

Tips for Frequently Coded Services: From A-Scans to YAGs, Part One

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How many claims do practices submit incorrectly? Third-party audits place that number as high as 40 percent. To help you avoid some common mistakes, here—in alphabetical order—are some tips on coding for some of ophthalmology's most frequently performed exams, tests and special procedures.

A-scan ultrasound and IOLMaster for intraocular lens calculations.

When billing for an A-scan, use CPT code 76519, *Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation*. When using an IOLMaster, use code 92136, *Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation*.

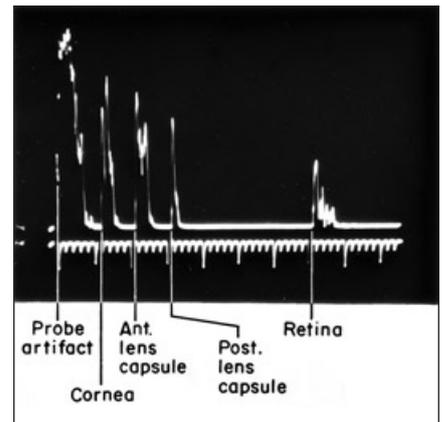
The rules used by Medicare differ from those used by non-Medicare payers. For Medicare, these codes have a global technical component (modifier –TC) and each eye has a professional component (modifier –26). As non-Medicare payers typically do not recognize these modifiers, only the –RT or –LT modifiers should be appended to codes 76519 or 92136.

Argon laser trabeculoplasty and selective laser trabeculoplasty. Use CPT code 65855, *Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)*. This code should be used for both ALT and SLT. Medicare has assigned this code a 10-day global

period. This means that when a separately identifiable exam is performed the same day, modifier –25 should be appended to the appropriate level of exam. Since non-Medicare payers still recognize a 90-day global period, modifier –57 should be appended to the exam that determines the need for surgery when the laser is performed on the same day. Since January 2008, this code has been payable in an Ambulatory Surgical Center (ASC).

Benign skin lesions. Depending on the lesion's size, use one of the following CPT codes: 11440 (diameter of 0.5 cm or less), 11441 (0.6 to 1 cm), 11442 (1.1 to 2 cm), 11443 (2.1 to 3 cm), 11444 (3.1 to 4 cm) or 11445 (more than 4 cm). Medicare as well as non-Medicare payers will cover benign skin lesion removal with appropriate documentation. The chief complaint should contain words such as red, increasing in size, oozing and itching. A photograph is helpful for documentation purposes. As with any procedure that may be considered cosmetic, it is best to obtain an Advance Beneficiary Notice (ABN) from the patient. Appending modifier –GA to the claim will indicate that an ABN is on file.

Blepharoplasty. Most Medicare payers have a local coverage determination (LCD) indicating the specific preoperative documentation that is required to distinguish whether a blepharoplasty procedure is cosmetic



A-SCAN. Code 76519 is unusual in that its technical component (the scan) is bilateral, but its professional component (the calculation) is unilateral.

or functional. CPT code 15822, *Blepharoplasty, upper eyelid* is typically used when the procedure is cosmetic, and appending modifier –GY will confirm your service was cosmetic. CPT code 15823, *Blepharoplasty, upper eyelid; with excessive skin weighting down lid*, is typically submitted for functional claims. One key component of the documentation is a visual complaint from the patient—but this is often missing from the chart. If, for example, the chart merely states, “patient complains of excessive baggy upper lid skin,” the claim is likely to be denied.

NEXT ISSUE: From cataract extraction to foreign body removal.