Billing for AMD Services – The Right Way

Joe W DeLoach, OD, FAAO

CEO, Practice Compliance Solutions

Financial Disclosures – Joe DeLoach, OD, FAAO

I Have Received Honoraria From or Served as a Consultant for:
(Partial Listing)

- Vision Source
- Alcon Laboratories
- Carl Zeiss Meditec
- Optos
- Diopsys
- Kowa
- PCS
- AllDocs
- OfficeMate
- Marco
- TSO
- NVision
- Cleinman Partners
- Vision Trends
- Konan
- Essilor of America
- Pearle Vision / SNAPP
- Vision West
- EyeMart Express
- AACO
- UHCO, RSO, UAB, Berkeley, *and other optometry schools*

Over half the state optometric associations

There are no conflicts or disclosures related to any of these groups

Practice Compliance Solutions, LLC – President and CEO

Coding Caveat

Any presentation on reimbursement must begin with a statement on the tenets of medical reimbursement and medical ethics.

Billing and coding in seven slides!

Coding Caveat

TENETS OF MEDICAL REIMBURSEMENT

- Every service must be based on the reason for the visit
- Every service must be justified by medical necessity
- Best to strongly consider applicable medical directives

Reason for the Visit

Understanding the reason for the visit is fundamental to the whole process of medical reimbursement

- Simple concept…it is why THE PATIENT is seeking care from you TODAY *(not what care YOU want to deliver)*
- Do not address the reason for the visit, an auditor can/will deny the entire encounter as not medically necessary
- **It doesn't matter what YOU want to do, the only reimbursable care is that which answers the RFV!**

Initial or Established?

- If initial visit, the decision to perform diagnostic testing must be based on symptoms that could be attributed to AMD – blurred vision, metamorphopsia, light adaptation issues
- If no related symptoms but signs detected during internal examination, the TESTS can be billed medical but usually best to bring patient back for additional testing

NOTE (opinion): Always best to separate vision/routine care and medical care – just like the rest of the healthcare world does!

Initial or Established?

- For established patients, the reason for the visit is easy! Use direction language…

  "Physician-directed evaluation of macular degeneration"

- Excellent place to include orders for testing…

  "Physician directed evaluation of macular degeneration. Order retinal OCT and dark adaptometry."

Medical Necessity

- Medical necessity is the ONLY justification for reimbursement for services rendered
- Specifically it dictates whether actions or testing are "necessary" in the patient's care
- Medical necessity by law can ultimately be **determined** ONLY by the attending physician, but reimbursement is often **dictated** by payor payment policy
- YOUR medical necessity and payment policy may not match – if they do not, **PATIENT PAYS**

Defining Medical Necessity

The easiest for me to understand

Will the results of this examination or testing influence or dictate my diagnosis and/or treatment of the patient?

"Panel Testing" – NOT Medically Necessary

Per CMS – Confirmatory Testing:

*Medical record documentation must clearly indicate rationale which supports the medical necessity for performing **each** test. Documentation should also reflect how the test results were used in the patient's plan of care.*

"It would not be considered medically reasonable and necessary to perform any diagnostic procedure simply to provide additional confirmatory information for a diagnosis or treatment which has already been determined." (my emphasis added)

Same as the old adage…***"Once you hit oil you stop digging"***

Example…

Great way to have a close and personal with an auditor

Joe's Best Eye Care
Anywhere USA

TESTING PROTOCOL FOR MACULAR DEGENERATION PATIENTS

Every Three Months

1. Retinal OCT
2. 10-2 visual field
3. Extended color vision

Every Six Months

1. Fundus photo
2. Retinal OCT
3. 10-2 visual field
4. Extended color vision

Coding Caveat

MEDICAL ETHICS

Every care decision is based on what is best for the patient

"Do what is best for the patient and the money will follow"

Now that’s out of the way

Let’s talk about how to take care of AMD patients and make money - **the right way**!

Diagnostic Services – Three Groups

HIGH VALUE

- Direct observation, including fundus photography
- Scanning laser technology (almost exclusive to SD)
- Preferential Hyperacuity Perimetry
- Dark Adaptometry
- Fundus autofluoresence

VERDICT COULD BE OUT

- Threshold fields and microperimetry
- Genetic testing
- Carotenoid testing

LOWER VALUE

- Macular pigment density tests
- Amsler Grid

All ensuing comments are based on:

- Preferred Practice Patterns of the American Academy of Ophthalmology
- Medicare Carrier Medical Policy
- Some more recent studies combined with subjective opinion (which will be noted)

Direct Observation

- Stereoscopic biomicroscopic examination of the macula is still the primary patient management tool for the detection of AMD and monitoring of early disease
- There are no preferred practice patterns or clinical guidelines published regarding use of any diagnostic technology in a screening capacity for AMD management. **Does not state or mean they are not valuable** – just further confirms that screening tests by definition are not medically necessary!
- Fundus photography is excellent for establishing baseline reference but loses necessity when other more sensitive technology is used (OCT, angiography, fundus fluorescence…almost anything). **What does that mean?**

Photography Rules

- ✓ Medical necessity dictates you can only take a photo when something is there to photograph (cannot photograph normal – with rare payer exception)
- ✓ Medical necessity dictates repeat photography must be based on documenting a change in the condition
- ✓ Therefore….you cannot order photos ahead of seeing the patient

And…cameras are cameras are cameras. Unless stated in a payment policy, payers never dictate what type or brand of equipment is used in a diagnostic test.

Optical Coherence Tomography

- OCTs are an essential tool in AMD for determining the presence of retinal thickening, intraretinal and subretinal fluid
- OCT analysis in AMD is less valuable for early detection and monitoring *("I see dots!)* than in intermediate to severe disease
- OCT angiography is becoming an excellent non-invasive tool for intra and subretinal evaluation but has not totally replaced the need for fluorescein angiography, especially in the evaluation of an established CNV

A comment on OCT + Fundus Photos

- The answer is no….**period**
- The -59 modifier is an inappropriate modifier and cannot be used to override a NCCI edit
- Use of “different diagnoses” is not a justification for overriding a NCCI edit
- The fact that **“I’m getting paid every time”** is the common blog justification. An auditor will deny the claim – every time. **IGNORE MOST ALL CODING ADVICE ON BLOGS!**

BUT…

BUT…Photos + OCT for AMD

The principal Medicare policy – First Coast L33670

- "Fundus photography may be indicated to **document abnormalities** related to a disease process affecting the eye, or to **follow changes** in the course of such disease"
- **"Fundus photography and posterior segment SCODI are frequently used together for the following diagnoses:"** **(NOTE: The actual list is a bit longer but VERY restrictive and NO glaucoma)**

H35.30 Unspecified macular degeneration (do NOT recommend usage)

H35.31xx Nonexudative age-related macular degeneration

H35.32xx Exudative age-related macular degeneration

- **Medical record still must justify medical necessity of using both tests** (mainly by statement in interpretation and report regarding use for patient care)
- Bill by appending **-59XU modifier to 92250.**
- This medical policy **may not** and commonly **IS NOT** adopted by major medical payers

OCT Billing Guidelines

CMS National Medical Policy – LCD L35038

- SCODI is a valuable tool for the evaluation and treatment of patients with retinal disease, **especially macular abnormalities**
- **Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina:** No more than one (1) exam every two (2) months will be considered medically reasonable and necessary.
  - That's a lot of OCTs…medical record must justify.
  - AAO PPPs place frequency of examinations at **every 6-24 months for early disease, every 6-18 months for more advanced**
  - You will be judged by your peers – **national OD use of 92134 for all conditions is 8%**
- Fundus photography and posterior segment SCODI performed on the same eye on the same day are generally mutually exclusive of one another. The provider is not precluded from performing both….**Frequent reporting of these services together may trigger focused medical review.**

Dark Adaptation

Dark Adaptation

- AMD in early stage interferes with rod intercept or RI (scotopic sensitivity recovery time)
- Initial study - 38% of patients with normal acuity and normal retinal findings showed subclinical AMD
- ALSTAT study showed dark adaptation can diagnosis AMD at least three years before any clinical evidence of disease

Dark Adaptation

Dark Adaptation

- FINALLY – something with **real** science behind it that can help monitor progression but more importantly serves as an early predictor of AMD – ***years before signs or symptoms***.
- Technology not associate with buying treatment products from the equipment company *(how novel!)*
- And the **confirmed, independent** science is over two decades old
- New technology makes testing much easier

Owsley C, et al. Delayed rod-mediated dark adaptation is a functional biomarker for incident early age-related macular degeneration. *Ophthalmology.* 2016;123:344-351.

Owsley C, et al. Psychophysical evidence for rod vulnerability in age-related macular degeneration. *Invest Ophthalmol Vis Sci*. 2000;41:267-273.

Dark Adaptometry Billing Guidelines

SCREENING PROGRAMS

Consider as a screening tool for anyone in your defined age risk or in patients with established risk

- For sure over 75 (3X higher risk) – many set at 45 y/o
- Smokers (300X higher risk)
- Obese
- High triglyceride levels / low carotenoid levels

- Screening tests are usually part of routine care – 1X year
- Industry collected fees average $29-49

Dark Adaptometry Billing Guidelines

DIAGNOSTIC PROGRAMS

- CPT 92284
- In general, most payers do not reimburse for a diagnosis of macular degeneration. Commonly acceptable diagnoses include: ICD H53.61 – dark adaptation abnormality; H53.62 – Acquired night blindness; H35.63 – Congenital night blindless; H53.60 – Other night blindness
- AAO PPP silent on procedure
- Average Medicare reimbursement around $60 (unilateral/bilateral)

NOTE REGARDING AMD SYMPTOMS

1. “Reduced night vision”/”Problems seeing at night” and “Night blindness” are not the same thing and not considered synonymous amount auditors
2. If you want to win the audit, this is a situation where the more you say in the reason for the visit to justify the diagnosis the better

Exs.

- Patient states experiences loss of vision after passing a car with bright headlights
- Patient states it takes an exceptionally long time to be able to see when going from a light to dark or dark to light area
- Patient feels like cannot see or function safely in dimly lit areas

DON’T PUT WORDS IN YOUR PATIENT’S MOUTH BUT OLDER PEOPLE HAVE PROBLEMS WITH LIGHTS!!!

Subjective Comment

- Remember, medical payer policy and your determination of medical necessity may not always coincide. **THIS DOES NOT MEAN THE CARE IS NOT VALID.**
- Medical necessity and insurance benefits may not always coincide. In those cases, **medically necessary care per the attending physician's determination becomes the responsibility of the patient** – as long as informed consent is provided.
- Lack of more accessible payment policies MAY be related to use / overuse of the technology – 75% of all 92284 billed by optometry. Refer to history of payment policies and electrodiagnostic testing.

Preferential Hyperacuity Perimetry

- Independent clinical studies showed a 82% sensitivity and an 88% specificity in identifying a choroidal neovascular membrane (Ophthalmology 2005)
- **Mild to moderate CNV membrane detected 94% of time with PHP** vs. 14% of time with Amsler Grid (Ophthalmology 2003)
- Far more sensitive in detecting CNV membrane than Amsler Grid (Retina 2005)
- **The problem is timing** – a subtle CNV can grow VERY fast and invade the retina within a few weeks. Practically speaking, the real value of PHP is **likely limited to in-home monitoring**

Threshold Visual Fields

Central (10-2) Visual Fields – Still Valuable?

1. NO value in early detection – payment policy that exists usually restricts use to patients with worse than 20/70 Snellen acuity (less than 25% of your AMD patients!)
2. More advanced AMD patients have significant loss of acuity, contrast and fixation ability – making the reliability of a subjective field test highly suspect
3. BUT…foveal threshold measurement can be helpful in estimating how much vision loss is due to the macular pathology in conjunction with other ocular co-morbidities

Amsler Grid

- More subjective than a visual field test.
- Average acuity (or equivalent change) required for AMD patient to report a subjective Amsler response – **20/70**
- Average acuity (or equivalent change) required for AMD patients to report change on Snellen chart – **20/40**
- Not a billable test

So why use them???

- Basically dogma – may be better to use a take home Snellen chart
- Has hung on as some bizarre standard of care
- MAYBE, just maybe a few patients will see something

Visual Fields Billing Guidelines

- 92083 (for 10-2) – very few limitations from diagnoses standpoint but note prior limitation comments
- CPT Hyperacuity Perimetry – depends
  - Opinions include 92081 or 92082 for in-office testing
  - 0379T for remote monitoring by a physician
  - AAO PPP states too new for determination of value
- Remote monitoring program fees and details best obtained from device manufacture

Fundus Autofluorescence

- Fundus autofluorescence is helpful to demonstrate areas of geographic atrophy and monitor their progression.
- Some patterns of autofluorescence may predict faster rates of geographic atrophy
- Fundus autofluorescence may be used to quantify lipofuscin in the RPE
- Fundus autofluorescence can be far more valuable than simple photography in accessing tissue viability in retinal disorders

Fundus Autofluorescence Billing Guidelines

- CMS classified autofluorescence as a fundus photo – billed as 92250
- Is this rational? FYI-NO
- Can you bill as a diagnostic tool?
- Can you bill FAF diagnostic and fundus photography for documentation during the same encounter?

Opinion…

Unlike photography, autofluorescence is DIAGNOSTIC. You can bill and over-ride photography limitations, but document well and be ready to appeal an audit.

Genetic Testing

Currently, detectable markers for:

- Complement Factor H (CFH)
- Compliment Component 3 (C3)
- Oxidative Stress Gene (ARMS2)
- Mitochondrial Factor (ND2)
- Genetic risks with zinc treatment

The question really is…

So What???

The only thing the markers show is an increased risk of vision loss if the macular degeneration is classified as intermediate to advanced (we already know their risk is about 50%!)

No genetic test predicts ARMD in an individual with a normal retina!!!

Genetic Testing

The clinical utility of **genetic testing** for AMD is currently limited. **There** are no preventive measures that can be undertaken outside of good health practices and no known association between specific genotypes and specific therapies. **Genetic testing for macular degeneration** is considered investigational.
Apr 23, 2020 bcbs.com

Genetic changes in and around several complement system **genes**, including the CFH **gene**, contribute to a person's risk of developing **age-related macular degeneration**. It is unclear how these **genetic** changes are **related** to the retinal damage and vision loss characteristic of this condition.
Medlineplus.gov Aug 18, 2020

Statistical experts found errors in the data used to support an association (between genetic testing and supplement risk or use), and bias in the analyses used to support genetic testing. They concluded that there was no evidence to support the need for genotyping to guide recommendations for use of supplements containing antioxidants and zinc in AMD.
Assel etal Ophthalmology, 2018; 125(3)

Genetic Testing Billing Guidelines

This one is easy….

- I know of no medical payer who does not consider genetic testing for macular degeneration to be **investigational and not medically necessary**
- You still have the option to provide the service and the patient pays after proper informed consent

Carotenoid Testing

- Non-invasive measurement of carotenoids at the skin level which correspond to your overall body carotenoid level
- Levels measured by resonant Raman spectroscopy – wavelength conversions in the 478nm range. Only carotenoids are capable of this conversion.
- POTENTIAL CAVEATS
  - Excellent as an overall marker for general health. Claims of skin carotenoid levels correspond to retinal levels – possibly more data needed. Even then, possibly more valid than MPOD testing.
  - Very high percentage of deficient levels
  - Test tied to proprietary nutritional products
  - Associated products likely excellent for general health but may need to consider more focused options when managing AMD

Carotenoid Testing Billing Guidelines

Another easy one…

- No CPT designation, no coverage by CMS or medical payers
- Consider for screening testing or part of overall nutritional counseling program

MPODs – What Do We Know?

- Carotenoids are the MAIN macular pigments (meso-zeazanthin in fovea, zeazanthin in macula, and lutein paramacular) – but NOT the only essential retinal nutrients
- Macular pigments are an essential element of normal macular function both now and as the eye ages
- Every MPOD test is a surrogate and shows significant test/repeat test unreliability
- Unclear what the normal rate of pigment decline is with age or how much decline relates to changes in macular function

But, more importantly….

Not just my opinion…

"Not a valid test at this time due to lack of conclusive evidence and high variability. There is lack of clinical evidence to support the use of MPOD tests as a predictor of ARMD or progression of ARMD" ArchClinExpOphthal 2011

"Commercially available photometers for macular pigment optical density assessment in the clinical environment appear to demonstrate particularly poor coefficient of repeatability values. Clinicians should exercise caution when considering the purchase of these instruments…" ClinExpOptom 2010

We could go on and on and on…

Some are a bit better now, but the limitations remain

More not just my opinion

What do studies sanctioned by the National Institute of Health say?

Vision Research Gallaher etal

There are no published studies of MPOD changes over time in elderly patients with minimal retinal changes or early ARM. Therefore the significance of these observations is presently unknown.

Vision Reseach Gallaher etal

Validity and reliability are two fundamental properties of any measurement method. In the absence of an alternative gold standard for MPOD measurements, it remains a matter of debate which methods may be accurate

Eye Kinfeider etal

We found low agreement between test:retest measurements with XXX (heterochromic flicker photometry). There was some better agreement with the fundus reflectance method.

MPOD Testing Billing Guidelines

And another easy one…

- No CPT designation, no coverage by CMS or medical payers
- Consider for screening testing or part of overall nutritional counseling program

Any other billing considerations?

Counseling on early modification of risk factors

- Stop smoking
- Increase exercise
- Decrease cardiovascular disease risk
  - Mainly lose weight. Increased BMI linked to AMD risk
  - Change diet
  - Increased vegetable intake (leafy green, orange/yellow/red pigment)
  - Increase fish intake (minimum once weekly)

Any other billing considerations?

Counseling on potential early intervention

- Nutritional supplementation
  - FAR MORE than AREDS
  - MORE than just carotenoids
    - Resveratrol, Vit D, Curcumin
- Same lifestyle recommendations
- Statins – HIGHLY controversial

Great Joe…but can I get PAID???

Code	Description
S9470	Nutritional counseling, dietitian visit
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

S9470

Obviously not

97802 /03

- CMS does not specifically exclude physicians from using the code and does not exclude use for AMD counseling.
- One carrier explanation (Novitas) limits coverage to registered dietitians
- Most all major medical players do not even have this on their radar…yet

So, again Joe…can we get paid?

One viable option to consider would be billing a counseling visit under the E/M codes

USING MEDICAL DECISION-MAKING PROTOCOL

- ✓ Problem – depending on individual presentation, an "AMD problem" could be stable chronic illness, chronic illness with progression, or chronic illness that poses threat to bodily function
- ✓ Data – likely would be of no help
- ✓ Risk of Complications – potentially meet Level II or III risk

USING TIME PROTOCOL

- ✓ Includes total time you spend with the patient
- ✓ Would likely involve a stand-alone visit (dedicated to nutrition/lifestyle counseling)
- ✓ Likely levels based on time
  - ✓ 99202 – 15-29 minutes
  - ✓ 99203 – 30-44 minutes
  - ✓ 99212 – 10-19 minutes
  - ✓ 99213 – 20-29 minutes

Macular Degeneration Summary

- ✓ Optometrists SHOULD manage this disease at a very high level
- ✓ There is WAY more to macular degeneration than counting drusen and VEGF injections
- ✓ There are many options for more comprehensive care of this disease