Puzzles & Solutions: Common Difficulties in Coding and Billing Ophthalmic Services
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Financial Interest
Ms. Abrams is an employee at Washington University and has no financial interest in the subject matter of this presentation.

Minor Procedures
- Minor Procedures are Defined by Global Periods of 0 or 10 days
- Listed in the Physician Fee Schedule
- ~127 Minor Procedures in Ophthalmology
  - Skin Lesion removal & Wound Repair
  - Lid, Lash & Lacrimal Procedures
  - Corneal Foreign Body Removal
  - Lasers for Glaucoma
  - Intravitreal Injections

Financial Interest
Ms. Kennedy acknowledges a financial interest in the subject matter of this presentation.

Minor Procedures & Office Visits
- Universally bundled
- Office Visit Typically Denied
- Modifier -25 Appended to Office Visit
- Both Services Likely Paid
  - Would payment withstand post-payment review?
  - Does it meet the requirements of Modifier -25?

Modifier -25
- “Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service”
- “Same Physician” includes all physicians within a group practice
Modifier -25

“It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service **above and beyond** the other service provided or associated with the procedure that was performed.”

Modifier -25

“Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See Modifier -57.”

- Modifier -57 applies to major surgery not minor surgeries or procedures
- Does not apply to new patients

Trichiasis Case Scenario #1

**CC/HPI:**
- Pt returns for evaluation of trichiasis OU. C/O scratching & irritation OD x 2 wks. 1 mo s/p epilation OU.

**Exam:**
- Trichiasis RUL & RLL temporally with Conjunctival irritation

**Plan:**
- Epilation with Forceps OD

**Claim Submission**
- CPT code 67820-RT w/ICD-9 code 374.05
- The patient complaint and exam are specific to the underlying condition for which the procedure was performed
- This is a known chronic condition for the patient

Trichiasis Case Scenario #2

**CC/HPI:** LEE 10 mos ago
- C/O FBS, stringy mucous, tearing & irritation RT > LT x 3 wks. AT no improvement.

**Exam:**
- Trichiasis RUL & RLL & LLL with Conjunctivitis, & SPK irritation, No other FB

**Plan:**
- Epilation with Forceps OU, ABT & AT

**Claim Submission**
- CPT codes 9xxxx-25 & 67820-RTL
- ICD-9 codes 374.05 & 370.40
- The patient does not have a history of trichiasis and the complaint required an exam to determine the underlying cause
Trichiasis Case Scenario #3

- **CC/HPI:**
  - Pt here for epilation
- **Exam:**
  - Trichiasis RUL & RLL temporally with Conjunctival irritation
- **Plan:**
  - Epilation today

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Trichiasis Case Scenario #3

- **Claim Submission**
  - No code
  - There is no complaint to support the medical necessity for either the exam or the procedure
  - The history must either be one or more patient symptoms or one or more chronic illnesses being followed
  - There is no detail to the operative note

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Blepharospasm Case Scenario #1

- **CC/HPI:** New Patient
  - Pt referred for evaluation of bilateral blepharospasm
- **Exam:**
  - Blepharospasm OU
- **Plan:**
  - Botulinum Injection lids

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Blepharospasm Case Scenario #1

- **Claim Submission**
  - Exam only
  - There is a medical condition, but the extent is not described
    - Patient symptoms
    - Exam description
  - No details on the injection
    - Injection amounts
    - Total amount injected
    - Wastage (required by some contractors)

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Blepharospasm Case Scenario #2

- **CC/HPI:** New Patient
  - Pt referred for evaluation of bilateral blepharospasm. Pt had to D/C driving due to frequent involuntary lid closure.
- **Exam:**
  - Frequent spasm with full lid closure OU
- **Plan:**
  - Botulinum injections all lids. See op-note under procedures

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Blepharospasm Case Scenario #2

- **Claim Submission**
  - CPT Code 9xxxx (modifier -25 possible)
  - CPT Code 64612-RTL
  - HCPCS Code J0585 with total # of units
  - HCPCS Code J0585-JW if there is wastage with total # of units wasted
  - ICD-9 Code 333.81

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Blepharospasm Case Scenario #3

- **CC/HPI:**
  - Pt returns for bilateral blepharospasm and possible injection

- **Exam:**
  - Frequent spasm with full lid closure OU

- **Plan:**
  - Botulinum injections same as last time

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Claim Submission

- **CPT Code 64612-RTLT**
- **HCPCS Code J0585 with total # of units**
- **HCPCS Code J0585-JW if there is wastage with total # of units wasted**
- **ICD-9 Code 333.81**
- **May not hold up in post-payment review due to lack of procedure details**

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Foreign Body Case Scenario

- **CC/HPI:**
  - EP presents with C/O FBS OS x 6 hrs. Worse with blink, very light sensitive, ++ tearing.

- **Exam:**
  - FB embedded palpebral conjunctiva LUL. Secondary corneal abrasion

- **Plan:**
  - FB removal w/ 30 g needle. ABT ungt tid. RTO 1 day

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Claim Submission

- **CPT Code 9xxxx-25**
- **CPT Code 65210-LT**
- **ICD-9 Code 930.1**
  - FBS can be in one or more locations of different materials or a different disease with FBS symptoms
  - Exam required to determine

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Laser Peripheral Iridotomy Case Scenario

- **CC/HPI:** EP Work in
  - Pt C/O severe pain, redness & cloudy vision OD worsening since yesterday

- **Exam:**
  - IOP 19 / 56. Angle closure OS
  - Gonioscopy: Angle Closed OS – Cloudy view. Narrow OD 360º - Occludable

- **Plan:**
  - LPI OS – See Laser form under Procedures

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Claim Submission

- **CPT Code 9xxxx-25**
- **CPT Code 92020**
- **CPT Code 66761-RT**
- **ICD-9 Code 365.22**
  - New acute complaint that could be more than one condition
  - Exam required to determine
Argon Laser Trabeculoplasty Case Scenario
- CC/HPI: COAG OU Target<16mm Hg OU
  - XYZ drop added to regimen 2 wks ago for poor control. Possible laser if suboptimal control. Pt states strict med compliance.
- Exam:
  - IOP 20 / 18. Gonio – 3+ debris 360° OU
- Plan:
  - T-plasty OU OD first– See Laser form under Procedures

Intravitreal Injection Case Scenario #1
- CC/HPI:
  - Pt returns for re-evaluation of ARMD & possible Lucentis inj. OD. Last Inj. 1 mo ago.
- Exam:
  - Wet Macular Degeneration RT > LT
  - OCT = CS Macular Thickening
- Plan:
  - Lucentis Injection OD

Intravitreal Injection Case Scenario #2
- CC/HPI:
  - Pt returns for re-evaluation of ARMD. Pt c/o ++ floaters OS since last injection 1 mo ago. Denies flashes.
  - Exam:
    - Wet Macular Degeneration OU. Vitreous floaters OS w/o ret tear, hole or detachment
    - OCT = CS Macular Thickening OS > OD
  - Plan: Lucentis Injection OS

Claim Submission
- CPT Code 92020
- CPT Code 65855-RT
- ICD-9 Code 365.11, 365.72
  - Decision for surgery based on maximum medical therapy control
    - If control failure – laser

Claim Submission
- CPT Code - 92134
- CPT Code - 67028
- HCPCS Code - J2778
- ICD-9 Code 362.52
  - The exam is specific to the injection
  - “Possible injection” implies that the decision for the injection will be made at the time of exam. Modifier -25 does not apply.
Intravitreal Injection Case Scenario #3

- CC/HPI:
  - Pt here for Injection #13
- Exam:
  - Wet Macular Degeneration OU
  - OCT = CS Macular Thickening
- Plan: Lucentis Injection Today

Claim Submission

- CPT Code 92134 – as long as there is an order & I&R
- ICD-9 – 362.52
  - No complaint or chronic illness in the CC or HPI
  - No details for the procedure

Cataract Surgery Complication Case Scenario

- 66 year old female presents with painless loss of vision that is interfering with her tennis game and reading
- Exam reveals a significant mixed cataract
- Manifest refraction does not improve vision
- The remainder of the exam is unremarkable
- The decision is made to take the patient to cataract surgery on the right eye

- During surgery on Thursday, the chief resident “drops” the nucleus
- The IOL is implanted
- Wound closed
- Patient told to see retina specialist during her post-operative visit on Friday
- During the post-op visit, it is decided a vitrectomy will occur on Monday

Cataract Surgery Complication Case Scenario

- On Monday, the retinal surgeon performs a Pars Plana Vitrectomy on the right eye capturing the lens fragments in the vitrector
- What can be billed?

- Chief resident – 66984-RT on Thursday
  - ICD-9 Code – 366.19 Other and combined forms of senile cataract
  - Retina specialist – 67036-78RT on Monday
  - ICD-9 Code – 998.82 Cataract fragments in the eye
  - Neither ophthalmologist can bill for an exam on Friday
Anterior Chamber Evacuation

- 65800 - Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous
- 65810 - with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection
- 65815 - with removal of blood, with or without irrigation and/or air injection

Anterior Chamber Evacuation
Case Scenario

- Patient presents to the emergency room with painless LOV
- On-call physician diagnoses an 8-ball hyphema of the left eye
- Anterior Chamber Evacuation is performed
- Over 4 post-operative appointments, the hyphema recurs with secondary pressure rise
- The physician refers the patient to a glaucoma specialist who sees the patient the next day

Amniotic Membrane

- 65778 – Placement of amniotic membrane on the ocular surface; without sutures
- 65779 – single layered, sutured
  - Considered office-based procedures
  - Cost of the AMT is included in the reimbursement of the procedure

Amniotic Membrane
Case Scenario

- 68 year old male is 2 weeks status post “Aqueous shunt to extraocular equatorial plan reservoir, external approach; without graft” CPT code 66179
  - Presents to his post-operative exam with a persistent tube exposure
  - It is elected to place amniotic membrane tissue (AMT) over the tube during the visit in the office. No sutures were used.
  - What can be billed if anything?
Amniotic Membrane
Case Scenario

- If the AMT was applied in the lane, nothing can be billed.
- If the AMT was applied in a dedicated procedure room, 65778-78 can be billed.
  - ICD-9 code 996.5 mechanical complication of other specified prosthetic device, implant, and graft NEC.

Superior Orbital Lesion

- A 40 year old female presents to the clinic with a complaint of tender mass of the right upper brow area starting -6 mos ago increasing in size.
- The physician diagnoses a mass of unknown etiology.
- Surgery is planned to remove the mass.
- Assistance is requested of a neurosurgeon.

Superior Orbital Lesion

- Approach through upper lid to orbital rim.
- Orbital rim defect discovered.
- Lesion gray & vascularized prolapsed through defect – biopsied, removed & sent to pathology.
- AlloDerm™ & Duraseal™ to repair rim defect.
- Oculoplastic ophthalmologist & Neurosurgeon performed the procedure.

Superior Orbital Lesion

- What was the surgery?
  - Orbitotomy.
  - Orbital Implant.
  - Two surgeons.
- What to code?
  - 67412-62RT – Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of lesion.
  - 67550-62RT – Orbital implant (outside the muscle cone); insertion.
- Diagnosis code?

Questions