CODING ADVISOR
A Collaboration Between *Retina Today* and AMERICAN ACADEMY™ OF OPHTHALMOLOGY
Protecting Sight. Empowering Lives.

CODING COMPETENCIES FOR THE FIRST-YEAR RETINA SPECIALIST

Joining a new group? Start here for a crash course in common coding scenarios.

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Congratulations! You finished fellowship and are starting real-world practice at a multispecialty group. You have heard about the importance of proper coding and know that the physician is ultimately responsible in an audit. This article provides coding competencies to master and scenarios you may face during your first year.

NEW VERSUS ESTABLISHED

Your new practice is a group of several ophthalmologists, not all of whom are retina specialists. A patient is referred to you from your associate, the comprehensive ophthalmologist, for a retinal tear. When you are coding for the office visit, is this patient considered new or established?

Payer guidelines interpret the phrase "new patient" to mean a patient who has not received any evaluation and management or eye visit services or other face-to-face services (eg, testing or surgical procedures) from the physician or physician group practice (same specialty) within the previous 3 years. Although specific taxonomy codes exist for subspecialties in ophthalmology, all ophthalmologists are considered the same specialty for this purpose.

The recovery auditors for Medicare have identified this as a hot target for audits. They often identify payments for new patient services provided two or more times within a 3-year period by the same physician or physician group. When this error is uncovered, a recoupment is requested.

Although retina-specific taxonomy codes don't differentiate you from your non-retina peers for the purpose of new patient status, designating your National Provider Identifier number may be beneficial for value-based systems. More information can be found at aao.org/taxonomy.

GLOBAL PERIOD WITHIN THE SAME GROUP

Another scenario you might encounter concerns a postoperative referral of a patient from your associate. Assume that this patient is in the global period of cataract surgery performed by a physician in your group. It has been determined that she has cystoid macular edema and is referred to you. In this case, is the office visit billable?

Ophthalmologists in a group practice share the same global period. The patient encounter would be considered postoperative for all physicians in the group. This prompts a next question: Would it be appropriate to bill the exam with modifier -24 (Unrelated evaluation and management service or eye visit code by the same physician during the global period)?

Because the patient's cystoid macular edema is related to a complication of the cataract surgery, modifier -24 would not be appropriate. Medically necessary testing services or surgical treatments would be payable in the global period. Modifier -78 (unplanned return to the operating or procedure room for a

Want to Know More About Modifiers?

Learn more about modifiers in the Coding Advisor article "Pop Quiz: Know Your Modifiers."
You can find it at http://bit.ly/Modifiers0320.

related procedure during the global period) should be appended to any surgical codes reported during the global period.

ROUTINE AND STANDING ORDERS

Assume that, to streamline the clinic and create efficiency, the practice you join requires all patients with diabetes to have fundus photography before seeing a physician. In this case, would CPT code 92250 be payable by the insurance carrier?

The answer is no. Although this streamlining effort may increase clinical efficiency, all delegated testing services require a physician order that includes documented medical necessity. Routinely providing testing services before the patient is seen is considered nonpayable by insurance payers.

WPS, a Medicare Administrative Contractor (MAC), added this language to its website:

> *Routine orders are orders for those services and treatments that are applied to patients who have the same or similar medical condition(s). These frequently called 'routine, protocol or standing orders' are based on an assessment of the impact of a given condition in the population of patients with that condition (medical illness or injury) and are widely applied to those patients. Medicare defines any order(s) that does not specifically address an individual patient's unique illness, injury or medical status, as not reasonable and necessary. As is required by law, Medicare does not accept such 'standing orders' as supporting medical necessity for the individual patient. Services related to population-based or condition-based orders are not reimbursable.*

NGS, another MAC, provided this guidance in a fundus photography local coverage determination (L33567): "Furthermore, the ordering/physician of fundus photography by eye specialists prior to a face-to-face encounter is similarly not covered or reimbursable."

ADVANCED BENEFICIARY NOTICE

Let's say that, when a patient receives an intravitreal injection, your practice routinely asks the patient to sign a Medicare advance beneficiary notice (ABN) in case the claim is denied. Is the ABN necessary?

An ABN is a written notice that a physician obtains from a Medicare Part B patient before services are rendered, alerting the patient that the services may not be covered. Examples of when an ABN might be used include when services are provided for a noncovered diagnosis or when the physician desires greater testing service frequency than is usual or allowed per policy.

Because intravitreal injections for medically necessary indications based on policy are a covered service, an ABN is not necessary.

Need to Brush Up on LCDs and Payer Policies?

Learn more about LCDs, payer policies, and key coding principles in the Coding Advisor article "Become a Master of Retina Coding." You can find it at http://bit.ly/MasterCoder0320.

TREATING FAMILY MEMBERS

Your mother-in-law, who is a Medicare beneficiary, is referred for an evaluation due to wet age-related macular degeneration. Can services provided to family members be billed to Medicare?

According to CMS Guidance Transmittal 2332, physicians cannot bill for services they provide to family members. Commercial carriers agree with this rule. The following degrees of relationship are included within the definition of immediate relatives:

- Members of your household;
- Domestic partners;
- Your husband or wife;
- Your natural or adoptive parent, child, or sibling;
- Your stepparent, stepchild, stepbrother, or stepsister;
- Your grandparents or grandchildren or their spouses;
- Your father-in-law or mother-in-law;
- Your son-in-law or daughter-in-law.

NEED MORE INFO?

More retina coding fundamentals can be found in *2020 Retina Coding: Complete Reference Guide*, available at the Academy Store (aao.org/store). ■

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