

Nuances of Reimbursement Part 2

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Last month's *EyeNet* reviewed 5 lesser-known nuances of reimbursement. They covered issues ranging from care of hospice patients to execution of standing orders. This month, the focus shifts to scenarios that are a little more common.

Modifier –50 bilateral procedure for testing service claims. When a testing service that has unilateral payment is performed on both eyes and pathology is in both eyes, Medicare requires you to submit the claim as a single-line item with modifier –50 (bilateral procedure) appended to the testing CPT code. The fee should be doubled. Other payers may require a 2-line claim with modifiers –RT (right eye) and –LT (left eye) appended to the testing service. No matter which way the claim is submitted, payment should be 100% of the allowable per eye. Unlike bilateral surgeries, testing service's second eye is not reduced by 50% of the allowable. The only reduction would be based on the multiple procedure payment reduction (MPPR) rule—a 20% cut in the technical component for the test on the second eye and subsequent tests.

Billing retina and glaucoma optic nerve OCTs on the same day for the same patient. When billing an OCT, whether for retina or glaucoma, it is not appropriate to bill both 92133 and 92134 at the same service. Why not?

The CPT codes for the 2 services are mutually exclusive, meaning they can never be unbundled. In addition to National Correct Coding Initiative (NCCI) edits that have been in place since the inception of the 2 codes, CPT states that both codes should never be billed the same day for the same patient at the same practice.

Also note that each test is inherently bilateral, so it would be inappropriate to append modifiers –RT, –LT, –50, or –52. The service should be billed as a 1-line item, and the unit field should be left as 1, regardless of whether imaging is done in 1 or both eyes.

Modifier –57 recap. When a major surgery is performed either the day after or the day of an exam, modifier –57 would be the appropriate choice to append to the E&M or Eye code. Modifier –57 indicates that a decision to perform a major surgery was made at this encounter. Major procedures are defined as having 90 days of postoperative care for Medicare Part B; however, non-Medicare payers may have 45 or 60 days assigned to major surgeries. It is always best practice to review your payer policies on a routine basis.

On call for another practice. When an ophthalmologist is on call for another practice and sees a postoperative patient with a problem during the surgery's global period, can he or she charge for an exam? Not if the problem falls within the surgery's global pack-

age. When a physician is covering for another physician, it is as if he or she were the operating surgeon.

Know the payer rules for Eye codes. The first rule in coding is to identify the payer. When it comes to Eye codes (92XXX):

- Medicare Part B does not have frequency edits. However, most commercial payers limit the number of times Eye codes can be billed during a calendar year.

- Diagnosis codes such as lupus or rheumatoid arthritis are typically not payable by insurance with an Eye code. This means the patient is responsible for payment of the claim. But if the claim is submitted with the appropriate level E&M code, it is a covered benefit. Checking payer websites can be a useful tool in verifying regulations. ■

Banned From Medicare

The Office of Inspector General (OIG) maintains a list of individuals who are excluded from billing federal programs, including Medicare and Medicaid (<http://exclusions.oig.hhs.gov/>). The OIG urges you to check the list prior to hiring licensed personnel and to also check your current staff monthly against the latest version of the list. The OIG offers a downloadable data file that can assist when searching multiple names.