

OPHTHALMOLOGY CODING ALERT

The practical adviser for ethically optimizing coding reimbursement and efficiency in ophthalmology practices

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Reporting 1 Code for Bilateral Strabismus Surgery? Read This First

► ***There's no business like strabismus, especially when billing bilaterally can save you \$160 per procedure***

Coders — especially those for pediatric ophthalmologists — know how difficult sorting out the various eye muscles involved in strabismus surgery can be. With 12 ocular muscles to keep track of, one simple coding mistake could cost your practice hundreds, unless you know the ropes.

Make Modifier 50 Your Secret Weapon

Scenario: An ophthalmologist removes a 6.5-mm section of the lateral rectus muscle of the patient's left eye and resects the muscle to strengthen it and correct strabismus. He then repeats the procedure on the right eye, again removing 6.5 mm of the lateral rectus muscle and then resecting it. Two different codes might look correct — but only one will bring you the reimbursement you deserve.

Be careful: Because the ophthalmologist performed a resection procedure on two horizontal muscles, 67312 (*Strabismus surgery, recession or resection procedure; two horizontal muscles*) may look correct, but don't fall into this trap.

The strabismus surgery codes (67311-67318) describe procedures done in one eye only. Although the surgeon did resect two muscles, they were in different eyes, so 67312 is not correct.

Instead, you should report 67311 (*Strabismus surgery, recession or resection procedure; one horizontal muscle*) bilaterally, says **Riva Lee Asbell**, ophthalmic coding and reimbursement educator and principal of Riva Lee Asbell Associates in Ft. Lauderdale, Fla., who led the "Strabismus Surgical Coding Challenges" seminar at *The Coding Institute's* Ophthalmology Coding and Reimbursement Conference in March. Most Medicare carriers want you to report the entire session on one line with modifier 50 (*Bilateral procedure*) and a "1" in the units field.

Warning: Reporting 67312 would even hurt your reimbursement in this case. In the Medicare Physician Fee Schedule, 67311 has a "1" bilateral status indicator. That means Medicare will allow you to report bilateral services and will process them for payment, says **Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO**, with MJH Consulting in Denver.

If you report 67311-50 or two instances of 67311 on two lines — for example, 67311-LT for the left eye and 67311-RT-51 (*Multiple procedures*) for the right —

Medicare will base payment on 150 percent of the fee schedule amount for a single code.

Medicare multiplies the facility relative value units (RVUs) for 67311 (13.72) by the conversion factor of 38.0870, arriving at \$522.55. Appending modifier 50 for the bilateral procedure means that Medicare would reimburse you 150 percent of that, giving you \$783.83 (unadjusted for geographical location).

Reporting 67312, however, even though the descriptor mentions “two horizontal muscles,” will short-change you. With no bilateral pay adjustment, the RVUs for 67312 would only bring in \$623.87.

Select a Single Code for Single-Eye Muscles

To code strabismus surgery correctly, you also need to know when you can appropriately report strabismus surgery bilaterally.

If the ophthalmologist recesses both the lateral rectus and medial rectus muscles of the left eye, that is not a bilateral procedure. This is a case for which 67312 would be appropriate. The same rules apply for the vertical muscles (the superior rectus, inferior rectus and inferior oblique muscles).

Use these CPT codes for the following strabismus scenarios, based on which muscles the ophthalmologist worked on:

- 67311 for one horizontal muscle in one eye
- 67312 for two horizontal muscles in one eye
- 67314 for one vertical muscle in one eye
- 67316 for two or more vertical muscles in one eye
- 67318 for the superior oblique muscle in one eye.

If the ophthalmologist operates on one vertical and one horizontal muscle in one eye, however, use two codes — 67311 and 67314 (... *one vertical muscle [excluding superior oblique]*).

Practice: So how would you code if your ophthalmologist operates on both horizontal muscles in the left eye but only one horizontal muscle in the right eye? Use 67312-LT (for the two muscles in the left eye) and 67311-51-RT (for the single muscle in the right eye). Reporting 67311 bilaterally for the horizontal muscles in both eyes would not be appropriate.

Save Add-On Code for Special Occasions

You should use add-on codes whenever the operative report clearly documents an additional procedure — an adjustable suture, for instance — or a complicating condition or history.

A careful coder may be aware of a condition in the patient history that the surgeon doesn't state in the operative report. You should call this fact to the

CONTACT INFORMATION

We would love to hear from you. Please send your comments, questions, tips, cases and suggestions for articles related to ophthalmology coding, reimbursement and/or compliance to Jerry Salley at jerrys@eliresearch.com or call (888) 779-4546.

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physician's attention so that he can edit it in the operative report to allow billing.

Requirement: You must report all add-on procedures and services — those CPT codes preceded by a “+” — with another code representing the primary procedure.

For example, you can use +67320 (*Transposition procedure [e.g., for paretic extraocular muscle], any extraocular muscle [specify] [list separately in addition to code for primary procedure]*) with strabismus surgery codes 67311-67318, according to CPT guidelines.

Likewise, you can only report these codes with 67311-67318:

- +67331 — *Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles*
- +67332 — *Strabismus surgery on patient with scarring of extraocular muscles or restrictive myopathy*
- +67334 — *Strabismus surgery by posterior fixation suture technique, with or without muscle recession.*

Don't overlook: You can report +67335 (*Placement of adjustable suture[s] during strabismus surgery, including postoperative adjustment[s] of suture[s] [list separately in addition to code for specific strabismus surgery]*) and +67340 (*Strabismus surgery involving exploration and/or repair of detached extraocular muscle[s] [list separately in addition to code for primary procedure]*) not only with strabismus-surgery codes 67311-67318 but also with add-on codes 67320-67334.

But you must report 67320-67334 with a primary procedure code. Many trauma cases may involve multiple add-on codes — for instance, in the case of an open globe in which the ophthalmologist would have to explore for damaged muscles and insert an adjustable suture.

Watch out: The bilateral status is different for the six strabismus add-on codes. Their bilateral status of “0” means that the 150 percent payment adjustment for bilateral procedures does not apply, Hammer says. Do not use modifiers LT/RT or 50 with these codes. □

Newsletter Question or Comment?



If you have a question or comment about what you've read here, please contact the editor, Jerry Salley, at (888) 779-4546 or jerrys@eliresearch.com.

News You Can Use:

Distinguish Major Retinopathy of Prematurity With New Codes

► Proposed ICD-9 codes would break down ROP by stages

Good news for ophthalmologists treating patients with retinopathy of prematurity (ROP): Starting in October, you'll be able to code more accurately with diagnosis codes for each stage of the condition.

CMS has released its list of new ICD-9 codes for 2009, including a new series describing stages 0-5 of ROP, a disease that can lead to blindness in prematurely born infants. The new codes take effect on Oct. 1, 2008 — prior to that, ophthalmology coders' only option is to report 362.21 (*Retrolental fibroplasia*), which refers to the name by which ROP used to be known.

New Codes Add Detail

The more detailed codes will help with early intervention in the disease by distinguishing between minor and major ROP, according to information that **Patrick Romano, MD, MPH**, presented to the ICD-9-CM Coordination and Maintenance Committee on behalf of the Agency for Healthcare Research and Quality.

(Continued on next page)

You Be the Coder

Cataract Removal With Vitrectomy

Question: *One of our ophthalmic surgeons performed a vitrectomy (67005) for a vitreous prolapse diagnosis and a cataract removal (66984) for pseudoexfoliated lens and nuclear sclerosis diagnoses. I see on the CCI edits that 66984 includes 67005. But if the surgeon made the vitreous prolapse diagnosis prior to surgery, can I report both 66984 and 67005? Do I need a modifier?*

Washington Subscriber

Answer: Decide how you would answer, and then turn to page 47. □

The new ICD-9 codes, and the ROS stages they describe, are as follows:

- 362.20 (*Retinopathy of prematurity, unspecified*)
- 362.22 (*Retinopathy of prematurity, stage 0*) — immature retina without vascular changes; no clear demarcation of vascular and avascular retina
 - 362.23 (*Retinopathy of prematurity, stage 1*) — mildly abnormal blood vessel growth; a flat line demarcates the vascular and avascular areas
 - 362.24 (*Retinopathy of prematurity, stage 2*) — moderately abnormal blood vessel growth; fibrous tissue protrudes into the vitreous between the vascular and avascular areas
 - 362.25 (*Retinopathy of prematurity, stage 3*) — severely abnormal blood vessel growth; new blood vessels and fibrous tissue along ridge or extending into vitreous
 - 362.26 (*Retinopathy of prematurity, stage 4*) — partial retinal detachment
 - 362.27 (*Retinopathy of prematurity, stage 5*) — total retinal detachment.

Look for: ICD-9 2009 will also introduce new codes for plateau iris syndrome (364.82), a condition ophthalmologists sometimes see in managing post-iridectomy patients, and pingueculitis (372.34), which occurs when small corneal lesions known as pinguiculae become swollen and inflamed.



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Check Out New Secondary Diabetes Series

In October, ophthalmologists may also see more options for coding the diabetes that underlies many ophthalmic conditions. The new diagnosis codes include a new series, 249.xx, with 20 codes describing various manifestations of secondary diabetes mellitus (diabetes that occurs as a result of another medical condition).

Before October, coders should still use 251.8 (*Other specified disorders of pancreatic internal secretion*) for secondary diabetes diagnoses.

Take note of these codes in the new 249.xx series:

- 249.50 — *Secondary diabetes mellitus with ophthalmic manifestations, not stated as uncontrolled, or unspecified*
- 249.51 — *Secondary diabetes mellitus with ophthalmic manifestations, uncontrolled.*

For patients with type I or type II diabetes, continue to report codes from the 250.5x series (*Diabetes with ophthalmic manifestation*), with the fifth digit corresponding to whether the diabetes is type I, type II, controlled or uncontrolled.

Chemical Conjunctivitis Code May Also Debut

Coders should also look for a new diagnosis code describing acute chemical conjunctivitis. The American Academy of Pediatrics proposed the new code at the March meeting of the ICD-9-CM Coordination and Maintenance Committee. Acute chemical conjunctivitis can result when any irritating substance, like household cleaners, smoke, smog or chlorine, enters the eyes.

Currently, ICD-9 points coders to 372.01 (*Serous conjunctivitis, except viral*), which the AAP does not think allows for adequate monitoring of the condition. The new code, 372.06 (*Acute chemical conjunctivitis*), would include a note that the diagnosis excludes burns of eye and adnexa (940.0-940.9) and chemical corrosion injury of eye (940.2-940.3).

The code does not appear on the lists released by CMS but may still appear on future lists.

Go to the Source for Info

Learn more: To see all of the new, deleted and revised ICD-9 codes for 2009, visit www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp. □

Eliminate NEMB Jumble With New ABN

► Update now if you're not already using the revised form

If your practice is like most ophthalmology offices, every day you perform services, like refractions, that Medicare does not cover. If you've never quite understood when you should provide a patient with an ABN rather than an NEMB for a noncovered service, CMS has just made your life easier.

Medicare has unveiled its new advance beneficiary notice. This new form not only replaces the previous advance beneficiary notice (ABN-G for physician services) but also incorporates the notice of exclusions from Medicare benefits (NEMB) form. CMS expects this new, combined form to "eliminate any widespread need for the NEMB in voluntary notification situations," according to the new ABN Form Instructions document.

The old way: Previously, you would use an ABN only for procedures that Medicare might not cover. The ABN did not apply to procedures that CMS statutorily excluded from Medicare benefits — that's where the NEMB came in.

The new way: Now, CMS will accept the new ABN form for either a "potentially noncovered" service or for a statutorily excluded service. "The revised version of the ABN may also be used to provide voluntary notification of financial liability," CMS says.

Get ready for the change now: Medicare carriers began accepting the new ABN on March 3, but CMS has implemented a six-month transition period. Although you aren't required to submit the new form until Sept. 1, you may find making the change immediately a little easier.

How to get it: You can view a sample copy of the revised ABN, as well as CMS' complete instructions for implementing and using the form, on the CMS Web site at www.cms.hhs.gov/BNI/02_ABNGABNL.asp.

Although the ABN form has changed, many previous ABN "best practices" remain (mostly) the same. Here are four guidelines to follow anytime you use the form.

1. Provide the ABN Up-Front

If you discover that Medicare won't pay for a patient's upcoming procedure but the patient still wants you to perform the service, the ABN will inform the patient that he may be responsible for paying the noncovered portion.

ABNs help patients decide whether they want to proceed with a service even though they might have to pay. A signed ABN ensures that the physician will receive payment directly from the patient if Medicare won't pay. Without a valid ABN, you cannot hold a Medicare patient responsible for denied charges, says **Kara Hawes, CPC-A**, with Advanced Professional Billing in Tulsa, Okla.

"The patient has to sign the ABN form at the time of service, otherwise the form is not valid," Hawes says. "When the claim is denied without an ABN, Medicare will not allow you to be reimbursed for the service or collect money from the patient."

2. Explain the ABN to the Patient

ABNs help the patient understand his options. Once you have completed the ABN and discussed it with the patient, he can: 1) sign the ABN and assume financial responsibility for the service or procedure in question; 2) cancel the service or procedure; or 3) reschedule the procedure or service for a future date when he can afford it, or when Medicare may cover the procedure.

3. Give the Patient an Estimate

"Medicare is going to require that the estimated cost be included on the form starting in September. That's a big change," says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-OBGYN, CPC-CARDIO**, manager of compliance education for the University of Washington Physicians (UWP) and Children's University Medical Group (CUMG) Compliance Program. You might as well adapt now and save risking mistakes later on.

4. Apply Modifiers to Explain ABN Status

When you expect Medicare to deny all or part of a service, you should append the correct modifier to the service code so Medicare's explanation of benefits (EOB) will properly outline when the patient has to pay. Use the following descriptions to guide your modifier choice:

"You should use the GA modifier (*Waiver of liability statement on file*) when the service provider believes the service is not covered and the office has a signed ABN on file," says **Dena Rumisek**, biller for a practice in Grand Rapids, Mich. This might include tests ordered without a payable diagnosis code or those ordered more frequently than covered.

(Continued on next page)

Modifier GY (*Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit*) applies when Medicare excludes the service and you're using the new ABN as you previously would have used the NEMB.

Modifier GZ (*Item or service expected to be denied as not reasonable and necessary*) means that you didn't issue an ABN when you probably should have, and you cannot bill the patient when Medicare denies the service. □

READER QUESTIONS

Don't Change Insertion Code by Plug Type

Question: *Our ophthalmologist uses both temporary and permanent punctal plugs. Should I code differently for each type?*

California Subscriber

Answer: How you code the plug placement doesn't change based on the type of plug. There are three types of punctal plugs that your ophthalmologist may use: temporary collagen, semipermanent silicone, and intracanalicular plugs.

You should use 68761 (*Closure of the lacrimal punctum; by plug, each*) for punctal plug insertion, regardless of type. For Medicare claims, you should append the E modifiers to the procedural code to explain the plug's location. Use modifier E1 (*Upper left lid*), E2 (*Lower left lid*), E3 (*Upper right lid*) or E4 (*Lower right lid*), depending on where the ophthalmologist placed the punctal plug.

Alternative: Most non-Medicare carriers do not recognize the E modifiers. Instead, you can use modifiers RT (*Right side*) and LT (*Left side*).

Supplies: Don't expect payment for punctal plug supplies from Medicare — it considers the plugs non-billable. Non-Medicare carriers, however, may pay for the plug supply.

Depending on the type of plug, you'll report A4262 (*Temporary, absorbable lacrimal duct implant, each*) or A4263 (*Permanent, long-term, nondissolvable lacrimal duct implant, each*) for some carriers. Still other carriers may prefer 99070 (*Supplies and materials [except spectacles], provided by the physician over and above those usually included with the office visit or*

other services rendered [list drugs, trays, supplies, or materials provided]).

Tip: Carriers pay close attention to whether punctal plugs are medically necessary. The ophthalmologist's documentation should show that your physician first tried other treatments, such as eye drops or ointments, and that they failed.

Use Paper as a Backup for Modifier 22 Claims

Question: *Must I always file modifier 22 claims manually? Is there an easier and faster way to submit these claims?*

Arkansas Subscriber

Answer: Every modifier 22 (*Increased procedural services*) claim will require that you submit substantial documentation, but many payers would prefer that you submit the claim electronically and send the documentation, if requested, following the claim's adjudication.

The payer may deny the claim using a denial code that would require you to re-submit the claim for review with supporting documentation.

Document Ultrasonic FB Localization Necessity

Question: *During surgery, the ophthalmologist performed an ultrasound of the patient's eye to locate a foreign body. How should I code these services?*

Illinois Subscriber

Answer: You should report 76529 (*Ophthalmic ultrasonic foreign body localization*) along with the appropriate code for the foreign-body removal procedure (65205-65265).

The Correct Coding Initiative (CCI) doesn't bundle these codes, and payers should pay for both. Be sure your documentation supports the need for the ultrasound localization.

Expect More Money From In-Office Procedure

Question: *What is the difference between facility and nonfacility relative value units (RVUs)?*

South Carolina Subscriber

Answer: CMS assigns codes facility and nonfacility RVUs based on where the physician provides the service. You'll see this variation in RVUs called "site-of-service differential."

Nonfacility RVUs are used to calculate payment when the ophthalmologist provides a service in the office or clinic. CMS applies facility RVUs when the ophthalmologist provides a service in a hospital or ambulatory surgery center.

The higher the RVUs, the more money your office can expect for the procedure or service. Nonfacility RVUs usually pay at a higher rate than facility RVUs because nonfacility RVUs include the expenses required to perform the procedure within an office setting.

For example, the ophthalmologist repairs a retinal detachment with photocoagulation (67105, *Repair of retinal detachment, one or more sessions; photocoagulation, with or without draining of subretinal fluid*). If the physician performs this procedure in the office, the RVUs are 16.47, but RVUs for the same procedure performed at a hospital are 14.69. These are the national average without figuring in the geographical cost.

Aim for Proper Ametropia ICD-9 Code

Question: Which ICD-9 code should I report for ametropia?

Kansas Subscriber

Answer: The appropriate diagnosis code for ametropia, a refractive error when viewing distant objects, is 367.9 (*Unspecified disorder of refraction and accommodation*).

If you have a more specific diagnosis, you should report that instead, such as 367.1 (*Myopia*).

Watch for: If you're working from dictated notes, be sure the transcriptionist distinguishes between ametropia and emmetropia, the eye's normal refractive state, in which no refractive error is present.

If the patient is indeed emmetropic, find out what brought him into the office, such as generalized eye pain (379.91, *Unspecified disorder of eye and adnexa; pain in or around eye*), asthenopia (368.13, *Visual discomfort*) or a headache (784.0). Use the complaint to select the diagnosis code.

(Continued on next page)

You Be the Coder

(Question on page 43)

Cataract Removal With Vitrectomy

Answer: Whether you can report a vitrectomy separately from a cataract surgery procedure depends on whether the vitreous collapse was an iatrogenic (inadvertently introduced) complication. Ophthalmologists often have to perform a vitrectomy during cataract surgery due to vitreous collapse while removing a dense, senile cataract. In those cases, Medicare considers the vitrectomy a component of the cataract surgery, and thus not separately payable.

The Correct Coding Initiative (CCI) bundles vitrectomy codes 67005 (*Removal of vitreous, anterior approach [open sky technique or limbal incision]; partial removal*) and 67010 (... *subtotal removal with mechanical vitrectomy*) into cataract surgery codes 66982 and 66984 (*Extracapsular cataract removal with insertion of intraocular lens prosthesis [one stage procedure], manual or mechanical technique ...*).

Exception: If a prolapsed vitreous exists and the surgeon knows about it in advance — and documented it in the patient medical record — it is not a complication of the cataract surgery. Therefore, the physician who plans to perform a vitrectomy during the same operative session as a cataract surgery could code separately for the vitrectomy using modifier 59 (*Distinct procedural service*): 67005-59 or 67010-59.

Key: Documentation and diagnosis codes can get you reimbursement. Use 379.26 (*Vitreous prolapse*) for the vitrectomy, and the appropriate cataract diagnoses (in this case, 366.11, *Pseudoexfoliation of lens capsule*, and 366.16, *Nuclear sclerosis*) for the cataract removal. Remember that you should always code based on documentation, or you could face fraud allegations.

Be prepared to provide documentation showing the ophthalmologist's intent to repair a known vitreous prolapse found prior to surgery in case you receive denials when using these codes together, despite using modifier 59. Payers are aware of the potential for abuse of 59 and may want you to go through the review process to prove you've met the definition of "distinct procedural service." □

NPI Deadlines Still Loom — Be Prepared

Question: *I'm still confused about what the May 23 deadline is for the NPI changes. What does that date really mean?*

Pennsylvania Subscriber

Answer: By May 23, you need to be able to submit Medicare claims with only the National Provider Identifier (NPI) in the primary fields.

Caution: If your carrier has asked you to resubmit information on its 855 enrollment form, proceed with particular caution. If you haven't yet submitted a new 855, your carrier may be paying your claims by virtue of a "temporary crosswalk match" that links your legacy number and NPI. But the carriers' upcoming maintenance of the provider enrollment system may soon throw a wrench into that temporary fix, leaving you in a situation with carriers suddenly rejecting all claims.

To avoid this tripping point, get the 855 form in — and communicate with your carrier to ensure the system picks up the corrections in a timely manner.

Simply turning in the corrected 855 — without following up with your Medicare carrier — may not be enough. CMS has warned that the process of revising the enrollment data "can take a number of months to accomplish."

Resource: Learn more about NPIs at www.cms.hhs.gov/NationalProvIdentStand.

— *Advice for You Be the Coder and Reader Questions provided by Maggie M. Mac, CMM, CPC, CMSCS, consulting manager for Pershing, Yoakley and Associates in Clearwater, Fla.* □

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