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Optometry Coding & Billing Alert

Not Appending Modifier 55 to Post-Op Cataract Management Claims? Read This

Communication with the surgeon can be the key to earning over $100 per patient

You may already be crystal-clear on the rules for coding and billing postoperative care for cataract patients. But if the surgeon's office has coded his claim incorrectly, you could lose over $100 just the same.

Postoperative care for patients who have had cataract surgery continues to be one of the services that optometrists provide most--and, as such, it's one topic **optometry billers and coders** often have questions about. Because the answers to these questions can be worth over $100 per patient, read on to make sure you-re coding and billing correctly for these important services.

Question: What's the correct modifier for postoperative management?

Answer: Append modifier 55 (Postoperative management only) to the CPT code for the surgery the patient has had -quot; for example, 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis [one-stage procedure], manual or mechanical technique [e.g., irrigation and aspiration or phacoemulsification]) or, less frequently, 66982 (- complex, requiring devices or techniques not generally used in routine cataract surgery or performed on patients in the amblyogenic developmental stage).

Rationale: Medicare divides global surgical procedures into three periods: preoperative, intraoperative and postoperative. By appending modifier 55, you are telling the carrier that you are only claiming the postoperative portion of the global surgical package.

The ophthalmic surgeon who performed the cataract surgery appends modifier 54 (Surgical care only) to the CPT code.

Modifier 56 (Preoperative management only) is rarely used, -because now pre-op is bundled into surgery,- says **Laureen Jandroep**, **OTR, CPC, CCS-P, CPC-H, CCS, CPC-EMS,** coding analyst for New Jersey's CodeRyte Inc., national speaker, teacher of coding review courses, and former AAPC National Advisory Board member.

Caution: Make sure the surgeon appends modifier 54, or your claim for modifier 55 will be denied. If the surgeon submits a claim with no modifier appended, he is claiming that he is responsible for the entire global surgical package, including postoperative care. A phone call to the surgeon after you see the patient is a great way to remind that office to code properly as well--and to find out how many days of postoperative care the surgeon is filing for.

Try this: -If the surgeon doesn't already have a postoperative form to use, offer to help design one,- says **David Gibson, OD, FAAO,** practicing optometrist in Lubbock, Texas.

-A good form could show the date of surgery, which eye (if not both), the dates of the surgeon's postoperative care, and the number of days that represents. An additional part of the form could have a place to indicate the date you first saw the patient, your initial refraction, and resultant acuities. By faxing or e-mailing this form back to the surgeon, you share your information, and the surgeon is assured that his or her patient has received continuing care. Everybody wins.-

Tip: To make the claims match up better to Medicare, you should always use the same diagnosis code that the surgeon used to file the surgical claim (e.g., 366.16, Senile cataract; nuclear sclerosis).

Q: When does postoperative care start?

A: When you assume postoperative care of a cataract patient, your days of service begin the day after the ophthalmic surgeon relinquishes care--even if that day is before your first visit with the patient.

Example: The patient has cataract surgery on the right eye on Aug. 7. The 90-day global period for this surgery ends on Nov. 5. The ophthalmic surgeon relinquished care on Aug. 14. The optometrist first sees the patient on Aug. 17. The optometrist's postoperative care begins on Aug. 15, even though he does not see the patient until Aug. 17.

Because the surgeon did not relinquish care until the postoperative period was already in progress, he should bill for seven days of postoperative care (Aug. 8-14). This leaves 83 days of postoperative care for the optometrist to report--Aug. 15 through Nov. 5.

Q: How do I report all this on a CMS-1500 form?

A: Using the above example, the surgeon would bill 66984-54-RT for date of service Aug. 7, 2006, as well as seven days of follow-up care with 66984-55-RT, with dates of service Aug. 8, 2006, to Aug. 14, 2006.

Check your local carrier for its rules--but in most cases, on the 1500 form, the optometrist bills for the postoperative care as follows:

- **Line 14** (Date of Current Illness): Leave blank or enter -08-15-2006- (the date the optometrist's postoperative care starts).

- **Line 17** (Name of Referring Physician): Enter the surgeon's name.

- **Line 17a** (I.D. Number of Referring Physician): Enter the surgeon's UPIN.

- **Line 19** (Reserved for Local Use): Write -Assumed post-op care 08-15-2006 through 11-05-2006- (these days must match the number of days you enter on Line 24g).

- **Line 21** (Diagnosis): Enter cataract diagnosis ICD-9 code (e.g., 366.16).

- **Line 24a** (Dates of Service): Enter -08-15-2006- in -From- space. Leave -To- space blank. (Check with your carrier; some prefer you to put the date of the original surgery in this space, instead of the date you assume care.)

- **Line 24c** (Type of Service): Leave blank.

- **Line 24d** (Procedures): Enter -66984-55-RT.-

- **Line 24g** (Days): Enter -83.-

- **Line 24k** (Reserved for Local Use): Enter your UPIN.

Q: When should we submit the bill?

A: Although the optometrist's days of care start the day after the surgeon relinquished the patient's care, the optometrist cannot bill until he has done the first follow-up visit.

So even though your postoperative care starts on Aug. 15, if you don't see the patient until Aug. 17, don't submit a bill until Aug. 17 or later, says **Charles Wimbish, OD,** president of Wimbish Consulting Group in Martinsville, Va.

As for the co-management reimbursement, Medicare considers the 90-day period following cataract surgery reimbursable at 20 percent of the overall procedure charge (the pre- and intraoperative work making up the other 80 percent of the reimbursed payment).

To figure the split, you first calculate 20 percent of the overall charge for the service. Then, divide that total by 90. This gives you the per-day value of the post-op management service. Multiply that by the number of days of post-op care you-re providing for your total reimbursement.

In the above example, the national average reimbursement for the global service of 66984 is $683.67 (based on 18.04 RVUs in the 2006 Physician Fee Schedule, multiplied by a 37.8975 conversion factor).

Postoperative care is worth $136.73 total (20 percent of $683.67) or $1.52 per day ($136.73 divided by 90).

The optometrist would earn $126.16 for 83 days of postoperative care of this patient. The amount will vary with different carriers, however.