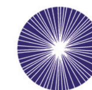
CODING ADVISOR

A Collaboration Between *Retina Today* and 

2019 RETINA CODING AND REIMBURSEMENT CHANGES

What you need to know for the new year.

BY JOY WOODKE, COE, OCS, OCSR

With each new year comes changes to coding and reimbursement. From new codes to policy updates, following are changes relevant to retina practice.

NEW CODES

Electroretinography

Effective December 31, 2018, the Current Procedural Terminology (CPT) code 92275, electroretinography (ERG) with interpretation and report, will be deleted and replaced by more specific codes based on the type of ERG performed (Table 1), such as full field (ffERG), flash (fERG), multifocal (mfERG) and pattern (pERG). The new codes are as follows:

- 92273: ERG with interpretation and report; full field (eg, ffERG, fERG, Ganzfeld ERG)
- 92274: ERG with interpretation and report; multifocal (mfERG)
- 0509T: ERG with interpretation and report; pattern (pERG)

ERG Local Coverage Determinations

During this transition to the new codes for ERG, the local coverage determination (LCD) policies for your Medicare Administrative Contractor (MAC) should be monitored for new active policies and articles that are effective January 2019. The MACs First Coast, NGS, Novitas, and WPS had existing LCD policies for the now-deleted CPT code, 92275.

These policies had specific coverage guidance for ERG (92275) testing. For example, Novitas L37371 LCD provided covered indications including the following:

- "To diagnose loss of retinal function or distinguish between retinal lesions and optic nerve lesions." A complete list of covered ICD-10-CM codes was provided.
- "To detect chloroquine (Aralen) and hydroxychloroquine (Plaquenil) toxicity (mfERG) per AAO guidelines, which does not recommend mfERG for routine primary screening, but can provide objective confirmation of suspected visual loss."

For some payers, one of the limitations for CPT code 92275 was with its use for glaucoma because it is considered experimental and investigational for this indication. This limitation included ERG, fERG, mfERG, and pERG.

With the expansion of the ERG codes and the specificity of the tests, new policies may reflect the unique coverage per diagnostic test. When they are published, the active LCDs related to ERG can be found at aao.org/lcds.

New Category III Code 0506T

A new Category III Code, used for

TABLE 1. CHANGES IN CPT CODES FOR ERG IN 2019

Code	Status	RVU	Approximate Medicare Allowable
92275	Deleted 12/31/18	4.25	$153.00
92273	New 1/1/19	3.78	$136.23
92274	New 1/1/19	2.56	$92.26
0509T	New 1/1/19	2.24	$80.73

Abbreviation: RVU, relative value unit.

temporary tracking of emerging technology, will be available at the beginning of 2019:

- 0506T: Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report

These devices measure macular pigment optical density, and they can detect low macular pigment, which could be an early sign of age-related macular degeneration. It would not be appropriate to report this test with CPT code 92250, fundus photography.

With all Category III codes, it is best to confirm the insurance policies for coverage. Many carriers may not have a published policy or established relative value units, or they may deny payment for these services. For more information, see Table 2.

TABLE 2. CATEGORY III CODES: WHAT YOU NEED TO KNOW
Temporary codes to identify emergency technology, services, and procedures
Numeric with alpha character T as the fifth digit
Physicians should use these instead of unlisted procedure codes for proper tracking
No relative value units are typically assigned to Category III codes
Insurance carriers have the option to cover
With a negative payment policy, the patient is responsible for payment
These codes are assigned a "sunset date," which is the end of a 5-year review period, at which time the code may: • Expire • Be assigned a Level 1 CPT code • Have an extended sunset date

CHANGES

Medicare Physician Fee Schedule and Payment Policy Changes

In November 2018, CMS finalized important policies related to physician fee schedules and payment policies. Some proposed rules were eliminated, others finalized, and yet others delayed. The following topics are those most relevant to retina practices. Additional information regarding the final ruling can be found at aao.org/advocacy/medicare-fee-schedule/2019.

E/M Office Visits

Beginning in 2019, there will be a significant change in documentation of the history for Evaluation and Management (E/M) office visit codes (99201-99205 new patient and 99211-99215 established patient). The history will now require the interval history since the previous encounter. The requirement that physicians redocument information recorded by staff has been eliminated.

No Reduction for E/M Same Day as Injection

The final ruling eliminated the proposal for a 50% reduction of payment for office procedures billed the same day as an E/M code with the -25 modifier. Any reduction to a same-day intravitreal injection encounter would have affected retina practices dramatically. Maintaining the current reimbursement model and not expanding the multiple-procedure payment reduction is a positive development.

New E/M Coding Changes for 2021

CMS delayed until 2021 making significant changes to E/M coding and reimbursement. If these proposed changes are implemented, there will be a single code and payment replacing the current levels 2 through 4 E/M visits (99202-99204 and 99212-99214). The level 1 (99201, 99211) and level 5 (99205, 99215) codes will remain. Eye visit codes (92002, 92004, 92012, 92014) will not be affected by this transition.

Refer to Table 3 for an outline of the E/M Code transition proposed for 2021. Because retina encounters often meet the requirements for level 3 or 4 E/M codes, the consolidation to a new single code may affect overall reimbursement for retina office visits. These changes continue to be discussed, and could be significant as proposed or modified as refinements.

Merit-Based Incentive Payment System Changes

For the 2019 performance year, the threshold to avoid a 7% penalty in 2021 will be 30 points. Refer to *Performance Categories Scores* on the next page to see how performance categories will be weighted.

CMS has eliminated several measures for reporting quality in 2019. These changes will affect retina practices reporting with electronic health records requiring the use of new measures:

- Measure 18: Diabetic retinopathy documentation of

TABLE 3. E/M CODING CHANGES PROPOSED FOR 2021

Current E/M System		2021 E/M Changes
CPT code	Description	
99201	New patient, level 1	99201
99202	New patient, level 2	
99203	New patient, level 3	*NEW SINGLE CODE*
99204	New patient, level 4	
99205	New patient, level 5	99205
99211	Established patient, level 1	99211
99212	Established patient, level 2	
99213	Established patient, level 3	*NEW SINGLE CODE*
99214	Established patient, level 4	
99215	Established patient, level 5	99215

PERFORMANCE CATEGORIES SCORES

45%	Quality
25%	Promoting Interoperability
15%	Improvement Activities
15%	Cost

macular edema and severity of diabetic retinopathy;
- Measure 140: Age-related macular degeneration counseling on antioxidant supplements; and
- Measure 224: Melanoma overutilization of imaging studies.

Beginning in 2019, retina specialists will start seeing positive or negative MIPS payment adjustments on Medicare Remittance Advices based on their performance in 2017. MIPS payment adjustments apply to covered professional services payable under the Medicare Physician Fee Schedule. They do not apply to Medicare Part B drugs, noncovered services, or covered services provided by a newly enrolled ophthalmologist in his or her first year.

When posting your positive or negative MIPS payment adjustment, an internal charge should be posted to apply or offset the payment adjustment. If the payment adjustment is applied only to the patient account, it will inappropriately reduce or increase the patient responsibility.

For tips for posting MIPS incentive payments, please visit aao.org/2019-mips-payments-understanding-remittance-advice-codes or refer to one of the resources listed in Table 4.

KEEP THESE ON YOUR RADAR

Step Therapy

CMS has approved the use of step therapy for intravitreal injection medications for patients with Medicare Advantage Plans (Part C). This policy, implemented on January 1, 2019, requires the use of a less expensive drug and documented failure of that drug before using a high-dollar medication. Although many agencies, including the AAO, will continue lobbying efforts to convey the consequences of these policies, retina practices should be prepared to facilitate this change. Refer to Table 5 for best practices tips for step therapy.

Prior Authorizations

There continues to be opposition from many agencies regarding the overwhelming burden that prior authorization (PA) requirements from Medicare Advantage plans impose on retina treatments, including intravitreal injections. As these discussions continue, practices still face the challenges of obtaining PAs every day in their clinics. As a response, performing a continuous process evaluation and implementing subsequent improvement will help retina specialists streamline reimbursement.

The evaluation process can consist of questions including the following:
- What is our current process?
- Who is responsible for completing each step?
- How are we monitoring current PA requirements from each insurance carrier?
- How are we documenting the process in our computer system? Is it accessible to all users?
- How do we track approval and expiration dates?
- Do we document unusual requirements or exclusions in the PA?
- Are there steps in our process that are inefficient?
- Do we track all denials related to PAs?
- What is our current accounts receivable aging for drugs?
- How do we know we have approval for an intravitreal injection during an encounter?

After this evaluation, necessary changes to the protocol may present. Staying current on changes, responding with a process evaluation, and developing resources may help to minimize the impact on the practice. ■

TABLE 4. ADDITIONAL MIPS RESOURCES
CURRENT AND COMPLETE INFORMATION REGARDING MIPS aao.org/medicare
PATH TO SUCCESS FOR RETINA SPECIALISTS aao.org/eye-on-advocacy-article/academy-charts-new-path-toward-mips-success-retina
MIPS REPORTING VIA IRIS REGISTRY aao.org/iris

TABLE 5. BEST PRACTICES FOR STEP THERAPY WITH ANTI-VEGF DRUGS IN MEDICARE ADVANTAGE PLANS
Contact all Medicare Advantage Plans plans requesting policies on step therapy.
Identify any documentation requirements for failure or timeline for treatments.
Create a quick reference guide outlining requirements per payer.
Develop an internal protocol for facilitating approval for drugs prior to encounter.
Communicate Medicare Advantage policies with all physicians and staff.
Stay current on all advocacy efforts regarding step therapy.

JOY WOODKE, COE, OCS, OCSR
- AAO Private Consultant
- joywoodke@gmail.com
- Financial disclosure: None