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Mastering Retina Coding

ASRS – The Business of Retina
Dallas, Texas
Sunday, March 31, 2019
Joy Woodke, COE, OCS, OCSR

Financial Disclosure

- Joy Woodke, COE, OCS, OCSR
- **This presenter does not have a financial interest or relationship to disclose relative to this activity.**

- NOTE: Ms. Woodke serves as a Codequest instructor, private consultant and contributing author to coding products for the American Academy of Ophthalmology.

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Master Retina Coding

- Understand the essential topics
  - CPT, ICD-10, modifiers, global periods, compliance, CCI edits
- Identify retina coding resources
- Review steps for successfully coding drugs
- Strengthen audit armor and reduce denials
- Become the master coder

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ESSENTIAL TOPICS

Master the Fundamentals of Retina Coding

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Rules of Coding

- Who's ultimately responsible?
  - The physician
- #1 Rule in Coding - Who is the payer?
  - Documentation rules vary by payer.
  - Commercial payers may not follow Medicare's policies, so remember not to take one payer's guidelines and apply it to all.
  - Policies may be available online, or perhaps staff will need to contact provider representative for guidance.

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Modifiers

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Modifiers

- Modifiers can be appended to
  - Office visits
    - -24, -25, -57
  - Diagnostic testing services
    - -RT, -LT, -TC, -26, -50, -59
  - Surgery
    - -50, -54, -55, -58, -59, -78, -79, -RT, -LT
- Appropriate use **will avoid denials**

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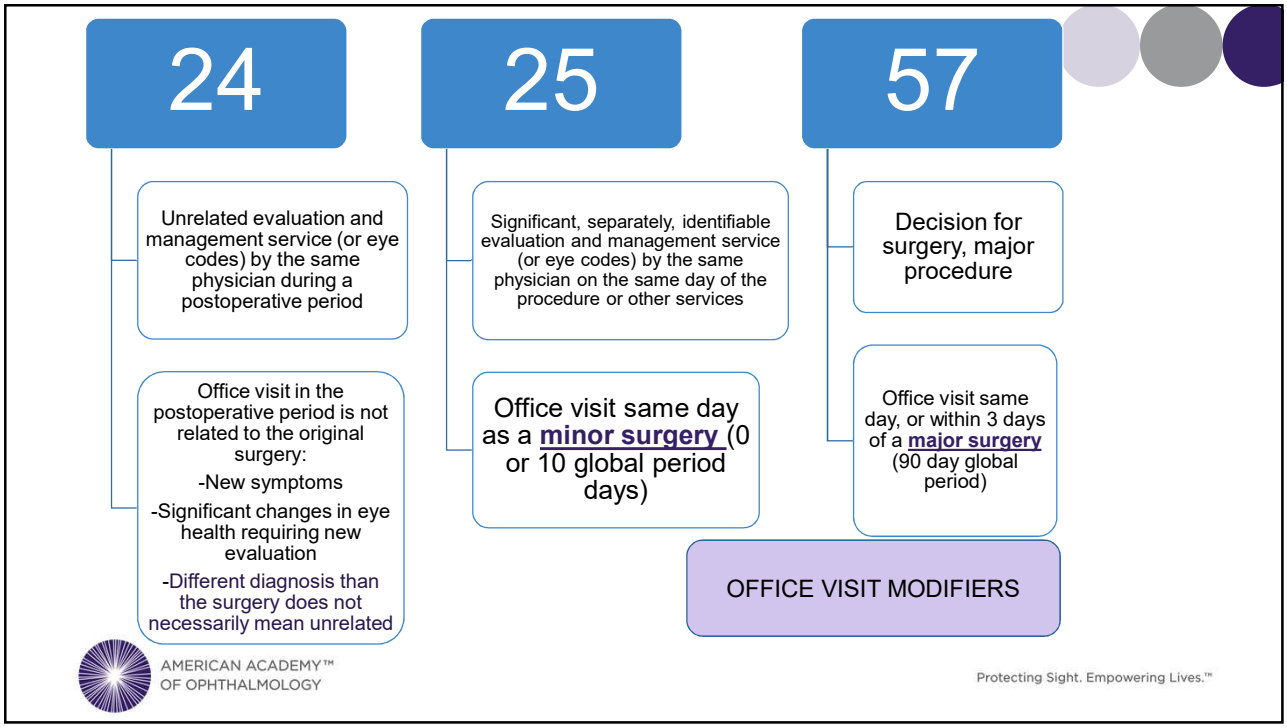
24
Unrelated evaluation and management service (or eye codes) by the same physician during a postoperative period
Office visit in the postoperative period is not related to the original surgery:
-New symptoms
-Significant changes in eye health requiring new evaluation
-Different diagnosis than the surgery does not necessarily mean unrelated
25
Significant, separately, identifiable evaluation and management service (or eye codes) by the same physician on the same day of the procedure or other services
Office visit same day as a minor surgery (0 or 10 global period days)
57
Decision for surgery, major procedure
Office visit same day, or within 3 days of a major surgery (90 day global period)
OFFICE VISIT MODIFIERS
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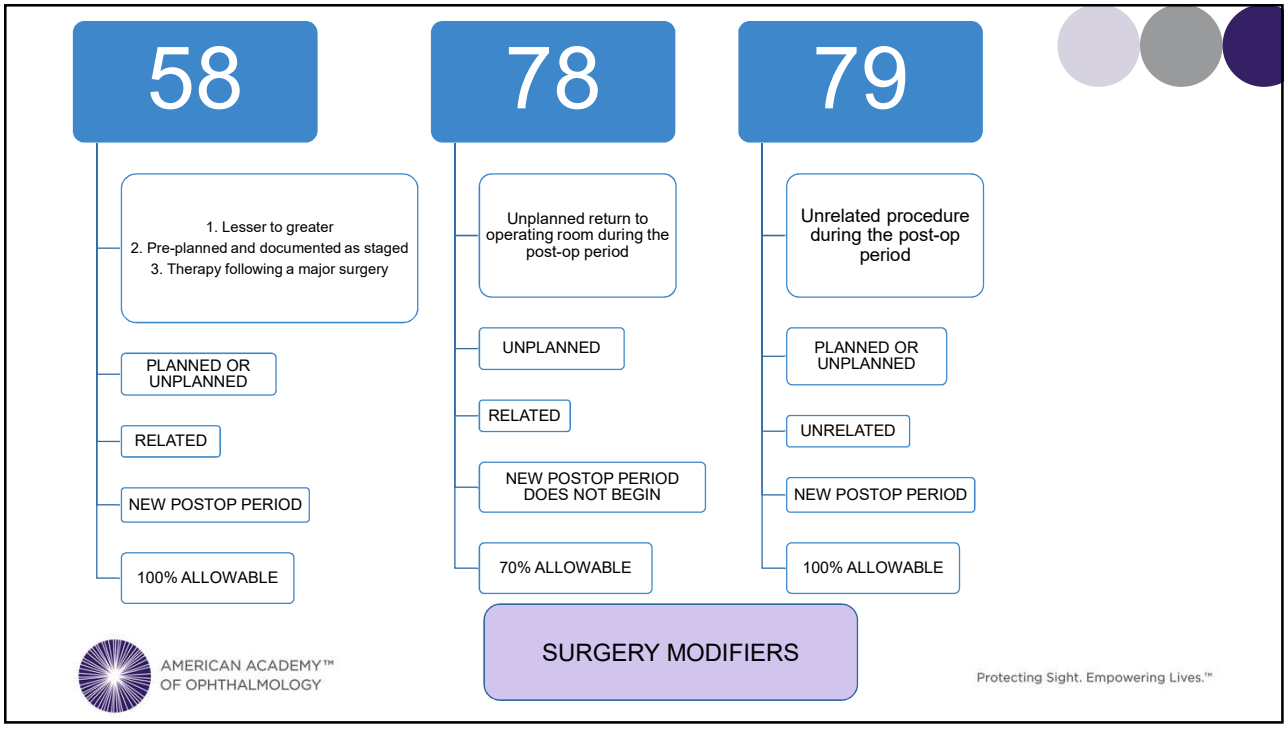
58
1. Lesser to greater
2. Pre-planned and documented as staged
3. Therapy following a major surgery
PLANNED OR UNPLANNED
RELATED
NEW POSTOP PERIOD
100% ALLOWABLE
78
Unplanned return to operating room during the post-op period
UNPLANNED
RELATED
NEW POSTOP PERIOD DOES NOT BEGIN
70% ALLOWABLE
79
Unrelated procedure during the post-op period
PLANNED OR UNPLANNED
UNRELATED
NEW POSTOP PERIOD
100% ALLOWABLE
SURGERY MODIFIERS
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Test Your Knowledge

- The correct coding for a bilateral intravitreal injection:

A. 67028-LT, 67028-RT, J-Code double units

B. 67028-50 (double fee), J-Code double units

C. 67028-RT, 67028-50-LT, J-Code double units

D. 67028, 67028-50, J-Code double units

Test Your Knowledge

- The correct coding for a bilateral intravitreal injection:

A. 67028-LT, 67028-RT, J-Code double units

B. 67028-50 (double fee), J-Code double units

C. 67028-RT, 67028-50-LT, J-Code double units

D. 67028, 67028-50, J-Code double units

Who is the payer?

Test Your Knowledge

- The correct coding for a bilateral intravitreal injection:

A. 67028-LT, 67028-RT, J-Code double units

B. 67028-50 (double fee), J-Code double units - Medicare

C. 67028-RT, 67028-50-LT, J-Code double units

D. 67028, 67028-50, J-Code double units

Who is the payer? Commercial, MA or Medicaid payers may require A, C, D

Global Periods

Global Periods

- The global periods vary *by surgery* and by *insurance carrier*
- Medicare's 10 day global period = 90 day global period for some commercial insurance carriers
- How can you confirm the global period?
  - RVU / allowable

Test Your Knowledge

- 3 weeks s/p PRP (67228) in the left eye, the same patient is seen for a retinal tear in the right eye
- Correct coding:

A. Exam only

B. Exam, -24 modifier

C. Exam, -79 modifier

D. No charge, postop

Test Your Knowledge

- 3 weeks s/p PRP (67228) in the left eye, the same patient is seen for a retinal tear in the right eye
- Correct coding:

A. Exam, no modifier – 10 day global, Medicare

B. Exam, -24 modifier – if 90 day global, other payers

C. Exam, -79 modifier

D. No charge, postop

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Test Your Knowledge

- An established patient is examined. The diagnosis today is retinal detachment, left eye. The patient is treated with laser (67105).
- Correct coding would be:

A. Exam with modifier -57 and 67105-LT

B. Exam with modifier -25 and 67105-LT

C. 67105 only

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Test Your Knowledge

- An established patient is examined. The diagnosis today is retinal detachment, left eye. The patient is treated with laser (67105).
- Correct coding would be:

A. Exam with modifier -57 and 67105-LT – some payers with 90 day global

B. Exam with modifier -25 and 67105-LT – Medicare, confirm meets the definition of -25

C. 67105 only

Laser Global Period Grid

CPT code	Medicare Global	Same Day Office Visit Modifier	Other payers' possible Global*	Same Day Office Visit Modifier
66761 Yag PI	10 days	-25	90 days	-57
66821 Yag PCO	90 days	-57	90 days	-57
67105 Laser repair RD	10 days	-25	90 days	-57
67145 Laser repair retinal tear, prophylaxis RD	90 days	-57	90 days	-57
67210 Focal laser	90 days	-57	90 days	-57
67220 Laser for choroid lesion, CNV	90 days	-57	90 days	-57
67228 PRP laser	10 days	-25	90 days	-57

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* Confirm global period per insurance carrier based on allowable and/or RVU

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ICD-10-CM

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ICD-10-CM Rules of Coding

- Best code is the actual disease
  - Without a confirmed diagnosis, the next best is . . .
- A sign or symptom
- The next best code is ‘other’
- The least appropriate code is ‘unspecified’
  - Note: Only use unspecified when there is not a more definitive code

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ICD-10-CM Rules of Coding

- Do not code:
  - Probable;
  - Suspected;
  - Questionable; or
  - Rule out conditions until they are confirmed.

Uveitis

ICD-10-CM coding

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ICD-10-CM Coding for Uveitis

- What is process to determine the correct diagnosis?
- What is the best diagnosis for specific cases?
- As billers / coders, what questions should we ask the physician?

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Types of Uveitis

- Anterior
  - Anterior Chamber, Iris
- Intermediate
  - Vitreous, Pars Plana
- Posterior
  - Retina, Choroid
- Panuveitis
  - Anterior Chamber, Vitreous, and Retina/Choroid

Adapted from AJO 2005, SUN working group

Anterior Uveitis

- ICD-10-CM codes
  - Primary acute, recurrent acute, chronic
  - Secondary
    - Noninfectious
    - Infectious
    - Add system disease

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ICD-10-CM Uveitis

Description	OD	OS	OU	Single Code
Primary Acute Uveitis, Anterior	H20.011	H20.012	H20.013	X
Recurrent Acute Uveitis, Anterior	H20.021	H20.022	H20.023	X
Chronic Uveitis, Anterior	H20.11	H20.12	H20.13	X
Intermediate Uveitis	X	X	X	H43.89
Vitritis	X	X	X	H43.89
Posterior Uveitis, Posterior Pole	H30.021	H30.022	H30.023	X
Posterior Uveitis, Peripheral	H30.031	H30.032	H30.033	X
Retinitis NOS	H30.91	H30.92	H30.93	X

ICD-10-CM Uveitis

Description	OD	OS	OU	Single Code
Panophthalmitis	H44.011	H44.012	H44.013	X
Endophthalmitis, Purulent	H44.001	H44.002	H44.003	X
Endophthalmitis, Chronic	H44.021	H44.022	H44.023	X
Endophthalmitis, Parasitic	H44.111	H44.112	H44.113	X
Panuveitis	H44.111	H44.112	H44.113	X
Sympathetic Uveitis	H44.131	H44.132	H44.133	X

ICD-10-CM Uveitis

Description	OD	OS	OU	Single Code
Secondary, Anterior Uveitis, Non Infectious	H20.041	H20.042	H20.043	X
HLA-B27 (secondary non infectious)	H20.041	H20.042	H20.043	X
Add systemic disease:				
Reactive arthritis	X	X	X	M02.3
Psoriatic arthritis	X	X	X	L40.50
Ankylosing spondylitis	X	X	X	M45.9
Inflammatory bowel disease	X	X	X	K52.8

ICD-10-CM Uveitis

Description	OD	OS	OU	Single Code
Secondary, Anterior Uveitis, infectious	H20.031	H20.032	H20.033	X
Add systemic disease:				
Anterior Uveitis Due to Tuberculosis	X	X	X	A18.54
Anterior Uveitis Due To HSV	X	X	X	B00.51
Anterior Uveitis Due To VZV	X	X	X	B02.32

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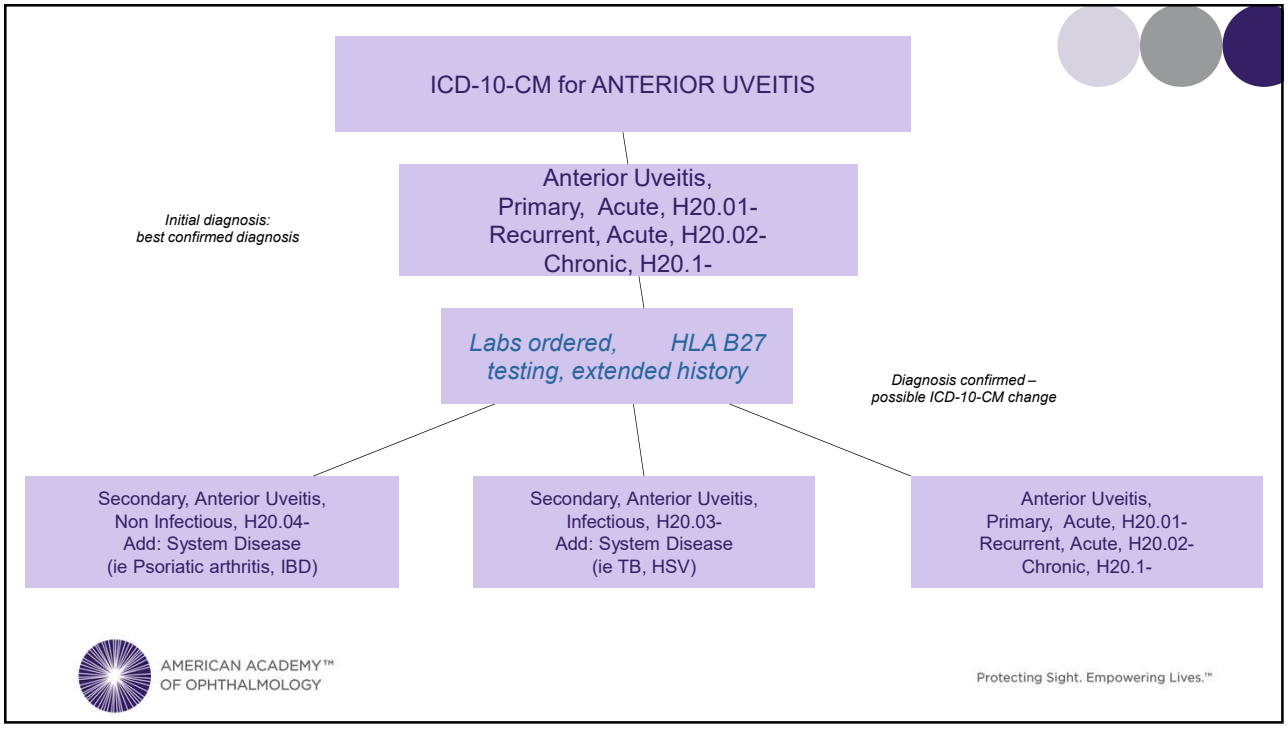
ICD-10-CM for ANTERIOR UVEITIS
Anterior Uveitis,
Primary, Acute, H20.01-
Recurrent, Acute, H20.02-
Chronic, H20.1-
Initial diagnosis:
best confirmed diagnosis
Labs ordered, HLA B27
testing, extended history
Diagnosis confirmed –
possible ICD-10-CM change
Secondary, Anterior Uveitis,
Non Infectious, H20.04-
Add: System Disease
(ie Psoriatic arthritis, IBD)
Secondary, Anterior Uveitis,
Infectious, H20.03-
Add: System Disease
(ie TB, HSV)
Anterior Uveitis,
Primary, Acute, H20.01-
Recurrent, Acute, H20.02-
Chronic, H20.1-
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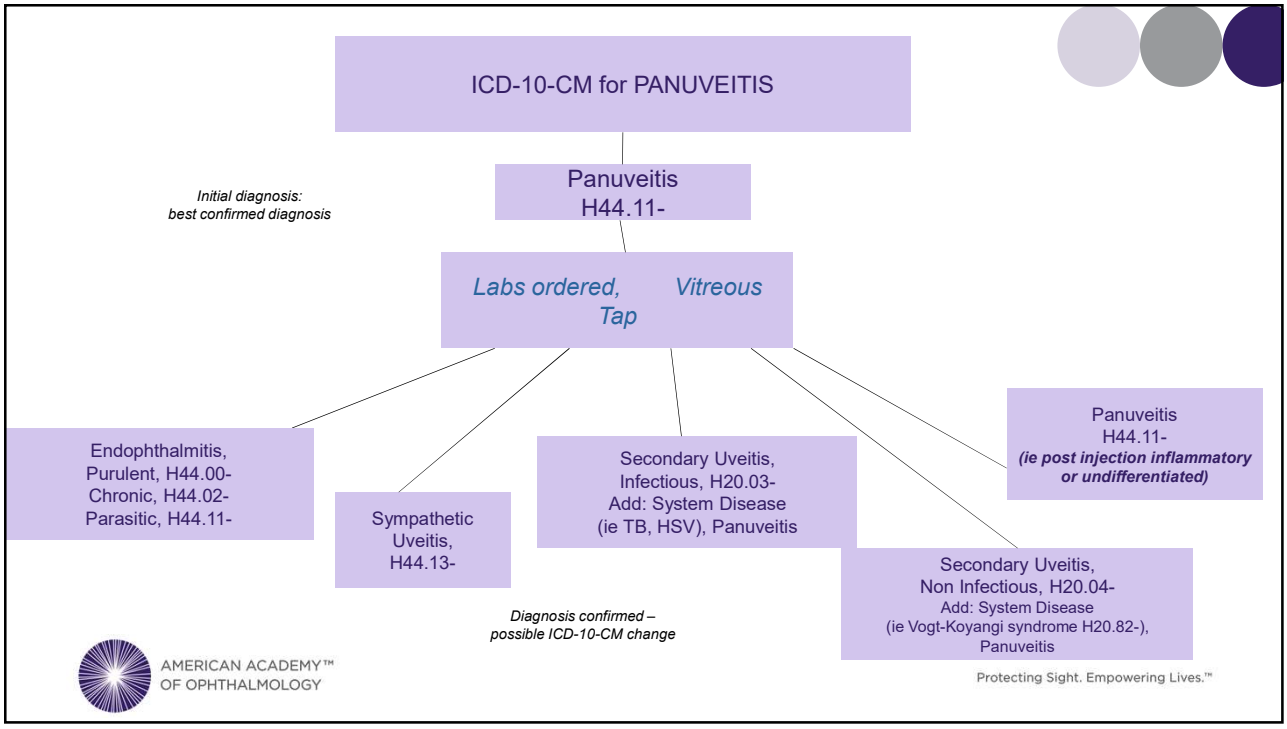
ICD-10-CM for PANUVEITIS
Initial diagnosis:
best confirmed diagnosis
Panuveitis
H44.11-
Labs ordered,
Tap
Vitreous
Endophthalmitis,
Purulent, H44.00-
Chronic, H44.02-
Parasitic, H44.11-
Sympathetic
Uveitis,
H44.13-
Secondary Uveitis,
Infectious, H20.03-
Add: System Disease
(ie TB, HSV), Panuveitis
Panuveitis
H44.11-
(ie post injection inflammatory
or undifferentiated)
Secondary Uveitis,
Non Infectious, H20.04-
Add: System Disease
(ie Vogt-Koyangi syndrome H20.82-),
Panuveitis
Diagnosis confirmed –
possible ICD-10-CM change
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STEPS FOR SUCCESS

Coding Retina Injectable Drugs

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#1 – Identify the Appropriate J-Code

- Each medication has a HCPCS code used for coding
  - J code mostly used
  - C code for some facility and office-based (rare) claims
- The HCPCS code contains
  - Description
  - Dosage
  - Route of administration, i.e., IV
- Example:
  - J0178 Injection, aflibercept, 1 mg

#2 Confirm Single-Use or Multi-Dose Vials

- Vials are designated as single-use or multi-dose
  - Specified on vial or package insert
- Necessary for correct coding

Single-Use	Multi-dose
Triesence	Kenalog
Eylea	

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#3 Identify National Drug Code (NDC)

- Obtain NDC number and convert to 5-4-2 format for billing

Drug	NDC format	NDC code	NDC claim format	NDC code for claim
Lucentis 0.5 mg	5-3-2	50242-080-03	5-4-2	50242-0080-03
Kenalog	4-4-2	0003-0293-28	5-4-2	00003-0293-28

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#4 Review Documentation

- Documentation meets insurance policies requirements
  - ✓ Diagnosis supporting medical necessity
  - ✓ Any relevant diagnostic testing services, with interpretation and report
  - ✓ Risks, benefits and alternative discussed
  - ✓ Physician order including;
    - ✓ Date of service
    - ✓ Medication name and dosage
    - ✓ Diagnosis
    - ✓ Physician signature
  - ✓ Interval of administration is appropriate such as 28-day rule

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#4 Review Documentation

- Documentation meets insurance policies requirements
  - ✓ Procedure record includes:
    - Appropriate diagnosis
    - Route of administration (intravitreal injection) and medication name
    - Site of injection - eye (s) treated
    - Dosage in mg and volume in ml, (i.e., Avastin 1.25 mg@ 0.05 ml) and lot number
    - Single vial medications record wastage greater than 1 unit (i.e., Triesence)
      - Wastage less than 1 unit, *"any residual medication less than one unit have been discarded."*
    - Consent completed for injection and medication used.
    - For initial treatment of Avastin, a consent stating off-label use is completed.
    - Advance Beneficiary Notice (ABN) or waiver of liability is complete if applicable

#4 Review Documentation

- Documentation meets insurance policies requirements
  - ✓ Chart record is legible and have correct patient name and date of birth
  - ✓ Physician signature is legible
    - ✓ Paper chart records have a signature log
    - ✓ EHR, the electronic physician signature is secure
  - ✓ Abbreviations are consistent with approved list and readily available for audits

#5 Calculate ASP Pricing and Units

- 106% of the Average Sales Price (ASP) calculated from CMS data
- CMS website
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2018ASPFiles.html
- Note: Commercial and Medicare Advantage payer contracts may pay you based on CMS ASP pricing or a ***percentage of your billed fee***.

#5 Calculate ASP Pricing and Units

- ASP is provided on a quarterly basis

Triesence J3300	ASP price per 1 unit
Q1 2017	$3.72
Q2 2017	$3.74
Q3 2017	$3.89
Q4 2017	$3.89
Q1 2018	$3.87
Q2 2018	$3.87
Q3 2018	$3.86
Q4 2018	$3.86
Q1 2019	$3.86

Eylea J0178	ASP price per 1 unit
Q1 2017	$980.38
Q2 2017	$980.14
Q3 2017	$978.09
Q4 2017	$978.09
Q1 2018	$971.95
Q2 2018	$968.79
Q3 2018	$967.67
Q4 2018	$967.33
Q1 2019	$963.54

$16.84 less per unit – Eylea 2 units billed, **total $33.68** reduced reimbursement per injection

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#5 Calculate ASP Pricing and Units

- **Review the CMS ASP pricing files to identify per drug:**
  - J code to bill
  - Description and dosage
  - Payment limit (allowable) per HCPCS Code dosage

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#5 Calculate ASP Pricing and Units

Payment Allowance Limits for Medicare Part B Drugs

Effective January 1, 2019 through March 31, 2019

Note 1: Payment allowance limits subject to the ASP methodology are based on 3Q18 ASP data.
Note 2: The absence or presence of a HCPCS code and the payment allowance limits in this table does not indicate Medicare a payment allowance limit within a specific column does not indicate Medicare coverage of the drug in that specific category. Medicare contractor processing the claim.

HCPCS Code	Short Description	HCPCS Code Dosage	Payment Limit	Vaccine AWP%	Vaccine Limit	Blood AWP%	Blood limit
J3285	Treprostinil injection	1 MG	66.125				
J3300	Triamcinolone a inj prs-free	1 MG	3.855				
J3301	Triamcinolone acet inj nos	10 MG	1.699				

Triesence

Kenalog

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#5 Calculate ASP Pricing and Units

- **Calculating units**
  - If the dosage injected is less than the HCPCS code descriptor (the minimum dosage for the drug), bill for one unit to identify the minimum dosage amount.
  - For example, Kenalog (Triamcinolone acet inj nos):
    - Per CMS ASP pricing files, Kenalog has a minimum dosage of 10mg. If 4mg are injected:
      - Submit 1 unit
    - If Kenalog is a multi-dose vial, no wastage billed

J3301	Triamcinolone acet inj nos	10 MG	1.699

#5 Calculate ASP Pricing and Units

- **Calculating units**
  - If the dosage is the same as the HCPCS code descriptor
    - **Example 1:** HCPCS description of drug is 6 mg
      6 mg are administered = 1 unit is billed
  - If the dosage is more than the HCPCS code descriptor
    - **Example 2:** HCPCS description of drug is 50 mg
      200 mg are administered = 4 units are billed
    - **Example 3:** HCPCS description of drug is 1 mg

      10 mg are administered = 10 units are billed

#5 Calculate ASP Pricing and Units

- **Calculating units**
  - Triesence has a minimum dosage of 1 MG, if 1MG are injected and 39 MG wasted
    - Submit 40 units
  - Single use vial billed as:

J3300	1 units x 3.855 =	$ 3.86
J3300-JW	39 units x 3.855=	$150.35
	Total reimbursement	$154.21

J3300	Triamcinolone a inj prs-free	1 MG	3.855

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#5 Calculate ASP Pricing and Units

- **Calculating units**
  - Eylea has a minimum dosage of 1 MG, if 2 MG are injected
    - Submit 2 units
  - Single use vial billed, no wastage* -

    J0178 2 units x 963.54 = $1927.07

- *If residual medication less than 1 unit was discarded, do not bill wastage -JW

J0178	Aflibercept injection	1 MG	963.537

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#6 Review Medication Inventory Log

- **Medication inventory**
- Current medication inventory log tracking purchase and use of medication. Record will include:
  - Invoice number
  - Date of purchase,
  - Lot number,
  - Expiration date,
  - Patient name and
  - Date of service administered.

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#6 Review Medication Inventory Log

- **Medication inventory**
- Use inventory log and reports to confirm billing accuracy
  - Compare chart documentation and inventory log for correct medication dispensed
  - Run billing accuracy report or productive report to confirm

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#7 Code the Injection

- CPT 67028, eye modifier appended
- HCPCS J code for medication
- Appropriate units administered (i.e., Eylea 2 units)
- HCPCS J code on a second line for wasted medication, if appropriate
- Diagnosis appropriately linked to 67028 and J codes
- On claim in box 24a or EDI loop 2410
  - 11 digit NDC code in 5-4-2 format
  - Description of dosage per insurance guidelines

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#7 Code the Injection

- 67028 -RT
- J0178 2 units
- H35.3211 Active wet AMD, right eye

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Academy Resources

- Coding for Injectable Drugs

  aao.org/practice-management/coding/injectable-drugs

- Retina Coding: The Complete Reference Guide

  aao.org/store

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Strengthen Your Audit Armor & Reduce Denials

Four-step process

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4-Step Process

1. Identify retina ***audit targets*** and understand types of audits types and their agencies
2. Discover and monitor Medicare Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and other ***insurance policies*** for specific services
3. Develop ***internal checklists*** based on insurance policies to provide guidance regarding medical necessity, frequency and documentation requirements
4. Perform ***internal audits*** focused on targeted services utilizing internal checklists and resources

Identify Audit Targets & Types

- Visit aao.org/audits Academy or AAOE membership required

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Identify Audit Targets & Types

Targeted Probe and Educate (TPE)

All current MAC reviews are now TPE pre- or post-payment reviews.

TPE is intended to increase accuracy in very specific areas. MACs use data analysis to identify physicians and suppliers who have high claim error rates or unusual billing practices, and items and services that have high national error rates and are a financial risk to Medicare. Physicians whose claims are compliant with Medicare policy won't be chosen for TPE.

You may face up to three rounds of review. If you receive an audit notice, you must respond within 45 days or you will fail the round. Each round examines 20 to 40 claims. After each round a letter with results will be mailed and may require a one-to-one review. If you fail the first round, you will face a second review. If a physician fails all three rounds, further action will be taken.

Identify Audit Targets & Types

- TPE

Target Areas

CGS

1. Critical care 99291-99292
2. ED Visit 99284-99285
3. Initial inpatient 99222-99223
4. Subsequent exam inpatient 99232-99233
5. E/M 99213 with modifier -25
6. New physician billing

FCSO

1. Critical care 99291
2. ED Visit 99285
3. Initial inpatient 99222-99223
4. Subsequent inpatient 99232-99233
5. Office new patient E/M 99204-99205
6. Office established patient 99213-99214
7. Avastin J9035
8. Lucentis J2778

NGS

1. Office established patient 99214-99215
2. Inpatient E/M 99223, 99233
3. Extended and subsequent ophthalmoscopy 92225 and 92226

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Discover Current LCDs

- **If the #1 Rule in Coding is - Who is the payer?**
- The #2 Rule would be –

KNOW THEIR RULES

Do not take one payer's rules, or perceived payer rules and apply it to all payers.

Discover Current LCDs

- Visit aao.org/lcds

Medicare Administrative Contractors

The Academy is not responsible for the contents or accuracy of these policies, but maintains this listing as a service to members. For questions about a policy, contact your carrier.

Note for Alabama, Georgia, Tennessee: On Feb. 23, Jurisdiction J transitioned to Palmetto GBA.

- Cigna Government Services: Kentucky, Ohio
- First Coast Service Options: Florida, Puerto Rico, Virgin Islands
- National Government Services
  - JK- Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont
  - J6- Illinois, Minnesota and Wisconsin
- Noridian
  - JE- California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands
  - JF- Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming
- Novitas
  - JL- Pennsylvania, New Jersey, Maryland, Delaware and the District of Columbia
  - JH- Texas, Oklahoma, Colorado, New Mexico, Arkansas, Louisiana, Mississippi
- Palmetto:
  - JM- Alabama, Georgia, Tennessee
  - JJ- North Carolina, South Carolina, Virginia and West Virginia
- WPS Government Health Administrators
  - J5- Iowa, Kansas, Missouri, and Nebraska
  - J8- Indiana and Michigan

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Monitor Current LCDs

- Visit aao.org/lcds
- Identify new LCDs
  - Confirm effective date
  - Review policy
    - Medical necessity
    - Covered ICD-10 codes
    - Documentation requirements
    - Frequency limitations
    - Unusual bundles

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Novitas LCD Policies

Current **Novitas** local coverage determination policies for common ophthalmic procedures. For achived/previous versions, scroll to the "associated documents" section of each policy. Each archived version includes the date it was updated and when it was in effect.

Note: This MAC has different policies based on the region/jurisdiction.

- JL - Pennsylvania, New Jersey, Maryland, Delaware and the District of Columbia (metro area)
- JH - Texas, Oklahoma, Colorado, New Mexico, Arkansas, Louisiana, Mississippi

Current Policies

Avastin, Eylea & Lucentis

- **A53121** Updated June 3, 2016 with effective date July 11, 2016

Blepharoplasty

- **L35004** Updated Oct. 19, 2018 with effective date Oct. 1, 2018

Co-management

- **L34862** Updated March 31, 2015 with effective date Oct. 1, 2015
- **A52989** Updated Apr. 10, 2015 with effective date Oct. 1, 2015

Cosmetic surgery

- **L24090** Updated June 2, 2017 with effective date April 14, 2017

Cataract surgery

- **L35091** Updated Aug. 4, 2017 with effective date Aug. 10, 2017

Electroretinography (ERG)

- **L37371** Updated Feb. 8, 2019 with effective date Jan. 1, 2019

Monitor NCDs

- National Coverage Determinations (NCDs)
- Link at aao.org/lcds
- Examples:
  - 160.10 Evoked Response Tests
  - 80.2.1 Ocular Photodynamic Therapy (OPT)
  - **80.11 Vitrectomy**
  - 80.6 Intraocular Photography
  - 80.2 Photodynamic Therapy

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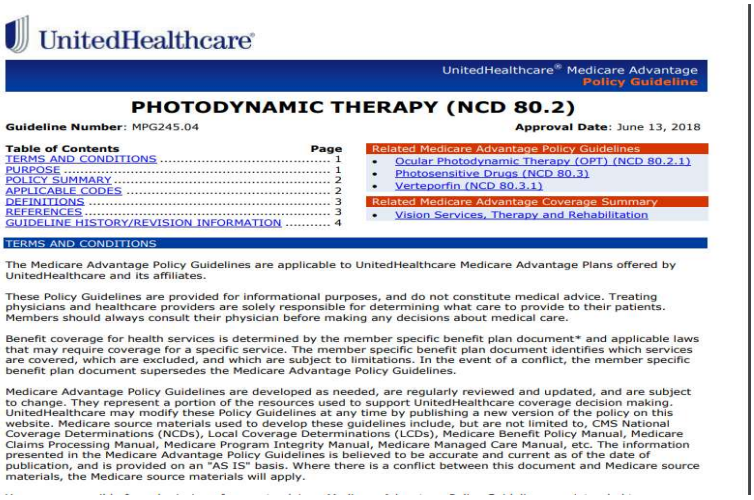
Commercial Policies

- Identify and review current policies
- Understanding each payer's unique policy will ***reduce denials***



UnitedHealthcare®

UnitedHealthcare® Medicare Advantage
Policy Guideline

PHOTODYNAMIC THERAPY (NCD 80.2)

Guideline Number: MPG245.04 **Approval Date**: June 13, 2018

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Related Medicare Advantage Policy Guidelines
- Ocular Photodynamic Therapy (OPT) (NCD 80.2.1)
- Photosensitive Drugs (NCD 80.3)
- Verteporfin (NCD 80.3.1)

Related Medicare Advantage Coverage Summary
- Vision Services, Therapy and Rehabilitation

TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Source: https://www.uhcprovider.com

Develop Internal Checklists

- Based on insurance policies and coding products develop an internal checklist or compliance policy as a resource

Check List for Fluorescein Angiography (FA) Documentation

- ☐ **All tests that can be delegated require a written or electronic physician order which includes:**
  - ☐ Which test
  - ☐ Which eye(s)
  - ☐ Chart note reflects medical necessity for test
- ☐ **Use insurance policies as a reference**
  Review of the Medicare Administrative Contractors (MAC) Local Coverage Determination (LCD) and National Coverage Determination (NCD) or other commercial insurance policies, as applicable. These policies provide guidance for insurance coverage and documentation requirements.

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Check List for Fluorescein Angiography (FA) Documentation, continued

- ☐ **Chart notes supporting medical necessity per insurance policies**
  A review of the patient's medical records provides documentation of the medical necessity for the diagnostic test billed including the pathology per eye and reflects the context of a changing clinical picture.
  - ☐ Diagnostic testing performed for screening purposes would not be deemed as medically necessary.
  - ☐ When reviewing documentation for insurance payers without policies, the AAO Coding Coach can be used as guideline for medically necessary diagnoses.
    i. Fluorescein Angiography is used to identify by fluorescence the leaking from damaged vessels and make it useful in the diagnosis of chorioretinal vascular disorders, especially relating to choroidal neovascularization, noninfective vasculitis and age-related macular degeneration.
- ☐ **Medical records include**
  - ☐ A copy of the photography for each diagnostic test (digital or photographic) is maintained in the medical record.
  - ☐ Whether the pupil was dilated and the medication that was used.
  - ☐ Relevant examination, history and diagnostic testing related to the medical necessity.
- ☐ **Interpretation and report**
  - ☐ An interpretation and report is completed for each test performed and per eye.
  - ☐ There are no published documentation requirements for the interpretation and report. The required documentation could include; diagnosis and findings and the impact on the treatment plan.

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Check List for Fluorescein Angiography (FA) Documentation, continued

- ☐ **Frequency**
  - ☐ The frequency of the medically necessary test should be billed based on the insurance policies guidelines.
  - ☐ Some MACs have published LCDs with the following frequency requirements:
    i. FA should not be billed more than 9 times per year. (Palmetto L34426)
    ii. FA billed within 30 days of billing for Indocyanine Green Angiography (ICG) may be considered not medically necessary. (Palmetto L34426)
    iii. The frequency for performing FA is based on indication.
    iv. FA is used to document recurrent leakage for patients with dry AMD every 6-12 months. (First Coast L33997)
- ☐ **Physician Signature**
  The physician signature is legible on paper chart records and a signature log created for provide during an audit. For EHR, the electronic physician signature is secure. The practice has an Electronic Signature policy and provides it in the event of an audit.
- ☐ **Chart notes have the correct beneficiary name and date of birth**
- ☐ **Abbreviation list**
  The practice has an approved abbreviation list for acronyms used as documentation in the medical record and is readily available for all audits.

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Resources

- Note: Checklists are taken from
  - AAO's Coding Audit Success Toolkit
- Ophthalmic Coding Specialist Exam – Retina
  - Details and practice test available aao.org/ocs

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Internal Audits

- Using your resources, conduct internal audits on targeted services
  - Confirm correct coding per competencies and insurance policies
- Comparative Billing Reports
  - Provide the opportunity to audit services seen as outliers
- Internal Productivity Reports
  - Focus on most frequently billed codes
  - Group practice – compare billing patterns within the practice, audit outliers
- Audit insurance payments for correct allowables
  - Especially focus on drug reimbursement

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Case Study #1

- Extended Ophthalmoscopy

1. Identify Audit Targets
2. Review Insurance Policies
3. Develop Internal Checklists
4. Perform Internal Audits

Case Study #1 - EO

1. Identify Audit Targets
   - Targeted Probe and Educate (TPE)
     - MAC: National Government Services (NGS)
       - CT, ME, MA, NH, NY, RI, VT, IL, MN, WI
     - Pre-payment audit
     - Three rounds of review
     - Must respond in 45 days, or fail the round
     - Each round examines 20-40 claims
     - After each round, results will be provided. If you fail, you will proceed to the next round.
     - Failure of three rounds will prompt further action.

Case Study #1 - EO

2. Review insurance policies
   - NGS – LCD
   - L33567 effective date 1/1/2019
   - Appendix A – Documentation requirements for EO

Case Study #1 - EO

2. Review insurance policies
   - NGS LCD unique guidance
     - Indications and definition for medical necessity
     - Covered ICD-10-CM codes for EO
     - Documentation requirements
     - Limitations
       - Screenings and absence of pathology not covered
       - EO performed in the global period by the same provider will not be covered unless unrelated to the surgery
       - Although not bundled under NCCI, NGS LCD bundles:
         - FP, FA, OCT and ultrasound the same day unless documentation provides “reasonable medical exception” for providing EO and “additive (non-duplicative) information”

Case Study #1 - EO

2. Review insurance policies
   - NGS LCD unique guidance
     - Frequency
       - Active treatment for AMD may require 12 EO per eye, per year
       - Diagnosis of Diabetes may require up to six EO per eye, per year
       - Malignant / benign neoplasm may require up to 4 per eye, per year
       - Other conditionals usually require no more than 2 per eye, per year
     - *Note: must meet definition for 92225, initial and 92226, subsequent*
       - *92225 – diagnosis of an initial event of condition*
       - *92226 - documentation of progression of a chronic condition*

Case Study #1 - EO

2. Review insurance policies – NGS LCD and Appendix A
   - Retinal drawing
     - Minimal size of 3-4 inches
     - Drawing must be identified and labeled
     - Non-colored drawings are acceptable, but color drawings with 4-6 standard colors are preferred
       - Colors and Meaning defined in Appendix A
     - Separate drawing for optic nerve abnormalities
     - Drawing must accurately represent findings

Note: Other MACs and insurance carriers may not have these same requirements

Extended Ophthalmoscopy

- Basic documentation requirements:
  - Documentation of medical necessity
  - A drawing that is clearly identified, labeled and appropriately represents the retinal pathology
  - Interpretation and report
  - Extended fundus exam with documentation of diagnostic technique (ie 360 degree scleral depression)
  - *Assessment of change in pathology for subsequent EO*

EO – Current LCDs and LCAs

MAC	Jurisdictions	Policy	Effective Date	Last Update
Cigna Government Services (CGS)	J15 – Kentucky, Ohio	Local Coverage Determination (LCD) L34399	10/1/2017	5/31/2018
Cigna Government Services (CGS)	J15 – Kentucky, Ohio	Local Coverage Article (LCA) A52397	10/1/2015	5/31/2018
First Coast Service Options (FCSO)	JN – Florida, Puerto Rico, Virgin Islands	Local Coverage Determination (LCD) L34017 and fact sheet	10/1/2017	9/22/2017
Palmetto	JM-AL, GA, TN JJ-NC, SC, VA, WV	Local Coverage Determination (LCD) L33467	3/15/2018	3/9/2018
Palmetto	JM-AL, GA, TN JJ-NC, SC, VA, WV	Local Coverage Article (LCA) A53060	2/26/2018	1/31/2018
National Government Services (NGS)	JK-CT, ME, MA, NH, NY, RI, VT J6-IL, MN, WI	Local Coverage Determination (LCD) L33567 and documentation guidelines (Appendix A)	10/1/2015	1/1/2019

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aao.org/lcds

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Case Study #1 - EO

3. Develop Internal Checklists
   - The following checklist represents typical requirements and should be revised per individual payer policies:

Check List for Extended Ophthalmoscopy (EO) Documentation

- ☐ **Documentation is not for a routine direct and/or indirect ophthalmoscopy**
  - ☐ Routine ophthalmoscopy is included in the appropriate level of office visit coded.
  - ☐ The definition of EO is a more extensive examination that requires a detailed and labeled drawing that cannot be documented in any other way.
- ☐ **Retinal drawing**
  - ☐ Although it may be preferred, a color drawing for EO is not a documentation requirement for most payers.
    - i. Confirm any drawing requirements (color or size) per payer policy.
  - ☐ A drawing that is clearly identified, labeled and appropriately represents the retinal pathology is required.
  - ☐ Documentation of the diagnostic technique used is completed (360 degree scleral depression, fundus contact lens, or a 90D lens).
  - ☐ Completing the retinal drawing directly from the OCT findings is not appropriate.

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Case Study #1 - EO

3. Develop Internal Checklists

- The following checklist represents typical requirements and should be revised per individual payer policies:

- ☐ **Interpretation and report**
  - ☐ An interpretation and report is completed for each test performed and per eye.
  - ☐ There are no published documentation requirements for the interpretation and report. The required documentation could include; diagnosis and findings and the impact on the treatment plan.
- ☐ **Chart notes supporting medical necessity per insurance policies**
  - ☐ A review of the patient's medical records provides documentation of the medical necessity for EO including the pathology per eye if billed bilaterally.
  - ☐ Medicare MACs with local coverage determinations (LCDs) include; Palmetto, NGS, CGS and First Coast.
  - ☐ Confirmation that an EO of the fellow eye without pathology was not billed to insurance as this would be considered not medically necessary.
- ☐ **The documentation and billing of the initial and subsequent EO meets the coding definitions.**
  - ☐ EO initial (92225) documents the initial extended ophthalmoscopy or a new event (diagnosis).
  - ☐ EO subsequent (92226) is used when following a chronic condition, after the initial extended ophthalmoscopy, with progression of the disease
- ☐ **Check CCI bundles for services performed the same day as EO**
  - ☐ Note: retina surgical procedures are bundled the same days as EO
  - ☐ Confirm payer policies for EO coverage the same day as other ophthalmic diagnostic testing services.

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Case Study #1 - EO

3. Develop Internal Checklists

- The following checklist represents typical requirements and should be revised per individual payer policies:

☐ **Insurance claim**
CMS-1500 paper claim or Electronic Data Interface (EDI) transaction 837P electronic claim completed with:
- 92225 or 92226 with appropriate diagnosis linkage and modifiers.
- Most payers recognize –RT and –LT modifiers when billing for the bilateral EO. Some payers may require the -50 modifier.
- EO is bundled the same day as retinal procedures.
- 92225 and 92226 have a bilateral indicator of 3, which would pay 100% allowable per eye.

☐ **Physician Signature**
The physician signature is legible on paper chart records and a signature log created to provide during an audit. For Electronic Health Records (EHR), the electronic physician signature is secure. The practice has an Electronic Signature policy and provides it in the event of an audit.

☐ **Chart notes have correct beneficiary name and date of birth on all chart records, including the retina drawing**

☐ **Abbreviation list**
The practice has an approved abbreviation list and is readily available for all audits.

Case Study #1 - EO

4. Perform Internal Audits
   - Using your checklist and coding resources as a guide, perform an internal audit on EO
   - Confirm all documentation requirements are completed per payer policies
   - Identify any deficiencies or incorrect coding
     - Voluntary refund as appropriate
   - Conduct internal training based on findings
     - All physicians and relevant staff should participate

Case Study #2 - OCT

1. Identify Audit Targets
   - Not currently a target area for Medicare
   - Previously was a SMRC target (diagnostic testing)
   - High frequency in retina practices
   - Should stay current on policy requirements

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Case Study #2 - OCT

2. Review Insurance Policies
   - Comprehensive knowledge of insurance policies will reduce denials and strengthen audit armor
   - Medicare LCDs
     - Frequency –review per your MAC
     - When receiving insurance denials, refer to the LCD for possible answers
       - *Why was our OCT denied when billed at 28 days?*

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Cigna LCD L34061

CGS States: OH, KY

- 92134 – SCODI Retina
- CGS – new policy effective 4/1/2018
  - Frequency
    - No more than 1 exam every 2 month with exceptions
    - Active treatment (AMD, CNV, DR, ME) – **monthly**
    - Rapid clinical changes requiring therapy and follow-up (macular hole, TRD) - monthly
    - Drug related (CQ and/or HCQ) – baseline examination within the first year and annual follow-up

First Coast LCD L33751

- 92134 – SCODI Retina
- First Coast – new policy effective 1/2019
  - Frequency
    - No more than 1 exam every 2 month with exceptions
    - Active treatment (AMD, CNV, DR, ME, VO, CME) – no more than one (1) exam per month will be considered medically reasonable.
      - Monthly
      - Subsequent less frequent based on protocol and response
    - Rapid clinical changes requiring therapy and follow-up (macular hole, TRD) – monthly
    - Drug related (CQ and/or HCQ) – baseline examination within the first year and annual follow-up after five years of treatment. Higher-risk, annual testing may begin immediately (without a 5-year delay).

First Coast States:
PR, VI, FL

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NGS LCD L34380

- 92134 – SCODI Retina
- NGS – new policy effective 1/1/2018
  - No frequency language
  - Limitations of coverage
    - Absence of an indication
    - Screening

NGS States: VT, ME, NH, NY, MA, RI, CT, MN, WI, IL

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Noridian

- 92134 – SCODI Retina
- Noridian –LCA effective 10/2017
  - Intraocular Avastin
  - Frequency
  - 92134 is appropriate at 4-6 week intervals

Noridian States: UT, AK, WA, AZ, ND, SD, OR, MT, ID, WY, NV, GU, HI, CA

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Novitas LCD L35038

- 92134 – SCODI Retina
- Novitas – new policy effective 1/2018
  - Frequency
    - One exam every 2 month manage primary retina conditions
    - Active treatment (AMD, CNV, DR, VO, ME) – no more than one (1) exam per month will be considered medically reasonable.
      - Monthly
    - Drug related (CQ and/or HCQ) – baseline examination within the first year and annual follow-up after five years of treatment. Higher-risk, annual testing may begin immediately (without a 5-year delay).

Novitas States: TX, CO, OK, MS, NM, LA, AR, DC, PA, DE, NJ, MD

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Palmetto LCD L34431

Palmetto States: VA, NC, WV, SC, AL, GA, TN

- 92134 – SCODI Retina
- Palmetto – new policy effective 5/2018
  - Frequency
    - Performed at clinically reasonable intervals
    - Clinically reasonable intervals – no more than one (1) exam per month will be considered medically reasonable.
      - Generally do not require SCODI more than once per month
    - Drug related (CQ and/or HCQ) –
      - Baseline exam first year of commencement if any macular abnormalities are present
      - Annual screening beginning at the 5th year of exposure to drug

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WPS LCD L34760

WPS States: IN, MI, KS, NE, MO, IA

- 92134 – SCODI Retina
- WPS – new policy effective 9/2018
  - Frequency
    - One exam every 2 month manage primary retina conditions
    - Active treatment (AMD, CNV, DR, VO, ME) – *may be allowed* one (1) scan per month
    - Rapid clinical changes requiring therapy and follow-up (macular hole, TRD) – monthly
  - Limitations of coverage – same day
    - 92250, 92225 *, 92226 *, 76512 *

**not CCI bundled with OCT – limitations in LCD. Documentation must justify the procedures*

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Case Study #2 - OCT

3. Develop Internal Checklists
   - Include guidance from insurance policies including;
     - Frequency and limitations
     - Medical necessity and indications
     - Approved ICD-10-CM codes
     - Unique bundles
   - Standard documentation requirements
     - Physician order
     - Interpretation & Report
     - Image stored in chart

Case Study #2 - OCT

4. Perform Internal Audits
   - High frequency of service requires internal audits
   - Provide education regarding insurance policies
   - Monitor denials and policy updates

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Be the Master Retina Coder!

- Use trusted resources for Coding Competencies
- Stay current on all coding & reimbursement changes
- Monitor audit targets and denials
- Manage drug reimbursements and nuances
  - Including; prior authorization and step therapy

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Academy Resources

Medicare LCDs	aao.org/lcds
Audits	aao.org/audits
ICD-10-CM	aao.org/icd10
Coding Resources	aao.org/coding
Codequest Courses	aao.org/codequest
MIPS	aao.org/medicare
Coding Products, Webinars	aao.org/store

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