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Optometry Coding & Billing Alert

FBR: Bust These Foreign Body Removal Myths for Foolproof Claims

Treating punctal plugs like FBRs? Read this first.

Even more irritating than having something stuck in your eye is having Medicare deny a claim for what you thought was a run-of-the-mill foreign-body removal. Is one of these FBR myths keeping you from getting reimbursed for 65205-65222?

Myth #1: The type of instrument you use determines what foreign-body removal code to report.

Reality: The codes in the FBR code series (65205-65222) do not indicate any particular instrument for removing the FB. You should choose a code according to the specific location and level of penetration of the FB in the eye.

For example, for the removal of a superficially penetrating FB in the conjunctiva, you would report 65205 (Removal of foreign body, external eye; conjunctival superficial). On superficial conjunctival FBRs, **Joshua Tepperberg, CPC, EMT-D,** reports that the optometrist will typically use one of the following methods, or a combination of the three:

irrigation

a cotton swab

the tip of a beveled needle.

This does not affect your code choice, however.

Not so fast: If you perform an FBR in the cornea, you will need to consider whether you use a slit lamp to visualize the FB. Report 65220 (Removal of foreign body, external eye;corneal, without slit lamp) if you did not use the slit lamp; otherwise, report 65222 (...corneal, with slit lamp).

Myth #2: All FBRs within the same eye are bundled, which means you can only bill an FBR code once per eye.

Reality: This is true if you remove multiple foreign bodies only from the same part of the eye. If you remove FBs from different parts of the same eye -- the cornea and the conjunctiva, for example -- you can code a service for each part.

In the Correct Coding Initiative, the codes concerning FBs in the conjunctiva, 65205 and 65210 (... conjunctival embedded [includes concretions], subconjunctival, or scleral nonperforating), are not bundled with corneal FB codes 65220 and 65222, which means you are free to report both codes -- 65210 and 65222, for example -- separately.

Good news: Notch a higher-paying code in 65210 if the physician removes an embedded conjunctival FBR.

Bad news: No exact definition of "embedded conjunctival FBR" exists, says **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas.

Myth #3: You can't code for both an FBR and an E/M service.

Reality: Like Myth #2, Myth #3 isn't always a myth. If you are dealing with a new patient, you may be able to report a low-level E/M in addition to an FBR. Otherwise, unless you need to do a history, exam and decision-making with the performance of the FBR, you should not code for and bill an office visit. But if you think the patient requires a full workup to rule out other problems and you consider this to be medically necessary, you should code and bill both services.

Whether you report an E/M code will depend on the patient's complaint. If he just complains of eye pain, you will probably need to examine the patient to find the source of the pain. Document the exact complaint the patient has if you want to defend using an office visit and an FBR procedure together.

Smart idea: Be sure to document the history, exam and medical decision-making components of the E/M service in a separate, dated entry. You also need a separate, dated entry for the FBR, and be sure that the optometrist has signed both sections. Choose an appropriate examination code depending on the documentation and append modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) to this exam code.

Different ICD-9 codes for the exam and the FBR may not be necessary, but some carriers may prefer that you have a distinct diagnosis for each service. The ICD-9 code for the exam should reflect the reason you performed the exam -- the patient's complaint of eye pain or a foreign-body sensation. For the FBR, use an ICD-9 code that documents what you found in the examination -- the foreign body itself.

Myth #4: You can code a foreign body diagnosis even if your exam doesn't turn up a foreign body.

Reality: You can code for the foreign-body sensation with an eye pain code, such as 379.91 (Unspecified disorder of eye and adnexa; pain in and around eye), but if your exam revealed no foreign body, you should not report a foreign-body ICD-9 code (930.0-930.9, Foreign body on external eye).

Myth #5: You should code punctal plug removal as FB removal.

Reality: Punctal plugs may be foreign bodies, but reporting your punctal plug removal as an FBR will get you nowhere with Medicare. Unfortunately, there is no appropriate way to charge in the Medicare program for removing plugs, even if you're not the optometrist who put them there in the first place.

If there is no specific code in CPT for the removal of a suture or implanted device, Medicare considers the removal to be included in the global package of insertion, even if it's after the 10-day global period.

If you have to remove a punctal plug that another optometrist inserted, Medicare believes the service should be coded as a low-level E/M office visit.