Optometry Coding & Billing Alert

Post-Op Care: 5 Steps to Cataract Care Claims Success

Keep your eye on modifiers and diagnosis codes.

Providing postoperative care to a cataract patient can be one of the most vital parts of any optometry practice. It can also be one of the most vexing to code and bill correctly.

For claims success, you've got to stay on top of the codes and modifiers, and coordinate your coding efforts with the ophthalmic surgeon -- much like you're coordinating efforts for the patient's care.

Step 1: Call the Surgeon for His ICD-9 Code

When handling a claim for postoperative cataract care, you've got to contact the patient's surgeon. Find out what diagnosis the ophthalmologist is using on the surgery claim, says **David Gibson, OD, FAAO,** practicing optometrist in Lubbock, Texas.

Do this: Report the same diagnosis for the postoperative care as the surgeon does. For instance, if the ophthalmologist uses 366.13 (Anterior subcapsular polar senile cataract), the optometrist, who is co-managing the cataract post-op care, would also report 366.13 in box 21.

You might be tempted to use V43.1 (Organ or tissue replaced by other means; lens), "pseudophakos." But the V code is for status after surgical care is complete. When you're billing for the cataract's postoperative care, you're actually billing for part of the global surgical service, so you should use the cataract surgery diagnosis.

Step 2: Use Modifier 55 to Stress 'Post-Op'

CPT® doesn't provide you with a specific post-op cataract surgery code, so you and the ophthalmologist will be reporting the same surgery code: 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis [one stage procedure], manual or mechanical technique [e.g., irrigation and aspiration or phacoemulsification]).

Encourage the surgeon to use modifier 54 (Surgical care only) to designate that he is billing for surgical care only (valued at 80 percent of the total procedure).

If the surgeon does not append modifier 54 to the surgery code, the insurer will assume that the surgeon was responsible for the entire global package of care. The payer will remit the entire fee to the surgeon, and pay nothing to the optometrist providing post-op care.

Key: To indicate you're billing for the postoperative care only, you've got to use modifier 55 (Postoperative management only).

Without the modifier, the carrier will include the follow-up visit in the surgery's global period. Cataract surgery has 90 global days, according to the 2012 Medicare Physician Fee Schedule.

How to: On the CMS-1500 form in 24d, enter 66984 and modifier 55. Indicate the surgery eye with modifier RT (Right side) or LT (Left side).

Watch out: When you're billing for a portion of the postoperative period rather than its full 90 days, some carriers want you to also use modifier 52 (Reduced services).

Step 3: List Surgery or Transfer Date for DOS

When reporting the service date on the form, pay attention to Medicare versus private payer rules.

For Medicare, make sure you don't use the patient's visit date. In the date of service (DOS) field, enter the surgery date,.

CMS example: If an ophthalmologist provides cataract surgery with an intraocular lens implant on June 1, 2012, and provides care for six days, you would enter "06/01/12" and "06/07/12" in box 24a.

All other insurers, however, want the date of transfer in box 24a, say experts. For a surgery on June 1, 2012, in which the ophthalmic surgeon transferred care to you on June 8 as indicated in a post-op referral letter, you would list 06/08/12 in box 24a. The ending date would be the last date of the postoperative period.

Step 4: Report 4 Details in Box 19

The really tricky part of filing a post-op cataract surgery claim comes in box 19 "reserved for local use" of the CMS-1500 form (or in the narrative record of its electronic version). Report this information:

1. The specific eye treated, such as "LT" for cataract surgery on the left eye.

2. The first date of post-op. Medicare dubs this the assumed care date (asmd) or the date the surgeon referred the patient to you. For instance, if you first saw the patient in the above scenario seven days after surgery (June 1), you would enter "asmd 060812."

3. The relinquished (relnq) date. Enter the last day of the 90-day global period; for instance, "relnq 013008,"

4. The total number of post-op days. Then type the total (TL) number of days you see the patient during the global, such as "TL 83."

Summary: When filing electronically, you would report the above scenario in line 19 as "LT asmd 06/08/12 relnq 08/30/12, TL 83."

Regional variations exist. Other insurers may prefer you to list the assumed care date range -- for instance, 06/08/12 -- 08/30/12 without "asmd" and "relnq," along with the total number of days. So line 19 would read "LT Post-op care 06/08/12 -- 08/30/12, 83 days."

Be patient: Because line 19 is nonstandard, claims with narrative field completion are sidetracked for manual processing, which results in slower payment, Gibson says. Find out exactly what information your carrier wants in line 19.

Best bet: When you receive a denial, call the carrier to resolve the problem. Then keep that information handy for use on the next post-op claim you have.

Step 5: Go With NPI on Referring Line

Finally, list the surgeon's name in box 17 and his NPI number in box 17a.

Bottom line: Be consistent and patient when filing cataract post-op care claims, and you will learn to get paid the first time around, Gibson says.