

## Optometry Coding & Billing Alert

### Streamline Your Post-Op Cataract Claims With a Payment-Producing Action Plan

The right ICD-9 code, surgery dates can prevent initial rejection

You can get paid for post-op cataract care the first time around. Our eye experts will show you how to steer through multiple diagnoses and complicated filing instructions -- including what you need to enter in line 19.

**Problem:** "I keep getting denied from Medicare for my post-op cataract claims," says **Trina Link**, insurance coordinator at Cedar Park Eye Care in Austin, Texas. With processing of post-op claims being so slow, you can't afford to waste any additional time appealing for cataract aftercare services.

Dodge denials by following these five steps.

#### 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, says **Mary Pat Johnson, COMT, CPC, COE**, senior consultant, at the San Bernardino, Calif.-headquartered Corcoran Consulting Group, a practice management consulting firm specializing in optometry reimbursement issues. 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, Johnson says. "When you're billing for the cataract's postoperative care, you're actually billing for part of the global surgical service," she says. 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).

"The 54 -drives the bus,- because if the surgeon neglects to append the 54 modifier to the surgery code, the entire fee will be paid to the surgeon, and the doctor providing the postoperative care will receive nothing," according to "Coding Cataract Surgery Comanagement" in the June 1, 2007, Primary Care Optometry News.

**Key:** To indicate you're billing for the postoperative care only, you've got to use modifier 55 (Postoperative management only), says **Sylvia Nadean** with Your Eye Solution in Jacksonville, Fla.

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 2007 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).

"The postoperative physician files the date of surgery (11/30/06) with modifier 55 (postoperative management only) and 52 (reduced services)," instructs Cahaba Government Benefit Administrators (GBA) (Medicare Part B carrier for Alabama, Georgia and Mississippi) in its Medicare B Newsline March 2007 on "Split Care."

#### 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, according to Florida's Fourth Quarter 2003 Medicare B Update pages 13-14. "This is box 24a, which has a -from- and -to-area," Nadean says.

**CMS example:** If an ophthalmologist provides cataract surgery with an intraocular lens implant on Nov. 1, 2007, and provides care for six days, you would enter "11/01/07" and "11/07/07" in box 24a.

All other insurers, however, want the date of transfer in box 24a, according to Pacific Cataract and Laser Institute in its article "How to Bill for Cataract Surgery Post-Op Care." For a surgery on Nov. 1, 2007, in which the ophthalmic surgeon transferred care to you on Nov. 8 as indicated in a post-op referral letter, you would list 11/08/07 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 (P/O)," says **Ken Singh, CPC, CCS-P, CHCO**. 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 (Nov. 1), you would enter "asmd 110807."
3. the relinquished (relnq) date. Enter the last day of the 90-day global period, for instance "relnq 013008," Nadean says. "I have to count the global out exactly to 90 days from the date of surgery, or Medicare denies or wants to see medical notes," she says.

**Calculation tip:** You can simply calculate 90 days by counting forward 12 weeks on a calendar and then adding six days. "For example, if surgery was on Monday, count ahead 12 Mondays. Then, adding six days, the 90th day would be the next Sunday," says Pacific Cataract and Laser Institute. These two dates make up the optometrist's assumed care date range or post-op span date.

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

**Summary:** When filing electronically, you would report the above scenario in line 19 as "LT asmd 11/08/07 relnq 01/30/08, TL 83."

Regional variations exist. Other insurers, such as Cahaba GBA, prefer you to list the assumed care date range, for instance 11/08/07 -- 01/30/08 without "asmd" and "relnq," along with the total number of days. So line 19 would read "LT Post-op care 11/08/07 -- 01/30/08, 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, with all the changes from UPINs to NPIs, you might not know which referral number to list on the claim. 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