



CODING ADVISOR

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CODING ESSENTIALS TO MASTER SOONER RATHER THAN LATER



A little preparation upfront will save you from unnecessary claim denials and audit failures.

BY JOY WOODKE, COE, OCS, OCSR

When facing frequent claim denials, escalating accounts receivables, or consistent audit failures, the recurring theme echoed from retina specialists is, “I wish I had known this sooner.” Often not a priority until a catastrophe emerges, achieving expert knowledge in retina coding and committing to ongoing education is a proactive measure that is essential to maintaining a viable retina practice. Here are four coding essentials you and your team should work on.

NO. 1. WHO IS THE PAYER?

Medicare usually publishes its guidelines, but other payers, including Medicare Advantage, commercial, and Medicaid, often have policies that vary. For example, in its National Coverage Determinations, Medicare only covers photodynamic therapy (PDT) reported as CPT code 67221 with a diagnosis of choroidal neovascular membrane secondary to AMD. There are also specific testing and documentation requirements outlined in the AAO’s PDT documentation checklist.¹

Alternatively, Aetna’s policy for PDT covers this procedure for choroidal neovascular membrane due to AMD, pathologic myopia, presumed ocular histoplasmosis, or chronic central serous chorioretinopathy.²

Because of these nuanced coverage limitations, it is always best to answer the question, “Who is the payer?” before scheduling a procedure.

NO. 2. FIND AND CORRECT YOUR CODING MISTAKES BEFORE THE AUDITORS

Mistakes happen. But, if a Medicare auditor identifies your coding error, it will result in an audit failure, even if you were underpaid. For example, one of the top reasons for recent Supplemental Medicare Review Contractor audit failures was reporting the incorrect units for intravitreal injection medications.³ Billing for 1 unit, instead of 2, 3, 5, or even 60 units, is not only a significant underpayment, but is also considered incorrect coding when auditing chart documentation. After the audit failure, the entire claim is recouped, and resubmission of a corrected claim may be denied due to issues with timely filing limitations.

To avoid an audit failure, and a declining cash flow, create internal reports to monitor all medication billing and identify errors at least monthly. This will allow you to resolve issues promptly with a voluntary refund and a subsequent corrected claim.⁴ Along with using the correct units, ensure the appropriate medication was billed and indicated per FDA label or payer policies and the appropriate -JW or -JZ modifiers were employed.⁵

NO. 3. UNDERSTAND WHEN TO USE AN E/M OR EYE VISIT CODE

Appropriately maximizing reimbursement and avoiding denials depends on the correct coding of each office visit scenario, per payer. If you’re exclusively reporting either E/M or eye visit codes, denials are inevitable, and

reimbursements are unnecessarily low.

Armed with the current Medicare fee schedule and that of your top insurance payers, as well as a comprehensive knowledge of coding guidelines, you should review the chart documentation and select the appropriate level of E/M and eye visit code.⁶

Next, consider when you shouldn't report an eye visit code; for example, when the commercial payer has frequency limitations for the comprehensive eye visit codes, CPT codes 92004 or 92014.

Finally, choose the E/M or eye visit code based on the highest reimbursement. For example, if the E/M overall medical decision making is moderate for a new patient or CPT code 99204, this is the best selection over the eye visit comprehensive code, CPT code 92004. In 2024, choosing the E/M code for this scenario will be approximately \$18 more for the Medicare Part B patient.

NO. 4. MASTER MODIFIERS

Understand the definition of each modifier and its appropriate use to minimize claim denials. For all procedures—including vitrectomies, intravitreal injections, and lasers—always report the appropriate anatomical modifier: -RT for the right eye, -LT for the left eye, or -50 for a bilateral procedure. This will help you avoid any claim denial due to a duplicate service or frequency limitations (eg, injections), which the Medicare Administrative Contractor for Kentucky and Ohio has reported as the top reason for claim denials in those regions.

Continue the mastery with a focus on office visit modifiers, or those to be reported only with an E/M or eye visit code.⁷ These modifiers include:

- **Modifier -24:** An unrelated E/M service (or eye visit code) by the same physician during the postoperative period, or an office visit in the postoperative period not related to the original surgery (eg, new symptoms, significant changes in eye health requiring an evaluation of an unrelated problem or fellow eye)⁸
- **Modifier -25:** A significant, separately identifiable E/M service (or eye visit code) by the same physician on the same day of the procedure or other service, or an office visit on the same day as a minor surgery (0- or 10-day global period)
- **Modifier -57:** A decision for a major surgery, or an office visit on the same day or within 3 days of a major surgery (90-day global period)

Determining whether to use modifier -25 or -57 depends on the type of surgery (major or minor), which is defined by the global period. A decision for a vitrectomy (CPT code 67036) the next day, for example, would prompt the use of modifier -57 because this procedure has a 90-day global period.

Coding for retina laser procedures can be challenging,

as the global periods vary between 10 and 90 days and the surgeries can be minor or major.⁹ CPT code 67210, destruction of localized lesion of retina (eg, macular edema, tumors) with one or more sessions, has a 90-day global period, and modifier -57 would be applicable when a same-day examination is performed. Alternatively, CPT code 67228, treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), has a 10-day global period per Medicare and for most other payers. In this instance, when a same-day examination is performed and meets the definition of modifier -25, append it to the office visit code.

Next, understand when to append a surgical modifier to an additional procedure performed during a global period. The following should be considered for these scenarios:

- **Modifier -58:** A staged or related procedure or service by the same physician during the postoperative period
- **Modifier -78:** An unplanned return to the OR by the same physician for a related procedure during the postoperative period
- **Modifier -79:** An unrelated procedure or service by the same physician during the postoperative period

Modifier -58 has three definitions for use and is applicable for many retina procedures. First, when a lesser-to-greater procedure, or when a pneumatic retinopexy (CPT code 67110) is performed and then a repair of the retinal detachment is performed during the global period in the same eye (CPT code 67108), the subsequent procedure would be reported with modifier -58, as it is more extensive based on the definition and relative value unit.

Next, when preplanned and documented in the medical record that a subsequent procedure is planned in the global period, use modifier -58. For example, document that in the global period of pneumatic retinopexy, laser and/or cryotherapy is planned.

Finally, when an injection is performed in the global period to treat the same problem as the original major surgery, for example, report with modifier -58. ■

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