AN ANALYSIS OF CMS RETINA UTILIZATION STATISTICS

Recent changes in reimbursement will likely lead to changes in utilization.

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The Medicare Part B National Summary Data File (previously known as BESS files) is a downloadable public file that provides detailed breakdowns of volume of physician services delivered to Medicare beneficiaries, and payments for those services, by individual procedure code. Entries in this file are limited to Medicare fee-for-service Part B Physician/Supplier data. Beneficiaries in the Medicare Advantage (managed care) portion of the program are not included.

Statistics in the currently available BESS files are based on calendar year 2014, the last year that these statistics were compiled.[1] In Table 1, I have ranked the top 10 retina procedures in the BESS files in order of highest utilization (allowed services) and then by the amount of dollars allowed (allowed charges) by Medicare for those same procedures.

Allowed services are those that Medicare deems valid for payment. The Medicare Physician Fee Schedule database lists the total dollar amount allowed for each service. Medicare pays 80% of the allowed amount fee-for-service, and the remaining 20% is paid by either supplementary insurance or the patient.

This year began with some alarming reimbursement cuts, and this article discusses coping with some of the problems that have emerged and offers a peek into future potential audits.

SURGERY

Below are allowed services for selected retina procedures, along with their Current Procedural Terminology (CPT) codes and discussion of relevant issues, recent changes, and the effects of these changes. Note that the rankings used in Table 1 precede each description.

External Laser Procedures

No. 2: Destruction of localized lesion of retina; photocoagulation (CPT code 67210, focal laser)

No. 3: Treatment of extensive or progressive retinopathy with photocoagulation (CPT code 67228, panretinal photocoagulation [PRP])

No. 5: Prophylaxis of retinal detachment (RD) without drainage; photocoagulation (CPT code 67145)

- The global period for PRP was changed from 90 days to 10 days, thus classifying it as a minor procedure rather than a major procedure. When a procedure is classified as major, an office visit can be billed within 24 hours of making the initial decision for surgery by using modifier 57. For procedures now considered minor, with a global period of 0 or 10 days, the office visit is packaged with the procedure, and caution is warranted when using modifier 25.[2] Modifier 25 is rarely warranted for a second or third treatment of PRP and is only appropriate for a first treatment specifically if another significant, separate condition is being evaluated. With the global period rule changes for 2016, you may find your utilization of PRP increasing. If this is the case, make sure your rationale for the additional procedures is clearly documented in the chart.
- The National Correct Coding Initiative (NCCI) lists sets of codes known as code pairs that cannot be used together. Do not allow your billers and coders to break the NCCI bundles except in unusual, well-documented circumstances.
- The BESS statistics reveal a surprisingly high number of focal lasers considering that the procedure is bundled with all vitrectomy surgery codes. See the bullet above.
- A common use of external focal laser is for treatment of diabetic macular edema. Intravitreal injections of various drugs are becoming more popular options for treatment. Utilization of the laser modality will probably decrease.

Vitrectomy Codes

No. 4: Pars plana vitrectomy (PPV) with macular hole repair (CPT code 67042)

No. 7: PPV with epiretinal membrane (ERM) peeling (CPT code 67041)

- One of the unexpected reimbursement decreases for 2016 resulted in macular hole repair and ERM peeling having the same level of reimbursement. In previous years, 67042 paid more than 67041. Many retina cases involve both procedures; however, the procedures are bundled, so only one should be selected for coding purposes. Both should be documented. It is advisable to use the code most important to the procedure(s) being

TABLE 1. CMS 2014 BESS STATISTICS FOR SELECTED RETINA PROCEDURES

Rank for Allowed Services	CPT Code/ Descriptor	No. of Allowed Services	Rank for Allowed Charges	Amount of Total Allowed Charges	Author's Comments (Allowed services includes all POS)
1	67028 / Intravitreal injection of a pharmacologic agent	2625485	1	$211563175	• Correlates with high utilization (No. 1) for OCT (92134) • In general, do not code with office visit using modifier 25
2	67210 / Destruction of localized lesion of retina; photocoagulation	84454	4	$43940908	• If using intravitreal injections for DME, make sure utilization is decreased • Still has 90-day global period; do not bill additional sessions
3	67228 / Treatment of extensive progressive retinopathy; photocoagulation	82027	2	$81827901	• 2016 CPT changes will result in more utilization • Do not code office visits with subsequent sessions for original problem
4	67042 / PPV with removal of ILM	41081	3	$61161616	• Reflects older coding when repair of macular hole paid more than ERM peeling
5	67145 / Prophylaxis of RD; photocoagulation	24428	10	$12723748	• Retains 90-day global period; do not bill additional sessions
6	67036 / PPV	23659	8	$25847097	• Do not use for removal of silicone oil; use 67121 (removal of implants material, posterior segment)
7	67041 / PPV with removal of precellular membrane	22718	6	$30963885	• Mandatory to use with 67108 for complex RD repair • Peeling of the hyaloid membrane does not usually count for this code
8	67108 / Repair of RD with vitrectomy, etc.	21723	5	$33116038	• If performed with cataract extraction and IOL, may need to break NCCI bundle with modifier 59
9	67113 / Repair of complex RD with vitrectomy and membrane peeling	17464	7	$27796444	• Make sure peeling of ERM is clearly documented in coding complex RD repair
10	67040 / PPV with endolaser PRP	16273	9	$22621490	• Always check NCCI bundles; it is frequently bundled with other surgical procedures

Abbreviations: CPT, Current Procedural Terminology; DME, diabetic macular edema; ERM, epiretinal membrane; ILM, internal limiting membrane; IOL, intraocular lens; NCCI, National Correct Coding Initiative; OCT, optical coherence tomography; PPV, pars plana vitrectomy; RD, retinal detachment; POS, places of service

performed; however, there are times when PPV with ERM (67041) must be the procedure code of choice. This is imperative when coding for complex RD repair (CPT code 67113), which mandates that both a retinal detachment and ERM peeling be performed.

No. 6: PPV (CPT code 67036)
No. 10: PPV with endolaser PRP (CPT code 67040)

- NCCI bundles frequently appear when multiple CPT codes are used in complex cases. The same caveat applies regarding not unbundling NCCI code pairs. Unbundling is accomplished by using modifier 59. This usage has been heavily audited and continues to garner attention from the US Department of Health and Human Services Office of Inspector General and the Centers for Medicare and Medicaid Services (CMS).

Example: A trauma case involved a corneoscleral laceration with a magnetic foreign body that was removed by nonmagnetic extraction. A PPV and lensectomy for traumatic cataract were performed. The following codes would be used: 65265 (nonmagnetic foreign body extraction); 65280 (repair of corneal-scleral laceration); and 66850 (lensectomy). The PPV (67036) is bundled with the foreign body extraction (65280) and it is the lower-paying code of this code pair edit and thus should not be coded. Full coding for this case will be described in the next issue.

Repair of Retinal Detachment

No. 8: Repair of RD by vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique (CPT code 67108)

No. 9: Repair of complex RD with vitrectomy and membrane peeling, etc. (CPT code 67113)

Large cuts in reimbursement occurred for these codes in 2016.

In order to use complex *RD* repair code, you must also perform membrane peeling. No matter how complicated the case, without the ERM peeling, it cannot be coded as complex.

Special Case: Intravitreal Injections

No. 1: Intravitreal injection of pharmacological agent (CPT code 67028)

- Intravitreal injections rank first both in the number of allowed charges and as the most highly utilized procedure in ophthalmology, and that definitively puts them on CMS's radar for audits.
- Practices should not routinely engender unwarranted payment for the office visit by using modifier 25 without a significantly separate clinical problem being addressed at the same time as the intravitreal injection.[2]
- Be cautious regarding the level of office visit when one is billed. There should be medical necessity for any of the elements performed, and they should not be performed solely to "count the bullets."

DIAGNOSTIC TESTS

Table 2 presents the top five ophthalmic diagnostic tests used in retina practices. With the high total payments and utilization statistics for some of these services, comments on chart documentation and audit prevention are warranted.

For chart documentation it is important to keep in mind that there has to be an order for each diagnostic test except extended ophthalmoscopy and gonioscopy, both of which are considered physician services. Additionally, with the exception of gonioscopy, each test requires an Interpretation and Report (I&R).

Avoid unbundling NCCI code pair edits. The most frequent code pairs that practices want to unbundle are fundus photos with optical coherence tomography (OCT) and extended ophthalmoscopy with office visits in the global period including the day of intravitreal injections.

Extended Ophthalmoscopy (CPT codes 92225 and 92226)[3]

The I&R does not have to be a lengthy report, but it should be separately identifiable in the chart documentation. The I&R may duplicate information in other areas of the chart note for that day, such as in the Assessment and Plan, and it must contain a diagnosis; comparative data, when applicable; and clinical management of the patient as a result of this information.

With most practices now using electronic health records (EHRs), the mandatory drawing becomes problematic in that the software of most EHRs does not permit making a drawing that meets Medicare guidelines. Each Medicare Administrative Contractor (MAC) may issue its own Local Coverage Determination (LCD) with requirements for the drawing, and each provider is beholden to follow these determinations. If your MAC does not have an LCD use the one at NGSMedicare.com.

Extended ophthalmoscopy continues to be a heavily audited service, and voluntary refunds resulting from internal or external audits are quite common. Medical necessity must be present for each eye because it is a unilateral service. Furthermore, the NCCI bundles should be adhered to. Medicare generally does not pay for extended ophthalmoscopy in the global period of a major or minor surgery. There is some confusion when it is performed with intravitreal injections and other procedures with a global period of 0 days. For the day of service, the extended ophthalmoscopy and other NCCI edits do apply.

Fundus Photography (CPT code 92250) and OCT (CPT code 92134)

Fundus photography always must have its own I&R, even when performed with fluorescein angiography (FA). FA is a unilateral test, meaning there must be medical necessity for each side, and each side must be addressed. Fundus photography, on the other hand, is a bilateral test, so the fee encompasses testing of both eyes. If only one eye is tested, then modifier 52 should be applied.

Fundus photography and OCT are bundled. There has been significant application of modifier 59 to break the NCCI bundles. Unless there is a separate medical reason for breaking the bundle, the practice is best avoided. Much of this was prompted by the payment differential between the two codes; for 2016, the national average payment for fundus photography is $78.82 and for OCT is $45.50.

More important, in terms of medical necessity, the diagnostic test that is the standard of care for medical decision-making in wet macular degeneration treated with intravitreal injections is OCT, not fundus photography.[4] All related clinical studies are designed around OCT results.

TAKE-HOME POINTS

- Make sure the rationale for billing additional sessions for PRP (67228) are well documented now that the global period has been reduced to 10 days. Increased utilization invites increased scrutiny.
- The coding of complex retinal detachment repair mandates both repair of retinal detachment with vitrectomy and peeling of ERM.
- Office visits are packaged with all minor procedures (0- or 10-day global period). If you do not have a separate, significant clinical problem that is being addressed, do not use

TABLE 2. CMS 2014 BESS STATISTICS FOR SELECTED RETINA DIAGNOSTIC TESTS

Rank for Allowed Services	CPT Code / Descriptor	No. of Allowed Services (All POS)	Rank for Allowed Charges	Amount of Total Allowed Charges	Author's Comments (Allowed services includes all POS)
1	92134 / Scanning computerized ophthalmic diagnostic imaging, posterior segment, with I&R, unilateral or bilateral; retina	5 401 832	1	$243 598 345	• Do not unbundle the NCCI code pair edits between 92134 and 92250. The test that is medically necessary for intravitreal injection treatment for the diagnosis of wet macular degeneration is OCT
2	92225 / Ophthalmoscopy, extended, with retinal drawing with I&R; initial	883 934	5	$28 450 902	• NCCI bundles in place when performed the same day as surgical procedures and in global period when related
3	92226 / Ophthalmoscopy, extended, with retinal drawing with I&R; subsequent	2 234 441	3	$67 419 209	• see above • Make sure LCDs are adhered to for drawings and medical necessity. EHR sketches are usually not in compliance
4	92235 / FA with I&R	1 104 945	4	$126 027 741	• Unilateral test: must have medical necessity for each side • I&R must address each side
5	92250 / Fundus photography with I&R	2 907 318	2	$219 994 673	• Do not unbundle with NCCI • Do not bill in place of OCT • Document medical necessity and different diagnosis if billed with OCT

Abbreviations: CPT, Current Procedural Terminology; DME, diabetic macular edema; EHR, electronic health records; I&R, interpretation and report; LCDs, Local Coverage Determinations; NCCI, National Correct Coding Initiative; POS, places of service; OCT, optical coherence tomography; FA, fluorescein angiography

modifier 25 to engender payment for the office visit.

- Caution is advised in selecting the proper level code when using modifier 25 because there may not be medical necessity for some of the elements.
- Avoid breaking NCCI bundles by using modifier 59, especially bundles involving OCT and fundus photography and those involving extended ophthalmoscopy when performed on the day of a procedure.

CONCLUSIONS

Our peek into the future based on the analysis of statistics from the BESS files shows the likelihood that, for the near future, intravitreal injections will remain the No. 1 surgical service. Be over-compulsive and obsessive with your chart documentation and do not be reckless with your use of modifier 25 to engender payment for a same-day office visit; this will serve you in good stead for audits. The utilization for repair of macular hole and removal of ERM will likely come closer together because the payments for each are the same. Additionally, utilization of PRP will most certainly increase.

For billing and coding of diagnostic tests, make every effort to follow the instructions for the I&R. This is the crux of diagnostic testing reimbursement, and it is where audits will trap you. Although there is usually sufficient evidence to prove that the test itself was performed, it is the I&R, which is considered the physician's work, that is often missing or incomplete. ■

1. Centers for Medicare & Medicaid Services. Part B National Summary Data File (Previously known as BESS). www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-National-Summary-Data-File/Overview.html. October 22, 2015. Accessed April 28, 2016.
2. Asbell RL. Same-day office visits and surgery: getting paid. *Retina Today*. 2015;10(7):25–28.
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