# CODING ADVISOR

A Collaboration Between *Retina Today* and AMERICAN ACADEMY™ OF OPHTHALMOLOGY Protecting Sight. Empowering Lives.

# PROTECT YOUR REVENUE

Take the coding quiz and test your expert coding knowledge.

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The ultimate goal for coding and reimbursement in the retina practice is to appropriately maximize reimbursement by producing clean claims and providing audit-proof documentation. This can be achieved by a commitment to developing expert-level knowledge. Start with building an exceptional foundation and continue growing each year.

## MASTER THE FUNDAMENTALS

You can develop a solid coding foundation by understanding a few essential topics in retina coding. These areas should be continually reviewed to build a solid foundation of coding knowledge.

- Evaluation and management (E/M) and eye visit codes
- Modifiers
- Correct coding initiative bundles
- Testing services
- Global periods
- ICD-10 coding rules
- Payer policies

Coding is a team sport, and each person in the practice contributes to appropriate documentation and correct coding. Although the physician is ultimately responsible, staff provide an important supporting role and, everyone should receive ongoing education related to their individual roles. Each step of the patient encounter and revenue cycle management provides an opportunity to contribute expert coding knowledge.

## TEST YOUR KNOWLEDGE

Take this quiz based on specific coding scenarios to test your knowledge and see how much you know!

### Questions

1. An established patient was seen for a follow-up evaluation of an epiretinal membrane in the left eye and proliferative retinopathy in each eye with previous panretinal photocoagulation. Fluorescein angiography and OCT were performed. The plan was to continue to observe and schedule a follow-up visit in 6 months. Based on the multiple problems and testing, would this be moderate level of medical decision making (MDM) and E/M level 4, CPT code 99214?

2. In the global period of a pars plana vitrectomy in the right eye, a laser to repair a retinal tear was performed in the left eye. Which modifier should you use?

3. When can CPT codes 92133 and 92134 be unbundled with modifier -59, distinct procedure scheduled when performed on the same day?

4. How frequently can CPT code 92134 be billed for a patient receiving monthly intravitreal injections?

5. We billed Medicaid for an office visit because the patient was 14 days status-post; we used CPT code 67228 and received a denial with the explanation that the visit was considered postoperative. Doesn't this laser treatment have a 10-day global period?

**6** We received the results from a Medicare audit and one of our intravitreal injections was denied as not medically necessary. The ICD-10 codes H35.3122 (nonexudative AMD, intermediate, left eye) and H35.321 (exudative AMD, right eye) were linked to CPT code 67028-LT. Why was the claim denied?[1]

## Answers

1. The final determination for the level of E/M is based on the level of the three MDM components: problem, data, and risk. To meet an overall MDM as moderate, two of three components must meet or exceed that level. In this case, two or more stable chronic illnesses would be a moderate level problem. Additionally, the level of risk would be low with a final MDM of low, and CPT code 99213 would be appropriate.

**Fundamental:** For E/M code selection, consider the level of MDM for each category, then determine the final E/M MDM based on meeting or exceeding two or three categories.[2]

2. Append modifier -79, unrelated procedure by the same physician in the postoperative period, along with the appropriate anatomical modifier (ie, -RT or -LT).

**Fundamental:** Master modifiers, including surgical modifiers -58 and -78.[3]

3. CPT codes 92133 and 92134 are mutually exclusive and should never be unbundled. Bill the test that contributes most to the MDM on the day of the encounter.

**Fundamental:** Review National Correct Coding Initiative edits and the scenarios in which it is appropriate to unbundle.[4]

4. The answer depends on the insurance payer policy. For the Medicare Administrative Contractor, Novitas, its two policies for OCT, L35038 and A57600, state "No more than one (1) examination per month will be considered medically reasonable and necessary to manage the patient with retinal conditions undergoing active treatment, or in conditions suggestive of rapid deterioration."[4] For patients not on active treatment "no more than one (1) examination every two (2) months" or "in conditions suggestive of rapid deterioration."[5] Note: 1 month is defined in A57600 as every 28 days. Policies for other contractors can be found at aao.org/lcds.

**Fundamental:** Confirm payer-published policies for retina services provided to identify documentation requirements, frequency edits, and covered diagnoses.

5. Medicare has a 10-day global period for CPT code 67228, but some payers, including Medicaid plans, may still recognize it as a 90-day global period and a major surgery.

**Fundamental:** Identify the global period for all retinal procedures per insurance payer and create an internal reference guide for correct coding.[6]

6. Link only the ICD-10 code that supports medical necessity to the injection. Reporting nonexudative AMD as a diagnosis for an intravitreal injection may lead to a denial as not medically necessary.

**Fundamental:** The appropriate ICD-10 to CPT code link is crucial as it supports the medical necessity for the service reported.

## HOW DID YOU DO?

Knowing how to bill for retina services correctly and efficiently is crucial in any retina practice. For more information on the *Fundamentals of Retina Coding*, visit aao.org/retinapm or explore the *Retina Coding: Complete Reference Guide*, available at aao.org/store. ■

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