Specialty Procedure Documentation and Coding

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1

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, NOVA *and other optometry schools*

Over half the state optometric associations

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

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2

Agenda

- General overview of surgery
  - How is surgery different
  - Global surgery periods
  - Modifiers
  - Operative reports
- Specialty procedures
  - Descriptions
  - Preferred practice patterns https://www.aao.org/about-preferred-practice-patterns
  - Documentation guidelines
  - Coding considerations

3

Here's the new privileges we need to talk about…

Whew….we will need to move fast. Some slides will provide more details than we will go over or are for reference only. You can refer back to them!

- ✓ Laser peripheral iridotomy (66761)
- ✓ Laser selective trabeculoplasty (65855)
- ✓ YAG laser capsulotomy (66821)
- ✓ Treatment of chalazion (67800/01/05 / J3301 typically)
- ✓ Excision of lid lesions (67810/40, 11200)
- ✓ Botox injections (64612 / J0585)
- ✓ Suturing lacerations (12051-57, 67930/35)

NOTE: All descriptions, documentation and coding recommendations based on available CMS carrier directives. Rules may differ for other medical payers.

4

SURGERY PROCEDURES

5

General Overview
How is Surgery Different?

- Surgery is almost always a **planned event** – if you find you are not doing it that way, reconsider.
- Why??? Because there is a **50% payment penalty** for every surgical procedure past the first surgery performed during the same encounter.
- Documentation requirements for surgery are FAR less precise and stated in payment policy – mostly center around an **operative report**
- Reimbursement for surgical procedure may or may not include post-operative care – more on that next

6

GLOBAL SURGERY PERIODS

7

Global Surgery Periods

- The global surgery period includes:
  - The day before the surgery (major surgeries only)
  - The day of the surgery
  - A designated number of days after the surgery period – either 0, 10, or 90 (post-op period)
- All minor surgery procedures have a zero to 10-day global surgery period (it's actually 11 days!)
- All major surgery procedures have a 90-day global surgery period (it's actually 92 days!)

https://med.noridianmedicare.com/web/jeb/specialties/surgery/global-surgery

8

Global Surgery Periods

- **20% of the surgical fee** is designated as reimbursement during the post-op period
- The post-op fee covers **ALL services during the post-op period that are related to or a complication from surgery** – ALL OF THEM *(don't play games here)*!
- CMS has rumored for over five years that the whole Global Surgery payment system will be eliminated

9

SURGERY MODIFIERS

(unlike non-surgical services, modifiers are hard to avoid in surgical services)

10

Surgery Modifiers

There are three groups

1. Those used **before** the surgery (pre-operative)
2. Those used **during** the surgery (intra-operative)
3. Those used **after** the surgery (post-operative)

11

Surgery Modifiers Before Surgery

Modifier 57: An evaluation and management service that resulted in the initial decision to perform the surgery

This is the first attempted way around the inclusion of the E/M service the day of surgery into the surgical fee…***but not really***. This code is very difficult to justify and mostly limited to emergency care – VERY uncommon in primary ocular surgery

Forget it exists….

12

Surgery Modifiers Before Surgery

Modifier 58: Staged or related procedure or service by the same physician during the post-operative period.

VERY ambiguous code. Applies:

- When the surgeon knew a second procedure would be needed before or during the first procedure
- Second procedure would be more extensive than the first
- Second procedure related to the first procedure

Let's put another way…I cannot think of a clinical situation related to your scope that would apply to this.

Forget it exists as well…

13

Surgery Modifiers Before Surgery

Modifier 25: Significant, separately identifiable evaluation and management service by the same physician on the day of the procedure or other service

This is one of the most mis-understood and improperly utilized modifiers in optometry. Second most audited modifier in Medicare. **IGNORE THE BLOG DESCRIPTIONS WHICH ARE OFTEN BETTER DESCRIBED AS FRAUD!**

A few examples should explain it!

14

Example: Proper use and billing of encounter with -25

Ms. Jones presents stating that morning she feels like she got makeup in her left eye and it is bothering her. Exam finds a makeup particles on her on her left cornea.

The left eye corneal FB is TOTALLY the primary reason for the visit and you CANNOT be paid for evaluating that primary complaint that is obviously related to the primary reason for the visit.

65222	**Removal of corneal FB, with slit lamp**
T15.02XA	**Corneal foreign body, left eye, initial encounter**

15

Example: Proper use and billing of encounter with -25

Ms. Jones presents for her scheduled SLT on her right eye. That morning she feels like she got makeup in her left eye and it is bothering her. Exam finds a mild scratch on her left cornea.

The left eye corneal abrasion is UNRELATED to the primary reason for the visit and you DESERVE to be paid for evaluating and treating that secondary complaint.

99213-25	**S05.00XA Injury to conjunctiva or cornea w/o FB**
65855	**H40.1112 POAG, moderate, right eye**

16

Caveat: Proper use and billing of encounter with -25

Do NOT play games with this code. It is strictly audited and interpreted. Perfect example of blog experts that WILL be denied.

Patient presents stating left eye hurts. Patient was sawing wood yesterday and eye started hurting after that. You find wood particles stuck to left cornea.

OK…phooey. The surgery fee pays less than an office visit so blog expert told me to bill the office visit and blow off the surgery fee.

NO – that breaks CPT rule stating you must bill for the service that most accurately describes the service delivered.

17

Surgery Modifiers During Surgery

Modifier 22: Increased procedural service

- A surgery turned out to be more complicated, took longer or had unanticipated complications.
- Attach modifier and request higher fee. Will need to attach a separate explanation and the medical record for review.
- Good luck…**probably can forget this one exists too**

18

Surgery Modifiers During Surgery

Modifier 50: Multiple procedures (same procedure) during same encounter

In most cases, any attempt to bill two of the same procedures during the same encounter will be denied. With the modifier, you are saying you want to be paid.

Good luck with that….

19

Surgery Modifiers During Surgery

Modifier 51: Multiple procedures (different procedure) during the same encounter

In most cases, every surgical procedure performed in addition to the primary procedure will have a 50% reduction in reimbursement. Attach a -51 modifier to the second and subsequent procedures and reduce your fee 50% **(whether you do or not - guarantee you will still have the fee reduced!)**.

20

Surgery Modifiers During Surgery

Modifier 51: Multiple procedures

Another thing to remember…

Some isolated payers REQUIRE that if you perform multiple procedures during the same encounter, you must attach the –AG modifier to the primary procedure and -51 to second and subsequent procedures. Just remember this if you run in to denials without –AG.

21

The –AG Modifier confusion continues…

The –AG modifier is the "primary physician" modifier. It is used to denote the primary surgeon when more than one surgeon is involved in the procedure.

Despite this clearly delineated use, isolated payers (not Medicare) state you must attach the modifier for all surgical claims.

22

Surgery Modifiers During Surgery

Modifier 52: Bilateral procedure

- Most all diagnostic tests are designated unilateral or bilateral (paid same whether you do one or both eyes). Exceptions are external and fundus photography. Use -52 modifier to indicate service on only one eye.
- Surgical codes are typically unilateral so this code would not apply.
- **SAME EXACT SURGERY BILLED TWICE DURING SAME ENCOUNTER WILL ALWAYS BE DENIED!**

23

Surgery Modifiers After Surgery

Modifier 24: "Unrelated E/M service by the same physician during a post-operative period"

Modifier 79: "Unrelated procedure or service by the same physician during a post-operative period."

- Examples of rare times when the payer system uses a rational thought process.
- Make sure services truly are unrelated – **again do not play games here.**

24

Surgery Modifiers After Surgery

Modifier 78: "Unplanned return to the operating or procedure room by the same physician following initial procedure for a related procedure during the post-operative period."

- The subsequent procedure was not planned/anticipated
- The subsequent procedure must take place in the operating room (can include a laser suite)
- The subsequent procedure must be related to the first
- **This would be very rare in optometric surgical services**

25

So, we made modifiers pretty easy!

For the most part all you need to remember

-25 E/M service unrelated to reason for visit
-24 E/M service during postop unrelated to surgery
-79 Other procedure during postop unrelated to surgery

Maybe, sometimes

-AG Primary surgeon – sometimes primary surgical procedure
-50 Multiple, SAME surgery during same encounter
-51 Multiple, DIFFERENT surgeries during same encounter

26

OK…the details

27

Laser Peripheral Iridotomy (66761)

CHARACTERISTIC	
Major / Minor	Minor
Global Surgery Period	10 days
Unilateral / Bilateral	Unilateral
Can perform procedure on both eyes during same encounter?	Yes- report with -50 modifier on two lines with RT/LT identifiers but second eye reimbursement decreased 50%. In general you would want to avoid this practice.
LCD Reference	First Coast L29207*
Medicare Allowable	Around $305

- **Regarding LCD: Noridian has no payment policies on any of these procedures. They are allowed to use any other carrier determinations. The most cited carrier is First Coast Service Option - https://www.fcso.com WHY FIRST COAST?**

28

LPI Documentation and Coding LCD L29207

- *"Iridotomy by laser surgery is a procedure to treat a variety of angle-closure glaucomas that have **at least some component of pupillary block.**"*
- *"Iridotomy by laser surgery will be considered medically necessary and reasonable to treat **acute, sub-acute, intermittent or chronic angle-closure glaucoma.**"*
- *"Additionally, when a patient is noted to have **an occludable angle upon gonioscopic examination**, even in the absence of symptoms, a peripheral iridotomy may be performed to prevent angle-closure glaucoma."*

29

LPI Documentation – The BIG One

"The patient's medical record must clearly show the medical necessity of performing the procedure including, but not limited to, the symptoms experienced by the patient, the intraocular pressure and the status of the angle as evaluated with gonioscopy."

30

Laser Peripheral Iridotomy Preferred Practice Patterns

https://www.aao.org/summary-benchmark-detail/glaucoma-summary-benchmarks-2020

Management Plan for Patients in Whom Iridotomy is Indicated

- Iridotomy may be considered to **reduce the risk of developing angle closure**
- In acute angle-closure crisis (AACC), use **medical therapy first** to lower the IOP to reduce pain and to clear corneal edema. Iridotomy should then be performed as soon as possible.
- Laser iridotomy is the **preferred surgical treatment for AACC (MAYBE!)**. Patients with PACS who have not had an iridotomy should be warned of risk for AACC and certain medicines could cause pupil dilation and induce AACC
- The **fellow eye should be scheduled for a prophylactic iridotomy** if the chamber angle is anatomically narrow, since approximately half of fellow eyes can develop AACC within 5 years
- Given the lack of convincing evidence for prophylactic use of iridoplasty in patients with plateau iris, the decision of whether to observe or treat these eyes is left to the judgment of the testing ophthalmologist

31

Laser Peripheral Iridotomy Preferred Practice Patterns

https://www.aao.org/summary-benchmark-detail/glaucoma-summary-benchmarks-2020

The ~~ophthalmologist~~ optometrist has the following responsibilities:

- **Obtain informed consent** from the patient or patient's surrogate decision maker after discussing the risk, benefits, and expected outcome of surgery
- Ensure that preoperative evaluation **confirms the need for surgery**
- Consider the preoperative use of **a parasympathomimetic** to facilitate LPI
- Use topical ocular **hypotensive agents perioperatively** to prevent sudden IOP elevation
- **Ensure the patency of the iridotomy** by directly visualizing fluid flow of aqueous and pigment from the posterior to anterior chamber. Visualization of a red reflex alone is insufficient to confirm patency.
- Enlarge the iridotomy as necessary to achieve diameter of **at least 100 microns**
- **Perform at least one IOP check immediately prior to surgery and within 30 minutes to 2 hours following surgery**
- Prescribe **topical corticosteroids** in the postoperative period
- Ensure that the patient receives adequate postoperative care **(NO criteria)**

32

Laser Peripheral Iridotomy Preferred Practice Patterns

"Laser peripheral iridotomy is the standard first-line treatment in closed angle glaucoma and eyes at risk for this condition." Glaucoma Research Foundation 10/1/2020

TRUE???

33

J Glaucoma. 2021 Apr 1;30(4):332-339. doi: 10.1097/IJG.0000000000001799.

Ten-Year Clinical Outcomes of Acute Primary Angle Closure Randomized to Receive Early Phacoemulsification Versus Laser Peripheral Iridotomy

Poemen P Chan [1 2], Fang Y Tang [1], Dexter Y Leung [1 3], Thomas C Lam [1 2], Nafees Baig [1 4 3], Clement C Tham [1 2 5]

Affiliations + expand

PMID: 33769358 DOI: 10.1097/IJG.0000000000001799

Abstract

Purpose: To compare the 10-year clinical outcomes of eyes with acute primary angle closure (APAC) randomized to receive either early phacoemulsification or laser peripheral iridotomy (LPI).

Methods: Sixty-two APAC patients, who underwent either early phacoemulsification (phaco group) or laser peripheral iridotomy (LPI group) in a previous randomized controlled trial, were invited for assessment 10 years after the interventions. The results of the 2 groups were compared.

Results: Forty of 62 patients (64.5%; 19 in phaco group and 21 from LPI group) were examined. None of them underwent additional glaucoma procedure but 15 (71.4%) patients in the LPI group received lens extraction before this assessment. The mean follow-up duration was 10.7±0.7 years. The phaco group used less medication (0.16±0.37 vs. 0.76±1.09 bottle per eye, P=0.028), had less extensive anterior synechiae (120.0±116.12 vs. 244.3±139.8 degree, P=0.010), and greater mean Shaffer gonioscopy grading (1.79±0.84 vs. 1.40±0.67; P=0.021) than the LPI group. Five eyes had persistent intraocular pressure elevation of >21 mm Hg in 2 consecutive visits and 4 eyes had blindness (best-corrected visual acuity worse than 6/60 and/or central visual field of <20 degree) in the LPI group, compared with none in the phaco group (P=0.022 and 0.045, respectively). There was no significant difference in the mean intraocular pressure, best-corrected visual acuity, and the number of eyes with visual field progression.

Conclusion: At 10 years, APAC eyes that underwent early phacoemulsification required less medication, less peripheral anterior synechiae, lower incidence of intraocular pressure elevation and a lower incidence of blindness compared with APAC eyes that underwent initial LPI.

Early phaco group required less meds, had less PAS, and lower incidence of IOP elevation and BLINDNESS compared with LPI.

34

Effectiveness of early lens extraction for the treatment of primary angle-closure glaucoma (EAGLE): a randomised controlled trial

Augusto Azuara-Blanco, Jennifer Burr, Craig Ramsay, David Cooper, Paul J Foster, David S Friedman, Graham Scotland, Mehdi Javanbakht, Claire Cochrane, John Norrie, for the EAGLE study group

Summary

Background Primary angle-closure glaucoma is a leading cause of irreversible blindness worldwide. In early-stage disease, intraocular pressure is raised without visual loss. Because the crystalline lens has a major mechanistic role, lens extraction might be a useful initial treatment.

Methods From Jan 8, 2009, to Dec 28, 2011, we enrolled patients from 30 hospital eye services in five countries. Randomisation was done by a web-based application. Patients were assigned to undergo clear-lens extraction or receive standard care with laser peripheral iridotomy and topical medical treatment. Eligible patients were aged 50 years or older, did not have cataracts, and had newly diagnosed primary angle closure with intraocular pressure 30 mm Hg or greater or primary angle-closure glaucoma. The co-primary endpoints were patient-reported health status, intraocular pressure, and incremental cost-effectiveness ratio per quality-adjusted life-year gained 36 months after treatment. Analysis was by intention to treat. This study is registered, number ISRCTN44464607.

Findings Of 419 participants enrolled, 155 had primary angle closure and 263 primary angle-closure glaucoma, 208 were assigned to clear-lens extraction and 211 to standard care, of whom 351 (84%) had complete data on health status and 366 (87%) on intraocular pressure. The mean health status score (0·87 [SD 0·12]), assessed with the European Quality of Life-5 Dimensions questionnaire, was 0·052 higher (95% CI 0·015–0·088, p=0·005) and mean intraocular pressure (16·6 [SD 3·5] mm Hg) 1·18 mm Hg lower (95% CI −1·99 to −0·38, p=0·004) after clear-lens extraction than after standard care. The incremental cost-effectiveness ratio was £14 284 for initial lens extraction versus standard care. Irreversible loss of vision occurred in one participant who underwent clear-lens extraction and three who received standard care. No patients had serious adverse events.

Lancet 2016; 388: 1389–97

See Editorial page 1349

See Comment page 1352

Centre for Public Health, Queen's University Belfast, Belfast, UK (Prof A Azuara-Blanco PhD); School of Medicine, University of St Andrews, St Andrews, UK (Prof A Azuara-Blanco, Prof C Ramsay PhD, D Cooper PhD, G Scotland PhD, C Cochrane MSc, Prof J Norrie PhD); Health Economics Research Unit (C Cochrane, M Javanbakht PhD), and Centre for Health Care Randomised Trials (Prof J Norrie), University of Aberdeen, Aberdeen, UK; NIHR Biomedical Research Centre, Moorfields Eye Hospital and University College London, London, UK (Prof P J Foster PhD); and

EAGLE study

Lens extraction showed 75% less loss of vision as compared to LPI

35

YAG Laser Capsulotomy (66821)

CHARACTERISTIC	
Major / Minor	Major
Global Surgery Period	**90 days**
Unilateral / Bilateral	Unilateral
Can Bill Bilateral?	Yes- report with -50 modifier on two lines with RT/LT identifiers but second eye reimbursement decreased 50%. In general you would want to avoid this practice.
LCD Reference	CMS L37644
Medicare Allowable	Around $335

36

YAG Capsulotomy Documentation and Coding L37644

- *"(YAG) laser capsulotomies are performed in cases of opacification of the posterior capsule, **generally** **no less than 90 days** following cataract extraction"*
- *"Diagnosis of functional visual impairment due to capsular opacification is based on **clinical judgment** regarding **one or more** of the following":*
  - *"Visual loss and/or symptom of glare (visual acuity 20/30 or worse under Snellen conditions, **OR** using contrast sensitivity, **OR** simulated glare testing);*
  - ***Symptoms of decreased contrast**;*
  - ***Documented amount of posterior capsular opacification** or;*
  - *Other possible causes of decreased vision following cataract surgery."*

37

YAG Capsulotomy Documentation and Coding L37644

- *"This procedure will not be covered within 3 months post cataract surgery unless justified by **one of** the following indications:*
  - *Posterior capsular plaque/opacity which **cannot be safely removed during primary phacoemulsification** cataract procedure*
  - ***Capsular block** during which cataract remnants and fluid become trapped within the lens capsule and addressed with YAG laser posterior capsulotomy*
  - ***Contraction of the posterior capsule** with displacement of the intraocular lens."*

IT'S ALL ABOUT ADEQUATE MEDICAL RECORD DOCUMENTATION!!!

38

YAG Capsulotomy: Preferred Practice Patterns (AAO)

- Frequency of PCO noted between 5-54%
- Incidence increase with:
  - Capsular wrinkles
  - Hydrophilic IOLs
  - Younger patients
- Indication based on ***"impairment of vision to a level that does not meet the patient's functional needs or critically interferes with visualization of the fundus"*** ***(NOTE: Not exactly the same as the LCD – but close!)***

39

Laser Trabeculoplasty (65855)

CHARACTERISTIC	
Major / Minor	Minor
Global Surgery Period	10 days
Unilateral / Bilateral	Unilateral
Can Bill Bilateral?	Yes- report with -50 modifier on two lines with RT/LT identifiers but second eye reimbursement decreased 50%. In general you would want to avoid this practice unless dictated by emergent situation.
LCD Reference	First Coast l33917
Medicare Allowable	Around $249

40

Laser Trabeculoplasty LCD L33917

- *"Argon Laser Trabeculoplasty (ALT), Selective Laser Trabeculoplasty (SLT), and Diode Laser Trabeculoplasty (DLT) will be considered medically necessary and reasonable for the following indications:*
  - ***Primary treatment** for open-angle glaucoma*
  - *Primary open-angle glaucoma when the raised intraocular pressure is **unresponsive to topical or oral medications***
  - *Primary open-angle glaucoma with **normal pressure** and evidence of optic nerve damage.*
  - *Patient is **unable to tolerate medications**."*

41

Laser Trabeculoplasty LCD L33917

- *"The medical record should include documentation of symptoms, intraocular pressure, the status of the angle and the status of the disc.*
- *It is expected that these services would be performed as indicated by current medical literature and/or standards of practice."*

42

Laser Trabeculoplasty: Preferred Practice Patterns (AAO)

- Laser trabeculoplasty may be used as **initial or adjunctive therapy** in patients with POAG. Laser trabeculoplasty is effective in lower IOP and may be performed to 180 degrees or 360 degrees of the angle
- The ~~ophthalmologist~~ optometrist who performs surgery has the following responsibilities:
  - Obtain **informed consent** from the patient or patient's surrogate decision maker after discussing the risk, benefits, and expected outcomes
  - Ensure that the **preoperative evaluation** confirms that surgery is indicated
  - At least one **IOP check** immediately prior to surgery and within 30 minutes to 2 hours after surgery
  - Follow-up examination within **6 weeks of surgery** or sooner if concern about IOP-related damage to the optic nerve

43

Laser Trabeculoplasty: Preferred Practice Patterns - AAO

Medications that are not being used chronically may be used perioperatively to **avert temporary IOP elevations**, particularly in those patients with severe disease. 2017 Cochrane Systematic Review found that perioperative medications are superior to no medication to prevent the occurrence of spikes in IOP but it was **unclear whether one medication was better than other medications** in this class of drugs. Therefore, in consultation with the individual patient, treating ophthalmologists should use perioperative medications if temporary IOP elevations are a concern. **Brimonidine has been shown to be as effective as apraclonidine** in preventing immediate IOP elevation after laser trabeculoplasty. **Treating 180 degrees reduces the incidence and magnitude of postoperative IOP elevation** compared with 360-degree treatment.

44

Laser Trabeculoplasty Preferred Practice Patterns

So…is SLT considered A / THE primary treatment for open-angle glaucoma?

YES. The only Medicare Administrative Contractor (MAC) with a specific policy, First Coast Service Options, considers SLT as a primary treatment for OAG (primary and low tension)

45

And what about a yearly tune-up

Multiple studies confirm that low power, yearly SLTs result in sustained IOP control as far out as ten years – esp. the **LiGHT Study**. In the LiGHT Study, 21 of 32 patients undergoing yearly SLT treatment were **controlled without meds at 10 year follow up** – superior to standard medication therapy.

https://pubmed.ncbi.nlm.nih.gov/28903966/

46

Parameters for a yearly tune-up

Standardization of SLT delivery was achieved by protocol-defined settings and clinical end points. The protocol defined 360-degree TM treatment, delivered by 100 non-overlapping shots (25 per quadrant) of a preset 3 nanoseconds duration and preset 400-µm spot size, with the laser energy from 0.3 to 1.9 Mj.

Many ophthalmologists have adopted this strategy as a standard treatment.

47

Chalazion Treatment

Billing for surgical treatment of chalazion dependent on three service items:

- Chalazion excision – 67800/01/05
  - 67800 Single chalazion excision/removal
  - 67801 Multiple chalazia, same eyelid
  - 67805 Multiple chalazia, different eyelid
- Intralesional injection - 11900
- Medication
  - Triamcinolone (most common) – J3301

48

Chalazion Excision / Injection
67800/01/05
11900 + J-Codes for Medication)

CHARACTERISTIC	
Major / Minor	Minor
Global Surgery Period	67800/01/05 are 10 days - 11900 is 0 days
Unilateral / Bilateral	Unilateral – report with eyelid code (E1-E4)
Can Bill Excision AND Injection?	Yes- report with eyelid code (E1-E4) + 11900-51 + J-Code for medication used
LCD Reference	Noridian L33979
Medicare Allowable	**Excision:** 67800 – around $133; 67801 around $165; 67805 around $204 **Injection:** 11900 around $57

49

Lesion Removal - Know which code to use!

67810 – if eyelid lesion **partially removed and sent for biopsy**

67840 – if **eyelid total lesion removed** with or without biopsy (this is by far the most common service code used!)

68100 – if **conjunctival lesion totally removed with biopsy**

What about **11200**?

This is the code for removal of **cosmetic skin lesions**. This typically would include "skin tags", cutaneous horns – **anything where ONLY skin is removed**. Coverage for these types of lesions vary but TYPICALLY denied. Either collect up front from patient (best idea) or bill to insurance and obtain signed ABN from patient.

50

Skin lesion removal (67810/40, 68100 and 11200)

CHARACTERISTIC	
Major / Minor	Minor
Global Surgery Period	11200 – 10 days; 67810/40 and 68100 – 10 days
Unilateral / Bilateral	Unilateral. Use eyelid modifier (E1-E4) or for conjunctiva eye modifier (RT/LT)
Can Bill Multiple Lesion Removal?	Yes- report with -51 on second and subsequent lesions all with appropriate location modifiers.
LCD Reference	Noridian L33979
Medicare Allowable	67810 – around $192 67840 – around $294 68100 – around $187 11200 – your UCR

51

Medicare Noridian LCD
Benign Skin Lesion Removal 33979

- Removal of benign skin lesions that **do not pose a threat to health or function is considered cosmetic** and as such is not covered by the Medicare.
- Medicare will consider the removal of benign skin lesions as medically necessary, and not cosmetic, if one or more of the following conditions is present and clearly documented in the medical record:
  - The lesion has one or more of the following characteristics:
    - **Bleeding**
    - **Intense itching**
    - **Pain**
  - The lesion has physical evidence of **inflammation**, e.g., purulence, oozing, edema, erythema.
  - The lesion **obstructs an orifice or clinically restricts vision**.
  - The clinical diagnosis is uncertain and malignancy is a realistic consideration. **However, if the diagnosis is uncertain, either biopsy or removal may be more prudent than destruction.**
  - A **prior biopsy** suggests or is indicative of lesion malignancy or premalignancy.
  - The lesion is in an anatomical region subject to **recurrent physical trauma** and there is documentation that such trauma has in fact occurred.
  - Wart removals will be covered under the above. In addition, wart destruction will be covered when the following clinical circumstance is present:
    - Periocular warts associated with chronic recurrent conjunctivitis thought secondary to **lesional virus shedding**
    - **Evidence of spread** from one body area to another, particularly in immunocompromised/immunosuppressed patients.

52

What about microdissection radio frequency ablation (MRA) procedures? (Ellman, etc)

Fantastic way to incise, excise and remove skin lesions (eyelid) but considered simply a substitute for a knife…there are no codes specific to MRA technique and no additional reimbursement. But…

- ✓ Easy to learn
- ✓ Nearly bloodless field
- ✓ No lateral heat
- ✓ Minimal postop pain
- ✓ Rapid healing

Ellmann
Cooper
Valley Lab Force **OPTIONS**
Wallach
Circon

53

Botox injection (64612 + J0585)

CHARACTERISTIC	
Major / Minor	Minor
Global Surgery Period	10 days
Unilateral / Bilateral	Unilateral – payment limited to one injection per body side
Can Bill Bilateral?	Yes- report with -51 modifier on two lines with RT/LT identifiers but second eye reimbursement decreased 50%. In general you would want to avoid this practice.
LCD Reference	Noridian L35172
Medicare Allowable	Around $135

54

Botox utilization in eyecare

- ✓ Hemifacial spasm
- ✓ Blepharospasm
- ✓ Certain strabismic conditions (non-accommodative especially of smaller amount)
- ✓ Eyelid retraction (thyroid)
- ✓ Aberrant nerve regeneration in Bell's Palsy

55

Medicare Noridian LCD Botulinum Toxin Types A and B

- Before consideration of coverage may be made, it should be established that the patient has been **unresponsive to conventional methods of treatments. Exception – blepharospasm**
- Repeat treatments considered not medically necessary unless **documentation of positive effect from initial treatment**.
- **Payment made per injection site** – one eyelid=one injection site
- **Not covered for skin wrinkles, strabismic deviations over 50 prism diopters, restrictive strabismus, paralytic strabismus or Duane's Syndrome**

56

Billing Medication Codes

- Injected medication reimbursement is based on amount used defined as a unit – **1 unit of medication yields 1 unit of reimbursement**
- With multiple use vial medications, reimbursement based on number of units utilized. Triamcinolone is a multiple vial med- one unit is designated at 10ml (10ml = 1 unit). If you use less than 1 unit, must specify amount discarded with –JW modifier.
- With single vial medications, reimbursement based on amount in the vial. Botox is a single vial med – one unit is one vial. Must specify amount used and amount discarded.

Find out more at: https://med.noridianmedicare.com/web/jeb/topics/drugs-biologicals-injections

NOTE: Where you record medication amounts used and discarded is TYPICALLY on Line 19 but can vary widely based on nuances of individual payers.

57

Reporting Medication Use

- Due to the short life of Botulinum toxin, Medicare will reimburse the unused portion of these drugs only when vials are not split between patients. Use modifier JW to code for drug wastage on a separate line of the claim form. The documentation must show in the patient's medical record the exact dosage of the drug given, exact amount and reason for unavoidable wastage, and the exact amount of the discarded portion of the drug.
- Scheduling of more than one patient is encouraged to prevent wastage of Botulinum toxins. If a vial is split between two patients, the billing in these instances must be for the exact amount of Botulinum toxin used on each individual patient. Medicare would not expect to see billing for the full fee amount for Botulinum toxin on each beneficiary when the vial is split between two or more patients.

58

Suturing Lacerations (multiple 12000; 67930/35)

CHARACTERISTIC	
Major / Minor	Minor
Global Surgery Period	All 10 days
Unilateral / Bilateral	Unilateral
Can Bill More Than One Repair?	Yes- report with -51 modifier on two lines with RT/LT identifiers but second eye reimbursement decreased 50%. In general you would want to avoid this practice.
LCD Reference	None
Medicare Allowable	67930 around $385; 67935 around $613 12011-12017 codes range $290 - $633

Per CPT, cannot bill suturing laceration codes in repair of wound dehiscence

59

Which code??? Typically NOT These!

Intermediate Repair (12031-12057)

Unusual use – requires deep repair or layered suturing

Complex Repair (13100-13160)

Rare use- scar revisions and the like

Repair involving lid margin (67930-67935)

Rare use – requires repair of lid margin

All better served by oculoplastic specialist

60

Which code??? THESE!

Simple Repair (12001 – 12021)

A simple wound repair code is used when the wound is **superficial**, primarily involving **epidermis, dermis, or subcutaneous tissues** without significant involvement of deeper structures where only **one layer of closure** is necessary using **sutures, staples, tissue adhesive**, or other closure materials. Simple repair can be billed for **chemical and electrocauterization of wounds** not closed and include local anesthesia

You will use 12011-12017 (eye) – depends on length of repair

- 12011: 2.5 cm or less
- 12012: 2.6cm to 7.5cm
- 12014: 7.6cm t 12.5cm
- 12015: 12.6cm to 20.0cm
- 12016: 20.1cm to 30.0cm
- 12017: over 30.0cm

61

DOCUMENTATION AND CODING

OPERATIVE REPORTS

62

In general

- The medical record, typically on the prior visit, must demonstrate medical necessity for the surgery
  - If you are audited, send the prior encounter along with the documentation from the day of surgery
- Reason for visit day of surgery should clearly indicate what you are doing

"Physician directed LPI to reduce risk of acute angle closure"

- Some payers have specific documentation requirements
- Most all payers require an operative report

63

Operative Reports

NOTE: There are few to no written standards for operative report. What I present is my opinion but pretty much guarantee will survive any audit!

- ✓ Procedure(s) performed
- ✓ Indication(s) for surgery
- ✓ Complexity statement (if billing -22 modifier)
- ✓ Notation of anesthesia
- ✓ Description of procedure
- ✓ Discharge instructions
- ✓ Physician signature

64

Operative Reports

Procedure(s) performed

- ✓ You can simply list the correct CPT designation
- ✓ Make sure this matches what your prior records state you are going to do

Indication(s) for surgery

- ✓ A sentence stating why you are doing the surgery
- ✓ A specific ICD-10 code that matches diagnosis(s) in prior medical record

65

Operative Reports

Complexity statement

- ✓ Only required if asking for increased reimbursement using -22 modifier
- ✓ Will have to write a lot – auditor must "feel your pain"

Notation of anesthesia

- ✓ Almost always local
- ✓ State anesthetic and mode of administration (typically either topical or injection)
- ✓ Note any reactions to anesthesia

66

Operative Reports

Description of procedure
- ✓ Somewhat detailed including eye involved, instrument(s) used, any complications. For lasers include wavelength, number and size of spots, time or duration, and use of laser lens

Discharge instructions
- ✓ Statement that patient tolerate procedure well
- ✓ Postop instructions – heat/cold, medications, restricted activities, instructions related to pain and/or bleeding

Physician signature

67

Operative Reports

- ✓ Easiest way to manage is **standardized form** created inside EMR
- ✓ If not option of EMR, create standardized form and scan into EMR
- ✓ If not using EMR, create standardized form and keep in patient's file

68

Let's all work for an optometry with a scope we and our patients deserve!!!

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69

CODING EXAMPLES (for reference)

70

Laser peripheral iridotomy

Patient returns to office on Tuesday after medical management of AAC in the right eye the night before

Dx: H40.211
Procedures:
1. Primary reason for visit related to need for surgery – NO office visit
2. 66761-RT
3. Schedule postop visit in one week (optional – inside Global Period)
4. Schedule prophylactic iridotomy on left eye in two weeks

71

YAG laser capsulotomy #1

Patient returns for scheduled YAG in the right eye after prior examination revealed capsular opacification obscuring functional vision in both eyes

Dx: H26.40
Procedures:
1. Primary reason for visit related to need for surgery – NO office visit
2. 66821-RT
3. Schedule medically necessary postop visit

72

YAG laser capsulotomy #2

Patient returns for scheduled YAG in both eyes after prior examination revealed capsular opacification obscuring functional vision

Dx: H26.40
Procedures:
1. Primary reason for visit related to need for surgery – NO office visit
2. Line 1 66821-RT
   Line 2 66821-LT-50 **Note fee reduced by 50%** (if you don't payer will anyway!)
3. Schedule medically necessary postop visit

73

Selective laser trabeculoplasty

Patient presents for physician directed moderate POAG examination. Patient reports can no longer use drops well due to progressive arthritis in fingers. SLT RT performed.

Dx: H40.1132
Procedures:
1. Primary reason for visit related to need for surgery – NO office visit
2. 65855-RT
3. Schedule 65855-LT in two weeks (outside Global Period – can also count as postop RT but would still not qualify for office visit)

NOTE: Much better decision to schedule the SLT after the glaucoma progress visit

74

Chalazion treatment #1

Patient presents concerned over non-tender bump in upper right eyelid. Dx chalazion and recommend intralesional steroid injection. You draw 10ml triamcinolone but only use 5ml

Dx: H00.11
Procedures:
1. Primary reason for visit related to need for surgery – NO office visit
2. 11900-E3
   J3301 – unit of 1
   J3301-JW
3. Usually, in line 19 note 5ml administered and 5ml discarded

75

Chalazion treatment #2

Patient presents concerned over non-tender bump in upper right eyelid. Dx chalazion and recommend intralesional steroid injection – patient instructed to return for that treatment. You draw and inject 10ml triamcinolone.

Dx: H00.11
Procedures:
1. Appropriate level office visit
2. Upon return for treatment
   1. 11900-E3
   2. J3301 – unit of 1

76

Chalazion treatment #3

Patient presents concerned over non-tender bumps in upper right eyelid (3). Dx chalazion and recommend intralesional steroid injection – patient instructed to return for that treatment.

Dx: H00.11
Procedures:
1. Appropriate level office visit
2. Upon return for treatment
   1. 11900-E3-50 Unit of 3 – increase fee X3

   OR – have seen recommended

   1. 11900-E3 Unit of 1
      11900-E3-50 Unit of 1
      11900-E3-50 Unit of 1

77

Chalazion treatment #4

Patient presents concerned over non-tender bump in right upper eyelid with a long history of multiple recurrence. Dx chalazion and recommend excision and intralesional steroid injection – patient instructed to return for that treatment. You excise the chalazion, draw and inject 10ml triamcinolone.

Dx: H00.11
Procedures:
1. Appropriate level of initial examination
2. Upon return for treatment
   1. 67800-E3
   2. 11900-E3-51
   3. J3301 – unit of 1

NOTE: When billing multiple procedure code, always list the higher reimbursing procedure as primary

78

Lesion removal #1

Patient presents for routine examination. Also states does not like cosmetic appearance of growth on eyelid. You diagnose as cutaneous horn.

Dx: L91.8
Procedures:
1. Primary reason for visit related to need for surgery – BUT surgery not medical necessary and billed to patient so can bill office visit

See next slide for three ways to bill this.

79

OPTION ONE
92004 or S0620 with vision diagnosis to patient or vision plan
11200 collect from patient
(LIKELY BEST OPTION WITH MAXIMUM REIMBURSEMENT)
OPTION TWO
99203 with medical diagnosis to patient or medical payer
11200 collect from patient
(SECOND BEST OPTION – DOESN'T AS ACCURATELY FOLLOW REASON FOR VISIT AND MAY HAVE LOWER REIMBURSEMENT)
OPTION THREE
99203 with medical diagnosis to medical payer
11200 with medical diagnosis to medical payer; obtain ABN from patient if insurance denies (which is very likely)
(WORST OPTION – CHASING PATIENT DOWN FOR UNPAID INSURANCE CLAIM NEVER FUN)

80

Lesion removal #2

Patient returns after routine visit for surgical removal of mole from left upper eyelid diagnosed at last visit.

Dx: D22.1
Procedures:
1. Primary reason for visit related to need for surgery – NO office visit
2. 67840-E1
3. Schedule follow up visit (NOTE: If outside the 10-day Global Period you are fee to bill for that visit)

81

Botox treatment

Patient presents concerned over constant twitching of right eyelid. Has been present for months and nothing will stop it. You recommend patient return for botox injection.

Dx: G24.5
Procedures:
1. Primary reason for visit related to need for surgery – NO office visit
2. 64612-RT (NOTE: Some payers prefer eyelid identifier)
   J0585 unit of 1
   J0585-JW
   Typically box 19, indicate amount administered and amount discarded

82

Repair of laceration

Patient presents for emergency visit after being "poked" in eye in a basketball game. A 5cm eyelid laceration is noted on the right upper eyelid. Repair is recommended.

Dx: S01.111A
Procedures:
1. Primary reason for visit related to need for surgery – BUT this is an emergency presentation that requires an evaluation to determine need for surgery
2. 99203
   12012-E3
3. Schedule appropriate follow up – likely inside the Global Period

83

Repair of laceration

Patient presents after being scratched in the eye by a kitten. A 1 cm eyelid laceration is noted on the right upper eyelid. Repair is recommended which you perform using surgical glue. (**GLUE?** That's not a suture! Remember…*"simply repair can be made with chemical…")*

Dx: S01.111A
Procedures:
1. Unlikely can argue the point of an office visit like the prior example
2. 12011-E3
3. Schedule appropriate follow-up (again, if outside ten days the follow up visit is reimbursable. This is a minor injury.)

84