Coding for Retina and Vitreous Procedures Using a Drug Delivery System

BY RIVA LEE ASBELL

There usually is an applicable CPT procedure code when coding for vitreoretinal procedures. However, if a drug is new, then it is important to ascertain that an HCPCS code exists for the drug and that the MAC has notified providers they will pay for it. The information in this article pertains to reimbursement guidelines of CMS and Medicare.

**CPT CODING BY TREATMENT DELIVERY SYSTEM**

There are 2 categories of CPT codes used for surgical coding: Category I codes and Category III codes. Category I codes are found in the main body of the CPT manual. Category III codes are a set of temporary codes for emerging technology services and procedures. Coding problems occur when Category III codes are used because most MACs consider them experimental and deny payment. NGS Medicare states the following in LCD L25275 and Article A46075 on coverage for Category III codes:

NGS will not consider items, services, or procedures represented by these codes to be medically necessary unless there is a published local coverage determination or coverage article specifically extending coverage to a particular Category III code.

Codes that do not advance to Category I status within 5 years are removed from the CPT Category III list. Two such codes were deleted from CPT this year: 0186T Suprachoroidal delivery of pharmacologic agent (does not include supply of medication) and 0124T Conjunctival incision with posterior juxtascleral placement of pharmacological agent (does not include supply of medication).

The Table summarizes how to choose the correct CPT code according to the delivery system used. If there is a brand-new treatment modality that does not fit into a category, then use the CPT unlisted code (67299) for the coding.

**OFF-LABEL USES OF DRUGS**

Retinal physicians also are faced with the conundrum of not knowing whether they can legitimately bill and be paid by Medicare for drugs or biologics used off-label, regardless of the delivery system.

CMS is the government agency that oversees the Medicare program. In a few instances there are national policies for coding and reimbursement, such as the Evaluation and Management Guidelines (E/M services) and NCDs. MACs (formerly referred to as Medicare car-
riers) govern the day-to-day Medicare program, and their areas of responsibility include claims processing, conducting various types of audits, and the writing and enforcement of LCDs, as well as educating providers about those LCDs. LCDs define which CPT codes and corresponding diagnoses are covered for payment. Most important, the MAC decides whether a service is medically necessary and, thus, entitled to be paid.

Adminastar Federal, the MAC for Indiana, determined in a bulletin in 2005 that it would not reimburse providers for off-label ophthalmic use of bevacizumab (Avastin, Genentech). It ruled that:

Recent interest in the ophthalmology community has developed about the intraocular injection of bevacizumab to treat age-related macular degeneration (AMD). Interest may spread to other retinal disorders. The carrier considers this off-label use to be investigational due to the paucity of peer-reviewed literature. We understand that ophthalmologists may choose to use this medication outside of clinical trials. ... Neither the drug nor the injection should be reimbursed.

Practices in that area billed Medicare for the procedure and required patients to pay for the drug. Initially, Adminastar Federal paid for the procedure, but upon learning that it involved a drug being used off-label, it subsequently recouped payment until it decided at a later date that the off-label use of bevacizumab for treatment of neovascular AMD was a suitable therapeutic option and was eligible for payment going forward.

**DRUG COVERAGE**

When Medicare is billed for off-label drug use, it is the MAC that has the authority to determine which drugs...
and corresponding diagnoses are covered for payment, as well as determining any other criteria for coverage. Most important, if the drug is not covered for payment, neither is the method of delivery. This is the prime dictum in billing Medicare for off-label drugs and their delivery. A colleague in another MAC jurisdiction may have claims covered, and you may not, for the very same procedure. MACs have LCDs for Drugs and Biologics that include information on a provider’s off-label use of drugs. One example used in this article is NGS Medicare’s LCD (L25820). The LCD, accessible on their website (NGSMedicare.com) under Medical Policy, states:

An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug’s official label/prescribing information. An indication is defined as a diagnosis, illness, injury, syndrome, condition, or other clinical parameter for which a drug may be given. Off-label use is further defined as giving the drug in a way that deviates significantly from the labeled prescribing information for a particular indication. This includes but is not necessarily limited to, dosage, route of administration, duration and frequency of administration, and population to whom the drug would be administered. Drugs used for indications other than those in the approved labeling may be covered under Medicare if it is determined that the use is medically accepted, taking into consideration the major drug compendia, authoritative medical literatures and/or accepted standards of medical practice. Determinations as to whether medication is reasonable and necessary for an individual patient are made on appeal on the same basis as all other such determinations (i.e., with support from the peer-reviewed literature, with the advice of medical consultants, with reference to accepted standards of medical practice, and in consideration of the medical circumstance of the individual case).

Novitas Solutions (Jurisdiction L), another MAC, has developed a policy/article (A49034) that states:

Bevacizumab and ranibizumab, used on or off-label, may be considered eligible for coverage when provided in keeping with the ’Community Standard of Practice’ for the treatment of retinal disease, for example: AMD, ischemic retinal vein occlusions, and decreasing the vascularity of proliferative diabetic retinopathy prior to vitreous surgery.

This article was written for bevacizumab and ranibizumab (Lucentis, Genentech) specifically because of their common use as anti-VEGF medications for the treatment of the retinal diseases described above. Other current or future anti-VEGF medications, when used as described above, would also be considered eligible for coverage.

INFORMED CONSENT

When a drug or device is used off-label, an informed consent specific to that usage should be included in the standard informed consent.

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