Choosing Sides in Coding

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INTRODUCTION

One of the recent controversial discussions I overheard involved the following dilemma – how does one know whether to choose to bill per extraocular muscle versus per eye; per eyelid versus per side; per facial muscle(s) versus per side; per lash versus per eyelid per procedure? Help!!! Get your CPT books out before continuing!

MEDICARE

Medicare's Physician Fee Schedule Data Base (MPFSDB) has various indicators that are listed in what might be considered funny places. The indicators for diagnostic tests and sides in surgery are listed in the column entitled "Bilateral Surgery" and use the following system (I know it's difficult but it has to be mastered):

Bilateral Surgery Indicator provides for services subject to a payment adjustment.

0 = Payment adjustment for bilateral procedures does not apply.

Bilateral modifier is inappropriate for reasons such as (a) physiology; (b) code descriptor specifically states a unilateral procedure; or (c) procedure is not performed as a bilateral procedure.

1 = Payment adjustment applies if billed with modifier 50 (payment based on billed amount or 150% of the fee schedule amount).

2 = Payment adjustment does not apply. Payment already based on procedure being a bilateral procedure. Pays 100 % of allowable.

3 = Usual payment adjustment does not apply (primarily radiology procedures). Pays 100 % of each side.

9 = Concept does not apply.

In the MPFSDB for 2008 (also referred to as MPFS, PFS or MFSDB) most ophthalmology surgical procedures have an indicator of 1; however, there are a few codes with an indicator of 9 and approximately 12 codes with an indicator of 0.

CPT

Add-on codes. Add-on codes do not stand alone and must be appended to another code as listed in CPT. They were developed to compensate surgeons for extra difficulty that may be encountered due to previous surgery, trauma or various medical conditions.

Previously, you could code the strabismus add-on codes once per eye; however, this was changed and now you may only code them **once per session**. This applies to codes 67320,67331, 67332, 67334, 67335, and 67340.

As most of my steady readers know, I only deal with Medicare – so it is with great trepidation that I venture into this paragraph. Nevertheless, a few years ago Medicare adapted CPT as its formal coding system. CPT communicates its coding regulations through various mechanisms, including the CPT manual and a newsletter available through subscription entitled "CPT Assistant" and also issues a CD-ROM version of all archived articles. In the professional edition of CPT, coding guidance is cited in various sources by annotations after the codes. Most other insurers are supposed to be following CPT guidelines, but due to many reasons, including lack of trained personnel, the guidelines may not be known by the people processing claims or adjudicating appeals.

The guidelines for specific situations are those that are expounded in both Medicare and CPT guidelines.

STRABISMUS SURGERY

Adjustable sutures. CPT code *67335 Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s)* was developed for the adjustment of the sutures and the physician is not really being paid for the insertion of the sutures. CPT Assistant states, " Code 67335 does not represent the operating room performance of the strabismus surgery. Rather it is used to code for the adjustment procedure, regardless of the

number of adjustable sutures placed." [1] **You may code it once per session.**

Transposition procedure. CPT Assistant states, " A transposition procedure is performed when a patient has lost functioning in one of the extraocular muscles…An add-on code is **not used for minor transpositions of a muscle coincident to a recession or resection**." Transposition procedures are coded when the surgical procedure is for correction of a paretic/paralyzed muscle – not for raising or lowering the insertions of muscles for correction of A or V pattern. **You may code it once per session.**

BLEPHAROSPASM

Chemodenervation of facial muscles for the correction of blepharospasm is coded using CPT code 64612 Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm).

CPT Assistant states, "CPT codes 64612…should be reported only one time per procedure, even if multiple injections are performed in sites along a single muscle or if several muscles are injected. Chemodenervation for strabismus involving the extraocular muscles is reported using code 67345."[2]

It is quite apparent that the code was developed and priced for the typical patient receiving this procedure per side, not per muscle nor per number of injections on that side. **You may code it once per side but not per muscle nor per number of injections.** Your Medicare Administrative Contractor (MAC) may have a LCD on this.

TRICHIASIS

One of the most frequent questions is "Do I code for lash removal per lash, per eyelid or what?" CPT Assistant specifies, "Codes 67820 and 67825 are intended to be reported per procedure, not per eyelash or per eyelid."[3] **You may bill the code per procedure but not per eyelid nor per side nor per lash.** Again, your MAC may have a policy that varies from this.

CONCLUSION

These coding guidelines are often not well known and therefore not followed. For Medicare, payments are calculated by RVU's (relative value units) that take into consideration the work, practice expenses and malpractice costs involved for the typical patient or case – and that is why the specific examples we discussed are paid per session or per side and not per muscle or per injection. Be aware, getting paid for a procedure does not equate to correct coding and payors can ask for their money back. It's important to code correctly – even if you don't agree and don't like it!

The following is a historical note to the original article and remains here for archival purposes.

Choosing Sides in Coding – A Happy Follow-up

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In my article "Choosing Sides in Coding" in the February, 2005 issue of EyeWorld there was a sidebar listing those CPT procedure codes with a bilateral surgery indicator of "0" for Medicare, indicating that a payment adjustment for performing the procedure bilaterally did not apply. In practical terms, this means that you could only be paid for one side when a procedure was performed bilaterally.

I am pleased to report that Medicare has now issued a program memorandum dated February 11, 2005 with an effective date of January 1, 2005 (date of service) which will be implemented on April 4, 2005 for the codes listed below. These codes now carry a bilateral surgery indicator of "1" in the Medicare Fee Schedule Data Base, signifying that the procedures should be paid at 150 percent of the fee schedule amount when performed bilaterally. You should be able to retroactively bill for the second side and now get paid for claims dating back to January 1, 2005.

Get your CPT books out - the affected codes are: 67950, 67961, 67966, 67971, 67973, 67974, 67975, 67999, 68020, 68040, 68100, 68110, 68115, 68130, 68135, 68320, 68325, 68356, 68328, 68330, 68335, 68340, 68360, 68362, 68371, 68399, 68400, 68420, 68440, 68500, 68505, 68510, 68520, 68525, 68530, 68540, 68550, 68700, 68705, 68720, 68745, 68750, 68770, 68840, 68850, 68899.

[1]CPT Assistant March 1997 issue, page 5
[2]CPT Assistant April 2001issue, page 1
[3]CPT Assistant July 1998 issue, page 10
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MEDICARE INDICATORS

Bilateral Surgery Indicators

The following CPT codes have an indicator of "0": 67221, 67225, 67800, 67801, 67805, 67808, 67810, 67820, 67825, 67830, 67835, 67840, 67850, 67875, 67880, 67882, 67900, 67930, 67935, 67938, 67950, 67961, 67966, 67971, 67973, 67974, 67975, 67999,
68020, 68040, 68100, 68110, 68115, 68130, 68135, 68320, 68325, 68326, 68328, 68330, 68335, 68340, 68360, 68362, 68371, 68399, 68400, 68420, 68440, 68500, 68505, 68510, 68520, 68525, 68530, 68540, 68550, 68700, 68705, 68720, 68745, 68750, 68770, 68840, 68850, 68899.

The following CPT codes have an indicator of "9": 65760, 65765, 65767, 65771.