CODING Q&A: Challenges in Remote Screening of Diabetic Patients

Part 2 of 2: coding and payer contracting.

By SUZANNE L. CORCORAN, COE  April 1, 2019

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CODING Q&A: Challenges in Remote Screening of Diabetic Patients: Part 1 of 2
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Telemedicine is the remote diagnosis and management of patients by means of telecommunication technology. In eye care, digital fundus photography (FP) lends itself to successful telemedicine because the camera can be placed in a primary care physician’s (PCP’s) office and operated by the PCP’s staff. The images are then transmitted to an ophthalmologist for interpretation. The result: patients benefit from access to specialists who are not otherwise available. However, there are legal and regulatory issues pertinent to screening for retinal diseases using a nonmydriatic fundus camera in the context of asynchronous telemedicine. In the first part of this series, we discussed patient care and reimbursement, and in this part we will discuss coding and payer contracting.

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CODING

Two CPT codes, 92227 and 92228, for remote imaging, were introduced in 2011. The AMA said the rationale for establishing these new telemedicine codes was to “… meet the needs of diabetic retinopathy screening programs which provide remote imaging and data submission to a centralized reading center.” These 2 codes and, for the sake of comparison, the longstanding fundus photography code, 92250, are as follows:

- 92227: Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
• 92228: Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral

• 92250: Fundus photography with interpretation and report

These codes are mutually exclusive — choose only one to identify a service. In addition, the remote imaging codes are not billed with an exam according to CPT.

The highest value is attached to 92250, which explains the attraction of it; however, AMA would not have created 92227 and 92228 if 92250 applied to FP in telemedicine. Yet 92227 and 92228 are flawed. 92227 doesn’t take into account physician interpretation and isn’t used for previously identified retinopathy. Conversely, code 92228 does contemplate an ophthalmologist’s involvement, does require an interpretation, and is only used for monitoring and management of patients with previously identified retinopathy; it is not screening. A comparison of the three CPT codes reveals important differences (Table 1).

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>REMOTE USE</th>
<th>INTERPRETATION REQUIRED</th>
<th>HISTORY OF DIABETIC EYE DISEASE</th>
<th>2019 RVU</th>
<th>TC/26</th>
</tr>
</thead>
<tbody>
<tr>
<td>92227</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>0.40</td>
<td>No</td>
</tr>
<tr>
<td>92228</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>0.97</td>
<td>Yes</td>
</tr>
<tr>
<td>92250</td>
<td>Yes or no*</td>
<td>Yes or no</td>
<td>Yes or no</td>
<td>1.43</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Varies depending on payer.

PAYER CONTRACTING

The legal, regulatory, billing, and reimbursement landscape includes many challenges (Table 2). Within traditional Medicare (Part B), screening FP in telemedicine is a noncovered service and the beneficiary is financially responsible for payment.

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>SOLUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex billing and unforeseeable outcome</td>
<td>Agreement with payer containing acceptable billing</td>
</tr>
<tr>
<td>Imperfect CPT codes</td>
<td>Agreement agnostic to coding</td>
</tr>
<tr>
<td>Screening FP not covered</td>
<td>Amend payer agreement</td>
</tr>
<tr>
<td>Fundus camera provided to PCP</td>
<td>Employ Safe Harbor agreement</td>
</tr>
<tr>
<td>Legal jeopardy associated with referral</td>
<td>Employ Safe Harbor agreement</td>
</tr>
<tr>
<td>Interpretation of FP by eye doctor</td>
<td>Amend payer agreement for reading center</td>
</tr>
<tr>
<td>Payer recaptures overpayment</td>
<td>Initiate agreement with payer prior to starting program</td>
</tr>
</tbody>
</table>
There’s little doubt that beneficiaries, providers, and payers all could potentially win with telemedicine. Payer executives at the highest level don’t need further convincing; they only require a mechanism to move forward. That mechanism is a 3-way arrangement between the payer, the reading center (RC), and the PCP, that ensures coverage for screening FP in telemedicine, authorizes flexible billing, and guarantees payment at reasonable intermediate rates (Figure 1). Specific elements are as follows:

- The payer counts fundus photographs as credit for HEDIS annual diabetic eye exam,
- The RC leases space for fundus camera and personnel from PCP,
- The RC provides fundus camera to PCP and trains staff to operate it,
- The RC receives remote image from PCP and provides written interpretation, and
- The RC submits claims for FP and receives global payment.

Medicare Advantage Organizations (Part C), Medicaid programs, closed-panel managed care plans (e.g., Kaiser Permanente), rural health plans, or other payers with a large population of underserved at-risk beneficiaries are likely to be receptive to an arrangement of this sort. RP

REFERENCES


