What Puzzled Your Colleagues: 6 Questions Are Answered

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Each year the Academy and AAOE receive more than 4,000 coding questions. These come from coders, practice managers, and physicians in all subspecialties and at every stage of their career. Here are six typical queries.

Six Questions

Q. What is the appropriate way to bill for a surgical procedure performed bilaterally during the same operative session?

A. Effective April 1, 2013, CMS changed the way it implements the Medically Unlikely Edits (MUE) program that it uses to screen claims. As a result, you should no longer submit the surgical code as a two-line item with modifiers –RT and –LT. Instead, append the surgical code with modifier –50, which indicates a bilateral procedure, and put 1 in the unit field. Failure to submit claims in this manner has resulted in payment denial.

If, for example, bilateral blepharoplasties are performed, you should submit 15823–50 with 1 in the unit field. Since each unit of service is now bilateral, you should double the fee you charge. The Multiple Procedure Payment Reduction rule still applies: The payer will reimburse 100 percent of the allowable of the first of those two procedures and 50 percent of the allowable for the second.

Q. During the global period, a postoperative cataract patient presents with the complaint of flashes and floaters. Can we bill an exam as unrelated to the surgery?

A. It depends on whether it is related or unrelated to the surgery. If related, it is part of postop care and not separately billable.

If you are going to bill, you need to clearly indicate in your chart note why your diagnosis is unrelated to the surgery. Submit the appropriate level of exam with modifier –24, indicating an office visit unrelated to the surgery. The ICD-9 code for floaters is 379.24; there is no code for flashes. The ICD-10 equivalent of 379.24 is H43.39-. When an ICD-10 code ends with the "-" symbol, you add an extra digit, which often is used to indicate the right, left, or both sides of the body.

Q. When probing and insertion of a tube are performed during the same surgical session, are both payable?

A. There is one code that describes both services: 68815 *Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent.*

Q. Probing of the left lacrimal duct didn't resolve a problem and the surgeon performed a snip procedure a week later. How should this be coded?

A. Submit 68440–78–LT if the snip is performed within the 10-day global of the first probing procedure, 68815. Modifier –78 indicates that an unplanned procedure was performed in the operating room or office procedure room. Payment is 80 percent of the allowable, as an additional 10 days is not added to the global period.

Q. Can we submit CPT code 66170* Trabeculectomy *if we know that an insurance company denies payment for Category III code 0192T* Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach*?

A. No. Prior to surgery for the Medicare Part B patient, you should obtain an Advance Beneficiary Notice (ABN) and submit 0192T–GA, which informs Medicare that an ABN is on file. For commercial payers, it is best to inform the patient in writing that he or she may be responsible for payment.

Submitting a Level 1 CPT code when there is a specific Category III code that you can use would be considered a fraudulent claim submission.

Q. When payment for a test is inherently bilateral and we only test one eye, should we use modifier –52, indicating a reduced service, or use –RT/–LT?

A. No modifier is required. With inherently bilateral tests, the payer recognizes that the test is sometimes for one eye, sometimes for both—payment is the same in either case. ■