screening for other eye conditions, (V58.69) Long term use of other medications – High Risk Medications, Chemotherapy session (V58.0), (V67.51) Following completed treatment with high risk medications, NEC. Avoid the use of V codes as the principal diagnosis unless a diagnosis of a condition can be made.

4.2 V codes are used in outpatient coding when a person who is not currently ill obtains health services for a specific purpose, such as, to act as a donor, or when a circumstance influences the persons health status but is not in itself a current illness or injury. Patients receiving preoperative evaluations receive a code from category V72.8.

4.3 Avoid using codes that lack specificity. These vague codes should not be used if it is possible to obtain the information required to assign a more specific code.
4.4 Signs and symptoms are coded when a specific diagnosis cannot be made or when the etiology of a sign or symptom is unknown. Do not code symptoms if the etiology is known and the symptom is usually present with a specific disease process.

4.5 Outpatient coding requires that diagnoses documented as "probable, suspected, questionable, rule out or working", should not be coded. Code the condition for that visit, i.e., signs or symptoms or abnormal test results. The statement “Rule out Orbital Fracture” cannot be coded. Code signs, symptoms presented. Be sure to ask your provider if unclear how to code Rule-Outs.

4.6 Chronic conditions may be coded as many times as the patient receives treatment.

4.7 Code abnormal laboratory tests only when noted on the face sheet by the attending physician.

5. Code all services and procedures performed in the hospital from the time of admission to the time of discharge.

5.1 Be certain procedures were actually performed, not just ordered or consents obtained.

5.2 Code procedures clearly documented in the record but not indicated on the face sheet or in the discharge summary. Note codes for such procedures in pencil on the face sheet.
Appendix 2

Essentials Of Accurate Coding

1. Identify all main terms or procedures included in the diagnostic/procedural statements(s).

2. Locate each main term/procedure in the Alphabetical Index. A main term may be followed by a series of terms in parentheses. The presence or absence of these parenthetical terms in the diagnosis has no effect upon the selection of the code listed for the main term.

3. Refer to any sub-terms indented under the main term. These sub-terms for individual line entries and describe essential differences by site, etiology or clinical type.

4. Follow cross-reference instructions if the needed code is not listed under the first main entry consulted.

5. Verify code selected from the Index in the Tabular List.

6. Read and be guided by any instructional terms in the Tabular List.

7. Fourth and fifth digit sub-classification codes must be used where provided.

8. Continue coding diagnostic and procedural statements until all of the component elements are fully identified. This instruction applies even when no "use" statement appears.

9. Use both codes when a specific condition is stated as both acute (or sub-acute) and chronic and the Alphabetic Index provides unique codes at the third, fourth, or fifth digit level.

10. The term hypertensive means "due to", but the presence of words such as "and or with hypertension" does not imply causality.

11. If the cause of a sign or symptom is specified in the diagnosis, code the cause but do not assign a code for the sign or symptom.

12. When coding outpatient services, do not code diagnoses documented as "probable, suspected, questionable, rule out or working diagnosis". Code the condition necessitating that visit, such as signs or symptoms, abnormal test, or other reasons.

13. Do not confuse V codes, which provide for classifying the reason for visit with procedure codes documenting the performance of a procedure.

14. V codes are found in the Alphabetic Index under references such as Admission, Examination, History of, Problem, Observation, Status, Screening, Aftercare, etc.

15. When an endoscopic approach is utilized to accomplish another procedure (such as biopsy, excision of lesion or removal of foreign body), assign the code for the endoscopy and the procedure unless the code books contain instructions to the contrary or the code identifies the endoscopic approach.

16. Surgical procedures, which were started but not completed due to procedural reasons, are to be coded as follows:

   A. Assign a code for exploratory procedure if a cavity or space was entered.
   B. Assign a code for incision if the site was opened but the cavity was not entered.
   C. Use an appropriate modifier for terminated or reduced procedures.

17. No procedure code is assigned if an incision was not made. Code canceled surgeries to V64.1, V64.2 and V64.3.
18. Consult the Alphabetical Index first to code neoplasms in order to determine whether a specific histological type of neoplasm has been assigned a specific code.

19. Do not assign the code for primary malignancy or unspecified site if the primary site of the malignancy is no longer present. Instead, identify the previous primary site by assigning the appropriate code in category (e.g., V10.84) “Personal history of malignant neoplasm of the eye.”

20. Cancer "metastatic from" a site should be interpreted as primary of that site and cancer described as "metastatic to" a site should be interpreted as secondary of that site.

21. Diagnostic statements expressed in terms of a malignant neoplasm with "spread to..." or "extension to..." are to be coded as primary site with metastases.

22. If no site is stated in the diagnosis but the morphologic type is identified as metastatic, code as primary site unknown and also assign the code for secondary neoplasm or unspecified site.

23. Code only the most severe degree of burn when different degrees of burns occur at the same site.

24. Assign separate codes for multiple injuries unless the coding books contain instructions to the contrary or sufficient information is not available to assign separate codes.

25. Poisoning by drugs includes drugs given in error, suicide and homicide, adverse effects of medicines taken in combination with alcohol, or taking a prescribed drug in combination with self prescribed drugs.

26. Adverse reactions to correct substances properly administered include: allergic reaction, hypersensitivity, intoxication, etc. The poisoning codes 960-979 are never used to identify adverse reactions to correct substances properly administered.

27. Complications of medical and surgical care are located in the Alphabetical; Index under Complication or the name of the condition.

28. The causes or residual illnesses or injuries are located in the Alphabetical Index under Late Effect.

29. When the late effect of an illness or injury is coded in the main classification, the E code assignment must also be one for late effect.

I. Outpatient Coding

1. The appropriate code(s) must be used to identify diagnoses, symptoms, conditions, problems, complaints or any other reason for the visit. List the chief diagnosis, condition or other reason for the visit. List additional codes to describe any coexisting condition.

2. Do not code diagnoses documented as "probable, suspected, questionable, rule out, or working diagnosis". Code the condition(s) for that visit, such as signs or symptoms.

Discharge diagnosis stated as operative procedure, medical diagnosis, or diagnosis (e.g., operative report, pathology report and/or discharge summary) does not indicate why the procedure was performed, consult the physician for clarification and request he document the diagnosis.

Late effect-the code for the residual (the current condition) is sequenced before the late effect code. If a specific residual cannot be identified after thorough review of the record, consult the physician.
Ophthalmology Clinic Coding Compliance Plan

Multiple injuries—the most severe injury is the principal diagnosis.

Poisoning to drug—the poisoning code is sequenced before the manifestation and E codes.

Principal procedure—a therapeutic procedure should be designated as the principal procedure when both a diagnostic and a therapeutic procedure were performed in relation to the principal diagnosis; regardless of which procedure was performed first. Unrelated diagnostic or therapeutic procedures may be listed as the principal procedure if not procedures were performed that relate to the principal diagnosis.

**Rule out, Ruled out and R/O:**

For outpatient coding, do not code rule out, working, suspected or questionable diagnosis. Instead code the condition, sign or symptoms or other reason for the visit.

Code V codes for screenings when appropriate. If no appropriate V code is found, code the sign or symptoms.

Symptom, signs and abnormal test results—these may be used if no underlying cause has been diagnosed.

Two or more diagnoses or equal importance—if medical record documentation does not indicate otherwise, the principal diagnosis is the one for which a definitive surgical or nonsurgical procedure was performed.

**II. E & M Coding**

Always document at least three characteristics of the History of Present Illness. These include: Location Quality Severity Duration Timing Context Modifying Factors and Associated Signs/Symptoms.

Except for a level 1 visit, never leave the Review of Systems blank. Always document, at the very least, 2 ROS systems for every visit.

Every provider should have a copy of the 1997 Medicare Ophthalmology specific Exam requirements.

**III. Surgical Coding**

For Foreign body *(FB) removal the provider should always document (as appropriate):

1. Location of the FB
2. Depth of the FB (superficial, embedded, perforating)
3. Removal approach
4. Removal Method (magnetic, forceps, laser, fulguration, cryotherapy)
5. Whether a Slit Lamp was Used (6522x)
6. When removing neoplasms, it must be confirmed whether they are benign, malignant, a cutaneous vascular proliferative lesion (think port-wine stain birthmark) or a skin tag. Each requires a different CPT® code.
7. Whether hospitalization was required (CPT® 6527x for a Laceration of the Conjunctiva)
8. If Uveal Tissue was involved (Choroid, Cilliary body and Iris laceration of the Cornea)

For a surgical team be sure to document the extent of the assistant surgeon's involvement.

**III. Surgical Coding**

For all **preoperative progress notes** document the following:
Preoperative Diagnosis:
Procedure Planned:
Type of Anesthesia Planned:
Laboratory Data: Electrolytes, BUN, creatinine, CBC, PT/PTT, UA, EKG, Chest X-ray; type and screen for blood or cross match if indicated; liver function tests, ABG.
Any Risk Factors: Cardiovascular, pulmonary, hepatic, renal, coagulopathic, nutritional risk factors.
Consent: Document explanation to patient of risk and benefits of procedure, and document patient’s informed consent or guardian’s consent and understanding of procedure.
Allergies:
Major Medical Problems:
Current Medications:
The Surgical Operative Note should include at minimum the following:

Date of the Procedure:
Preoperative Diagnosis:
Postoperative Diagnosis:
Procedure:
Names of Surgeon and Assistant:
Anesthesia:
Estimated Blood Loss (EBL):
Fluids and Blood Products Administered During Procedure:
Specimens: Pathology specimens, cultures, blood samples.

The Post Surgical Progress Note should include at minimum the following:

Subjective: Mental status & patient's subjective condition; pain control.
Vital Signs: Temperature, blood pressure, pulse, respirations.
Physical Exam: Chest and lungs; inspection of wound and surgical dressings; conditions of drains; characteristics and volume of output of drains.
Labs:
Assessment/Impression:
Plan:
Appendix 3

I. Coding Resources.

1. Medicare (Add our Jurisdiction Here) Guidelines
2. Local Medical Review Policies
4. Ophthalmology Specific Coding Manuals (Ingenix, PMIC, AAOE)
5. AMA CPT® Assistant (on CD-ROM)
6. AHA Coding Clinic
7. OIG Compliance Plan
8. Associations (AAO)
Appendix 4.

I. Coding Compliance Plan Recommended Forms

These Forms are located in a separate document.

1. OPHTHALMOLOGY CLINIC Coding Personnel Internal Education Form
2. Provider Evaluation and Management Audit Evaluation Form
3. Coding Compliance Incident Report Form
4. Ophthalmology Clinic Exit Interview Report Form
5. Annual Employee Coding Certification Form
6. Confidentiality Agreement Form
7. Third Party Company Letter Agreement Form
### Appendix 5 – Illegal Medical Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>0.5</td>
<td>signifies 05</td>
</tr>
<tr>
<td>1.0 (trailing zero)</td>
<td>signifies 1</td>
</tr>
<tr>
<td>3d</td>
<td>for three days</td>
</tr>
<tr>
<td>A/A</td>
<td>albuterol and atrovent</td>
</tr>
<tr>
<td>ARA-A</td>
<td>vidarabine</td>
</tr>
<tr>
<td>AZA</td>
<td>azathioprine</td>
</tr>
<tr>
<td>AZT</td>
<td>zidovudine</td>
</tr>
<tr>
<td>CPZ</td>
<td>compazine</td>
</tr>
<tr>
<td>HCT</td>
<td>hydrocortisone</td>
</tr>
<tr>
<td>IU</td>
<td>international unit</td>
</tr>
<tr>
<td>ms</td>
<td>morphine sulfate, magnesium sulfate</td>
</tr>
<tr>
<td>MTX</td>
<td>methotrexate</td>
</tr>
<tr>
<td>Nitro</td>
<td>Nitro and &quot;Pit&quot; stemmed names pitocin</td>
</tr>
<tr>
<td>Q.D., Q.O.D.</td>
<td>every day, every other day</td>
</tr>
<tr>
<td>q.n.</td>
<td>every night</td>
</tr>
<tr>
<td>q.o.d.</td>
<td>every other day</td>
</tr>
<tr>
<td>TAC</td>
<td>triamcinolone</td>
</tr>
<tr>
<td>TIW</td>
<td>three times a week</td>
</tr>
<tr>
<td>TTP</td>
<td>Tender To Palpation</td>
</tr>
<tr>
<td>U</td>
<td>unit</td>
</tr>
<tr>
<td>ZNSO4</td>
<td>zinc sulfate</td>
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