Stay Tuned for Webinar

Audio dial-in: 323–920–0091; PIN: 256 7691#
For technical assistance contact support@anymeeting.com

CBR201504: Ophthalmology

Begins at 3:00 P.M. ET
The CBR project has made every reasonable effort to ensure the accuracy of the information and web links provided in the CBR materials at the time of publication; however, Medicare policy changes frequently, so the information and links within the material may change without further notice. It is the responsibility of the provider to remain up-to-date with Medicare Program requirements.
CBR materials are prepared as a service to the public and are not intended to grant rights or impose obligations. The information provided in the CBR material is only intended to be a general summary. It does not supersede or alter the coverage and documentation policies outlined in the local coverage determinations (LCD) and policy articles for the A/B Medicare Administrative Contractors (MAC) or DME Medicare Administrative Contractors (DME MAC). Please refer any specific questions you may have to the A/B or DME MAC for your region. We encourage providers to review the specific statutes, regulations, and other interpretive material for a full and accurate statement of their contents.
Webinar Outline

1. Introduction
2. Coverage & Documentation Overview
3. Methods & Results
4. References & Resources
5. Next Steps
6. Contact Information
7. Q&A
8. Survey
Webinar Requirements

- Landline for conference call (cell phones are not recommended)
- Wired (not wireless) broadband internet connection
  - Not Recommended: Access Points/Mobile Air Connections
- PC computer using Windows or Mac operating system
- Android or iPad tablets
- Latest version of Adobe Flash installed
Webinar Protocol

- All attendee lines are muted
- Submit questions via chat when prompted by speaker
- Submit questions during the Q&A session at the end of webinar
- Ask questions pertinent to webinar
- Contact MAC for specific claims questions
Webinar Objective

Upon completion of this webinar the participant should be able to:

- Demonstrate a general understanding of CBR201504: Ophthalmology
- Comprehend the analytical methods used to develop the report
- Locate policy references and resources
Sample CBR

Provided for each topic

http://www.cbrinfo.net/
CBR Purpose

Designed to:
- Provide education to the provider community
- Compare billing practices among Medicare providers and their peer groups

Gives providers an opportunity to:
- Check their records against data in CMS files
- Review Medicare guidelines to ensure compliance
CBR Focus

Ophthalmology Claims
- Specialty Code 18
- Extracapsular Cataract Removals
- General Ophthalmological Services
- E/M Services
CBR Comparisons

This CBR examines:

- Percentage of complex cataract surgeries (CPT® 66982) to routine cataract surgeries (CPT® 66984)
- Percentage of comprehensive eye exams to intermediate eye exams (CPT® 92002–92014)
- Average minutes for new and established patient E/M services (CPT® 99201–99215)
# CPT® Codes

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Abbreviated Description (Typical Minutes when Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>66982</td>
<td>Extracapsular cataract removal, complex</td>
</tr>
<tr>
<td>66984</td>
<td>Extracapsular cataract removal, routine</td>
</tr>
<tr>
<td>92002</td>
<td>General ophthalmology intermediate, new</td>
</tr>
<tr>
<td>92004</td>
<td>General ophthalmology comprehensive, new</td>
</tr>
<tr>
<td>92012</td>
<td>General ophthalmology intermediate, established</td>
</tr>
<tr>
<td>92014</td>
<td>General ophthalmology comprehensive, established</td>
</tr>
<tr>
<td>99201</td>
<td>E/M focused, new (10 mins)</td>
</tr>
<tr>
<td>99202</td>
<td>E/M expanded, new (20 mins)</td>
</tr>
<tr>
<td>99203</td>
<td>E/M detailed, new (30 mins)</td>
</tr>
<tr>
<td>99204</td>
<td>E/M comprehensive, MDM* moderate, new (45 mins)</td>
</tr>
<tr>
<td>99205</td>
<td>E/M comprehensive, MDM* high, new (60 mins)</td>
</tr>
<tr>
<td>99211</td>
<td>E/M minimal, established (5 mins)</td>
</tr>
<tr>
<td>99212</td>
<td>E/M focused, established (10 mins)</td>
</tr>
<tr>
<td>99213</td>
<td>E/M expanded, established (15 mins)</td>
</tr>
<tr>
<td>99214</td>
<td>E/M detailed, established (25 mins)</td>
</tr>
<tr>
<td>99215</td>
<td>E/M comprehensive, established (40 mins)</td>
</tr>
</tbody>
</table>

* Medical Decision Making

CPT codes, descriptors, and other data only are copyright 2013 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply. © 2015 Palmetto GBA, Graphic for CBR201504, All Rights Reserved.
Demographics

- 10,000 ophthalmology providers (18)
- Data from claims paid by traditional Fee For Service (FFS) Medicare
- Billing patterns different from their peers
Webinar Materials

- References and Resources
- Webinar slides
- MP4 of webinar
- Webinar Handout
- Webinar Q&A Handout

Recommended Links:
http://www.cbrinfo.net/cbr201504-recommended-links.html
Resources from event:
http://www.cbrinfo.net/cbr201504-webinar.html
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>LCA</td>
<td>Local Coverage Article</td>
</tr>
<tr>
<td>LCD</td>
<td>Local Coverage Determination</td>
</tr>
<tr>
<td>MPFS</td>
<td>Medicare Physician Fee Schedule</td>
</tr>
<tr>
<td>OEI</td>
<td>Office of Evaluation and Inspections</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
<tr>
<td>RAC</td>
<td>Recovery Audit Contractors</td>
</tr>
</tbody>
</table>
Coverage & Documentation
Overview
Ophthalmology Research

- Ophthalmologists bill/receive high percentage of Medicare dollars
- Estimated 3 million will have age-related macular degeneration (AMD) by 2020
- More than 20.5 million Americans have a cataract in one or both eyes
- Glaucoma affects an estimated 2.2 million Americans and accounts for 9% to 12% of all cases of blindness
- Ophthalmologists receive 50% or more of their income from Medicare patients
Procedures & Claim Lines

- Over 100 procedure codes billed by ophthalmologists
- Procedure codes billed on as few as 1,900 claim lines
- Procedure codes billed on as many as 8.5 million claim lines
CBR Findings

- More than 16,000 providers used CPT® code 92014
- Medicare paid over $1B for CPT® code 92014
- Allowed charges for general ophthalmological and E/M services totaled $2.2B
- Total charges for all services billed by ophthalmology $8.3B
- Potential $290M in incorrect payments
Office of Inspector General (OIG)
http://oig.hhs.gov

- **Ophthalmological Services—Questionable Billing, Work Plans: Fiscal Years 2013 and 2014**
- **Ophthalmologists—Inappropriate and questionable billing, Work Plan: Fiscal Year 2015**
- **Medicare Paid $22 Million in 2012 for Potentially Inappropriate Ophthalmology Claims, OEI–04–12–00281, December 2014**

Work Plans:

False Claims Act

The United States Attorney’s Office, District of Maryland

- Ophthalmologist Agrees To Pay $1.4 Million And To 20 Year Voluntary Exclusion From Federal Programs To Settle Claims That He Performed Medically Unnecessary Laser Procedures, Press Release: March 13, 2014

First Coast News, Fla. Ophthalmologist charged in $7 million fraud case, Posted May 5, 2014

- Accused of performing/billing unnecessary laser procedures

LCD L31860: Cataract Extraction. CGS Administrators

- Medicare coverage for cataract extraction, with or without intraocular lens implant, may be covered when the patient has impairment due to cataracts and the following criteria are met and documented:
  - Decreased ability to carry out activities of daily living (ADLs) including but not limited to: reading, watching television, driving or meeting occupational or vocational expectations; and

Cataract Coverage Criteria

- The patient has a best corrected visual acuity of 20/50 or worse at distant or near; or additional testing shows one of the following:
  - Consensual light testing decreases visual acuity by two lines, or
  - Glare testing decreases visual acuity by two lines
- The patient has determined that he/she is no longer able to function adequately with the current vision function; and

More Cataract Coverage Criteria

- Other eye disease(s) have been ruled out as the primary cause of decreased visual function; and
- Significant improvement in visual function can be expected as a result of cataract extraction; and
- The patient has been educated about the risks and benefits of surgery and the alternative(s) to surgery and
- The patient has undergone an appropriate preoperative ophthalmologic evaluation
Complex Cataract Extraction

Complex cataract extraction requires devices or techniques not generally used in routine cataract surgery such as:

- Iris expansion device
- Suture support for intraocular lens
- Primary posterior capsulorrhexis
- Use of dye for visualization
- Endocapsular rings

NGS Cataract LCD

LCD L26853: Cataract Extraction. National Government Services, Inc. Requires specific primary and secondary ICD–9 codes for complex extractions (CPT® code 66982)

Includes:

- A miotic pupil which will not dilate sufficiently
- Disease that produces weak/absent lens support
- Pediatric cataract surgery
- Extraordinary work during postoperative period

Locate LCD:

http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=ambulance&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAAAAAAAAA%3d%3d=&
FCSO & CGS
Cataract LCDs

- LCD L29095: Cataract Extraction. No specific diagnosis requirements for complex surgery
- LCD L29110: Cataract Extraction. No specific diagnosis requirements for complex surgery
- LCD L31860: Cataract Extraction. Requires specific primary and secondary ICD–9 codes for complex surgery

Locate LCD:
http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=ambulance&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAMAMAA%3d%3d&=
Novitas
Cataract LCDs

- LCD L32690: Cataract Extraction (including Complex Cataract Surgery). Lists specific diagnoses dependent on device or technique used for complex surgery
- LCD L34344: Cataract Extraction (including Complex Cataract Surgery). Lists specific diagnoses dependent on device or technique used for complex surgery

Locate LCD:
Other MAC
Cataract LCDs

- LCD L32379: Cataract Surgery. No specific diagnosis requirements for complex cataract extraction, but article A52100 refers to situations which justify the use

- LCD L33681: Cataract Surgery in Adults. No specific diagnosis requirements for complex surgery

- LCD L30058: Surgery: Cataract Extraction. No specific diagnosis requirements for complex surgery

Locate LCD: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=ambulance&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAAAAAAAAA%3d%3d&=
General Ophthalmology Services

Two levels of service:

- CPT® codes 92002/92012—Intermediate: an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis

- CPT® codes 92004/92014—Comprehensive: includes a general evaluation of the complete visual system, may be performed over two sessions
Intermediate Exam

CPT® codes 92002 & 92012 documentation includes:

- Chief complaint
- History
- General medical observation
- External ocular and adnexal examination
- Other diagnostic procedures, as indicated
- May include dilation of the pupil, referred to as Mydriasis
Comprehensive Exam
Part I

CPT® codes 92004 & 92014 documentation includes:

- Chief complaint
- History
- General medical observation
- Ophthalmoscopical examination
- External examination
Comprehensive Exam
Part II

CPT® codes 92004 & 92014 documentation includes:

- Gross visual fields
- Basic sensorimotor exam
- May include cycloplegia/mydriasis and tonometry, as indicated
- Always includes initiation of diagnostic and treatment program
CPT® codes 99201 through 99215

- 99201 through 99205 used for new patient exams—all three key components must meet or exceed level billed

- 99211 through 99215 used for established patient exams—two of the three key components must meet or exceed level billed
E & M continued

Key Components

- History comprised of:
  - Chief Complaint
  - History of Present Illness
  - Review of Systems and
  - Past History, Family History and Social History

- Examination—per 1997 Documentation Guidelines for E/M Services

- Medical Decision Making—straightforward, low, moderate and high

# Medical Decision Making

<table>
<thead>
<tr>
<th>Number of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Complications and/or Morbidity or Mortality</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

© 2015 Palmetto GBA, Graphic for CBR201504, All Rights Reserved.
# Key Components: New Patients

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Presenting Problem(s)</th>
<th>Key Components</th>
<th>M.D.M.</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Self-limited or minor; the physician typically spends 10 minutes face-to-face with the patient and/or family</td>
<td>Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99202</td>
<td>Low to moderate severity; the physician typically spends 20 minutes face-to-face with the patient and/or family</td>
<td>Expanded Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203</td>
<td>Moderate severity; the physician typically spends 30 minutes face-to-face with the patient and/or family</td>
<td>Detailed</td>
<td>Low Complexity</td>
</tr>
</tbody>
</table>

© 2015 Palmetto GBA, Graphic for CBR201504, All Rights Reserved.
# New Patient E/Ms

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Presenting Problem(s)</th>
<th>Key Components</th>
<th>M.D.M.</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204</td>
<td>Moderate to high severity; the physician typically spends 45 minutes face-to-face with the patient and/or family</td>
<td>Patient History: Comprehensive</td>
<td>Comprehensive 12 ophthalmic elements + 1 neuropsych element</td>
</tr>
<tr>
<td>99205</td>
<td>Moderate to high severity; the physician typically spends 60 minutes face-to-face with the patient and/or family</td>
<td>Patient History: Comprehensive</td>
<td>Comprehensive 12 ophthalmic elements + 1 neuropsych element</td>
</tr>
</tbody>
</table>
Eye Examination

- Test visual acuity (does not include determination of refractive error)
- Gross visual field testing by confrontation
- Test ocular motility including primary gaze alignment
- Inspection of bulbar and palpebral conjunctivae
- Examination of ocular adnexa including lids
- Examination of pupils and irises
- Slit lamp examination of corneas
Eye Examination Cont.

- Slit lamp examination of the anterior chambers
- Slit lamp examination of the lenses
- Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)
- Ophthalmoscopical examination through dilated pupils (unless contraindicated) of
  - Optic discs including size, cup-to-disc ratio, appearance
  - Posterior segments including retina and vessels
92XXX vs. 99XXX

Eye code or E/M code? *That* is the question.

- Common elements:
  - Medical documentation
  - Definition of New VS Established
  - Identifiable signature

Complying with Medicare Signature Requirements. Medicare Learning Network®. ICN 905364, October 2013

Methods & Results
Medicare Part B Rendering Provider
- Located by National Provider Identifier (NPI)
- Specialty 18 (Ophthalmology)
- CPT® codes for:
  - Extracapsular cataract removals
  - General ophthalmology services
  - Evaluation and management services
Peer Groups

State
- Medicare providers in the provider’s state
- Specialty of 18
- Selected Codes

National
- All Medicare providers in the nation
- Specialty of 18
- Selected Codes
Data Source

CMS Integrated Data Repository (IDR)

- Extracted: February 24, 2015
- Dates of Service:
  July 1, 2013 – June 30, 2014
Table 1: Summary of Your Utilization
July 1, 2013 - June 30, 2014

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Abbreviated Description (Typical Minutes when Applicable)</th>
<th>Allowed Charges</th>
<th>Allowed Services</th>
<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>66982</td>
<td>Extracapsular cataract removal, complex</td>
<td>$8,370.17</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>66984</td>
<td>Extracapsular cataract removal, routine</td>
<td>$45,877.56</td>
<td>69</td>
<td>53</td>
</tr>
<tr>
<td>92002</td>
<td>General ophthalmology intermediate, new</td>
<td>$81.94</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>92004</td>
<td>General ophthalmology comprehensive, new</td>
<td>$299.16</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>92012</td>
<td>General ophthalmology intermediate, established</td>
<td>$7,075.78</td>
<td>82</td>
<td>82</td>
</tr>
<tr>
<td>92014</td>
<td>General ophthalmology comprehensive, established</td>
<td>$46,490.72</td>
<td>373</td>
<td>368</td>
</tr>
<tr>
<td>99201</td>
<td>E/M focused, new (10 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99202</td>
<td>E/M expanded, new (20 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99203</td>
<td>E/M detailed, new (30 mins)</td>
<td>$428.20</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>99204</td>
<td>E/M comprehensive, MDM* moderate, new (45 mins)</td>
<td>$18,062.46</td>
<td>112</td>
<td>112</td>
</tr>
<tr>
<td>99205</td>
<td>E/M comprehensive, MDM* high, new (60 mins)</td>
<td>$606.09</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>99211</td>
<td>E/M minimal, established (5 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99212</td>
<td>E/M focused, established (10 mins)</td>
<td>$433.30</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>E/M expanded, established (15 mins)</td>
<td>$15,412.28</td>
<td>214</td>
<td>168</td>
</tr>
<tr>
<td>99214</td>
<td>E/M detailed, established (25 mins)</td>
<td>$26,009.58</td>
<td>246</td>
<td>220</td>
</tr>
<tr>
<td>99215</td>
<td>E/M comprehensive, established (40 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>$169,147.24</td>
<td>1,126</td>
<td>820</td>
</tr>
</tbody>
</table>

*Medical Decision Making*

CPT® codes, descriptors, and other data are copyright 2013 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
Comparison Outcomes

Four possible outcomes:
1. Significantly Higher
2. Higher
3. Does Not Exceed
4. Not Applicable (N/A)
Percentage of Complex Extracapsular Cataract Removals

Calculated as follows:

\[
\left( \frac{\text{Number of Complex Extracapsular Cataract Removals}}{\text{Total Number of Extracapsular Cataract Removals}} \right) \times 100
\]
Table 2: Percentage of Complex Extracapsular Cataract Removals
July 1, 2013 - June 30, 2014

<table>
<thead>
<tr>
<th>Your Percentage of Complex Cataracts</th>
<th>Your State’s Percentage of Complex Cataracts</th>
<th>Comparison with Your State’s Percentage</th>
<th>National Percentage of Complex Cataracts</th>
<th>Comparison with the National Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex</td>
<td>13%</td>
<td>16%</td>
<td>Does Not Exceed</td>
<td>9%</td>
</tr>
</tbody>
</table>

A chi-square test was used in this analysis, alpha=0.05.
Percentage of Complex Extracapsular Cataracts Example

\[
\left( \frac{10}{10 + 69} \right) \times 100 \approx 13
\]
Percentage of Comprehensive General Ophthalmological Services by Patient Type

Calculated as follows:

\[
\left( \frac{\text{Number of Comprehensive General Ophthalmological Services by Patient Type}}{\text{Total Number of General Ophthalmological Services by Patient Type}} \right) \times 100
\]
Table 3: Percentage of Comprehensive General Ophthalmological Services by Patient Type
July 1, 2013 - June 30, 2014

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Your Percentage of Comprehensive Services</th>
<th>Your State’s Percentage of Comprehensive Services</th>
<th>Comparison with Your State’s Percentage</th>
<th>National Percentage of Comprehensive Services</th>
<th>Comparison with the National Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
<td>91%</td>
<td>N/A</td>
</tr>
<tr>
<td>Established</td>
<td>82%</td>
<td>73%</td>
<td>Significantly Higher</td>
<td>61%</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>

A chi-square test was used in this analysis, alpha=0.05.
### Table 1: Summary of Your Utilization
**July 1, 2013 - June 30, 2014**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Abbreviated Description (Typical Minutes when Applicable)</th>
<th>Allowed Charges</th>
<th>Allowed Services</th>
<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>66982</td>
<td>Extracapsular cataract removal, complex</td>
<td>$8,370.17</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>66984</td>
<td>Extracapsular cataract removal, routine</td>
<td>$45,877.56</td>
<td>69</td>
<td>53</td>
</tr>
<tr>
<td>92002</td>
<td>General ophthalmology intermediate, new</td>
<td>$81.94</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>92004</td>
<td>General ophthalmology comprehensive, new</td>
<td>$299.16</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>92012</td>
<td>General ophthalmology intermediate, established</td>
<td>$7,075.78</td>
<td>82</td>
<td>82</td>
</tr>
<tr>
<td>92014</td>
<td>General ophthalmology comprehensive, established</td>
<td>$46,490.72</td>
<td>373</td>
<td>368</td>
</tr>
<tr>
<td>99201</td>
<td>E/M focused, new (10 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99202</td>
<td>E/M expanded, new (20 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99203</td>
<td>E/M detailed, new (30 mins)</td>
<td>$428.20</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>99204</td>
<td>E/M comprehensive, MDM* moderate, new (45 mins)</td>
<td>$18,062.46</td>
<td>112</td>
<td>112</td>
</tr>
<tr>
<td>99205</td>
<td>E/M comprehensive, MDM* high, new (60 mins)</td>
<td>$606.09</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>99211</td>
<td>E/M minimal, established (5 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99212</td>
<td>E/M focused, established (10 mins)</td>
<td>$433.30</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>E/M expanded, established (15 mins)</td>
<td>$15,412.28</td>
<td>214</td>
<td>168</td>
</tr>
<tr>
<td>99214</td>
<td>E/M detailed, established (25 mins)</td>
<td>$26,009.58</td>
<td>246</td>
<td>220</td>
</tr>
<tr>
<td>99215</td>
<td>E/M comprehensive, established (40 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>$169,147.24</strong></td>
<td><strong>1,126</strong></td>
<td><strong>820</strong></td>
</tr>
</tbody>
</table>

*Medical Decision Making*

CPT® codes, descriptors, and other data are copyright 2013 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
**Percentage of Comprehensive General Ophthalmological Services Example (Established)**

Table 1: Summary of Your Utilization
July 1, 2013 - June 30, 2014

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Abbreviated Description (Typical Minutes when Applicable)</th>
<th>Allowed Charges</th>
<th>Allowed Services</th>
<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>66982</td>
<td>Extracapsular cataract removal, complex</td>
<td>$8,370.17</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>66984</td>
<td>Extracapsular cataract removal, routine</td>
<td>$45,877.56</td>
<td>69</td>
<td>53</td>
</tr>
<tr>
<td>92002</td>
<td>General ophthalmology intermediate, new</td>
<td>$81.94</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>92004</td>
<td>General ophthalmology comprehensive, new</td>
<td>$299.16</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>92012</td>
<td>General ophthalmology intermediate, established</td>
<td>$7,075.78</td>
<td>82</td>
<td>82</td>
</tr>
<tr>
<td>92014</td>
<td>General ophthalmology comprehensive, established</td>
<td>$46,490.72</td>
<td></td>
<td>368</td>
</tr>
<tr>
<td>99201</td>
<td>E/M focused, new (10 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99202</td>
<td>E/M expanded, new (20 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99203</td>
<td>E/M detailed, new (30 mins)</td>
<td>$428.20</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>99204</td>
<td>E/M comprehensive, MDM* moderate, new (45 mins)</td>
<td>$18,062.46</td>
<td>112</td>
<td>112</td>
</tr>
<tr>
<td>99205</td>
<td>E/M comprehensive, MDM* high, new (60 mins)</td>
<td>$606.09</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>99211</td>
<td>E/M minimal, established (5 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99212</td>
<td>E/M focused, established (10 mins)</td>
<td>$433.30</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>E/M expanded, established (15 mins)</td>
<td>$15,412.28</td>
<td>214</td>
<td>168</td>
</tr>
<tr>
<td>99214</td>
<td>E/M detailed, established (25 mins)</td>
<td>$26,009.58</td>
<td>246</td>
<td>220</td>
</tr>
<tr>
<td>99215</td>
<td>E/M comprehensive, established (40 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>$169,147.24</strong></td>
<td><strong>1,126</strong></td>
<td><strong>820</strong></td>
</tr>
</tbody>
</table>

*Medical Decision Making|

\[
\left(\frac{373}{82 + 373}\right) \times 100 \approx 82
\]
Calculating Total E/M Weighted Services by Visit

1. Separate claim lines by new and established patient type
2. Assign value to each CPT® code by typical minutes
3. Multiply assigned value by number of services
4. Visits with multiple claims are combined
Calculating Average Allowed Minutes per E/M Visit by Patient Type

Calculated as follows:

\[
\left( \frac{\text{Total E/M Weighted Services by Patient Type}}{\text{Total Number of E/M Visits by Patient Type}} \right)
\]
### Table 4: Average Allowed Minutes per E/M Visit by Patient Type
#### July 1, 2013 - June 30, 2014

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Your Average E/M Minutes per Visit</th>
<th>Your State’s Average E/M Minutes Per Visit</th>
<th>Comparison with Your State’s Average</th>
<th>National Average E/M Minutes Per Visit</th>
<th>Comparison with the National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>44.87</td>
<td>40.82</td>
<td>Significantly Higher</td>
<td>42.01</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>Established</td>
<td>20.13</td>
<td>19.71</td>
<td>Higher</td>
<td>18.21</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>

A t-test was used in this analysis, alpha=0.05.
Average Allowed Minutes per E/M Visit by Patient Type Example (New)

Table 1: Summary of Your Utilization
July 1, 2013 - June 30, 2014

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Abbreviated Description (Typical Minutes when Applicable)</th>
<th>Allowed Charges</th>
<th>Allowed Services</th>
<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>66962</td>
<td>Extracapsular cataract removal, complex</td>
<td>$8,370.17</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>66984</td>
<td>Extracapsular cataract removal, routine</td>
<td>$45,877.56</td>
<td>69</td>
<td>53</td>
</tr>
<tr>
<td>92002</td>
<td>General ophthalmology intermediate, new</td>
<td>$81.94</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>92004</td>
<td>General ophthalmology comprehensive, new</td>
<td>$299.16</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>92012</td>
<td>General ophthalmology intermediate, established</td>
<td>$7,075.78</td>
<td>82</td>
<td>82</td>
</tr>
<tr>
<td>92014</td>
<td>General ophthalmology comprehensive, established</td>
<td>$46,490.72</td>
<td>373</td>
<td>368</td>
</tr>
<tr>
<td>99201</td>
<td>E/M focused, new (10 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99202</td>
<td>E/M expanded, new (20 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99203</td>
<td>E/M detailed, new (30 mins)</td>
<td>$428.20</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>99204</td>
<td>E/M comprehensive, MDM* moderate, new (45 mins)</td>
<td>$18,062.46</td>
<td>112</td>
<td>112</td>
</tr>
<tr>
<td>99205</td>
<td>E/M comprehensive, MDM* high, new (60 mins)</td>
<td>$606.09</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>99211</td>
<td>E/M minimal, established (5 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99212</td>
<td>E/M focused, established (10 mins)</td>
<td>$433.30</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>E/M expanded, established (15 mins)</td>
<td>$15,412.28</td>
<td>214</td>
<td>168</td>
</tr>
<tr>
<td>99214</td>
<td>E/M detailed, established (25 mins)</td>
<td>$26,009.58</td>
<td>246</td>
<td>220</td>
</tr>
<tr>
<td>99215</td>
<td>E/M comprehensive, established (40 mins)</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>$169,147.24</strong></td>
<td><strong>1,126</strong></td>
<td><strong>820</strong></td>
</tr>
</tbody>
</table>

\[
\frac{(10 \times 0) + (20 \times 0) + (30 \times 4) + (45 \times 112) + (60 \times 3)}{(0 + 0 + 4 + 112 + 3)} \approx 44.87
\]
References & Resources
## LCDs & LCAs

<table>
<thead>
<tr>
<th>LCD &amp; LCA</th>
<th>Medicare Administrative Contractor (MAC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>L30058</td>
<td>Cahaba GBA, LLC</td>
</tr>
<tr>
<td>L31860</td>
<td>CGS Administrators, LLC</td>
</tr>
<tr>
<td>L29110</td>
<td>First Coast Service Options, Inc.</td>
</tr>
<tr>
<td>L29095</td>
<td>First Coast Service Options, Inc.</td>
</tr>
<tr>
<td>L26853</td>
<td>National Government Services</td>
</tr>
<tr>
<td>L33681</td>
<td>Noridian Healthcare Solutions, LLC</td>
</tr>
<tr>
<td>L34344</td>
<td>Novitas Solutions, Inc.</td>
</tr>
<tr>
<td>L32690</td>
<td>Novitas Solutions, Inc.</td>
</tr>
<tr>
<td>L32379</td>
<td>Palmetto GBA</td>
</tr>
<tr>
<td>A52100</td>
<td>Palmetto GBA</td>
</tr>
</tbody>
</table>

© 2015 Palmetto GBA, Graphic for CBR201504, All Rights Reserved.
Office of Inspector General

  [Link](http://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf)

  [Link](https://oig.hhs.gov/oei/reports/oei-04-12-00281.pdf)

- HHS OIG Work Plans
  - Fiscal Years: 2013 through 2015
Medicare Learning Network®

- Medicare Vision Services Fact Sheet, ICN 907165, July 2014

- Evaluation and Management Services Guide, ICN 006764, November 2014

- MLN Matters® Number: MM5853

- How to Use the Medicare NCCI Tools, ICN 901346, January 2013
Medicare Manuals

**National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services**, Revision Date: January 01, 2014

- Chapter I—General Correct Coding Policies
- Chapter VIII—Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems, CPT Codes 60000–69999

**Claims Processing Manual**

- Chapter 12—Physicians/Nonphysician Practitioners


Additional Resources

- American Medical Association
  - *CPT® 2013 Professional Edition*
  - *CPT® 2014 Professional Edition*


CBR Website

www.cbrinfo.net

- About Us
- CBR Releases
- CBR Support
- Education
- Recommended Links
- FAQs
- Contact Us
FAQs

General FAQs

CBR Specific FAQs
- CBR201504: Ophthalmology

http://www.cbrinfo.net/cbr201504-faqs.html
Next Steps
Provider Self-audit

- Providers and suppliers have an obligation to ensure claims are submitted to Medicare correctly
- Self-audits allow providers and suppliers to identify coverage and coding errors
- Refer to the following CBR sections for assistance
  - Documentation and Billing
  - References
Contact Information
CBR Support Help Desk

Monday–Friday: 9:00 a.m. to 5:00 p.m. ET

- Toll Free 1–800–771–4430
- Email: cbrsupport@eglobaltech.com
Contacting MACs

Providers should contact the Medicare Administrative Contractor (MAC) for assistance with:

- Claim Information
- Documentation Requirements
- Billing and Coding

Locate Your MAC:
National Plan & Provider Enumeration System

- Source for mailing address used for the CBR
- Correct your mailing information at https://nppes.cms.hhs.gov/NPPES
Questions & Answers
We make every effort to address all questions submitted during our webinars. However, we cannot provide responses related to coding issues or to specific claims/scenarios. Since your Medicare Administrative Contractor (MAC) makes the determination to pay or deny a claim based on the CPT® codes, medical documentation and description of the circumstances, and we do not have access to this documentation, we cannot respond to these types of questions. Please contact your MAC with questions that we do not address or if you identify any claims discrepancies while reviewing your CBR. The contact information for your MAC is located at http://go.cms.gov/IMap.