Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Collect for Your Cataract Procedures by Avoiding These 3 Common Myths

Tip: You can code vitrectomies separately sometimes.

With several possible surgical treatments for cataract procedures, which eye surgeons probably code more often than any other surgery, there's a lot of room for error and over $800 at stake for complex cataract procedures in 2013.

Bust the myths on these three tricky scenarios to guide you through some of the most problematic cataract coding situations:

Document Necessity for Planned Vitrectomy

Myth 1: During the course of a cataract removal, the vitreous collapses and the ophthalmologist finds it necessary to perform a vitrectomy, but you have to eat the cost because you can never code separately for the vitrectomy.

Reality: The answer to whether the vitrectomy is separately billable depends on whether the vitreous collapse was an iatrogenic (inadvertently introduced) complication. Ophthalmologists often have to perform a vitrectomy during cataract surgery due to vitreous collapse in the course of removing a dense, senile cataract. In these cases, Medicare considers the vitrectomy a component of the cataract surgery, and thus not separately payable.

The National Correct Coding Initiative 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 [e.g., irrigation and aspiration or phacoemulsification], complex ...) and 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis [one stage procedure], manual or mechanical technique [e.g., irrigation and aspiration or phacoemulsification]).

Rationale: When procedures are performed together that are basically the same, or performed on the same site but are qualified by an increased level of complexity, the less extensive procedure is included in the more extensive procedure. The column 1 code generally represents the comprehensive service, and the column 2 code is the component that is part of the more extensive column 1 procedure.

Exception: If a prolapsed vitreous exists and is known in advance and documented in the patient medical record it is not considered a complication of the cataract surgery. Therefore, the physician who plans to perform a vitrectomy during the same operative session of cataract surgery could code separately for the vitrectomy using modifier 59 (Distinct procedural service): 67005-59 or 67010-59.

Key: Use 379.26 (Vitreous prolapse) for the vitrectomy and the appropriate cataract diagnosis (366.x, Cataract) for the cataract removal.

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

Provide the chart notes to show that you knew about the vitreous collapse in advance and that you made plans to repair it prior to the surgical session of another service. Also, you should provide the operative report with clear documentation showing that there was another condition, besides the cataract surgery, that made the vitrectomy medically necessary.

Append 79 for Surgery in Fellow Eye

Myth 2: On February 1, an ophthalmologist 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. The cataract procedure, 66984, has a 90-day global period. Therefore, you cannot report 66984 for the surgery performed on the left eye a month after the original surgery.

Reality: You can report both procedures, but you'll need a modifier to ensure that you get paid for the second surgery. 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 or other qualified healthcare professional 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 considered 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 or other qualified healthcare professional during the postoperative period).

Remember also to append the "side" modifiers, LT (Left side) or RT (Right side), to demonstrate that the ophthalmologist performed the procedures on opposite eyes. Report 66984-79-LT for the second cataract surgery.

Report Related Procedures With 78

Myth 3: On May 10, the patient in Myth 2 above presents with after-cataracts in his left eye. The ophthalmologist incises the posterior capsule with a YAG laser.The global period for the original cataract surgery expired before May 10. Therefore, no modifier is required for the YAG capsulotomy.

Reality: 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 ophthalmologist performed 66984 on the left eye on March 1, a new 90-day global period started, which would end at the end of May, says **Maggie M. Mac,CPC, CEMC, CHC, CMM, ICCE,** president of Maggie Mac-Medical Practice Consulting in Clearwater, Fla. 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; Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period).

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 already have expired.

Know When Cataract Removal Is 'Complex'

When an ophthalmologist performs a particularly difficult complicated cataract extraction one that requires a vitrectomy, for instance he's often attracted by the high relative value units (RVUs) of the complex cataract code, 66982. But that code can be a trap, experts say, and can lead to costly denials, even audits.

Even if the ophthalmologist thinks he's using "devices or techniques not generally used in routine cataract surgery," this doesn't automatically allow you to report 66982 (Extracapsular cataract removal with insertion of intraocular lens prosthesis [one stage procedure], manual or mechanical technique [e.g., irrigation and aspiration or

phacoemulsification], complex, requiring devices or techniques not generally used in routine cataract surgery [e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis] or performed on patients in the amblyogenic developmental stage).

4 Questions Point the Way to 66982

Ask yourself these questions when you're deciding whether to report 66982:

- Is the pupil miotic?
- Is the patient very young, and still in the amblyogenic developmental stage?
- Does the IOL need extra support, such as permanent intraocular sutures or capsular tension rings?
- Does the ophthalmologist use dye to help him visualize the anterior chamber?

If the answers are "yes," you may be able to report 66982 instead of the lower-reimbursing 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis ...) for an extracapsular cataract removal.

Payment for 66982, based on the unadjusted national Medicare Physician Fee Schedule and the 34.023 conversion factor, is about $828.46, compared to $667.87 for 66984.

Watch out: Don't report 66982 just because the ophthalmologist encounters a surgical complication, such as the need to perform a vitrectomy. A true complex cataract extraction is prospectively planned based on pre-existing conditions.

Bottom line: Report 66982 only if the ophthalmologist knows preoperatively that a more complex procedure is necessary and meets the requirements of the code descriptor. Documentation in the medical record prior to the surgery will support this decision.