Scoring An "A" with RCM Management

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So Joe…What's the Pr

WHO SHOULD YOU LISTEN TO?

Wolfe, Newman, Rumpakis, Gadsby (not an OD), Sandy…***and me?***

There are likely some more (not many)

- 2021: CMS CERT study concludes claims paid incorrectly
- 2022: Somewhere between $100- is it is getting worse
- 2023: Too many optometrists focused on stretching reimbursement instead of accurate coding
- 2023: Too many optometrists listening to **"pseudo experts"** at the podium and especially on blogs
- 2023: Too much blog advice focused on **"I'M GETTING PAID"**

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PROOF??? Here's the latest from CERT

ov%202021%20Medicare%20FFS%20Supplemental%20Improper%20Payment%20Data_20211201%20-%20508%20Compliant_0.pdf

Improper Payment Rate made to Optometry – 6.4%

By comparison to Ophthalmology - 1.9%

Improper Payment Rate to Optometry DME – 89.5%

By comparison to national average – 28.6%

Reasons for Improper Payment

Insufficient Documentation – 79%

Incorrect Coding – 21%

WHY DOES THE ROBBER ROB THE BANK???

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How Complicated is Billing and Coding

In a word – **NOT!**

There are only four concepts that you need to understand and follow

- ✓ Reason for the visit
- ✓ Medical Necessity
- ✓ CPT, ICD and Payer rules
- ✓ Physician ethics

"Always do what's right for the patient and the money will follow"
Numerous Credits

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Get these right and your chances BEING audited go down by 75% and of LOSING an audit by 95%

1. Understand and follow reason for the visit – especially routine vs. medical
2. Understand what medical necessity means – especially related to office visit type and diagnostic tests
3. Understand trying to beat the system will only beat you
4. Understand that rational or not, rules are rules in vision plans

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#1
Reason For The Visit

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What Is The Reason for the Visit - RFV

- Simple concept…it is why THE PATIENT is seeking care from you TODAY *(not what care YOU want to deliver)*

Understanding this concept is fundamental to the whole process of medical reimbursement

- Do not address the reason for the visit, an auditor can/will deny the entire encounter as not medically necessary

→**It doesn't matter what YOU want to do, the only reimbursable service component is the one that answers the RFV!**

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NO!!! PROVE THAT? NO PROBLEM…

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 his/her physician for an eye examination* ***with no medical finding specific to the reason for the visit****,* ***the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathologic condition.***"

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You're kidding right – you're not saying a patient states their only concern is a "bump" on their eyelid and all I do is diagnose and treat the eyelid problem – not a comprehensive history, refraction, cover tests, ductions, screening visual fields, dilated internal, and give them three glasses prescriptions?

Actually, that is EXACTLY what the core principles of medical reimbursement say!

And talk to a health care attorney about the "liability fantasy" perpetuated by optometry

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Other "myths" about comprehensive eye exams

First and foremost, they are not medically necessary and NOT medical. And all these "creative" chief complaints mean absolutely nothing!

- Optometry creations for medical care
  - Comprehensive eye examination
  - Comprehensive medical eye examination
  - Eye health evaluation
  - Diabetic eye examination ← ?
- But my patient expects one
- I'm bound legally to do one
- I'm bound ethically to do one

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Diabetic patient is not medical???

A diabetic patient presenting with no symptoms and no abnormal findings technically is **routine.** It was made POSSIBLY medical by a CMS exception/ruling - ***IF YOU WANT IT TO BE.***

If you choose to bill medical for patients with diabetes, your best code choice is a 92004/14 because an uncomplicated diabetic diagnosis will not likely get you past a Level 3 EM.

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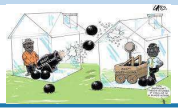
But Joe…

What about the blog "experts" saying not billing diabetic patient examinations as medical is insurance fraud?

That is 100% horse manure

What about the blog "experts" saying not billing diabetic patient examinations as medical is demeaning to our profession?

That is 100% their opinion and they are entitled to it. I suggest people who live in glass houses……..



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Vision vs Medical – Not That Hard!

Patient presents stating having trouble with near work. You find increasing their add gives them perfect near vision. No other findings

ROUTINE

Patient presents stating having trouble with near work. You find cataracts but increasing their add gives them perfect near vision.

YOUR CHOICE – BUT ONLY IF CATARACTS MAKING VISION WORSE

Patient presents stating having trouble with near work. You find AMD that limits vision despite increasing their add.

MEDICAL

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Vision vs Medical – Not That Hard!

Patient presents for new contacts and reports dry eyes. You find mild MGD and increase distance Rx.

YOUR CHOICE – BUT WAIT FOR NEXT TOPIC

Patient presents for yearly exam and has no symptoms or concerns and everything normal except you find a new choroidal nevus.

ROUTINE

Patient presents for new glasses but reports new Dx DM. You find no problems. Patient has VSP with $10 copay and BCBS with a $40 copay and and unmet $500 deductible.

NAME YOUR POISION

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BOTTOM LINE…

Patient's examination results in no findings related to the reason for the visit.

ROUTINE – EVERY SINGLE TIME

Patient's examination results in MEDICAL findings related to the reason for the visit that do not interfere with you conducting a comprehensive ocular examination

YOUR CHOICE – *POSSIBLY THE PATIENTS!*

Patient's examination results in MEDICAL findings related to the reason for the visit that limit your ability to conduct a comprehensive ocular examination

MEDICAL – EVERY SINGLE TIME

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Summary - Reason For the Visit

Unless dictated by the patient's payor or unless you have to fulfill some mindless requirements of your state law or vision plan, you perform a RFV/symptom-oriented exam and bill for medically necessary services just like the rest of the medical world does

It's SO SIMPLE…how does the rest of the healthcare world do it???

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BTW – Two Ways To Do That

Patient with VSP and BCBS presents with blurred vision simply needing Rx change. You find ocular hypertension and suspicious rim changes. You want to conduct and bill 92004, 92133 and 92083.

OPTION ONE

Bill 92004 to VSP with ametropic diagnosis. Bill 92133 and 92083 to BCBS. **MUST COLLECT COPAYS AND APPLICABLE DEDUCTIBLES FOR BOTH PAYERS.** *Which means…..*

OPTION ONE

Bill 92004 to VSP with ametropic diagnosis. Reschedule for glaucoma evaluation – bill 92133, 92083 AND appropriate office visit code to BCBS.

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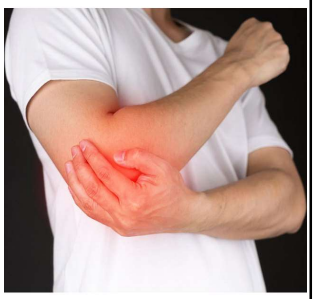
This is so simple!

"Doc…my elbow hurts!"



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#2
Medical Necessity

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Medical Necessity - Several Definitions

The easiest for me to understand

Will the results of this examination or testing influence or dictate my diagnosis and/or treatment of the patient?

(somewhat the basis of medical ethics)

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Medical Necessity

- Medical necessity is the ONLY justification for reimbursement for services rendered
- Specifically, it dictates whether actions or testing are "necessary" in the patient's care
- Medical necessity by law can ultimately be **determined** only by the attending physician, but operationally is often **dictated** by payor payment policy

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Medical Necessity vs Payment Policy

Payor Payment Policy is NOT really medical necessity. It is based on:

- Preferred Practice Patterns
- Established standards of care
- Scope of licensure
- Opinions / bias of payment determination panel
- Intangibles / unknowns / cost **(big and getting bigger)**

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Essential concept in medical reimbursement

Medical necessity ≠ Insurance benefits

If medically necessary – SOMEONE pays!

(because the rules say so, not Joe)

MDs never have a problem with this concept. ODs don't seem to have a problem with that concept when it comes to upselling products in the optical the patient has to pay for out of pocket (ouch!)

Why is medical care different?

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Let's revisit – "Your Choice"

Core Principle of Reimbursement

The only **REIMBURSABLE SERVICE COMPONENT** is one that is medically necessary based on the reason for the visit.

Let's visit how that determines the service code you should consider!

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Overuse of Comprehensive Ophthalmologic Code

Just the facts…

SERVICE CODE	CMS AVERAGES	OPTOMETRY AVERAGES	PCS AUDIT AVERAGES
92004 / 14	56%	**81%**	**92%**
92002 / 12	44%	19%	8%

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When can I use 92004 / 14? Straight from the CPT descriptor

*Ophthalmological services: **medical examination** (initiation of diagnostic and treatment program; co visits. Requires:*

- General evaluation of the complete visual system
- A medical history
- General medical observation
- Examination of external eye and adnexa
- Ophthalmoscopic examination (***usually*** dilated)
- Gross visual fields
- Basic sensorimotor exam
- Always includes initiation of diagnostic and treatment programs

Dilation does NOT mean the event was comprehensive

BIG POINT

Each item must be medically necessary based on the reason for the visit!

Code selection is NEVER based on what you did – **it is based on what you NEEDED TO DO**

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LET'S COMPARE

Potential complications from DM

Requires?
- General evaluation of the complete visual system **Y**
- A medical history **Y**
- General medical observation **Y**
- Examination of external eye and adnexa **Y**
- Ophthalmoscopic examination (***usually*** includes dilation) **Y**
- Gross visual fields **Y**
- Basic sensorimotor exam **Y**
- Always includes initiation of diagnostic and treatment programs **Y**

My eyes feel dry

Requires?
- General evaluation of the complete visual system **N**
- A medical history **Y**
- General medical observation **Y**
- Examination of external eye and adnexa **Y**
- Ophthalmoscopic examination (***usually*** includes dilation) **N**
- Gross visual fields **N**
- Basic sensorimotor exam **N**
- Always includes initiation of diagnostic and treatment programs **Y**

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Remember this one???

Patient presents for new contacts and reports dry eyes. You find mild MGD and increase distance Rx. **YOUR CHOICE – BUT WAIT FOR NEXT TOPIC**

CHOICE ONE
Decide this is medical. Bill 92012 (typically around $90) or 99213 (typically around $70-90 to medical plan) plus testing and treatment
TOTAL REVENUE: $70-90 all the way to $1000+

CHOICE TWO
Decide this is vision. Bill 92014 to vision plan (typically anywhere $40-80)
TOTAL REVENUE: $40-80

WHO IS GOOD AT MATH HERE?

CHOICE THREE
Provide vision care. Bill 92014 to vision plan (typically anywhere $40-80)
Return for medical care. Bill appropriate service code plus testing and treatment
TOTAL REVENUE: $110-170 all the way to $1000+
or other way around…depends

CHOICE FOUR
Bill vision care to vision plan and medical care to medical plan all at same encounter.

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AND – STRONGLY consider adopting the use of Evaluation and Management codes.

Did they change in 2021???

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YES! All the codes have new definitions…and every one of them requires "medically appropriate history and examination"….***MEANS WHAT?***

For services to be adjudicated as reimbursable…you must pass **two tests – not just medical decision-making**:

MEDICAL NECESSITY

Includes medically appropriate history/examination

COMPLETE REQUIREMENTS OF CPT DEFINITION

You MUST understand the new system of medical decision making

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MEANS WHAT???

Basic tenet of reimbursement DOES NOT CHANGE

1. The ONLY service code you are legally allowed to be reimbursed for is the one **BASED ON THE REASON FOR THE VISIT**
2. Medical decision making is defined by the **medically necessary services provided based on the reason for the visit**

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THE CARE DICTATES THE CODE

What the LAW says:

The individual patient presentation or what you have them returning for determines everything that you do with them, and therefore determines the services performed and the subsequent coding of those services.

THIS IS THE WAY IT WORKS

1. Why is the patient here
2. What do I do to answer that need
3. **What code(s) represent the care I delivered**

NOT THE OTHER WAY AROUND!!!

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Changes in E/M coding system

- Determination of code level based on the complexity of medical decision making
- Rules for a new patient same as an established patient
- This will likely result in the following ***estimated*** % changes
  - Level 2 – **DOWN**, new est. 10-15% of total
  - Level 3 – somewhat **down**, new est. 25-35% of total
  - Level 4 – **UP**, new est. 40-50% of total
  - Level 5 – somewhat **up**, new est. 10-15% of total
- ***Estimated minimum 18% raise using E/M vs Ophthalmologic codes***
- Definition of time changed, but **unless you are doing low vision or vision rehab, billing based on time will cost you money – KNOW WHAT THE NEW RULES SAY!!!**

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Explanation of the new EM coding system takes at least half an hour on its own.

For all attendees, PCS is willing to send you a copy of our Evaluation and Management Coding Primer – free.

Send a request to joe@pcscomply.com

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Medical Necessity of Diagnostic Testing

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One of the biggest misunderstandings in optometry – "Confirmatory Testing"

Per CMS:

*Medical record documentation must clearly indicate rationale which supports the medical necessity for performing **each** test. Documentation should also reflect how the test results were used in the patient's plan of care.*

"It would not be considered medically reasonable and necessary to perform any diagnostic procedure simply to provide additional confirmatory information for a diagnosis or treatment which has already been determined." (my emphasis added)

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So How Do I Decide If I Will Keep My Testing Money After an Audit?

In general, this is how an audit will come down:

- ✓ Is the need for the test related to the reason for the visit or incidental finding related to exam for the reason for the visit?
- ✓ Is the data usable?
- ✓ Does the outcome of the test directly contribute to the care of the patient?
- ✓ Need for the test stand alone against other known data (not confirmatory)?
- ✓ Is there a more simple or less expensive alternative test?
- ✓ Was the need for the test clear (explicit or ordered)?
- ✓ Was an interpretation and report documented?
- ✓ If a payment policy exists, was if followed?

(NOTE: If there wasn't one – all the other seven still apply!)

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#3
Pushing the Envelope

aka Playing Games With Your Reimbursement Money

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Playing With Diagnosis Codes

You MUST be specific to avoid audit denial – if not initial denial

- Per ICD Guidelines – ***"Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients."***
- "Other" codes – used when physical data meets no established ICD code
- "Unspecified" – used when your physical data is insufficient to assign a more specific code **(TRANSLATION: You didn't document enough – aka you didn't do your job. ACTION: Likely denial)**
  - **SUBNOTE: In glaucoma, "indeterminate" (OK to use) is NOT the same as "unspecified" (Do NOT use)**
- Signs and symptom codes – patient's complaint cannot be related to definitive diagnosis (TRANSLATION: You possibly didn't do your job. ACTION: Possible denial)
- **USING A NON-SPECIFIC OR ALTERNATE CODE TO "GET AROUND" PAYMENT RULES IS INSURANCE FRAUD AND TREATED AS SUCH**

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Playing With Diagnosis Codes

Z-Codes are VERY Complex

There are Z-codes for LOTS of things: exposure to disease, status of disease, history of disease, social determinant of health, screening procedures, counseling, follow up care…goes on.

Do NOT be misled by misinformation out there – Z-Codes are stated by ICD to be primary codes but expect denials and a fight for your money. **Better to come up with a better diagnosis!!!**

SPECIAL NOTE: If you are claiming a social determinant of health as part of your medical decision-making in the selection your level of EM service, **you MUST document the appropriate Z-code** (see list at end of the handout and those that could be most applicable to optometry)

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Playing With Credentialing

You have a new OD or more permanent fill in doc. Again, choices

CHOICE ONE
Simply bill all the new doctor's services under your established NPI
PROS: You'll "get paid" - illegally
CONS: Get caught, you will pay every dime back plus

CHOICE TWO
"Sign off" on all the new doctor's services and fill under your established NPI
PROS: You'll get paid – legally
CONS: It is a major hassle and looks weird to patients

CHOICE THREE
Utilize specific payer rules.
PROS: Works, IF the rules exist
CONS: Most payers DON'T have rules allowing uncredentialed doctor services

CHOICE FOUR
As a Texas OD – utilize the rapid credentialing law the TOA passed for you.
PROS: Works
CONS: May have to fight for your right to party and not accepted by Federal payers

BOTTOM LINE
Get to work on credentialing FAST

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Letting Your Staff Play Doctor

Don't like finishing your chart? Think your tech, billing person or remote worker can do it for you?

Guess what – that is NOT legal!!!

Per ICD-10-CM Guidelines April 1, 2023 FY23

*"Code assignment is based on the documentation by the patient's provider. Information is typically or may be documented by others involved in the care of the patient. However, the associated diagnosis **MUST BE DOCUMENTED BY THE PATIENT'S PROVIDER**."*

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Playing With Modifiers - 59

- Ten years running still the most audited modifier in healthcare
- ALMOST never an application in primary eye care – some rare applications for complex retinal disease
- ***NEVER applicable to bill fundus photos and scanning lasers during the same encounter in glaucoma***

(You may have heard there is an acceptable diagnosis list…there was…that is gone…replaced by a national edit against the two codes)

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Can they make it any more clear?

*Fundus photography and posterior segment SCODI performed on the same eye on the same day are mutually exclusive of one another **(National Correct Coding Initiative [NCCI] Policy Manual for Medicare Services)**. The provider is not precluded from performing both on the same eye on the same day when each service is necessary to evaluate and treat the patient. The medical record should clearly document the medical necessity of each service. **Frequent reporting of these services together will likely trigger focused medical review**.*

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=35038

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Playing With Modifiers - 25

The second most abused and actively audited modifier. Two problems:

- Certain "coding experts" are teaching to add the -25 modifier to all office visits to "bypass" the rules. That is called fraud. Three important words in healthcare reimbursement start with the letter "F" – fraud, felony, you are f….
- Providers do not understand that the office visit is included in the fee for a surgical procedure with only one exception – has been since 2007

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The OIG feels abuse of the -25 is a NATIONAL HEALTH CARE CONCERN and says…

"We (*NOT you…my edit*) will determine whether providers used modifier –25 appropriately. ***In general, a provider should not bill evaluation and management codes on the same day as a procedure or other service unless the evaluation and management service is unrelated to such procedure or service."***

CLEAR ENOUGH?

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Two common blog solutions…that do NOT hold up in an audit

Patient presents - pain after getting something in eye….needs corneal foreign body removal. Bill 65222 with NO office visit for about $60 bucks. ***Not fair…..***

CREATIVE SOLUTION #1: 99203 pays about $119 bucks…bill that instead of surgical code!

NO NO NO…you just broke CPT rules. You must bill the code that MOST ACCURATELY represents the service provided.

CREATIVE SOLUTION #2: Bill the office visit with diagnosis of corneal pain and FB removal with diagnosis of foreign body. NO NO NO – what does CMS say?

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

https://www.cms.gov/medicare/coding/icd10/downloads/2018-icd-10-cm-coding-guidelines.pdf

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Still not convinced? JUST IN!

Massachusetts Eye and Ear just got nailed for **$2.6 MILLION** for violations of False Claim Act

What did they violate?

IMPROPER USE OF THE -25 MODIFIER

Did someone just hear the mic drop??

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Playing With Cameras

Biggest issues

- ✕ Cannot document the absence of disease *(a few exceptions)*
- ✕ Cannot document absence of change *(no exceptions)*
- ✕ Screening vs medically necessary photos
- ✕ Photos substituting for ophthalmoscopy

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#4 Not Following Vision Plan Directives / Rules

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Not Making Vision Plan Happy – Part 1

Exam Requirements

- ➢ Read the history requirements, they are extensive
- ➢ Read the examination requirements, they are extensive
- ➢ Read the dilation requirements
- ➢ While you're at it, read what the agreement says about compliance issues

And understand they are ruthless, relentless and unforgiving. Let's talk about their new law…

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Not Making Vision Plan Happy – Part 2

Contact Lens Requirements (example VSP)

1. History must include the lenses worn, how they are worn, solutions used
2. Examination must document the fitting characteristics of the lenses (NOTE: Simply documenting WHAT trial lenses were used is not sufficient – need to note the fit)
3. Findings must include K's and SOR (mandate of VSP)
4. Assessment must state how the patient is doing with the lenses
5. The plan must state what you are doing going forward, even if that is no change

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Right now I start getting accused of costing doctors money…totally the opposite

- Do things the RIGHT way, always putting the patient first, you will **ALWAYS make more money in the end**
- Instead of trying to bend the system, make sure you are adhering to established preferred practice patterns. **You are likely leaving money on the table!**

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Just two examples – while too many are trying to run unnecessary tests on glaucoma and AMD patients to make more money – they leave this RECOMMENDED care on the table!

WHAT IS THE STANDARD OF CARE FOR FREQUENCY OF MONITORING A PATIENT WITH ALLERGIC CONJUNCTIVITIS?

According to the National Institute on Asthma, Allergy and Immunology – **once every six months**

PLAQUENIL IS NOT THE ONLY HIGH RISK MEDICATION IN EYE CARE

Patients taking ANY of the following medications should be monitored for potential ocular side effects: Thorazine, Nolvadex, Flomax, All corticosteroids, Aredia, Fosamax, Boniva, Zometa, Actonel, Topamax, Viagra etal, Accutane, Cordone, Zyrtec, Myambutol, Fluoroquinolones

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Time Permitting

REAL-LIFE EXAMPLES FROM THE WORLD OF OPTOMETRY BILLING AND CODING GONE WRONG

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CRAZY

Billing services for non-credentialed providers

Dr. Joe has two associate doctors that have worked with him for three years. The two associate doctors are not credentialed under Medicaid but the practice sees a lot of Medicaid patients so Dr. Joe files all services the other doctors provide under Dr. Joe's NPI. He has researched this on numerous blogs and finds ***everyone does things this way.***

Thank you blog experts….Dr Joe pays back $186,111

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CRAZIER

New, female patient presents with red eyes – OU progressive (10 days) mild pain, light sensitivity, decreased vision (20/80). Examination reveals injection, cells with elevated IOP 24mmHg (????). **Dx: Acute iritis.** Administered two drops **Lumigan** and asked the patient to return in the afternoon to see if pressure has gone down so further treatment can be initiated.

QUESTION: ***Do I bill a 92004 for the morning visit and a 92014 for the afternoon?***

EXPERT ANSWERS: FIFTEEN blog experts all agreed this would be the correct way to bill this encounter.

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MORE CRAZY

"Panel" Testing

Dr. Joe reads in a blog post – set up a list of tests his tech is delegated to perform whenever a patient comes in with certain complaints – like flashes/floaters, Hx AMD, patient has glaucoma, etc. The experts recommend bill everything on the list and let the payer decide what they will pay for then write off the rest. Dr. Joe implements these new protocols and is getting paid…very well. Life is good…

Thank you blog experts….Dr Joe pays back $189,312

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CRAZY? Listen up associate docs!

♬Money for nothing ♬ aka ♬ Smugglers Blues ♬

Added attraction…Who goes to jail here?

Dr Kim, Dr Joe's associate doctor, works hard and codes what he thinks is ethical and legally correct. Dr. Joe has testing "protocols" based on diagnoses. The billing person augments Dr. Kim's insurance submissions based on Dr. Joe's protocols. Dr. Kim has no idea this is happening until he is audited and receives a letter from Medicare asking for **over $253K** in overpayments and references an ongoing investigation of fraud charges.

Thank you blog experts. Dr Kim pays back $186,111. Dr Joe AND BILLING STAFF under investigation for insurance fraud.

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THE CRAZIEST EVER

STRAIGHT FROM ONE OF THE MOST POPULAR FACEBOOK SITES

Want a perfect example of why legislators may have a tough time believing your training story and why ophthalmologists may want to testify against you to protect the public???

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New patient came in for comprehensive medical examination. (?) She had no complaints (?). Stated in history she had occasional seizures and told technician she felt one coming on but wanted to continue with examination (?). Pre-test took a long time - patient wouldn't focus and was having trouble understanding directions (?). Refraction took 20 minutes - patient said she just couldn't concentrate. (?) We asked if she wanted to stop but she said she wanted to continue. Her words were slurring (?) but she said she had called her husband to come pick her up after exam. Went ahead and put dilating drops in (?) and when I came back to do internal ***patient was lying unconscious in husband's lap on the floor. Husband said he had already called 911.***

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Get ready…*remember this is a coding blog*

The question:

Since I couldn't complete the examination elements, how do I bill this?

Expert opinions from the insanity site.

Bill 92004 – you can complete the examination when the patient feels better

Bill 99203 today and 92014 when the patient comes back in

Bill 99205 with a diagnosis of seizures

Bill 92004 and complete on return but I don't think I would have dilated a patient who was having a seizure

They went on and on and on…17 creative billing suggestions

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THANK YOU!

Any questions… maybe at the bar or email me

joe@PCScomply.com

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Social Determinant of Health Z-Code Categories

- **Z-55** Problems related to education or literacy
- **Z-56** Problems related to employment or unemployment
- **Z-57** Occupational exposure to risk factors
- **Z-58** Problems related to physical environment
- **Z-59** Problems related to housing or economic circumstances
- **Z-60** Problems related to social environment
- **Z-63** Problems related to upbringing
- **Z-63** Problems related to primary support (family issues)
- **Z-64** Problems related to certain psychosocial circumstances
- **Z-65** Problems related to other psychosocial circumstances

POTENTIAL CODE USE IN OPTOMETRY SETTINGS

Z55.0	Illiteracy or low-level literacy
Z56.0	Unemployment
Z56.6	Physical or mental strain related to work
Z59.0	Homelessness
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other housing and economic conditions (problems with transportation)
Z63.4	Death of family member
Z60.2	Problems with living alone
Z59.3	Problems living in residential institution (nursing facility, etc.
Z63.0	Problems with relationship with spouse or partner
Z62.0	Inadequate parental supervision and control
Z62.22	Institutional upbringing
Z62.82	Parent-child conflict

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