Module 11: Optimizing Reimbursement for Low Vision Services

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Outline

• Introduction
• Medicare
• Medicaid
• Private Insurance Providers
• Federal/State Programs
• Conclusion
Introduction

• This presentation provides information that is general in nature and current at the time of creation, but insurance carriers can change their policies and/or reimbursement rates at any time.

• Check with your local Medicare or other insurance carriers to get the most accurate information for your area.
Medicare
Medicare

• Medicare covers the time a qualifying health-care professional spends with a patient providing low vision care or therapy, as a Part B service.

• This includes initial evaluations, follow-up visits and units of low vision therapy.

• Medicare does not cover low vision devices.
Low vision practitioners may seek reimbursement from Medicare based on the service provided:

1. Initial Low Vision Evaluation
2. Low Vision Follow-up Visit
3. Low Vision Therapy Units provided

Different approaches or strategies are used for each aspect (1-3) of the low vision rehabilitation process!
Medicare

Low Vision Practitioners may employ one of two strategies for billing Medicare for Initial Low Vision Evaluations:

1. Use of Ophthalmic Examination Codes
   CPT 92012 or CPT 92014
   OR

2. Use of Evaluation and Management Codes
   CPT 99000 through CPT 99999
Medicare

Initial Low Vision Evaluation:

Ophthalmic Examination Codes
Medicare

Medicare and Initial Low Vision Evaluation

- The use of the Ophthalmic Examination codes will provide $75-135 per new or established patient
- Aspects of the process may be delegated to physician extenders
- Required elements may make it impractical
Medicare and Initial Low Vision Evaluation

The use of the Ophthalmic Examination codes require the following minimum procedures:

- Initiation of diagnosis and treatment programs
- Complete system evaluation
- History, medical observation, external and ophthalmoscopic, gross visual fields, and sensorimotor
Medicare

Initial Low Vision Evaluation:

Evaluation & Management CPT Codes
Medicare

Medicare and Initial Low Vision Evaluation

• The use of the Evaluation and Management Codes (CPT 99000 through CPT 99999) or “E&M Codes” have become the standard convention for most practitioners

• The Code to be used for any particular initial patient evaluation will vary…
Medicare

Medicare and Initial Low Vision Evaluation

... based on 3 criteria:

1. Level of provider
2. Time spent with the patient (in face-to-face consultation) or “thoroughness and complexity” of service
3. Source of patient
Medicare

Medicare and Initial Low Vision Evaluations

1. Level of provider

**Physician** – Ophthalmologist (Other MD), Optometrist, Occupational or Physical Therapist

**Non-Physician** – any other provider working under the direct supervision of the above (a.k.a. “Physician Extenders”)
Medicare

Medicare and Initial Low Vision Evaluations

2. Time spent with the patient or “thoroughness and complexity” of service

Historically, this second criteria has represented a measure of degree of difficulty of the procedure performed. This is done one of two ways…
Medicare

Medicare and Initial Low Vision Evaluations

1) by assessing:
   a) the thoroughness of the history taking
   b) the complexity of the medical decision making, and
   c) the risk of morbidity of the condition, or…

or 2) by measuring the amount of time the physician spends in face-to-face consultation with the patient
Medicare

Medicare and Initial Low Vision Evaluations

3. The ‘source’ of the patient

Sources are:
• **New patient** (not been seen by the practice in 3 years)
• **Established patient** (been seen by the practice within 3 years)
Medicare

Medicare and Initial Low Vision Evaluations

5-digit “E&M” CPT Codes:

- First 2 digits designate health-care service provided by anatomical specialty or E&M range
  Ex. 99204 99 indicates E&M

- Third and fourth digits indicate the source of the patient
  New patient = 9920X
  Established patient = 9921X

- Fifth digit indicates the code level of the service provided
  (1 – 5) ex. 99215
**Low Vision Training Module #11**

**Medicare**

**CPT E&M Codes Typically used for LV Services**

<table>
<thead>
<tr>
<th>Time spent w/ patient*</th>
<th>Nature/Severity of problem</th>
<th>E&amp;M Code</th>
<th>Rate Allowed**</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient Seen For Low Vision Evaluation</td>
<td>10 min.</td>
<td>Low to Moderate</td>
<td>99201</td>
</tr>
<tr>
<td>New Patient Seen For Low Vision Evaluation</td>
<td>20 min.</td>
<td>Moderate</td>
<td>99202</td>
</tr>
<tr>
<td>New Patient Seen For Low Vision Evaluation</td>
<td>30 min.</td>
<td>Moderate to High</td>
<td>99203</td>
</tr>
<tr>
<td>New Patient Seen For Low Vision Evaluation</td>
<td>45 min.</td>
<td>Moderate to High</td>
<td>99204</td>
</tr>
<tr>
<td>New Patient Seen For Low Vision Evaluation</td>
<td>60 min.</td>
<td>Moderate to High</td>
<td>99205</td>
</tr>
<tr>
<td>Established Patient Seen for Low Vision Evaluation</td>
<td>5 min.</td>
<td>Low to Moderate</td>
<td>99211</td>
</tr>
<tr>
<td>Established Patient Seen for Low Vision Evaluation</td>
<td>10 min.</td>
<td>Moderate</td>
<td>99212</td>
</tr>
<tr>
<td>Established Patient Seen for Low Vision Evaluation</td>
<td>15 min.</td>
<td>Moderate to High</td>
<td>99213</td>
</tr>
<tr>
<td>Established Patient Seen for Low Vision Evaluation</td>
<td>25 min.</td>
<td>Moderate to High</td>
<td>99214</td>
</tr>
<tr>
<td>Established Patient Seen for Low Vision Evaluation</td>
<td>40 min.</td>
<td>Moderate to High</td>
<td>99215</td>
</tr>
<tr>
<td>Patient Referred for Neuro-Muscular Re-education**</td>
<td>15 min.</td>
<td>N/A</td>
<td>97112</td>
</tr>
<tr>
<td>Patient Referred for Neuro-Muscular Re-education</td>
<td>15 min.</td>
<td>N/A</td>
<td>97114</td>
</tr>
<tr>
<td>Patient Referred for Gait Training</td>
<td>15 min.</td>
<td>N/A</td>
<td>97116</td>
</tr>
<tr>
<td>Patient Referred for Therapeutic Activities</td>
<td>15 min.</td>
<td>N/A</td>
<td>97530</td>
</tr>
<tr>
<td>Patient Referred for Self-care/ Home Mgt. Training</td>
<td>15 min.</td>
<td>N/A</td>
<td>97535</td>
</tr>
<tr>
<td>Patient Referred for Community/Work Re-integration Training</td>
<td>15 min.</td>
<td>N/A</td>
<td>97537</td>
</tr>
<tr>
<td>Patient Referred for Visual Capability Testing</td>
<td>15 min.</td>
<td>N/A</td>
<td>97750</td>
</tr>
<tr>
<td>Low Vision Appliances - Fitting Spectacle LVA, Single Element</td>
<td>N/A</td>
<td>N/A</td>
<td>92354</td>
</tr>
<tr>
<td>Low Vision Appliances - Fitting Spectacle LVA, Compound/Telescopic</td>
<td>N/A</td>
<td>N/A</td>
<td>92355</td>
</tr>
<tr>
<td>Low Vision Appliances - Supply of Low Vision Aids</td>
<td>N/A</td>
<td>N/A</td>
<td>92392</td>
</tr>
</tbody>
</table>

*Time spent with patient (as determining factor): For the 992xx codes, 50% of time must be face-to-face consultation and levels 4 or 5 should be supported by systems review. For the 97xxx codes, provided in 15 minute units to a maximum of 24 or 32 units depending on carrier. Modifier “GO” should be used to address $1500 Part B cap.

**Rates vary by Medicare carrier.**
Medicare

Use of ICD-10 Codes with E&M CPT Codes

- Two ICD-10 codes are required for every billing
- Support the CPT Code billed by stating a “purpose” or “cause” for procedure
- “Visual Impairment” should be primary diagnosis code used (H54.xx - see charts)
- Cannot be the same as used by the referring MD/OD
- The secondary ICD-10 diagnosis code should be for the disease causing the visual impairment
### Medicare ICD-10 Codes for Low Vision Care

#### Table of Category of Vision Impairment Codes*

<table>
<thead>
<tr>
<th>Category of Vision Impairment</th>
<th>Visual Acuity with Best Possible Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maximum less than</td>
</tr>
<tr>
<td>1</td>
<td>20/70</td>
</tr>
<tr>
<td>2</td>
<td>20/200</td>
</tr>
<tr>
<td>3</td>
<td>20/400</td>
</tr>
<tr>
<td>4</td>
<td>5/300</td>
</tr>
<tr>
<td>5</td>
<td>No Light Perception</td>
</tr>
<tr>
<td>9</td>
<td>Undetermined / Unspecified</td>
</tr>
</tbody>
</table>

*Notes:

1) This table provides a classification of severity of vision impairment used by ICD-10 as recommended by a WHO Study Group on the Prevention of Blindness (1972).

2) If the extent of the visual field is taken into consideration, patients with a field no greater than 10 degrees but greater than 5 degrees around central fixation should be placed in Category 3. Patients with a field no greater than 5 degrees around central fixation should be placed in category 4, even if the central acuity is not impaired.

3) This is only meant as a guide. Check with your Billing Manager and/or local Medicare Carrier for details about the use of ICD-10 codes.
Commonly Used ICD-10 Codes for Low Vision*

<table>
<thead>
<tr>
<th>Vision Impairment Category (OD)</th>
<th>Normal</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>H54.51</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>H54.52</td>
<td>H54.2</td>
<td>H54.2</td>
<td>H54.11</td>
<td>H54.11</td>
<td>H54.11</td>
<td>H54.10</td>
</tr>
<tr>
<td>2</td>
<td>H54.52</td>
<td>H54.2</td>
<td>H54.2</td>
<td>H54.11</td>
<td>H54.11</td>
<td>H54.11</td>
<td>H54.10</td>
</tr>
<tr>
<td>3</td>
<td>H54.42</td>
<td>H54.12</td>
<td>H54.12</td>
<td>H54.0</td>
<td>H54.0</td>
<td>H54.0</td>
<td>H54.10</td>
</tr>
<tr>
<td>4</td>
<td>H54.42</td>
<td>H54.12</td>
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<tr>
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<td>H54.42</td>
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<td>H54.0</td>
<td>H54.0</td>
<td>H54.0</td>
<td>H54.10</td>
</tr>
<tr>
<td>9</td>
<td>H54.62</td>
<td>H54.10</td>
<td>H54.10</td>
<td>H54.10</td>
<td>H54.10</td>
<td>H54.10</td>
<td>H54.3</td>
</tr>
</tbody>
</table>

*Notes:
1) Vision Impairment Categories 1 and 2 are for vision impairment deemed to be Low Vision; Categories 3, 4 and 5 for vision impairment deemed to be Blindness; and Category 9 for Undetermined / Unspecified vision impairment. See back side for specific description of each category’s parameters.
3) This is not a comprehensive list of ICD-10 codes for Low Vision and is only meant as a guide. Check with your Billing Manager and/or local Medicare Carrier for details about the use of ICD-10 codes.
Medicare

Key Points about E&M Codes:

- Patient becomes “established” after first “billable event”
- “Time Spent” criteria for code level must be face-to-face physician with patient
- Bill refraction separately!
- No two billable events allowed on same day
- 99211 is only code allowed with no physician involvement, but physician must be on premises (direct supervision)
- 4 or 5 level CPT codes should be supported by systems review
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Medicare Systems Review Checklist

Extended Medical History

Patient Name ___________________________ Date ___________________________

1. Do you presently have or have you had any of the following conditions?
   - Blurred or distance vision
   - Decreased vision
   - Crossed eyes
   - Amblyopia or lazy eye
   - Sudden change in visual acuity

2. Have you had any of the following conditions within the past 12 months?
   - Astigmatism
   - Anesthesia
   - Cataracts
   - Glaucoma
   - Diabetes
   - Hypertension
   - Heart disease
   - High blood pressure
   - History of smoking
   - History of cancer
   - History of allergies
   - History of head injuries
   - History of previous surgery

If you answered "Yes" to any of the above in 1 or 2, please explain:______________________________________________________________

3. Do you smoke? ___________________________ How much? ___________________________
4. Do you drink alcohol? ___________________________ How much? ___________________________
5. Please list any previous eye or other surgery you have had:______________________________________________________________

   Procedures ____________________________________________________ Date _____________________________________________________

   Procedures ____________________________________________________ Date _____________________________________________________
Medicare

Follow-up Low Vision Evaluation
Low Vision Practitioners may employ one of two strategies for billing Medicare for Low Vision Follow-Up visits:

1. Use of Evaluation and Management Codes (for Physician Extenders)
   
   *CPT 99000 through CPT 99999*

2. Use of Physical Medicine Codes (for MDs, ODs, & O/Ts)
   
   *CPT 97000 series*
Medicare

Follow-up Low Vision Evaluation:

Evaluation & Management CPT Codes
Medicare

Medicare and Low Vision Follow-up Visits

5-digit “E&M” CPT Codes:

- Third and fourth digits indicate the source of the patient
  Established patient = 9921X

  By definition, all “Follow-up Visits” are for established patients

- Fifth digit indicates the code level of the service provided (1 – 5) ex. 99215
# Low Vision Training Module #11

## Medicare

### CPT E&M Codes Typically used for Follow-up LV Exams

<table>
<thead>
<tr>
<th>Nature/Severity of problem</th>
<th>Time spent w/ patient*</th>
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<tbody>
<tr>
<td>Low to Moderate</td>
<td>5 min.</td>
<td>99211</td>
<td>$28</td>
</tr>
<tr>
<td>Moderate</td>
<td>10 min.</td>
<td>99212</td>
<td>$52</td>
</tr>
<tr>
<td>Moderate to High</td>
<td>15 min.</td>
<td>99213</td>
<td>$72</td>
</tr>
<tr>
<td>Moderate to High</td>
<td>25 min.</td>
<td>99214</td>
<td>$112</td>
</tr>
<tr>
<td>Moderate to High</td>
<td>40 min.</td>
<td>99215</td>
<td>$172</td>
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| Patient Referred for Neuro-Muscular Re-education** | 15 min. | N/A | 97112 | $40 |
| Patient Referred for Gait Training                  | 15 min. | N/A | 97114 | $40 |
| Patient Referred for Therapeutic Activities         | 15 min. | N/A | 97530 | $40 |
| Patient Referred for Self-care/ Home Mgt. Training | 15 min. | N/A | 97535 | $40 |
| Patient Referred for Community/Work Re-integration Training | 15 min. | N/A | 97537 | $40 |
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| Low Vision Appliances - Fitting Spectacle LVA, Single Element | N/A | N/A | 92354 | Not Covered under Medicare |
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| Low Vision Appliances - Supply of Low Vision Aids   | N/A | N/A | 92392 |

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Use of ICD-10 codes

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**Low Vision Training Module #11**

Medicare

ICD-10 Codes for Low Vision Care

**Commonly Used ICD-10 Codes for Low Vision**

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<tr>
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<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>H54.51</td>
<td>H54.51</td>
<td>H54.41</td>
<td>H54.41</td>
<td>H54.41</td>
<td>H54.61</td>
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<tr>
<td>1</td>
<td>H54.52</td>
<td>H54.2</td>
<td>H54.2</td>
<td>H54.11</td>
<td>H54.11</td>
<td>H54.11</td>
<td>H54.10</td>
</tr>
<tr>
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<td>H54.52</td>
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<td>H54.2</td>
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<td>H54.11</td>
<td>H54.10</td>
</tr>
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<td>H54.42</td>
<td>H54.12</td>
<td>H54.12</td>
<td>H54.0</td>
<td>H54.0</td>
<td>H54.0</td>
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<td>H54.12</td>
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<td>H54.12</td>
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<td>H54.62</td>
<td>H54.10</td>
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3) This is not a comprehensive list of ICD-10 codes for Low Vision and is only meant as a guide. Check with your Billing Manager and/or local Medicare Carrier for details about the use of ICD-10 codes.*
Medicare Evaluation and Management Codes

- Patient becomes “established” after first “billable event”
- “Time Spent” criteria for code level must be face-to-face physician with patient
- Bill refraction separately!
- No two billable events allowed on same day
- 99211 is only code allowed with no physician involvement, but physician must be on premises (direct supervision)
- 4 or 5 level CPT codes should be supported by systems review
**Medicare**

**Example #1:** Reimbursement potential from seeing one Low Vision patient using E&M Codes for both Initial and Follow-up Appointments:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Low Vision Evaluation (45 min. w/OD, 15 w/asst.)</td>
<td>99243</td>
<td>$109</td>
</tr>
<tr>
<td>Refraction (not covered)</td>
<td></td>
<td>$25*</td>
</tr>
<tr>
<td>Initial follow-up visit (15 min. w/OD, 15 w/asst.)</td>
<td>99213</td>
<td>$75</td>
</tr>
<tr>
<td>Second follow-up visit (15 min. w/OD, 15 w/asst.)</td>
<td>99213</td>
<td>$75</td>
</tr>
</tbody>
</table>

**Low Vision Devices Dispensed**

~ $300

**Total Revenue Generated**

$475

*Refraction not reimbursable by Medicare.

**Assumes a Makrolux illuminated stand magnifier and a Solar Shield contrast-enhancing filter are dispensed at 2x markup.
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Medicare

Follow-up Low Vision Evaluations:

Physical Medicine Codes
(for use by MDs, ODs, & O/Ts)
Medicare

Medicare and Low Vision Follow-up Visits

5-digit “Physical Medicine” CPT Codes:

- First 2 digits indicate codes are for rehabilitative therapy
  
  Ex. 97535 97 indicates therapy

- Digits three through five indicate the type of therapy provided:
  
  Ex. 97535 535 indicates “Self-care/Home Management Training”
Medicare
Commonly used Physical Medicine Codes:

97533 Sensory Integrative Techniques
  Used for scotoma / PRL training; 15 minute units

97535 Self care/Home management training
  Used for ADLs, compensatory training, meal prep., use of adaptive equipment; 15 minute units – the most successfully applied code!

97537 Community/work re-integration training
  Used for shopping, transportation, money management, work environment/modification analysis, work task analysis; 15 minute units
Medicare

Physical Medicine Codes

Documentation required of ordering physician

1. Statement documenting a need for rehabilitation

2. Statement of patient’s potential to benefit from low vision rehabilitation (excellent/good/fair)

3. ICD-10 codes for impairment level

4. Therapy ordered. Can simply be a list of therapy codes to be utilized.
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Medicare

Physical Medicine Codes

Documentation required of LV care provider

1. Plan of Care, including:
   a. Assessment of needs
   b. List of specific goals to be achieved
   c. Activities to be undertaken to achieve goals
   d. Est. time required (3 months max.)
   e. Est. frequency of visits
2. Daily progress notes, including:
   a. Start and Stop times of session
   b. Description of activity under each code billed
   c. Time devoted to activity under each code
      How many 15 minute units?
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Medicare

Physical Medicine Codes

Documentation required of LV care provider (cont.)

3. Monthly Progress Report, including:
   a. Progress to date on each goal
   b. Patient’s need for ongoing services
   c. Ordering physician’s signature
Medicare

Physical Medicine Codes

Documentation required of LV care provider (cont.)

4. Discharge Summary, including:
   a. Description as to extent to which each goal was met
   b. Final disposition (equipment provided)
   c. Reviewed by physician
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## Medicare

Documentation techniques for Physical Medicine Codes: Short-form approach

![Plan of Treatment for Low Vision Rehabilitation](image)

- **Assessment of needs**
- **List of goals**
- **Activities to be undertaken to achieve goals**
- **Monthly Progress Report or Discharge Summary**
- **Estimated time required**
- **Estimated frequency of visits**
- **Physician Signature**
- **Daily Progress Notes and Description of activities**
- **Session time/units**
Low Vision Training Module #11

Medicare

Documentation techniques for Physical Medicine Codes: Short-form approach
Low Vision Training Module #11

Medicare Documentation techniques for Physical Medicine Codes: Long-form approach
Low Vision Training Module #11

Medicare

Documentation techniques for Physical Medicine Codes: Long-form approach

LOW VISION REHABILITATION DISCHARGE SUMMARY

Patient: ___________________________ Date: ___________________________

Time: ___ : ___ to ___ : ___ Total number of treatments

Patient’s overall cognitive/physical/emotional state upon discharge:

__________________________

__________________________

__________________________

__________________________

PROGRESS NOTED SINCE INITIAL EVALUATION:

1. Scotoma Awareness:

   ______________________

   ______________________

   ______________________

   ______________________

2. Lighting/glare/contrast:

   ______________________

   ______________________

   ______________________

   ______________________

3. Safety:

   ______________________

   ______________________

   ______________________

   ______________________
Medicare

Physical Medicine Codes

• May be provided by any Medicare defined “Physician” or O/Ts under the supervision of a “Physician”

• May be provided by OT’s, independently if licensed

• May be ordered/prescribed by ODs as well as MDs, depending on state (Medicare allows, some state O/T licenses do not)

• Billed in units: one “unit” equals one 15 minute time block
Physical Medicine Codes (cont.)

- “GO” modifier to be used for exemption from $1500 cap
- Patients with acuities of better than 20/60 may be eligible via ICD-10 codes for Central Scotoma (OD: H53.411, OS: H53.412, OU: H53.413), Scotoma of Blind Spot area (OD: H53.421, OS: H53.422, OU: H53.423), or Homonymous Bilateral Field Defects (right side: H53.461, left side: H53.462).
- Are limited to a total of 6 or 8 hours of therapy per patient based on location
- One therapy at a time (hip/stroke/other)!
- Three months max. time allowed to complete therapy
- New therapy plans may be available
Example #2: Reimbursement potential from seeing one Low Vision patient using Physical Medicine Codes:

<table>
<thead>
<tr>
<th>Seen by Betty Jones, CLVT (Utah)</th>
<th>Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Initial Low Vision Evaluation</td>
<td>n/a</td>
<td>0</td>
</tr>
<tr>
<td>(45 min. w/OD, 15 w/asst.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Refraction* (not covered)</td>
<td>n/a</td>
<td>0</td>
</tr>
<tr>
<td>• Initial follow-up visit</td>
<td>n/a</td>
<td>0</td>
</tr>
<tr>
<td>(15 min. w/OD, 15 w/asst.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Second follow-up visit</td>
<td>n/a</td>
<td>0</td>
</tr>
<tr>
<td>(15 min. w/OD, 15 w/asst.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Visits</td>
<td>97535</td>
<td>$290</td>
</tr>
<tr>
<td>(3 visits/10 units/15 min./$29 ea.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Low Vision Devices Dispensed** ~ $300
Total Revenue Generated $590

*Refraction not reimbursable by Medicare.
**Assumes a Makrolux illuminated stand magnifier and a Solar Shield contrast-enhancing filter are dispensed at 2x markup.
Low Vision Training Module #11

Medicare

Maximum Reimbursement Strategy

• The maximum reimbursement can be obtained by using the E&M Codes for the Initial Low Vision Evaluation and 2 Follow-up appointments and the Physical Medicine Codes for the additional Follow-up appointments
• This strategy also provides the most comprehensive care for the patient and highest likelihood of a successful patient outcome.
Example #3: Maximum reimbursement potential from seeing one Low Vision patient using E&M Codes for the Initial Evaluation and 2 Follow-up appointments, and Physical Medicine Codes for the additional Follow-up appointments:

<table>
<thead>
<tr>
<th>Seen by Tom Brown, OD (Missouri)</th>
<th>Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Initial Low Vision Evaluation</td>
<td>99243</td>
<td>$109</td>
</tr>
<tr>
<td>(45 min. w/OD, 15 w/asst.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Refraction* (not covered)</td>
<td></td>
<td>$25</td>
</tr>
<tr>
<td>• Initial follow-up visit</td>
<td>99213</td>
<td>$75</td>
</tr>
<tr>
<td>(15 min. w/OD, 15 w/asst.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Second follow-up visit</td>
<td>99213</td>
<td>$75</td>
</tr>
<tr>
<td>(15 min. w/OD, 15 w/asst.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Visits</td>
<td>97535</td>
<td>$290</td>
</tr>
<tr>
<td>(3 visits/10 units/15 min./$29 ea.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Low Vision Devices Dispensed**  
~ $300

Total Revenue Generated  
$874

*Refraction not reimbursable by Medicare.

**Assumes a Makrolux illuminated stand magnifier and a Solar Shield contrast-enhancing filter are dispensed at 2x markup.
Other Reimbursement:

- Medicaid
- Private Insurance
- Federal/State Governments
Medicaid
Medicaid

- Varies state to state
- Investigate in states without established “Commission for the Blind”
Private Insurance
Private Insurance:

Vision Service Plan (VSP) coverage:

1. Requires pre-authorization on part of plan provider (MD/OD):
   1. “Supplemental Testing Request for Low Vision Evaluation” form
   2. “Approval of Low Vision Therapy Request Form 2”

2. Not all plan members are eligible, different sub-plans have different coverage levels

3. Coverage includes:
   1. Up to $125 for supplemental testing procedures
   2. Up to 75% up to $1000 every two years
Low Vision Training Module #11

Private Insurance:
Vision Service Plan (VSP) coverage:

“Supplemental Testing Request for Low Vision Evaluation”

“Approval of Low Vision Therapy Request Form 2”

[Image of form]
Private Insurance: Davis Vision Plan coverage:

Davis Vision is one of the nation’s leading managed vision and eye care providers.
1. Requires pre-authorization on part of plan provider (MD/OD):
   1. “Medically Necessary Services” form
2. Coverage includes:
   1. One LV evaluation every 5 years (max $300 / evaluation)
   2. Max. LV aid allowance of $600 with lifetime max of $1200
   3. 4 follow-up visits every 5 yrs. ($100/ ea.)
Private Insurance:
Davis Vision Plan coverage:

Description of Benefits

“Medically Necessary Services Prior Approval” Form
Federal / State Government Programs
Federal / State Government

Affordable Care Act Pediatric Low Vision Coverage (for those under age 19):

- Federal mandate, but implemented at the state level
- Coverage varies, but most states offering coverage through a plan similar to the FED VIP BlueVision plan offered to federal workers
Federal / State Government

Affordable Care Act Pediatric Low Vision Coverage typically is the following after pre-authorization*:

- 1 comprehensive LV evaluation every 5 years, with a maximum charge of $300
- maximum low vision aid allowance of $600 with a lifetime maximum of $1,200
- 4 follow-up visits in any five-year period, with a maximum charge of $100 each visit.

*Check with your state for actual coverage.
Conclusion

• There are a number of ways to get reimbursement for Low Vision Services
• The determination of which reimbursement strategy is best for your practice depends much on your delivery model
Conclusion

To help you determine what reimbursement strategy is best, it is helpful to answer the following questions:

• Where do your low vision patients come from?
• How long are initial low vision evaluations in your practice?
• Who performs these evaluations?
• How do you currently obtain reimbursement for initial low vision evaluations?
• Do you conduct follow-up appointments with your low vision patients?
• How long are these “follow-up” visits?
• Who performs these “follow-ups”?
• How do you currently obtain reimbursement for “follow-ups”?
• Are you open to expanding your low vision care model?
Conclusion

Once you’ve answered those questions and selected a delivery model, you can use this Reimbursement Template to estimate your potential reimbursement income from Low Vision Care:

<table>
<thead>
<tr>
<th>Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Low Vision Evaluation</td>
<td>______</td>
</tr>
<tr>
<td>Refraction (not covered)</td>
<td>______</td>
</tr>
<tr>
<td>Initial follow-up visit</td>
<td>______</td>
</tr>
<tr>
<td>Second follow-up visit</td>
<td>______</td>
</tr>
<tr>
<td>Additional visits</td>
<td>______</td>
</tr>
<tr>
<td>Low Vision Devices Dispensed</td>
<td>______</td>
</tr>
<tr>
<td>Total revenue generated</td>
<td>______</td>
</tr>
</tbody>
</table>
Questions?
Thank You!