MAKING SPECIALTY CONTACT LENS BILLING WORK

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JULY 31, 2022

TOA / PCS PRACTICE PERFECT SEMINAR: SUMMER VACATION EDITION

FINANCIAL DISCLOSURES

- PAID CONSULTANT
  - GPLI
  - REVIEW OF OPTOMETRY
  - NOVARTIS
  - PERCEPT
- EXPERT TESTIMONY
- CONTRIBUTING EDITOR: *CONTACT LENS SPECTRUM*
- NO PROPRIETARY INTEREST IN ANY SUBJECTS DISCUSSED
- FDA "OFF-LABEL" USES WILL BE DISCUSSED

COURSE OBJECTIVES

- THE OBJECTIVE OF THIS COURSE IS TO DISCUSS METHODS FOR CODING AND BILLING FOR MEDICALLY NECESSARY CONTACT LENSES AND FOR INCORPORATING ICD-10-CM INTO MEDICALLY NECESSARY CONTACT LENS PRESCRIBING.

LEARNING OBJECTIVES

- ATTENDEES OF THIS COURSE WILL LEARN:
  - EFFECTIVE CODING AND BILLING STRATEGIES FOR MEDICALLY NECESSARY CONTACT LENSES (MNCL)

BIG-TIME DISCLAIMER!!!!!!

This meeting is a gathering of competitors, which is one of the two criteria for violating the Sherman Anti-Trust Act. The other criterion for a *per se* violation is to agree to, or appear to agree to, do something, like set fees, or boycott a supplier, or another competitor. This lecture includes a discussion of fees. HOWEVER, THIS LECTURE IS NOT INTENDED IN ANY WAY TO BE CONSTRUED AS A DISCUSSION OF FEE SETTING. THE EXAMPLES GIVEN ARE INSTRUCTIONAL, AND ARE NOT INTENDED IN ANY WAY TO ENCOURAGE ANYONE TO SET ANY FEE AT ANY AMOUNT. QUESTIONS ABOUT FEES WILL NOT BE ANSWERED, AND DISCUSSION ABOUT FEES AMONG THE ATTENDEES OF THIS LECTURE, DURING THIS LECTURE, WILL NOT BE PERMITTED, AND IS STRONGLY DISCOURAGED AT ANY TIME AFTER THIS LECTURE!

The Ethics of This Stuff

I believe that it is a moral failure to possess a skill or a body of knowledge that can end human suffering, and then fail to use that skill or knowledge because you do not charge enough to make that service a viable part of your practice.

Most doctors fail in medically necessary prescribing not because they lack the skill, but because they lose interest and motivation when they start to lose money.

When you charge enough so that you don't lose money, then you stay motivated enough to solve these complicated cases. I submit to you, that that is ethical!

"CLARKE, EVERYTHING THAT HAPPENS IN YOUR PRACTICE IS YOUR FAULT"

-IRV BORISH

WHAT WE SAY DOESN'T MATTER (SORTA)

There is no escaping the fact that YOU have to do your homework to be successful at billing for medical services. There are enough contractual differences between carriers and between regions, that you have to determine what the payment policies and fees are for each type of service and for each carrier. If you practice in more than one locale, you have to do this legwork for each locale—PERIOD!

INTRODUCTION

- BASIC THIRD PARTY CONCEPTS
  - WHAT IS THE CONSUMER / PROVIDER / PAYOR / PURCHASER RELATIONSHIP?
  - WHAT IS THE DEFINITION OF "MEDICALLY NECESSARY?"
  - WHAT IS THE DIAGNOSIS / SERVICE / PAYMENT RELATIONSHIP?
  - WHAT ARE "COVERED" AND NON-COVERED" SERVICES?
- OPTOMETRIC FINANCIAL OATH
- MEDICALLY NECESSARY BILLING AND CODING
- SPECIALTY BILLING AND CODING

HEALTH CARE SERVICES

- CONTRACTED SERVICES
  - NEGOTIATED COVERAGE PRODUCTS BETWEEN PURCHASERS AND PAYORS
  - MOST INDEMNITY CARRIERS HAVE SEVERAL STANDARD PLAN OFFERINGS FROM WHICH PURCHASERS MAY CHOOSE
  - SOME HAVE CUSTOM NEGOTIATED PLANS
- HEALTH CARE SERVICES
  - COVERED SERVICE—DEEMED MEDICALLY NECESSARY IN THE TERMS OF THE NEGOTIATED COVERAGE PRODUCT
  - NON-COVERED SERVICES—DEEMED NOT MEDICALLY NECESSARY IN THE TERMS OF THE NEGOTIATED COVERAGE PRODUCT

COVERED *VS.* NON-COVERED

- THIS CONCEPT IS IMPORTANT TO MEDICALLY NECESSARY CONTACT LENS PRESCRIBING
- NON-COVERED SERVICES ARE LISTED BY EXCLUSIONS IN THE NEGOTIATED COVERAGE PRODUCT ("INSURANCE PLAN") AS DETAILED IN THE "SUMMARY PLAN DESCRIPTION" (SPD)
- NON-COVERED SERVICE EXCLUSIONS DO NOT DECIDE WHAT CARE YOU PROVIDE, JUST WHO PAYS FOR THE CARE YOU PROVIDE
  - INDEPENDENT CLINICAL JUDGMENT
  - NON-COVERED SERVICES ARE PAID BY THE CONSUMER DIRECTLY TO THE PROVIDER

THE OPTOMETRIC FINANCIAL OATH

I, [state your name], do solemnly swear or affirm that neither I, nor any of my business partners, spouses, concubines, long time companions, assigns, or heirs will never, ever, never, ever sign, or caused to be signed, any contract that I have not fully read and do not fully understand. Further, I swear or affirm that I shall not take food out of the mouths of my beloved family members by entering into any contract that is so onerously structured as to make no financial sense for me or my business. This oath I pledge, before God, Irv Borish, and all other Deities, to be my solemn vow.

PROPER STORAGE FACILITY FOR MOST CONTRACTS

WHAT IS THE DEFINITION OF MEDICALLY NECESSARY?

AMA Definition (1999)

"Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, treating, or rehabilitating an illness, injury, disease or its associated symptoms, impairments, or functional limitations in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site and duration; and (3) not primarily for the convenience of the patient, physician or other health care provider."

THE CMS DEFINITION

As published in CMS IOM Pub. 100-08, Chapter 13, Section **13.5.1**, in order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:
Safe and effective.

Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).

THE CMS DEFINITION

•Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

- Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
- Furnished in a setting appropriate to the patient's medical needs and condition.
- Ordered and furnished by qualified personnel.
- One that meets, but does not exceed, the patient's medical needs.
- At least as beneficial as an existing and available medically appropriate alternative.

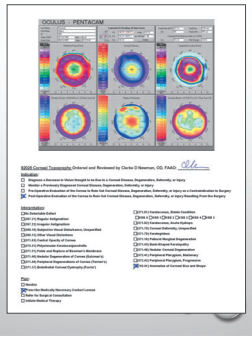
WHAT DOES THAT MEAN?

- THE PATIENT MUST HAVE AND ILLNESS, INJURY, OR DISEASE THAT HAS A SYMPTOM, IMPAIRMENT, OR FUNCTIONAL LIMITATION
- A TEST PERFORMED MUST HAVE AN INDICATION (SEE THE PREVIOUS POINT), AND THE RESULT MUST INFLUENCE THE TREATMENT PLAN
- A TREATMENT MUST BE A STANDARD OF CARE
- A TREATMENT CANNOT BE FOR MERE CONVENIENCE (COSMETIC LENSES)
- THE SERVICE OR PROCEDURE CANNOT BE EXPERIMENTAL AND MUST BE AT LEAST AS EFFECTIVE AS OTHER WELL-ESTABLISHED TREATMENTS

ESTABLISHING MEDICAL NECESSITY FOR A COVERED SERVICE

- A CHIEF COMPLAINT RATIONAL TO A COVERED SERVICE SUCH AS AN INJURY, ILLNESS, OR DISEASE
- PROVIDING A COVERED SERVICE MUST BE INDICATED BY THE CHIEF COMPLAINT AND MUST BE ORDERED
- IF THE COVERED SERVICE IS A DIAGNOSTIC TEST, THEN THE DIAGNOSTIC TEST MUST BE INTERPRETED AND IT MUST AFFECT YOUR CLINICAL DECISION MAKING

MORE ON DOCUMENTATION FOR MEDICAL NECESSITY


OCULUS – PENTACAM

92025 Corneal Topography Ordered and Reviewed by Clarke D Newman, OD, FAAO:

Indication:
- ☐ Diagnose a Decrease in Vision thought to be Due to a Corneal Disease, Degeneration, Deformity, or Injury
- ☐ Monitor a Previously Diagnosed Corneal Disease, Degeneration, Deformity, or Injury
- ☐ Pre-Operative Evaluation of the Cornea to Rule Out Corneal Disease, Degeneration, Deformity, or Injury as a Contraindication to Surgery
- ☒ Post-Operative Evaluation of the Cornea to Rule Out Corneal Disease, Degeneration, Deformity, or Injury Resulting From the Surgery

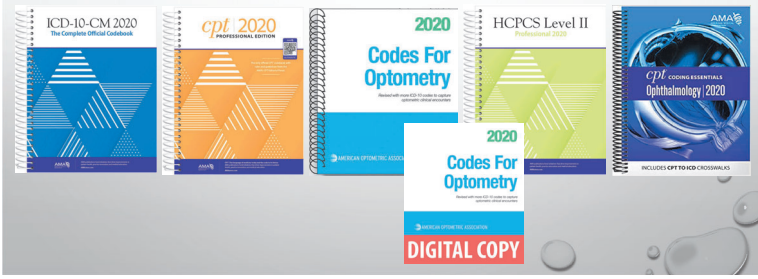
Interpretation:
- ☐ No Detectable Defect
- ☐ (367.21) Regular Astigmatism
- ☐ (367.22) Irregular Astigmatism
- ☐ (368.15) Subjective Visual Disturbance, Unspecified
- ☐ (368.15) Other Visual Distortions
- ☐ (371.03) Central Opacity of Cornea
- ☐ (370.31) Phlyctenular Keratoconjunctivitis
- ☐ (371.31) Folds and Rupture of Bowman's Membrane
- ☐ (371.46) Nodular Degeneration of Cornea (Salzmann's)
- ☐ (371.48) Peripheral Degenerations of Cornea (Terrien's)
- ☐ (371.57) Endothelial Corneal Dystrophy (Fuchs')
- ☐ (371.61) Keratoconus, Stable Condition
  - ☐ KS 0 ☐ KS 1 ☐ KS 2 ☐ KS 3 ☐ KS 4 ☐ KS 5
- ☐ (371.62) Keratoconus, Acute Hydrops
- ☐ (371.70) Corneal Deformity, Unspecified
- ☐ (371.70) Keratoglobus
- ☐ (371.10) Pellucid Marginal Degeneration
- ☐ (371.43) Bank-Shaped Keratopathy
- ☐ (371.46) Nodular Corneal Degeneration
- ☐ (372.41) Peripheral Pterygium, Stationary
- ☐ (372.42) Peripheral Pterygium, Progressive
- ☒ (743.41) Anomalies of Corneal Size and Shape

Plan:
- ☐ Monitor
- ☒ Prescribe Medically Necessary Contact Lenses
- ☐ Refer for Surgical Consultation
- ☐ Initiate Medical Therapy

GUIDANCE MATERIALS

- WEBSITES
  - CMS WWW.CMS.GOV
  - FISCAL INTERMEDIARY
    - FIND YOUR JURISDICTION
  - PRIVATE CARRIERS
- REFERENCE BOOKS
  - 2022 ICD-9-CM
  - 2022 CPT
  - 2022 HCPCS
  - 2022 ICD-10-CM
- MEETINGS & JOURNALS

REFERENCE BOOKS



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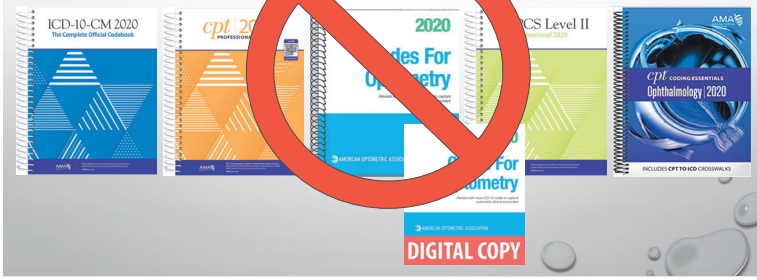
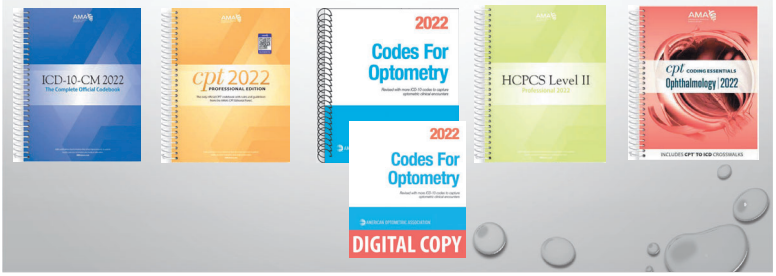


REFERENCE BOOKS



WEB BASED GUIDANCE

- OPTOMETRIC BILLING SOLUTIONS, INC.
  - DRS. JOE DELOACH AND PETER CASS, AND BJ AVERY AND SANDY YANKEE
  - HTTP://OPTOMETRICBILLING.COM/
- AOA EXCEL
  - HTTP://WWW.AOA.ORG/AOAEXCEL
- PRACTICE MANAGEMENT RESOURCES, INC.
  - DR. JOHN RUMPAKIS
  - HTTP://WWW.PRMI.COM/

ESTABLISHING THE DIAGNOSTIC CODE SET

- DIAGNOSIS CODES
  - ICD-10-CM, USED SINCE OCTOBER 1, 2015—IF YOU ARE STILL USING ICD-9, WTF?
  - CPT LEVEL I CODES (CREATED BY THE AMA CPT EDITORIAL PANEL)
  - HCPCS (CPT LEVEL II)
- CARRIER DETERMINATION POLICIES
  - NATIONAL CARRIER DETERMINATIONS (NCD) FOR EYES NCD 80
    - HTTP://WWW.CMS.GOV/REGULATIONS-AND-GUIDANCE/GUIDANCE/MANUALS/DOWNLOADS/NCD103C1_PART1.PDF
  - LOCAL CARRIER DETERMINATIONS (LCD)

WHAT WE SAY DOESN'T MATTER (SORTA)

There is no escaping the fact that YOU have to do your homework to be successful at billing for medical services. There are enough contractual differences between carriers and between regions, that you have to determine what the payment policies and fees are for each type of service and for each carrier. If you practice in more than one locale, you have to do this legwork for each locale—PERIOD!

VERY IMPORTANT CONCEPT: A TAUTOLOGY

It Is Not What You Get Paid!!!!

It Is What You Get to Keep at Audit!!!!

UNDERSTANDING CPT CODES

- CODE TEXT
  - PLAIN LANGUAGE RULES, UNLESS SPECIFICALLY SUPERSEDED BY OTHER INSTRUCTIONS
- CODE SUB-TEXT
  - OFTEN, THESE OTHER INSTRUCTIONS ARE CONTAINED IN SUB-TEXT COMMENTS
- CODE PRE-TEXT / PREAMBLE
  - A PREAMBLE CAN CONTAIN INFORMATION THAT SHAPES A CODE OR A GROUP OF CODES
    - E/M CODES HAVE A PREAMBLE AND CODE SUBTEXTS
    - 9231X CODES HAVE A PREAMBLE
- CPT ASSISTANT
- CPT CHANGES
- CMS PUB-100 GUIDANCE
  - NCD'S ARE PROMULGATED HERE

SERVICE CODE COMPONENTS

- GLOBAL COMPONENT
  - ALL COMPONENTS NECESSARY TO PERFORM THE PROCEDURE
- TECHNICAL COMPONENT
  - THE PORTION OF THE GLOBAL FEE ATTRIBUTED TO PERFORMING THE PROCEDURE
  - DESIGNATED BY MODIFIER -TC
- PROFESSIONAL COMPONENT
  - THE PORTION OF THE GLOBAL FEE ATTRIBUTED TO THE INTERPRETATION OF THE PROCEDURE RESULTS
  - DESIGNATED BY MODIFIER -26
- NOT ALL PROCEDURE CODES ARE SPLIT INTO TECHNICAL AND PROFESSIONAL COMPONENTS; THE CMS FEE SCHEDULE WILL BREAK IT OUT FOR YOU

THE RESOURCED BASED RELATIVE VALUE SYSTEM (RBRVS)

- THIS SYSTEM WAS DESIGNED TO ASSIGN VALUES TO SERVICES BASED ON THE "REALITIES" OF DELIVERING THAT SERVICE
- THESE VALUES ARE ESTABLISHED AND MODIFIED BY THE AMA RELATIVE VALUE UNIT AUDIT COMMITTEE (RUC), AND ARE SUPPOSED TO REPRESENT THE "AVERAGE WORK" TO DELIVER THE SERVICE IN QUESTION
- RVU = PHYSICIAN WORK + PRACTICE EXPENSE + MALPRACTICE EXPENSE X GPCI
- PAYMENT IS DETERMINE BY MULTIPLYING THE RVU BY A "CONVERSION FACTOR" THAT IS DETERMINED BY THE RESPECTIVE PAYORS—MAINLY CMS
- THE NEW MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) REPLACES THE OLD SUSTAINABLE GROWTH RATE FORMULA (SGR)
- THE 2022 CMS CONVERSION FACTOR IS $34.6062

EVALUATION AND MANAGEMENT SERVICES—NEW PATIENT

- 99201—LEVEL ONE
- 99202—LEVEL TWO
- 99203—LEVEL THREE
- 99204—LEVEL FOUR
- 99205—LEVEL FIVE
- A "NEW PATIENT" IS A PATIENT WHO HAS NOT RECEIVED ANY PROFESSIONAL SERVICES FROM THE PHYSICIAN / QUALIFIED HEALTH CARE PROFESSIONAL OR ANOTHER PHYSICIAN / QUALIFIED HEALTH CARE PROFESSIONAL OF THE **EXACT** SAME SPECIALTY **AND SUBSPECIALTY** WHO BELONGS TO THE SAME GROUP PRACTICE, WITHIN THE PREVIOUS THREE YEARS

EVALUATION AND MANAGEMENT SERVICES—ESTABLISHED PATIENT

- 99211—LEVEL ONE
- 99212—LEVEL TWO
- 99213—LEVEL THREE
- 99214—LEVEL FOUR
- 99215—LEVEL FIVE

GENERAL OPHTHALMOLOGICAL SERVICES

- NEW PATIENT
  - 92002—INTERMEDIATE SERVICE
  - 92004—COMPREHENSIVE SERVICE
- ESTABLISHED PATIENT
  - 92012—INTERMEDIATE SERVICE
  - 92014—COMPREHENSIVE SERVICE

OFFICE OR OTHER OUTPATIENT CONSULTATIONS

- 99241—LEVEL ONE
- 99242—LEVEL TWO
- 99243—LEVEL THREE
- 99244—LEVEL FOUR
- 99245—LEVEL FIVE
- NEW OR ESTABLISHED
- ONLY APPROPRIATE WHEN REQUESTED BY A PHYSICIAN (THAT WOULD BE US, OR AN MD, DO, DC, DDS, DPM) OR OTHER APPROPRIATE SOURCE (PA, RN, NP, DC, PT, OT, SW, PSYCH, ATTORNEY, OR INS. COMPANY)
- THE REQUEST MAY BE WRITTEN OR VERBAL THAT IS DOCUMENTED IN THE PATIENT RECORD, AND A WRITTEN REPORT IS REQUIRED IN RETURN
- CMS PUBLICATION 100-4, CHAPTER 12, SECTION 30.6.10 HTTP://WWW.CMS.HHS.GOV/MANUAL/DOWNLOADS/CLM104C12.PDF
- NEW CPT PREAMBLE TO THE E/M CODES THAT SPEAKS TO THE "TRANSFER OF CARE" VS. "CONCURRENT CARE"

OFFICE OR OTHER OUTPATIENT CONSULTATIONS

- 99241—LEVEL ONE
- 99242—LEVEL TWO
- 99243—LEVEL THREE
- 99244—LEVEL FOUR
- 99245—LEVEL FIVE
- NEW OR ESTABLISHED
- ONLY APPROPRIATE WHEN (BE US) OR OTHER APPROPRIATE SOURCE (PA, R NP, DC, PT, OT, SW, CH, ATTORN OR INS. COMPANY)
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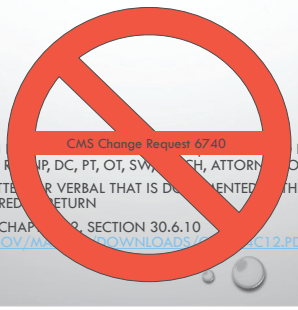
- CMS PUBLICATION 100-4, CHAP R, SECTION 30.6.10 HTTP://WWW.CMS.HHS.GOV/M OWNLOADS/ C12.PDF



OFFICE OR OTHER OUTPATIENT CONSULTATIONS

- THESE CODES USED TO BE THE BREAD AND BUTTER OF SPECIALTY LENS PRESCRIBING WHEN RUNNING A CONSULTATION PRACTICE
- SUBSEQUENT (FOLLOW UP) VISITS ARE BILLED AS EITHER E/M SERVICES OR GENERAL OPHTHALMOLOGICAL CODES
- ALL BUT DRIED UP

OTHER IMPORTANT PROCEDURE CODES

- 76514—CORNEAL PACHYMETRY, UNILATERAL OR BILATERAL (DETERMINATION OF CORNEAL THICKNESS)
- 76511—QUANTITATIVE A-SCAN ONLY(AXIAL LENGTH MEASUREMENT)
- 92015—DETERMINATION OF REFRACTION STATE
  - BASIC
  - COMPLEX (USE THE -22 MODIFIER FOR 150% OF THE U&C FEE)
- 92025—COMPUTERIZED CORNEAL TOPOGRAPHY, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT
- 92312—SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, ANTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL

OTHER IMPORTANT PROCEDURE CODES

- 92285—EXTERNAL OCULAR PHOTOGRAPHY WITH INTERPRETATION AND REPORT FOR DOCUMENTATION OF MEDICAL PROGRESS (E.G., CLOSE-UP PHOTOGRAPHY, SLIT LAMP PHOTOGRAPHY, GONIOPHOTOGRAPHY, STEREO-PHOTOGRAPHY (BILATERAL)
- 92286—ANTERIOR SEGMENT IMAGING WITH INTERPRETATION AND REPORT; WITH SPECULAR MICROSCOPY AND ENDOTHELIAL CELL COUNT (BILATERAL)
- 92499—ABBEROMETRY (UNLISTED OPHTHALMOLOGICAL SERVICE OR PROCEDURE)

MULTIPLE PROCEDURE PAYMENT REDUCTION (MPPR)

- NEW IN JANUARY 2013
- HTTP://WWW.CMS.GOV/OUTREACH-AND-EDUCATION/MEDICARE-LEARNING-NETWORK-MLN/MLNMATTERSARTICLES/DOWNLOADS/MM7848.PDF
- FOR OPHTHALMOLOGY SERVICES, FULL PAYMENT IS MADE FOR THE -TC SERVICE WITH THE HIGHEST PAYMENT UNDER THE MPFS. PAYMENT IS MADE AT 75 PERCENT FOR SUBSEQUENT -TC SERVICES FURNISHED BY THE SAME PHYSICIAN (OR BY MULTIPLE PHYSICIANS IN THE SAME GROUP PRACTICE, I.E., SAME GROUP NPI) TO THE SAME PATIENT ON THE SAME DAY.
- FOR THE PROCEDURE CODES COVERED BY THIS POLICY, LOOK AT APPENDIX "B" AT: HTTP://WWW.CMS.GOV/REGULATIONS-AND-GUIDANCE/GUIDANCE/TRANSMITTALS/DOWNLOADS/R1149OTN.PDF

WHAT CODES ARE AFFECTED?

Attachment 2

Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction	
Code	Descriptor
76510	Ophth us b & quant a
76511	Ophth us quant a only
76512	Ophth us b w/non-quant a
76513	Echo exam of eye water bath
76514	Echo exam of eye thickness
76516	Echo exam of eye
76519	Echo exam of eye
92025	Corneal topography
92060	Special eye evaluation
92081	Visual field examination(s)
92082	Visual field examination(s)
92083	Visual field examination(s)
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92136	Ophthalmic biometry
92228	Remote retinal imaging mgmt
92235	Eye exam with photos
92240	Icg angiography
92250	Eye exam with photos
92265	Eye muscle evaluation
92270	Electro-oculography
92275	Electroretinography
92283	Color vision examination
92284	Dark adaptation eye exam
92285	Eye photography
92286	Internal eye photography

WHAT CODES ARE AFFECTED?

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92060	Special eye evaluation
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92082	Visual field examination(s)
92083	Visual field examination(s)
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92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92136	Ophthalmic biometry
92228	Remote retinal imaging mgmt
92235	Eye exam with photos
92240	Icg angiography
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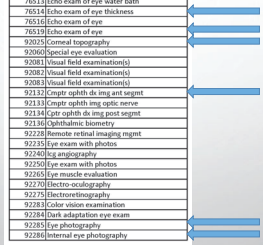
92284	Dark adaptation eye exam
92285	Eye photography
92286	Internal eye photography



IMPORTANT CPT CODE MODIFIERS
CPT MANUAL APPENDIX A

- -22: **UNUSUAL 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 MUST SUPPORT THE SUBSTANTIAL ADDITIONAL WORK AND THE REASON FOR THE ADDITIONAL WORK (I.E., INCREASED INTENSITY, TIME, TECHNICAL DIFFICULTY OF PROCEDURE, SEVERITY OF PATIENT'S CONDITION, PHYSICAL AND MENTAL EFFORT REQUIRED).
- THIS MODIFIER SHOULD NOT BE APPENDED TO E/M SERVICES
- EXAMPLE: USING THE 92310 ON A BI-TORIC OR QUADRANT SPECIFIC PRESCRIPTION
- EXAMPLE: DIFFICULT REFRACTION

IMPORTANT CPT CODE MODIFIERS
CPT MANUAL APPENDIX A

- -22: **UNUSUAL 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 MUST SUPPORT THE SUBSTANTIAL ADDITIONAL WORK AND THE REASON FOR THE ADDITIONAL WORK (I.E., INCREASED INTENSITY, TIME, TECHNICAL DIFFICULTY OF PROCEDURE, SEVERITY OF PATIENT'S CONDITION, PHYSICAL AND MENTAL EFFORT REQUIRED).
- THIS MODIFIER SHOULD NOT BE APPENDED TO E/M SERVICES
- EXAMPLE: USING ON
- EXAMPLE: DIFFICU

In January 2013, CMS decided that the -22 modifier only applied to surgeries or 60000 codes. HOWEVER, CPT rules state that the plain language text of a discrete code is operative, and the code does not say "surgical service," it says "service"

SOME GUIDANCE

"Modifier -22 is for physician reporting only (facilities may not report modifier -22), and should not be appended to evaluation and management (E/M) codes, according to CPT® guidelines. Most commonly, modifier -22 will accompany surgical claims—although modifier -22 also might apply to anesthesia services, pathology and lab services, radiology services, and medicine services. "

-AAPC, 2014

IMPORTANT CPT CODE MODIFIERS

- -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
- EXAMPLE: 92310 IS A BILATERAL PROCEDURE. IF YOU PRESCRIBE FOR ONE EYE, YOU SHOULD USE THE REDUCED SERVICE MODIFIER
- EXAMPLE: 92025 IS A UNILATERAL OR BILATERAL PROCEDURE. IF YOU PERFORM THE TEST ON BOTH EYES OR JUST ONE EYE ONLY, YOU DO NOT USE THE -51 MODIFIER
- EXAMPLE: 92285 SPECIFIES NEITHER BILATERAL OR UNILATERAL. CONTROVERSIALLY, ONE DOES NOT NEED TO USE THE -51 MODIFIER ON THESE CODES EVEN THOUGH THE CODE IS SPECIFIED AS "BILATERAL"

ADVANCED BENEFICIARY NOTIFICATION (ABN) MODIFIERS

- GA—WAIVER OF LIABILITY STATEMENT ISSUED, AS REQUIRED BY PAYER POLICY
- GX—NOTICE OF LIABILITY ISSUED, VOLUNTARY UNDER PAYER POLICY
- GY—ITEM OR SERVICE STATUTORILY EXCLUDED, DOES NOT MEET THE DEFINITION OF ANY MEDICARE BENEFIT
- GZ—ITEM OR SERVICE EXPECTED TO BE DENIED AS NOT REASONABLE AND NECESSARY

HTTPS://WWW.NOVITAS-SOLUTIONS.COM/WEBCENTER/PORTAL/MEDICAREJH/PAGEBYID?CONTENTID=00144508&_AFRLOOP=476331289924 58#!%40%40%3F_AFRLOOP%3D476331289924 58%26CONTENTID%3D00144508%26_ADF.CTRL-STATE%3DMG5VJGXVT_33

THE PRESCRIBING CODES

GET THIS STUFF RIGHT IF YOU WANT TO GET PAID

CPT PREAMBLE FOR THE 9231X CODES

The prescription of contact lenses includes specification of optical and physical characteristics (such as power, size, curvature, flexibility, gas-permeability). It is NOT a part of the general ophthalmological services.

The fitting of a contact lens includes instruction and training of the wearer and incidental revision of the lens during the training period.

Follow-Up of successfully fitted extended wear lenses is reported as part of a general ophthalmological service. (92012 *et seq*)

The supply of contact lenses may be reported as part of the fitting. It may also be reported separately by using the appropriate supply code."

CONTACT LENS SERVICES

- 92310(4)—PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEAL LENS, BOTH EYES, EXCEPT FOR APHAKIA
- 92311(5)—CORNEAL LENS FOR APHAKIA, ONE EYE
- 92312(6)—CORNEAL LENS FOR APHAKIA, BOTH EYES
- 92313(7)—CORNEOSCLERAL LENS
- 92325—MODIFICATION OF CONTACT LENS (SEPARATE PROCEDURE), WITH MEDICAL SUPERVISION OF ADAPTATION
- 92326—REPLACEMENT OF CONTACT LENS
- 92499—UNLISTED OPHTHALMOLOGICAL SERVICE OR PROCEDURE

CONTACT LENS SERVICES: IMPORTANT CONCEPTS

- CHARGE ANOTHER CONTACT LENS SERVICE FEE IF YOU CHANGE THE LENS DESIGN "SUBSTANTIALLY"
  - THAT IS, A CHANGE THAT IS NOT AN "INCIDENTAL REVISION"
- FOLLOW UP VISITS ARE NOT PART OF THE 9231X CODES. THE "SUPERVISION OF ADAPTATION" REQUIREMENT IS MET AT THE FIRST FOLLOW-UP VISIT IF THEY HAVE REACHED THE PRESCRIBED WEARING TIME
- SUBSEQUENT FOLLOW-UP VISITS ARE A PART OF A GENERAL OPHTHALMOLOGICAL SERVICE—YOU ARE MEDICALLY EVALUATING THE EFFECT OF THE PRESENCE OF THE CONTACT LENS ON THE OCULAR TISSUE

CONTACT LENS SERVICES—BANDAGE LENS

- 92070—BANDAGE CONTACT LENS CODE—NO LONGER IN USE!!!! IT WAS DELETED IN 2012. (I STILL GET QUESTIONS ON THIS)
- 92071—FITTING OF CONTACT LENS FOR TREATMENT OF OCULAR SURFACE DISEASE
  - DO NOT REPORT 92071 IN CONJUNCTION WITH 92072
  - REPORT SUPPLY OF LENS SEPARATELY WITH 99070 OR APPROPRIATE SUPPLY CODE

CONTACT LENS SERVICES—KERATOCONUS

- 92072—FITTING OF CONTACT LENS FOR MANAGEMENT OF KERATOCONUS, INITIAL FITTING
  - FOR SUBSEQUENT FITTINGS, REPORT USING EVALUATION AND MANAGEMENT SERVICES OR GENERAL OPHTHALMOLOGICAL SERVICES
  - DO NOT REPORT 92072 IN CONJUNCTION WITH 92071
  - REPORT SUPPLY OF LENS SEPARATELY WITH 99070 OR APPROPRIATE SUPPLY CODE

GUIDANCE ON THE 92072 CODE: "INITIAL FITTING"

ACCORDING TO THE CPT ASSISTANT, CODE 92072, FITTING OF CONTACT LENS FOR MANAGEMENT OF KERATOCONUS, INITIAL FITTING, IS REPORTED FOR INITIAL FITTINGS ONLY. THE DESCRIPTION OF WORK FOR INITIAL FITTINGS INCLUDES THE RESULTS OF DIAGNOSTIC TESTS DONE PRIOR TO CONTACT LENS FITTING TO ASSESS THE CORNEAL ECTASIA, WHICH ARE USED IN CONCERT WITH SLIT LAMP EXAMINATION TO ASSESS CORNEAL SHAPE AND DETERMINE INITIAL CONTACT LENS PARAMETERS (E.G., DIAMETER, BASE CURVE AND SECONDARY CURVES). LENS DESIGNS CAN INCLUDE CORNEAL, SCLERAL, HYBRID, OR PIGGYBACK SYSTEMS. KERATOMETRY, LID ANATOMY, TEAR FILM AND REFRACTION ARE ALSO PERFORMED AND/OR RECHECKED. IF THE LENS NEEDS TO BE CHANGED BECAUSE IT NO LONGER FITS THE PATIENT'S NEEDS, THE FITTING OF A NEW LENS IS CONSIDERED AN INITIAL FITTING AND SHOULD INCLUDE ALL OF THE SERVICES NOTED ABOVE.

GUIDANCE ON THE 92072 CODE: "INITIAL FITTING"

ACCORDING TO THE CPT ASSISTANT, CODE 92072, FITTING OF CONTACT LENS FOR MANAGEMENT OF KERATOCONUS, INITIAL FITTING, IS REPORTED FOR INITIAL FITTINGS ONLY. THE DESCRIPTION OF WORK FOR INITIAL FITTINGS INCLUDES THE RESULTS OF DIAGNOSTIC TESTS DONE PRIOR TO CONTACT LENS FITTING TO ASSESS THE CORNEAL ECTASIA, WHICH ARE USED IN CONCERT WITH SLIT LAMP EXAMINATION TO ASSESS CORNEAL SHAPE AND DETERMINE INITIAL CONTACT LENS PARAMETERS (E.G., DIAMETER, BASE CURVE AND SECONDARY CURVES). LENS DESIGNS CAN INCLUDE CORNEAL, SCLERAL, HYBRID, OR PIGGYBACK SYSTEMS. KERATOMETRY, LID ANATOMY, TEAR FILM AND REFRACTION ARE ALSO PERFORMED AND/OR RECHECKED. IF THE LENS NEEDS TO BE CHANGED BECAUSE IT NO LONGER FITS THE PATIENT'S NEEDS, THE FITTING OF A NEW LENS IS CONSIDERED AN INITIAL FITTING AND SHOULD INCLUDE ALL OF THE SERVICES NOTED ABOVE.

HCPCS MATERIAL CODES

- V2510—CONTACT LENS, GP, SPHERICAL, PER LENS
- V2511—CONTACT LENS, GP, TORIC, PER LENS
- V2512—CONTACT LENS, GP, BIFOCAL, PER LENS
- V2513—CONTACT LENS, GP, EXTENDED WEAR, PER LENS
- V2520—CONTACT LENS, HYDROPHILIC, SPHERICAL, PER LENS
- V2521—CONTACT LENS, HYDROPHILIC, TORIC, PER LENS
- V2522—CONTACT LENS, HYDROPHILIC, BIFOCAL, PER LENS
- V2523—CONTACT LENS, HYDROPHILIC, EXTENDED WEAR, PER LENS
- V2530—CONTACT LENS, IP, SCLERAL, PER LENS
- V2531—CONTACT LENS, GP, SCLERAL, PER LENS
- V2627—SCLERAL COVER SHELL
- V2599—CONTACT LENS, OTHER TYPE

USING THE UNLISTED CODES

- USE THE "UNLISTED CODES" (92499 & V2599) FOR SERVICES AND MATERIALS THAT ARE BEYOND THE SCOPE OF THE OTHER CONTACT LENS PRESCRIBING CODES
- MEDICALLY NECESSARY LENSES IN THIS CATEGORY
  - HYBRID LENSES
  - HAND PAINTED PROSTHETIC LENSES
  - LENSES MADE FROM OCULAR SURFACE MOLDING
  - MYOPIA MANAGEMENT
- NEED TO DESCRIBE IN BOX 19
- NEED LETTERS OF MEDICAL NECESSITY

IMPORTANT CONCEPTS

- THE DUMBEST OPTOMETRIC CONCEPT EVER!!!
  - THE "CONTACT LENS FITTING FEE"
- THE SECOND DUMBEST OPTOMETRIC CONCEPT EVER!!!
  - THE "CONTACT LENS CHECK"
- ONLY USE THE 92071 CODE FOR BANDAGE LENSES
- NCD 80.1—BANDAGE CONTACT LENS DETERMINATION
- NCD 80.4—APHAKIA AND COSMETIC EXCLUSION DETERMINATION
- NCD 80.5—SCLERAL SHELL DETERMINATION

NATIONAL CARRIER DETERMINATION 80.1 THERAPEUTIC BANDAGE

Some hydrophilic contact lenses are used as moist corneal bandages for the treatment of acute or chronic corneal pathology, such as bullous keratopathy, dry eyes, corneal ulcers and erosion, keratitis, corneal edema, descemetocele, corneal ectasis, Mooren's ulcer, anterior corneal dystrophy, neurotrophic keratoconjunctivitis, and for other therapeutic reasons.

Payment may be made under §1861(s)(2) of the Act for a hydrophilic contact lens approved by the Food and Drug Administration (FDA) and used as a supply incident to a physician's service. Payment for the lens is included in the payment for the physician's service to which the lens is incident. Contractors are authorized to accept an FDA letter of approval or other FDA published material as evidence of FDA approval. (See §80.4 of the NCD Manual for coverage of a hydrophilic contact lens as a prosthetic device.)

NATIONAL CARRIER DETERMINATION 80.4 COSMETIC EXCLUSION

Hydrophilic contact lenses are eyeglasses within the meaning of the exclusion in §1862(a)(7) of the Act and are not covered when used in the treatment of nondiseased eyes with spherical ametropia, refractive astigmatism, and/or corneal astigmatism. Payment may be made under the prosthetic device benefit, however, for hydrophilic contact lenses when prescribed for an aphakic patient.

Contractors are authorized to accept an FDA letter of approval or other FDA published material as evidence of FDA approval. (See §80.1 of the NCD Manual for coverage of a hydrophilic lens as a corneal bandage.)

NATIONAL CARRIER DETERMINATION 80.5 SCLERAL SHELL

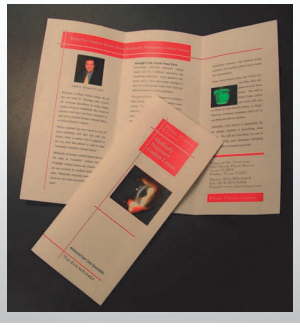
Scleral shell (or shield) is a catchall term for different types of hard scleral contact lenses. A scleral shell fits over the entire exposed surface of the eye as opposed to a corneal contact lens which covers only the central non-white area encompassing the pupil and iris. Where an eye has been rendered 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.

Scleral shells are occasionally used in combination with artificial tears in the treatment of "dry eye" of diverse etiology. Tears ordinarily dry at a rapid rate, and are continually replaced by the lacrimal gland. When the lacrimal gland fails, the half-life of artificial tears may be greatly prolonged by the use of the scleral contact lens as a protective barrier against the drying action of the atmosphere. Thus, the difficult and sometimes hazardous process of frequent installation of artificial tears may be avoided. The lens acts in this instance to substitute, in part, for the functioning of the diseased lacrimal gland and would be covered as a prosthetic device in the rare case when it is used in the treatment of "dry eye."

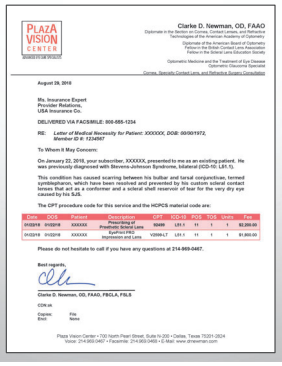
PATIENT MANAGEMENT ISSUES

- HAVE YOUR STAFF CONFIRM ELIGIBILITY AND REIMBURSEMENTS PRIOR TO THE PATIENT COMING IN WHENEVER POSSIBLE
- MATCH APPROPRIATE ICD-10-CM DIAGNOSTIC CODES TO THE APPROPRIATE CPT AND HCPCS SERVICE CODES
- USE A PATIENT BROCHURE TO EXPLAIN THE PROCESS OF PRESCRIBING MEDICALLY NECESSARY CONTACT LENSES
- SEND LETTERS OF MEDICAL NECESSITY WHEN NEEDED (HAVE THEM ALREADY WRITTEN IN DOCUMENT TEMPLATES)
  - SOME PRIVATE CARRIERS REQUIRE LMN'S
  - WHEN USING THE -22 MODIFIER—ALWAYS

BROCHURE ON MEDICALLY NECESSARY CONTACT LENS PRESCRIBING



LETTERS OF MEDICAL NECESSITY (LMN'S)



PLAZA VISION CENTER

Clarke D. Newman, OD, FAAO

August 29, 2018

Ms. Insurance Expert
Provider Relations,
USA Insurance Co.

DELIVERED VIA FACSIMILE: 800-555-1234

RE: *Letter of Medical Necessity for Patient: XXXXXX, DOB: 00/00/1972,*
Member ID #: 1234567

To Whom It May Concern:

On January 22, 2018, your subscriber, XXXXXX, presented to me as an existing patient. He was previously diagnosed with Stevens-Johnson Syndrome, bilateral (ICD-10: L51.1).

This condition has caused scarring between his bulbar and tarsal conjunctivae, termed symblepharon, which have been resolved and prevented by his custom scleral contact lenses that act as a conformer and a scleral shell reservoir of tear for the very dry eye caused by his SJS.

The CPT procedure code for this service and the HCPCS material code are:

Date	DOS	Patient	Description	CPT	ICD-10	POS	TOS	Units	Fee
01/22/18	01/22/18	XXXXXX	Fitting of Prosthetic Scleral Lens	92395	L51.1	11	1	1	$2,200.00
01/22/18	01/22/18	XXXXXX	EyePrint PRO Impression and Lens	V2599-LT	L51.1	11	1	1	$1,800.00

Please do not hesitate to call if you have any questions at 214-869-0467.

Best regards,

Clarke D. Newman, OD, FAAO, FBCLA, FSLS

CDN:sb

Copies:
Encl: File
None

Plaza Vision Center • 700 North Pearl Street, Suite N-200 • Dallas, Texas 75201-2824
Voice: 214-953-0467 • Facsimile: 214-953-0468 • E-Mail: www.drnewman.com

DOCUMENTATION

- REMEMBER, ALL DOCUMENTATION SHOULD SUPPORT YOUR DIAGNOSIS AND TREATMENT PLAN
- EACH TEST MUST BE RATIONAL TO THE DIFFERENTIAL DIAGNOSIS AS GUIDED BY THE CHIEF COMPLAINT
- FAILURE TO DOCUMENT FULLY THE CHIEF COMPLAINT, THE ASSOCIATED HPI, THE OBJECTIVE TESTING (INCLUDING THE ORDER, THE INTERPRETATION, AND CLINICAL DECISION MAKING), THE CL DIAGNOSTIC EVALUATION AND RESULTS MAY RESULT IN A FAILED AUDIT

CLINICAL EXAMPLES

LET'S WALK THROUGH ONE OR TWO OF THESE CASES

A KERATOCONUS PATIENT

- A 33 Y/O, WHITE, MALE
- REFERRED BY ANOTHER OD WITH A DX OF KERATOCONUS X 5 YRS TRANSFER OF CARE IMPLIED
- CC: MULTIPLE CL FAILURES
  - HPI: WORN CORNEAL RGP'S, MAINTAINS LESS THAN THREE HOURS OF LENS WEAR
- HX: OTHERWISE UNREMARKABLE

BILLING FOR THE INITIAL VISIT*

- DX: ICD-10-CM: H18.623—KERATOCONUS, UNSTABLE, BILATERAL

• 99205—E/M, LEVEL 5, NEW PATIENT	$245.16
• 92015-22—REFRACTION, COMPLEX (LMN)	$ 52.00
• 92285—EXTERNAL PHOTOGRAPHY	$ 26.01
• 76514—PACHYMETRY	$ 12.81
• 92025—CORNEAL TOPOGRAPHY	$ 40.72
• 92286—SPECULAR MICROSCOPY	$ 44.21
• 92499-RT—ABBEROMETRY	$ 40.00
• 92499-LT—ABBEROMETRY	$ 40.00
• 92072-RT—PRESCRIBING FOR KERATOCONUS	$143.74
• V2599—CONTACT LENS, OTHER TYPE, PER LENS (2 @ $387.00)	$774.00 (ULTRAHEALTH®)
TOTAL	$1,418.65

* 2022 LIMITING CHARGES FOR JURISDICTION H, TEXAS, LOCALITY 11

BILLING FOR THE INITIAL VISIT*

- DX: ICD-10-CM: H18.623—KERATOCONUS, UNSTABLE, BILATERAL

• 99205—E/M, LEVEL 5, NEW PATIENT	$245.16
• 92015-22—REFRACTION, COMPLEX (LMN)	$ 52.00
• 92285—EXTERNAL PHOTOGRAPHY	$ 26.01
• 76514—PACHYMETRY	$ 12.81
• 92025—CORNEAL TOPOGRAPHY	$ 40.72
• 92286—SPECULAR MICROSCOPY	$ 44.21
• 92499-RT—ABBEROMETRY	$ 40.00
• 92499-LT—ABBEROMETRY	$ 40.00
• 92072-RT—PRESCRIBING FOR KERATOCONUS	$143.74
• V2599—CONTACT LENS, OTHER TYPE, PER LENS (2 @ $387.00)	$774.00 (ULTRAHEALTH®)
TOTAL	$1,418.65

* 2022 LIMITING CHARGES FOR JURISDICTION H, TEXAS, LOCALITY 11

BILLING FOR THE INITIAL VISIT*

- DX: ICD-10-CM: H18.621—KERATOCONUS, UNSTABLE, RIGHT EYE

• 99205—E/M, LEVEL 5, NEW PATIENT	$0.00
• 92015-22—REFRACTION, COMPLEX (LMN)	$0.00
• 92285—EXTERNAL PHOTOGRAPHY	$0.00
• 76514—PACHYMETRY	$0.00
• 92025—CORNEAL TOPOGRAPHY	$0.00
• 92286—SPECULAR MICROSCOPY	$0.00
• 92499-RT—ABBEROMETRY	$0.00
• 92499-LT—ABBEROMETRY	$0.00
• 92072-RT—PRESCRIBING FOR KERATOCONUS	$0.00
• V2599—CONTACT LENS, OTHER TYPE, PER LENS (2)	$0.00 (ULTRAHEALTH®)
TOTAL	$0.00

* 2022 LIMITING CHARGES FOR JURISDICTION H, TEXAS, LOCALITY 11

BILLING FOR THE INITIAL VISIT*

- DX: ICD-10-CM: H18.621—KERATOCONUS, UNSTABLE, RIGHT EYE

• 99205—E/M, LEVEL 5, NEW PATIENT	$245.16
• 92015-22—REFRACTION, COMPLEX (LMN)	$0.00
• 92285—EXTERNAL PHOTOGRAPHY	$0.00
• 76514—PACHYMETRY	$0.00
• 92025—CORNEAL TOPOGRAPHY	$0.00
• 92286—SPECULAR MICROSCOPY	$0.00
• 92499-RT—ABBEROMETRY	$0.00
• 92499-LT—ABBEROMETRY	$0.00
• 92072-RT—PRESCRIBING FOR KERATOCONUS	$0.00
• V2599—CONTACT LENS, OTHER TYPE, PER LENS (2)	$0.00 (ULTRAHEALTH®)
TOTAL	$245.16

* 2022 LIMITING CHARGES FOR JURISDICTION H, TEXAS, LOCALITY 11

BILLING FOR THE INITIAL VISIT*

- DX: ICD-10-CM: H18.621—KERATOCONUS, UNSTABLE, RIGHT EYE

• 99205—E/M, LEVEL 5, NEW PATIENT	$245.16
• 92015-22—REFRACTION, COMPLEX (LMN)	$ 52.00
• 92285—EXTERNAL PHOTOGRAPHY	$ 26.01
• 76514—PACHYMETRY	$ 12.81
• 92025—CORNEAL TOPOGRAPHY	$ 40.72
• 92286—SPECULAR MICROSCOPY	$ 44.21
• 92499-RT—ABBEROMETRY	$ 40.00
• 92499-LT—ABBEROMETRY	$ 40.00
• 92072-RT—PRESCRIBING FOR KERATOCONUS	$143.74
• V2599—CONTACT LENS, OTHER TYPE, PER LENS (2)	$440.00 (ULTRAHEALTH®)
TOTAL	$1,418.65

* 2022 LIMITING CHARGES FOR JURISDICTION H, TEXAS, LOCALITY 11

BILLING FOR THE INITIAL VISIT*

- DX: ICD-10-CM: H18.621—KERATOCONUS, UNSTABLE, RIGHT EYE

• 99205—E/M, LEVEL 5, NEW PATIENT	$245.16
• 92015-22—REFRACTION, COMPLEX (LMN)	$ 52.00
• 92072-RT—PRESCRIBING FOR KERATOCONUS	$409.69
• V2599—CONTACT LENS, OTHER TYPE, PER LENS (2)	$774.00 (ULTRAHEALTH®)
TOTAL	$1,480.85

* 2022 LIMITING CHARGES FOR JURISDICTION H, TEXAS, LOCALITY 11

BILLING EYEMED*

- DX: ICD-10-CM: H18.621—KERATOCONUS, UNSTABLE, RIGHT EYE

• 99205—E/M, LEVEL 5, NEW PATIENT	$245.16
• 92015-22—REFRACTION, COMPLEX (LMN)	$ 52.00
• 92072-RT—PRESCRIBING FOR KERATOCONUS	$409.69
• 92012—GENERAL OPHTHALMOLOGICAL SERVICE, INTERMEDIATE, ESTABLISHED PATIENT (THREE VISITS @ $142.84)	$428.52
• V2599—CONTACT LENS, OTHER TYPE, PER LENS (2)	$774.00 (ULTRAHEALTH®)
TOTAL	$1,909.37

* 2022 LIMITING CHARGES FOR JURISDICTION H, TEXAS, LOCALITY 11

BILLING EYEMED*

- DX: ICD-10-CM: H18.621—KERATOCONUS, UNSTABLE, RIGHT EYE

• 92004—GENERAL OPHTHALMOLOGICAL SERVICE, COMPREHENSIVE NEW PATIENT	$169.18
• 92072-RT—PRESCRIBING FOR KERATOCONUS	$708.61
• V2599—CONTACT LENS, OTHER TYPE, PER LENS (2)	$774.00 (ULTRAHEALTH®)
TOTAL	$1,651.79

* 2022 LIMITING CHARGES FOR JURISDICTION H, TEXAS, LOCALITY 11

AN ANISOMETROPIA PATIENT

- A 25 Y/O, WHITE, FEMALE, ESTABLISHED PATIENT
- CC: EYE STRAIN WITH GLASSES
  - HPI: ALSO POOR DEPTH PERCEPTION
- HX: OTHERWISE UNREMARKABLE
- MANIFEST REFRACTION
  - OD: - 5.00 - 3.75 X 140 $20 / 25^{+2}$
  - OS: - 3.50 – 1.75 X 034 $20 / 20^{+1}$
- CORNEAL CURVATURE
  - OD: 48.00 / 51.00 @ 037
  - OS: 42.00 / 43.00 @ 127

BILLING FOR THE INITIAL VISIT*

- DX: ICD-10-CM: H52.3 ANISOMETROPIA

• 99205—E/M, LEVEL 5, NEW PATIENT	$245.16
• 92015-22—REFRACTION, COMPLEX	$ 52.00
• 92025—CORNEAL TOPOGRAPHY	$ 40.72
• 92313—RT: PRESCRIBING OF CORNEOSCLERAL LENS	$114.54
• 92313—LT: PRESCRIBING OF CORNEOSCLERAL LENS	$114.54
• V2521—CONTACT LENS, HYDROPHILIC, TORIC, PER LENS (12)	$280.00 (BIOFINITY®XR TORIC)
• V2521—CONTACT LENS, HYDROPHILIC, TORIC, PER LENS (12)	$280.00 (BIOFINITY®XR TORIC)
TOTAL	$1,126.96

* 2022 LIMITING CHARGES FOR JURISDICTION H, TEXAS, LOCALITY 11

VISION CARE PLAN MNCL BENEFITS

KNOW THESE PROCEDURES OR PAY THE PRICE

VISION CARE PLANS (VCP'S)

- VISION SERVICE PLAN (VSP)
- EYEMED (EM)
- SUPERIOR VISION
- VISION BENEFITS OF AMERICA (VBA)
- SPECTERA

THE LIMITED DATA SET

- PAYORS WILL SOMETIMES LIMIT THE DIAGNOSES THAT ARE CONSIDERED TO BE *PER SE* MEDICALLY NECESSARY TO A LIST
- THESE DATA SETS ARE PROMULGATED IN "CARRIER DETERMINATIONS"

VSP: VISUALLY NECESSARY CONTACT LENSES

- LOOK IN THE 2022 MANUAL
  - GO WWW.EYEFINITY.COM, AND LOG IN
  - CLICK "VSPONLINE" DOWN THE RIGHT-HAND SIDE
  - CLICK "MANUALS" DOWN THE LEFT-HAND SIDE
  - CLICK "VSP"
  - UNDER "PLANS AND COVERAGE," CLICK "CONTACT LENS BENEFITS"
  - SCROLL DOWN TO "VISUALLY NECESSARY CONTACT LENSES"
  - PRINT THE PDF VERSION AND KEEP IT AVAILABLE TO ANSWER QUESTIONS

VSP: QUALIFIED DIAGNOSES

- APHAKIA
- NYSTAGMUS
- KERATOCONUS
- ANIRIDIA
- CORNEA TRANSPLANT
- HEREDITARY CORNEAL DYSTROPHIES
- ANISOMETROPIA ≥ 3.00 D IN ANY MERIDIAN
- AMMETROPIA ≥ 10.00D IN ANY MERIDIAN
- IRREGULAR ASTIGMATISM

VSP: QUALIFIED DIAGNOSES

- ACHROMATOPSIA
- ALBINISM
- POLYCHORIA, ANISOCORIA (CONGENITAL)
- PUPILLARY ABNORMALITIES

VSP VISUALLY NECESSARY CONTACT LENSES

- VISUALLY NECESSARY CONTACT LENSES AREN'T TYPICALLY COVERED FOR PATIENTS WHO HAVE RECEIVED ANY ELECTIVE COSMETIC EYE SURGERY (E.G., LASIK, PRK, OR RK). HOWEVER, PROCEDURES RESULTING WITH CONCERNS SUCH AS ECTASIA, SCARRING OR IRREGULAR CORNEAS CAUSING VISION PROBLEMS THAT REQUIRE CONTACT LENSES TO PROVIDE FUNCTIONAL VISION, ARE COVERED UNDER THE NCL BENEFIT, SO LONG AS PATIENTS MEET THE NCL CRITERIA.
- IRREGULAR ASTIGMATISM BILLED IN THE PRIMARY POSITION AS THE CHIEF MEDICAL COMPLAINT DOES NOT MEET NCL COVERAGE CRITERIA. IRREGULAR ASTIGMATISM IS A CONDITION CAUSED BY OTHER UNDERLYING DISORDERS.
- FEES BILLED TO VSP FOR ALL CONTACT LENS PLAN BENEFITS MUST BE CONSISTENT WITH YOUR U&C CHARGES, REGARDLESS OF THE PATIENT'S COVERAGE OR ALLOWANCES.

VSP VISUALLY NECESSARY CONTACT LENSES

- TO SUBSTANTIATE BILLING FOR KERATOCONUS, BE SURE YOUR RECORDS INCLUDE: PATIENT HISTORY; K READINGS; BCVA WITH REFRACTION; SLIT LAMP EXAMINATION OF THE CORNEA; CORNEAL TOPOGRAPHY OR ANTERIOR OCT OF THE CORNEA.
- ENSURE THAT YOUR MEDICAL RECORDS ACCURATELY SUPPORT THE DIAGNOSIS SUBMITTED ON THE CLAIM WHEN BILLING FOR VISUALLY NECESSARY CONTACT LENSES. BY DOING SO YOUR PAYMENT WILL NOT BE DENIED IF THE DIAGNOSIS BILLED IS SUBSTANTIATED BY THE CLINICAL FINDINGS DOCUMENTED IN THE PATIENT'S RECORD.
- FAILURE TO RECORD YOUR CONTACT LENS EVALUATIONS, FITTINGS AND FOLLOW-UPS MAY RESULT IN THE DENIAL OF PAYMENT FOR SERVICES.
- DO NOT BALANCE BILL YOUR PATIENT THE DIFFERENCE BETWEEN VSP'S ALLOWED AMOUNTS AND YOUR U&C FEES FOR MATERIALS. EXAM AND MATERIAL (SPECTACLE LENSES AND FRAME) COPAYS APPLY UNLESS OTHERWISE SPECIFIED. ANY FITTING FEES INCURRED AFTER THE INITIAL 90 DAY PERIOD ARE CONSIDERED A PRIVATE MATTER BETWEEN YOU AND THE PATIENT.

VSP VISUALLY NECESSARY CONTACT LENSES

- FILE ON E-CLAIM
- FOR ANISOMETROPIA AND HIGH AMETROPIA, PROVIDE THE SPECTACLE RX
- FOR SCLERAL LENSES, USE HCPCS V2531
  - DO NOT USE THE V2530; ONLY USE THE V2531
- BILL HYBRID LENSES WITH HCPCS V2599
- FOR SCLERAL AND HYBRID LENSES, PROVIDE THE BRAND AND TYPE IN BOX 19
  - STATE WHETHER OR NOT THE LENS IS A "SCLERAL" OR HYBRID"
  - PROVIDE THE MANUFACTURER AND THE BRAND
- USE THE V2599 FOR LENSES THAT DO NOT HAVE A HCPCS CODE
  - HAND PAINTED LENSES, ETC

VSP VISUALLY NECESSARY CONTACT LENSES

- PIGGYBACK BENEFIT IS AVAILABLE FOR A PATIENT WHO MEETS THE PREVIOUSLY DISCUSSED CRITERIA, AND WHO IS INTOLERANT OF GP LENSES
  - PROVIDE INFORMATION ON PIGGYBACK LENS IN BOX 19
- SPECTACLE LENSES TO WEAR OVER CONTACTS BENEFIT
  - APHAKIA
  - HIGH AMMETROPIA ≥ 10.00D
  - PRESBYOPIA
  - ACCOMMODATIVE DISORDER
  - BINOCULAR FUNCTION DISORDER
  - DIFFERENT PRISM REQUIREMENTS FOR DISTANCE AND NEAR
  - PRESCRIPTION REQUIRED
  - CALL VSP (800-615-1883) FOR CLAIM NUMBER
  - 30 DAY TIME LIMIT
- 85% OF USUAL AND CUSTOMARY CHARGES FOR "CONTACT LENS EXAM SERVICES (FITTING AND EVALUATION)"

VSP: VISUALLY NECESSARY CONTACT LENSES

- THE BASIC EXAMINATION IS BILLED AND PAYABLE PER THE TERMS OF THE PLAN
- VSP REIMBURSES 85% OF USUAL AND CUSTOMARY CHARGES FOR "CONTACT LENS EXAM SERVICES (FITTING AND EVALUATION)"
- VSP REIMBURSES USUAL AND CUSTOMARY FEES FOR MATERIALS UP TO THE PLAN LIMITS
  - TWO SCHEDULES ON PLAN LIMITS
    - COVERED AND BASE VISUALLY NECESSARY CL MAXIMUMS
    - VISUALLY NECESSARY CL SPECIALTY MAXIMUMS
      - SERVICE DRIVEN OR DIAGNOSIS DRIVEN (SEE CHART)
      - MUST BILL 92072, 92311, OR 92312 OR ONE OF THE DIAGNOSES
- THE PATIENT IS RESPONSIBLE FOR EXAM AND MATERIAL COPAYMENTS

VSP VISUALLY NECESSARY CONTACT LENSES

Covered and Base Visually Necessary Contact Lens Maximums

HCPCS	Annual Replacement[1]	Planned Replacement[1]	Daily Replacement[1]
V2500*	$251	—	—
V2501*	$251	—	—
V2502*	$385	—	—
V2503*	$491	—	—
V2510*	$405	—	—
V2511*	$450	—	—
V2512*	$650	—	—
V2513*	$750	—	—
V2520	$500	—	—
V2521	$375	$525	$750
V2522	$525	$650	$810
V2523	$537	$650	$1000
V2530*	$475	$600	$625
V2531*	$499	—	—
V2599**	$987	—	—
Piggyback	$1,150	$1,500	—

VSP VISUALLY NECESSARY CONTACT LENSES

Visually Necessary Contact Lens Specialty Maximums

HCPCS	Annual Replacement[1]	Planned Replacement[1]	Daily Replacement[1]
V2500*	$451	—	—
V2501*	$585	—	—
V2502*	$691	—	—
V2503*	$605	—	—
V2510*	$657	—	—
V2511*	$800	—	—
V2512*	$900	—	—
V2513*	$825	—	—
V2520	$500	$650	—
V2521	$679	$804	—
V2522	$750	$863	—
V2523	$650	$775	$800
V2530*	$700	—	—
V2531*	$2,300	—	—
V2599**	$1,300	$1,650	—
Piggyback	$1,300	$1,650	—

VSP VISUALLY NECESSARY CONTACT LENSES

[1]Annual Replacement is 1-2 units. Planned Replacement is 3-360 units. Daily Replacement is 361+ units.
*These services shouldn't be billed for more than 2 units. If billed with higher unit counts, we'll pay up to the Annual Replacement lens maximum.
**These services shouldn't be billed for more than 360 units. If billed with higher unit counts, we'll pay up to the Planned Replacement lens maximum.
***Effective 2/6/2012, maximum reimbursement increased to $2,300. For dates of service between 10/1/2011 and 2/5/2012 maximum reimbursement is $1,300.
****As of 7/16/2012, V2520, V2521, and V2522 with units of 361+ are not covered under the Specialty Maximums. For dates of service between 10/1/2011 to 7/15/2012 maximum reimbursement is: V2520= $698; V2521= $833; V2522= $950.

EYEMED MEDICALLY NECESSARY CONTACT LENS BENEFIT

- CLICK HTTPS://EYEMED.COM/EN-US/PROVIDER LOG INTO SITE
- CLICK ON "PROVIDER SIGN IN"
- CLICK ON "PROVIDER MANUAL"
- GO TO PAGE 19

EYEMED MEDICALLY NECESSARY CONTACT LENS BENEFIT

- ANISOMETROPIA ≥ 3.00D
- HIGH AMETROPIA ≥ +/- 10.00D
- KERATOCONUS
- VISION IMPROVEMENT OTHER THAN KERATOCONUS FOR MEMBERS WHOSE VISION CAN BE CORRECTED BY TWO LINES ON THE VISUAL ACUITY CHART WHEN COMPARED TO THE BEST CORRECTED STANDARD SPECTACLE LENSES.
- PEDIATRIC ANIRIDIA (CA ONLY)
- PEDIATRIC APHAKIA (CA ONLY)
- PEDIATRIC CORNEAL DISORDER OR POST-TRAUMATIC DISORDER (CA HEALTH NET)
- PEDIATRIC PATHOLOGICAL MYOPIA (CA HEALTH NET)

EYEMED MEDICALLY NECESSARY CONTACT LENS BENEFIT

- KERATOCONUS
  - **EMERGING/MILD:** CONTACT LENSES IN THIS TIER ARE ANTICIPATED TO INCLUDE, HOWEVER NOT BE LIMITED TO, SCLERAL, SEMI-SCLERAL AND HYBRID DESIGNS/MATERIALS. THE BELOW SEVERITY SCALE APPLIES: MULTIPLE SPECTACLE REMAKES
  - UNSTABLE TOPOGRAPHY
  - LIGHT SENSITIVITY/GLARE ISSUES
  - SIGNS INCLUDING FLEISCHER RING, VOGT'S STRIAE AND SCISSOR REFLEX WITH RETINOSCOPY
  - NO SCARRING
  - TOPOGRAPHY (STEEP K <53D)
  - CORNEAL THICKNESS >475 MICRONS

EYEMED MEDICALLY NECESSARY CONTACT LENS BENEFIT

- KERATOCONUS
  - **MODERATE/SEVERE**: PATIENTS WHO BEGIN IN THE EMERGING OR MILD CATEGORIES AND ARE NOT SUCCESSFUL WITH CONTACT LENS MATERIALS AND KERATOCONUS DESIGNS MAY BE ELEVATED INTO THIS MODERATE/SEVERE TIER. CONTACT LENSES IN THIS TIER ARE ANTICIPATED TO INCLUDE HOWEVER NOT BE LIMITED TO SCLERAL, SEMI-SCLERAL AND HYBRID DESIGNS/MATERIALS. PATIENTS WHO QUALIFY AS MODERATE/SEVERE WILL HAVE ALL OF THE EMERGING/MILD SYMPTOMS, PLUS MILD TO NO SCARRING OR SOME SCARRING
  - TOPOGRAPHY (STEEP K OF 53D OR HIGHER)
  - CORNEAL THICKNESS UP TO 475 MICRONS
  - REFRACTION NOT MEASURABLE

EYEMED MEDICALLY NECESSARY CONTACT LENS BENEFIT

- ONE BENEFIT PER CALENDAR YEAR
- CALL 888-581-3648 FOR AUTHORIZATION
- REPORT ON A EYEMED NECESSARY CONTACT LENS FORM (DOWNLOAD) AND FAX TO 866-293-7373

EYEMED MEDICALLY NECESSARY CONTACT LENS BENEFIT

Qualifying Criteria	Contracted Provider Reimbursement
Anisometropia	95% of U&C up to $700
High Ametropia	95% of U&C up to $700
Keratoconus	95% of U&C up to $1,200 (Mild/Moderate) 95% of U&C up to $2,500 (Advanced/Ectasia)
Vision Improvement	95% of U&C up to $2,500

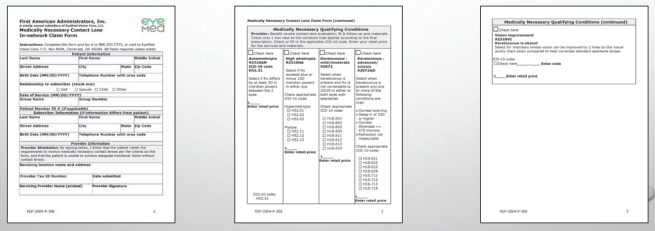
EYEMED MEDICALLY NECESSARY CONTACT LENS BENEFIT

Qualifying Criteria (Only in CA for Pediatric Plan)	Contracted Provider Reimbursement
Pediatric Aniridia	95% of U&C up to $3,730
Pediatric Aphakia	95% of U&C up to $5,800
Pediatric Corneal & Post-Trauma Disorder (Billed as Visual Improvement)	95% of U&C up to $2,500
Pediatric Pathological Myopia	95% of U&C up to $700

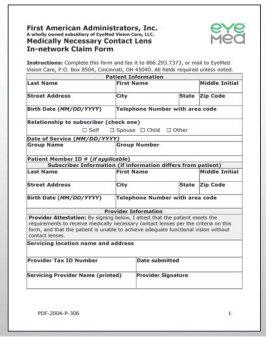
EYEMED MEDICALLY NECESSARY CONTACT LENS BENEFIT

Qualifying Criteria	Non-Standard Medically Necessary Contact Lens Codes*
Anisometropia	92310AN
High Ametropia	92310HA
Keratoconus	92072
Vision Improvement	92310VI
Pediatric Aniridia	92310AI
Pediatric Aphakia	92310AP
Pediatric Corneal Post-Trauma Disorder	92310VI
Pediatric Pathological Myopia	92310PM

EYEMED MEDICALLY NECESSARY CONTACT LENS CLAIM FORM



EYEMED MEDICALLY NECESSARY CONTACT LENS CLAIM FORM



First American Administrators, Inc.
A wholly owned subsidiary of EyeMed Vision Care, LLC.
Medically Necessary Contact Lens In-network Claim Form

Instructions: Complete this form and fax it to 866.293.7373, or mail to EyeMed Vision Care, P.O. Box 8004, Cincinnati, OH 45240. All fields required unless noted.

Patient Information

Last Name	First Name	Middle Initial
Street Address	**City**	**State** **Zip Code**
Birth Date (MM/DD/YYYY)	**Telephone Number with area code**	

Relationship to subscriber (check one)
☐ Self ☐ Spouse ☐ Child ☐ Other

Date of Service (MM/DD/YYYY)	
Group Name	**Group Number**

Patient Member ID # (if applicable)

Subscriber Information (if information differs from patient)

Last Name	First Name	Middle Initial
Street Address	**City**	**State** **Zip Code**
Birth Date (MM/DD/YYYY)	**Telephone Number with area code**	

Provider Information

Provider Attestation: By signing below, I attest that the patient meets the requirements to receive medically necessary contact lenses per the criteria on this form, and that the patient is unable to achieve adequate functional vision without contact lenses.

Servicing location name and address	
Provider Tax ID Number	**Date submitted**
Servicing Provider Name (printed)	**Provider Signature**

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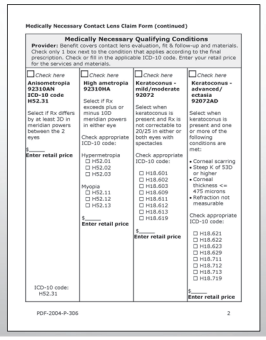
EYEMED MEDICALLY NECESSARY CONTACT LENS CLAIM FORM



Medically Necessary Contact Lens Claim Form (continued)

Medically Necessary Qualifying Conditions

Provider: Benefit covers contact lens evaluation, fill & follow-up and materials. Check only 1 box next to the condition that applies according to the final prescription. Check or fill in the applicable ICD-10 code. Enter your retail price for the services and materials.

☐ Check here **Anisometropia** **92310AN** **ICD-10 code** **H52.31**	☐ Check here **High ametropia** **92310HA**	☐ Check here **Keratoconus - mild/moderate** **92072**	☐ Check here **Keratoconus - advanced/ectasia** **92072AD**
Select if Rx differs by at least 3D in meridian powers between the 2 eyes $ _____ **Enter retail price**	Select if Rx exceeds plus or minus 10D meridian powers in either eye Check appropriate ICD-10 code: Hypermetropia ☐ H52.01 ☐ H52.02 ☐ H52.03 Myopia ☐ H52.11 ☐ H52.12 ☐ H52.13 $ _____ **Enter retail price**	Select when keratoconus is present and Rx is not correctable to 20/25 in either or both eyes with spectacles Check appropriate ICD-10 code: ☐ H18.601 ☐ H18.602 ☐ H18.603 ☐ H18.609 ☐ H18.611 ☐ H18.612 ☐ H18.613 ☐ H18.619 $ _____ **Enter retail price**	Select when keratoconus is present and one or more of the following conditions are met: • Corneal scarring • Steep K of 53D or higher • Corneal thickness <= 475 microns • Refraction not measurable Check appropriate ICD-10 code: ☐ H18.621 ☐ H18.622 ☐ H18.623 ☐ H18.629 ☐ H18.711 ☐ H18.712 ☐ H18.713 ☐ H18.719 $ _____ **Enter retail price**

ICD-10 code: H52.31

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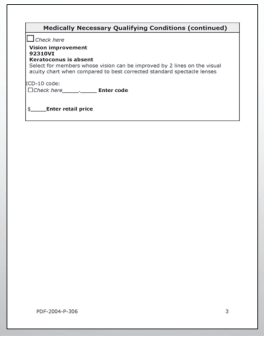
EYEMED MEDICALLY NECESSARY CONTACT LENS CLAIM FORM



Medically Necessary Qualifying Conditions (continued)

☐ Check here

Vision improvement
92310V2
Keratoconus is absent
Select for members whose vision can be improved by 2 lines on the visual acuity chart when compared to best corrected standard spectacle lenses

ICD-10 code:
(Check here)_____ **Enter code**

$_____**Enter retail price**

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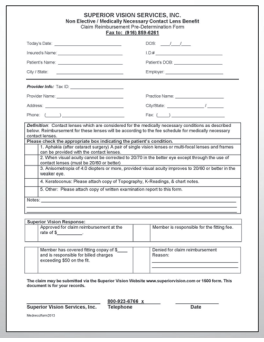
SUPERIOR VISION NON ELECTIVE/MEDICALLY NECESSARY CONTACT LENS BENEFIT

- GO TO WWW.SUPERIORVISION.COM
- CLICK "PROVIDERS"
- LOG IN WITH USER NAME AND PASSWORD
- CLICK "PROVIDER RESOURCES" DOWN THE LEFT HAND SIDE
- CLICK "EMPLOYER GROUP"
- CLICK "FORMS AND PUBLICATIONS"
- CLICK ON "MEDICALLY NECESSARY CONTACT LENS CLAIM REIMBURSEMENT AUTHORIZATION FORM"

SUPERIOR VISION NON ELECTIVE/MEDICALLY NECESSARY CONTACT LENS BENEFIT



SUPERIOR VISION SERVICES, INC.
Non Elective / Medically Necessary Contact Lens Benefit
Claim Reimbursement Pre-Determination Form
Fax to: (816) 559-6261

Today's Date: _____ DOB: ___/___/___
Insured's Name: _____ I.D.#: _____
Patient's Name: _____ Patient's DOB: _____
City / State: _____ Employer: _____

Provider Info: Tax ID: _____
Provider Name: _____ Practice Name: _____
Address: _____ City/State: _____/_____
Phone: (___)___-____ Fax: (___)___-____

Definition: Contact lenses which are considered for the medically necessary conditions as described below. Reimbursement for these lenses will be according to the fee schedule for medically necessary contact lenses.

Please check the appropriate box indicating the patient's condition.

☐ 1. Aphakia (after cataract surgery) A pair of single vision lenses or multi-focal lenses and frames can be provided with the contact lenses.
☐ 2. When visual acuity cannot be corrected to 20/70 in the better eye except through the use of contact lenses (must be 20/60 or better)
☐ 3. Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weaker eye.
☐ 4. Keratoconus: Please attach copy of Topography, K-Readings, & chart notes.
☐ 5. Other: Please attach copy of written examination report to this form.

Notes: _____

Superior Vision Response:

☐ Approved for claim reimbursement at the rate of $_____. ☐ Member is responsible for the fitting fee.

☐ Member has covered fitting copay of $____ and is responsible for billed charges exceeding $50 on the fit. ☐ Denied for claim reimbursement Reason: _____

The claim may be submitted via the Superior Vision Website www.superiorvision.com or 1500 form. This document is for your records.

Superior Vision Services, Inc. **800-922-0768 x** _____ **Telephone** _____ **Date**

MedicareRuns2013

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Notes: _____

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OTHER BILLING CONSIDERATIONS

- KNOW YOUR CHAIR COSTS (NOV, 2008 *SPECTRUM*)
- KNOW HOW MUCH TIME IT TAKES TO PRESCRIBE, ORDER, RECEIVE, DISPENSE, INSTRUCT, AND FOLLOW THROUGH ADAPTION EACH TYPE OF SPECIALTY LENS
- ADD YOUR PROFIT FOR A RATIONAL AND DEFENSIBLE INITIAL DISPENSING FEE
- CHARGE FOR FOLLOW UP VISITS AFTER THAT
- KNOW THE LENS COST, NUMBER OF LENSES PER EYE IT TAKES TO ACHIEVE SUCCESS, THE RETURN POLICY, AND THE DELIVERY COST OF EACH LENS
- ADD YOUR PROFIT FOR A RATIONAL AND DEFENSIBLE LENS FEE

FINAL THOUGHT

- THE GROSS PER PATIENT VISIT FOR PRESCRIBING SPECIALTY CONTACT LENSES, ESPECIALLY MEDICALLY NECESSARY LENSES, IS NEARLY TWICE THE NATIONAL AVERAGE FOR ALL OTHER TYPES OF EYE CARE
- THESE PATIENTS NEED GLASSES ALSO
- THESE PATIENTS HAVE OTHER MEDICAL CONDITIONS ALSO
  - GLAUCOMA
  - DRY EYE DISEASE
  - MACULAR DEGENERATION

CONCLUSIONS

- KNOW WHAT THE CONTRACTS SAY FOR EACH CONTRACT FOR EACH CODE THAT YOU USE IN YOUR OFFICE
- USE THE CORRECT CODES AND MODIFIERS TO MAXIMIZE THE REIMBURSEMENT FOR THE SERVICES RENDERED
- BILL APPROPRIATELY FOR ALL OF YOUR SERVICES—FORGET ABOUT "FITTING FEES"
- MAKE SURE THAT YOUR FEES ARE IN LINE WITH THE CONTRACTS THAT YOU HAVE SIGNED, BUT HIGH ENOUGH TO BE COMMENSURATE WITH THE COMPLEXITY, TIME, AND LIABILITY INVOLVED
- LEARN TO CONSULT WITH YOUR COLLEAGUES—IT WON'T HURT ONE BIT
- LEARN TO PROMOTE THIS ASPECT OF YOUR PRACTICE

CONCLUSIONS

- BE CONSISTENT
- HAVING THE RIGHT TOOLS—KNOW WHERE TO FIND THE INFORMATION, I.E., CODE BOOKS, CONTRACTS, ETC.
- DON'T BE A SLAVE TO THIRD PARTY PAYERS—YOU DECIDE WHAT TESTS AND PROCEDURES NEED TO BE DONE; THEY DECIDE WHAT THEY WILL PAY FOR
- COMMUNICATE WITH YOUR PATIENTS
- DON'T BE AFRAID TO APPEAL REJECTIONS OR SEND THIRD PARTY PAYERS TO COLLECTION (BE CAREFUL ABOUT THE ARBITRATION AGREEMENTS IN YOUR CONTRACTS)

REIMBURSEMENT PARADIGMS IN MYOPIA MANAGEMENT

CLARKE D. NEWMAN, OD, FAAO, FBCLA, FSLS, FNAP

JULY 31, 2022

TOA / PCS PRACTICE PERFECT SEMINAR: SUMMER VACATION EDITION

COURSE OBJECTIVES

- THE OBJECTIVE OF THIS COURSE IS TO DISCUSS METHODS FOR CODING AND BILLING FOR MYOPIA MANAGEMENT CONTACT LENSES AND FOR INCORPORATING ICD-10-CM INTO MYOPIA MANAGEMENT CONTACT LENS PRESCRIBING.

LEARNING OBJECTIVES

- ATTENDEES OF THIS COURSE WILL LEARN:
  - EFFECTIVE CODING AND BILLING STRATEGIES FOR MYOPIA MANAGEMENT CONTACT LENSES (MMCL)
  - HOW ICD-10-CM HAS CHANGED THE GAME FOR MMCL

BIG-TIME DISCLAIMER!!!!!!

This meeting is a gathering of competitors, which is one of the two criteria for violating the Sherman Anti-Trust Act. The other criterion for a *per se* violation is to agree to, or appear to agree to, do something, like set fees, or boycott a supplier, or another competitor. This lecture includes a discussion of fees. HOWEVER, THIS LECTURE IS NOT INTENDED IN ANY WAY TO BE CONSTRUED AS A DISCUSSION OF FEE SETTING. THE EXAMPLES GIVEN ARE INSTRUCTIONAL, AND ARE NOT INTENDED IN ANY WAY TO ENCOURAGE ANYONE TO SET ANY FEE AT ANY AMOUNT. QUESTIONS ABOUT FEES WILL NOT BE ANSWERED, AND DISCUSSION ABOUT FEES AMONG THE ATTENDEES OF THIS LECTURE, DURING THIS LECTURE, WILL NOT BE PERMITTED, AND IS STRONGLY DISCOURAGED AT ANY TIME AFTER THIS LECTURE!

INTRODUCTION

- BEFORE CREATING A REIMBURSEMENT PARADIGM FOR A PARTICULAR CONDITION, A PAYOR MUST KNOW:
  - THE BOUNDARIES FOR THAT SPECIFIC CONDITION
  - THE STANDARD OF CARE IN DIAGNOSING AND TREATING THAT SPECIFIC CONDITION
  - THE MEDICAL NECESSITY OF TREATING THE SPECIFIC CONDITION
    - MORBIDITY
    - MORTALITY
- KNOWING THESE THINGS MAKE UP THE "WHY" OF CODING AND BILLING

INTRODUCTION

- ONE OF THE IMPORTANT ELEMENTS OF MYOPIA MANAGEMENT IS UNDERSTANDING THAT PATHOLOGICAL MYOPIA IS A CHRONIC DISEASE FOR WHICH THE STANDARD OF CARE IS PREVENTION
  - HYPERTENSION
  - DIABETES
- DEFINITIONS—GOAL OF STANDARDIZING TERMINOLOGY
  - PATHOLOGICAL MYOPIA
- SCHEMA FOR CODING AND BILLING
  - ICD 10-CM 2020-2021: ESTABLISHING MEDICAL NECESSITY
  - CPT CATEGORY I—III CODING FOR PAYMENT
  - CATEGORY I—CPT
  - CATEGORY II—HCPCS
  - CATEGORY III—TEMPORARY CODE SET

DEFINITIONS

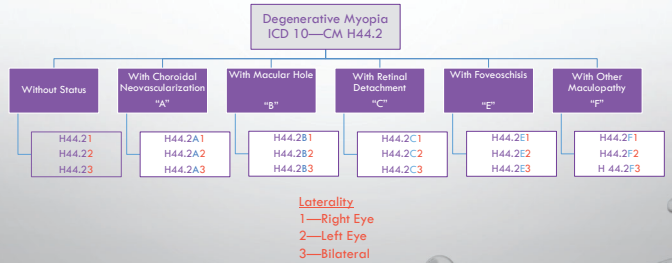
- PATHOLOGICAL MYOPIA
  - EXCESSIVE AXIAL ELONGATION ASSOCIATED WITH MYOPIA THAT LEADS TO STRUCTURAL CHANGES IN THE POSTERIOR SEGMENT OF THE EYE (INCLUDING POSTERIOR STAPHYLOMA, MYOPIC MACULOPATHY, AND HIGH MYOPIA-ASSOCIATED OPTIC NEUROPATHY) AND THAT CAN LEAD TO LOSS OF BEST CORRECTED VISUAL ACUITY.[1]

[1]Flitcroft D I, *et al.* IMI – Defining and Classifying Myopia: A Proposed Set of Standards for Clinical and Epidemiologic Studies. **IOVS.** 2019; 60 (3); M20—M30

ICD-10-CM—ESTABLISHING MEDICAL NECESSITY

- ESTABLISHING MEDICAL NECESSITY
  - ONE NEEDS A DIAGNOSABLE CONDITION UNDER THE WORLD HEALTH ORGANIZATION'S (WHO) INTERNATIONAL CLASSIFICATION OF DISEASE (ICD) 10TH EDITION, OR ICD 10-CM ("CLINICAL MODIFICATION" IS THE US VERSION)
- DISEASES OF THE EYE ARE CONTAINED IN CHAPTER VII, AND ARE DESIGNATED BY THE LETTER "H" THERE ARE 59 CATEGORIES IN CHAPTER VII, CATEGORY 44.2 IS "DEGENERATIVE MYOPIA"
  - IN 2020, ICD-10 WAS MODIFIED TO EXPAND H44.2 TO ADD DISEASE STATUS AND LATERALITY DENOMINATORS TO MAKE THE DISEASE STATE A BILLABLE DIAGNOSIS

ICD 10—CM CODES FOR PATHOLOGICAL MYOPIA: H44.2



DISTINGUISHING PATHOLOGICAL MYOPIA FROM DISORDERS OF REFRACTION

- ICD 10-CM CATEGORY H52 IS "DISORDERS OF REFRACTION"
  - H52.10—MYOPIA, UNSPECIFIED
  - H52.11—MYOPIA, RIGHT EYE
  - H52.12—MYOPIA, LEFT EYE
  - H52.13—MYOPIA, BILATERAL
- NOT REIMBURSABLE UNDER ALMOST ALL PAYOR REGIMES
  - EXCEPTIONS—MEDICAID AND VISION CARE PLANS

COMMON PROCEDURAL TERMINOLOGY® (CPT)

- CPT IS OWNED BY THE AMERICAN MEDICAL ASSOCIATION AND SANCTIONED BY THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES(HHS) CENTERS FOR MEDICARE AND MEDICAID SERVICES(CMS)
- LEVEL I CPT® CODES CONTAIN THE CONTACT LENS PRESCRIBING CODES
- LEVEL II CPT® CODES CONTAIN THE "V" CODE MATERIAL CODES
- ONE OF THE PRINCIPLES OF CPT CODING IS TO CHOOSE THE CODE FOR WHICH THE PLAIN TEXT OF THE CODE MOST CLOSELY MATCHES THE SERVICE PROVIDED

THE CONTACT LENS PRESCRIBING CODES

- 92310/92314:PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEAL LENS, BOTH EYES, EXCEPT FOR APHAKIA
- 92311/92315: PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEAL LENS FOR APHAKIA, ONE EYE
- 92312/92316:PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEAL LENS FOR APHAKIA, BOTH EYES
- 92313/92317:PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEOLSCLERAL LENS

THE CONTACT LENS PRESCRIBING CODES

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- 92313/92317:PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEOSCLERAL LENS

THE UNLISTED OPHTHALMOLOGICAL SERVICE CPT CODE

- 92499: UNLISTED OPHTHALMOLOGICAL SERVICE
- ONE COULD MAKE A LEGITIMATE CASE THAT THE PLAIN LANGUAGE OF THE CPT CODE 92313/92317 DOES NOT ACCURATELY DESCRIBE THE SERVICE OF MYOPIA MANAGEMENT WITH A CONTACT LENS. THEREFORE, THE 92499 IS LIKELY THE BEST CODE FOR THIS SERVICE
- THE DRAWBACKS TO THIS CODE ARE THAT, FIRST, NO PAYOR LISTS THE 92499 AS A COVERED SERVICE, AND, SECOND, IT ALWAYS REQUIRES A LETTER OF MEDICAL NECESSITY FOR THE PAYOR TO DETERMINE COVERAGE
- USING THE 92499 CODE WILL MOST LIKELY MAKE THE USE OF THE A ORTHO-K OR HYDROGEL LENS USED FOR MYOPIA MANAGEMENT A PRIVATE PAY REGIME

CPT LEVEL II HCPCS CODE FOR MATERIALS

- THE HEALTHCARE COMMON PROCEDURE CODING SYSTEM® (HCPCS, COMMONLY KNOWN AS "HICK-PICKS") DEFINES THE BILLING CODES USED FOR MATERIALS, AS OPPOSED TO SERVICES
  - THE V25XX CODES—CONTACT LENS MATERIAL CODES
- V2510: CONTACT LENS, GAS PERMEABLE, SPHERICAL, PER LENS
- V2522: CONTACT LENS, HYDROPHILIC, BIFOCAL, PER LENS

VISION CARE PLANS (VCP'S): COVERED *VS* NON-COVERED SERVICES

- MANY PRIVATE INSURANCE COMPANIES "CARVE OUT" "ROUTINE" (NOT MEDICALLY NECESSARY) EYECARE SERVICES
- 90% OF ROUTINE EYECARE SERVICES ("PRIMARY CARE") FALL UNDER THESE PLANS
  - VISION SERVICE PLAN (VSP)
  - EYEMED
  - SPECTERA
  - SUPERIOR VISION / DAVIS VISION
- ALL OF THESE PLANS HAVE A (MEDICALLY) NECESSARY CONTACT LENS BENEFIT THAT PAY IN A RANGE FROM TERRIBLE (SPECTERA, SUPERIOR VISION) TO FAIRLY REASONABLE (VSP AND EYEMED)

STANDARD OF CARE IN MYOPIA MANAGEMENT

- 92004/ 92014: COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION
- 92015: REFRACTION (MANIFEST AND CYCLOPLEGIC)
- 76511: QUANTITATIVE A-SCAN
- 92025: CORNEAL TOPOGRAPHY
- 92132: SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, ANTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL
- 92499: CONTACT LEN PRESCRIBING WITH PATIENT / PARENT INSTRUCTION

BILLING STRATEGY

- THE BEST OUTCOME FROM A PROVIDER PROFITABILITY AND PATIENT COVERAGE STANDPOINT WOULD BE FOR THE VCP'S TO COVER THE COMPREHENSIVE EXAMINATION AND TO PAY THE MAXIMUM UNDER THE PLAN FOR THE MATERIALS. CURRENTLY, VCP'S ALLOW FOR BALANCE BILLING OF MATERIALS OVERAGE, BUT NOT ON CONTACT LENS PROFESSIONAL SERVICES
- SO, IT WOULD BE BEST IF THE VCP'S CONSIDER THE CONTACT LENS PRESCRIBING SERVICES AS NON-COVERED, WHICH IS LIKELY WITH A 92499 CODING
- EVENTUALLY, A PRESCRIBING CODE FOR MYOPIA MANAGEMENT WILL BE PROMULGATED
- UNTIL THAT DAY, WE WOULD DO WELL TO ADVOCATE FOR THE USE OF THE UNLISTED CODE

THANK YOU!!

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