# Retina Coding Isn't All Black & White

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An earlier version of the Medicare Carriers Manual, now online as the Internet Only Manual, included the following statement:

"The coverage of services rendered by an ophthalmologist is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient's condition."[1]

The keyword is purpose and I have become more and more dependent on that word to teach medical necessity. All Medicare services demand that medical necessity be present in order for the service to be covered and thus paid for — no matter if it is a diagnostic test, office visit, or surgery.

How purpose affects the choice of code(s) and, ultimately, determines reimbursement for Medicare (fee-for-service) services, is reviewed in this column.

## DIAGNOSTIC TESTS

Whereas we all desire optimization of reimbursement for the services provided, compliance still rules and attempts to better the system usually have unpleasant consequences.

One of the biggest controversies in diagnostic testing reimbursement involves OCT versus fundus photography coding. Because both CPT codes (92134 and 92250) are bundled under the National Correct Coding Initiative (NCCI), the bundle should be respected in almost all cases.

The purpose of testing when treating AMD using an intravitreal injection with one of the various anti-VEGF drugs is to determine how the patient is faring and what future treatment should be. The diagnostic test should provide information to the physician to facilitate the decision making — and that information is best obtained from OCT in its various forms.

Another important concept that Medicare promotes is that once the "gold standard" diagnostic test is performed, there may no longer be medical necessity for performing additional diagnostic tests that provide the same, similar, or duplicative information.

## OFFICE VISITS

As noted previously, the purpose of the office visits determines whether or not that service is covered, be it one coded with Eye Codes or Evaluation and Management (E/M) codes. The coverage of an office visit is determined by the chart documentation in the Chief Complaint (CC).

If the reason for the encounter is for screening of any type (except glaucoma and fundus examinations in diabetic patients), then it is not a covered service under Medicare. For example, a family history of retinitis pigmentosa or choroidal melanoma does not provide medical necessity for coverage for an office visit in the absence of symptoms or findings.

High level E/M codes require that all 14 examination elements need to be performed. Attempting to access the high level E/M codes by "hitting all the bullets" is a practice that is in total disregard of medical necessity and will result in over-coding. Examination elements should not be performed without an inherent medical necessity for each one.

Using the established patient comprehensive eye codes (CPT code 92014) when a comprehensive exam is not warranted — due to lack of medical necessity of repeating mandated elements in the eye codes, will result in over-coding, particularly when performed in conjunction with the aforementioned intravitreal injections.

## USING CPT CODES

***Reading and Comprehending the Descriptor, Intent, and Purpose of a CPT Code***

In CPT, it is not infrequent that outdated codes are still in place … the technology rushes forward and the CPT book does its best to play catch-up. A few examples are reviewed that have been brought up for discussion in recent list servs and coding courses.

**Example 1:**
**CPT Codes 67145 versus 67105**

***67105*** - Repair of retinal detachment with drainage of subretinal fluid when performed; photocoagulation

Global Period: 10 days
Nonfacility national average: $301.46
Facility national average: $279.93
Nonfacilitiy utilization: 5,982
Facility utilization: 93

***67145*** - Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions; photocoagulation (laser or xenon arc)

Global Period: 90 days
Nonfacility national average: $535.10
Facility national average: $506.74
Nonfacilitiy utilization: 25,882
Facility utilization: 292

## SURGERY CODE CHOICES

Sometimes, retina-vitreous surgical coding falls in a grey area and this is when it is most important to be guided by asking and answering the question "What is the purpose of this surgery?" Too often, financial optimization is given more importance than compliance and medical necessity. There are many different types of statistically based audits and, if a provider falls outside of the range, audits commonly occur.

**Selective Elimination of Codes**

The following case illustrates coding by purpose rather than trying to gain unwarranted reimbursement by eliminating a code with a longer global period in order to bill more frequent office visits.The patient was referred to a retinal specialist presenting with endophthalmitis in the right eye 2 days after a Kenalog injection. Emergent surgery consisted of: 1) vitreous tap; 2) anterior chamber tap; 3) intravitreal injection of antibiotics.

**SURGICAL CODING**

Diagnoses: 1) H44.011 Unspecified endophthalmitis, right eye;
2) Z98.89 History of personal surgery

| DIAGNOSIS | PROCEDURE CODES | MODIFIERS | MEDICARE GLOBAL PERIOD | NCCI BUNDLES |
|---|---|---|---|---|
| 1) 1, 2 | 67015 Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach | -RT | 90 days | 67015 is bundled with 67028 (intravitreal injection) |
| 2) 1, 2 | 65800 Paracentesis of anterior chamber of eye | -51-RT | 0 days | 65800 is bundled with 67028 (intravitreal injection) |

**NOTE:** The purpose of the procedures was to diagnose and subsequently treat the endophthalmitis. Do not eliminate CPT code 67015 (90 day global period) to capitalize on obtaining more frequent office visits by selective elimination of code 67015. Doing so would garnish unwarranted reimbursement by billing postoperative visits more frequently by elimination of the procedure within the 90-day global period.

Both of these procedures are performed with an external laser; however, the emphasis for 67145 is the word "prophylactic" ... in other words, treating pathology that is a precursor of the retinal detachment (as described in the CPT definition), whereas 67105 is treatment for an actual retinal detachment.

There are times when the incidental retinal detachment accompanying a small retinal tear increases so that possibly the next treatment would be considered *treatment* of a retinal detachment rather than *prophylaxis* of a retinal tear in which case, the code would change along with the purpose.

I very rarely use CPT code 67105. CMS statistics for 2015 show CPT code 67105 allowed by CMS 5,982 times in a nonfacility setting and 93 times in a facility setting compared with CPT code 67145, which is allowed 25,882 times in a nonfacility setting and 292 times in a facility setting.[2] External lasers are bundled into other cutting procedures and are not paid separately.

**Example 2:**
**CPT Codes 67101 versus 67110**

***67101*** - Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy
Global Period: 10 days
Nonfacility national average: $333.05
Facility national average: $289.62
Nonfacilitiy utilization: 601
Facility utilization: 0

***67110*** - Repair of retinal detachment by injection of air or other gas (eg, pneumatic retinopexy)
Global Period: 10 days
Nonfacility national average: $890.75
Facility national average: $826.88
Nonfacility utilization: 2942
Facility utilization: 27

The purpose of each of these codes is repair of retinal detachment so better financial optimization is achieved by using CPT code 67110 without compliance infringement.

In both examples, the pairs are bundled under the National Correct Coding Initiative and unbundling is ill-advised.

In summary, it behooves the physician to gauge the reason for the procedure and determine the proper choice of CPT code accordingly. *NRP*



## REFERENCES

1. Medicare Carriers Manual B3 2320 Routine Services And Appliances. Available online: http://www.cms.hhs.gov/manuals; accessed August 16, 2017.
2. Part B National Summary File (Previously known as Bess). Available online: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-National-Summary-Data-File/Overview.html; accessed August 16, 2017.