On behalf of Vision Expo, we sincerely thank you for being with us this year.

Vision Expo Has Gone Green!

We have eliminated all paper session evaluation forms. Please be sure to complete your electronic session evaluations online when you login to request your CE Letter for each course you attended! Your feedback is important to us as our Education Planning Committee considers content and speakers for future meetings to provide you with the best education possible.

VISION EXPO

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Dry Eye Billing and Coding: Maximize your profit

Crystal M. Brimer, OD, FAAO
Dry Eye Institute
Wilmington, NC

VISION EXPO

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Dr. Crystal Brimer has received honorarium from Abbvie, B&L, Biotissue, MDelite, NuSight, and Oculus in the past 3 years.
She is on the Speakers Beaureau for B&L, Biotissue, Oculus, NuSight, and Sun.
She is on medical advisory board for NuSight and B&L.
She receives royalties from Oculus.
She no longer has a relationship with Mdelite.

Financial Conflicts include:

- Dry Eye Institute: Founder
- Vision Source: Dry Eye Protocol I (2017) and II (2022)
- Oculus: Crystal Tear Report/5M platform, consultant and speaker
- MD Elite: PAST Advisor and speaker
- Biotissue: Speaker
- Abbvie: Consultant
- NuSight: Medical advisory board
- Bausch & Lomb: Speaker and Consultant
- Dompe: Clinical trial
- Sun: Consultant and speaker

All relevant financial relationships have been mitigated. The content of this COPE Accredited CE activity was planned and prepared independently by Dr. Crystal Brimer without input from members of an ineligible company.

VISION EXPO

3

first things first...

billing the office visit

92 codes vs 99 codes

VISION EXPO

4

5

992XX CODING:
You have TWO options

Use traditional medical justification guidelines, BEING CERTAIN to diagnose each OSD issue to show management of multiple conditions

Code	Level of MDM (Based on 2 out of 3 elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury; or • 1 stable, acute illness; or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (Must meet the requirements of at least 1 out of 2 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 2 from the following: ◦ Review of prior external note(s) from each unique source*; ◦ Review of the result(s) of each unique test*; ◦ Ordering of each unique test*; or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable, chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute, complicated injury	Moderate (Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: ◦ Review of prior external note(s) from each unique source*; ◦ Review of the result(s) of each unique test*; ◦ Ordering of each unique test*; ◦ Assessment requiring an independent historian(s); or Category 2: Assessment requiring an independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet the requirements of at least 3 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: ◦ Review of prior external note(s) from each unique source*; ◦ Review of the result(s) of each unique test*; ◦ Ordering of each unique test*; ◦ Assessment requiring an independent historian(s); or Category 2: Assessment requiring an independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances

6

2. Track doctor time, unrelated to a test or procedure, not including staff time, and apply time guidelines

E&M CODE CHANGES

Most significant change for office-based evaluation and management (E&M) codes when using time to determine code level

- Revised to indicate required time thresholds that must be met
- No longer a time range
- Any prolonged time (99417 or G2212) reporting requires a minimum of 15 minutes per unit used beyond the times indicated for 99205 or 99215 codes

The new times are as follows:

99211: Not applicable

99202: 15 minutes must be met/exceeded	99212: 10 minutes must be met/exceeded
99203: 30 minutes must be met/exceeded	99213: 20 minutes must be met/exceeded
99204: 45 minutes must be met/exceeded	99214: 30 minutes must be met/exceeded
99205: 60 minutes must be met/exceeded	99215: 40 minutes must be met/exceeded

Slide is courtesy of Dr. Rebecca Wartman, AOA Coding Committee

Instructions for Selecting a Level of Office or Other Outpatient E/M Service

Select the appropriate level of E/M services based on the following:

1. The level of the medical decision making as defined for each service; **or**
2. The total time for E/M services performed on the date of the encounter.

Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not be counted in the medical decision making when selecting a level of office or other outpatient service. When the physician or other qualified professional is reporting a separate service for discussion of management with a physician or other qualified health care professional, the discussion is not counted in the medical decision making when selecting a level of office or other outpatient service.

Excerpt from https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

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Slides are courtesy of Dr. Rebecca Wartman, AOA Coding Committee

CMS Final Rule Comments

Prolonged Clinical Staff Services

Requires Direct Physician Supervision

Total Duration of Prolonged Services	Code(s)
less than 45 minutes	Not reported separately
45-74 minutes (45 minutes - 1 hr. 14 min.)	99415 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99415 X 1 AND 99416 X 1
105 or more (1 hr. 45 min. or more)	99415 X 1 AND 99416 X 2 or more for each additional 30 minutes.

Clinical Staff Time for prolonged services would be RARELY if ever used in eye care and requires a full hour of dedicated staff time outside of the time they might spend for any E&M services

DRY EYE INSTITUTE **PROLONGED SERVICES**

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual	Rendering Provider ID.#
1	1	2021	1	1	2021	11	Day	99215			A,B	180.00	1		NPI	xxxxxxxxx
1	1	2021	1	1	2021	11	Day	G2212			A,B	35.00	1		NPI	xxxxxxxxx

MEDICARE EXAMPLE: Use G2212

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual	Rendering Provider ID.#
1	1	2021	1	1	2021	11	Day	99215			A,B	180.00	1		NPI	xxxxxxxxx
1	1	2021	1	1	2021	11	Day	99417			A,B	35.00	1		NPI	xxxxxxxxx

COMMERCIAL PAYER EXAMPLE: Use 99417 instead of G2212

AVERAGE MEDICARE REIMBURSEMENT:

- 99215 - $177.47
- G2212 - $31.76 "Prolonged Service With/Without Direct Patient Contact on the Date of an Office or Other Outpatient Service"
- 99415 - $20.30 "Prolonged Clinical **Staff** Services With Physician or Other Qualified Health Care Professional Supervision"
- 99416 - $9.50 "Prolonged Clinical **Staff** Services With Physician or Other Qualified Health Care Professional Supervision"

THINGS YOU MUST KNOW:

- You no longer must have the majority of the time spent on "counseling and coordination of care," so this documentation is no longer necessary, but you must document your time.
- You can only use these codes if you are billing the E/M service via "time" and not Medical Decision Making
- Time spent performing separately reported services other than the E/M service is not counted toward the time to report 99205, 99215 and prolonged services time.
- Tests without their own CPT codes (TBUT, Schirmer, vital dyes) will count as time BUT not for the Data section of Medical Decision Making
- See the rules above as to what activities are applicable

VISION EXPO

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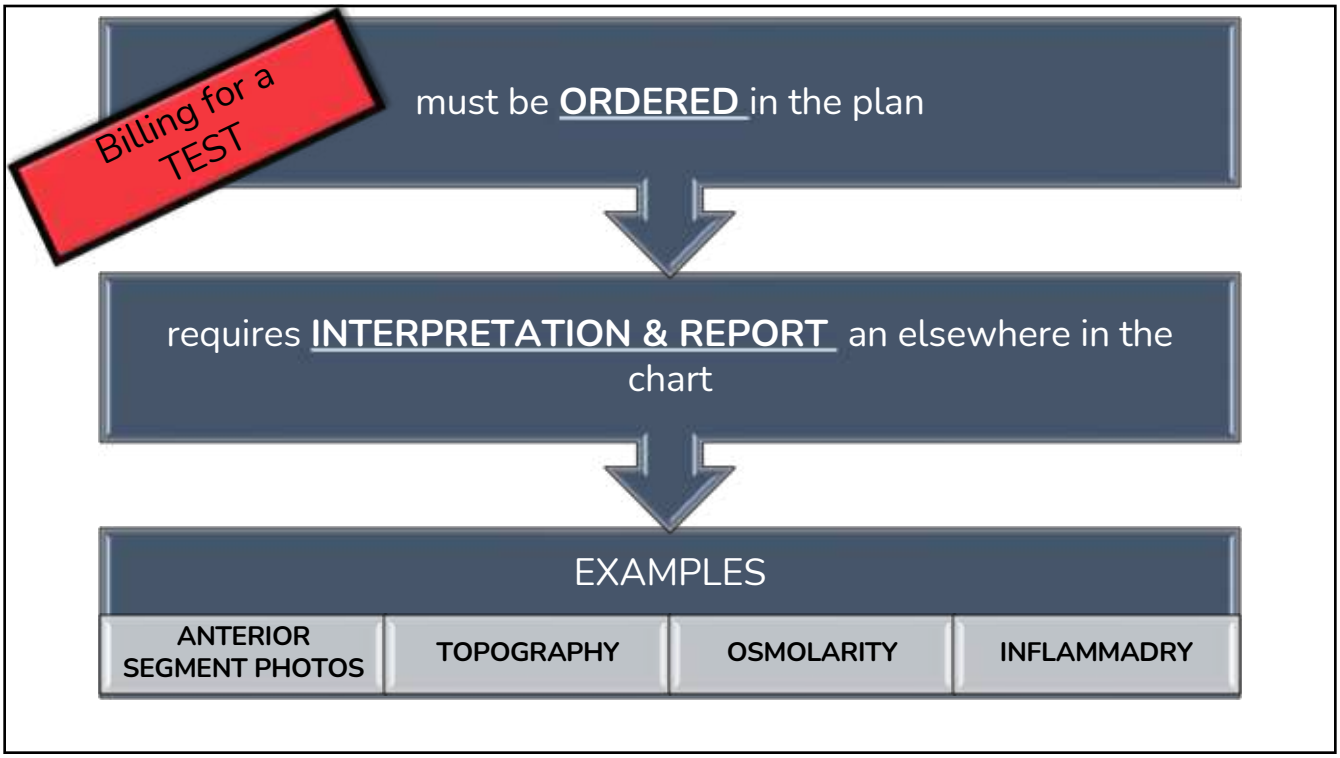
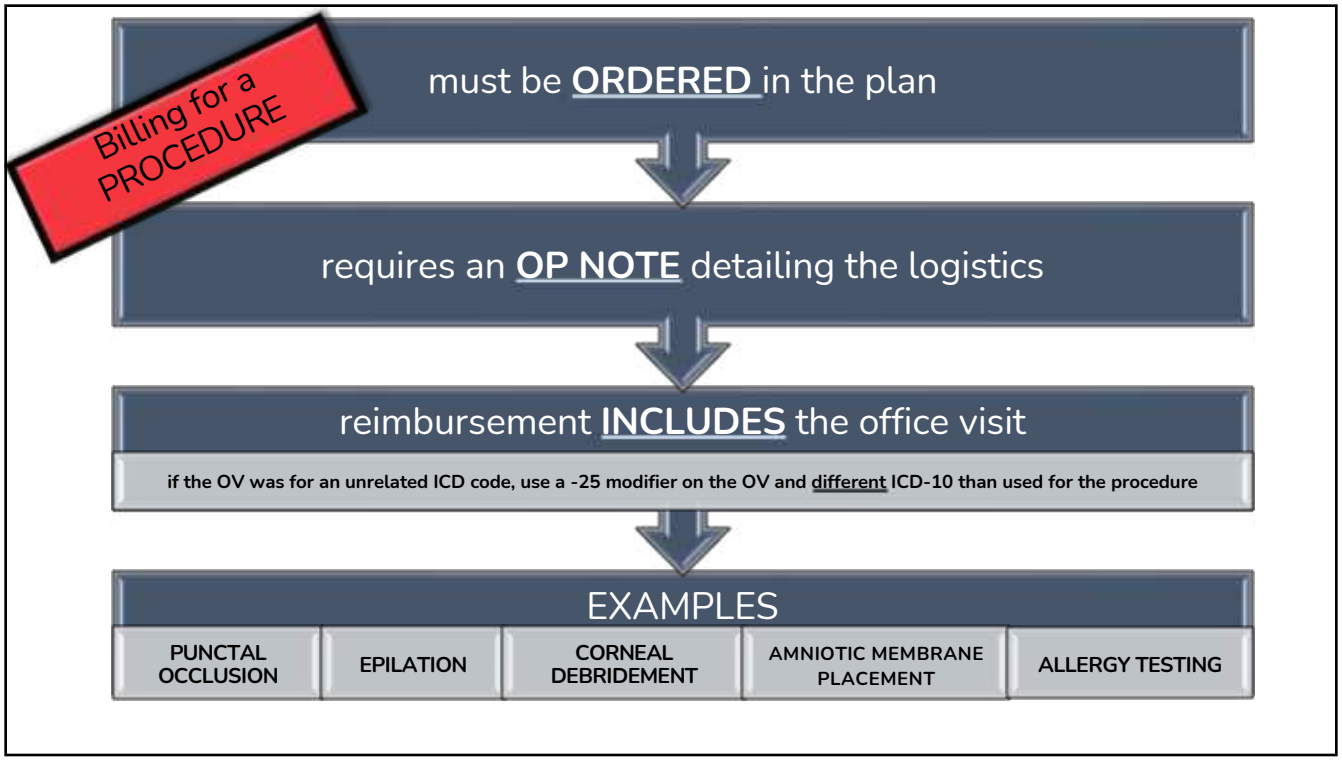
the 3 billing rules you should memorize

seriously

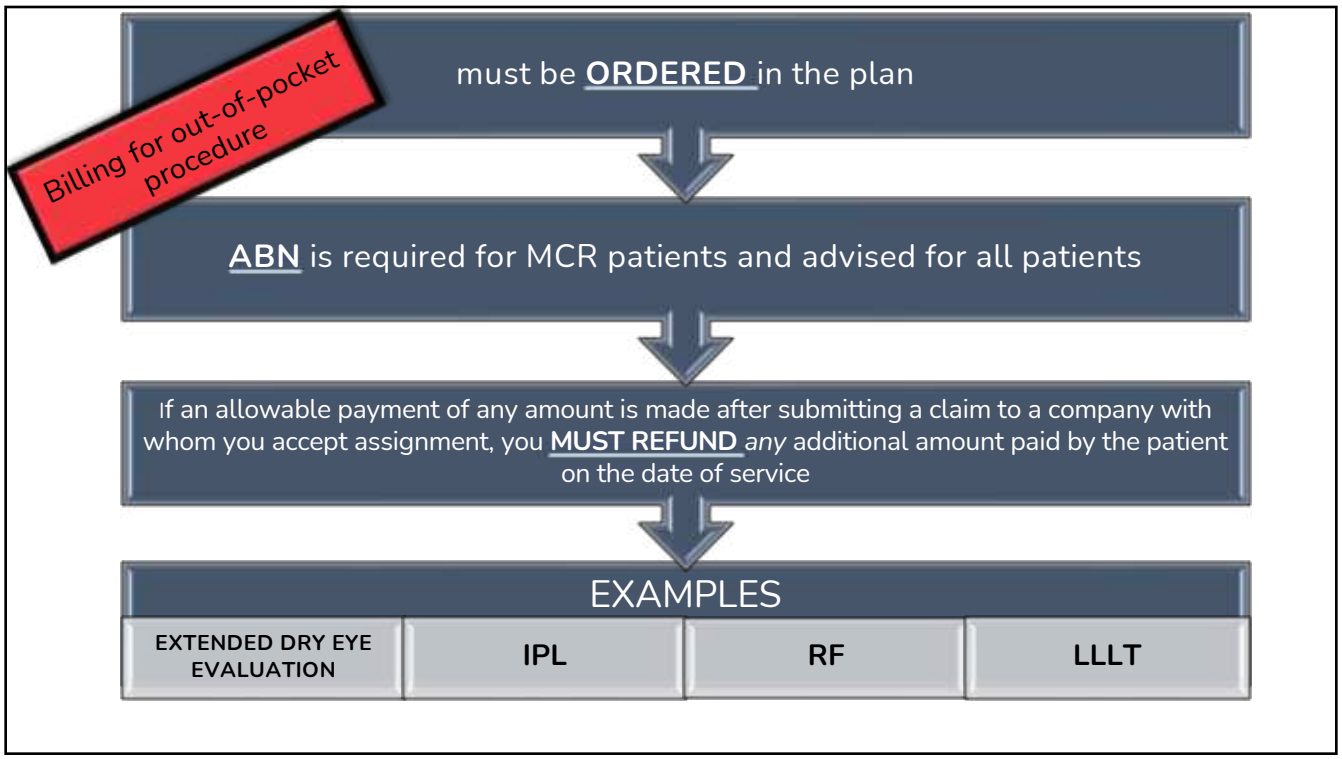
9



10


Billing for a PROCEDURE
must be ORDERED in the plan
requires an OP NOTE detailing the logistics
reimbursement INCLUDES the office visit
if the OV was for an unrelated ICD code, use a -25 modifier on the OV and different ICD-10 than used for the procedure
EXAMPLES
PUNCTAL OCCLUSION
EPILATION
CORNEAL DEBRIDEMENT
AMNIOTIC MEMBRANE PLACEMENT
ALLERGY TESTING

11


Billing for out-of-pocket procedure
must be ORDERED in the plan
ABN is required for MCR patients and advised for all patients
If an allowable payment of any amount is made after submitting a claim to a company with whom you accept assignment, you MUST REFUND any additional amount paid by the patient on the date of service
EXAMPLES
EXTENDED DRY EYE EVALUATION
IPL
RF
LLLT

12

A WORD ON PRIOR AUTHORIZATIONS

- PAs are often quicker and more successful if completed over the phone!
- However, for OptumRx or Express scripts, covermymeds.com is likely the fastest way to get a response
- There's no such thing as too MUCH information! Include:
  - EVERY OTC and Rx ever used (with dates if possible)
  - Detailed symptoms
  - All poor test findings
  - Diagnosis list
- Submit a PA even if the pharmacy doesn't initiate one. Often the PA will still result in approval even if you received a Change Request instead

Apex Pharmacy : 681.207.7334

- Apex will perform the PA for you once give the proper information
- You provide Diagnosis, past medication history, and any helpful test results via "pharmacy notes" section on the prescription that is faxed or e-scribed directly to Apex Pharmacy
- If PA is approved: Apex automatically fills the prescription and mails it directly to the patient at no additional cost
- If PA is denied: Apex will contact you directly and ask for your second choice. HOWEVER, as a time saver, they keep a list of my preferences and proceed accordingly.
- Example, if a prescription is denied for Cequa they will automatically go to my second choice and then third choice if required. After 30 days, they will contact the patient and send a new PA for the first choice prescription again.

Pinnacle Health Group

- https://thepinnaclehealthgroup.com/
- Obtain log-in from your Biotissue rep
- A service provided by Biotissue to ensure PAs are acquired when needed and that payments are received for Prokera. They can also help with claim appeals if denied
- Go to the cases tab at the top of the screen and create a new case, in this tab you will enter the case type (Prior Auth or Denial appeal), product information (Prokera), Physicians name, patients name, DOB, and address
- Input the patient's insurance information, procedure code, ICD-10, place of service, and procedure date
- The authorization is pulled and you will know if there are any issues before placement, such as ATD or non-coverage

VISION EXPO

13

Updated ABN form for 2024

Don't forget:
Good Faith Estimates are required by the No Surprises Act

(ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

VISION EXPO

14

Sample pre-certification letter

Sample Letter for Pre-Certification

Date

[Insurer Name] [Attn:_____][Street Address][City, State, Zip Code]

Re: [Patient Name][Patient's Identification Number]

Dear [Insurer]:

This letter is to request pre-certification for punctal occlusion with plugs for the treatment of dry eye syndrome, or keratoconjunctivitis sicca (KCS). This letter provides the clinical rationale for performing the procedure along with a description of the procedure.

Background

An estimated 50 to 60 million Americans suffer from dry eye syndrome. Common treatments include ointments, eye drops, protective glasses and anti-inflammatory therapy. In cases where these treatments are ineffective or contraindicated, surgical intervention may be warranted. Punctal occlusion is a safe and effective treatment for KCS, as well as ocular surface disease, reflex tearing, and other conditions caused by dry eyes.

Punctal occlusion with plugs is used for moderate to severe dry eye sufferers to help retain tear fluid by stemming drainage. It may also enhance the delivery and absorption of topical medications in the eye. This procedure may prevent more serious corneal disease and facilitate a return to contact lenses.

Patient's Diagnosis and Clinical Rationale for Selecting Treatment: The history and clinical course of **[Patient Name]'s** dry eye syndrome is as follows:

[Please insert a paragraph discussing your patient's diagnosis and history. Include copies of test results, a complete summary of all previous treatments (including treatment response or failure) and documentation of clinical improvements and failures.]

A variety of treatments are available to individuals with dry eye syndrome. Selecting the most appropriate treatment depends on a thorough evaluation of all the relevant factors that could cause or contribute to the condition. Because of **[Patient Name]'s** continued battle with dry eye syndrome and despite prior treatment with artificial tears and after careful examination and review of this patient's condition, I would like to perform punctal occlusion with plugs.

Treatment Description

The physician gently places **<Named Plug>** into the punctum. Inside the punctum, the plug expands in width, adjusting itself to fit the punctum.

Request for Coverage Approval

Dry eye syndrome is a serious and often neglected ophthalmic condition. Unfortunately **[Patient Name]** has received other available therapies without success. In light of the patient's medical history, it is my opinion that this procedure is medically necessary. I request that you consider coverage of this procedure and provide pre-certification. If you have any further questions about this procedure, please contact me at **[Phone].**

Sincerely,

[Physician Name]

VISION EXPO

15

Sample Op Note

Sample Operative Report: Punctal Occlusion with Plugs

Date: _____ Patient's name:_____
Preoperative diagnosis: Dry eye syndrome Postoperative diagnosis: Dry eye syndrome Procedure: Punctal occlusion with **<Named Plug>[Indicate lid]**

The patient has been previously diagnosed with dry eye syndrome and treated with a number of different artificial tears with little or no improvement. The procedure, alternatives, risks and possible complications have been explained to the patient and the patient has given consent for punctal occlusion with **<Named Plug>**. No guarantee or assurance has been given to the patient as to the results that may be obtained.

<Named Plug> was removed from its package with forceps and the distal end was gently inserted into the punctum at slit lamp. A drop of topical antibiotics was instilled afterwards.

The procedure was repeated for the other punctum.

The patient tolerated the procedure well and left in good condition. The postoperative instructions were given including the medications as well as a follow-up appointment. Signs of infection explained and patient was instructed to return to office at first onset.

Physician's signature _____

VISION EXPO

16

Sample letter of appeal

Sample Letter of Appeal for Claims Denied Coverage

Date

[Insurer Name] [Attn:_____]□[Street Address]□[City, State, Zip Code]

Re: [Patient Name]□[Patient's Identification Number]

Dear [Insurer]:

This letter is in response to your denial of the enclosed claim for punctal occlusion with plugs for the treatment of dry eye syndrome or keratoconjunctivitis sicca (KCS). I am submitting this claim for reconsideration. This letter provides the clinical rationale for performing the procedure along with a description of the procedure.

Background

An estimated 50 to 60 million Americans suffer from dry eye syndrome. Common treatments include ointments, eye drops, protective glasses and anti-inflammatory therapy. In cases where these treatments are ineffective or contraindicated, surgical intervention may be warranted. Punctal occlusion is a safe and effective treatment for KCS, as well as ocular surface disease, reflex tearing, and other conditions caused by dry eyes.

Punctal occlusion with plugs is used for moderate to severe dry eye sufferers to help retain tear fluid by stemming drainage. It may also enhance the delivery and absorption of topical medications in the eye. This procedure may prevent more serious corneal disease and facilitate a return to contact lenses.

Patient's Diagnosis and Clinical Rationale for Selecting Treatment□The history and clinical course of **[Patient Name]'s** dry eye syndrome is as follows:

[Please insert a paragraph discussing your patient's diagnosis and history. Include copies of test results, a complete summary of all previous treatments (including treatment response or failure) and documentation of clinical improvements and failures.]

A variety of treatments are available to individuals with dry eye syndrome. Selecting the most appropriate treatment depends on a thorough evaluation of all the relevant factors that could cause or contribute to the condition. Because of **[Patient Name]'s** continued battle with dry eye syndrome and despite prior treatment with artificial tears and after careful examination and review of this patient's condition, I would like to perform punctal occlusion with plugs.

Treatment Description

The ophthalmologist or optometrist gently places **<Named Plug>** into the punctum. Inside the punctum, the plug expands in width, adjusting itself to fit the punctum.

Request for Coverage Approval

Dry eye syndrome is a serious and often neglected ophthalmic condition. Unfortunately **[Patient Name]** has received other available therapies without success. In light of the patient's medical history, it is my opinion that this procedure is medically necessary. I request that you reconsider coverage of this procedure and pay my claim for reimbursement. If you have any further questions about this procedure, please contact me at **[Phone].**

Sincerely,

[Physician Name]

VISION EXPO

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Sample letter of medical necessity

Date: _____

Insurance Company/Payer Name: _____
Address: _____
City, State, Zip Code: _____

RE: Letter of Medical Necessity for LipiFlow® Thermal Pulsation System
Patient/Member Name: _____
Patient/Member Number: _____
Group Number: _____

To Whom It May Concern:

Writing on behalf of patient, (patient name) to document the medical necessity of LipiFlow® System for treatment of Meibomian Gland Disease/Disorder. This letter provides information about the patient's medical history and diagnosis and a statement summarizing the treatment rationale.

Patient's Medical History and Diagnosis:
(information regarding patient's condition and specific diagnosis)
(Patient's diagnosis, date of diagnosis, lab results and date, current condition, and history)
(Previous therapies and procedures the patient has undergone for management of their condition)
(Patient's response to these therapies)
(Brief description of the patient's recent symptoms and conditions)

(Patient Name) is a (age)-year-old (male/female) diagnosed with MGD/DED. (Patient Name) has been receiving care since (first exam date). As a result of MGD/DED, my patient (brief description of patient history). Additionally, (patient) has tried (prev. Tx, warm compress, etc…) and (outcomes/NI).

Treatment Rationale:
(information on treatment up to this point, course of care, and why LipiFlow® System is necessary and how it is expected to help the patient)
Based on the above facts, I am confident that you will agree that LipiFlow® System is indicated and medically necessary for this patient.
Considering the patient's history, condition, and the full supported uses of LipiFlow®, I believe treatment with LipiFlow® at this time is warranted, appropriate, and medically necessary, and should be a covered and reimbursed service.

Duration:
The LipiFlow® System treatment takes 12 minutes for each eye. The results are known to last 9-15 months. It may be necessary to repeat the LipiFlow® System treatment annually.

Summary:
In summary, LipiFlow® System is medically necessary for this patient's dry eye condition. Please consider coverage, approve use, and subsequent payment for LipiFlow® System as planned. If any additional information is required to ensure the approval of LipiFlow® System, please do not hesitate to call at (telephone number). Thank you for your prompt attention to this matter.

Sincerely,
(Physician's Name and provider identification number)
(Physician's Signature)

VISION EXPO

18

ANTERIOR SEGMENT PHOTOGRAPHY: CPT

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual	Rendering Provider ID #
1	1	2018	1	1	2018	11	Day	99214			A,B,C, D	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	92285			A,B,C	20.00	1		NPI	xxxxxxxxxx

AVERAGE MEDICARE REIMBURSEMENT:

- $22.92

THINGS YOU MUST KNOW:

- Bill bilaterally, 1 line
- External photos are medically warranted when it will affect your decision making
- Must order the test in the plan
- Must include an Interpretation and Report in the record

APPLICABLE DIAGNOSIS CODES:

UNSPECIFIED BLEPHARITIS	OD UL	H01.001
	OD LL	H01.002
	OS UL	H01.004
	OS LL	H01.005
SENILE ECTROPION	OD UL	H02.131
	OD LL	H02.132
	OS UL	H02.134
	OS LL	H02.135
UNSPECIFIED LAGOPHTHALMOS	OD UL	H02.201
	OD LL	H02.202
	OS UL	H02.204
	OS LL	H02.205
BLEPHAROCHALASIS	OD UL	H02.30
	OD LL	H02.32

	OS UL	H02.34
	OS LL	H02.35
UNSPECIFIED PTOSIS	OU	H02.403
	OD	H02.401
	OS	H02.402
DERMATOCHALASIS	OD UL	H02.831
	OD LL	H02.832
	OS UL	H02.834
	OS LL	H02.835
DRY EYE SYNDROME	OU	H04.123
	OD	H04.121
	OS	H04.122
UNSPECIFIED ACUTE CONJUNCTIVITIS	OU	H10.33
	OD	H10.31
	OS	H10.32
UNSPECIFIED CHRONIC CONJUNCTIVITIS	OU	H10.403
	OD	H10.401
	OS	H10.402
UNSPECIFIED CHRONIC ALLERGIC CONJUNCTIVITIS		H10.45
UNSPEFICIED BLEPHAROCONJUNCTIVITIS	OU	H10.503
	OD	H10.501
	OS	H10.502
PINGUECULA	OU	H11.153
	OD	H11.151
	OS	H11.152
PINGUECULITIS	OU	H10.813
	OD	H10.811
	OS	H10.812
CONJUNCTIVAL CONCRETIONS	OU	H11.123
	OD	H11.121
	OS	H11.122
CONJUNCTIVAL HYPEREMIA	OU	H11.433
	OD	H11.431
	OS	H11.432
CONJUNCTIVOCHALASIS	OU	H11.823
	OD	H11.821
	OS	H11.822
UNSPECIFIED EPISCLERITIS	OU	H15.103
	OD	H15.101
	OS	H15.102
UNSPECIFIED SUPERFICIAL KERATITIS	OU	H16.103
	OD	H16.101
	OS	H16.102
FILAMENTARY KERATITIS	OU	H16.123
	OD	H16.121
	OS	H16.122
PUNCTATE KERATITIS	OU	H16.143
	OD	H16.141
	OS	H16.142

EXPOSURE KERATOCONJUNCTIVITIS	OU	H16.213
	OD	H16.211
	OS	H16.212
KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S	OU	H16.223
	OD	H16.221
	OS	H16.222
NEUROTROPHIC KERATOCONJUNCTIVITIS	OU	H16.233
	OD	H16.231
	OS	H16.232
UNSPECIFIED INTERSTITIAL KERATITIS	OU	H16.303
	OD	H16.301
	OS	H16.302
SCLEROSING KERATITIS	OU	H16.333
	OD	H16.331
	OS	H16.332
UNSPECIFIED CORNEAL NEOVASCULARIZATION	OU	H16.403
	OD	H16.401
	OS	H16.402
PANNUS (CORNEAL)	OU	H16.423
	OD	H16.421
	OS	H16.422
OTHER KERATITIS		H16.8
UNSPECIFIED KERATITIS		H16.9
ENDOTHELIAL CORNEAL DYSTROPHY		H18.51
EPITHELIAL (JUVENILE) CORNEAL DYSTROPHY		H18.53
LATTICE CORNEAL DYSTROPHY		H18.54
MACULAR CORNEAL DYSTROPHY		H18.55
OTHER HEREDITARY CORNEAL DYSTROPHIES		H18.59
UNSPECIFIED CORNEAL DEFORMITY		H18.70
OTHER CORNEAL DEFORMITIES	OU	H18.793
	OD	H18.791
	OS	H18.792

RECURRENT EROSION OF CORNEA	OU	H18.833
	OD	H18.831
	OS	H18.832
MEIBOMIAN GLAND DYSFUCNTION	OD UL	H02.881
	OD LL	H02.882
(unspecified lid)	OD	H02.883
	OS UL	H02.884
	OS LL	H02.885
(unspecified lid)	OS	H02.886
(unspecified eye / unspecified lid)		H02.889
	OD UL/LL	H02.88 A
	OS UL/LL	H02.88B
ROSASEA CONJUNCTIVITIS	OD	H10.821
	OS	H10.822
	OU	H10.823
(unspecified eye)		H10.829

Disclaimer: Rules and reimbursement will vary to the carriers in your zip code.

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TOPOGRAPHY: CPT 92025

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual	Rendering Provider ID #
1	1	2018	1	1	2018	11	Day	99214			A,B,C,D	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	92025			D	37.00	1		NPI	xxxxxxxxxx

MEDICARE EXAMPLE

AVERAGE MEDICARE REIMBURSEMENT:

- $35.69

THINGS YOU MUST KNOW:

- Can be billed same day as 92285, some private payers require 51 modifier (Multiple procedures/same day) on 92025 line
- MUST order the test in the plan
- MUST have an Interpretation and Report in the record

APPLICABLE DIAGNOSIS CODES:

UNSPECIFIED INTERSTITIAL KERATITIS	OU	H16.303
	OD	H16.301
	OS	H16.302
DIFFUSE INTERSTITIAL KERATITIS	OU	H16.323
	OD	H16.321
	OS	H16.322
SCLEROSING KERATITIS	OU	H16.333
	OD	H16.331
	OS	H16.332

ENDOTHELIAL CORNEAL DYSTROPHY		H18.51
EPITHELIAL CORNEAL DYSTROPHY		H18.52
GRANULAR CORNEAL DYSTROPHY		H18.54
MACULAR CORNEAL DYSTROPHY		H18.55
OTHER HEREDITARY CORNEAL DYSTROPHIES		H18.59

Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.

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MICROFLUIDIC ANALYSIS UTILIZING AN INTEGRA COLLECTION AND ANALYSIS DEVICE, TEAR OSMOLARITY: CPT 83861

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual	Rendering Provider ID #
1	1	2018	1	1	2018	11	Day	99214			A,B	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	83861	QW	RT	A	23.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	83861	QW	LT	A	23.00	1		NPI	xxxxxxxxxx

MEDICARE EXAMPLE

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual	Rendering Provider ID #
1	1	2018	1	1	2018	11	Day	99214			A,B	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	83861	RT		A	23.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	83861	59	LT	A	23.00	1		NPI	xxxxxxxxxx

COMMERCIAL PAYER EXAMPLE (some, not all)

AVERAGE MEDICARE REIMBURSEMENT:

- $22.48

THINGS YOU MUST KNOW:

- Must have CLIA Waiver certificate before billing
- For Medicare: Must have QW modifier (indicates that the diagnostic lab service is a CLIA *(Clinical Laboratory Improvement Amendment)* waived test and that the provider holds at least a Certificate of Waiver) as well as location (RT/LT) modifier
- For some private insurances: Must have 59 modifier (distinct procedural service / used to unbundle services) on the second line
- Must have CLIA # on Line 19 "Additional Claim Information" of CMS 1500 form
- Must order the test in the plan
- Must have an Interpretation and Report in the record

APPLICABLE DIAGNOSIS CODES:

UNSPECIFIED BLEPHARITIS	OD UL	H01.001
	OD LL	H01.002
	OS UL	H01.004
	OS LL	H01.005
DRY EYE SYNDROME OF LACRIMAL GLAND	OU	H04.123
	OD	H04.121
	OS	H04.122
UNSPECIFIED ACUTE CONJUNCTIVITIS	OU	H10.33
	OD	H10.31
	OS	H10.32
UNSPECIFIED CHRONIC CONJUNCTIVITIS	OU	H10.403
	OD	H10.401
	OS	H10.402
UNSPECIFIED CHRONIC ALLERGIC CONJUNCTIVITIS		H10.45
UNSPEFICIED BLEPHAROCONJUNCTIVITIS	OU	H10.503
	OD	H10.501
	OS	H10.502
PINGUECULA	OU	H11.153
	OD	H11.151
	OS	H11.152
PINGUECULITIS	OU	H10.813
	OD	H10.811
	OS	H10.812
CONJUNCTIVAL CONCRETIONS	OU	H11.123
	OD	H11.121
	OS	H11.122
CONJUNCTIVAL HYPEREMIA	OU	H11.433
	OD	H11.431
	OS	H11.432
UNSPECIFIED EPISCLERITIS	OU	H15.103
	OD	H15.101
	OS	H15.102
UNSPECIFIED SUPERFICIAL KERATITIS	OU	H16.103
	OD	H16.101
	OS	H16.102
FILAMENTARY KERATITIS	OU	H16.123
	OD	H16.121
	OS	H16.122
PUNCTATE KERATITIS	OU	H16.143
	OD	H16.141
	OS	H16.142
EXPOSURE KERATOCONJUNCTIVITIS	OU	H16.213
	OD	H16.211
	OS	H16.212
KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S	OU	H16.223
	OD	H16.221
	OS	H16.222
UNSPECIFIED CORNEAL NEOVASCULARIZATION	OU	H16.403
	OD	H16.401
	OS	H16.402
PANNUS (CORNEAL)	OU	H16.423
	OD	H16.421
	OS	H16.422
OTHER KERATITIS		H16.8
UNSPECIFIED KERATITIS		H16.9
MEIBOMIAN GLAND DYSFUCNTION	OD UL	H02.881
	OD LL	H02.882
(unspecified lid)	OD	H02.883
	OS UL	H02.884
	OS LL	H02.885
(unspecified lid)	OS	H02.886
(unspecified eye / unspecified lid)		H02.889
	OD UL/LL	H02.88A
	OS UL/LL	H02.88B
ROSASEA CONJUNCTIVITIS	OD	H10.821
	OS	H10.822
	OU	H10.823
(unspecified eye)		H10.829

Disclaimer: Rules and reimbursement will vary to the carriers in your zip code.

TearLab Tear Osmolarity Billing Guidance

This guide addresses billing recommendations for CPT® 83861, "Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity", a covered service by CMS Medicare under the Clinical Laboratory Fee Schedule. CLIA Certification is required to perform and bill laboratory tests.

Billing Codes and Modifiers

• CMS Medicare Part B

- 2018 allowable - $22.48 per test ($44.96 per patient) – no deductible or patient co-payment applies
- Code CPT 83861 as one unit of service with LT/RT and QW modifiers on two lines, once for each eye tested:
  - 83861 QW RT (1 unit)
  - 83861 QW LT (1 unit)
- Include ordering physicians individual NPI number (NOT group NPI) in Box 17
- Check "No" on Box 20
- Include CLIA license number in Box 23

CPT 83861 has universal coverage under CMS Part B Medicare. Claim denials from CMS are usually due to errors in coding or transmission of pertinent information by billing software. If any denial is received for CPT 83861 contact the TearLab Reimbursement Support Center promptly at rsc@tearlab.com for assistance.

• Commercial Third Party, Medicare Advantage Part C and Medicaid

Reimbursement, coding and coverage policies will vary by carrier, provider contract and patient benefit plan. Contact the TearLab Reimbursement Support Center at rsc@tearlab.com for payer specific billing guidance.

Diagnostic Codes

Medical necessity rules are met when a patient presents with a sign or symptom of dry eye as determined by the clinician, which should be documented in the patient's medical record. Codes commonly used for coding dry eye diagnosis and/or dry eye symptoms, as referenced in the clinical literature, are available on the "ICD-10 Coding for Dry Eye" brochure, available on the TearLab website.

Currently CMS has no National Coverage Determinations (NCD) that define diagnosis codes to bill for CPT 83861 tear osmolarity test, so a decision to perform a test based on signs or symptoms of dry eye is up to the physician. Always ensure that all the items listed below in "Documenting a Laboratory Test" are included in the patient record to meet medical necessity guidelines.

Documenting a Laboratory Test

Medicare has several documentation requirements for laboratory tests such as tear osmolarity, which must be noted in the patient chart or Electronic Health Record (EHR).

1. The sign or symptom of disease that prompted the ordering of the test
2. A notation in the medical record that a "tear osmolarity test was ordered" with "tear osmolarity" specifically identified
3. The numerical tear osmolarity test results and indication if the results were normal or abnormal
4. Treatment/Management Plan - the medical action taken as a result of the tear osmolarity test, and referencing the test results in the plan.
5. Managing clinician's signature at the end of the record indicating that everything in the record that day was reviewed and confirmed as medically necessary

Note that Medicare and most commercial payers do not cover screening tests. Plus a sign or symptom of dry eye, or a previously diagnosed but "unstable" dry eye under management, must be properly documented prior to submitting a claim for reimbursement for a tear osmolarity test.

What if the tear osmolarity test is normal?

If the tear osmolarity test result is normal and dry eye is "ruled out", code for the final or confirmed diagnosis, and the symptoms that prompted ordering the test may also be reported as additional diagnosis if they are not fully explained or related to the confirmed diagnosis". (ref: CMS Program Memorandum AB-01-144, Sept 28, 2001)

CMS coverage rules for laboratory tests state, "The testing of a person to rule out or to confirm a suspected diagnosis because the patient has a sign and/or symptom is a diagnostic test, not a screening. In these cases, the sign or symptom should be used to explain the reason for the test". (ref: Fed Reg Vol 65, No. 226, Nov 21, 2000)

How often can I perform a tear osmolarity test?

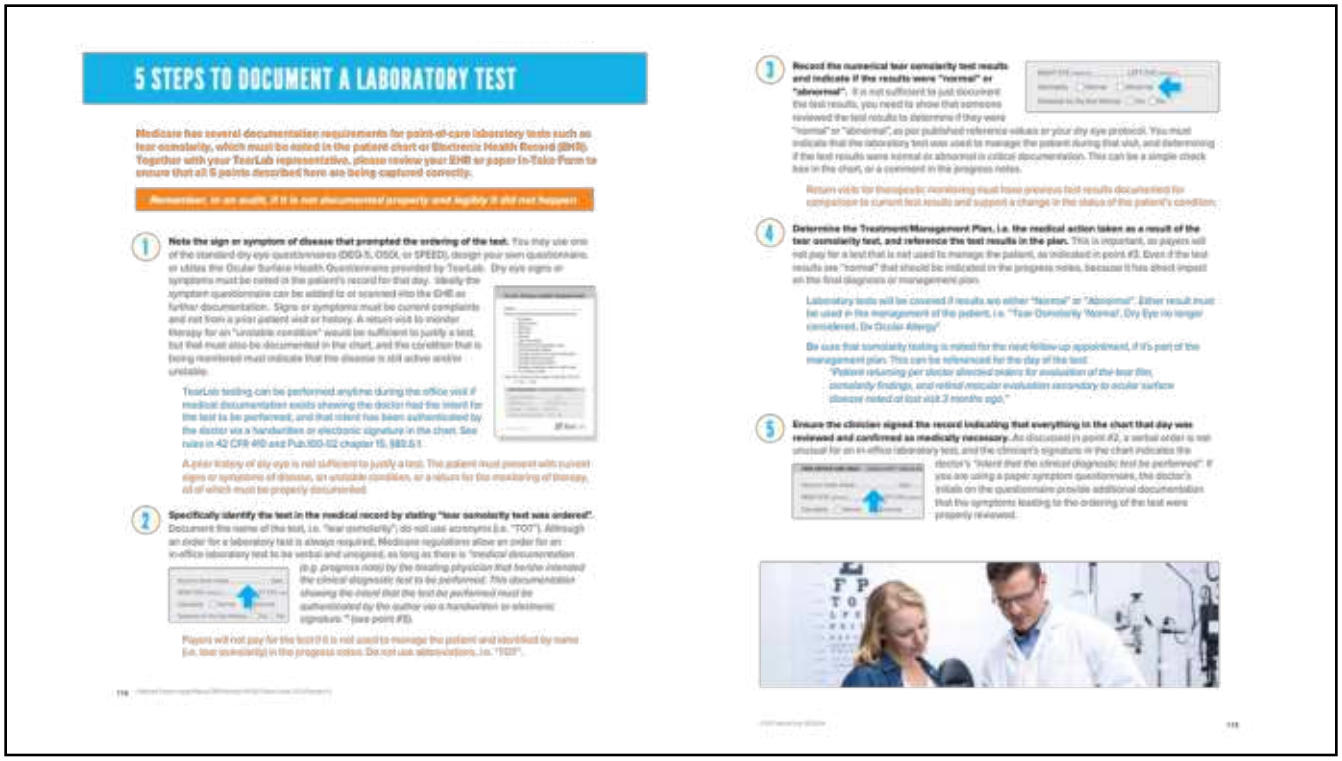
Medical necessity as determined by the clinician determines how often a test reasonably test may be performed and must accompany proper documentation consisting of either a current sign or symptom of disease, or a patient under therapy that is being managed for a previously diagnosed but "unstable" dry eye. Testing a patient with a prior history of dry eye without current signs or symptoms of disease would likely be considered a "screening" test.

All items noted in "Documenting a Laboratory Test" must be included in the patient medical record to ensure proper support for medical testing.

Are there Global Period exclusions?

No, laboratory tests do not apply to "global period" exclusions for procedures such as the 10-day global period for eyelid inclusion and 90-day post-operative global exclusion for cataract surgery. (ref: Medicare Claims Processing Manual -Chapter 12, Section 40.1)

TearLab requests that the office billing department NOT spend time to resolve billing issues for CPT 83861, and instead contact the TearLab Reimbursement Support Center, under a Business Associate Agreement. Remittance Advisements or EOBs indicating billing or payment problems should be faxed to TearLab at the following HIPAA secure number - (858) 412-8940 - promptly upon receipt. TearLab will review the denial for you and determine the reason for denial and best method to resolve - rsc@tearlab.com



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DRY EYE INSTITUTE **PERCUTANEOUS TEST WITH ALLERGENIC EXTRACTS: CPT**

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual.	Rendering Provider ID.#
1	1	2018	1	1	2018	11	Day	99214	25		A	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	95004			B	8.00	80		NPI	xxxxxxxxxx

AVERAGE MEDICARE REIMBURSEMENT:

- $3.60 - $8.00 per unit

THINGS YOU MUST KNOW:

- Office visit is only billable if allergy testing was NOT the reason for their visit:
  - MUST use a 25 modifier on the OV (separate procedure / same day)
  - MUST use a unique diagnosis code for the allergy testing verses the OV
- MUST indicate the number of units / test spots (80 for Allerfocus)
- MUST order the procedure in the plan
- MUST have an Operative Note

APPLICABLE DIAGNOSIS CODES:

Allergic Conjunctiivitis, bilateral	H10.13

Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.

VISION EXPO

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CORRECTION OF TRICHIASIS; EPILATION, BY FORCEPS ONLY: CPT 67820

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual	Rendering Provider ID.#
1	1	2018	1	1	2018	11	Day	99214	25		A,B	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	67820	E2		C	49.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	68720	51	E4	D	49.00	1		NPI	xxxxxxxxxx

AVERAGE MEDICARE REIMBURSEMENT:

- $18.34

THINGS YOU MUST KNOW:

- Office visit is only billable if epilation is NOT the reason for the visit.
  - MUST use a 25 modifier on OV (separate procedure / same day)
  - MUST have separate diagnosis code from office visit
- MUST use location modifiers: E1 (UL),E2 (LL),E3 (UR),E4 (LR). However, Medicare and some others are now paying PER EYE only, so use RT and LT instead
- MUST list each separately as 1 unit
- SOME payers require the use of -51 modifier (multiple procedures /same day) on additional lines
- MUST order the procedure in the plan
- MUST have an Operative Note

APPLICABLE DIAGNOSIS CODES:

TRICHIASIS WITHOUT ENTROPION	OD UL	H02.051
	OD LL	H02.052
	OS UL	H02.054
	OS LL	H02.055

Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.

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PUNCTAL OCCLUSION: CPT 68761

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual	Rendering Provider ID.#
1	1	2018	1	1	2018	11	Day	99214	25		A	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	68761	E2		B	144.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	68761	51	E4	B	144.00	1		NPI	xxxxxxxxxx

AVERAGE MEDICARE REIMBURSEMENT:

- $142.76, however reimbursement will only be 50% for any occlusion after the first

THINGS YOU MUST KNOW:

- Office visit is only billable if punctal occlusion was NOT the reason for their visit:
  - MUST use a 25 modifier on the OV(separate procedure / same day)
  - MUST use a unique diagnosis code for the punctal occlusion verses the OV
- SOME payers require a 51 modifier (multiple procedures/same day) on second line
- Must add location modifier: E1 (UL),E2 (LL),E3 (UR),E4 (LR)
- Bill the total amount for each line item, though reimbursement will be different for each line
- Includes a 10 day global period: do not bill an OV within 10 days, unless for a separate identifiable reason
- MUST order the procedure in the plan
- MUST have an Operative Note (see example)

APPLICABLE DIAGNOSIS CODES:

DRY EYE SYNDROME OF LACRIMAL GLAND	OU	H04.123
	OD	H04.121
	OS	H04.122
UNSPECIFIED SUPERFICIAL KERATITIS	OU	H16.103
	OD	H16.101
	OS	H16.102
FILAMENTARY KERATITIS	OU	H16.123
	OD	H16.121
	OS	H16.122
PUNCTATE KERATITIS	OU	H16.143
	OD	H16.141
	OS	H16.142
EXPOSURE KERATOCONJUNCTIVITIS	OU	H16.213
	OD	H16.211
	OS	H16.212
KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S	OU	H16.223
	OD	H16.221
	OS	H16.222
NEUROTROPHIC KERATOCONJUNCTIVITIS	OU	H16.233
	OD	H16.231
	OS	H16.232
SICCA SYNDROME, UNSPECIFIED		M35.00
SICCA SYNDROME WITH KERATOCONJUNCTIVITIS		M35.01

Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.

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A FRESH PERSPECTIVE

LACRIVERA

Billing Guide for Punctal Occlusion

Lacrivera has created this guide to serve as an introduction to the billing procedures, requirements and codes relative to punctal occlusion.

General Information

- **All punctal occlusion is billed the same,** regardless if permanent silicone plugs or temporary synthetic/collagen inserts are used.
- **Allow a 10 day post-op period** following the insertion of collagen plugs before inserting permanent plugs.
- **When occluding more than one punctum at the same time,** the first procedure is allowed at 100% and each additional procedure is allowed at 50%.

Documentation

In addition to proper coding, be sure the procedure is properly and sufficiently documented.

- **Document the patient's dry eye complaint.** Be sure to note the patient's pertinent history, symptoms and affect on daily activities.
- **Document unsuccessful alternative treatments.** This should include the use of artificial tear supplements with continued dry eye symptoms.
- **Document examination and evaluation of tear production to confirm Dry Eye Syndrome.** This may include ZoneQuick, Schirmer, Rose Bengal Staining, and/or Tear Break-Up Time tests. Some tests may not be separately billable.
- **Document that you have clearly explained to the patient the potential risks and benefits of punctal occlusion.**

THE CODES TO KNOW

Primary Diagnosis Codes

H04.121	Dry Eye Syndrome of Right Lacrimal Gland
H04.122	Dry Eye Syndrome of Left Lacrimal Gland
H04.123	Dry Eye Syndrome of Bilateral Lacrimal Glands
H04.129	Dry Eye Syndrome of Unspecified Gland

Secondary Diagnosis Codes

H16.109	Unspecified superficial keratitis
H16.229	Keratoconjunctivitis sicca
H57.8	Redness or discharge
M35.01	Keratoconjunctivitis sicca associated with Sjögren's disease

CPT Procedure Code

68761	Closure of the lacrimal punctum by plug, each

Supply Code

A4263 (HCPCS) or **99070**

Medicare combines the office visit, procedure and supply of collagen/silicone plugs, thus they are not billed separately. Some private insurance companies may accept a separate supply code.

Punctum Identification

E1	Upper lid, left
E2	Lower lid, left
E3	Upper lid, right
E4	Lower lid, right

Modifiers

25	Separately identifiable service by the same doctor on the same day
51	Additional procedure

The information in this guide is believed to be accurate but is not intended to serve as an authority or to comprehensively address proper billing procedures. Always refer to official documentation provided by Medicare and/or private insurance carriers.

lacrivera.com (855) 857-0518 2500 Sandersville Rd – Lexington KY 40511 USA – info@lacrivera.com

VISION EXPO

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DRY EYE INSTITUTE

REMOVAL OF CORNEAL EPITHELIUM; WITH OR WITHOUT CHEMOCAUTERIZATION (ABRASION, CURETTAGE):CPT 65435

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual.	Rendering Provider ID.#
1	1	2018	1	1	2018	11	Day	99214	25		A,B	110.00	1		NPI	xxxxxxxxx
1	1	2018	1	1	2018	11	Day	65435	RT		C	79.00	1		NPI	xxxxxxxxx

AVERAGE MEDICARE REIMBURSEMENT:

- $80.55

THINGS YOU MUST KNOW:

- Office visit is only billable if debridement is NOT the reason for the visit.
  - MUST use a 25 modifier on OV (separate procedure / same day)
  - MUST have separate diagnosis code from office visit
- MUST use location modifier: RT or LT
- 0 day global period: ok to bill any subsequent OV as necessary
- MUST order the procedure in the plan
- MUST have an Operative Note

APPLICABLE DIAGNOSIS CODES:

FILAMENTARY KERATITIS, BILATERAL	OU	H16.123
	OD	H16.121
	OS	H16.122

Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.

VISION EXPO

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PLACEMENT OF AMNIOTIC MEMBRANE ON THE OCULAR SURFACE; WITHOUT SUTURES (PROKERA): CPT 65778

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual.	Rendering Provider ID.#
1	1	2018	1	1	2018	11	Day	99214	25		A,B	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	65778	RT		C	1500.0	1		NPI	xxxxxxxxxx

MEDICARE EXAMPLE

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual.	Rendering Provider ID.#
1	1	2018	1	1	2018	11	Day	99214	25		A,B	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	65778	RT		C	1500.0	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	V2790	RT		C	500.00	1		NPI	xxxxxxxxxx

COMMERCIAL PAYER EXAMPLE

AVERAGE MEDICARE REIMBURSEMENT:

- $1,068 - $1,523

THINGS YOU MUST KNOW:

- 0 day global period: Subsequent visits can be billed independently of the procedure
- Prokera fee includes an office visit for insertion. It would be a very RARE occasion to bill an OV on this day, and only if there is a separate identifiable reason. In this case, you MUST add a 25 modifier on the OV
- Some commercialinsurances may reimburse supply code, V-2790. This is rare, but worth submitting initially.
- Strongly advised that you call *all* commercial payers beforehand to confirm that no Prior Authorization is needed and to confirm if Prokera will be applied to their deductible. No one wants a surprise.
- Must order the procedure in the plan
- Must have an Operative Note (see example)
- It is wise to have Prokera on hand in order to respond immediately to unexpected epithelial disruption

APPLICABLE DIAGNOSIS CODES:

KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S	OU	H16.223
	OD	H16.221
	OS	H16.222
EXPOSURE KERATOCONJUNCTIVITIS	OU	H16.213
	OD	H16.211
	OS	H16.212
PUNCTATE KERATITIS	OU	H16.143
	OD	H16.141
	OS	H16.142
FILAMENTARY KERATITIS	OU	H16.123
	OD	H16.121
	OS	H16.122
NEUROTROPHIC KERATOCONJUNCTIVITIS	OU	H16.233
	OD	H16.231
	OS	H16.232
RECURRENT EROSION OF CORNEA	OU	H18.833
	OD	H18.831
	OS	H18.832
UNSPECIFIED CORNEAL ULCER	OU	H16.003
	OD	H16.001
	OS	H16.002
CENTRAL CORNEAL ULCER	OU	H16.013
	OD	H16.011
	OS	H16.012
OTHER SPECIFIED DISORDERS OF CORNEA	OU	H18.893
	OD	H18.891
	OS	H18.892
CORNEAL ULCER WITH HYPOPYON	OU	H16.033
	OD	H16.031
	OS	H16.032
SCLEROSING KERATITIS	OU	H16.333
	OD	H16.331
	OS	H16.332
PANNUS (CORNEAL)	OU	H16.423
	OD	H16.421
	OS	H16.422
BAND KERATOPATHY	OU	H18.423
	OD	H18.421
	OS	H18.422
NODULAR CORNEAL DEGENERATION	OU	H18.453
	OD	H18.451
	OS	H18.452
OTHER HEREDITARY CORNEAL DYSTROPHIES		H18.59
HERPESVIRAL KERATITIS		B00.52
OTHER DISORDERS OF SCLERA		H15.89

*These are general guidelines however local carriers will vary (Ex: BCBS in FL and AL will not reimburse if billed with H16.143/H16.141/H16.142/H16.149)

*Use caution when billing BCBS. In some states BCBS will only reimburse if the membrane is stitched in place. This is new! In this case, collect from the patient on the day of service.

Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.

VISION EXPO

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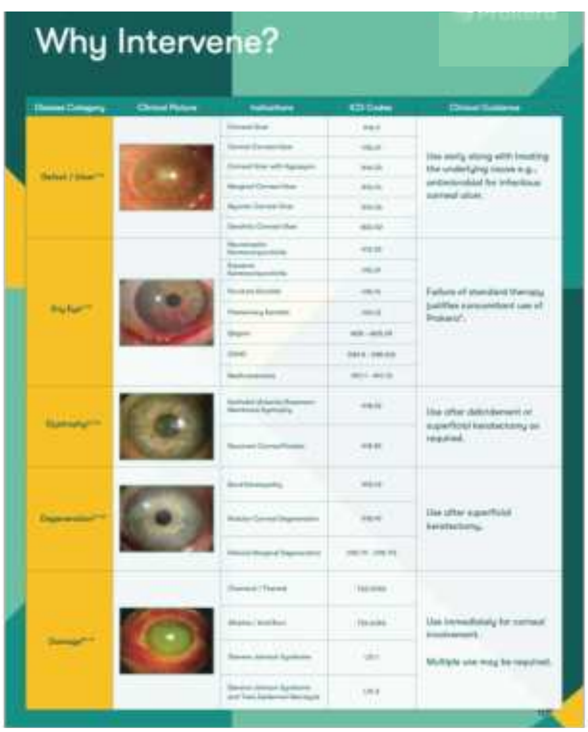

REFERENCES

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Thermal Evacuation

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual	Rendering Provider ID.#
1	1	2018	1	1	2018	11	Day	0270T			D	1500.0	1		NPI	xxxxxxxxx

AVERAGE MEDICARE and PRIVATE PAYER REIMBURSEMENT:

- $0-???

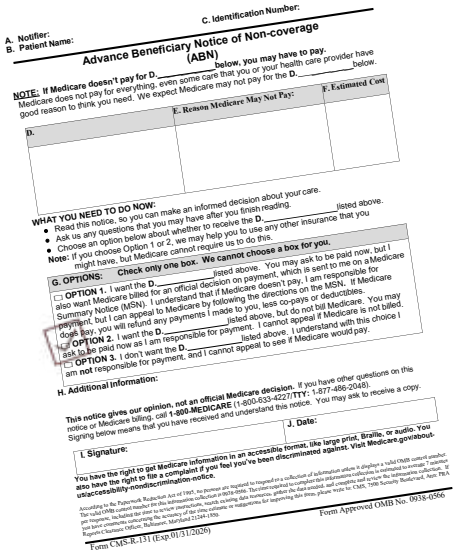
THINGS YOU MUST KNOW:

- Currently no CPT code and not typically covered by any insurance (Check with your local insurance carrier as insurance claims maybe required in your state)
- Though it is rare, there are carriers willing to pay small amounts. Be sure to get an ABN signed!
- Some patients desire to submit for reimbursement themselves. Provide patient with itemized bill/receipt. If you must, 0270T is the closest applicable code
- Patients will often ask for a letter of necessity, as requested by their carrier (see example)
- There is often a small patient rebate from Tear Science

APPLICABLE DIAGNOSIS CODES:

UNSPECIFIED BLEPHARITIS	OD UL	H01.001
	OD LL	H01.002
	OS UL	H01.003
	OS LL	H01.004
MEIBOMIAN GLAND DYSFUCNTION	OD UL	H02.881
	OD LL	H02.882
(unspecified lid)	OD	H02.883
	OS UL	H02.884
	OS LL	H02.885
(unspecified lid)	OS	H02.886
(unspecified eye / unspecified lid)		H02.889
	OD UL/LL	H02.88A
	OS UL/LL	H02.88B

Disclaimer: Rules and reimbursement will vary. Please review local regulations according to insurance carriers in your zip code.



A. Notifier:
B. Patient Name:
C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D_____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the D_____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature: **J. Date:**

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp.01/31/2026) Form Approved OMB No. 0938-0566

VISION EXPO

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IPL: INTENSE PULSE LIGHT

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To					Procedures, Services, or Supplies (Explain Unusual Circumstances)						Ready Plan		
MM	DD	YY	MM	DD	YY	Place of Service	EMG	CPT / HCPCS	Modifier		Diagnosis Pointer	$ Charges	Days or Units		ID Qual.	Rendering Provider ID.#
1	1	2018	1	1	2018	11	Day	17999			A	1600	1		NPI	xxxxxxxxx

AVERAGE MEDICARE and PRIVATE PAYER REIMBURSEMENT:

- $0

THINGS YOU MUST KNOW:

- Currently no CPT code and not typically covered by any insurance
- Some patients desire to submit for reimbursement themselves. Provide patient with itemized bill/receipt. If you must, 17999 is the closest applicable code
- Patients will often ask for a letter of necessity, as requested by their carrier

APPLICABLE DIAGNOSIS CODES:

Rosacea Conjunctiivitis, bilateral		H10.823

Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.

VISION EXPO

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out-of-pocket considerations

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"I'm on a budget …where do I begin?"

Pay per box diagnostics	Product sales	In office treatments
Inflammadry Fluorescein Lissamine green Red thread test	Sell what they can't get elsewhere Take advantage of drop ship programs with profit share	Start with lower cost or pay per box treatments Manual heat and expression Blepharoexfoliation in office Refer out for advanced treatments

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How long does it take to pay for the average diagnostic instrument?

Assuming ~$25K

At $99/dry eye eval and 1/week

+

$20/ext photos on 6 patients/day

⏭ Paid in full in ~8 months

At $99/dry eye eval and 2/week

+

$20/ext photos on 10 patients/day

⏭ Paid in full in < 4 months

VISION EXPO

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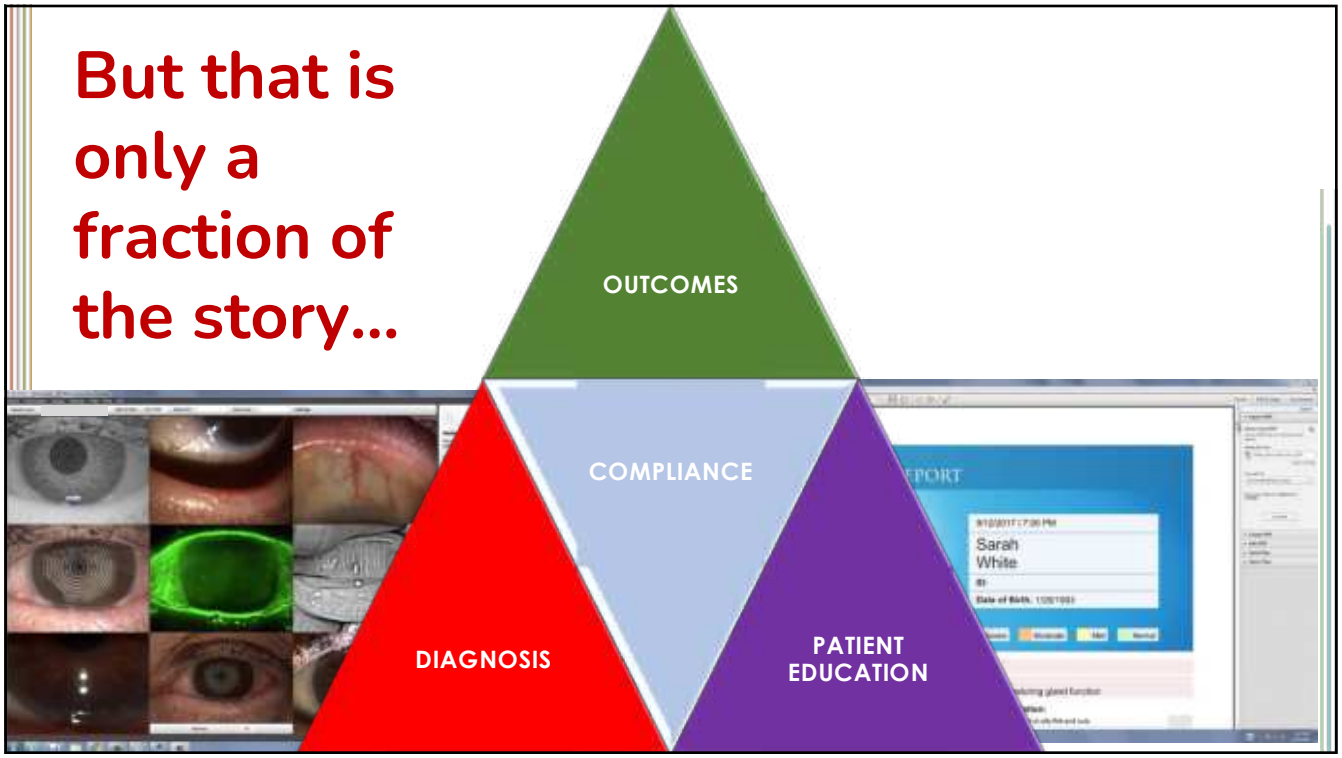
But that is only a fraction of the story…



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POTENTIAL ROI: VISIT #1

- OFFICE VISIT (99205): $216.77
- OSMO: $22.48 X 2
- INFLAMMADRY: $14.24 X 2
- EXTERNAL PHOTOS: $22.92
- DRY EYE EVAL (OOP FOR 5M): $99
- PLUS TOPO (IF WARRANTED): $35.69

- TOTAL FEES COLLECTED: **$447.82**

- WARM COMPRESS MASK: $80 (-40)
- OMEGA 3: $108 (–45)
- LID SCRUB: $18 (-9)
- Hypochlorous acid: $38 (-18)
- SLEEP MASK: $60 (-30)

- TOTAL POTENTIAL PURCHASES: **$304**
- **NET = $162**

- **TOTAL NET = $609.82**

VISION EXPO

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Mild:
Potential Annual revenue per patient

- 3 visits / year : $431
  (DEE + 99205, 99214, 99213)
- 6 month Plugs: $217 x 2 = $434
  (-60)
- Osmolarity at each visit: $135
  (-60)
- Inflammadry at each visit: $90
  (-48)
- External photos at each visit: $66

TOTAL COLLECTED = $2,771
MINUS COGS ~$712
NET ~ $2,059
@1/WEEK = $107,068

- Omega 3: $648 (-270)
- Tranquileyes W/C Mask: $80 (-40)
- Lid scrubs X 9: $108 (-54)
- Pure & Clean x 10: $380 (-180)

- In office lid exfoliation: $200
- In office expression with Eye Cloud x 2: $100

*Treatment equipment investment: ~$300

VISION EXPO

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Moderate:
Potential Annual revenue per patient

- 5 visits / year : $646 (DEE + 99205, 99214, 99214, 99213, 99213)
- 6 month Plugs: $217 x 2 = $434 (-60)
- Osmolarity at each visit: $225 (-100)
- Inflammadry at each visit: $150 (-80)
- External photos at each visit: $110

- Omega 3: $648 (-270)
- Tranquileyes W/C Mask: $80 (-40)
- Pure & Clean
- NuLids: $309 (-$189) + $360 (-$252)
- Eye Wash x 6: $36 (-15)
- Sleep mask: $60 (-30)

- IPL: $1800

TOTAL COLLECTED = $5,337
MINUS COGS ~$1,216
NET ~ $4,121
@1/WEEK = $214,292

VISION EXPO

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Severe:
Potential Annual revenue per patient

- 8 visits / year : $1061 (DEE + 99205, 99214 x 6, 99213)
- 6 month Plugs: $217 x 2 = $434 (-60)
- Osmolarity at each visit: $360 (-160)
- Inflammadry at each visit: $240 (-128)
- External photos at each visit: $176
- Topography: $35

- Omega 3: $648 (-270)
- Omega 6: $456 (-324)
- Tranquileyes W/C Mask: $80 (-40)
- Pure and Clean x
- Cliradex Light x 3: $90(-45)
- NuLids: $309 (-$189) + $360 (-$252)
- Eye wash x 20: $120 (-50)
- Sleep mask: $60 (-30)
- PM Tear gel x 8: $160(-80)

- **IPL**: $1800

- **Amniotic membrane** x 2 = $2700 (-1300)

- **Thermal evacuation**: $1000 (-260)

TOTAL COLLECTED = $10,568
MINUS COGS ~$3,368
NET ~ $7,200
@2/MONTH = $172,800

VISION EXPO

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Very Severe: Potential Annual revenue per patient

- 10 visits / year : $ 1,150 (DEE + 99205, 99214 x 6, 99213 X 2)
- 6 month Plugs: $217 x 2 = $434 (-60)
- Osmolarity at each visit: $450 (-200)
- Inflammadry at each visit: $300 (-160)
- External photos at each visit: $220
- Topography: $35

- Omega 3: $648 (-270)
- Omega 6: $456 (-324)
- Tranquileyes W/C Mask: $80 (-40)
- Pure and Clean x 10: $380 (-180)
- NuLids: $309 (-$189) + $360 (-$252)
- Eye wash x 20: $120 (-50)
- Sleep mask: $60 (-30)
- PM Tear gel x 8: $160(-80)
- Cliradex Light x 3: $90(-45)

- **IPL**: $1800
- **Amniotic membrane** x 2 = $2700 (-1300)
- **Thermal evacuation** : $1000 (-260)
- **Scleral lens fit:** $3000 (-340)

TOTAL COLLECTED = $13,851
MINUS COGS ~$3,780
NET ~ $10,071
@2 /MONTH = $241,704

VISION EXPO

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MILD: 1/WEEK >> $107,068 /YR

MODERATE: 1/WEEK >> $214,292 / YR

SEVERE: 2/ MONTH >> $172,800 / YR

VERY SEVERE: 2/ MONTH >> $241,704 / YR

4 DRY EYE PATIENTS PER WEEK

= $735,864 ADDITIONAL ANNUAL REVENUE

VISION EXPO

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National Average = $274 ARPP

Consider COGS and COO…

What is the ratio according to production??

make 3x more?

OR WORK 1/3 AS HARD?

AvgAnnualRevenuePerPatient = **$2,072.55**

AvgRevenuePerVisit = **$517.33**

VISION EXPO

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How do I know what to buy???

Follow these 4 guidelines and …you will know.

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caveat:

MUST BE IN THIS ORDER

1. efficacy

If it works… IT WILL PAY FOR ITSELF!

If it doesn't… DON'T GET IT, EVEN IF IT'S FREE!

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2. experience

What is the patient's perception… on COMFORT?

on VALUE?

46

3. business model

To compare apples to apples, consider…

Cost of device

Cost of applicators

Profit margin per treatment

Conversion rate considering value and MSRP

Repeat interval

…over 3 years

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4. the people

warrantee

training

resources

support

reputation

marketing

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Thank you!!
Questions??
DRY EYE
INSTITUTE
HTTPS://DRYEYE.INSTITUTE
CONTACT US

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