

Practical Glaucoma Coding Tips

Helpful hints from a physician's perspective.

BY GEOFFREY T. EMERICK, MD

I will begin with a few caveats. This article is based on my experience in doing my own coding for the past 7 years. I am not a coding expert, and, although I have tried to be as accurate as possible, you should check the details with your local carriers. Coding changes frequently, and it is worth your while to stay up to date. Even if you do not perform your own coding, you should be able to teach your staff how to do it. Another good reason for familiarizing yourself with coding is that doing so usually increases your revenue, which allows you to spend more time with your patients. Ultimately, everyone benefits.

The AAO has excellent coding resources in a variety of formats, including an Ophthalmic Coding Specialist Examination. The Centers for Medicare & Medicaid Services Web site, <http://www.cms.hhs.gov/apps/pfslookup/>, is another helpful resource, which includes a tool for looking up reimbursements by code and locality. Scrubbing programs, available from many practice management software firms, can also be useful for identifying coding errors and sending out cleaner claims. Even with such programs, it is more efficient to code accurately from the start. I hope this article helps you meet that goal.

NEW PATIENTS

New patients are those whom neither you nor any other member of your practice has seen in the past 3 years. Established patients are those seen within the past 3 years. If you participate in a multispecialty practice, parties would include the other ophthalmologists or optometrists in your group.

GLOBAL PERIODS

Most procedures (including the majority performed in the OR) have a 90-day global period. Qualifying office procedures include laser iridotomy and cyclophotocoagulation. A major exception is laser trabeculoplasty,

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which has a 10-day global period. Be careful not to be caught within the global period of a procedure performed by one of your partners. For example, if you see a patient for a glaucoma follow-up visit a few weeks after he underwent a retinal laser procedure, you should use a -24 modifier. It is helpful to write the dates of all procedures in the same location on every patient's chart so that everyone who sees the patient is aware of when the global period ends. Medicaid global periods may be different. In my area, the global period for most procedures is 30 days.

Visits or procedures related to the surgery that are done in the global period are not generally billed, other than the rare return trip to the OR. In that circumstance, use a -78 modifier for related procedures in the postoperative period. Bleb needling or other revisions performed after 90 days should be billed as 66250, whether or not they are performed in the OR. Postoperative subconjunctival 5-fluorouracil injections can be billed using the -58 modifier. Be sure preoperatively to document in the patient's chart that the injections will be given, however.

EYE VERSUS EVALUATION AND MANAGEMENT CODES

Many coding experts recommend using eye codes for most visits, because there are fewer required elements. You cannot use eye codes alone, however. For example,

if a patient returns for an IOP check 4 weeks after starting a new drop and has no side effects or other issues to address, the visit is usually considered a problem-focused examination, code 99212, and does not merit the intermediate eye examination code, 92012. Conversely, a patient with a complicated problem may require more extensive evaluation than that covered by a comprehensive eye code and merit a level-five evaluation and management (E&M) code. You should also note that some non-Medicare payers require an E&M code for medical diagnoses and an eye code for refractive errors. Another issue is how often the eye codes may be used in a year. Contrary to popular belief, the comprehensive examination code 92014 may be billed more than once yearly, but you should be careful to make sure that the level is justified.

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Regardless of the chosen code, a reason for the visit must be documented. Generally, this documentation consists of a chief complaint, not a need for glasses or a “routine” eye examination. New patient eye codes require “initiation of diagnostic and treatment program.” Return codes require “initiation or continuation of diagnostic and treatment program.” A 3- or 4-month follow-up visit for stable glaucoma does not qualify for a 92012 code unless a “new diagnostic or management problem” is addressed during the visit.

The eye codes (comprehensive and intermediate) require a history and general medical observation as well as external ocular and adnexal examination. Comprehensive codes (92004, 92014) also require an ophthalmoscopic examination, gross visual fields and basic sensory-motor examination, and “often” (wording I interpret to mean “almost always”) biomicroscopy, dilation, and tonometry.

You should also only consider the problem for which the patient is seeing you. For example, if you are managing his glaucoma and someone else is seeing the patient for other stable eye conditions, you would not count the latter in determining the level of decision making. Of course, if the patient presents with a new issue concerning an old problem (eg, worsening macular degeneration), then that may be counted.

SPECIFICS

Visits to a Nurse or Technician

When a physician has specifically instructed a nurse or technician to perform tonometry on a particular patient, the code 99211 may be used. Documentation must be included in the patient’s chart, and no other physician charge may be billed on the same day.

Complex Cataract Surgery

Many of the cataracts glaucoma specialists tackle require pupil stretching, iris or capsular hooks, capsular dyes, capsular tension rings, sutured haptics, or other acrobatics that justify the use of code 66982. Enter the OR aware that you will probably apply this. It may not be used if unexpected complications such as a posterior capsular rupture occur in an otherwise uncomplicated case.

Trabeculectomy in the Presence of Conjunctival Scarring With the Use of Antimetabolites

Code 66172 is inappropriate for primary trabeculectomy, even with the use of 5-fluorouracil or mitomycin C. This code may be used only in the presence of conjunctival scarring from previous surgery or trauma. It does not matter what type of surgery caused the scarring.

Multiple Procedures

When performing multiple procedures such as combined trabeculectomy and cataract surgery, list the higher-paying procedure under code 66170 first, because each secondary procedure is reimbursed at half the usual rate.

Patch Grafts

If scleral reinforcement with donor pericardium or sclera is needed during glaucoma drainage implant surgery (code 66180), use code 67255 with the -51 modifier for additional procedures.

Diagnostic Testing

Don’t forget to code for gonioscopy (92020), pachymetry (76514), visual fields (usually 92083), analysis of the nerve fiber layer and/or optic nerve head (92135), disc photography (99250), and serial tonometry (92100). A -25 modifier is not needed on the visit code with any of these diagnostic procedures. Because the fundus photography code (92250) and nerve fiber layer scan code (92135) are bundled, you should not bill for both on the same visit. The 99250 code is bilateral, and the 92135 code is unilateral; use code 92135-50 if testing both of the patient’s eyes. Some non-Medicare payers prefer billing on two lines, so it would be coded as 92135-RT for the right eye

and 92135-LT for the left eye. All ancillary tests require a written interpretation and report, which include test quality and reliability as well as the implications for the patient's care. Some practices report problems with payment for diagnostic tests done on the same day as an established examination and for visual fields and nerve-fiber imaging done on the same day. I have not encountered that problem, but regional differences in payment rules may occur.

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One code you may not commonly use, but should not forget, is extended ophthalmoscopy (92225). It requires a detailed drawing, interpretation, and report. For example, the code may be justified in a patient with flashes and floaters of new onset in whom you observe lattice degeneration. Like nerve fiber layer analysis, extended ophthalmoscopy is a unilateral code. If you are evaluating pathology in both eyes, use modifier -50 (or 92225-RT and 92225-LT).

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Serial Tonometry

CPT code 92110 requires that you check the patient's IOP three or more times during the same session, usually over a period of 6 or more hours. In addition to the usual indication of establishing a diurnal IOP curve, this code may be used in other situations such as when a patient has a high IOP and stays in the office for the monitoring of the provided treatment's effect.

Consultations

Many initial visits to a glaucoma specialist are consultations, referrals from either ophthalmologists or optometrists. You and your staff should carefully document the name and address of the referring doctor. Of course, consultations can come from outside or inside your practice. Those from one of your partners generally are not billed at as high a level because a lot of the work (eg, patient history, medication lists, and review of systems) has been done for you.

Level-five consultations from any source are rare. If you do bill a consultation code, which is reimbursed at a higher rate, follow the rules carefully. First, the referring practitioner must request your advice or opinion, whether via a phone call, a note scribbled on a prescription pad, or a formal letter. All phone calls that impact the care of the patient should be documented in the patient's chart.

A written report of the consultation must be sent to the referring doctor. If you share a chart, your clinical note may suffice, but it is probably a good idea to write a letter as well. Most referral sources appreciate receiving copies of the visual fields as well as color copies of nerve fiber layer analyses and disc photographs.

You may bill a consultation even if you initiate treatment, ranging from administering eye drops to performing surgeries. If the initial visit includes laser treatment, use a -25 modifier. If you perform incision-based surgery on the same or next day, the decision-for-surgery modifier -57 would apply.

Consultations that occur in the ER are a special circumstance. In most cases, you do not have to name a referring physician but instead usually list the emergency department of the hospital at which the consultation took place. They are billed as outpatient consultations, even if the patient is later admitted. If you admit the patient yourself and do the admissions H&P, you would bill under the initial hospital care code (99221-3) and not under the consultation code.

Prolonged Services

Although uncommon, these codes can be useful. They may apply in circumstances such as the management of a patient with acute angle-closure glaucoma. They are add-on codes, billed in addition to the usual E&M and procedural codes. The + symbol is used to designate add-on codes that do not take the -51 modifier. The code 99354 is used for prolonged physician service in the outpatient setting requiring physician-patient contact. Prolonged, in this case, means more than 30 minutes of direct contact. Code 99354 covers minutes 30 to 74, whereas code 99355 covers any additional 30-minute time blocks thereafter. Different codes apply to the inpatient setting.

Happy coding! □

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