THE SUCCESSFUL OPHTHALMIC ASC

Complete Guide to Coding

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THE SUCCESSFUL OPHTHALMIC ASC:

Complete Guide to Coding

Any coding issue not addressed in this module should be e-mailed to **svicchrilli@aao.org**.

Written by:

Sue Vicchrilli, COT, OCS, Academy Coding Executive

Sue Vicchrilli's 29-year ophthalmic background includes all aspects of coding, reimbursement, practice management, and clinic and surgical assistance. Sue is the author of *EyeNet*'s Savvy Coder, AAOE's *Coding Bulletin*, the *Ophthalmic Coding Coach*, *Code This Case* and the *Ophthalmic Coding Module Series*.

Credits:

My thanks to those who contributed to the content based on their personal experiences in claims submission:

John M. Haley, MD, OCS
Charlotte A. Timmons
Trexler M. Topping, MD

Reviewer:

Donna Lock

Academy/AAOE staff:

Heather Serginia, Print Production Manager
James Frew, Senior Designer
Peggy Coakley, Administrative Manager
Sangeeta Fernandes, Program and Content Manager

Complete Guide to Coding | Survey data from the American Academy of Ophthalmology indicates that 40 percent of ophthalmologists own or have ownership in an ambulatory surgical center (ASC). Unlike physician billing, very little information is available about ASC billing that is ophthalmology specific. That need prompted research and development of this module.

What Defines an ASC?

Ambulatory surgical centers (ASCs) are commonly referred to as day surgery centers. They are freestanding facilities that operate exclusively for the purpose of providing outpatient surgical procedures to patients not requiring hospitalization.

The facilities must be surveyed and approved by Medicare.

The place of service (POS) for ASC claims is 24.

ASC facility claims are processed as assigned. Physician services provided in an ASC may be submitted as either assigned (participating) or nonassigned (nonparticipating).

Noncovered ASC services will be denied. For cosmetic procedures, payment is the responsibility of the patient. For noncosmetic, noncovered services, the surgeon is responsible for payment should the surgeon opt to provide the surgery in an ASC rather than in a hospital or in the office. An Advance Beneficiary Notice (ABN) is not required.

ASC Covered and Noncovered Procedures

Under the ASC payment system, Medicare has made facility payments to ASCs for only a specified list of covered surgical procedures. However, the November 2007 *Federal Register* revealed an expansion of approximately 790 procedures that became payable in an ASC beginning January 2008. More than 60 of the procedures were ophthalmic.

The current rule essentially permits all procedures to be performed in an ASC unless prohibited by CMS as posing a significant safety risk, requiring an overnight stay or containing in the CPT description the words "requiring hospitalization."

Examples:

- From the Eye and Ocular Adnexa section: CPT code 65273 Repair of laceration; conjunctiva, by mobilization and rearrangement, with hospitalization
- CPT code 92018 Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete
- 92019 limited
- And for a very few codes in the radiology section of CPT, payment is for the technical component (TC) only of 76519 Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation

All of the general coverage rules regarding the medical necessity of a given procedure for a given patient are applicable to ASC services in the same manner as to all other covered services.

The ASC facility service reimbursement rate includes:

- The use of an ASC facility, operating and recovery rooms, preparation area, emergency equipment and observation room, including the use of a waiting room or lounges by the patients and relatives
- Administrative services such as scheduling, record keeping, housekeeping and related items, coordination for discharge, utilities and rent
- Services connected to the procedure and other related services provided by nurses, orderlies, technical staff and others involved in the patient's care

- Radiology and laboratory services performed just before surgery or those integral to the performance of the procedure. Laboratory services that are performed under a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or chest X-rays are included in the ASC facility reimbursement rate.
- Anesthetic and any materials, disposable or reusable, needed to administer anesthesia
- Drugs and biologicals including preparation, administration and monitoring of patient
- Surgical dressings, supplies, splints, casts, appliances and equipment related to the surgical procedure
- Intraocular lenses for insertion during or after cataract surgery
- Supervision of the services of an anesthetist by the operating surgeon
- Therapeutic items
- Three units of blood and blood products per procedure

The ASC facility service reimbursement rate excludes:

- Physicians' services, including anesthesia
- The sale, lease or rental of durable medical equipment to ASC patients for use in their home
- All prosthetic devices except for intraocular lenses
- Leg, arm, back and neck braces
- Artificial legs, arms and eyes
- Services furnished by an independent laboratory
- Ambulance services
- Laboratory, X-ray and diagnostic procedures (other than those directly related to performance of the surgery)

Guidelines for Terminated Procedures

Procedures terminated for any reason before the ASC has expended "substantial resources" are not eligible for reimbursement, with the following exceptions:

The ASC is paid at 50 percent of the allowable rate if the procedure is terminated due to an onset of medical complications after the patient has been prepared for surgery and taken to the operating room, but before anesthesia has been induced. The ASC must use modifier -73 to report an outpatient procedure discontinued prior to the administration of anesthesia.

The ASC is paid at 100 percent of the allowed rate if the procedure is terminated after anesthesia has been induced. The ASC must use modifier -74 to report an outpatient procedure discontinued after the administration of anesthesia.

To document the claim for terminated surgery, the ASC must submit an operative report that specifies the following:

- The reason for termination
- Services actually performed
- Supplies actually provided
- Services not performed that would have been if surgery had continued
- Supplies not provided that would have been if surgery had continued

CPT Modifiers

Unacceptable Modifiers

Table 1 lists two CPT modifiers that are not recognized for use in ASC billing.

Table 1:
Unacceptable CPT Modifiers (TT)

CPT MODIFIER	DEFINITION
-50	Bilateral procedure
-51	Multiple procedures

Modifier -50 Bilateral Procedures

Modifier -50 is not an ASC-recognized modifier. Bilateral procedures should be reported as:

- a single unit on two separate lines; or
- with a "2" in the Until field.

The multiple procedure reduction of 50 percent payment for the second procedure applies to all bilateral procedures. See Table 2 for an example.

Table 2: Billing Bilateral Procedures

PROCEDURE CODE	DEFINITION	MEDICARE PAYMENT
15823-RT	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	$882.90
15823-LT	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	50 percent of $882.90, or $441.45

Modifier -51 Multiple Procedures

Modifier -51 is not an ASC-recognized modifier. When multiple surgical procedures are performed in the same operative session in an ASC, they are subject to the multiple procedure discount. Medicare will allow:

- 100 percent of the highest-paying surgical procedure on the claim
- 50 percent of the applicable payment rate for the other ASC-covered procedures

See the example in Table 3.

Table 3: Billing Multiple Procedures

PROCEDURE CODE	DEFINITION	MEDICARE PAYMENT
65875-RT	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); posterior synechiae	$876.30
66625-RT	Iridectomy, with corneoscleral or corneal section; peripheral for glaucoma (separate procedure)	50 percent of $572.40, or $286.20

Acceptable Modifiers

Table 4 lists six common CPT modifiers recognized for use in ASC billing.

Table 4: Acceptable CPT Modifiers

CPT MODIFIER	DEFINITION
-58	Staged or related procedure or service by the same physician during the postoperative period
-59	Distinct procedural service
-73	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia
-74	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia
-78	Unplanned return to operating room/procedure room for related procedures by the same physician during postoperative period
-79	Unrelated procedure or service by the same physician during postoperative period

Modifier -58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

For ASCs this means procedures performed the same day, some time following the original surgical case.

Modifier -59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. This modifier unbundles National Correct Coding Initiative (NCCI) edits.

Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

ASC NCCI edits may not be the same as physician NCCI edits.

Modifier -73 Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical predation (including sedation when provided and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure code and appended by modifier -73.

Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

Modifier -74 Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc.). Under these circumstances, the procedure started but terminated can be reported by its usual CPT code and appended by modifier -74.

Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

Modifier -78 Unplanned return to operating room/procedure room for related procedures by the same physician during postoperative period

This modifier should be used when the same surgeon returns the patient to the operating room during the global postoperative period for a procedure related to the original surgery.

Example: Cataract extraction with an IOL is performed in the right eye. During the 90-day global period, a YAG capsulotomy is performed in the same operative eye.

Modifier -79 Unrelated procedure or service by the same physician during postoperative period

This modifier applies to any unrelated surgical procedure performed during the global surgical period of another procedure.

Example: The second-eye cataract extraction is performed within the global period of the first eye.

HCPCS Modifiers

Table 5 summarizes and defines some Healthcare Common Procedure Coding System (HCPCS) modifiers.

Table 5: **Selected HCPCS Modifiers and Their Definitions**

HCPCS MODIFIER	DEFINITION
-E1	Left upper eyelid
-E2	Left lower eyelid
-E3	Right upper eyelid
-E4	Right lower eyelid
NOTE: -E modifiers prevent claims from being rejected as duplicate claims. They are typically recognized by Medicare payers only.	
-PA	Surgery wrong body part
-PB	Surgery wrong patient
-PC	Wrong surgery on patient
NOTE: Additional information on these modifiers can be found under **Billing Wrong Surgical or Other Invasive Procedure Performed on a Patient**.	
-LT	Left eye
-RT	Right eye
-SG	Indicating procedure was performed in the ASC. No longer required for claims on or after January 2008.
-TC	Technical component. When the physician owns the equipment, the test should be billed by appending -TC to the CPT code. The physician should bill -26 to indicate that he/she will be providing the interpretation and report of the test.

National Correct Coding Initiative

CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and eliminate improper coding of certain code pairs that are not separately payable except under certain circumstances. NCCI edits are based on current standards of medical and surgical coding practices with input from specialty societies such as the American Academy of Ophthalmology. NCCI is also referred to as the Correct Coding Initiative (CCI).

NCCI edits apply to services billed by the same provider for the same patient on the same date of service. There are two types of edits:

1. Those that under special circumstances can be unbundled by appending modifier -59 (indicator of 1), and
2. Mutually exclusive edits (indicator of 0) that are code pairs that can never be unbundled under any circumstances.

NCCI edits are updated quarterly: January 1, April 1, July 1 and October 1.

Services that are denied based on NCCI edits may not be billed to Medicare patients. The Advance Beneficiary Notice of Noncoverage (ABN) form cannot be used to seek payment from the beneficiary.

ASC NCCI edits may not always be the same as those that pertain to physician NCCI edits.

Note: To view NCCI edits, visit **http://www.aao.org/aaoesite/coding/#5**.

Site of Service Differential

Only the surgeon's payment is affected by site of service differential payment. Certain office-based services are subject to a facility-based reduction when performed in an ASC. Physician payment is higher when these services are performed in the office than in a facility.

Example: The physician performs CPT code 67904 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach. When the procedure is performed in the ASC, the surgeon's allowable is $589; it is $715 when the surgeon performs the procedure in the office.

Tissue, Devices and Injectable Drugs

Amniotic Membrane Tissue

Amniotic membrane tissue used in pterygium, wound repair or any other surgery is not separately payable by the insurance company. It is inappropriate to bill the patient for the cost of the tissue.

Corneal Tissue

The CMS Medicare Learning Network (MLN) Matters SE0742, with an implementation date of January 1, 2008, indicates that there is no change to the payment policy for corneal tissue acquisition. Payment for corneal tissue will continue to be made at a reasonable cost when corneal transplants are performed in ASCs.

Payment may be made by submitting HCPCS code V2785 Processing, preserving and transporting corneal tissue when associated with corneal transplant procedures performed in an ASC. Claims with code V2785 must be supported by an invoice from the supplying eye bank showing the actual cost incurred to acquire the corneal tissue. HCPCS code V2785 may be reimbursed as an add-on to the ASC facility fee. Invoices must be kept on file in the provider's office for carrier review and verification purposes.

Insurance companies may try to bundle the tissue with the surgical procedure. If you don't catch this in the original negotiations, it can be a costly error.

Glaucoma Valves

With the exception of HCPCS code 0192T Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach for the Express Shunt or Aquaflow, no other glaucoma devices are separately payable in an ASC.

According to CPT 2011, HCPCS code 0192T is slated to sunset in January 2014.

Gold Weights

Although gold weights were assigned HCPCS code L8610 Ocular implant in 1992, they are not separately payable when inserted in an ASC setting.

The ASC must absorb the cost. The patient is not responsible.

Injectable Drugs

Any drug not included in a surgical pack is separately billable with the appropriate HCPCS code when administered in the ASC. See Table 6 for some commonly administered drugs.

Table 6: **Drugs Commonly Administered in the ASC**

HCPCS CODE	DESCRIPTION	UNITS
C9257	Avastin	5
J0585	Botox	As needed
J0702	Celestone	As needed
J1100	Dexamethasone	As needed
J9190	5-FU	As needed
J2778	Lucentis	5
J2503	Macugen	As needed
J9250/J9260	Methotrexate (MTX)	As needed
C9256	Ozurdex	7
J3301	Triamcinalone (Kenalog)	As needed
J3300	Triesence	As needed
J3370	Vancomycin	As needed

Intraocular Lenses

Astigmatism-Correcting Intraocular Lenses (A-C IOLs) and Presbyopia-Correcting Intraocular Lenses (P-C IOLs)

CMS published HCPCS codes for reporting noncovered charges associated with the insertion of the toric IOL or the presbyopia-correcting IOL — also known as premium IOLs. The codes are:

- V2787 Astigmatism-correcting function of intraocular lens
- V2788 Presbyopia-correcting function of intraocular lens

ASCs may collect the dollar difference between the $105 already included in the cataract surgical fee and the additional cost of the premium IOL, plus a small handling fee.

New Technology Intraocular Lenses (NTIOL)

The ASC services include intraocular lenses (IOLs) effective for services furnished during or after March 1990.

As of May 18, 2000, ASCs will receive an additional $50 from Medicare when the surgeon implants during or subsequent to cataract surgery a new technology intraocular lens (NTIOL).

The FDA has classified IOLs into the following categories:

- Anterior chamber angle fixation lenses
- Iris fixation lenses
- Irido-capsular fixation lenses
- Posterior chamber lenses
- NTIOL Category 3. This category expired on February 26, 2011.

Table 7: **NTIOL Manufacturers and Models**

MANUFACTURER	MODEL
AMO	Tecnis Z9000, Z9001, Z9002, ZA9003, AR40xEM, Tecnis 1-Piece IOL ACB00
Alcon	AcrySof IQ SN60WF, Acrysert Delivery System Model SN60WS
Bausch & Lomb	Sofport L161AO, L161AOV, Akreos AO
Hoya	FY-60AD
STAAR	Affinity Collamer CQ2015A, CC4204A, Elastimide AQ2015A

For additional NTIOL information, visit the CMS website: **http://www.cms.gov/ASCPayment/08_NTIOLs.asp**.

Note: NTIOL Category 1 and NTIOL Category 2 expired in May 2005.

When ASC and Physician Claims Don't Match

When the physician is unable to perform an exam in the office, he or she may elect to perform an exam under anesthesia. There are two coding options:

- 92018 Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete
- 92019 limited

The ASC does not receive payment for either of these two codes. It is not appropriate to bill the patient.

The following sections offer examples by specialty where the surgeon and ASC claims do not match due to payer allowable.

Anterior Chamber Cases

Anterior Chamber Case 1 (Tables 8a and 8b)

Procedure(s): Phacoemulsification with intraocular lens implantation of the right eye and trabeculectomy of the right eye

Anterior Chamber Case 2 (Tables 9a and 9b)

Procedure(s): Cataract extraction with vitrectomy of the left eye

Table 8a: **ASC Claim**

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)	-RT	366.16 Nuclear sclerosis	$954.20
66172 Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	-RT	365.23 Chronic angle-closure glaucoma	50 percent of $876.30

Table 8b: **Surgeon Claim**

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
66172 Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	-RT	365.23 Chronic angle-closure glaucoma	$1,445
66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)	-RT	366.16 Nuclear sclerosis	50 percent of $744

Cornea Cases

Table 9a: ASC Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
67005 Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal	-LT	743.30 Congenital cataract, unspecified	$766.40
66840 Removal of lens material; aspiration technique, one or more stages	-LT	743.30 Congenital cataract, unspecified	50 percent of $620.30

Table 9b: Surgeon Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
66840 Removal of lens material; aspiration technique, one or more stages	-LT	743.30 Congenital cataract, unspecified	$689
67005 Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal	-LT	743.30 Congenital cataract, unspecified	50 percent of $468

Cornea Case 1 (Tables 10a and 10b)

Procedure(s): Repair of corneal laceration of the left eye and removal of metallic intraocular foreign body of the left eye

Table 10a: ASC Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
65280 Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue	-LT	871.0 Ocular laceration without prolapse of intraocular tissue	$766.40
65235 Removal of foreign body, intraocular; from anterior chamber of eye or lens	-LT	360.51 Foreign body, magnetic, in anterior chamber	$589.80

Table 10b: Surgeon Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
65235 Removal of foreign body, intraocular; from anterior chamber of eye or lens	-LT	360.51 Foreign body, magnetic, in anterior chamber	$681
65280 Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue	-LT	871.0 Ocular laceration without prolapse of intraocular tissue	50 percent of $663

Cornea Case 2 (Tables 11a and 11b)

Procedure(s): Repair full-thickness scleral corneal laceration of the left eye

Table 11a: ASC Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
67005 Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal	-LT	871.1 Ocular laceration with prolapse or exposure of intraocular tissue	$766.40
65280 Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue	-LT	871.1 Ocular laceration with prolapse or exposure of intraocular tissue	50 percent of $766.40

Table 11b: Surgeon Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
65280 Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue	-LT	871.1 Ocular laceration with prolapse or exposure of intraocular tissue	$663
67005 Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal	-LT	871.1 Ocular laceration with prolapse or exposure of intraocular tissue	50 percent of $468

Cornea Case 3 (Tables 12a and 12b)

Procedure(s): Removal of corneal, limbal and conjunctival squamous cell carcinoma superiorly measuring two relatively circular lesions adjacent to each other of approximately 8 to 10 mm each with an adjacent small amount of corneal epithelium and conjunctival epithelium on either side for a margin

Table 12a: **ASC Claim**

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
68115 Excision of lesion, conjunctiva; over 1 cm	-LT	190.3 Malignant neoplasm of conjunctiva	$646.60
65400 Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium	-LT	190.4 Malignant neoplasm of cornea	50 percent of $563

Table 12b: **Surgeon Claim**

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
65400 Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium	-LT	190.4 Malignant neoplasm of cornea	$578
68115 Excision of lesion, conjunctiva; over 1 cm	-LT	190.3 Malignant neoplasm of conjunctiva	50 percent of $177

Glaucoma Case (Tables 13a and 13b)

Procedure(s): Repair of exposed Ahmed valve of the right eye, using tuboplasty and conjunctival autograft

Table 13a: **ASC Claim**

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
66185 Revision of aqueous shunt to extraocular reservoir	-RT	996.59 Infection and inflammatory reaction due to other implant and internal device	$832.60
67255 Scleral reinforcement (separate procedure); with graft	-RT	996.59 Infection and inflammatory reaction due to other implant and internal device	50 percent of $738

Table 13b: **Surgeon Claim**

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
67255 Scleral reinforcement (separate procedure); with graft	-RT	996.59 Infection and inflammatory reaction due to other implant and internal device	$829
66185 Revision of aqueous shunt to extraocular reservoir	-RT	996.59 Infection and inflammatory reaction due to other implant and internal device	50 percent of $732

Oculoplastics Cases

Oculoplastics Case 1 (Tables 14a and 14b)

Procedure(s):

1. Cicatricial ectropian repair with lysis of scar and full thickness skin graft, left eye
2. Harvesting of full thickness skin graft from left clavicle 50 x 20 mm
3. Placement of Frost suture, left eye

Table 14a: **ASC Claim**

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
67966 Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin	-LT	374.14 Cicatricial ectropion	$661.80
15260 Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids and/or lips; 20 sq cm or less	-LT	374.14 Cicatricial ectropion	50 percent of $584

Table 14b: **Surgeon Claim**

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
15260 Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids and/or lips; 20 sq cm or less	-LT	374.14 Cicatricial ectropion	$871
67966 Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin	-LT	374.14 Cicatricial ectropion	50 percent of $649

Oculoplastics Case 2 (Tables 15a and 15b)

Procedure(s):

1. Blepharoptosis repair of the left upper eyelid
2. Symblepharon repair of the left eye

Table 15a: ASC Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
68330 Repair of symblepharon; conjunctivoplasty, without graft	-LT	372.63 Symblepharon	$876.30
67904 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	-LT	374.30 Ptosis of eyelid, unspecified	50 percent of $690.30

Table 15b: Surgeon Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
67904 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	-LT	374.30 Ptosis of eyelid, unspecified	$589
68330 Repair of symblepharon; conjunctivoplasty, without graft	-LT	372.63 Symblepharon	50 percent of $454

Oculoplastics Case 3 (Tables 16a and 16b)

Procedure(s):

1. Excision of left lateral lower eyelid tumor with fresh frozen section control
2. Reconstruction of left lower eyelid, less than half of the lid dimension in full thickness, using tarso-conjunctival flap and extensive undermining of local skin
3. Entropion repair, suture technique

Table 16a: ASC Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
67924 Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)	-LT	374.04 Cicatricial entropion	$690.30
67966 Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin	-LT	173.1 Other malignant neoplasm of skin of eyelid, including canthus	50 percent of $661.80

Table 16b: Surgeon Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
67966 Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin	-LT	173.1 Other malignant neoplasm of skin of eyelid, including canthus	$649
67924 Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)	-LT	374.04 Cicatricial entropion	50 percent of $445

Retina Case (Tables 17a and 17b)

Procedure(s): Exam under anesthesia and peripheral retinal cryopexy of the left eye

Table 17a: ASC Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
67141 Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy	-LT	361.30 Retinal defect, unspecified retinal break(s) NOS	$231.60

Table 17b: Surgeon Claim

CPT CODE	MODI FIER(S)	ICD-9 CODE	ALLOWABLE
92019	-57	361.30 Retinal defect, unspecified retinal break(s) NOS	$67
67141 Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy	-LT	361.30 Retinal defect, unspecified retinal break(s) NOS	$476

Claim Submission Tips

The submitted CPT code(s) must be on the approved ASC facility list.

- On or after January 1, 2008, modifier -SG is not longer required.
- On or after January 1, 2008, modifier -50 is not valid when billing for bilateral procedures.
- The claim must be submitted as assigned.
- The appropriate place of service is 24.
- ASCs are not required to submit an operative report by fax, mail or electronically when multiple surgery procedures are performed within the same operative session.
- Many non-Medicare payers require the UB92 form instead of the CMS 1500 form when submitting a claim.
- The ASC claim does not always mirror the physician claim.

Charging the Patient

ASCs may charge the patient for deductible, for coinsurance of covered procedures and for non-covered procedures.

Billing Wrong Surgical or Other Invasive Procedure Performed on a Patient

Effective January 15, 2009, Medicare will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the surgeon erroneously performs:

- A different procedure altogether
- The correct procedure, but on the wrong body part
- The correct procedure, but on the wrong patient

Medicare will not cover ASC or hospital and other services related to these noncovered procedures.

ASCs, hospitals and physicians are required to append one of the applicable HCPCS modifiers in Table 18 to all lines related to the erroneous surgery(ies):

Table 18: **HCPCS Modifiers for Erroneous Surgeries**

HCPCS MODIFIER	DEFINITION
-PA	Surgery wrong body part
-PB	Surgery wrong patient
-PC	Wrong surgery on patient

The denial notice on the explanation of benefits will read, "These are noncovered services because this is not deemed a medical necessity by the payer."