How to Document the Need for Cataract Surgery

Here's a tip for staying off an auditor's radar: Do not bill for removing more than 1 cataract from the same eye. That may sound obvious, but—thanks to human error —some practices have done exactly that. How? When billing for a second cataract surgery, they submitted the wrong CPT modifier or ICD-10 code.

Make sure your documentation stacks up. You can minimize the risk of human error by using checklists, such as the one below. This article focuses on Medicare Part B's documentation requirements for the office visit that determines the need for cataract surgery.

6 Quick Tips

Know your local Medicare rules. Under Medicare Part B, the Centers for Medicaid & Medicare Services (CMS) delegates the reimbursement process to 8 Medicare Administrative Contractors (MACs). These MACs are allowed to develop their own coverage policies, which are known as Local Coverage Determinations (LCDs). Seven MACs have LCDs that outline specific documentation requirements for the office visit that demonstrates the need for surgery. (The Academy will post these at aao.org/practice-management/coding/updates-resources.)

Commercial payers may have different rules. Do not apply one payer's requirements or perceived requirements to all payers. When an individual payer has a policy on the need for cataract surgery, you will find it—along with any preauthorization requirements—on the payer's website.

Know the rules for signatures. If you don't comply with the signature rules, an auditor could automatically request a refund without even auditing the chart note. For paper charts, the physician's signature must be identifiable—and for electronic health records (EHR), the physician's signature must be secure. A 5-minute tutorial on signature requirements has been posted online by the First Coast MAC (https://medicare.fcso.com/signature_requirements/180170.asp).

The rules may change. You are held to the documentation requirements listed in the policy that was in place at the time of surgery.

No universal VA requirement. Despite what some practices believe, there is no national coverage determination (NCD) that requires a visual acuity (VA) of 20/50 or worse before cataract surgery is indicated. VA requirements, if any, vary by payer.

Review whether your past documentation supports what you submitted. If you are concerned about your documentation, you can perform a self-audit of the data submitted during the past 12 months. Any mistakes can be corrected with a phone review.

Checklist for Documenting the Need for Surgery

The checklist below is representative of the typical requirements of MACs, but you should review your MAC's LCD and personalize the checklist accordingly.

1. Chief complaint. The patient's chief complaint conveys symptoms, such as blurred vision, visual distortion, reduced contrast sensitivity, or complaints of glare associated with functional impairment.

2. Lifestyle complaint. A lifestyle complaint that is unique to the patient is documented. Auditors may seek to recoup payments if they determine that a practice is "cloning" patient lifestyle complaints. See if your MAC requires a "formal measure" of this, such as completion of the VF-14 or VF-8R activities of daily vision scale and visual activities questionnaire. You need to complete 1 for each eye.

3. Visual acuity. Most MACs do not have a specific VA requirement. However, First Coast sets a VA threshold of 20/40.

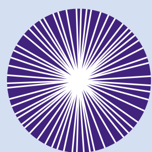
4. Cataract. Documentation should provide evidence of the existence of a cataract.

5. Other reasons for surgery. If applicable, the exam documentation should address other reasons for cataract surgery, such as a lens-induced glaucoma (e.g., phacomorphic or phacolytic) or a retinal disease that requires a clear media.

6. Expected improvement. The documentation should support a reasonable expectation that removal of the cataract will improve the patient's VA.

7. Glasses not enough. The documentation should indicate that glasses or other visual aids do not provide

BY **SUE VICCHRILLI, COT, OCS,** DIRECTOR OF CODING AND REIMBURSEMENT



List Your Training Opportunities

The Academy's **Global Directory of Training Opportunities** (**aao.org/training-opportunities**) is an online resource for ophthalmologists seeking training opportunities. It is the best way to reach the broadest pool of candidates. If your academic medical center or private practice have fellowships or observerships available to ophthalmologists outside your country, list your opportunities in the Directory. It is free and only takes 2 to 3 minutes to post:

1. Go to **aao.org/gdto-submission.**
2. Click "Submit a Training Opportunity."
3. Log in. (This will save you time.)
4. Enter opportunity information.

Questions? Email **gdto@aao.org**

Protecting Sight. Empowering Lives.™

satisfactory functioning vision and that the patient's lifestyle is compromised.

8. Informed consent. The documentation should indicate that the risks and benefits were discussed and, most importantly, that the patient desired surgery.

9. Operative report. The operative report should be signed by the surgeon.

10. Exam. With a *new patient,* when submitting CPT code 99204, you should make sure the following are documented:

- A chief complaint and a minimum of 4 pertinent elements pertaining to the history of the present illness
- A review of 10 or more body systems with an accompanying note of how the patient is caring for any medical problems identified
- A past, family, and social history
- All 12 elements of the exam performed through dilated pupils unless contraindicated
- A mental assessment
- A plan for additional workup (this should be documented by written order delegating measurements for the IOL calculation; the IOL calculations should contain the patient's name, the date, and surgeon's initials)
- Interpretation of the measurements used for IOL selection
- Moderate medical risk, which for E&M coding is supported by the patient's desire to undergo elective major surgery with no identified risk factors

With an *established patient,* when submitting CPT codes 92014 or 99214, the chief complaint and pertinent elements of the history of the present illness are documented, as are the past history and the pertinent review of systems. The exam is comprehensive and the medical decision making is of moderate risk. The IOL calculation, interpretation, and IOL selection should be documented as they would be with a new patient.

11. Signature. The physician signature is legible—or for EHR, the physician signature is secure.

12. Timing. Check whether your MAC has a timing requirement. For example, Novitas requires the exam be performed within 3 months of the surgery.