Part three of a three-part series on the important role of the CIRRUS HD-OCT and how it may ultimately allow practitioners to provide a higher standard of care to their patients.

Mark T. Dunbar, OD: As we become a more medical profession, and as the demand for eye care grows, it is incumbent on optometry to embrace and really utilize technology. ZEISS has led the way as far as optical coherence tomography (OCT) software, advancing the technology more than any other spectral-domain OCT (SD-OCT) company.

Kirk L. Smick, OD: I couldn’t agree more. In the next decade, optometrists as primary eye-care practitioners are going to be called upon to do more diagnostic work in terms of eye disease. It behooves us to take advantage of the technology that’s out there. CIRRUS HD-OCT is not a luxury piece of equipment; it’s an instrument we all really should have.

Diana L. Shechtman, OD: While I never think that any diagnostic modality takes the place of my clinical skills, CIRRUS HD-OCT does give me more confidence in understanding the disease process and in diagnosing and managing patients.

Dr. Dunbar: Let’s revisit the role of the CIRRUS HD-OCT in today’s retina practice from a practice management perspective.

CIRRUS IN THE RETINA PRACTICE
Dr. Dunbar: One of the main advantages of CIRRUS HD-OCT is Advanced RPE Analysis, which quantifies RPE elevation and sub-RPE illumination and gives you change over time. It gives you the ability to quantitatively follow patients with age-related macular degeneration (AMD) to reaffirm that there isn’t any fluid and that the patient hasn’t converted. It has been really astounding how far OCT technology has come in terms of following progression and picking up on subtle cases.

I. Ben Gaddie, OD: We see a lot of diabetic patients in my practice, and thanks to the CIRRUS HD-OCT, we can detect macular edema as well as any progression. We are also able to follow AMD patients in our office to see the resolution of that edema, enabling us to take care of these patients and minimize their need to travel to see another eye-care provider.

Dr. Shechtman: Regardless of what stage you can find clinically significant

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macular edema, I think it’s important to perform the CIRRUS HD-OCT early on.

Another key issue is that many patients with AMD are receiving anti-vascular endothelial growth factor (anti-VEGF) treatment. As we know, edema can return, so it is important that we re-evaluate patients for the need to re-treat—even after treatment has been initiated.

**Dr. Dunbar:** What key points regarding billing, coding and reimbursement are important to know or keep in mind when using OCT with retinal patients?

** Billing & Coding for Retinal Disease**

**Dr. Smick:** First and foremost, we need to take care of the patient’s vision care and address why they came in that day. Schedule them for a separate visit to perform any necessary tests and use 99213 again when we bring them back. Keep in mind that each state has different guidelines regarding how often you can perform tests for reimbursement. It’s helpful to go online and check with your own state’s regulations.

You may encounter a combination glaucoma-retina situation in the same practice with two different specialists and you need to do another test. In this case, we perform the second test and bill for it. If it gets rejected, which it sometimes does because of the rules regarding frequency of visits, then we have forms that we attach that explain why the additional test was necessary. In many cases, we’ll be reimbursed, but if not, the patient has signed an ABM and understands that he is ultimately responsible for the test.

**Dr. Dunbar:** How often would you say you are not reimbursed?

**Dr. Gaddie:** It’s variable. Not only do you have Medicare, but you also have Medicaid carriers and commercial payors, which all have different rules and regulations among themselves and between states. It is incumbent upon your billing staff—and especially the management team within your billing staff—to understand the nuances of each plan.

**Dr. Dunbar:** From a billing/coding/collecting issue, how do you handle diabetic patients?

**Dr. Smick:** We use the code for diabetic retinopathy background (250.50), which doesn’t have to include macular edema. Optometrists in states with both a retina and a glaucoma code, you would use the retina code for billing and coding.

**Dr. Dunbar:** How often in the course of a year can you bring a diabetic patient back in for a scan?

**Dr. Smick:** This also differs by state, so it depends.

**Dr. Dunbar:** We would be remiss in our retina discussion if we didn’t include the topic of Plaquenil (hydroxychloroquine, Sanofi-Aventis) toxicity. In February 2011, the recommendation on managing Plaquenil patients shifted from doing an Amsler grid, funduscopy and/or color vision to performing SD-OCT for fundus autofluorescence or multifocal electroretinogram (mfERGs). How has this changed the way you manage and treat your Plaquenil patients?

**Plaquenil Toxicity**

**Dr. Shechtman:** We perform CIRRUS HD-OCT on every Plaquenil patient at baseline. The scheduled monitoring visits vary depending on their risk.

**Dr. Gaddie:** According to the guidelines, you don’t need to perform OCT in those intermediate years. I will, however, still bring the patient back in those odd years to do the 10-degree visual field just to make sure that the co-managing physician is comfortable with the care.

**Dr. Dunbar:** In terms of billing, coding and reimbursement, Dr. Smick, do you need to bill for the systemic disease as well as for the procedure?

**Dr. Smick:** I believe you do. We had roughly 86 Plaquenil visual fields referred to us by optometrists in 2012, and in all of those cases, we billed for the technical component because we have invested in OCT. The technician does the study and gives the results to the patient in an envelope. The patient returns to the referring doctor, who reviews the information with the patient and bills for the professional component of the test. This works well and is a great way to build a rapport with optometrists who don’t have a CIRRUS HD-OCT and refer us their patients.

I give patients a copy of the OCT, and the referring physician loves that. We get these referrals all the time, and it’s a significant part of our practice.

Plaquenil toxicity is a condition in which the liability for informing the patient is really big. When the guidelines changed, we began to document in the chart that we informed each patient of the need to be vigilant about changes in their visual acuity and their perception. We also have an obligation to inform patients that there is no treatment and that the condition is not going to get better.

**Dr. Shechtman:** I actually send my
referred patients with a copy of the new guidelines, so the referring doctor is aware of them.

Dr. Dunbar: Assuming the patient doesn’t have maculopathy, how should you bill and code?

Dr. Smick: That’s a good question. This is one of those exceptions where it doesn’t matter if you have the pathology or not. There’s a V code—V58.69—that you check on your super bill that says, “Plaquenil user, or Mevacor, Visual Field.” And that’s what drives the payment of that diagnosis.

Dr. Shechtman: We note that a patient has rheumatoid arthritis or lupus in addition to this high-risk medication, which happens to be a V code. Then, we match that with the visual field and the OCT.

Dr. Dunbar: I do the same thing.

Dr. Gaddie: On our super bill, we have high-risk monitoring, the V code, then, underneath: rheumatoid arthritis, lupus and the different disease conditions.

Dr. Smick: We also need two entries: the office visit (V67.51 - Plaquenil/Mevacor) and the OCT or visual field. The mere fact that the patient is on the drug is what’s driving the office visit and the exam.

It takes just seconds to acquire a CIRRUS SmartCube. In return, you receive extensive applications for smarter analysis and faster throughput. The power of CIRRUS SmartCube means better decision-making is at hand.

Today’s eye-care practitioners can get layer maps, B-scans and advanced analyses from one SmartCube of data. But the CIRRUS SmartCube (ZEISS) is so much more than that. Just see what our panel of doctors has to say.

Mark T. Dunbar, OD: I never imagined the value that my macular cube scans from 2007 and 2008 would have today, but because I took these scans, I have all that data to use for my progression analysis information for retina and glaucoma. It provides a tremendous amount of information with regard to the rate of progression. I typically do my five-line raster to look at retinal anatomy in high resolution as well as a macular cube scan. The CIRRUS SmartCube™ provides a lot of great information, particularly in terms of establishing a baseline for retina and glaucoma, doing three-dimensional imaging and segmentation.

Diana L. Shechtman, OD: You have to do the cube if you want progression and macular change analysis. The raster scan also becomes more important when looking at the picture in more detail.

Kirk L. Smick, OD: I can track my glaucoma and AMD patients thanks to the cube scans. For the typical optometrist who doesn’t see too much wet age-related macular degeneration (AMD), but sees more dry AMD, it’s important to track these patients and find them earlier.

Dr. Dunbar: Experts predict that retina specialists are going to be slammed in the next 10 to 15 years. They don’t need any unnecessary referrals, and optometry has historically been guilty of over-referring drusen and dry AMD. The retina surgeon is going to do nothing more than we would do, so this is a great opportunity to keep those patients in our practices and follow them ourselves. Plus, establishing and maintaining a relationship with the patient is financially beneficial to us.

CIRRUS IN THE GLAUCOMA PRACTICE

Dr. Gaddie: I do macular cube and optic nerve scans on my glaucoma patients. The only time I perform a nerve fiber scan more than once a year with the CIRRUS HD-OCT is when I’m trying to establish a baseline or if a patient has been progressing. But for 95% of my glaucoma patients, I do it once a year.

Dr. Dunbar: Dr. Smick, tell us about billing and coding on the glaucoma side.

Billing & Coding Tips for Glaucoma

Dr. Smick: In Georgia, billing and coding for glaucoma is very similar to billing and coding for retina: the rules prevent us from performing two tests on the same date. We get audited a lot because of the size of our clinic, so we have changed a few things over the last year or two. The definition and rules in current procedural terminology (CPT) for performing special tests clearly require ordering the test. So, we have developed a special test sheet that we use to actually order the test. The sheet then goes with the technician to the testing room and when the patient comes back, we as practitioners are obligated to include our interpretation on the back of this special sheet.

I know of a few instances in which busy clinics were audited and then docked a lot of money because they
Practice Management Tips from the Expert Panel

Tips can be extremely valuable, but no one likes to invest time searching for those nuggets of information. As you’ve seen in this three-part series, our panel of experts knows a thing or two about the value of optical coherence tomography (OCT) in today’s optometric practice. We’ve picked out some of our favorite suggestions and pieces of advice and listed them below for you.

- Develop and use a designated form to order any special testing. Kirk L. Smick, OD, does this in his practice. The form follows the tech and the patient in and out of the testing room and once the testing is complete, he includes his interpretation on the back of the form.

- Dr. Smick also suggests keeping a binder at every special testing station. Technicians write down the names of patients and the test(s) performed on them. Then, at the end of the month, a tech reviews the binders to ensure that every test documented has been billed for.

- Keep a notebook in every one of your exam rooms. In it, list the different diagnoses that could drive payment or reimbursement for each particular test you perform.

- I. Ben Gaddie, OD, recommends utilizing a paper or electronic flow sheet to recognize when a diagnostic test was last performed (i.e., OCT, visual field, photo, gonio, etc.) so you can easily see and order testing that is crucial to patient management that perhaps was overlooked in the chart.

- A good baseline may require numerous initial tests within a short period of time to establish repeatability and reliability.

- Given that Plaquenil screening protocols are merely “recommended” guidelines, Diana L. Shechtman, OD, says it is up to the OD to determine the frequency of repeat testing.

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didn’t follow the rules of ordering a test and interpreting the results.

Dr. Gaddie: Most optometrists and ophthalmologists are not doing interpretations properly unless it is built into their electronic record systems. I see a lot of people just sign their name at the bottom of their visual fields or OCT printouts, and if they get audited, they’ll be writing a check to the payor. Order the test and in the interpretation report, include the reliability of the test and describe your findings. If you don’t see a defect on the visual field or on the retinal nerve fiber layer, clearly state what you do and don’t see. This goes to the reliability of the test and how the results are going to change your management of the patient.

Dr. Smick: That is critical; good point. I have a management tip that has saved us a lot of money. If you’re busy, it’s easy to ask your tech to get a photo or a quick raster and put it back in the room when they’re done. It’s also easy for the tech to forget to check that the test was done on the super bill and consequently, a lot of money gets left on the table. We now keep a binder at every special testing location and the technician must write down the name of every patient and the test that was performed. At the end of the month, a technician goes through the binders and makes sure that every one of those tests has been billed for.

Dr. Dunbar: That’s especially relevant, considering the fact that reimbursements have been declining over the last few years. What else is there to say about general affordability and reimbursement of OCT?

CIRRUS HD-OCT IN A TIME OF DECLINING REIMBURSEMENTS

Dr. Smick: After learning about all the applications of the CIRRUS HD-OCT, which we covered in the first two parts of this series, how could you not afford it? If you can make the investment and break even in three to five years, then you are ahead of the game. Besides, it’s difficult to practice without OCT.

It’s helpful to look up the diagnoses that codes that drive each test in your own state because it differs from one state to another. We have a notebook in each of the exam rooms in our practice where we list all the different diagnoses that we could check to drive payment or reimbursement for that particular test.

Dr. Gaddie: I speak to doctors around the country who are hesitant to purchase an OCT because they don’t think they see enough macular degeneration or diabetes to justify the purchase. I always reassure them that once they start using the technology, they’ll realize that there are so many different uses. Without OCT, they would have guessed and referred a patient out, but with OCT, they can do a simple scan and know exactly what’s going on. Very rarely have I seen a doctor purchase an OCT and not find the utilization.

Dr. Dunbar: It allows us to practice at a higher standard and, more importantly, at the end of the day, I think it allows us to take better care of our patients.

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