Cracking The Code

The Myths, Mysteries & Essentials Of Specialty Contact Lens Coding and Compliance

John Rumpakis, OD, MBA
Practice Resource Management, Inc.

Disclosures – John Rumpakis, OD, MBA
I Am A Project Based Consultant & Have Spoken For:
(Partial Listing)

• Alcon Laboratories
• Carl Zeiss Meditec
• Optos
• Vistakon
• CooperVision
• Inspire Pharmaceuticals
• EMRLogic
• ArcticDQ
• Oasis Medical
• Odyssey Medical
• Officemate
• Maxximeyes
• Luxottica
• Ista Pharmaceuticals
• Kova Optimed
• HeartSmart
• Eye-Tel Imaging
• Bausch & Lomb
• Essilor of America
• Wal-Mart
• Macuscope
• Topcon
• CyclopsEAMR

Chief Medical Clinical Coding Editor – Review Of Optometry
Founder – Opt-ED®, Professional Optometric Continuing Education
Founder – Opt-IN®, Optometric Marketing & Promotions
ReimbursementPLUS® (www.ReimbursementPlus.com)
WhatsMyPracticeWorth.com® - Online Practice Appraisals

Disclosures

• All fees represented within this presentation are the 2012 Medicare National Maximum Allowable Reimbursements for each procedure listed.
• All information regarding policies, procedures, guidelines and definitions is current as of January 28, 2012.
• Each viewer is responsible to be current in their own geographical jurisdiction interpretation of policies, procedures, guidelines and definitions prior to implementation within their own practice.
• The coding examples contained this presentation are examples only and each practitioner should apply these coding guidelines to what is actually recorded in the patients’ medical record before submitting any claim to a third party carrier.

J. Rumpakis, O.D., M.B.A.
Practice Resource Management, Inc.
John@PRMI.com
A Fundamental Principle

What do you do?
(hint... think evidence based medicine)

What does this patient need?
(hint... not what do you want to do)

What is in the patient’s best interest?

Medical Necessity Is...

“Services or supplies that are proper and needed for the diagnosis or treatment of the patient’s medical conditions, are provided for the diagnosis, direct care and treatment of the patient’s medical condition, meet the standards of good medical practice in the local area and aren’t mainly for the convenience of the patient or the physician.”

Source: www.Medicare.gov
UNDERSTANDING THE CONCEPT OF MEDICAL NECESSITY IS CRITICAL

- Often, carriers will not have a specific policy regarding the indications of medical necessity, nor a list of covered diagnoses or utilization guidelines that you can refer to.
- When this is the case, then the prevailing CPT definition and guidelines in combination WITH YOUR MEDICAL EXPERTISE become the defensible rule.

---

Medical Plans Vs. Refractive Plans

What’s The Difference?

---

Refractive Plans

- Do patients need a reason to see you?
  - Do they need to have something wrong with them?

- What conditions have to be met?
  - Policy in force
  - Coverage eligibility
  - Participating provider
Rule Number One

Question: What is the first thing that must be part of every medical visit?

Answer: A chief complaint

Cloned Documentation

- When documentation is worded exactly like or similar to previous entries, the documentation is referred to as cloned documentation.

Whether the cloned documentation is handwritten, the result of pre-printed template, or use or Electronic Health Records, cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Cloned Documentation

- It would not be expected that every patient had the same exact problem, symptoms, and required the exact same treatment. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information for each unique patient.
- Documentation exactly the same from patient to patient is considered cloned and often occurs when services have a specific set of limited or select criteria. Cloned documentation lacks the patient specific information necessary to support services rendered to each individual patient.
There Are **TWO** Types Of Chief Complaint

- **Patient Directed**
- **Physician Directed**

The Chief Complaint

The Medicare Carriers Manual, Part 3 §2320 reads:

"The coverage of services rendered by a physician is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient’s condition. When a beneficiary goes to a physician with a complaint or symptoms of an eye disease or injury, the physician’s services (except for eye refractions) are covered regardless of the fact that only eyeglasses were prescribed. However, when a beneficiary goes to his/her physician for an eye examination with no specific complaint, the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathologic condition."
The Chief Complaint

The Medicare Carriers Manual, Part 3 §2320 reads:

"The coverage of services rendered by a physician is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient’s condition. When a beneficiary goes to a physician with a complaint or symptoms of an eye disease or injury, the physician’s services (except for eye refractions) are covered regardless of the fact that only eyeglasses were prescribed. However, when a beneficiary goes to his/her physician for an eye examination with no specific complaint, the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathologic condition."
Keep The Order In Mind…

• Always provide the Standard of Care to the patient first, tell the medical record what you did and why you did it, then accurately translate what you did with the patient into CPT language
• Never code first, then do testing just to reach the level that specific code requires
  – This approach would not support the concept of Medical Necessity that is required by third party carrier rules and guidelines

Understanding Code Differences

Within the HCPCS system each code subset has it’s own implicit purpose

… and it’s own format

Health Care Procedural Coding System (HCPCS)

• Level One HCPCS ➔ CPT Procedural Codes
• Level Two HCPCS ➔ Non-CPT Codes for Materials, Services & PQRS
• Level Three HCPCS ➔ Emerging Technology Temporary Use Codes
Health Care Procedural Coding System (HCPCS)

- Level One HCPCS Are The CPT®-4
- CPT Codes Are Always…
  - One Five Digit Code Plus Up To Four, 2 Digit Modifiers

Health Care Procedural Coding System (HCPCS)

- Level Two - National Codes for Materials, Services & PQRI

  Level Two Codes: 5 Digit Alphanumeric

  Level II Designation: A-V1234

Health Care Procedural Coding System (HCPCS)

- Level Three - Emerging Technology Temporary Use Codes

  Level Three Codes:
  - Category III codes are temporary codes for emerging technology, services, and procedures. Category III codes consist of four numbers followed by the letter "T."

  Category III Designation: 1234T

ICD-9-CM

International Classification Of Disease – Ninth Edition Clinical Modification

ICD-9-CM Codes

- International Classification Of Disease, 9th Edition
- Owned By The World Health Organization
- Consistent World-Wide

Diagnosis Codes: Single 5 Digit Code with Decimal

Always use highest level of specificity

Can Also Be Single Digit

ICD-9-CM Codes

- The critical relationship between an ICD-9 code and a CPT code is that the diagnosis supports the medical necessity of the procedure
- List primary diagnosis code first
  - Keep in mind that ICD-9 rules prevent you from using the patients symptoms as a diagnosis if you know the cause of the symptoms
- Link specific procedures to appropriate diagnosis on CMS 1500 form
- Stay away from diagnosis codes: XXX.9
- There are still legitimate 3 and 4 digit ICD-9 codes to use
ICD-9-CM Codes

- The critical relationship between an ICD-9 code and a CPT code is that the diagnosis supports the medical necessity of the procedure
- List primary diagnosis code first
  - Keep in mind that ICD-9 rules prevent you from using the patient’s symptoms as a diagnosis if you know the cause of the symptoms
- Link specific procedures to appropriate diagnosis on CMS 1500 form
- Stay away from diagnosis codes: XXX.9
- There are still legitimate 3 and 4 digit ICD-9 codes to use

ICD-9 Critical Points

- Having a diagnosis that supports Medical Necessity is **REQUIRED** for coverage
- Having **ONLY** a covered diagnosis is not enough to survive an audit unless you have properly established Medical Necessity in the medical record

Office Visits

**Defining The Physician/Patient Encounter**
The Ophthalmic Office Visits

The Comprehensive Exam
&
The Intermediate Exam

Ophthalmological Service Coding System

• Ophthalmological Office Visit Codes
• 92004 - Comprehensive Exam NP
• 92014 - Comprehensive Exam EP
• 92002 - Intermediate Exam NP
• 92012 - Intermediate Exam EP
• 92015 – Refraction (always distinct & separate)

“only four 92XXX codes for office visits”

920x2 - Intermediate

CPT 2012 Definition:
• “… describes an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily related to the primary diagnosis
The service includes:
• History
• General medical observation
• External examination
• Adnexal examination
• other diagnostic procedures as indicated

It often includes, as indicated:
• Biomicroscopy
• And may include the use of mydriasis for ophthalmoscopy

It always includes initiation of diagnostic and treatment programs.
920x4 - Comprehensive

- CPT 2012 Definition:
  "...describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session."

The service includes:
- History
- General medical observation
- External examination
- Ophthalmological examinations
- Gross visual fields
- Basic sensorimotor examination

It often includes, as indicated:
- Biomicroscopy
- Examination with cycloplegia or mydriasis
- Tonometry

It always includes initiation of diagnostic and treatment programs.

The Evaluation & Management Office Visits

They Are NOT New Anymore!

Evaluation & Management Coding System

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>99211</td>
</tr>
<tr>
<td>99202</td>
<td>99212</td>
</tr>
<tr>
<td>99203</td>
<td>99213</td>
</tr>
<tr>
<td>99204</td>
<td>99214</td>
</tr>
<tr>
<td>99205</td>
<td>99215</td>
</tr>
</tbody>
</table>

J. Rumpakis, O.D., M.B.A.
Practice Resource Management, Inc.
John@PRMI.com
Elements of E/M Rationale

- History ★
- Examination ★
- Medical Decision Making ★
- Counseling
- Coordination of Care
- Nature of the Presenting Problem
- Time

The Big Three...

- History
  - Four levels of history
- Physical Examination
  - We are single system subspecialists
  - Four levels of physical examination
- Medical Decision Making
  - Four levels of medical decision making

Identifying Level of Service

New Patient – Must meet or exceed 3 of 3 to qualify for that code level
(Grade To Lowest Of Three)

<table>
<thead>
<tr>
<th></th>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Exam</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Decision Making</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Identifying Level of Service

Established Patient – Must meet or exceed 2 of 3 to qualify for code
(Grade To Middle Of Three)

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Exam</th>
<th>Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99212</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>99213</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>99214</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>99215</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Fitting Contact Lenses

Traditional Fits

Traditional Contact Lens Fitting

- The prescription of contact lens includes specification of optical & physical characteristics. It is NOT a part of the general ophthalmological services.
- Supply of materials may be reported as part of the service of fitting or may be reported separately using the appropriate supply codes.
- Follow-up of successfully fitted extended wear lenses is reported as part of a general ophthalmological service (92012).
Fitting Codes – Traditional Fits

- **92310** - “prescription of optical and physical characteristics of and fitting of a contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia.”
  
  This code encompasses all services that are provided up to the point at which you would issue a contact lens prescription, and it is charged at each visit during which a new lens is placed on a patient’s eye, or when the fit is altered.
  
  - It does not include contact lens follow-up care after the lenses have been dispensed.
  - Keep in mind that the modifier -52 should be used if fitting only one eye. Note - This is a change from 2011

- **92311** - Prescription of optical and physical characteristics of and fitting of contact lenses, with medical supervision of adaptation; corneal lens for aphakia, one eye.
  
- **92312** - Prescription of optical and physical characteristics of and fitting of contact lenses, with medical supervision of adaptation; corneal lens for aphakia, both eyes.
  
- **92313** - Prescription of optical and physical characteristics of and fitting of contact lenses, with medical supervision of adaptation; corneoscleral lens.

Fitting Codes – Traditional Fits (Tech)

- **92314** - Prescription of optical and physical characteristics of and fitting of a contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia.
  
- **92315** - corneal lens for aphakia, 1 eye
  
- **92316** - corneal lens for aphakia, both eyes
  
- **92317** - corneoscleral lens
Fitting Codes

• 92325 - modification of contact lenses. CPT defines this code as “modification of contact lens (separate procedure), with medical supervision of adaptation.”
  – This code applies when you polish or modify the parameters of an RGP lens using a contact lens modification instrument.
  – This is a unilateral service; use modifier -50 if done bilaterally.
• 92326 – Replacement of contact lens

Modifier To Note...

• -52 Reduced Services
  – Under certain circumstances a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
• In 2012, the CPT specifically designated -52 as the modifier to use when fitting a unilateral traditional lens in place of –RT or –LT

Modifier To Note...

• -22 Increased Procedural Services
  – When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier -22 to the usual procedure code.
  – Documentation in the medical record must support the substantial additional work performed
  – This allows us to “violate” the one price per CPT code rule.
  – This modifier should NOT be appended to an E/M service

J. Rumpakis, O.D., M.B.A.
Practice Resource Management, Inc.
John@PRMI.com
Material Codes

- V2500 - PMMA, Spherical, Per Lens
- V2501 - PMMA, Toric/Prism, Per Lens
- V2502 - PMMA, Bifocal, Per Lens
- V2503 - PMMA, Color Defined, Per Lens
- V2510 - Gas Perm, Spherical, Per Lens
- V2511 - Gas Perm, Toric/Prism, Per Lens
- V2512 - Gas Perm, Bifocal, Per Lens
- V2513 - Gas Perm, EW, Per Lens
- V2520 - Hydrophilic, Spherical, Per Lens
- V2521 - Hydrophilic, Toric/Prism, Per Lens
- V2522 - Hydrophilic, Bifocal, Per Lens
- V2523 - Hydrophilic, EW, Per Lens
- V2530 - Scleral Lens, PMMA, Per Lens
- V2531 - Gas permeable, scleral, per lens
- V2532 - Scleral Lens, PMMA, Per Lens
- V2533 - Gas permeable, scleral, per lens
- V2599 - Lens, Other

Scleral Shell – CMS NCD Policy 80.5

"Scleral shell (or shield) is a catchall term for different types of hard scleral contact lenses. A scleral shell fits over the entire exposed surface of the eye as opposed to a corneal contact lens which covers only the central non-white area encompassing the pupil and iris. Where an eye has been rendered sightless and shrunken by inflammatory disease, a scleral shell may, among other things, obviate the need for surgical enucleation and prosthetic implant and act to support the surrounding orbital tissue. In such a case, the device serves essentially as an artificial eye. In this situation, payment may be made for a scleral shell under §1861(s)(8) of the Act."

Two New Codes - 92071 & 92072

- CPT Code 92071 – Fitting of a contact lens for treatment of ocular surface disease.
- Please report materials IN ADDITION to this code using either 99070 or the appropriate HCPCS Level II material code.

Please do NOT report 92071 and 92072 on the same day of service.

J. Rumpakis, O.D., M.B.A.
Practice Resource Management, Inc.
John@PRMI.com
Fitting A Contact Lens For OSD

• Rigid gas permeable scleral lens may be considered medically necessary for patients who have not responded to topical medications or standard spectacle or contact lens fitting, for the following conditions:
  - Corneal ectatic disorders (e.g., keratoconus, keratoglobus, pellucid marginal degeneration, Terrien’s marginal degeneration, Fuchs’ superficial marginal keratitis, post-surgical ectasia);
  - Corneal scarring and/or vascularization;
  - Irregular corneal astigmatism (e.g., after keratoplasty or other corneal surgery);
  - Ocular surface disease (e.g., severe dry eye, persistent epithelial defects, neurotrophic keratopathy, exposure keratopathy, graft vs. host disease, sequelae of Stevens Johnson syndrome, mucus membrane pemphigoid, post-ocular surface tumor excision, post-glaucome filtering surgery) with pain and/or decreased visual acuity.
Patient Notification

What It Is...
...And Why We Need It

Patient Notification of Services

- Two Types Of Patient Notification
- Specific Use For Each
- The ABN and NEMB
  - **ABN** - Advance Beneficiary Notice (New Form 1/2012)
    - **Financial Informed Consent**
    - Patient May Pay
    - Patient Signature Required
  - **NEMB** - Notice Of Exclusion From Medicare Benefits
    - Patient Must Pay – excluded benefits
    - Patient Signature NOT Required

New ABN Rules

- 2011 Version of Advance Beneficiary Notice of Noncoverage Must Be Used Beginning Sun Jan 1, 2012
- In May 2011, CMS released an updated version of the Advance Beneficiary Notice of Noncoverage (ABN) (form CMS-R-131), which will replace the 2008 version of this form. The 2011 version contains no substantive changes from the 2008 version of the notice and was approved by the Office of Management and Budget. The 2008 and 2011 ABN notices are identical except that the release date of “3/11” is printed in the lower left hand corner of the new version.
New ABN Rules

• Providers and suppliers are allowed to use either the 2008 or 2011 version of the ABN through the end of this year; beginning Sun Jan 1, 2012, they must begin using the 2011 version.
• ABNs issued after Sun Jan 1 that are prepared using the 2008 version of the notice will be considered invalid by Medicare contractors.
• 2008 versions of the ABN that were issued prior to Sun Jan 1 as long-term notification for repetitive services delivered for up to one year will remain effective for the length of time specified on the notice.

Modifiers For Patient Notification

• GA – “Waiver of Liability Statement Issued as Required by Payer Policy”
• GX – “Notice of Liability Issued, Voluntary Under Payer Policy”
• GY – “Statutory exclusions”
• GZ – “Expected Denial, No ABN on file”
  – Example: 92310-22-GA

Billing Additional Tests

• Routine testing = standing orders
  – Never billable
• Ordered testing
  – Based upon medical necessity
  – Bill with office visit
    • Use modifier when appropriate
  – Be aware of specific code requirements
  – Generally require an Interpretive Report
The Interpretation & Report

- Should Contain
  - Indications for testing
  - Whether the test was ordered
  - Test reliability
  - Test results
    - Comparative findings
    - Plan
  - Initiation of treatment
  - Doctors signature

Corneal Topography

- 92025 – Corneal Topography
  - For topography to be filed with an insurance claim, there must be an image of the topography or a topography database and an interpretation or report associated with the medical record.
  - This is classified as an unilateral or bilateral code, which means that each eye is not billed separately using modifiers.
  - Generally, topography needs to be billed with specific diagnoses, such as irregular astigmatism, keratoconus, corneal scar or corneal transplantation. There are a number of other applicable diagnoses, which vary by state and carrier.

Anterior Segment Photography

- 92285 - External Ocular Photography.
  - Although photography is a much better and faster documentation tool than a drawing in the chart, it rarely meets the definition of medical necessity, which means it is almost always payable by the patient and not billable to a medical carrier.
  - There are cases when photography may be necessary to communicate with a lab, capture the details of a fluorescein pattern or document pre-existing conditions, such as corneal scarring, microcystic edema or neovascularization. If medical necessity can appropriately be established, the photos either need to be printed and placed in the patient record, downloaded to the patient’s electronic medical record or documented in the patient medical record.
  - The photos must be kept in a separate referenceable database, and a complete interpretative report must be completed. Photography is considered a bilateral procedure, though some carriers do classify it as a unilateral procedure.
Special Anterior Segment Photography

- 92286 – Special Anterior Segment Photography
  - With interpretation and report, including specular endothelial microscopy and cell count.
  - This code is used when performing endothelial cell counts, which are helpful in determining the appropriateness of contact lens fits in sick eyes, such as cases of graft failure or Fuch’s dystrophy. According to Medicare guidelines (NCD 80.5), photography of the corneal endothelium is a covered procedure when reasonable and necessary for patients who meet one or more of the following criteria:
    - Slit lamp evidence of endothelial dystrophy (e.g., corneal guttata).
    - Slit lamp evidence of corneal edema.
    - Is to undergo a secondary intraocular lens implantation.
    - Previous intraocular surgery and requires cataract surgery.
    - Evidence of posterior polymorphous dystrophy of the cornea or iridocorneal endothelial syndrome (ICE).
    - To be fitted with extended wear contact lenses after intraocular surgery
    - To undergo a surgical procedure associated with a higher risk to corneal endothelium, e.g., phacoemulsification or refractive surgery

Corneal Abrasion

- Patient Presentation
  - Patient- P.Q.
    - 34 YOAM
    - VSP Insurance
    - No Medical
  - Thinks he scratched his right eye.
Corneal Abrasion

- Uncorrected VA's: O.D. 20/25 O.S. 20/20
- Uncorrected Near VA: O.U. J2
- Refraction: O.D. PLANO –0.50 X177 20/20
- O.S. PLANO 20/20
- Slit lamp shows typical corneal abrasion with flourescein

What Was 92070?

- Bandage Contact Lens?
- Therapeutic Contact Lens?
- Special Type Of Lens Required?
What Was 92070?

- Bandage Contact Lens?
- Therapeutic Contact Lens?
- Special Type Of Lens Required?
- 92070 – Fitting of a contact lens for medical or therapeutic purposes including supply of lens.

As of January 1, 2012

92070 Is No Longer A Valid Code

Two New Codes - 92071 & 92072

- CPT Code 92071 – Fitting of a contact lens for treatment of ocular surface disease.
- Please report materials IN ADDITION to this code using either 99070 or the appropriate HCPCS Level II material code.

This is now thought (NOT?) to be appropriate for a bandage CL situation.

Please do NOT report 92071 and 92072 on the same day of service.
Corneal Abrasion

Therapeutic Considerations

- Cycloplegic
- Antibiotic
- NSAID
- Pressure Patch Bandage CL
- Long Term...
  - Hyperosmotics
  - Lubrication therapy

Why No Material Code

- We are entitled to bill for materials if we are using a revenue based product, however if we are using a non-revenue product such as a trial lens (disposable) as our lens there would be no charge.

J. Rumpakis, O.D., M.B.A.
Practice Resource Management, Inc.
John@PRMI.com
Corneal Abrasion

$213.92

Keratoconus
Two New Codes - 92071 & 92072

- CPT Code 92072 – Fitting of a contact lens for management of Keratoconus, Initial Fitting. For subsequent fittings please use either the 9921X or 9201X codes.
- Please report materials IN ADDITION to this code using either 99070 or the appropriate HCPCS Level II material code.

Please do NOT report 92071 and 92072 on the same day of service.

Keratoconus

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies</th>
<th>Diagnosis Code</th>
<th>Date or Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>From</td>
<td>To</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/1/2012</td>
<td>11</td>
<td>02004</td>
<td>1</td>
<td>92072</td>
<td>1</td>
</tr>
<tr>
<td>2/1/2012</td>
<td>11</td>
<td>02015</td>
<td>1</td>
<td>$22.35</td>
<td>1</td>
</tr>
</tbody>
</table>

Keratoconus

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Place of Service</th>
<th>Type of Service</th>
<th>Procedures, Services, Supplies</th>
<th>Diagnosis Code</th>
<th>Date or Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>From</td>
<td>To</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/1/2012</td>
<td>11</td>
<td>02004</td>
<td>1</td>
<td>$119.66</td>
<td>1</td>
</tr>
<tr>
<td>2/1/2012</td>
<td>11</td>
<td>02015</td>
<td>1</td>
<td>$36.49</td>
<td>1</td>
</tr>
<tr>
<td>3/1/2012</td>
<td>11</td>
<td>02012</td>
<td>1</td>
<td>$608.00</td>
<td>2</td>
</tr>
</tbody>
</table>

What's Wrong With This Claim?
### Keratoconus

<table>
<thead>
<tr>
<th>Diagnosis Code: Keratoconus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service</td>
</tr>
<tr>
<td>From</td>
</tr>
<tr>
<td>1/11/2012</td>
</tr>
</tbody>
</table>

---

### “Intent” vs. “Impact”

There is often a clear difference that occurs between what you had intended to do and what you actually did.

Just Do It vs. Just Think About It
The Power Of I to the 4\textsuperscript{th} Power

Intent

Impact

Integrate

Implement

My Action Plan

What Do I Do Now?...

Take Positive Steps – Do It Now!

- Get Your Resource Material
  - CPT 2012
  - ICD-9 2012
  - HCPCS Level II 2012
  - www.ReimbursementPLUS.com
  - AOA.ReimbursementPLUS.com
  - Whatever you do, you must Stay Updated! Be Vigilant!

J. Rumpakis, O.D., M.B.A.
Practice Resource Management, Inc.
John@PRMI.com
If you have ever considered subscribing ReimbursementPLUS or currently have a competitive product, some things to keep in mind. Unlike our competitors disk based system, each module in the ReimbursementPLUS Suite of products is completely web-based with no software to install or update - EVER! It’s all automatic and continually updated. The critical information that you need is ALWAYS UP-TO-DATE and just a click away from anywhere you have internet access without additional charges for multi-user licenses; or network installations.

More Detailed - Less Work - Always Current
You may have never experienced the convenience and confidence that the leading internet-based CPT Code Information and Reimbursement Solution - ReimbursementPLUS can provide. There is no better time for ReimbursementPLUS to be a vital part of your practice. With your special Vision Source pricing - there is just simply no other technology today that delivers so much, for so little.

Listed below are just some of the features that make the ReimbursementPLUS Suite such a fantastic tool:

• Reduced Set-Up time – our NEW intuitive interview based set-up process is a breeze to use – reduces set-up time to just minutes...
• Automatic geographic localization – all rules, guidelines, and reimbursable items are specific to your practice's zip code.
• Automatic CPT data verification system that checks and validates all CPT and ICD-9 codes used in your practice for validity and accuracy in real-time while you enter them. Complete CPT and ICD-9 look-ups and references.
• Full LCD index look-up and report tools. Know every rule that applies to a specific CPT code.
• Search any covered diagnosis by procedure and any covered procedure by diagnosis – specific to where you practice.
• In-depth analysis of all CCI edits and a new easy Quick-Check of all compatible code pairs. Unique three-way view of code pairing issues. Complete display of all bundled code pairs.
• Complete listing of all CPT modifiers and all applicable modifiers used to override the National Correct Coding Initiative Edits (NCCI), when appropriate.
• Our intuitive Fee Analyzer, now with the ability to store unlimited “What-If” pricing scenarios for your fee schedule. Set your fees with the confidence of designed in profitability.

An Invitation...
Go To:

• http://www.ReimbursementPLUS.com
• http://AOA.ReimbursementPLUS.com

If you don’t have Real-Time information you are operating at high risk in your practice.

John’s 12-Step Program
Hi, My Name Is <blank...>
I am a reformed coder...
John’s 12-Step Program

1. Identify carriers with whom you want to be on their plan – it’s a business decision!
2. Establish “Needs Assessment” for your situation
   • Obtain resource material that you need
3. Create disease protocols for your office
   • Review the findings regarding the health and vision of each patient
   • Correspond with the patients PCP regarding your care and the patients condition
   • Develop system for appointing the patients next visit before they leave the office
   • Put the process in flow chart format

John’s 12-Step Program

4. Everyone in the office must be educated about the protocol and the process
   • All staff must be onboard with providing the highest level of care
     • Diagnosis
     • Treatment
     • Selection of Medication
5. Market your ability to provide primary care to your patient base
   • Set Goals, Objectives, Strategies, and Tactics for what you want to achieve

John’s 12-Step Program

6. Always perform the standard of care as your baseline
7. Document the medical record with your thoughts and impressions
8. Be vigilant about proper coding
   • Perform internal audits on a regular basis
   • Use a grading sheet on a regular basis
   • Keep up with change in coding protocols
   • Develop office strategy for change mgmt

J. Rumpakis, O.D., M.B.A.
Practice Resource Management, Inc.
John@PRMI.com
John’s 12-Step Program

9. Set your fees appropriately to capture maximum allowable
   • Develop appropriate fee schedule to maximize income while maintaining complete compliance
10. Be audit proof
11. Never be complacent!
12. Attend another coding class within the next 6 months – stay on top of it!