Part B Insider (Multispecialty) Coding Alert

PART B REVENUE BOOSTER: Limit 69990 to Once Per Session -- Not Per Level

Medicare is finicky about reimbursing operating scope, so be careful

Just because your surgeon documents using a -microscope,- you aren't always justified in reporting 69990. Medicare's guidelines are written in stone, and practices should be careful to follow them to the letter.

You may have noticed that your CPT manual lists instructions for when to report +69990 (Microsurgical techniques, requiring use of operating microscope [list separately in addition to code for primary procedure]) in a note preceding the code descriptor.

Medicare payers, however, allow you to report 69990 in far fewer instances. For example, some private payers may reimburse you for using the operating scope with mastoidectomies (such as 69501), but Medicare won-t.

Specifically, Chapter 12 of the Medicare Claims Processing Manual, section 20.4.5, allows separate payment for using the operating microscope only with procedures 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898 and 64905-64907.

For example: A hand surgeon dictates that he used the operating microscope for microdissection during suture of a single digital nerve of the hand (64831, Suture of digital nerve, hand or foot; one nerve). In this case, you can report 69990 in addition to 64831.

Remember: Because 69990 is an add-on code and is valued for intraoperative work only, you do not need to append modifier 51 (Multiple procedures).

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, -In specific, payment for primary codes where an operating microscope is an inclusive component will be denied.-

Correct Coding Initiative (CCI) edits can signal that you shouldn't report certain services to Medicare with 69990, says **Heidi Weber**, coder for **Shekhar Dagam, MD**, in Waukesha, Wis. The CCI edits can also help you strengthen appeals if the carrier denies 69990 when it isn't bundled. -I regularly use the edits when coding to know when a modifier is required to unbundle a particular combination,- Weber says. -I also use the edits when appealing unpaid procedure codes. I find it helpful to send supporting documentation of the edits to the payer, which can only strengthen the appeal.-

Know your keywords: Keep in mind that using surgical loupes does not qualify you to report 69990. Key documentation you may find in the operative report may include terms such as -Weck scope,- -Zeiss scope- or -Leica.-

-I watch for words such as -under magnification,- which is a red flag for me,- says **Rena Hall**, coder and auditor with **KC Neurosurgery** in Kansas City, Mo. -The surgeon must be specific when he puts the microscope into the field. If I never see where the scope was set up and I see -under magnification,- I will not charge a microscope, even if he lists it on the -procedures performed- section of the report. It must be well documented in the body of the report.-

Consider separate lines: -I suggest to my physician to dictate a separate line in his operative report stating whether the assistant surgeon used the microscope,- Weber says. This process improves payment odds for the assist, she advises.

Although this may seem like an unpleasant effort, most payers will reimburse roughly $130 for 69990, so your work researching which codes you can report with it can be well worth the effort.

Don't Bill Multiple Units of 69990

Keep in mind that you should report 69990 only once per operative session no matter how many times the physician uses the operating microscope while in the OR. -There is only one microscope, and the surgeon can use it several times, but it is still only billed once,- Hall says.

Tip: Even if the surgeon addresses separate spinal levels or nerves during a procedure, you should only list one unit of 69990 on your claim.