



CODING ADVISOR

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DEBUNKING COMMON RETINA CODING MYTHS



These tips can help to ensure your claims are correct to avoid post-payment audits.

BY JOY WOODKE, COE, OCS, OCSR

Periodically, a colleague may provide you with coding advice. Perhaps the guidance is followed by statements like, “We have always billed this way. We get paid and have never been audited.” So, it must be correct, right? No. Just because a claim was paid does not mean it is correct or not subject to a post-payment audit or recoupment. Here are a few myths and the real facts to be aware of.

MYTH: All Payers Will Accept the Same Code for Bevacizumab Injections.

Fact: Each Medicare Administrative Contractor (MAC) has its own unique policies or articles related to intravitreal injection of bevacizumab (Avastin, Genentech/Roche). Thus, they all have varied health care common procedure coding system (HCPCS) codes to report the medication. For example, Novitas, Noridian, and First Coast Service Option require the code J7999, whereas Palmetto GBA and National Government Services accept J9035.¹ Others use unlisted or not otherwise classified HCPCS codes J3490 or J3590.

The Medicare Advantage, commercial, and Medicaid plans may have their own unique policies and requirements for reporting bevacizumab that are not the same as the local MAC. The Medicare Advantage plans often follow similar policies as their commercial counterparts and may even require prior authorization.

MYTH: Office Visits That Determine the Need for Retinal Detachment Surgery Are Always an E/M Level 5.

Fact: It is true that when a macula-on retinal detachment is diagnosed and emergency surgery is

scheduled in the near term (eg, within 24 hours), the overall medical decision making (MDM) would be high. The problem is high—an acute problem with a threat to bodily function—and risk is high when determining emergency major surgery.

However, not all retinal detachment surgery is scheduled as an emergency. For chronic retinal detachment or (often) retinal detachment with proliferative vitreoretinopathy, scheduling may be deferred to the next available appointment. In this case, the surgery would be considered a moderate MDM and an emergency and management (E/M) level 4.

MYTH: It Is Always Appropriate to Unbundle 92134 (Posterior Segment OCT) and 92250 (Fundus Photography) When There Are Two Separate Diagnosis Codes.

Fact: Current procedural terminology (CPT) codes 92134 and 92250 have a National Correct Coding Initiative bundle with an indicator of 1, which means there may be circumstances that warrant unbundling. Some payers have published policies with guidance on when to unbundle, including Novitas local coverage determination L35038 and Palmetto local coverage article A56825.¹

These two policies state that these two tests are generally mutually exclusive on the same day, but there may be a limited number of scenarios (eg, separate indications for each test) when both are medically necessary. One example could be OCT for diabetic macular edema and fundus photography for a choroidal lesion. Appending modifier -59 would indicate a distinct procedure service. The

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guidance notes that frequently unbundling may trigger a focused medical review.

In the absence of a payer policy that has published the unique conditions that warrant unbundling, it is best to bill only for the test that best supports the MDM during the encounter.

MYTH: Always Bill the Examination on the Same Day as an Intravitreal Injection as an E/M Level 4.

Fact: The first step is to determine if it is appropriate to bill the examination on the same day as the minor procedure, meeting the definition of modifier -25. While medically necessary, if the examination is performed solely to confirm the need for the injection, it is not separately billable.

If the examination is billable with modifier -25, identify the reason for the significant, separately identifiable evaluation. For example, for an initial injection of the left eye for bilateral disease, the problem would be moderate complexity, chronic illness with progression, and moderate risk due to the prescription drug management of an anti-VEGF agent. For this case, the overall MDM is moderate and a level 4 E/M code.

When confirming the need for the injection in one eye along with the medically necessary examination of the fellow eye, the reason for the examination and MDM would be determined based on the reason for the fellow eye examination. For example, if it is a 4-month evaluation of stable dry AMD and the intent is to evaluate again in a few months, the problem and risk would be low, resulting in an overall low MDM and a level 3 E/M code.

IN THE ABSENCE OF A PAYER POLICY THAT HAS PUBLISHED THE UNIQUE CONDITIONS THAT WARRANT UNBUNDLING, IT IS BEST TO BILL ONLY FOR THE TEST THAT BEST SUPPORTS THE MDM DURING THE ENCOUNTER.

MYTH: It is Best to Bill Eye Visit Codes Because They Pay More and Are Easier to Document.

Fact: With the 2021 revision to E/M documentation guidelines—the medically relevant history, examination, and final determination is based on MDM or total physician time—there are scenarios where E/M can be easier to document. Additionally, there was an increase in the relative value unit value of office-based E/M in 2021. In some cases, E/M has a higher reimbursement than the Eye Visit code.

For example, when it is determined during a new patient evaluation that the patient needs a vitrectomy at the next available appointment, this visit would be considered a new patient E/M level 4 with the CPT code 99204. Along with the moderate level of problem, there is a decision to perform a major surgery. If considering only Eye Visit codes, CPT code 92004 has a lower relative value unit and allowable than the E/M code for the comprehensive eye examination.

It is best to review the documentation and determine the level of E/M and Eye Visit code based on their unique documentation guidelines. You can then compare the allowable per the payer fee schedule to appropriately maximize reimbursement.

Visit aao.org/retinapm for more retina coding resources and review the 2023 Retina Coding: Complete Reference available at aao.org/store. More guidance on E/M coding can be accessed at aao.org/em. ■

1. Local coverage determination policies. AAOE Practice Management. Accessed December 19, 2022. aao.org/lcds

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