Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Master Microscope Codes to Bring a Possible $200 Boost to Your Reimbursement

Make proper use of +69990, 92504 to avoid rejection.

Your physician has invested training time and money in her telescope or binocular microscope, and it's no surprise she wants reimbursement when she uses it. But when can you separately code operating microscope use? Know the rules and the exceptions to get the dollars you deserve and to stay out of the auditors' field of vision. Our experts break it down for you.

Check for 'With Microscope' Code First

Numerous CPT codes provide for the use of an operating microscopeor telescope. Frequently, separate codes describe similar surgeries performed with and without these tools.

Surgical example: Say your doctor performs a direct laryngoscopy with dissection and removes a cyst.

If she does not use a microscope,you'd code 31540 (Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis). If she does use and document the use of a microscope, you'd code 31541 (... with operatingmicroscope or telescope).

Use +69990, 92504 Only in the Right Circumstances

In some cases, when there's no mention of a microscope in the code description for a service, you may be able to report +69990 (Microsurgical techniques, requiring use of operating microscope [List separately in addition to code for primary procedure]) or92504 (Binocular microscopy [separate diagnostic procedure]).

Key: You should report +69990 or 92504 only if the value of the procedure (relative value units, or RVUs) does not incorporate the use of the microscope in the calculation.

That means that depending on the procedures you perform, you may use these codes only rarely. "We never really bother with +69990 since it is considered to be an inclusive component," says **Renee Johnson,** office manager for Cape Fear Otolaryngology in Fayetteville, N.C. "I did bill +69990 a few times when I worked in plastic surgery."

92504 Is for Office Microscopy

When your doctor uses a microscope to examine and diagnose a patient in an office or clinic, you may be able to report 92504. Keep in mind that CPT designates this as a separate procedure; that means payers include it in any other procedure done in the same anatomic area. You would only use 92504 if that is the only procedure your physician performed and documented.

E/M example: Let's say in the clinic your doctor removes tubes from a 13-year-old's eardrum without anesthesia.

Because your physician isn't using anesthesia on the child, you can't report 69424 (Ventilating tube removal requiring general anesthesia). But if she uses the binocular microscope to help her see what she's doing, you could report 92504.

If the physician also performs and documents a significantly and separately identifiable E/M at the same encounter as the 92504 -- for instance, 99213 -- you will need modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to indicate the documentation supports the E/M service as significant and separately identifiable from the minor service included in the

microscopy.

The E/M can be the decision to do the removal. For instance, the doctor might say she needed the microscope to help get the tubes out.

(Note: If your didn't didn't use the microscope, you'd just charge the appropriate E/M.)

Sidestep This Common +69990 Pitfall

Watch out: Only report using an operating microscope for microdissection, not when the doctor uses the scope just to see better. For instance, when your physician places a tube in the ear, that doesn't require microdissection, so you won't code +69990.

And because +69990 is an add-on code, you should report it only with a related, primary procedure, says **Lori Montanez, CPC,** coder at SORC in Albuquerque, N.M. You should never report an add-on code alone.

By definition, an add-on code describes a service that occurs only at the same time as another, more extensive procedure.

Payers Differ on +69990

All payers are not equal when it comes to reimbursing for +69990. For Medicare payers, you shouldn't expect separate reimbursement with ear procedures.

Medicare just says no:

Medicare payers allow you to report +69990 in far fewer circumstances than payers that follow CPT guidelines. The Medicare Claims Processing Manual, Chapter 12, Section 20.4.5, allows separate payment for use of the operating microscope with only a few codes, all of which are in the 60000 series. Check out the manual online at www.cms.hhs.gov/manuals/downloads/clm104c12.pdf for more details.

For all other procedures, Medicare considers the operating microscope an inclusive component of the procedure and not payable. According to the July 22, 1999, Federal Register, "Payment for primary codes where an operating microscope is an inclusive component will be denied."

Wiggle room: If your patient's payer follows CPT guidelines, you still need to know the restrictions. Check the manual to find instructions on when -- and when not -- to report +69990.