Cataract, Glaucoma, Botox, and More: Can You Answer These 6 Questions?

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Each year, hundreds of physicians and billers attend the AAOE CODEquest seminars. Many of them use the Q&A section to raise issues—such as the ones described below—that had recently arisen in their practice. If you were in the audience, would you have been able to answer these questions?

6 Coding Conundrums

Q1. A Medicare Part B patient was spending time with his daughter in another state. While there, he underwent cataract surgery by a physician who is not connected to our practice. We are now seeing the patient for postoperative care. Is it possible for us to be paid for these visits? No comanagement agreement was made.

Q2. The physician cultured the discharge of the left upper lid and sent it to pathology. Can we bill for this?

Q3. If a physician is on call covering for another physician and sees a patient he or she has never seen before, is the patient considered new?

Q4. Our glaucoma specialist performs bilateral peripheral iridotomies for anatomically open angles. Within the postop period, he plans to perform bilateral selective laser trabeculoplasties for mixed mechanism glaucoma. How do we bill these two procedures?

Q5. A three-snip procedure was performed on a patient within the global period of a probing. Should modifier –58 or –78 be used?

Q6. Are there payer documentation requirements when injecting Botox for migraines?

Answers

1. Submit the appropriate level of E&M or Eye code for the exams performed. Chart notation should not indicate that it is solely postop.

2. The culture is not separately billable. It is part of the E&M or Eye code submitted for the exam.

3. According to the AMA newsletter, *CPT Assistant*: No. When a physician is on call for or covering for another physician, the patient's encounter is classified as it would have been if the patient had been seen by the physician who is not available.

4. For the first procedure, submit CPT code 66761 *Iridotomy/iridectomy by laser surgery (e.g., for glaucoma) (per session)* and append modifier –50.

For the second procedure, submit CPT code 65855 *Trabeculoplasty by laser surgery, 1 or more sessions (defined treatment series)* and append modifiers –50 and –58.

Note that for Medicare Part B, code 66761's global period is 10 days; for commercial payers it is 90 days.

5. Append –58 to CPT code 68440 *Snip incision of lacrimal punctum.*

6. It depends upon the payer. For those that do have payment policies for CPT code 64615 *Chemodenervation of muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (e.g., for chronic migraine)*, coverage will only be allowed for those patients with headache disorders occurring more than 15 days a month—in many cases daily with a duration of four or more hours—for a period of at least three months and who have significant disability due to the headaches and, furthermore, have been refractory to conventional therapy. The etiology of the chronic daily headache may be chronic tension-type headache or chronic migraine (CM). CM is characterized by headache on at least 15 days per month, of which at least eight headache days per month meet the criteria for migraine without aura or respond to migraine-specific treatment. In order to continue botulinum toxin therapy, the patient must demonstrate a significant decrease in the number and frequency of headaches and an improvement in function upon receiving botulinum toxin. ■

UPDATE ON MODIFIER –25: *See Academy Notebook's D.C. Report on page 55 for the last word on modifier –25, exams, and intravitreal injections.*