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AVOID COMMON RETINA TESTING PITFALLS

A breakdown of five diagnostic challenges and how to avoid them.

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Diagnostic testing services are essential to retina practices. However, high usage of diagnostic testing can prompt payer scrutiny and requires correct coding and proper documentation. One way to identify shortcomings and provide improvement opportunities is by conducting frequent internal reviews. To help with these reviews, let's take a close look at five common pitfalls to watch out for.

NO. 1: MISSING PHYSICIAN ORDER

After comprehensive error rate testing chart reviews, the Medicare administrative contractor (MAC) Wisconsin Physician Service reported that the majority of the deficiencies prompting audit failures and causing claim denials was a missing physician order.[1] Anecdotally, AAO consultants who provide external chart audits also found this absence to be the most common deficiency.

A physician order must be documented for all delegated testing services. This should include information detailing the tests being ordered, which eye is being tested, and the reason for the tests. New patients must be examined to establish the indication for the test. Standing orders and screening tests are not payable by any payer, even if pathology is found.

For established patients, the order for delegated tests is often documented on the previous encounter. This should be included in the chart notes provided during an audit.

Some electronic health record (EHR) vendors have the functionality to capture this crucial documentation. Others do not provide this in the standard templates. Furthermore, some vendors provide the ability to enter the physician order into the EHR, but it is not included in the printed chart note. No matter who your EHR vendor is, it is important to confirm that this crucial component of the medical record is captured.

NO. 2: MEDICAL NECESSITY PER PAYER

Payer policies vary, and they often have specific coverage requirements and definitions for medical necessity. For example, the MAC Palmetto GBA has published local coverage determination (LCD) L34426, which provides guidance for fluorescein angiography (FA) and ICG angiography (ICGA).[2] In the policy, ICGA has specific medical necessity requirements, which can be reported as current procedural terminology (CPT) code 92240 and, when provided with FA, as CPT code 92242.

This policy states that performing both tests may be a valuable evaluation for the following conditions:

- retinal neovascularization,
- choroidal neovascularization,
- serous detachment of the retinal pigment epithelium (RPE),
- hemorrhagic detachment of the RPE, and
- retinal hemorrhage.

When ICGA is ordered, the Palmetto GBA LCD L34426 guidance states that chart documentation should include one of the following:

- evidence of ill-defined subretinal neovascular membrane or suspicious membrane on previous FA,
- the RPE does not show subretinal neovascular membrane on current FA, or
- presence of subretinal hemorrhage or hemorrhagic RPE. An FA need not have been done previously.

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CODING QUICK LINKS


Retina Coding: Complete Reference Guide


Local Coverage Determination Policies


Practice Management Resources for Retina

Palmetto GBA provides the covered ICD-10-CM codes that support medical necessity for CPT codes 92235 for FA, 92240 for ICGA, and 92242 when combined.[2]

NO. 3: EXCEEDING FREQUENCY LIMITATIONS

Another common deficiency that can prompt audit failures and cause claim denials is exceeding outlined frequency limits.

For example, fundus photography (CPT code 92250), has frequency limitations published in many payer policies. The Medicare MACs Cigna Government Services (in LCA A57071) and National Government Services (in LCA A56726) both indicate that fundus photography is "usually medically necessary no more than two times per year."[2] Aetna, in its policy 0539, states that fundus photography provided more than twice a year would require chart documentation justifying medical necessity.[3]

OCT also has frequency limits in some payer policies. For example, WPS is one of six MACs with a policy for scanning computerized ophthalmic diagnostic imaging, or OCT. LCD L34760 limits OCT to every 2 months when managing retinal disease and monthly for patients treated with intravitreal injections.[2] Novitas has similar language in its LCD L35038 and defines monthly as every 28 days in LCA A57600.[2]

Noridian does not have a published policy for OCT but references frequency of use in its bevacizumab (Avastin, Genentech/Roche) LCAs for both jurisdiction E (A53008) and jurisdiction F (A53009).[2] It confirms the use of OCT to monitor and evaluate the need for additional intravitreal injections of bevacizumab every 4 to 6 weeks.

To avoid denials due to frequency limitations, review your payer policies to confirm their unique guidance.

NO. 4: INAPPROPRIATE UNBUNDLING

When multiple testing services are performed on the same day, National Correct Coding Initiative edits should be reviewed to identify if any of the services are considered bundled. If so, the CPT codes will either have an indicator defined as either 0, mutually exclusive, or 1, comprehensive.

Mutually exclusive edits identify services that are bundled and can never be unbundled with the modifier –59, distinct procedural service. When two tests are considered mutually exclusive (eg, CPT code 92134, OCT, posterior segment, and 92133), providers should bill for the test that contributes most to the treatment plan on the day of the encounter. Recovery auditors are monitoring for inappropriate unbundling of mutually exclusive testing services and can automatically recoup based on claims data.

When two tests are bundled with an indicator of 1, comprehensive, there may be circumstances where providers can unbundle. For retina testing services that are inherently bilateral, it's important to confirm published payer policies for appropriate scenarios. For example, CPT code 92134, OCT, posterior segment, and 92250, fundus photography, are bundled as comprehensive. To then unbundle with modifier –59, the tests must be distinct services.

In its LCD L35038, Novitas outlines that these tests may be performed on the same day when "necessary to evaluate and treat the patient" and should include documentation of the medical necessity.[2] The guidance continues that frequently unbundling these tests may "trigger focused medical review."

Two separate indications for the two tests (eg, fundus photography for a choroidal nevus and OCT for diabetic macular edema) would meet this payer's requirement.

NO. 5: WRONG PAYER'S RULE

Payer policies may vary, so using one payer's policy or perceived rules as guidance for another insurance carrier's claims may cause denials or prompt reviews. Although it is time consuming, it is necessary to research and review specific payer policies to confirm coverage, frequency limitations, and medical necessity definitions for the services provided.

Providers can start with a comprehensive review of local MAC policies and then confirm Medicare Advantage, commercial, and Medicaid guidelines. It is essential to communicate these nuances with the entire practice team.

Implementing frequent internal reviews and watching out for these deficiencies can help you avoid audit failures and claim denials. For more coding tips, common pitfalls to avoid, and policy outlines, check out the *Coding Quick Links*. ■

1. Diagnostic services – documentation requirements. WPS Government Health Administrators. Updated September 7, 2022. Accessed June 6, 2023. www.wpsgha.com/wps/portal/mac/site/medical-review/guides-and-resources/physician-orders-dx-services
2. Local Coverage Determination Policies. American Academy of Ophthalmology. Accessed June 20, 2023. www.aao.org/practice-management/coding/lcd-policies/carrier-list
3. Fundus photography. Aetna. Accessed June 6, 2023. www.aetna.com/cpb/medical/data/500_599/0539.html

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