Code This, Not That—What to Submit for These Scenarios

Some choices are better than others. The scenarios below (plus three more online) show that this is as true in coding as it is elsewhere.

1. E/M Versus Eye Visit Codes

A new patient was seen for evaluation of a cataract that was affecting her activities of daily living. BCVA was documented, and the comprehensive exam found a worsening, visually significant cataract. The doctor decided to schedule surgery for the next available slot.

Code this: 99204, which is the level 4 new patient E/M code.

Not: 92004, which is the comprehensive new patient Eye visit code.

Explanation: Although the documentation supports coding either 99204 or 92004, the average payment for this E/M code is around $17 more than for the Eye visit code. If a cataract surgeon only billed Eye visit codes and performed 750 cases per year, collections would be $12,000 less per year compared with billing the E/M code. Furthermore, some commercial payers have frequency edits for Eye visit codes but not for E/M codes. (Frequency edits limit the number of times that you can bill Eye visit codes in a year.)

2. Pterygium With Graft

Pterygium removal with sutured amniotic membrane tissue (AMT) placement was performed in a patient's right eye.

Code this: 65426–RT *Excision or transposition of pterygium; with graft.*

Not: 65420–RT *Excision or transposition of pterygium; without graft* and 65779–59-RT, *Placement of amniotic membrane on the ocular layer; single layer, sutured.*

Explanation: The descriptor for CPT code 65426 does not define the type of graft; therefore, the graft can include either conjunctival or AMT placement. Codes 65420 (without graft) and 65779 (placement of AMT) are bundled together, and it would not be appropriate to use modifier –59 to unbundle them.

3. Vitrectomy, IOL Exchange

An operative report documents the procedure as pars plana vitrectomy, removal of a dislocated IOL, and insertion of a new IOL into the left eye.

Code this: 66986–LT and 67036–LT for the IOL exchange and pars plana vitrectomy, respectively.

Not: 67121–LT *Removal of implanted material, posterior segment; intraocular* and 67036–59–LT, along with 66985-LT *Insertion of IOL prosthesis (secondary implant), not associated with concurrent cataract removal.*

Explanation: CPT code 67121 is bundled with 67036. Because both procedures were performed in the same structure (posterior segment) and same eye, it is not appropriate to unbundle with modifier –59. Additionally, CPT code 66986 represents more accurately the removal and insertion of the IOL.

Tip: When multiple CPT codes can be billed for the same patient encounter, the order in which you list those codes on CMS-1500 can impact how much you get paid. The first CPT code that you list will be paid at 100% of its allowable, and subsequent codes will be paid at 50% of their allowable. Because the allowable for a CPT code is based, in large part, on the number of Relative Value Units (RVUs) assigned to it, you should list multiple CPT codes based on their RVUs.

4. Canaloplasty and Goniotomy

During the same surgical session, both canaloplasty and goniotomy are performed in the patient's right eye.

Code this: 66174–RT *Transluminal dilation of aqueous outflow canal* [e.g., canaloplasty]*; without retention of device or stent.*

Not: 65820–RT *Goniotomy.*

Explanation: CPT codes 66174 and 65820 are bundled. Although 65820 has been assigned 24.41 RVUs, which is higher than the 18.36 RVUs of 66174, it is not appropriate to bill the goniotomy code. According to the AMA's *CPT Assistant,* only CPT code 66174 should be reported as it represents the service performed, and the incision through the trabecular meshwork is incidental to 66174. (For current coding guidance for canaloplasty and goniotomy, visit aao.org/migs.)

MORE ONLINE. For scenarios involving OCT, social determinants of health, and Botox wastage, see this article at aao.org/eyenet.

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