

Medical Necessity for AMD Diagnostic Testing

Tips on billing for OCT and fundus photography.

BY RIVA LEE ASBELL

Fundus photography and optical coherence tomography (OCT), also known by the Centers for Medicare and Medicaid Services (CMS) as scanning computerized ophthalmic diagnostic imaging, are bundled in the National Correct Coding Initiative (NCCI). However, when both diagnostic tests are performed on the same day and the physician or billing department must decide which one to bill for when performing intravitreal injections in patients with wet age-related macular degeneration (AMD), the decision is often made to unbundle them and get paid for both or to simply bill for the one that pays the most. Unfortunately, these are both wrong choices.

A PRIMER ON MEDICAL NECESSITY

The concept of medical necessity is elusive, but it is mandatory to master if you are a Medicare provider. Audits resulting in subsequent paybacks and claim denials occur when Medicare decides that there is no medical necessity for a given service. The Medicare Carriers Manual states that all services must be medically necessary and reasonable—and no more. How is one to always provide a medically necessary service if there is no precise definition?

Defining Medical Necessity

One of the best explanations of medical necessity was given by the former Michigan carrier medical director, Michael K. Rosenberg, MD, in his column for the February 2002 issue of the *Medicare Bulletin* for Michigan and Illinois:

The words “not medically necessary” are frequently used in Medicare provider and beneficiary messages and communications. It is a very unfortunate term. It evokes a lot of emotion... The implication inherent in a medical necessity denial is that the diagnostic or therapeutic service, provided by the physician, was

unnecessary, and, therefore, in some way bad or at the very least superfluous. This has the effect of confusing patients and angering physicians. ... What is not appreciated is the fact that Medicare has evolved, over the years, into a very defined benefit program. In Medicare terms, “not medically necessary” simply means that the service is not a benefit under this defined benefit, for this diagnosis, at this time. Time and diagnosis are the key words, in that neither is immutable. A given procedure may become medically necessary, for a given diagnosis, at future time, and vice versa. As the old movie says, “Things Change”; and so does medical necessity, along with Medicare rules and regulations. It is important to remember that the phrase is not a value judgment regarding the provider’s diagnostic acumen, therapeutic decisions, and/or services.

Rules and Regulations

There are some regulations promulgated by CMS and the Medicare Administrative Contractors (MACs) that may be confusing or unknown to providers but that nonetheless must be observed. These include National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and the NCCI.

NCDs

These regulations cannot be modified or overruled by MAC policies. National policies and regulations may be found in the Federal Register, Medicare Carriers Manual, CMS Internet-Only Manuals, and Medicare Coverage Issues Manual.

LCDs

These regulations address issues not covered in national policies and generally specify conditions under which a given service may be allowed. They correlate current procedural terminology (CPT) codes with ICD-10-CM codes. Topics covered may include the following:

- Whether a service itself is covered and when it is medically necessary
- The diagnoses for which the service is covered
- Chart documentation requirements
- Frequency of tests allowed
- Instrumentation mandated for the given testing

In his 2002 column, Dr. Rosenberg further stated:

The criteria for, and limitations of any given service are the basic subjects which are addressed in Local Medical Review Policies (LMRP) [Note: these are now LCDs]. The purpose of an LMRP is to define the conditions (ICD-9-CM codes) [Note: these are now ICD-10-CM codes] under which a service (CPT 4 codes) is covered, i.e., medically necessary.

“Medical necessity” has become a ubiquitous term in a vast array of Medicare documents, such as national coverage decisions, guidelines, claim denials, and provider education materials, as well as in LMRPs.

An analogy can be drawn to federal laws versus state laws. In the presence of a national regulation, a state cannot make its own laws; however, when no federal regulation exists, the state can then make its own. The same is true for Medicare. In the absence of a national policy, a MAC can put forth a local policy, or LCD.

MEDICAL NECESSITY AND SCREENING EXAMS

Medical necessity is required for a diagnostic test. In the absence of appropriate indications, the test is

“Medical necessity is required for a diagnostic test. In the absence of appropriate indications, the test is classified as a screening test and is consequently not eligible for payment.”

classified as a screening test and is consequently not eligible for payment. These indications are frequently cited in LCDs. There must be a medically necessary reason—either an examination finding or patient signs/symptoms—for ordering a test. Diagnostic tests can never be ordered before a patient is examined for the first time (see Table). For example, just because a new patient is referred with a diagnosis of wet AMD, you cannot perform an OCT before you examine the patient and document an order for the test. The ordering physician should be the treating physician.

OTHER ISSUES: UNILATERAL VS BILATERAL

In Medicare’s definition (as noted in the Medicare Physician Fee Schedule Data Base), a test is unilateral when each side is eligible for payment (100% of the allowable) by virtue of medical necessity for the test and correlating diagnosis being present for each side. This does not necessarily translate into good medicine. For example, a patient presents with symptoms

TABLE. PERILS IN EHR: CHART DOCUMENTATION FOR DIAGNOSTIC TESTS

Order for test	Make sure the chart documentation for the order precedes results of the test in the chart. Without the order, the test is considered a screening test and is not covered by Medicare. A test cannot precede physician examination for new patients. For established patients, an order can be written at the previous visit.
Interpretation and report requirements	Reports require the following documentation: ¹ • Clinical diagnosis • Comparative data • Clinical management
Audit requests	• Make sure copies of tests are included and are of high quality. • Be sure to include interpretation and report. • Make sure there is a signature. If not signed originally, use an attestation statement for each service not signed.²

Abbreviation: EHR, electronic health record.

1. Asbell RL. Chart documentation for ophthalmic diagnostic tests. Retina Today. 2014;9(4):29-30.

2. Asbell RL. Scribing, signatures, and attestations. Retina Today. 2015;10(4):30-32.

of flashes and floaters in his right eye. There is medical necessity only for performing extended ophthalmoscopy in the right eye, despite prudence and good medicine, which would dictate performing bilateral testing even though the test should only be billed for the right side. OCT is a *unilateral or bilateral test*, meaning the provider gets paid the same whether one or both eyes are imaged. Fundus photography is a *bilateral test*, and the fee includes its performance on both sides; if only one side is tested, modifier 52 (reduced services) should be added to the claim.

OCT VS FUNDUS PHOTOGRAPHY

The diagnostic test warranted for basic decision-making in treating AMD is OCT, not fundus photography. The medical necessity for OCT is based on the fact that the results from the OCT provide the primary guidance for the next decision in treatment. There may, however, be another condition—perhaps the presence or absence of pigment, lipid, or blood in the macula or a pathologic condition in the other eye—that warrants documentation using fundus photography. In that case, both tests may be billed using modifier 59 to break the NCCI bundle. However, this is rare and should not be done on a routine basis.

The fact that OCT imaging continues to be the gold standard for clinical trials and everyday practice in gauging the effectiveness of treatment with intravitreal injections supports the medical necessity of this particular test.

Unwisely, many practices unbundle the two tests routinely on each patient and perform fundus photography on every patient regardless of medical necessity. Another common practice is to bill for the higher paying test, completely ignoring the issue of medical necessity. Fundus photos should not be billed in lieu of OCT when both are performed on the same day.

QUESTIONS ANSWERED

Q. Code 92134 (Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina) is now unilateral or bilateral. Would it be acceptable to perform and bill for one eye at the first visit and the other eye at the follow-up visit? Have you seen audits with other codes that are unilateral or bilateral?

A. Revisit the distinction made above in the section headed “Other Issues: Unilateral vs Bilateral.” When a code descriptor states that a test is unilateral or bilateral, it does not make any difference whether one or both eyes are tested—you code just

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one time for the test. Medicare would consider the practice described to be fraudulent.

Q. How often can we perform retina OCT testing?

A. This information is generally found in your MAC’s LCD. If your MAC does not address this, I suggest that you follow one of the others, such as NGS Medicare for New York. For example, NGS Medicare’s policy states that four tests per year are appropriate for retina diagnoses, but that patients with retinal conditions undergoing active intravitreal drug treatment may be allowed one scan per month per eye.

Q. Where do I get the information on which ICD-10-CM codes are covered?

A. This information is also listed in the LCDs.

Q. Do I need to use modifier 52 if I perform OCT on only one eye?

A. Modifier 52 indicates a reduced service when a test that Medicare considers inherently bilateral, such as fundus photography, is performed on only one eye (92250; Fundus photography with interpretation and report). However, for OCT, the code descriptor unilateral or bilateral overrides the assumption of bilaterality, and you do not use modifier 52.

CONCLUSION

Medical necessity is multifaceted and elusive, changing from circumstance to circumstance. Understanding its meaning can significantly help to facilitate reimbursement and compliance. ■

Riva Lee Asbell is the principal of Riva Lee Asbell Associates, an ophthalmic reimbursement consulting firm located in Fort Lauderdale, Fla. Ms. Asbell may be reached at rivalee@rivaleeasbell.com.



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