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LESSONS LEARNED FROM MEDICARE AUDITS OF RETINA PRACTICES

Prepare your practice by reviewing published sources.

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They're back! After a (brief) reprieve during the public health emergency, CMS reinstituted audits in August 2020, including retina-specific probes and recovery audit contractor audits. Both CMS and Medicare Administrative Contractors (MACs) have published constructive feedback that can provide key lessons learned and prompt retina practices to conduct their own internal chart audits to ensure compliance and make sure they are prepared for an external audit.

In reviewing the publications from the CMS Education and Outreach team and the regional MACs, consistent themes emerge. The four most common reasons for denials as a result of postpayment probes and audits are insufficient documentation; does not support medical necessity; incorrect coding; and claim billed in error by provider.[1-3]

By exploring these deficiencies within retina-specific scenarios, practices can assemble a guide to ensure appropriate documentation and correct coding, and this guide can be used to mount a proactive response to the inevitable Medicare audit. Let's look at each category in turn.

INSUFFICIENT DOCUMENTATION

The bottom line is that all documentation must be complete and maintained for each unique patient and available to an insurance carrier upon request.[4] Each page of the chart should be legible, include patient identifiers, and be signed by the physician. These basic guidelines for documentation are outlined in payer policies and contracts.

Medicare published polices, local coverage determinations (LCDs), local coverage articles (LCAs), and national coverage determinations (NCDs) provide additional guidance and requirements for documentation of retina services. Specific requirements outlined in these documents, if missing or incomplete, would be considered insufficient documentation.

Consider these examples from Palmetto GBA's policy L33467, the MAC for several southeastern states:[5]

- For extended ophthalmoscopy, the chart documentation should include a retinal drawing that is clearly identified and labeled, along with the specific method of examination (eg, scleral depression, type of lens used), and whether the pupil was dilated.
- For fundus photography, the medical record must include a copy of the photo, an interpretation and report, and documentation of whether the pupil was dilated for the procedure.[5]

AT A GLANCE

- Constructive feedback published by Medicare and regional Medicare administrators can guide retina practices in preparing for—or, better yet, avoiding—audits.
- Based on the published information, practices can proactively perform internal chart audits and create processes to monitor compliance.

THE BOTTOM LINE IS THAT ALL DOCUMENTATION MUST BE COMPLETE AND MAINTAINED FOR EACH UNIQUE PATIENT AND AVAILABLE TO AN INSURANCE CARRIER UPON REQUEST.

When chart records are submitted for an audit, staff members should double-check that all required documentation is provided. Common errors include the following:

- Missing pages of a record for a specific date of service;
- Lack of documentation for an intravitreal injection procedure record, including indication, dosage, or wastage of 1 unit or greater;
- Documentation of testing services lacking patient identifiers and the date of service on each printed page;
- Not submitting the physician order for a delegated test or procedure (eg, intravitreal injection);
- Neglecting to send injection consents, or sending documentation for the wrong eye treated;
- Lack of a valid physician signature.

In a service-specific medical review of results for "Drug Injection Services (Eylea [Regeneron] and Lucentis [Genentech])," Novitas Solutions, the MAC for some southern and mid-Atlantic states, noted that it will "make multiple attempts to correct these error types before completion of the review" when documentation is insufficient.[6] But the same document also stated that, if documentation is not submitted in a timely manner or there is no response to requests, the denial will be upheld.

DOES NOT SUPPORT MEDICAL NECESSITY

The Palmetto MAC's report "Postpayment Service-Specific Probe Results for Drugs and Biological Services: Ranibizumab (Lucentis)" provides prevention recommendations for claims deemed not to support the medical necessity of services billed:[2]

- Documentation submitted for review should be complete and should support medical necessity of the service billed. Complete records include the original chart notes and any other records (eg, test interpretations, consents, prior chart notes) or other documentation supporting medical necessity.
- Documentation submitted should support the level of service reported by referencing Medicare policies. The medical record documentation must support the medical necessity of the services as stated in the policy.

For services provided in a retina practice, Medicare policies provide documentation requirements, indications, frequency edits, and usage guidelines that define medical necessity. Here are a few retina scenarios establishing medical necessity:

- Fluorescein angiogram documenting the evidence of classic choroidal neovascularization (CNV) membrane secondary to AMD or subfoveal minimally classic CNV (where the area of classic CNV occupies < 50% of the area of the entire lesion) must be present before photodynamic therapy (PDT) begins.[7]
- Documentation for scanning computerized ophthalmic diagnostic imaging (SCODI; ie, OCT) when reporting long-term drug therapy must include the medication name and the underlying systemic condition.[8]
- SCODI for retina will be considered medically necessary no more than once every 2 months for a retinal disease not undergoing treatment. SCODI will be considered medically necessary no more than one test per month (every 28 days) to manage a patient with a retinal condition undergoing active treatment.[8]
- For intravitreal injection of bevacizumab (Avastin, Genentech), records should include the appropriate informed consent with respect to off-label use.[9]
- Injecting one medication in one eye and another in the fellow eye would not be expected. If different medications are used, the rationale for the therapy must be clearly documented in the medical record.[9]

Local MAC policies may differ. Practices can confirm the requirements that pertain to their region by exploring their relevant LCDs on the AAO website: aao.org/lcds.

INCORRECT CODING

Chart documentation should support the coding reported on the CMS-1500 claim form for each encounter. Medicare LCAs list the CPT and ICD-10-CM codes that support medical necessity for specified services. During an audit, the coding is compared with the documentation, and common errors such as these may be identified:

- The number of units reported for the medication injected did not match the procedure note documentation;[3]
- Wasted medication of 1 unit or greater was not documented and/or reported with the -JW modifier;
- The HCPCS code reported for bevacizumab was incorrect per Medicare LCD;
- The medication billed does not match the chart documentation;
- The ICD-10-CM code linked to the testing service was not for the diagnosis documented in the medical record or an incorrect diagnosis linked to an intravitreal injection;
- Missing anatomic modifiers (-RT or -LT) appended to CPT code 67028 for procedures performed close

together—this can prompt a review of two treatments performed within 28 days of each other to confirm whether they were for the same eye;
- Inappropriate use of -59 modifier to unbundle services.

CLAIM BILLED IN ERROR BY PROVIDER

One of the top reasons for denials as a result of audit is claims billed in error by the provider. Scenarios of this can include a claim submitted for the wrong patient or billing for services not provided.

Practices can proactively avoid this type of error by performing internal chart audits and creating processes to monitor compliance. A proactive approach is also a key component of a compliance program offered by the Department of Health and Human Services Office of Inspector General, designed to assist practices in preventing the submission of erroneous claims.[10]

AUDIT PREPAREDNESS

The reports published by Medicare provide retina practices with a clear focus for internal reviews. Guided by published payer policies, practices can formulate detailed plans to ensure compliance prior to an audit.

To learn more about preparing for audits, review my article "Preparing for Targeted Retina Audits" in the May/June 2020 issue. Visit the AAO website (aao.org/retinapm) to find other resources. ■

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