GETTING PAID FOR TECHNOLOGY & ADVANCED PROCEDURES

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(contributions from Harvey Richman, OD)

KOA

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TERMINOLOGY

Unilateral = 1 eye only
Bill twice – once for each eyes when performing on both

Bilateral = 2 eyes only
Use -52 modifier - indicate 1 eye only when cannot perform on both

Unilateral or Bilateral = 1 or 2 eyes same $, No modifier
Typically expect 2 eyes even when pathology only in 1 eye

Interpretation and Report:
What test results show & what it means for that patient's care

Interpretation of diagnostic tests/studies (i.e., professional component) and preparation of separate distinct & identifiable signed written report

All special testing and procedures must be ordered and documented in the chart for that visit

TERMINOLOGY

Unlisted Services or an unusual, new or variable service
Use appropriate unlisted code & requires "Special Report"
Report should show:

- **Medical appropriateness of service**
- **An adequate definition/description of nature, extent, & need for service**
- **Time, effort, and equipment necessary to provide service**

Additional items that may be included:

- **Complexity of symptoms**
- **Final diagnosis**
- **Pertinent physical findings**
- **Diagnostic & therapeutic procedures**
- **Concurrent problems**
- **Follow-up care**

CPT® code description are relatively precise
If code does not match, then should not use it unless specific payor instructions

ANOTHER NOTE

CPT III codes: Temporary Codes for Emerging Technology
CPT III codes are covered
IF and WHEN the MAC has a fee set for that CPT®III code

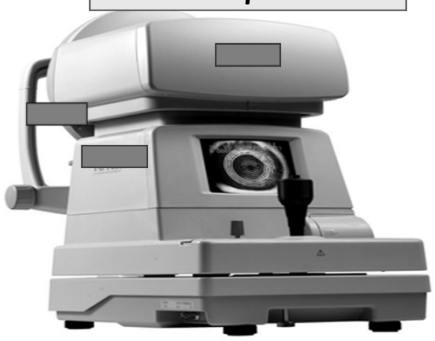
CORNEA & ANTERIOR SEGMENT

CORNEAL TOPOGRAPHY

92025
Computerized corneal topography, unilateral or bilateral, with interpretation and report

CGS= $33.28

Detection of subtle corneal surface irregularity & astigmatism



CGS: A56816, L34008

Denial Reasons
Refractive procedures
Contact lens evaluations

Consider ABN or private payor equivalent
Consider GFE when appropriate

CORNEAL WAVEFRONT ANALYSIS

Corneal wavefront allows direct comparison of corneal & ocular wavefronts

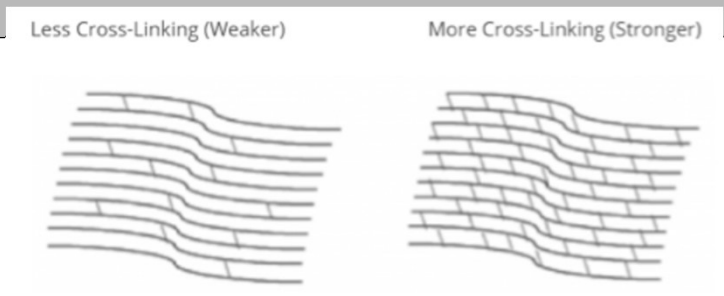
Currently, no separate code for Corneal Wavefront Analysis
Cannot use Corneal Topography for this procedure

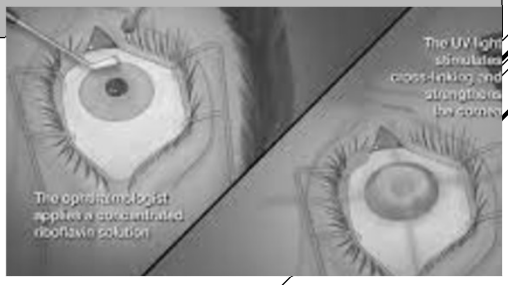
92499 possible but miscellaneous service often not covered and requires special report with claim

Consider an ABN or private payor equivalent
Consider a GFE when appropriate

THE FUTURE

0402T Collagen cross-linking of cornea (including removal of corneal epithelium and intraoperative pachymetry, when performed (Report medication separately)





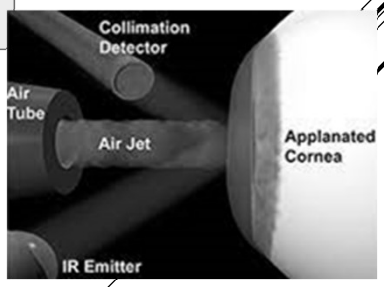
Carrier Pricing – No CGS fee

No LCDs or Articles

CORNEAL HYSTERESIS

92145 Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report

Cornea's ability to absorb and dissipate energy



Low Corneal Hysteresis

- Optic nerve damage
- Visual field loss
- Functional progression of GLC
- Larger magnitude of IOP reduction
- Dynamic finding may increase with medications

CGS Pricing = $11.82

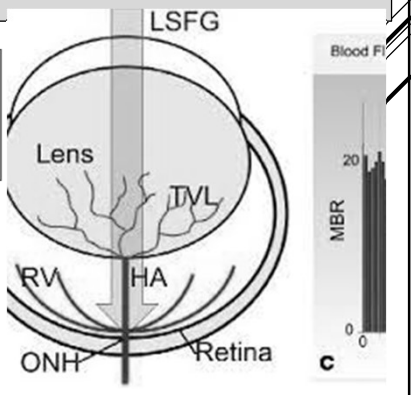
OCULAR BLOOD FLOW

0198T Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report

Consider ABN or private payor Non-coverage form
Consider GFE when indicated

No LCDs or Articles

No CGS Pricing



DIAGNOSTIC PACHYMETRY

76514 Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)

CGS Pricing = $10.52

CGS: A56457, L33999

Uses either ultrasonic or optical methods
Includes pachymetry using anterior OCT

Medicare typically considers corneal pachymetry to be medically necessary/reasonable, when performed to determine:

1. **Amount of endothelial trauma sustained during surgery involving cornea**
2. **Preoperative assessment of health of the cornea in Fuch's dystrophy**
3. **Assessment of corneal thickness after ocular trauma**
4. **Glaucoma, previously diagnosed or not is Once in a lifetime coverage**

PUPILLOMETRY

95919 Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral

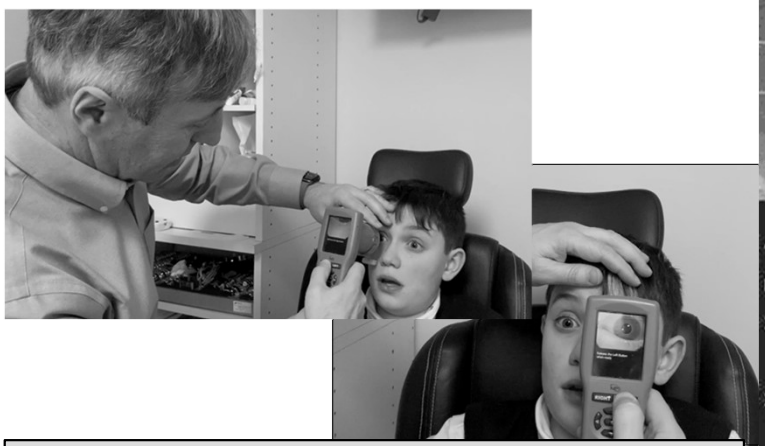
No CGS Policy

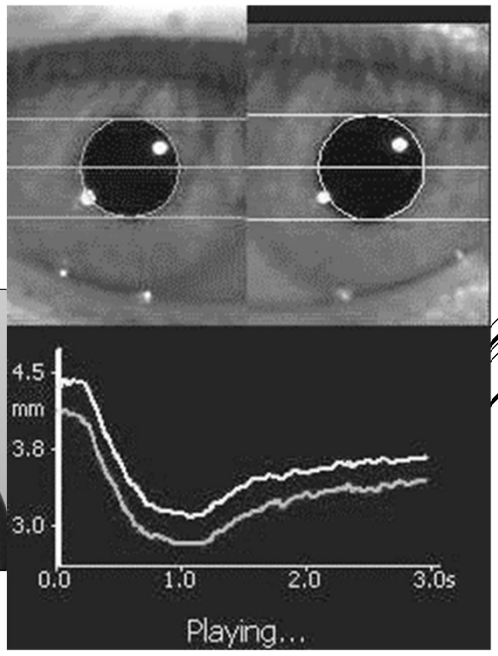
RATIONALE

- **Rapid, non-invasive measurement of autonomic nervous system function via assessment of pupil's response to light**
- **Allows for objective documentation of pupillometry-specific autonomic deficit as well as objective documentation of pupil's response to light**

CGS Pricing: $14.48

QUANTITATIVE PUPILLOMETRY

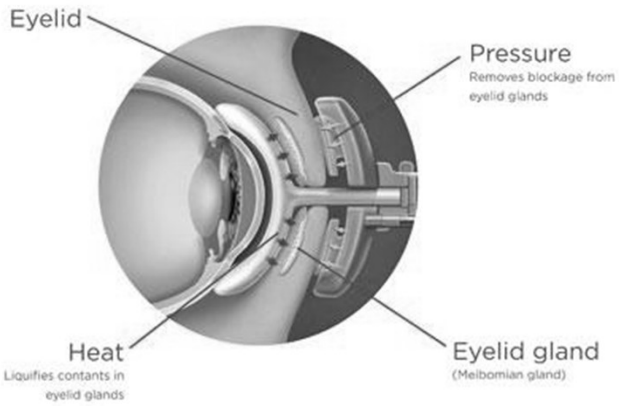


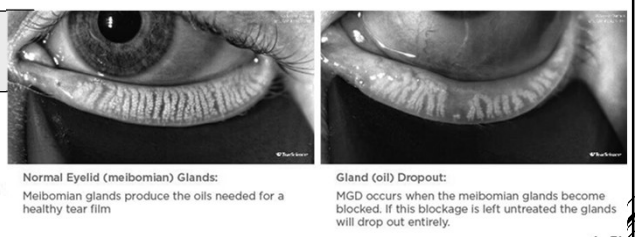


Recommendation: Save recording to chart for audit purposes

MGD DYSFUNCTION

MGD Imaging





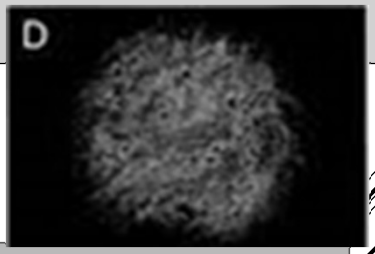
Normal Eyelid (meibomian) Glands:
Meibomian glands produce the oils needed for a healthy tear film

Gland (oil) Dropout:
MGD occurs when the meibomian glands become blocked. If this blockage is left untreated the glands will drop out entirely.

Ocular Surface Interferometer

CPT III CODES

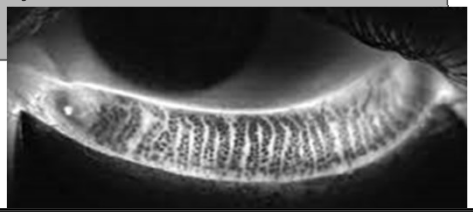
0330T Tear film imaging, <u>unilateral or bilateral</u>, with interpretation and report



No CGS pricing

Consider using an ABN or private payor equivalent
Consider using GFE when appropriate

0507T Near infrared dual imaging (ie, simultaneous reflective and transilluminated light) of meibomian glands, unilateral or bilateral, with interpretation and report



No CGS pricing

CPT III CODES

0207T Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral

No CGS pricing

0563T Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral

►(For evacuation of meibomian gland using manual gland expression only, use the appropriate evaluation and management code)◄

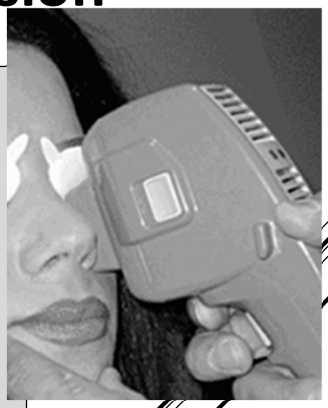
No CGS pricing

Consider using an ABN or private payor equivalent
Consider using GFE when appropriate

IPL and Meibomian Gland Expression

Rolando Toyos, MD (Memphis TN)

- **Brief, powerful bursts of light at specific wavelengths (500 and 800 nm) - blood vessels changed near skin surface can eliminate problematic flora and parasites eyelids MAY have in meibomian gland dysfunction**
- **Acts like the "world's best warm compress."**



IPL AND MEIBOMIAN GLAND EXPRESSION

Intense pulsed light improves signs and symptoms of dry eye disease due to meibomian gland dysfunction: A randomized controlled study. Rolando Toyos et al. PLOS ONE. June 23, 2022

88-patient study

"…moderate to severe symptoms, combination therapy of intense pulse light (IPL) and meibomian gland expression (MGX) could be a safe and useful approach for improving signs of dry eye disease (DED) due to meibomian gland dysfunction (MGD)"

Intense pulsed light improves signs and symptoms of dry eye disease due to meibomian gland dysfunction: A randomized controlled study | PLOS ONE

INTENSE PULSED LIGHT (IPL)

17106 Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq. cm
17107 ; 10.0 to 50.0 sq. cm
17108 ; over 50.0 sq. cm

UHC: Covered for port-wine stains and hemangiomas
CMS: Coverage for destruction of lesions

67999 Unlisted procedure, eyelids

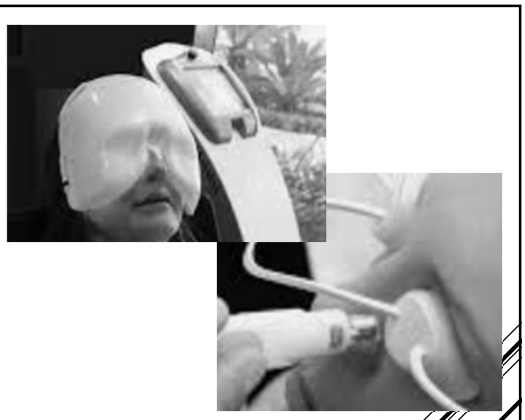
0552T Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional

IPL not technically a laser but often described as such – broad spectrum light source

92499 Unlisted ophthalmological service or procedure

ABN/Private Pay Release GFE

IPL AND LLT



Treatment options might include
- **Intense pulse light (IPL)**
- **Low-level light treatment (LLLT)**

Dry Eye Syndrome
Meibomian Gland Disease

Treatments may be effective but no separate CPT® codes
Typically, are not covered by insurance payers
0552T or 67999 or 92499 code choices for either therapy

ADVICE: **Get an ABN signed or a private payer non-coverage form**
Consider GFE signed , when indicated, prior to any procedure

LENS AUTO-FLUORESCENCE

FDA Market Clearance 2013

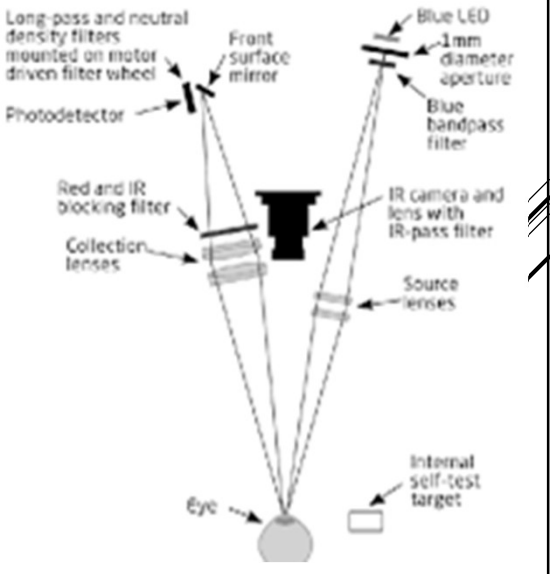
Detects presence of advanced glycation products, or AGEs, in crystalline lens
AGEs: yellow-brown & fluorescent proteins are modified when sugars metabolize
In lens, AGEs are long-lived and accumulate over time
Studies: AGEs are correlated with uncontrolled glucose

LENS AUTO-FLUORESCENCE

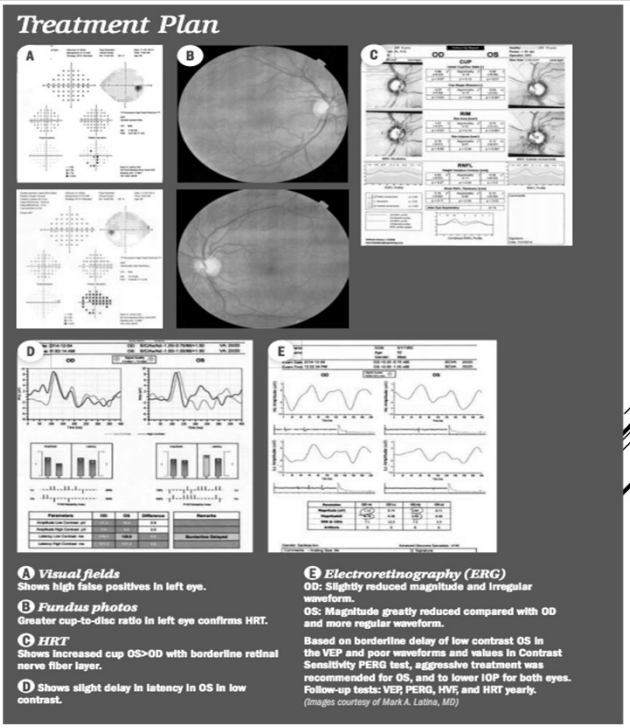
- Using Lens Fluorescence Biomicroscope calibrated with standards traceable to National Institute of Standards and Technology (NIST)
- Type 2 DM Detection via crystalline lens AGEs
  Sensitivity = 67%, Specificity = 94%
  (Hemoglobin A1C: Sensitivity= 44% Specificity= 79%)
  (Fasting Plasma Glucose: Sensitivity=50% Specificity= 95%)
- Takes 6 seconds, non-invasive, doesn't require fasting

LENS AUTO-FLUORESCENCE

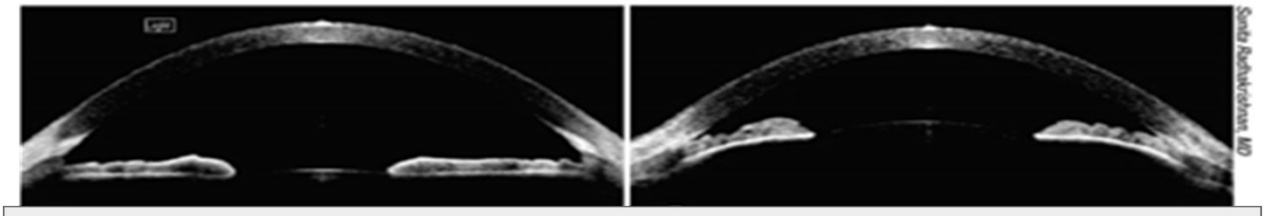
- Currently considered included in 92000 & 99000 code sets
- No LCD/ Medical Policy exists
- 92499 could be considered but not recommended



GLAUCOMA



ANTERIOR OCT 92132



Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation & report, unilateral or bilateral

CGS Pricing= $28.69

Do not use 52 modifier or LT /RT modifier if only one eye
CPT codes not covered with Anterior OCT: 76512, 76514
NOT GONIOSCOPY

76514 if Anterior OCT for corneal thickness

Some MAC LCDs:

ANTERIOR OCT 92132

Evaluate narrow angle, suspected narrow angle, mixed narrow-open angle glaucoma, & angle recession as all determined by gonioscopy

Determine proper intraocular lens for a patient who has had prior refractive surgery and now requires cataract extraction

Evaluate Iris tumor

Evaluate corneal edema or opacity that precludes visualization or study of the anterior chamber

Calculate lens power for cataract patients who have undergone prior refractive surgery

Evaluate and plan treatment for patients with diseases affecting the cornea, iris, lens and other anterior segment structures

Provide additional information during the planning and follow-up for corneal, iris, cataract, glaucoma and other anterior segment surgeries

OPHTHALMIC ULTRASOUND-76513

Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral

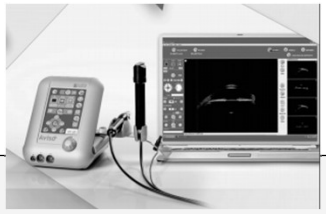
CGS Pricing = $68.17

2D ultrasonic procedure - determine detailed composition and contours of ocular and orbital structures for pathology

1. Water bath - ultrasound source to be held away from tissue
2. Supine patient position, eye cup placed between lids, filled with viscous solution
3. Ultrasound probe placed in water bath in proximity to patient's eye
4. High resolution, high magnification, detailed images obtained of anterior segment structures
5. Eye cup removed, eye rinsed, and examination performed to confirm no corneal abrasion

No LCDs or Articles

76513 OR 92132

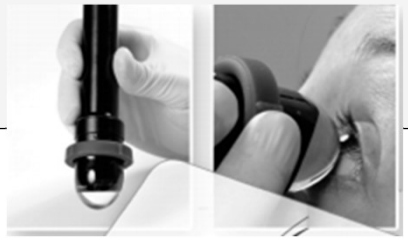


CPT differentiates between since use different technologies

If water bath ultrasound used: code 76513

If OCT technology used: code 92132

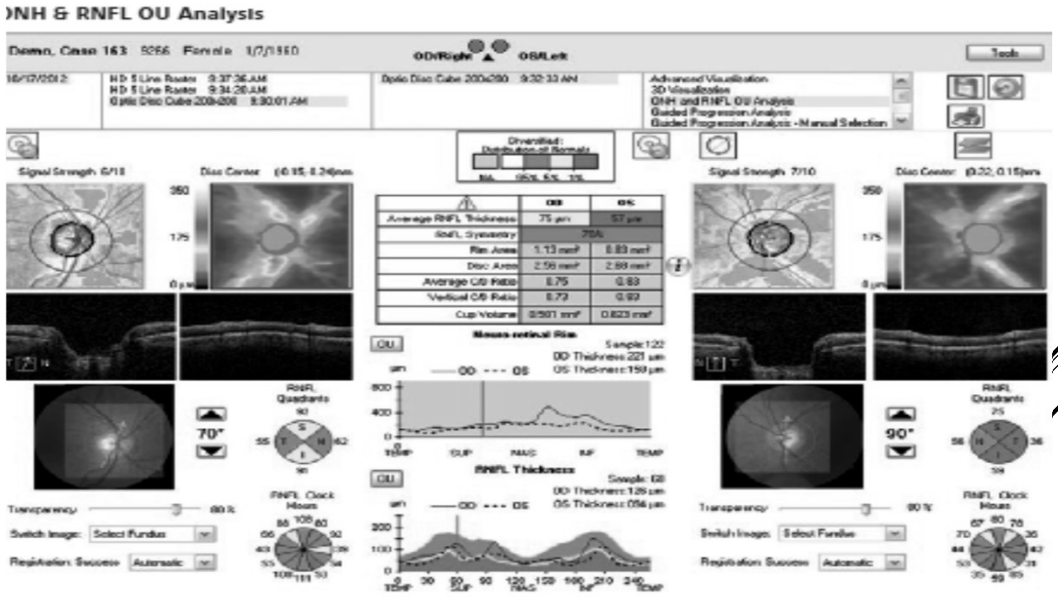
Reference CPT Asst 7-2013



SCANNING LASER TESTS

- **Confocal laser scanning ophthalmoscopy (topography)**
- **Optical Coherence tomography**

VERSATILE MULTI-MODALITY IMAGING



CODING GUIDELINES

- 92133-4 Scanning computerized ophthalmic diagnostic imaging (e.g., scanning laser) with interpretation and report, unilateral or bilateral
- Do Not use – 52, LT or RT modifier if one eye only
- CPT codes not covered with SCODI:
  - 92225, 92226, 92250
  - 59 modifier usage
  - GA modifier usage w/ ABN (or private payor form)
  - Consider using GFE when appropriate

92133-GLAUCOMA INDICATIONS

Scanning Computerized Ophthalmic Diagnostic Imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

CGS Pricing = $33.48

- **Medically necessary usually only one (1) or two (2) tests per year per patient**
- **Rarely be necessary or beneficial with patients who have advanced optic nerve damage**

L34399
A56692

SCODI not covered when used for screening
SCODI not covered in absence of indication

92134

Scanning Computerized Ophthalmic Diagnostic Imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina

CGS Pricing = $37.19

- **Valuable evaluation/treatment of retinal and macular disease abnormalities**
- **Useful to measure**
  - **Effectiveness of therapy**
  - **Need for ongoing therapy**
  - **Safety of therapy cessation**
- **Useful in evaluating retinal disorders and glaucoma**
- **High resolution images capture ocular structures**
- **Creating thickness maps of the retina directly correlated to ocular disease - including retinal disorders and glaucoma**

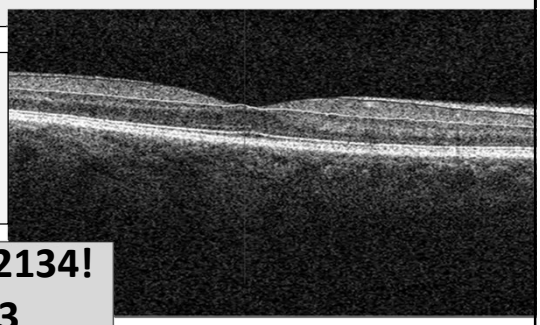
Spectral domain-optical coherence tomography (SD-OCT) used to detect retinal changes due CQ or HCQ

GANGLION CELL ANALYSIS→92134

Isolates Ganglion Cell Layer

Measures thickness for sum of GCL/IPL layers -data from Macular cube scans

RNFL distribution in the macula depends on individual anatomy, while the GCL+IPL appears regular and elliptical for most normal individuals

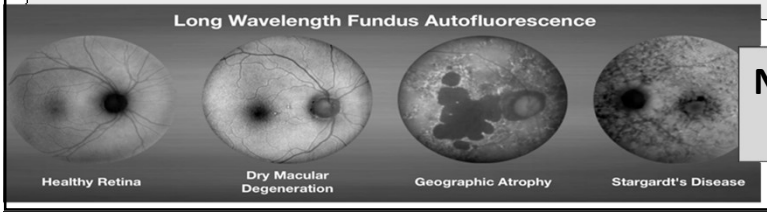


Propriety algorithms are adapted for specific anatomy, use GCL and IPL thickness

Issue with diagnosis of glaucoma and 92134! ABN? GFE? Different day than 92133

FUNDUS AUTOFLUORESCENCE (FAF)

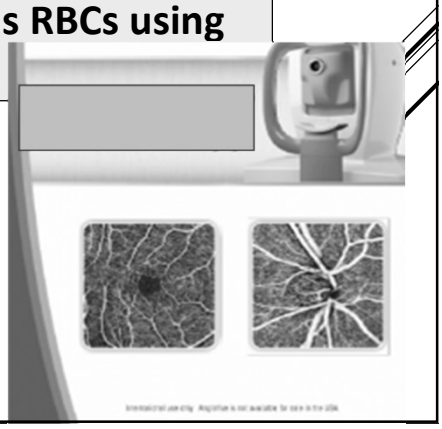
- **Potential information for health & function of entire retina**
- **Photoreceptors contain light-sensing molecules susceptible to damage/x-linking, & shed their damaged outer segments**
- **RPE phagocytize the segments & molecules stored in liposomes, forming lipofuscin (LF)**
- **Disease states & oxidative damage = ↑ LF**
- **Hyper-fluorescence = excess LF accumulation**
- **Hypo-fluorescence = RPE cells die/are absent**



Not paid separately at this time – part of examination

Angiography software - OCTA

- Non-invasive, dye-less
- Hi-resolution, 3-D visualization of retinal vasculature
- Images motion of scattering particles such as RBCs using sequential OCT x-sectional scans



Not paid separately
Report with 92134

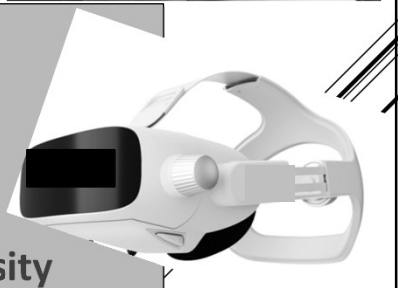
New OCTA Code coming in 2025

DARK ADAPTOMETRY

92284 Diagnostic dark adaptation examination with interpretation and report

CGS Pricing = $32.71

- Objective measurement of retinal function but NOT a screening test code
- Can bill with other tests and office visits
  - (eg OCT, fundus imaging, visual field)
- Multiple ICD-10 codes based on medical necessity
- Bilateral code



If not sure if use will be COVERED:
Use ABN or private payor equivalent
Consider GFE if applicable

92284: DARK ADAPTOMETRY

Now Retired First Coast LCD/Article listed diagnoses for 92284

No current LCDs or Articles

E50.5 Vitamin A deficiency with night blindness
H35.50 Unspecified hereditary retinal dystrophy
H35.52 Pigmentary retinal dystrophy
H35.53 Other dystrophies primarily involving the sensory retina
H35.54 Dystrophies primarily involving the retinal pigment epithelium
H40.20X0 - H40.20X4 Primary angle-closure glaucoma, stage unspecified
H53.60 Unspecified night blindness
H53.61 Abnormal dark adaptation curve
H53.63 Congenital night blindness
H53.69 Other night blindness

Dark adaptation function dramatically impaired in earliest stages of AMD
90% sensitivity/specificity for AMD
Could predict AMD 3 years earlier

RABIN CONE CONTRAST SENSITIVITY TESING

92283 Color vision examination, extended, eg, anomaloscope or equivalent
(Color vision testing with pseudoisochromatic plates [such as HRR or Ishihara] is not reported separately. It is included in the appropriate general or ophthalmological service, or 99172)

CGS Pricing = $48.30

Sensitive enough to detect changes associated with eye health & disease
Cone Function loss is affected early in disease –
(AMD, Diabetic Retinopathy, Glaucoma, Multiple Sclerosis, Parkinson's Disease, Optic Neuritis, high-risk medications (Plaquenil) & macular pigment density loss, for example)

Validated against Anomoloscope & Fully calibrated

https://www.healio.com/news/optometry/20160315/ods-recognize-clinical-value-of-color-vision-testing
Rabin Cone Test from INNOVA Systems, Inc. - Product Description and Details (ophthalmologyweb.com)

92250: FUNDUS PHOTOGRAPHY

CGS Pricing = $34.07

Fundus photography with interpretation and report

Bilateral Code

Do NOT bill with:

92250	92201
92250	92202
92250	92227
92250	92229

AND remember cannot bill with SCODI either per NCCI

FUNDUS PHOTOGRAPHY

- Involves the use of a retinal camera
- Diagnosis and/or Monitor abnormalities of disease processes affecting the eye, or to follow the progress of such disease or plan treatment
- For diabetic patients, in whom symptoms of visual disturbances may be present and in whom retinal examination may be unremarkable or normal, fundus photography MAY be indicated BUT is not a substitute for annual dilated examination
- Typically allowed 2 x/ year maximum
- If performed as a screening service, it is not covered by Medicare
- If can ONLY image 1 eye, file with –RT or -LT modifier

Not substitute for an annual dilated examination

L34339
A57071

FUNDUS PHOTOGRAPHY & SCODI

92133 AND 92134 WITH 92250

Caution!!!

- Continued confusion on billing photography & SCODI on same date of service
- They are "mutually exclusive" as defined by current NCCI
- Mutually exclusive is defined as "procedures that cannot reasonably be performed at the same anatomic site or same encounter"
- CMS guidance state there may be SOME cases where using together might be indicated BUT no specific examples

National Correct Coding Initiative (NCCI)

- Developed with RBRVS- 2003
- Insures proper Medicare payments
  (Resource Based Relative Value System)
- Identify pairs of services not billed together
  (Same physician for same patient on same day)
- Component element edits
  - 92012 and 92014
- Medically Unlikely Edits (MUE) policy manual
  - 92133 or 92134 and 92250 but MAY use -59 modifier
  - 92133 and 92134 may NOT be used together even with -59 modifier

https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

NCCI Edits

- MUE together, column 1 code is paid
- MUE MAY be allow together
- MUST READ AND UNDERSTAND WHAT CAN BE DONE TOGETHER AND WHEN
- Cannot use a modifier just to get paid

- 0 not allowed
- 1 allowed
- 9 non-applicable

If clinical circumstances justify appending a modifier to column 2 code of code pair, payment for both codes may be allowed

PROCEDURE TO PROCEDURE (PTP) EDITS

Be sure to view both codes of pair

Just because Modifier allowed does NOT mean can/should always append -59

Colum1/Column2 Edits

Column 1	Column 2	*=in existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Ration
92133	92132		20110101	20120331	1	Misuse of column two code with column one code
92133	92134		20110101	*	0	CPT Manual or CMS manual coding instructions
92133	92227		20110101	*	0	CPT Manual or CMS manual coding instructions
92133	92229		20210101	*	0	CPT Manual or CMS manual coding instructions
92133	92250		20110101	*	1	Mutually exclusive procedures
92134	92132		20110101	20120331	1	Misuse of column two code with column one code
92134	92227		20110101	*	0	CPT Manual or CMS manual coding instructions
92134	92229		20210101	*	0	CPT Manual or CMS manual coding instructions
92134	92250		20110101	*	1	Mutually exclusive procedures
92250	92227		20110101	*	0	CPT Manual or CMS manual coding instructions
92250	92229		20210101	*	0	CPT Manual or CMS manual coding instructions
92250	96523		20190401	*	0	CPT Manual or CMS manual coding instructions
92250	99211		20030401	20191231	1	Misuse of column two code with column one code
92250	99211		20201001	*	1	Misuse of column two code with column one cod

92133

92134

92250

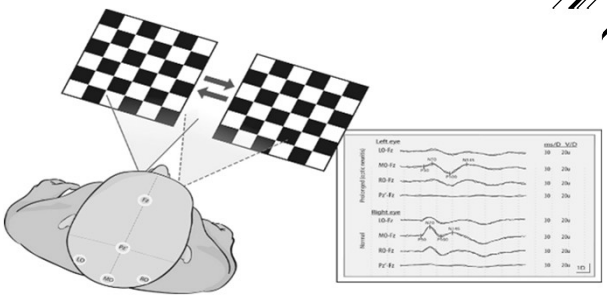
VISUAL EVOKED POTENTIAL - VEP

95930

Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report

CGS Pricing = $60.43

- **Bilateral Code**
- **General Supervision**
- **Special Training?**
- **Utilization Guidelines**
- **Carrier Dependent**



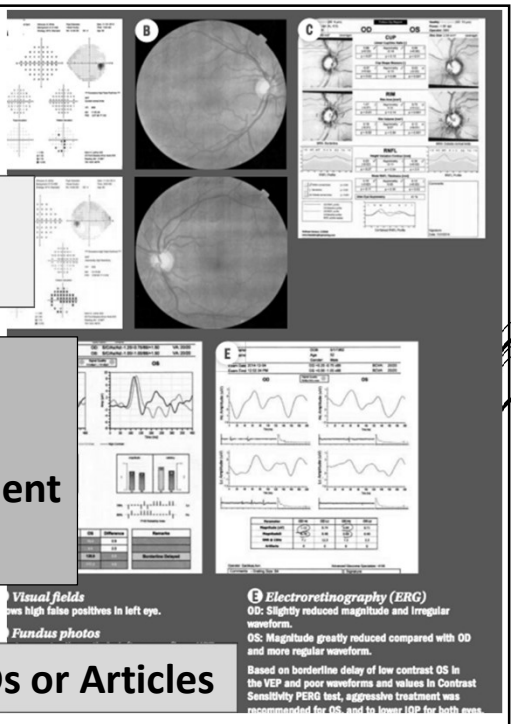
0464T

Visual Evoked Potential, testing for glaucoma, with interpretation and report

May NOT use any other VEP code with glaucoma diagnosis
Consider an ABN or private payor equivalent
Consider a GFE

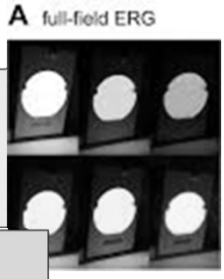
No CGS Pricing

No current LCDs or Articles



92273

Electroretinography (ERG), with interpretation and report; full field
(ie, ffERG, flash ERG, Ganzfeld ERG)



Full field (flash and flicker) (92273) for global response of photoreceptors of retina or macula

L38992
A58706

Electroretinography (ERG) is considered reasonable and medically necessary for:

CGS Pricing= $113.21

1. **Detection of loss of retinal function**
2. **To distinguish retinal from optic nerve lesions**
3. **Detecting chloroquine and hydroxychloroquine toxicity**

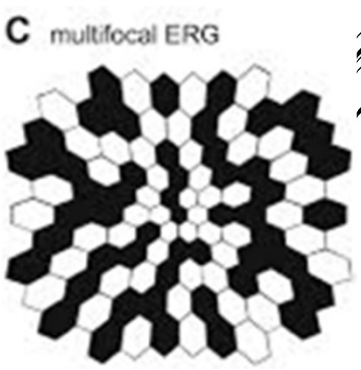
ERG is investigational for all other indications, including glaucoma

92274

Electroretinography (ERG) with interpretation and Report; multifocal (mfERG)

CGS Pricing = $80.76

Measuring local ERG responses and providing spatial information
Measures photoreceptors and aids in the detection of localized abnormalities within the macula



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0509T

Electroretinography (ERG) with interpretation and report, pattern (PERG)

CGS Pricing = $68.22

Pattern ERG (pERG) (0509T) to assess macular retinal ganglion cell (RGC) activity
used to detect subtle optic neuropathies
NOT GLAUCOMA!!!!

L38992
A58706

VISUAL ELECTROPHYSIOLOGY TESTING

Visual Evoked Potentials
(VEPs/VERs)

- **Confirm diagnosis of multiple sclerosis when clinical criteria are inconclusive**
- **Evaluate diseases of optic nerve**
- **Monitor visual system during optic nerve (or related) surgery**

Electroretinography (ERG)

- **Diagnose loss of retinal function or distinguish between retinal lesions & optic nerve lesions**
- **Detect chloroquine and hydroxychloroquine (Plaquenil) toxicity (mfERG) per AAO guidelines**

NEWER TECHNOLOGIES

New FDA approved for Glaucoma Management

Slit-lamp Mounted-Multifunctional-Single Use Tips

- **Tonometry – IOP Measurement**
- **Ophthalmodynamometry**
- **Tonography**
- **Ocular pulse amplitude**

James Thimons, OD:
Measures aqueous outflow and ocular perfusion pressure

New Falck Device Provides Several Glaucoma Diagnostics. Nancy Hemphill. Primary Care Optometry News. Nov 29, 2021
https://www.healio.com/news/optometry/20211129/new-falck-device-provides-several-glaucoma-diagnostics

SLIT-LAMP MOUNTED-MULTIFUNCTIONAL

Billing per Manufacturer BUT may or may not be covered by payors:

No current LCDs or Articles

92260 Ophthalmodynamometry **CGS Pricing = $17.76**

92100 Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure) **CGS Pricing= $76.96**

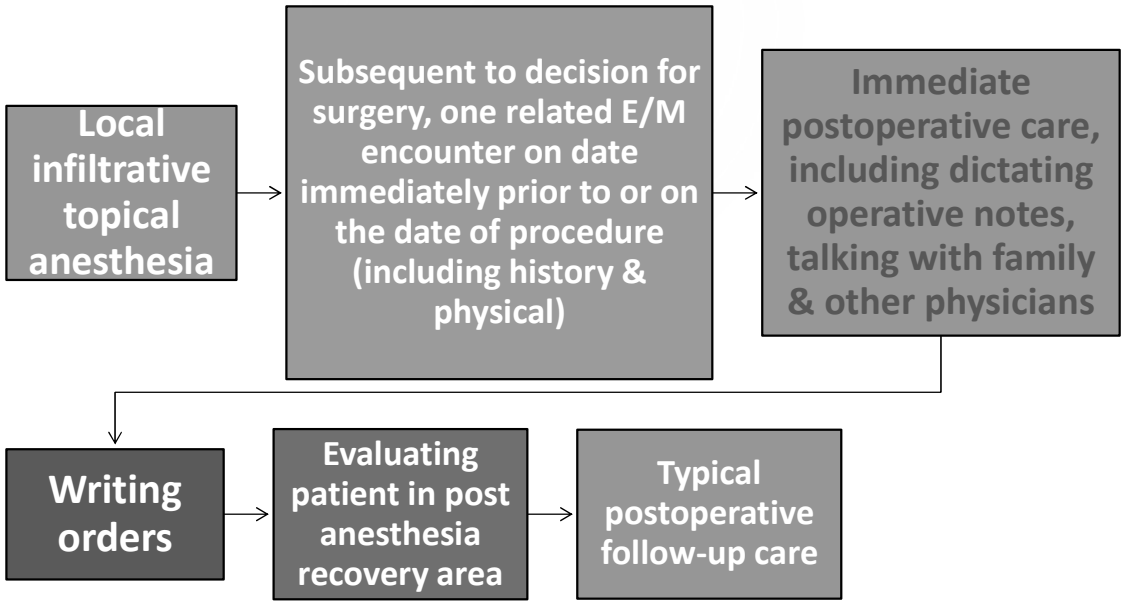
92499 Unlisted ophthalmological service or procedure **Carrier Pricing**

CO-MANAGEMENT

- COMPLICATED CATARACT SURGERY
- NOT FORMALLY COMANAGING
- HOW TO GET REIMBURSED

CO-MANAGEMENT

CPT SURGICAL PACKAGE



CO-MANAGEMENT

MEDICARE'S GLOBAL SURGICAL PACKAGE

Preoperative visits	Intra-operative Services	Complications Following Surgery
• Day before surgery or day of surgery	• Normal, usual and necessary part of surgical procedure	• All additional medical or surgical services required of surgeon during post-operative period

CO-MANAGEMENT

POST-OPERATIVE FOLLOW UP CARE

Surgical Days

- 0, 10, or 90 days
- See Medicare Physician Fee Schedule Database

http://www.cms.hhs.gov/FeeScheduleGenInfo/

CO-MANAGEMENT

SERVICES NOT INCLUDED IN MEDICARE'S IN GLOBAL SURGICAL PACKAGE

Initial consultation

Services of other physicians except where surgeon and other physician agree on transfer of care

Visits unrelated to the surgical procedure

Treatment of underlying conditions

CO-MANAGEMENT

SERVICES NOT INCLUDED IN MEDICARE'S GLOBAL SURGICAL PACKAGE

Diagnostic tests/procedures
(Includes diagnostic radiological procedures)

Distinct Surgical procedures during postoperative period - not re-operations or treatment complications

Treatment for postoperative complications for return to operating room

CO-MANAGEMENT

SERVICES NOT INCLUDED IN MEDICARE'S GLOBAL SURGICAL PACKAGE

- Less extensive procedure which requires more extensive procedure
- Surgical Tray
- Immunosuppressive Therapy (Organ Transplants)
- Critical Care Services unrelated to surgery

CO-MANAGEMENT

Package includes: Pre-operative, Intraoperative, Postoperative

PREOPERATIVE VISITS

- Subsequent to decision for surgery
- One related E&M on day of or prior to scheduled surgical procedure

CO-MANAGEMENT

CMS RESPONSE……

GLOBAL SURGERY PACKET REFERENCES THE INTERNET ONLY MANUAL - MEDICARE CLAIMS PROCESSING MANUAL, CHAPTER 12, SECTION 40.2, WITH FOLLOWING EXCEPTION THAT STATES A PHYSICIAN MAY BILL WITHOUT THE MODIFIER, WHEN A TRANSFER DID NOT OCCUR:

"EXCEPTIONS:

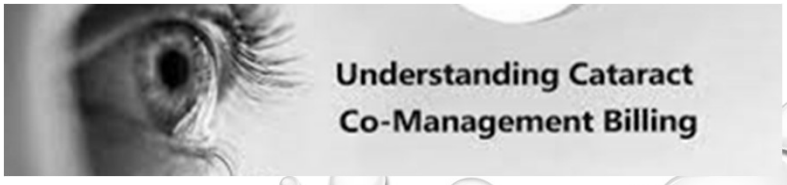
WHERE A TRANSFER OF CARE DOES NOT OCCUR, OCCASIONAL POST-DISCHARGE SERVICES OF A PHYSICIAN OTHER THAN THE SURGEON ARE REPORTED BY THE APPROPRIATE EVALUATION AND MANAGEMENT CODE. NO MODIFIERS ARE NECESSARY ON THE CLAIM."

SINCERELY,
PROVIDER RELATIONS RESEARCH SPECIALIST
CRITICAL INQUIRY UNIT
FIRST COAST SERVICE OPTIONS AND NOVITAS SOLUTIONS, INC.

CO-MANAGEMENT

IF no formal transfer of care –
Bill each visit using the appropriate E&M code (99000) or General Ophthalmological Visit Code (92000) without any modifiers

The ICD-10-CM code? The reason for which you are seeing them



BILLING POST-OPERATIVE CARE

How to code the exams for the co-management exams (YAG, cataract etc)
When post-op visits billed
Post-op for YAG OU, same date of service

BILLING POST-OPERATIVE CARE - CATARACTS

66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation

66989 with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more

66987 with endoscopic cyclophotocoagulation

66983 Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)

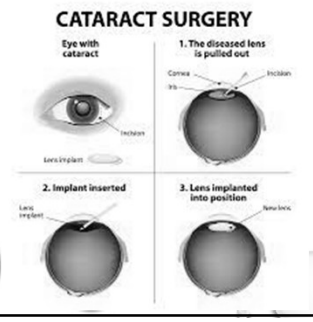
66985 Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal

66986 Exchange of intraocular lens

66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation

66991 with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more

66988 with endoscopic cyclophotocoagulation



BILLING POST-OPERATIVE CARE

Reasons for splitting care (different carrier)

- Operating surgeon unavailable & postoperative care managed by another physician
- Patient is unable to travel to surgeon's office for postoperative care
- Care provided in health professional shortage area (HPSA) & patient is unable to travel to surgeon's office
- Surgeon practices in a site remote from where patient recuperates (e.g., the surgery is performed in a remote area and the surgeon does not return to the area frequently enough to provide the preoperative or postoperative care)
- **Patient voluntarily wishes to be followed postoperatively by another physician**
- Surgery performed by itinerant surgeon in remote area

L33954
A56453

https://cgsmedicare.com/partb/pubs/news/2013/0213/cope21295.html

BILLING POST-OPERATIVE CARE

From Novitas

Transfer of postoperative care is not covered if

- Operating surgeon is available, and can manage other patients postoperatively, unless patient voluntarily wishes to be followed postoperatively by another provider
- Surgeon does follow patient postoperatively but splits the fee with another provider
- 2+ physicians co-manage patients indiscriminately as matter of policy & not case-by-case
- Physician demands to manage postoperative care & indicates will withhold making referrals to surgeons who would not agree to split global surgery payments
- Surgeon opts to transfer postoperative care
- Transfer is not made in writing
- Transfer is used as an incentive for obtaining referrals from providers to receive postoperative care reimbursement
- Patient has not consented to transfer of care even after being apprised of medical and/or logistic advisability or risks and benefits of transfer care

BILLING POST-OPERATIVE

55 Postoperative Management Only:
When 1 physician (orQHP) performed postoperative management and another performed the surgical procedure, postoperative component identified by adding modifier 55 to usual procedure number

Written transfer of care agreement between surgeon & physician assuming care
Both surgeon physician(s) providing post-operative care must keep copy of written transfer agreement in patient's medical records

Once receiving physician sees patient, may bill for period beginning with date assumed care of patient with surgery date as billed date of service

Surgical ICD-10-CM code typically used

Date of service = Date of surgical procedure
Procedure code = Surgical procedure, followed by modifier 55
Post-operative care dates – began + ended – plus # post-operative care days in narrative field on electronic claims, or item 19 on CMS 1500 claim form

BILLING POST-OPERATIVE CARE

Postoperative Management Only
Use when surgeon relinquishes all or part of postoperative days to another physician

Correct Use

Surgeon performs surgery and part of postoperative care

- **Submit claim - two lines - same date of service + procedure code + diagnosis**
  - **Append modifier -54 to line 1**
  - **Append modifier -55 to line 2**
  - **Date span of post-op care in Item 19 of CMS-1500 (or electronic equivalent)**
  - **Submit claim with number of units as 1**

Different physician rendering part or all postoperative care

- **Submit claim with surgery date and procedure code and diagnosis and 55 modifier**
- **Date span of assumed care in Item 19 narrative of CMS-1500 (or electronic equivalent)**
- **Submit claim with number of units as 1**

BILLING POST-OPERATIVE CARE

Date of service	CPT code and modifier	Place of service	Quantity	Item 19 or documentation field
04/15/21 (DOS) (date of surgery)	66984-55	11	1	Post-operative care assumed 04/24/2021 to 07/14/2021 - 82 days

Participating Provider	501.93
Non-Participating Provider	476.83
Limiting Charge Amount	548.35

Global Days	090
Pre-Operative %	0.1
Intra-Operative %	0.7
Post-Operative %	0.2

MPFS shows post-operative portion of the payment is 20% fee schedule amount for cost
Allowed amount for the service is $501.93

$501.93 x 20% = $100.39 (round up)
82/90=91.1% Did not perform 8.9% of PO
(Surgeon filed for 8.9% or $8.93)

100.39 x 91.1% = $91.46
$91.46 =allowed amount for post op provided

BILLING POST-OPERATIVE CARE

Documentation requirements

1. **Surgeon should write usual operative note**
2. **Postoperative Physician should document appropriate follow-up care notes**
3. **Transfer of care must be in writing and dated**
4. **Record must indicate exact date post-operative care is assumed by co-managing physician**
5. **Medical record must indicate patient was appropriately informed of medical and/or logistic advisability of transfer of care along with any risks or benefits of this arrangement, and that the patient gave consent to this arrangement prior to its inception**
6. **All documentation including documentation that patient was properly informed must be available to Medicare upon request**

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00101754

BILLING POST-OPERATIVE CARE

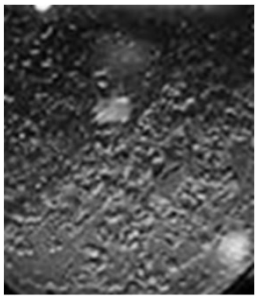
Who: Neodymium-doped **Y**ttrium **A**luminum **G**arnet **(YAG)** laser capsulotomies

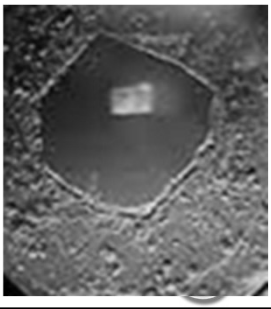
What: Laser to clear opacification of posterior capsule

When: No less than 90 days following cataract extraction, as general rule

- YAG performed < 90 days post cataract extraction must meet indications/limitations
- Number of patients requiring YAG varies greatly among ophthalmic surgeons

Why: Functional visual impairment due to capsular opacification (clinical judgment)





BILLING POST-OPERATIVE CARE

- Decreased ability for activities of daily living
- BVA = 20/50 or worse at distance or near
- Additional testing shows :
  - Consensual light testing decreases visual acuity by two lines
  - Glare testing decreases visual acuity by two lines
- Not functionally adequately visual function
- Other eye disease(s) excluded as primary cause of visual functional disability
- Physician concurrence with patient-defined improvement in visual function
- Educated about risks/ benefits of capsulotomy and alternative(s) to surgery
- Appropriate preoperative ophthalmologic evaluation

L33946 A56493

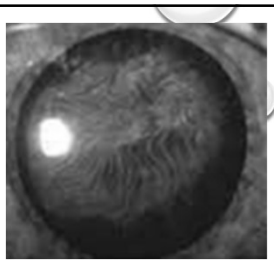
If all other criteria have been met and documented to support the medical necessity of the procedure for that patient even when vision 20/40 or better

CMS ON LASER USE

Medicare recognizes the use of lasers for many medical indications. **Procedures performed with lasers are *sometimes used in place of more conventional techniques.* In the absence of a specific noncoverage instruction, and where a laser has been *approved for marketing by the Food and Drug Administration, contractor discretion may be used* to determine whether a procedure performed with a laser is reasonable and necessary and, therefore, covered. The determination of coverage for a procedure performed using a laser is made on the basis that the *use of lasers to alter, revise, or destroy tissue is a surgical procedure. Therefore, coverage of laser procedures is restricted to practitioners with training in the surgical management of the disease or condition being treated*.**

(CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 2: 140.5 Laser Procedures)

BILLING POST-OPERATIVE CARE



Typically, YAG not typically covered within 3 months post cataract surgery without justification:

1. **Posterior capsular plaque/opacity which could not be safely removed during primary phacoemulsification cataract procedure**
2. **Capsular block during which cataract remnants and fluid become trapped within lens capsule and treatable with YAG laser posterior capsulotomy**
3. **Contraction of posterior capsule with displacement of the intraocular lens**

BILLING POST-OPERATIVE CARE

66821	**DISCISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID); LASER SURGERY (EG, YAG LASER) (1 OR MORE STAGES)**
H26.491	Other secondary cataract, right eye
H26.492	Other secondary cataract, left eye
H26.493	Other secondary cataract, bilateral
T85.21XA	Breakdown (mechanical) of intraocular lens, initial encounter
T85.29XA	Other mechanical complication of intraocular lens, initial encounter

90 day global period

Modifier -25: if on same day as unrelated E&M

Modifier -79: if during post operative period of another procedure

(More on -25 and -79 in this presentation)

Modifier RT/LT: to indicate which eye

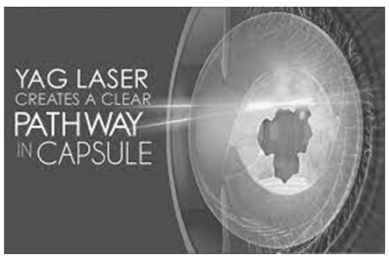
Modifier -55 if only performing post-operative care

BILLING POST-OPERATIVE CARE

Par	**305.65**
NonPar	**290.37**
Limiting	**333.93**

66821-55 →

61.13
58.07
66.79



Global Days	090
Pre-Operative %	0.1
Intra-Operative %	0.7
Post-Operative %	0.2
Multiple Procedures	2
Bilateral Surgery	1

← **Post Operative Care = 20%**

Note: If both eyes on same day, bill as surgeon: Either 55 and 79,55 with RT/LT OR with 50 modifier – CGS will pay 150% of allowable

BILLING POST-OPERATIVE CARE

- Directions on website for post-op (Shared/split) care billing (Often under Modifier -55 instructions)
- Bill DOS (surgery), surgery diagnosis & code,-55 modifier
- Dates of assumed care to/from with # days in Box 19
- Need written formal transfer of care + billing information & surgical notes from surgeon

ICD-10-CM ► Surgery DX

Bill post-operative care when you see patient for first post-op visit

- Bill 1st eye w/ -55 + RT/LT + appropriate diagnosis, DOS, post-op range
- Bill 2nd eye w/ -79 & -55 & RT/LT + appropriate diagnosis, DOS, post-op range
- If there are two different Assumed Care to and from dates, may need to consider billing as two different claims if surgeries on different day

https://www.cgsmedicare.com/partb/pubs/news/2013/0213/cope21295.html

PREMIUM IOL POST-OPERATIVE CARE

How to bill when you refer a patient for cataract surgery and they opted for a presbyopia-correcting IOL or other premium procedure

PREMIUM IOL POST OPERATIVE CARE

What Does CMS Cover?

- Conventional IOL implanted during cataract surgery
- Facility & physician services & supplies used to insert conventional IOL during cataract surgery
- 1 pair of prosthetic eyeglasses or contact lenses after each cataract surgery with IOL insertion

PREMIUM IOL POST OPERATIVE CARE

What Does CMS Not Cover?

Surgical correction for presbyopia or astigmatism (use of femtosecond laser)
Does not cover presbyopia-correcting IOLs, astigmatism-correcting IOLs and new technology IOLs such as Light-Adjusting-Lens (ALA)

Physician Services/Resources for premium lenses that exceed coverage for cataract surgery with insertion of conventional IOL
Refractive examinations associated with insertion of premium IOLs
Rx Changes to accommodate progression of postoperative presbyopia (after initial pair of covered glasses)

Some MA & private plans may have same coverage, or may offer more benefits to cover additional costs.
It is imperative that you verify the coverage policy for each individual payer

https://www.aao.org/eyenet/article/premium-iols-a-legal-and-ethical-guide

PREMIUM IOL POST OPERATIVE CARE

Medicare Claims Processing Manual, Chapter 32, Billing Requirements for Special Services
120 - Presbyopia-Correcting (P-C IOLS) and Astigmatism-Correcting Intraocular Lenses (A-C IOLs) (General Policy Information)

V2632*	• Posterior chamber intraocular lens
V2787**	• Astigmatism correcting function of intraocular lens
V2788	• Presbyopia correcting function of intraocular lens

***V2632 for P-C IOL or A-C IOL in an office setting for the IOL**
Medicare payment for lens based on reasonable cost for conventional IOL (POS= 11)

You can directly bill the patient for non-covered services/resources and not required to bill Medicare (statutorily excluded)

Must inform patient if non-coverage and statutorily excluded
ABN not required – similar to refraction
Consider Good Faith Estimate

ABN + use -GY modifier if filing requested

PREMIUM IOL POST OPERATIVE CARE

Bill 66984 as you would for regular post-operative care or 66982, 66985, 66986, etc

Report noncovered charges associated with premium IOLs using
V2788 for a presbyopia-correcting IOL
V2787 for an astigmatic-correcting IOL
Remember you do not have to bill Medicare unless patient requests that you do then use GY modifier

"Effective for dates of service January 1, 2008 and later, when inserting an approved A-C IOL in an ASC, HOPD, or physician office, V2787 should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens."

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1430CP.pdf

LESION REMOVAL: COVERED OR NOT COVERED

Small lid lesions removal,
25 gauge needle to make a small incision and drain
or
Surgical scissors (no stitches needed) to remove lesion all together

Appropriate CPT® codes?

LESION REMOVAL: COVERED OR NOT COVERED

In selected circumstances:
The removal of lesions is medically appropriate

Cosmetic Surgery
Performed to reshape and adjust normal structures of body to enhance the visual appearance

Provider must notify of beneficiary liability for cost of service ► ABN + consider Good Faith Estimate (GFE)

Medicare will consider removal as medically necessary, and not cosmetic, if one or more conditions are present and clearly documented in the medical record for …

L34200
A57044

Examples:
Seborrheic keratoses
Epidermoid cysts
Moles [nevi]
Acquired hyperkeratosis
Molluscum contagiosum
Milia
Viral warts
Benign neoplasms
Hemangiomas
Lipomas
Pyogenic granulomas

LESION REMOVAL: COVERED OR NOT COVERED

Lesion has become symptomatic or has undergone a change in appearance or displays evidence of inflammation or infection

- Bleeding
- Intense itching
- Pain
- Reddening
- Pigmentary change
- Recent enlargement
- Increase in the number of lesions
- Purulence, oozing, edema, erythema, etc.

LESION REMOVAL: COVERED OR NOT COVERED

Lesion Removal - Medical Necessity

The lesion obstructs an orifice

Lesion clinically restricts eye function. For example:

- Causes misdirection of eyelashes or eyelid
- Restricts lacrimal puncta and interferes with tear flow
- Restricts eyelid function
- Touches the globe
- Interferes with vision

Removal of molluscum contagiosum

Benign epidermal or pilar cyst with history of infection, drainage, or rupture

LESION REMOVAL: COVERED OR NOT COVERED

Lesion Removal - Medical Necessity

L34200
A57004

Lesion is in an anatomical region subject to recurrent physical trauma with documentation that such trauma has occurred

Wart removals will be covered under guidelines above. In addition, wart destruction will be covered when any of the following clinical circumstances are present:

- Periocular warts associated with chronic recurrent conjunctivitis perhaps secondary to lesion virus shedding
- Warts showing evidence of spread from one body area to another
- Lesions are condyloma acuminate

Destruction of actinic keratoses without restrictions based on lesion or patient characteristics (NCD 250.4)

LESION REMOVAL: COVERED OR NOT COVERED

Lesion Removal - Medical Necessity

Clinical uncertainty as to likely diagnosis, particularly if malignancy is realistic consideration based on lesion appearance or prior biopsy of related or similar lesion suggesting malignancy

Prior histological exam or biopsy suggests or is indicative of atypical (e.g., atypical nevus) or malignancy

LESION REMOVAL: COVERED OR NOT COVERED

"Medical record statement of 'irritated skin lesion' is insufficient justification for lesion removal when solely used to reference a patient's complaint or a physician's physical findings."

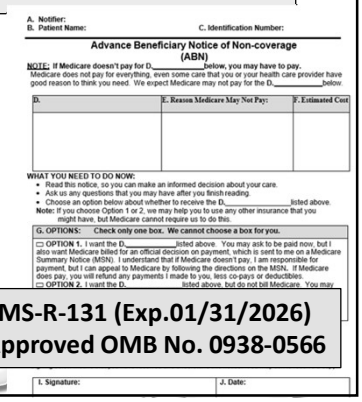
In summary :
Medicare will consider removal as medically necessary and not cosmetic, if one or more of conditions discussed are present and clearly documented
Along with all the other reasons previously discussed

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE ABN

Advance Beneficiary Notice of Noncoverage (ABN) to inform patient of non-coverage and patient liability
- **If coverage is uncertain, the claim can be filed with modifier –GA**
- **If cosmetic, the claim may be filed with modifier –GY**

Private Payers (Medicare Advantage Plans): Financial waiver is also required but check with the payer for its process and requirements

Good Faith Estimates (GFE) now required under No Surprise Billing when no insurance involved OR patient requests



A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D._____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D._____ listed above, but do not bill Medicare. You may

I. Signature: J. Date:

Form CMS-R-131 (Exp.01/31/2026)
Form Approved OMB No. 0938-0566

https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-abn

LESION REMOVAL: COVERED OR NOT COVERED

Denial Reasons:

ICD-10-CM code used?

Wrong lesion removal code used?

Inappropriate denial?

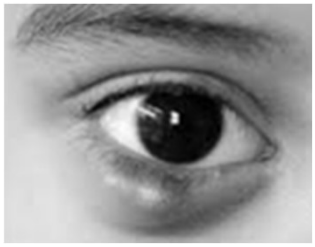
Need to have more specific information:

- **Specific denial reasons on EOB**
- **Claim copy**

More on this topic in a bit

LANCING EYE LID LESIONS

Best code to use for lancing a hordeolum, chalazion and other cyst excisions



LANCING EYE LID LESIONS

67700 Blepharotomy, drainage of abscess, eyelid

10 day global

Par	253.42
NonPar	240.75
Limiting	276.86

H00.01 Hordeolum externum
Hordeolum NOS
Stye
H00.011 Hordeolum externum right upper lid
H00.012 Hordeolum externum right lower lid
H00.014 Hordeolum externum left upper lid
H00.015 Hordeolum externum left lower lid

H00.02 Hordeolum internum
Infection of meibomian gland
H00.021 Hordeolum internum right upper lid
H00.022 Hordeolum internum right lower lid
H00.024 Hordeolum internum left upper lid
H00.025 Hordeolum internum Left lower lid

Global Days	010
Pre-Operative %	0.1
Intra-Operative %	0.8
Post-Operative %	0.1
Multiple Procedures	2
Bilateral Surgery	1

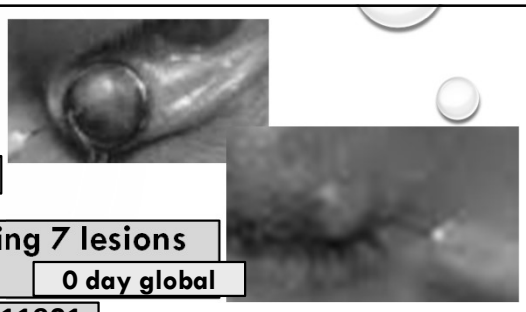
Modifier -50 when bilateral, pay 150%

Or E1, E2, E3, E4 Modifiers, one per line
67700-E1 100%
67700-E4 50%

Standard payment adjustment rules for multiple procedures

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
67700	2	3 Date of Service Edit: Clinical	Clinical: Data

LANCING EYE LID LESIONS



67800 Excision of chalazion; single
67801 ;multiple, same lid
67805 ;multiple, different lids

10 day global

11900 Injection, intralesional; up to and including 7 lesions
11901 ;more than 7 lesions

0 day global

	67800	67801	67805	11900	11901
Par	118.59	150.46	187.59	52.71	64.97
NonPar	112.66	142.94	178.21	50.07	61.72
Limiting	129.56	164.38	204.94	57.58	70.98

H00.11 Right upper eyelid
H00.12 Right lower eyelid
H00.14 Left upper eyelid
H00.15 Left lower eyelid

	67800/67801/67805	11900/11901
Global Days	010	000
Pre-Operative %	0.1	0.0
Intra-Operative %	0.8	0.0
Post-Operative %	0.1	0.0
Multiple Procedures	2	2
Bilateral Surgery	0	0

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
67800	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
67801	1	2 Date of Service Edit: Policy	Anatomic Consideration
67805	1	2 Date of Service Edit: Policy	Anatomic Consideration
11900	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
11901	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction

LANCING EYE LID LESIONS EPIDERMOID CYSTS

Solitary, elevated, round, freely mobile subcutaneous mass with smooth overlying skin
Most common site for the sebaceous or epidermoid cysts is meibomian glands of upper tarsus due to retention of meibomian gland material

67840 Excision of eyelid lesion (except chalazion) without closure or with simple direct closure **10 day global**

Par	253.11
NonPar	240.45
Limiting	276.52

67840 – describes removal of more than just skin
Cannot be used for ALL Lesions of eyelid

Global Days	010
Pre-Operative %	0.1
Intra-Operative %	0.8
Post-Operative %	0.1
Multiple Procedures	2
Bilateral Surgery	1

Can use if removing more than skin
(ie., involving lid margin, tarsus, and/or palpebral conjunctiva)
If only skin excision procedure: Use of 1144x or 1164x

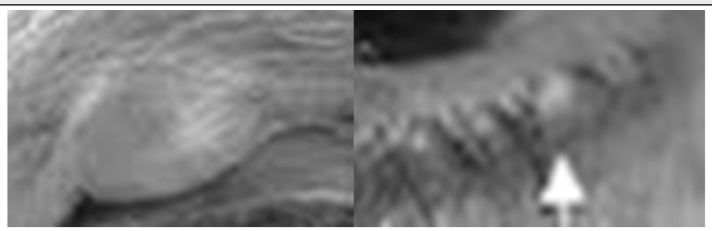
Remember to check the NCCI Procedure to Procedure Edits

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
67840	3	3 Date of Service Edit: Clinical	Clinical: Data

LANCING EYE LID LESIONS EPIDERMOID CYSTS

10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10061 ; complicated or multiple **10 day global**

	10060	10061
Par	116.96	199.29
NonPar	111.11	189.33
Limiting	127.78	217.73



	10060	10061
Global Days	010	010
Pre-Operative %	0.1	0.1
Intra-Operative %	0.8	0.8
Post-Operative %	0.1	0.1
Multiple Procedures	2	2
Bilateral Surgery	0	0

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
10060	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
10061	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction

LANCING EYE LID LESIONS EPIDERMOID CYSTS

10140 Incision and drainage of hematoma, seroma or fluid collection
10160 Puncture aspiration of abscess, hematoma, bulla, or cyst

	10140	10160
Par	156.19	119.45
NonPar	148.38	113.48
Limiting	170.64	130/50
Global Days	010	010
Pre-Operative %	0.1	0.1
Intra-Operative %	0.8	0.8
Post-Operative %	0.1	0.1
Multiple Procedures	2	2
Bilateral Surgery	0	0

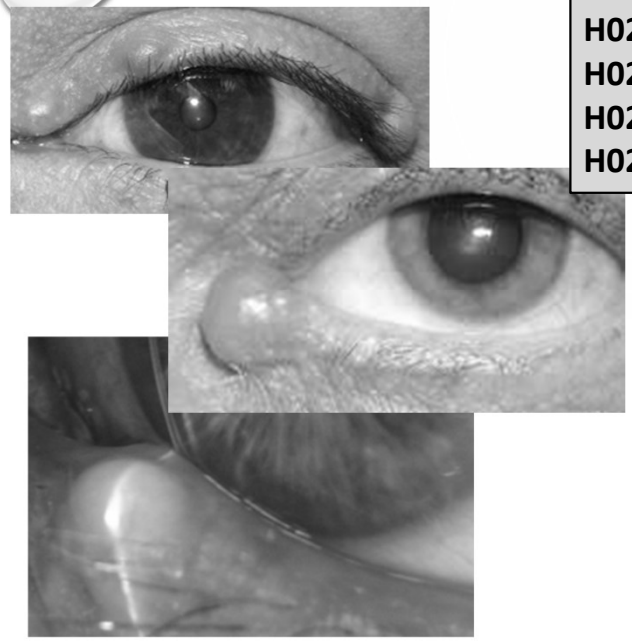
NCCI — **10 day global**

Column1/Column2 Edits		Modifier	PTP Edit Rationale
Column 1	Column 2	0=not allowed 1=allowed 9=not applicable	
10160	10140	1	Mutually exclusive procedures
10140	0597T		
10140	11055		

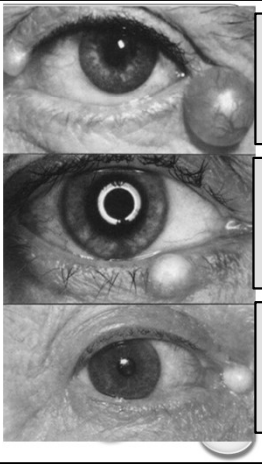
But if only view 10140, would miss the edit that 10160 and 10140 would not typically be billed together

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
10140	2	3 Date of Service Edit: Clinical	Clinical: Data
10160	3	3 Date of Service Edit: Clinical	Clinical: Data

LANCING EYE LID LESIONS EPIDERMOID CYSTS



H02.821 Cysts of right upper eyelid
H02.822 Cysts of right lower eyelid
H02.824 Cysts of left upper eyelid
H02.825 Cysts of left lower eyelid



Cyst of Moll

Cyst of Zeis

Sebaceous Cyst

LANCING EYE LID LESIONS CONJUNCTIVAL CONCRETIONS

H11.121 Conjunctival concretions, right eye
H11.122 Conjunctival concretions, left eye
H11.123 Conjunctival concretions, bilateral

65210 Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral non-perforating

0 day global

LANCING EYE LID LESIONS CONJUNCTIVAL CONCRETIONS

	65210
Par	35.81
NonPar	34.02
Limiting	39.12

Global Days	000
Pre-Operative %	0.0
Intra-Operative %	0.0
Post-Operative %	0.0
Multiple Procedures	2
Bilateral Surgery	1

This is not per concretion but per eye
65210-50 if Bilateral Procedure

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
65210	1	3 Date of Service Edit: Clinical	CMS Policy

OTHER LESION REMOVALS

WHY NOT JUST USE 17000 OR 67840 FOR ALL LESION PROCEDURES

OTHER LESION REMOVALS

17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement) premalignant lesions (eg, actinic keratoses); first lesion

17003 Second through 14 lesions, each (list separately in addition to code for first lesion)

(Use 17003 in conjunction with 17000)

(For destruction of common or plantar warts, see 17110,17111)

More on these codes in a moment!

OTHER LESION REMOVALS
GENERAL SURGICAL CONSIDERATIONS

Separate operative report for procedure and contain:

- Indications For Procedure
- Detailed Description Of Procedure
- Possible Complications And Side Effects
- Discharge Instructions
- Clearly Documented Written, Signed And Dated Consent

Informed Consent for In-Office Minor Surgery/Procedure

All details must be in medical record, including an order and reasoning for procedure carefully documented

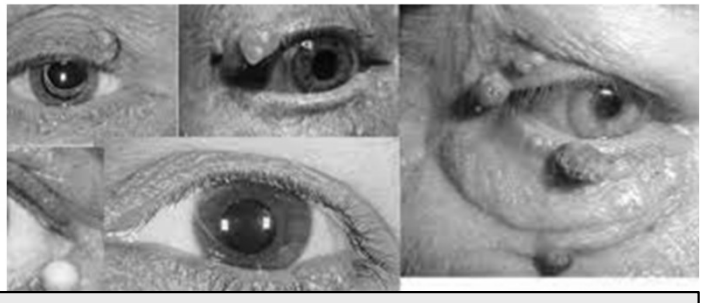
OTHER LESION REMOVALS
LUMP AND BUMP LESIONS

Determine Location
Corneal
Conjunctival
Lacrimal
Eyelid

Determine Histology
Benign Malignant Uncertain

Determine Removal Method
Cut Scrape Excise
Cauterize Incise Drain

Determine Closure
(If Necessary)
Simple Complex



THEN:
Choose CPT code(s) to match your documentation
Lesion removals - minor procedures
Post Operative Days - Either zero or 10 postop days
-25 modifier if with an office visit & for different reason

OTHER LESION REMOVALS
OTHER CONSIDERATIONS

Lid Lesion Measuring:

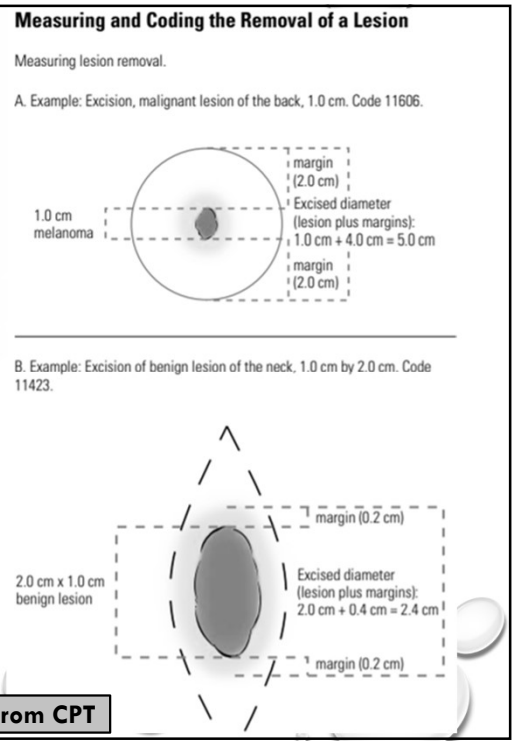
Measure greatest lesion diameter & margin required for complete excision

Document measure in procedure note

Histology of Lesion:

If unsure of histology of lesion & submitting specimen to pathology ►
Hold claims until pathology report is received to pick appropriate code

CPT Code from 1144x series or 1164x series



From CPT

OTHER LESION REMOVALS
BIOPSY VS LESION REMOVAL

Biopsy - portion of the lesion is removed and sent to pathology

Coded as 67810 if it is more than just skin

67810 Incisional biopsy of eyelid skin including lid margin

Entire lesion removed and sent to pathology,

Coded as 67840 if more than just skin

67840 Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure

OTHER LESION REMOVALS

67840 Excision of eyelid lesion (except chalazion) without closure or with simple direct closure

10 day global

Par	253.11
NonPar	240.45
Limiting	276.52

Global Days	010
Pre-Operative %	0.1
Intra-Operative %	0.8
Post-Operative %	0.1
Multiple Procedures	2
Bilateral Surgery	1

Coded as 67840 if more than just skin

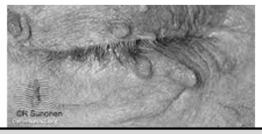
67810 Incisional biopsy of eyelid skin including lid margin

0 day global

Par	165.53
NonPar	157.25
Limiting	180.84

Global Days	000
Pre-Operative %	0.0
Intra-Operative %	0.0
Post-Operative %	0.0
Multiple Procedures	2
Bilateral Surgery	1

OTHER LESION REMOVALS
SKIN TAG REMOVAL



11200 Removal of skin tags, multiple fibrocutaneous tags, any area ;up to and including 15 lesions

11201 ;each additional 10 lesions, or part thereof

(List separately in addition to code for primary procedure)

10 day global

Par	84.91	17.28
NonPar	80.66	16.42
Limiting	92.76	18.88
	11200	11201

Global Days	010
Pre-Operative %	0.1
Intra-Operative %	0.8
Post-Operative %	0.1
Multiple Procedures	2
Bilateral Surgery	0

Skin Tags Removal (c or sc local anesthesia)

Scissoring or any sharp method Ligature strangulation
Electrosurgical destruction
Combination of treatment modalities
Chemical destruction Electrocauterization of wound

Usually considered cosmetic
Consider a GFE
Patient financially responsible -Medicare ABN or private equivalent

OTHER LESION REMOVALS

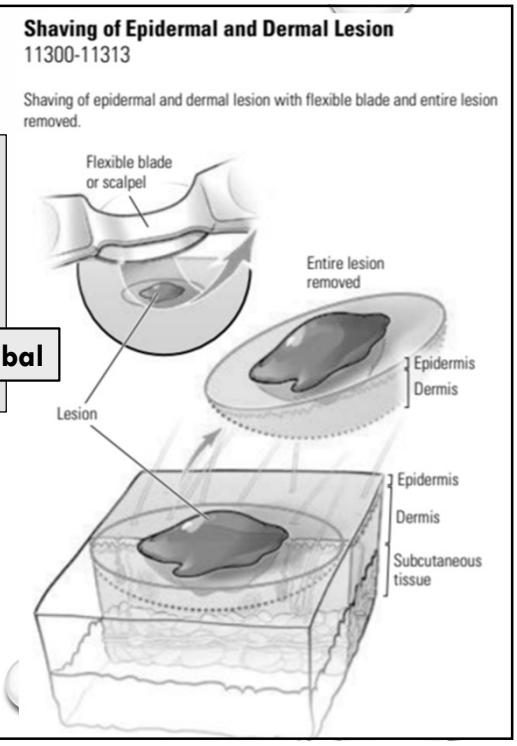
SHAVING EPIDERMAL/ DERMAL LESIONS

11310 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
11311 ;lesion diameter 0.6 to 1.0 cm
11312 ;lesion diameter 1.1 to 2.0 cm
11313 ;lesion diameter over 2.0 cm

0 day global

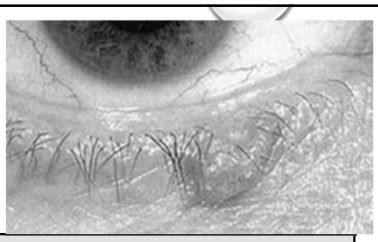
	11310	11311	11312	11313
Par	104.98	124.63	141.82	165.92
NonPar	99.73	118.40	134.73	157.62
Limiting	114.69	136.16	154.94	181.26

Global Days	000
Pre-Operative %	0.0
Intra-Operative %	0.0
Post-Operative %	0.0
Multiple Procedures	2
Bilateral Surgery	9



OTHER LESION REMOVALS

HYPERKERATOTIC LESIONS



11055 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11056 ;2 to 4 lesions
11057 ;more than 4 lesions

0 day global

	11055	11056	11057
Par	63.94	74.49	81.83
NonPar	60.74	70.77	77.74
Limiting	69.85	81.39	89.40

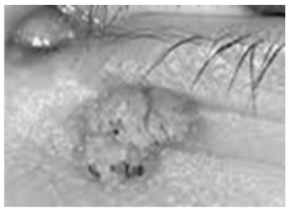
Global Days	000
Pre-Operative %	0.0
Intra-Operative %	0.0
Post-Operative %	0.0
Multiple Procedures	2
Bilateral Surgery	0

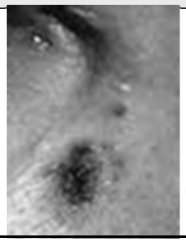
OTHER LESION REMOVALS
CPT DEFINITIONS: DESTRUCTION

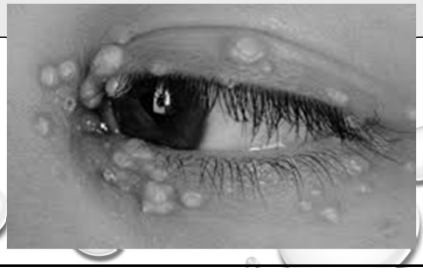
Destruction means the ablation of benign, premalignant or malignant tissues by any method, with or without curettement, including local anesthesia, and not usually requiring closure

Any method includes electrosurgery, cryosurgery, laser and chemical treatment

Lesions include condylomata, papillomata, molluscum contagiosum, herpetic lesions, warts (ie, common, plantar, flat), milia, or other benign, premalignant (eg, actinic keratoses), or malignant lesions







OTHER LESION REMOVALS
LESION DESTRUCTION CODES

17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion

17003 ;second through 14 lesions, each
(List separately in addition to code for first lesion)
(Use 17003 in conjunction with 17000)
(For destruction of common or plantar warts, see 17110, 17111)

17004 ;15 or more lesions

10 day global

Par	**62.12**	**6.00**	**152.92**
NonPar	**59.01**	**5.70**	**145.27**
Limiting	**67.86**	**6.56**	**167.06**
	17000	**17003**	**17004**

		ZZZ	
Global Days	010	ZZZ	010
Pre-Operative %	0.1	0.0	0.1
Intra-Operative %	0.8	0.0	0.8
Post-Operative %	0.1	0.0	0.1
Multiple Procedures	2	0	0
Bilateral Surgery	0	0	0
	17000	**03**	**04**

Global Days: ZZZ

Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post service time.)

OTHER LESION REMOVALS
LESION DESTRUCTION CODES

17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions

17111 ;15 or more lesions

10 day global

Par	**103.08**	**121.16**
NonPar	**97.93**	**115.10**
Limiting	**112.62**	**132.37**
	17110	**17111**

Global Days	010
Pre-Operative %	0.1
Intra-Operative %	0.8
Post-Operative %	0.1
Multiple Procedures	2
Bilateral Surgery	0

OTHER LESION REMOVALS
PAPILLOMA EXCISION

11440 Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less

11441 ; excised diameter 0.6 to 1.0 cm

11442 ; excised diameter 1.1 to 2.0 cm

11443 ; excised diameter 2.1 to 3.0 cm

11444 ; excised diameter 3.1 to 4.0 cm

11446 ;excised diameter over 4.0 cm

10 day global

Par	**130.84**	**160.06**	**178.02**	**210.81**	**262.90**	**358.23**
NonPar	**124.30**	**152.06**	**169.12**	**200.27**	**249.76**	**340.32**
Limiting	**A42.95**	**174.87**	**194.49**	**230.21**	**287.22**	**391.37**
	11440	**11441**	**11442**	**11443**	**11444**	**11446**

OTHER LESION REMOVALS

*** 92285 Caution**

92285 External photography with interpretation and report for documentation of medical progress

ICD-10-CM Code

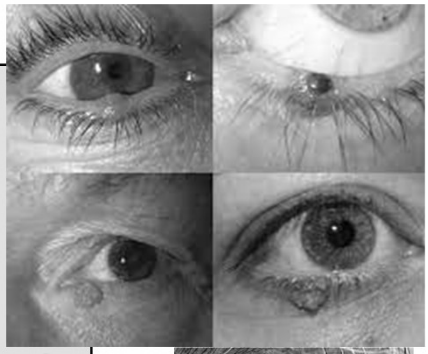
D23.111 Other benign neoplasm of skin of right upper eyelid, including canthus
D23.112 Other benign neoplasm of skin of right lower eyelid, including canthus
D23.121 Other benign neoplasm of skin of left upper eyelid, including canthus
D23.122 Other benign neoplasm of skin of left lower eyelid, including canthus

OTHER LESION REMOVALS

There are MANY codes to choose from when removing lid lesions

Be sure to understand:

- **What type of lesion removal is required**
- **Which procedure matches removal type used**
- **Which code applies to the procedure used**



RESOURCES

AOA.org
Practice
Coding and Reimbursement

HOME / PRACTICE / PRACTICE SUCCESS RESOURCES / CODING AND REIMBURSEMENT

Coding and Reimbursement

Coding and reimbursement is designed to educate doctors and staff on medical recordkeeping and documentation, compliance and coding. The guidance received by the coding experts will support doctors and staff in providing the best possible patient care while ensuring accurate reimbursements are received.

Many practice, coding and reimbursement resources on the right side of the page

Resources and support provided to AOA members include advisory and educational information related to:

- Accurate choices of procedure and diagnosis codes for eye care.
- Understanding and preparing for payer audits of patient care and coding.
- Changes in Medicare and coding policies.
- ICD-10 preparation and conversion.

Scroll to bottom of page to enter Coding Questions at Ask the Coding Experts

Online coding resources available for AOA members

AOACodingToday.com
point > click > code

AMERICAN OPTOMETRIC ASSOCIATION

Ask the Coding Experts

If you have any questions regarding medical records and coding submit the form below.

Name *
E-mail *
AOA Member ID *
State *
Your question: *
Submit

https://www.aoa.org/practice/practice-success-resources/coding-and-reimbursement

RESOURCES

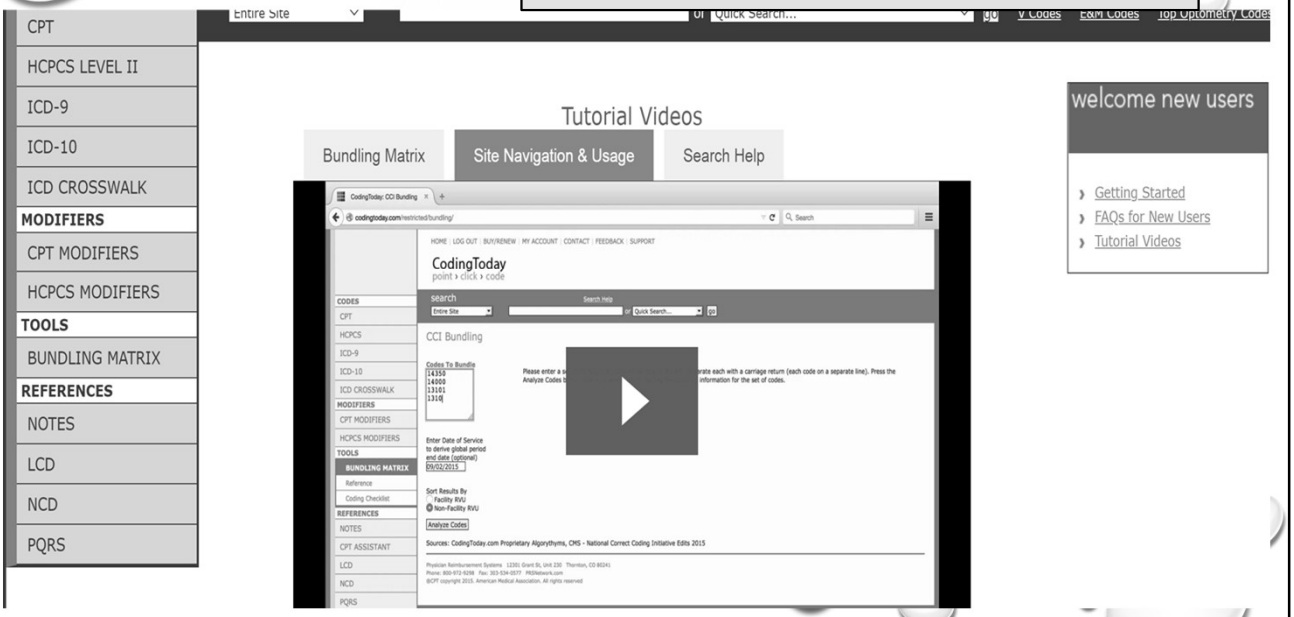
Elements of Medical Decision Making
(*For more details on E/M codes and their descriptors, please refer to the AMA's library of CPT resources at https://www.ama-assn.org/amaone/cpt-current-procedural-terminology.)

Code (99211 time is N/A)	Level of MDM (Based on 2 out of 3 elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none 99202 15 minutes 99212 10 minutes	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury; or • 1 stable, acute illness; or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (Must meet the requirements of at least 1 out of 2 categories) Category 1: Test and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment 99203 30 minutes 99213 20 minutes
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable, chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute, complicated injury 99204 45 minutes 99214 30 minutes	Moderate (Must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s); or Category 2: Assessment requiring an independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment - Examples: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function 99205 60 minutes 99215 40 minutes	Extensive (Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s); or Category 2: Assessment requiring an independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment - Examples • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances

2024
LINK TO MDM/TIME SUMMARY SHEET
HANDY FOR USE IN THE EXAM LANE

AOACODINGTODAY

- **User name and password same as AOA login**
- **CPT, HCPCS codes, ICD-10 codes, Modifiers, and more**



RESOURCES

- **NCD LCDs and Articles**: https://www.cms.gov/medicare-coverage-database/search-results.aspx?keyword=&areaId=all&docType=6,3,5,1,F,P&hcpcsOption=code&hcpcsStartCode=76513&hcpcsEndCode=76513&sortBy=title
- **CMS NCD**: https://www.cms.gov/medicare-coverage-database/reports/national-coverage-ncd-report.aspx?chapter=all&sortBy=title#
- **CMS PTP Edits**: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/PTP-Coding-Edits
- **CMS MUE**: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE
- **CMS NCCI** Edit Manual: https://www.cms.gov/medicare/national-correct-coding-initiative-edits/ncci-policy-manual-medicare (Introduction, Chapter 1, 8, 11, 12, 13)
- **Use of -59 Modifier**: https://www.cms.gov/files/document/proper-use-modifiers-59-xepsu.pdf

RESOURCES

CMS Claims Processing Manual Chapter 32: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf
CMS MedLearn Vision Services: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/visionservices_factsheet_icn907165.pdf

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/visionservices_factsheet_icn907165.pdf

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=35091

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf

AOA Informed Consent for In-Office Minor Surgery/Procedure

QUESTIONS??




https://www.aoa.org/practice/practice-success-resources/coding-and-reimbursement?sso=y

THANK YOU!!!

YOU SURVIVED!!!