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Optometry Coding & Billing Alert

Cataracts: Are These Myths Holding Back Your Cataract Post-Op Care Claims?

Tip: Communication with the surgeon is key to getting your deserved reimbursement.

By age 80, more than half of all Americans either have a cataract or have had cataract surgery, according to statistics from the National Eye Institute. With the aging of the Baby Boom generation, that means that your optometry practice is probably seeing its fair share of cataract patients for postoperative management. But is your practice seeing its fair share of deserved reimbursement for these procedures?

Read on to discover two common myths that often put cataract post-op management in optometrists' blind spots and how to avoid them to keep your claims focused.

Myth: The optometrist should report a different diagnosis code than the ophthalmic surgeon did.

Reality: The No. 1 reason for cataract co-management denials is the OD reporting a different diagnosis code than the ophthalmologist. If the code does not match up, one of those physicians is going to be denied, warn experts.

What to do: Avoid across-the-board use of 366.10 (Senile cataract, unspecified) and retrieve the precise diagnosis code from the ophthalmologist before sending out a claim.

Example: If the ophthalmologist uses 366.13 (Anterior subcapsular polar senile cataract), the optometrist should also report 366.13 in box 21.

ICD-10: Starting October 2015, instead of 366.10, report ICD-10 code H25.9 (Unspecified age-related cataract). Instead of 366.13, you would report an ICD-10 code from the H25.03- (Anterior subcapsular polar age-related cataract...) series.

Don't miss: The same applies to matching the surgical CPT® code you both are reporting. While 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis [1 stage procedure], manual or mechanical technique [e.g., irrigation and aspiration or phacoemulsification]) applies to the majority of cataract patients, occasionally the procedure will be difficult and the surgeon will report 66982 (... complex, requiring devices or techniques not generally used in routine cataract surgery [e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis] or performed on patients in the amblyogenic developmental stage). Good news: Because 66982 has a higher relative value than 66984, the postoperative care also will reimburse the OD at a higher level, according to **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas.

Be sure to append modifier 55 (Postoperative management only) to either 66984 or 66982 to accurately represent the post-op services you have provided.

Good idea: Insert a note on the claim form explaining that any documentation needed is available upon request. Many practices have successfully used this technique to avoid denials.

Myth: The ophthalmic surgeon's fees are irrelevant to the optometrist.

Reality: Another common co-management billing mistake is overlooking changes in the surgeon's fee structure. It's important to stay in the loop when the ophthalmologist increases her fees so you can earn the full 20 percent of the Medicare allowable to which you are entitled for postoperative care.

However: "That would only apply if the surgeon was charging less than the Medicare allowable, which is unlikely,"

observes Gibson.

Remember: Often, the surgeon will provide initial postoperative care before transferring the patient to the OD. In this case, it's important to coordinate on the number of days each physician is providing care and enter those numbers on separate claim forms.

Watch for: Does the surgeon keep each patient the same number of days before referring back to you? That may draw attention from insurers. If the surgeon always sends the patient back to you after the one-week visit, payers may suspect that you have a deal with that surgeon (for example, that you always get you patient back early as a "kickback" for referring the patient. Of course, it is up to the surgeon when to send the patient back, but try not to appear guilty of a prearranged deal.

Find your share: To figure the split, first calculate 20 percent of the overall charge for the service. Then, divide that total by 90, which is the cataract postoperative global period. This gives you the per-day value of the postoperative management service. In the units field, write in the number of days of service your OD provides, which, multiplied by the per-day rate described above, will yield your total charge for the service. Tip: The OD can assume care on the day after the patient is last seen by the surgeon.

Call the surgeon after you see the patient to find out if she is filing for postoperative care and, if so, how many days she will report, so you can bill for the balance. This is also a good time to remind that office to include modifier 54 (Surgical care only) on its claim form otherwise you run the risk of the payer denying your comanagement claim.

Try this: If the surgeon isn't already using a postoperative form that covers all the bases, offer to help design one. A good form could show the surgery date, which eye the surgeon treated (if not both), the surgeon's postoperative care dates, and the number of days that represents. Additionally, the form could indicate the date the OD assumed care, the initial refraction, and the resultant acuities. Fax or e-mail this completed form back to the surgeon to share the record of the patient's continuing care.