

Billing for Ophthalmic Surgery: 10 Steps for Successful Coding

When your practice performs surgery, are you appropriately maximizing reimbursement? Find out by completing a fundamental coding review. Follow these 10 steps to ensure crucial coding components are addressed and payer policies and guidelines are followed. The example below shows how to apply the 10 steps to a surgical case.

Code This Operative Report

The patient had moderate primary open-angle glaucoma (POAG) in her left eye and bilateral age-related cataracts. After undergoing cataract surgery in her right eye, she returned two weeks later for surgery in the left eye. The operative report states that the patient's left eye underwent standard cataract surgery and endoscopic cyclophotocoagulation (ECP). How would you bill for the surgery on the left eye?

Step 1—Identify all possible CPT codes and read their full CPT descriptors. CPT descriptors provide details that can help you select the correct CPT code. These descriptors outline the procedures included and the approach or devices used. Review the entire family of codes to ensure proper code selection.

In this case, the most relevant CPT codes to consider are as follows:

- 66984 *Extracapsular cataract removal with insertion of intraocular lens*

prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation.

- 66988 ; *with endoscopic cyclophotocoagulation.*
- 66711 *Ciliary body destruction; cyclophotocoagulation, endoscopic; without concomitant removal of crystalline lens.* (Note: This code is for a stand-alone procedure.)

Step 2—Obtain prior authorization, if it is required, before surgery. When prior authorization is required, your claim is likely to be denied if you didn't obtain that authorization before providing the service.

In this case, Medicare does not require prior authorization for cataract surgery but other payers may. For newer CPT codes—such as CPT code 66988—it is best practice to check whether prior authorization is needed.

Step 3—Meet the specific payer's preoperative documentation requirements. Different payers have different documentation requirements. For example, Medicare requires that, prior to surgery, you document that a cataract impairs activities of daily living (ADL). Medicare Administrative Contractors (MACs) describe such documentation requirements in local coverage determinations (LCDs) and local coverage articles (LCAs). To take one example,

Cigna Government Services—which is the MAC for Kentucky and Ohio—has an LCD for cataract surgery that says ADLs include “reading, watching television, driving, or meeting occupational or vocational expectations.”

In this case, as in any case, determine what documentation is required by the payer. To find the MAC for your state, and to get links to its LCDs and LCAs for ophthalmic procedures, visit aao.org/lcds. Other payers may provide published policies on their website or in provider manuals.

Step 4—Identify the global period for each CPT code and determine whether any procedures were performed during an existing global period. For surgery, the payer's coverage is known as the global surgical package. This covers the surgery plus certain related services and post-op visits that take place during a set number of days, known as the global period. Why does this matter? If a patient encounter takes place during the global period of an earlier surgery, the payer is likely to assume that it was covered by the initial global surgical package. If the later encounter was unrelated to the earlier surgery, you need to flag that fact by appending a modifier to the encounter's CPT code (see “Step 8,” next page). If you don't do that, you won't get paid.

In this case, the ophthalmologist operated on the left eye during the global period of the initial surgery on the right eye.

Step 5—List CPT codes by RVU, from highest to lowest. The reimburse-

ment rate for a CPT code is based, in large part, on the number of relative value units (RVUs) that have been assigned to it. List the CPT codes that you plan to bill in order from highest to lowest based on each code's RVUs and/or its allowable. Why does the order matter? When multiple procedures can be billed at the same encounter, the first CPT code that you list on CMS-1500 will be paid at 100% of its allowable, and subsequent codes will be paid at 50% of their allowable.

In this case, CPT code 66984 has been assigned 15.74 RVUs and would be listed above CPT code 66711, which has been assigned 14.64 RVUs. (Note: CPT code 66988 is new as of January 2020, and CMS hadn't assigned it an RVU value at time of press. Check with the payer to find out the code's allowable.)

Step 6—Consider the site-of-service differential. Reimbursement for some CPT codes varies depending on the place of service (POS). For some CPT codes, CMS assigns a different reimbursement if services were performed in a facility, such as an ambulatory surgery center (POS code: 24), versus a nonfacility, such as an office (POS code: 11).

In this case, CMS didn't assign any RVUs to CPT codes 66711 and 66984 when the services are performed in the office. Why? The agency expects those services to be performed in a facility. For CPT codes that haven't yet been assigned RVUs, such as 66988, check your payer's policies or fee schedules.

Step 7—Look for bundled codes.

Check for correct coding initiative (CCI) edits or commercial payer edits.

Each edit lists a pair of codes that are bundled together, which means that they can't both be billed when performed by the same physician on the same patient on the same day. Some of these pairs are mutually exclusive edits that can never be unbundled; others can be unbundled if you use a modifier to show that you are billing for distinct procedural services. For more information on CCI edits, see "Are You Bewildered by Bundles?" (Savvy Coder, May 2022) at aao.org/practice-management/coding/savvy-coder.

In this case, if you check the code listings in the Academy's *Coding Coach*, you will learn the following:

- 66984 is bundled with 66711 and 66988
- 66988 is bundled with 66984 and 66711
- 66711 is bundled with 66984 and 66988

Because all the possible CPT codes are bundled together, it is appropriate to bill only one of them. Based on the description in the operative note, choose the most appropriate code—CPT code 66988. This combination code accurately represents both the cataract surgery and ECP.

Step 8—Append modifier(s). While the CPT code that you submit indicates the service that you provided, it doesn't always tell the full story. You can convey additional information by appending one or more modifiers.

Common surgical modifiers include the following:

- -58 staged/related procedure during postoperative period
- -78 unplanned return to operating room/procedure room for related procedures by the same physician during postop period
- -79 unrelated procedure by the same physician during the postoperative period

You also should use anatomical modifiers to indicate laterality:

- -RT for right side
- -LT for left side
- -50 for bilateral

If you need to append both a non-anatomical modifier (e.g., -79) and an anatomical modifier (e.g., -LT), the anatomical one should be appended last.

In this case, submit 66988-79-LT. You append modifier -79 because step 4 confirmed that this surgery took place during the global period of an earlier surgery, and you need to flag the fact that this later procedure is unrelated to that initial one.

Step 9—Link to the appropriate diagnosis code. ICD-10 codes are alphanumeric diagnosis codes that help establish why a particular service was medically necessary. You should therefore be careful in linking each CPT code that you submit to the appropriate ICD-10 code(s).

Always code to the highest specificity, and do not use codes that include the word "unspecified." (If you submit an unspecified code, your claim is likely to be denied, as the payer will assume that you could have provided a more specific diagnosis code.)

In this case, the payer may require the cataract and the glaucoma diagnosis codes be linked to CPT code 66988, which is a combination code. Do that using the following ICD-10 codes:

- H25.12 Age-related nuclear cataract, left eye
- H40.1122 Primary open-angle glaucoma left eye, moderate stage

Step 10—Submit the claim and review the remittance advice to check that proper payment has been made.

For a bilateral procedure, the reimbursement should be 150%.

In this case, the reimbursement for a surgery billed with modifier -79 would be 100% of the allowable.

Ophthalmology's Coding Resources

The American Academy of Ophthalmic Executives (AAOE) has developed many ophthalmic coding products, including the following:

- **2022 Fundamentals of Ophthalmic Coding** is a training manual that includes many case studies for surgical coding. It serves as an excellent study guide for the Ophthalmic Coding Exam.
- **2022 Coding Coach: The Complete Ophthalmic Coding Reference** consolidates information from several sources, making it a one-stop resource that saves practices time on a daily basis.
- **2022 Coding Assistant: Cataract and Anterior Segment** includes more information on the combination cataract codes.

To browse AAOE's coding products, visit aao.org/codingtools.