BILLING WITH CONFIDENCE

Common Medicare billing myths and how to avoid them

Optometry
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NOTE:

This advice is correct at the time of publication. The current MBS optometric schedule can be found **HERE.** Optometry Australia is constantly lobbying on behalf of its members for a fairer Medicare benefits schedule and will keep you informed of updates as they occur.

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Introduction

Have you been audited by Medicare (yet)?

Correct billing of Medicare item numbers can be a source of anxiety for optometrists, especially as audit is on the increase. With a thorough understanding of what to bill and when, you can relax in the knowledge that you have done everything right.

If you haven't been audited by Medicare, you haven't experienced the particular combination of sleepless nights and nail-biting days that occurs after you receive THAT letter.

Medicare advisors have a responsibility to the government and the tax-payer to ensure that services are billed according to the law. And they are empowered to investigate the billing practices of any optometrist, particularly one they suspect may be billing incorrectly or whose profile looks unusual.

This can involve lengthy and stressful interviews and hearings and, if billing is found to be inappropriate, an order to repay the incorrectly-billed monies for all instances of that item number billing for the review period (usually two years). It may also involve a further period (typically 12-24 months) of disqualification from billing item numbers which raised significant concerns during the review.

If you are audited and your billing practices come under scrutiny, so too will your record keeping. Even if you are found to have billed Medicare correctly, you may still face a hearing regarding your clinical care and record keeping.

This ebook looks at the most commonly-investigated Medicare item numbers and **what you can do** to ensure you are billing appropriately.

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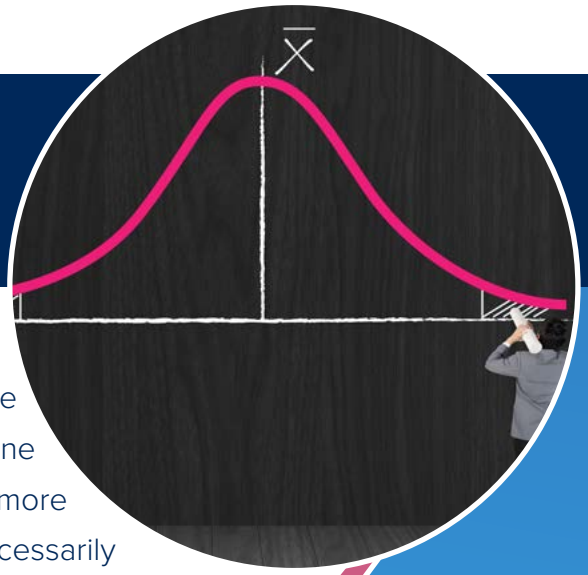
How does Medicare know if I'm billing incorrectly?

Medicare uses algorithms that run statistics across all registered optometrists. They look for providers that STAND OUT from the crowd. With all statistics, there is a normal bell curve of distribution – some providers will bill more of a particular item number and others will bill less.

What if I'm already billing correctly?



In any normal distribution, someone has to be at the top end of the bell curve. While most people fall somewhere in the middle zone of the curve, there will always be an optometrist who is billing more of a particular item number than anyone else. But this doesn't necessarily mean they are billing incorrectly!

Medicare's sophisticated analysis will pick up on anyone standing out from the curve, whether that is a higher incidence of billing than your peers or a change in billing profile over time, (e.g. your incidence of 10912 billing has doubled since the previous year).

But, standing out from the crowd is absolutely fine as long as you have a genuine reason and are billing correctly.

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> “standing out from the crowd is absolutely fine *as long as you have a* **genuine reason** and are billing correctly

There are many reasons why your billing patterns may have changed or why your billing profile is different to your peers:

- Your practice is involved with a particular type of patient (e.g. aged-care, myopia control or glaucoma co-management)
- You practice in a regional area with limited access to ophthalmology
- You receive lots of referrals from GPs or pharmacists
- You work closely with an ophthalmologist in a co-management model
- You have built up a reputation for managing a particular eye disease (such as severe dry eye or glaucoma)
- You have a much higher population of disadvantaged patients due to your practice location
- You see a lot of children or frequently receive referrals from optometric colleagues

All these factors (and more) mean that your billing practices may be completely appropriate, even if your use of an item number looks high on first pass. If audited, however, you will need to demonstrate this to the satisfaction of the Medicare advisors. Unfortunately, some practitioners occasionally stand out for other reasons – they are simply billing inappropriately. This is most commonly due to a misunderstanding about the definition of the MBS item in question.

10940

How do I bill item 10940/41 correctly every time?

Item number 10940 has possibly been discussed more than any other. There are so many Do's and Don'ts, it's no wonder that some optometrists are still uncertain about aspects of this item number.

Let's take a close look at the definition of Medicare item 10940:

> *"Full **quantitative** computerised perimetry (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, **performed by an optometrist,** where **indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report**, bilateral - to a maximum of two examinations (including examinations to which item 10941 applies) in any twelve month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies."*

Item number 10941 is almost identical except that it applies to unilateral assessment.

There are several key phrases to look at:

quantitative

The test must be quantitative, that is, determine thresholds. You cannot bill it for a visual field screening including Binocular Esterman driving field test. Medmont 'fast threshold' and Humphrey 'SITA' and 'SITA Fast' algorithms give an absolute threshold for each point tested and qualify for item 10940.

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performed by an optometrist

While you don't need to be present for the entirety of the test, you need to take full professional responsibility for it, i.e.

- determine the need for the test
- choose the appropriate test strategy and trial lenses
- ensure the test is correctly conducted and monitored
- interpret the results and take the appropriate action (e.g. review / repeat etc)
- provide results to comanaging practitioners where required

indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain

There must be a valid reason for the threshold field, relating to findings or suspicions of disease or pathology of the eye, visual pathways or brain.

- This reason must be documented in the patient record prior to the field test
- You should use your own clinical judgement to decide which test strategy is most appropriate for the suspected condition e.g. a Humphrey 30-2 field for a suspected neurological condition or 24-2 for suspected glaucoma

with assessment and report

The requirement to include an assessment and report is often missed.

- It is not enough to just print off the field results and attach or scan to the patient record. You must interpret the field test, document the findings and your management plan. This can be as simple as e.g. 'Nasal step depression OD correlating with wedge defect. Repeat 24-2 in two weeks.'

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When should I bill 10940?

Medicare provides **explanatory notes** with indications for computerised perimetry that attract Medicare rebates. Members can download Optometry Australia's Guideline on Medicare billing **HERE.**

What if two fields tests per year are not enough?

What if you need to perform perimetry more than twice in a 12-month period (for example to establish good baselines for a new glaucoma patient) and you've billed two 10940's for the year?

You may legitimately bill Medicare item 10918 for indicated additional field tests but only if they are clinically relevant.

You may also choose to bill the patient privately. Optometry NSW/ACT encourages all members to bill according to their professional time (rather than according to the Medicare benefits schedule). If you choose to bill privately, there is no set fee. Just make sure the patient is informed before proceeding with the test.

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What if a visual field screening shows abnormal findings?

Screening fields (such as confrontation or FDT) may pick up glaucoma, retinal disorders as well as neurological disorders. While there is the potential for false positives and false negatives, if the screening results clearly lead you to suspect an ocular disease or pathology of the visual pathway (and are not just scattered depressions in the visual field) you are justified to proceed to a full threshold field. But you MUST document this suspicion in the record card before proceeding with the field.

Example:

- Your patient has routine peripheral vision screening as part of pre-testing (or assessing fitness to hold a private driving licence) and results indicate a defect (e.g. hemianopia or arcuate defect). If this leads you to suspect a disease of the visual pathway and you DOCUMENT your relevant findings and suspicions, you CAN perform a threshold visual field and legitimately bill Medicare for it.

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When can I definitely NOT bill Medicare for a visual field test?

- Visual field assessment for occupational purposes (including commercial driving licence)
- Binocular Esterman field assessment for driving
- Baseline documentation
- Routine testing when patients report a general symptom of headache
- Testing based solely on patient's age or general family history
- Repeat testing performed due to inadequate procedures when test was first carried out
- No optometrist present when perimetry was carried out
- No *documented presence or suspicion* of relevant ocular disease or pathology of the visual pathway or brain
- When a threshold field test is performed because a screening test shows only scattered depressions or a general reduction suggestive of cataract or other ageing signs.

> "Always document the suspected condition

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What if I still want to do a field test?

If the reason for performing a visual field does not meet the Medicare descriptor, you can still do the field test. You just can't bill Medicare.

In these cases, you can (and should) still bill the patient appropriately for your professional time. Just make sure the patient is made aware of the out-of-pocket cost before the eye examination.

Most patients understand this when it is explained to them *before* the visual field test takes place. You can say words to the effect of:

> *"I'd like to do a baseline visual field test for future reference due to your family history of glaucoma."*

You may charge whatever you feel is appropriate for this test but most optometrists charge an amount similar to the Medicare schedule fee.

Don't confuse Medicare with appropriate standard of care. They're not the same!

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10940 v 10941 – which should I bill?

- If the patient is blind in one eye, item 10940 MUST NOT be billed. Bill item 10941 (unilateral field test) instead.
- 10941 is also appropriate where a binocular patient requires repeat testing in one eye only (e.g. if there was an abnormal test result in the left eye only)
- Where a patient returns for the visual field examination at a subsequent consultation, you can bill EITHER a visual field item (10940 or 10941) OR a subsequent consultation item (10918), but not both.
- You cannot bill 10940/41 in conjunction with items 10916, 10918, 10931, 10932 or 10933
- You can bill Medicare for a maximum of two threshold field tests per year, irrespective of whether 10940 or 10941 is billed.

But don't forget you CAN, where relevant, bill it with these: 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915.

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10940 take-home points:

- If you're billing Medicare, you MUST have a documented reason for a threshold field test before you proceed.
- If you proceed with a field test based on documented findings or suspicions of relevant disease, and the test is found to be normal, you CAN still bill Medicare.

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10914

Billing item 10914 with confidence

We're seeing a recent increase in investigations by Medicare into inappropriate billing of item 10914.

First, let's look at the definition of this item number:

> *"Professional attendance of more than 15 minutes duration, being the first in a course of attention, if the patient has a progressive disorder (excluding presbyopia) requiring comprehensive reassessment:*
>
> *a) for a patient who is less than 65 years of age – within 36 months of an initial consultation to which:*
>
> (i) *this item, or item 10905, 10907, 10910, 10912, 10913 or 10915 applies; or*
>
> (ii) *old item 10900 applied; or*
>
> *b) for a patient who is at least 65 years of age – within 12 months of an initial consultation to which:*
>
> (i) *this item, or item 10905, 10907, 10910, 10911, 10912, 10913 or 10915 applies; or*
>
> (i) *old item 10900 applied."*

There are several key phrases here:

more than 15 minutes: This reflects the comprehensive nature of the test, e.g. this is not simply the removal of an ingrown eyelash (whether you consider it a progressive disorder or not).

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a progressive disorder (excluding presbyopia):

Progressive conditions are, as the name suggests, those that may get worse over time. **A progressive condition does not necessarily have to progress at each visit; it could be stable in a particular patient.** They typically include cataract, AMD, glaucoma, corneal dystrophy and some moderate-to-severe dry eye conditions that worsen over time. Importantly, you MUST document the nature of the progressive disorder on the patient record. This may simply be 'intermediate AMD OU'. If you're billing this code, go back and check in the reason for visit that **you have recorded this vital piece of information.** In addition, you must perform tests for the appropriate monitoring of the condition and document a follow-up plan based on the severity of the condition.

requiring comprehensive reassessment:

This phrase is VERY important and the reason that many optometrists get into hot water with Medicare. *While there is no specific definition for what a comprehensive reassessment entails, Medicare will rely on advice from a panel of your peers in the event of an audit.* An early cortical cataract may be slowly but surely progressing, but this does not necessarily mean the patient requires 'comprehensive reassessment', particularly if it is not visually significant. You may need to recheck their refractive findings before dispensing new glasses (due to myopic shift) but can you justify a comprehensive reassessment if they've had one within the billing period?

within 12 / 36 months of:

Unlike item numbers 10912 and 10913, which cannot be billed the first time a patient comes to your practice, you CAN bill 10914 even on their first visit. This is good to know. If you see a patient for the first time at your practice and they have had a 10910 /10911 elsewhere within the billing period (12 or 36 months depending on age) you CAN bill a 10914 if you're satisfied that all the criteria in the definition are met.

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What if it's not actually a progressive condition but I've done a full eye examination?

If it's NOT a progressive condition, but you believe the patient requires comprehensive examination, then what?

Remember: don't confuse Medicare with appropriate standard of care. They're not the same!

If you need to carry out a comprehensive eye examination taking longer than 15 minutes and cannot legitimately bill Medicare for the consultation using another item number, you can (and should) still bill the patient appropriately for your professional time. Charge fairly for your time and bill appropriately. **Just make sure the patient is made aware up front that there may be an out-of-pocket cost.**

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10914 take-home points:

1. Progressive conditions may include cataract, glaucoma, AMD, hypertensive retinopathy, corneal dystrophies, some dry eye disease etc BUT...
2. ...It's not enough for the patient to simply have a progressive condition. It MUST necessitate 'comprehensive reassessment'.
3. You CAN bill 10914 the first time you see a patient at your practice, even if it's within the 12 (or 36) month billing period since they were billed 10910/10911.
4. You MUST document the nature of the progressive condition and an appropriate management plan in the patient's record.
5. We encourage you to bill appropriately for your professional time even if this means charging an out-of-pocket amount to the patient.

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10912

Don't stand out from the crowd (unless you have a genuine reason...)

How do I bill item 10912 correctly?

Another common Medicare item number to crop up in an audit is 10912.

First, let's review the Medicare definition of this item number:

> *Professional attendance of more than 15 minutes duration, being the first in a course of attention, if the patient has suffered a significant change of visual function requiring comprehensive reassessment:*
>
> *a) for a patient who is less than 65 years of age – within 36 months of an initial consultation to which:*
>
> *(i) this item, or item 10905, 10907, 10910, 10913, 10914 or 10915 at the same practice applies; or*
>
> *(ii) old item 10900 at the same practice applied; or*
>
> *b) for a patient who is at least 65 years of age – within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10913. 10914 or 10915 at the same practice applies; or*
>
> *(ii) old item 10900 at the same practice applied.*

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There are a number of key phrases here:

more than 15 minutes

This is self-explanatory, but it's not just the length of time it takes (sometimes the consultation can take longer than necessary due to prolonged discussion with the patient), rather it is the comprehensive nature of the exam. Make sure you meet all the requirements of the definition before billing.

first in a course of attention

If the consultation is not the first in a course of attention, i.e. not the first time this clinical issue has come up, item 10918 should be used. In this case, if they've been seen at your practice before, bill a 10918. If they haven't been to your practice before, bill a 10907.

significant change of visual function

If the patient has attended the same practice for an initial consultation within the past 36 months (for those age under 65) or within the past 12 months (for those aged 65 and over), there MUST be a significant change in visual function to justify the charging of item 10912.

This includes documented changes of:

- vision or visual acuity of two lines (0.2 logMAR) or more (corrected or uncorrected)
  - 'Vision' is uncorrected vision
  - 'Visual acuity' is best corrected vision
  - NOTE: Vision and visual acuity are not the same thing. For example, a progressive myope may have a significant change in *uncorrected vision (i.e. 'vision')*, but no deterioration in best corrected visual acuity. For patients with uncorrected vision less than 6/60, the best-corrected visual acuity is usually where the deterioration is seen.

- visual fields or previously undetected field loss
- binocular vision
- contrast sensitivity or previously undetected contrast sensitivity loss.

Importantly, you MUST document the nature of the changes in visual function on the patient record. If you're billing this code, go back and check in that you have recorded this vital piece of information.

requiring comprehensive reassessment

This phrase is VERY important and the reason that some optometrists can get into trouble with Medicare.

While there is no specific definition for what a comprehensive reassessment entails, Medicare will rely on advice from a panel of your peers in the event of an audit.

Refractive error may have increased, resulting in change in vision or visual acuity, but this may be due to latent hyperopia manifesting or myopic progression and not necessarily call for comprehensive reassessment. A short refraction may be all that's required, in which case a 10918 is the appropriate billing code.

If billing 10912, you must perform tests for the appropriate investigation of the change in visual function and document your findings.

10912 cannot be billed unless the patient has been seen at your specific practice location before. If they have been seen at another branch of your group practice, or even if your practice has moved address, you cannot bill this item number. Another item number may be more appropriate.

at the same practice applies

Can I bill 10912 for a refractive change of 0.50DS?

What about a change in prescription? There is a myth floating around that a refractive change of +/- 0.50 DS constitutes a 'significant change in visual function' and therefore justifies the use of 10912. But bear in mind:

- A change of +0.50DS may make little or no change to the vision or visual acuity of a hyperope, depending on their age.
- While a change of -0.50 **could** make a change of two lines or more on the chart, this refractive change does not necessarily require comprehensive reassessment.

If you bill 10912 on the basis of a change in refraction of +/- 0.50DS **only**, you may not pass audit. In a worst-case scenario, things can quickly escalate from there to deeper investigation, possible tribunal and significant refund to Medicare of inappropriately billed fees over a two-year period. This is a distressing and expensive experience and it is not worth taking the risk.

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What if it's not actually a change in visual function but I've done a full eye examination?

If it's NOT a change of visual function according to the Medicare definition, but you believe the patient requires comprehensive examination, then what?

Don't confuse **Medicare** with appropriate **standard of care. They're not the same!**

If you need to carry out a comprehensive eye examination taking longer than 15 minutes and cannot legitimately bill Medicare for the consultation using 10912, you can (and should) still bill the patient appropriately for your professional time.

Charge fairly for your time and bill Medicare appropriately. Just make sure the patient is made aware up front that there may be an out-of-pocket cost.

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10912 take-home points:

1. If you bill 10912 on the basis of a change in refraction of +/- 0.50DS only, you may not pass audit.
2. You cannot bill 10912 the first time you see a patient at your practice.
3. It's not enough for the patient to simply have a change in visual function. It MUST necessitate 'comprehensive reassessment' requiring more than 15 minutes duration.
4. If you bill this item number, you MUST document the nature of the change in visual function and the diagnostic tests you performed to determine this in the patient's record.
5. We encourage you to bill appropriately for your professional time even if this means charging an out-of-pocket amount to the patient – just make sure there are no surprises.

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Other common Medicare billing errors

- 10905 – this item allows one optometrist to refer to another but you must ensure the referral is at arm's length – not from a colleague in the same corporate or group practice. **The referral must be from an optometrist, and not from another health professional such as a GP.**
- 10907 – use this when you see a patient for comprehensive exam who is not eligible for 10910, 10911 or other comprehensive item numbers because they have been comprehensively assessed within the last 3 years (under 65) or 12 months (if they are 65+). Don't forget, you can (and should) charge an out of pocket fee for the consult.
- 10913 – it must have been previously seen in the same practice – the actual premises and not another branch of the same group. Must merit comprehensive consultation.
- 10915 - Must include pupil dilation in a patient with diagnosed diabetes.

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- 10916 – it might go over 15 minutes, especially with a talkative patient, but it should not be used for comprehensive reassessment. Don't use 10916 as substitute for 10907 if you do a comprehensive exam and your patient is not eligible for 10910 or 10911. While the amount of the rebate is the same, item 10907 resets the clock on when a comprehensive consult can next be billed to Medicare.
- 10918 – can only be used when the consultation is **related to** a previous examination and not a new symptom or new presentation. If it is **a new presentation** not requiring comprehensive consult and is less than 15 minutes, use 10916.

> "Don't forget, you can (and should) charge an out of pocket fee for the consult.

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Take home messages

- KNOW your definitions! Some practices put up summaries of the item numbers but they are often missing vital parts of the definition – such as ‘requiring comprehensive reassessment’
- Decide on the appropriate item number at the END of the consultation, not the start. E.g. 10940 needs to meet a very specific set of criteria to be eligible for billing.
- Your ‘REASON for VISIT’ must match your billing code.
- Avoid duplication of services. If patient is seen regularly elsewhere for glaucoma, avoid repeating all the glaucoma tests independently or it may be viewed as duplication of services.
- Poor record keeping cannot be excused by not being able to use the electronic patient record system. If you’re new to a patient record system, you need to learn how to use it before you see your first patient. Make sure you know where to record additional information.

> “Avoid duplication of services

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If you've just been audited by Medicare, call Optometry NSW/ACT on (02) 9712 2199 IMMEDIATELY!

We will mobilise our highly-experienced professional services team to support you right throughout the process. (Remember! We are your professional family – we've got this).

Better still, give yourself the best chance of passing audit with flying colours by downloading our comprehensive guide to Medicare Billing and ensure you don't stand out from the crowd!

> "Members can download Optometry Australia's Guideline on Medicare billing HERE.

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Still confused? Need further assistance?

The team at Optometry NSW/ACT is here to support you, and we're just a phone call or email away.

Contact us on: Ph: (02) 9712 2199

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Website: Click **HERE**

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