Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Don't Let Age-Related Macular Degeneration Reimbursement Fade Away

Focus on 3 key areas to keep your claims on track.

Nearly 2 million Americans have age-related macular degeneration (AMD), and more than 7 million are at risk. Are you getting the best reimbursement for all AMD related services? Watch these three areas to ensure you file correctly for this growing area of eye care.

1. Combine Services for Diagnosis

When your physician suspects AMD, he'll complete several tests to confirm the diagnosis. Some are as simple as a dilated eye exam, visual acuity test, or fundoscopy. He might also complete a fluorescein angiography if he suspects a patient might have wet AMD. "These can all be done on the same day, but it would be unlikely due to the amount of time that a fluorescein angiography takes to perform," says **Becky Zellmer, CPC, MBS, CBCS,** medical billing and coding supervisor for Suby, Von Haden and Associates in Neenah, Wis. Performing all the diagnostic tests on the same day, however, doesn't mean they're separately billable.

"Visual acuity and fundoscopy are part of the eye exam or E/M, not separately billable," says **Diane McVinney, CPC,** billing manager at the Jones Eye Institute at the University of Arkansas for Medical Sciences in Little Rock.

"Fluorescein angiography is separately billable per eye when pathology is present."

If your physician completes fluorescein angiography, you have three coding options depending on the type of test and imaging:

• 92230 -- Fluorescein angioscopy with interpretation and report

• 92235 -- Fluorescein angiography (includes multiframe imaging) with interpretation and report

• 92240 -- Indocyanine-green angiography (includes multiframe imaging) with interpretation and report.

You'll submit a diagnosis based on whether your physician confirms dry or wet AMD. Report 362.51(Nonexudative senile macular degeneration) for dry AMD or 362.52 (Exudative senile macular degeneration) for wet AMD.

Other possibilities: ICD-9 includes two more diagnosis choices for AMD, though you won't rely on them as often. 362.50 (Macular degeneration [senile], unspecified) isn't normally used because "the physician can tell what type it is by the examination performed," Zellmer explains. "You'll use 362.53 (Cystoid macular degeneration) if there is swelling and a cyst located in the macula."

2. Know Globals for Your Treatments

Treatment plans for AMD run the gamut from "widely accepted" to "rarely considered reimbursable." "Treatments are not normally combined, but some of the preventative measures can be done with procedures," Zellmer says. "For example, a patient can change his eating habits and take antioxidants while having laser treatment."

Watch your days: Many AMD treatments carry a 90-day global period (such as 67210, Destruction of localized lesion of retina [e.g., macular edema, tumors], 1 or more sessions; photocoagulation).

Most also state that the code covers "one or more sessions," so you can only report the initial treatment for the eye.

"When there are multiple sessions on the same eye during the global period, only the initial treatment is covered," McVinney says. "If more treatments are needed within the 90-day global, you can only bill the medication -- not the procedure," Zellmer adds.

A few procedures don't have a 90-day global period, however, so remember to charge follow-up treatments when applicable. For example, injections of drugs such as Lucentis, Macugen, and Avastin 67028 (Intravitreal injection of a. pharmacologic agent [separate procedure]) and photodynamic therapy 67221 (Destruction of localized lesion of choroid [e.g., choroidal neovascularization]; photodynamic therapy [includes intravenous infusion]) have a 0-day global.

3. Choose Your Visit Code Carefully

Ophthalmologists have the choice of using either eye codes (92002-92014) or outpatient E/M codes (99201-99215) for their examinations.

"Some Medicare payers have local coverage determination policies on the eye codes, with specific guidelines as to what needs to take place to use the eye codes," McVinney explains. "Other Medicare payers do not have such policies. When that is the case, physicians should use the descriptor in CPT as a guideline for what needs to take place to qualify for an intermediate or comprehensive eye exam."

These groups of codes will be your standbys, but a visit might sometimes merit one of the counseling codes 99401 (Preventive medicine counseling and/or risk factor reduction intervention[s] provided to an individual [separate procedure]; approximately 15 minutes) or 99402 (... approximately 30 minutes).

However: These codes (99401- 99404) are noncovered services by CMS and many private payers, warns **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE,** consulting manager for Pershing, Yoakley, and Associates in Clearwater, Fla. "If counseling dominates more than 50 percent of the face-to-face physician-patient encounter, physicians should report the appropriate E/M code based on the total time for the encounter," she says. "Documentation must include a detailed summary of the counseling, total time of the encounter and the amount of time spent for counseling. Again, keep in mind that the amount spent in counseling must be greater than 50 percent of the total time."

Counseling with caveat: "If a patient is being seen and there is a family history of AMD, a physician could include counseling on nutrition, smoking, obesity, and/or elevated blood pressure," Zellmer says. "This would be preventative counseling for the patient. However, I must say that it is pretty difficult to get some payers to recognize this code and pay it." With more patients being diagnosed with AMD each year, staying on top of new treatments and correct reporting can be the key to successful claims. Some carriers allow for more reimbursement than in the past, but experts say payment for new drug therapies will continue to be an uphill battle. Keep your documentation in order and continue submitting claims even if you don't expect reimbursement, and the challenges will someday pay off -- hopefully in your physician's pockets.

Use These Modifiers for Accurate AMD Claims

As with other medical services, the wrong modifier can wreck an AMD claim. Finish your claim with modifiers LT (Left side) or RT (Right side) as appropriate. You might also need to append modifier 24 (Unrelated evaluation and management service by the same physician during a postoperative period) or modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

"You can use modifier 24 if there is another problem that's not related to the surgery," Zellmer says.

Modifier 24 example: The patient sees your general ophthalmologist, has cataract surgery, and sees your retina specialist during the post-op period for follow-up of wet AMD. The wet AMD is unrelated to the cataract surgery, so you'll append modifier 24.

Modifier 25 time: "Modifier 25 is commonly used when the patient comes in for an examination and during the course of the exam, the doctor decides the patient needs an intravitreal injection," says McVinney says. "Append modifier 25 to the E/M or eye code to show that the exam and injection were separately identifiable services."