Codify
BY AAPC

Outpatient Facility Coding Alert

Reader Question: Cataract Coding Face-Off: Physician Practice vs. Surgery Center

Question: I code for a surgery center and an associated physician clinic. Most of our patients are diagnosed with bilateral cataracts, but only come in for surgery on one eye at a time. In case of an audit, is it important that the facility claims match the clinic claims?

Florida Subscriber

Answer: You should always be coding for the highest level of specificity, says **Rhonda Buckholtz, CPC, CPCI, CPMA, CDEO, CRC, CHPSE, COPC, CENTC, CPEDC, CGSC**, vice president of practice optimization at Eye Care Leaders. The coding guidelines for this situation say that when a patient presents for the office visit and is diagnosed with bilateral cataracts, use the bilateral diagnosis on the physician claim. One example would be H25.813 (Combined forms of age-related cataract, bilateral).

Now, say that the patient is having surgery on the right eye first. On the facility claim for that procedure, the guideline says to use the bilateral diagnosis, because at that point, the patient still has a bilateral condition. The bilateral code is still the highest level of specificity. Then, when the patient comes back and has the left eye done, code only for the left eye using H25.812 (Combined forms of age-related cataract, left eye).

"This makes sense from a clinical standpoint," says Buckholtz, "but what I tell everybody is that we have coding rules and we have billing rules, and they're not always the same." To get paid properly, follow the payer's billing rules. Check with your payer to verify that they want and will accept that bilateral code. If the payer doesn't have a specific billing rule, the surgery center and the clinic should both be submit claims the same way so that they match. If the claims are different, "it may not disrupt payment, but consistency is always better. Any time you can work hand-in-hand you'll get better results," Buckholtz says.