Medicare Controversies in Cataract Coding – One Consultant's Opinion

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INTRODUCTION

It would seem that coding for cataract surgery is a straightforward affair – not so at all. With the ever rapid changing technologies and the blurring of the frontiers between cataract and refractive surgery, accurate coding for these procedures has become more and more difficult. This article explores some of the more controversial and difficult issues that have emerged recently.

The information for this article is gleaned from CPT (Current Procedural Terminology) information, Medicare, and communications with representatives from various ophthalmic specialty societies.

DEFINITION OF COMPLEX CATARACT CODE (CPT CODE 66982) AND THE ROLE OF DYES

There is a serious controversy involving whether the use of the dye alone to stain the capsule qualifies the case as complex.

The complex cataract code was first introduced in 2001 at which time the following information was presented in *CPT – An Insider's View:*

> *66982 Extracapsular cataract extraction removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification, complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, endocapsular rings, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage.*

Centrist View. Normally, dye is used when the cataract is quite dense and it is difficult to distinguish the anterior capsule, thus making performing the anterior capsulorrhexis more difficult due to poor

visualization. Centrists believe this qualifies for the use of the complex code.

Far Left View. On the other hand, many academic medical centers use dye simply when training residents how to perform an anterior capsulorrhexis. The far left believes that use of the dye alone qualifies for use of the complex code.

Far Right View. The far right and opposite point of view states that one should never use the complex code with removal of dense white cataract using dye since there are so many of them and it would be overutilizing the code (national average estimates that the complex code should be used on two – three percent of a surgeon's total cataract caseload).

One Consultant's Opinion: Centrist View.

POSTERIOR AND ANTERIOR VITRECTOMIES AND THE NATIONAL CORRECT CODING INITIATIVE (NCCI)

Posterior Segment. One of the most unfair bundling fiascos was the bundling of all codes related to cataract surgery with all the retinal detachment and vitrectomy codes, leaving only the pars plana vitrectomy and associated codes (CPT codes 67036, 67038, 67039, 67040) billable with CPT code 66850 (phacoemulsification).

After more than a year of contesting this many of these bundles have been reversed (CPT codes dealing with insertion of secondary intraocular lenses and exchange of intraocular lenses earlier, and in the Version 11.0 effective January 1, 2005, those dealing with concurrent cataract removal and insertion of an intraocular lens).

In case you have claims pending from the **prior** bundles, or in case some of the bundles reappear – as has happened before - here is a way to capture fair reimbursement for these often very complex procedures. Modifier –59 must be used when appropriate "to break" the bundles.

Here are some clinical examples:

1. Repair of retinal detachment by vitrectomy (CPT code 67108) + Pars plana vitrectomy with epiretinal membrane peeling (CPT code 67038) + Extracapsular cataract extraction with insertion of intraocular lens. (The bundles were removed January 1, 2005).

Code as: 1. 67108
2. 67038-51
3. 66984-51-59

2. Pediatric cataract extraction with insertion of an intraocular lens (CPT code 66982) + Pars plana vitrectomy.

Code as: 1. 66982
2. 67036-51-59 (often reduced services modifier – 52 needs to be used)

Anterior Segment. Over the years, the bundles of the anterior vitrectomy codes with cataract extraction have come and gone. For many years now, anterior segment vitrectomies (CPT codes 67005, 67010) have been bundled with cataract extraction with insertion of intraocular lens codes.

Are there circumstances when these can be unbundled? Yes. If vitreous prolapse is present from previous surgery or trauma, for example, then that should be documented preoperatively and the anterior vitrectomy may be coded additionally, breaking the bundle using modifier -59.

Centrist View. It is sometimes appropriate to use modifier -59 for unbundling anterior and/or posterior vitrectomies with cataract/IOL surgery.

Far Left View. The NCCI bundles are basically unfair and the surgeon is entitled to unbundle code pair edits whenever they occur.

Far Right View. NCCI edits cannot and should never be broken.

One Consultant's Opinion: Centrist View.

Although I usually caution against unbundling using modifier –59, I think there are certain justifiable circumstances, such as with the retinal examples. Be very conservative with the anterior vitrectomy bundles.

Whether or not a code pair edit can be broken is indicated in the NCCI document by a modifier indicator that is assigned to each edit. A modifier indicator of "0" indicates that NCCI-associated modifiers cannot be used to bypass the edit. A modifier indicator of "1" indicates

that NCCI-associated modifiers can be used to bypass an edit under appropriate circumstances. A modifier indicator of "9" indicates that the edit has been deleted, and the modifier indicator is not relevant.

BILLING ASTIGMATIC KERATOTOMY/LIMBAL RELAXING INCISIONS IN CONJUNCTION WITH CATARACT SURGERY

AK and LRI are designated as non-covered procedures by Medicare and are only covered when the astigmatism was induced *prior* to the current surgery. Some surgeons are charging virtually every cataract patient for an AK/LRI – and the fee may be almost as much as 50 percent of the reimbursement for the cataract surgery itself.

Centrist View. There are certain indications for billing the patient for these non-covered procedures.

Far Left View. In order to get an optimal surgical result this should be done on every patient and the patient should be billed for it – after all, it's legal to bill for it.

Far Right View. These procedures should never be billed. It's part of doing a good surgical job.

One Consultant's Opinion: **Centrist View.**

Unless there is a clear indication that an AK/LRI is necessary to optimize visual outcomes in a patient, this practice should be avoided, particularly on a routine basis.

ADVANCE SCHEDULING OF YAG POSTERIOR CAPSULOTOMY

There are many practices who schedule the patient for a YAG posterior capsulotomy when the cataract surgery is being scheduled. Is this an acceptable practice?

Centrist View. It is an efficient way to practice and reduces scheduling problems.

Far Left View. Patients will need this procedure, so let's schedule it in advance and make it more convenient for everyone.

Far Right View. This should never be done since one never knows if and when a given patient will need or qualify for this procedure.

One Consultant's Opinion. Far Right View.

YAG posterior capsulotomy can never be scheduled in advance of the cataract surgery. Use of modifier –78 will engender payment during the global period. YAG anterior capsulotomy for anterior capsule phimosis has to be coded using the unlisted CPT code 66999. Medical necessity should be documented by using a questionnaire filled out and signed by the patient. Many Medicare carriers have LCD's and coding guidelines regarding YAG laser posterior capsulotomy.

Conclusion

I am continually amazed at the number of physicians who are totally unaware that their Medicare carrier has a website and they are legally responsible for adhering to the rules and regulations posted there. The first place you should check for guidance when wanting to bill a questionable item is your carrier's website. By December 2005 all LMRP's (Local Medical Review Policies) are to be converted to LCD's (Local Coverage Determinations) that may be supplemented with additional coding guidelines. The coding guidelines will be posted separately from the policies themselves by national mandate.

One Consultant's Opinion: Be conservative – when in doubt – don't!

Note: All LMRPs have been converted to LCDs. Medicare carriers are being amalgamated into Medicare Administrative Contractors and are now known as contractors.

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