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.

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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

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

Trichiasis Case Scenario #1

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

Trichiasis Case Scenario #2

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

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

Blepharospasm Case Scenario #1

CC/HPI: New Patient
- Pt referred for evaluation of bilateral blepharospasm

Exam:
- Blepharospasm OU

Plan:
- Botulinum Injection lids

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)

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

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
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

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

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

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

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

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

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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

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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

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Argon Laser Trabeculoplasty Case Scenario

- 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

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Intravitreal Injection Case Scenario #1

- 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.

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Intravitreal Injection Case Scenario #2

- Claim Submission
  - CPT Code 9xxxx-25
  - CPT Code - 92134
  - CPT Code - 67028
  - HCPCS Code - J2778
  - ICD-9 Code 362.52
    - The patient presents with a new complaint
    - The documentation reflects the extended exam of the entire retina, not just the macula
    - The pt cc was addressed
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

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

**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

**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?