Part B Insider (Multispecialty) Coding Alert

CPT Challenge: Are You Ready for These 3 Cataract Coding Scenarios? Test Yourself

Surgery on both eyes on different dates means two global periods -- and hundreds in reimbursement at stake

It's not always easy to keep your eye on accurate cataract coding, but today we've got a primer that can keep your eye surgery dollars coming in.

With several possible cataract surgery treatments available to physicians these days, you'll face a lot of room for coding error --which can equate to more than $600 at stake for cataract procedures in 2008.

Use these tricky scenarios as a guide through some of the most problematic cataract coding situations that you might face.

Append 79 for Surgery in Fellow Eye

Scenario 1: On Feb. 1, a physician performs an extracapsular cataract removal with IOL insertion on a patient's right eye. One month later, on March 1, he performs the same surgery on the patient's left eye.

Problem: The cataract procedure, 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis [one stage procedure], manual or mechanical technique [e.g., irrigation and aspiration or phacoemulsification]), has a 90-day global period, says **Kimberly A. Lewis, CPC, OCS,** coder for the **Duke University Health System** in Durham, N.C. To report 66984 performed on the left eye a month after the original surgery, you'll need a modifier -- but which one?

Solution: Because the two surgeries seem related, you may be tempted to append modifier 78 (Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period) to the second cataract surgery, but that would be a mistake. The surgery in the left eye is unrelated to the initial surgery in the right eye.

The best option here would be modifier 79 (Unrelated procedure or service by the same physician during the postoperative period), Lewis says.

Remember also to append the "side" modifiers, LT (Left side) or RT (Right side), to demonstrate that the physician performed the procedures on opposite eyes. Report 66984-RT for the first surgery and 66984-79-LT for the second cataract surgery, says **Maggie M. Mac, CMM, CPC, CMSCS,** consulting manager for **Pershing, Yoakley and Associates** in Clearwater, Fla.

Reimbursement for 66984 would be about $661.95, based on 17.38 relative value units (RVUs) multiplied by the 38.0870 conversion factor.

Scenario 2: On May 10, the patient in Scenario 1 presents with after-cataracts in his left eye. The physician incises the posterior capsule with a YAG laser.

Problem: The global period for the original cataract surgery expired before May 10. Do you need to append a modifier to the YAG capsulotomy? If so, which one?

Solution: In this case, the global period for 66984-RT is over -- but the patient is still in the postoperative period for 66984-LT.

When the physician performed 66984 on the left eye on March 1, a new 90-day global period started, which would end at the end of May.

Report code 66821-LT-78 (Discission of secondary membranous cataract [opacified posterior lens capsule and/or anterior hyaloid]; laser surgery [e.g., YAG laser] [one or more stages]; left side).

If the patient also had after-cataracts in his right eye, you would code 66821-RT-79. That procedure, although occurring within the global period of 66984-LT, is unrelated to it, warranting the use of modifier 79. The global period for the related procedure, 66984-RT, would have previously expired.

Document Necessity for Planned Vitrectomy

Scenario 3: During the course of a cataract removal, the vitreous collapses, and the physician finds he must perform a vitrectomy.

Problem: Can you code separately for the vitrectomy?

Solution: The answer depends on whether the vitreous collapse was an iatrogenic (inadvertently introduced) complication.

Physicians often have to perform a vitrectomy during cataract surgery due to vitreous collapse in the course of removing a dense, senile cataract. In those cases, Medicare considers the vitrectomy a component of the cataract surgery, and thus not separately payable.

The Correct Coding Initiative (CCI) bundles vitrectomy codes 67005 (Removal of vitreous, anterior approach [open sky technique or limbal incision]; partial removal) and 67010 (... subtotal removal with mechanical vitrectomy) into cataract surgery codes 66982 (Extracapsular cataract removal with insertion of intraocular lens prosthesis [one stage procedure], manual or mechanical technique, complex ...) and 66984.

Exception: If a prolapsed vitreous exists and is known in advance -- and documented in the patient medical record -- don't consider it a complication of the cataract surgery, says **Nancy LaVergne, CPC, OCS, CAPPM,** coder for **Jackson Eye Associates** in Missouri.

Therefore, the physician who plans to perform a vitrectomy during the same operative session as cataract surgery could code separately for the vitrectomy using modifier 59 (Distinct procedural service): 67005-59 or 67010-59.

Key: Documentation and diagnosis codes can get you reimbursement. Use 379.26 (Vitreous prolapse) for the vitrectomy and the appropriate cataract diagnosis for the cataract removal.

Be prepared to provide documentation in case you receive denials when using these codes together, despite the use of modifier 59. Payers are aware of the potential for 59 abuse and may want you to go through the review process to prove you've met the definition of the phrase "distinct procedural service."

Provide the chart notes to show that the vitreous collapse was known in advance and that the surgeon planned to repair it prior to the surgical session.

Also, provide the operative report with clear documentation showing that the vitreal prolapse was a known pre-operative diagnosis in addition to the cataract surgery, which made the vitrectomy medically necessary.