Optometry Coding & Billing Alert

Reader Question Spotlight: This Texas subscriber submitted a question no optometry practice can afford to miss ...

Split the Bill Correctly With -55

Question: Many local ophthalmologists rely on our optometrists from time to time to provide post-op care for cataract patients. Should I report the E/M and eye codes for these visits, or should I report the cataract surgery code with modifier -52? How will we be reimbursed?

Texas Subscriber

Answer: If you assume a patient's postoperative care from an ophthalmologist, you should report the code for the surgical procedure -- in this case, the cataract surgery -- and append modifier -55 (Postoperative management only).

The ophthalmologist should report the same procedure code but append modifier -54 (Surgical care only) to indicate that another physician (your optometrist) performed the postoperative care.

Understand the Rationale

Medicare's Physician Fee Schedule Database divides the percentage of relative value units into the procedure's pre-, intra- and postoperative components. Appending modifier -52 (Reduced services) to the surgical procedure tells the carrier that you performed the procedure but not the entire procedure as it is described and identified by the fee schedule - so this modifier is inappropriate in your scenario.

You should only report an E/M code for your co-management service in the rare case that you treat another problem, unrelated to the original surgery. If this is the case, you would append modifier -24 (Unrelated evaluation and management service by the same physician during a postoperative period) to the E/M code.

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).

Calculate Your Fee

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. In the units field, you should put in the number of days of service your physician provides, which calculated out like above will yield the total charge for the service.

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. 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 they are filing for. Then you should subtract their days from 90 and bill for the balance of the postoperative days.

While you are allowed to bill for days before you actually see the patient, you should not bill Medicare for the postoperative care until you actually see the patient. For example, if the surgeon sees the patient on the 23rd day after postoperative care and refers the patient to you for the balance of the postoperative care, and you don't see the patient until the 35th day, you could bill for as many as 67 days (or units) of care depending on how many days the surgeon (ophthalmologist) bills.

Your surgeon (as many others) may bill for 34 days, however, feeling as though he did not turn over care until you saw the patient in your office. Either way, don't submit your claim until the patient actually presents in your office for care.