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Top 5 Surgical Coding Errors

This article presents major categories in which ASC coders make errors, some of them quite serious. Let's visit the various categories and review some examples, as well as tips and guidance. The coding regulations applied to this review are those of Medicare and are easily accessible for verification.

1 Complex Cataract Extraction

The CPT code 66982 for complex cataract extraction and the coexisting coding parameters were issued in 2001 — yet, this remains one of the least understood codes in ophthalmic surgical coding.

- ***Complications:*** Do not use this code when complications, such as vitreous loss, dropping of the nucleus, misplacement of the IOL, and others occur. The terminology complex signifies that there was prior awareness of a potential issue(s) — the code never was intended for use solely when complications occur.
- ***Adjunctive use of medications/instrumentation/surgical techniques:*** None of the following would qualify a case as complex: pupillary dilation using medications, such as Omidria (phenylephrine and ketorolac intraocular solution 1%/3%, Omeros) or epi-Shugarcaine, routinely using a Malyugin ring, the sole use of dye in cases when a dense cataract is not present.
- ***Cataract surgery without insertion of an IOL:*** I often receive questions about this, especially with regard to pediatric cataract extraction, and the answer is NO. If an IOL is not placed, the case cannot be coded as complex.

Suggested Reading

- Asbell RL. Complex Cataract Surgery: Audit Considerations, Coding & Compliance. *The Ophthalmic ASC*; August 2018. Available at: https://bit.ly/2TY0BGr
- Asbell RL. Coding for Complications of Cataract Surgery. *The Ophthalmic ASC*; August 2017. Available at: https://bit.ly/2WbV10G
- Asbell RL. ASC Medicare Compliance and Chart Documentation in Cataract Surgery. *The Ophthalmic ASC*; May 2013. Available at: https://bit.ly/2ThrK2F

2 Retina and Vitreous Surgery

Here are two frequent errors:

- ***Removal of silicone oil as a second procedure, performed in a different session:*** Some of the more recent advisories have re-advocated using CPT code 67036 (vitrectomy, mechanical, pars plana approach) rather than CPT code 67121 (Removal of implanted material, posterior segment; intraocular). Despite the tempting financial advantage for ASCs to use CPT code 67036, both ASCs and surgeons should use CPT code 67121 as this is a second procedure in an eye in which a pars plana posterior vitrectomy has previously been performed. Indeed, on the physician side, as a subsequent procedure, the Relative Value Update Committee would most likely never agree that the amount of work and intensity involved the second time is the same as in the original procedure. For physicians, the payment is almost the same.
- ***Use of CPT code 66852 rather than 66850 when removing the crystalline lens or lens fragments from the eye (performed in conjunction with pars plana vitrectomy):*** CPT code 66850 (Removal of lens material; phacofragmentation technique [mechanical or ultrasonic] [e.g., phacoemulsification] with aspiration) is the one that must be used when a lensectomy is performed in conjunction with a pars plana vitrectomy procedure. This is based on the instruction in the CPT manual. It seems a bit bizarre to retinal surgeons, as an anterior approach is used and most want to use CPT code 66852 (Removal of lens material; pars plana approach, with or without vitrectomy). In fact, CPT code 66852 is not your code! There may be an occasional use for it when coding for pediatric cataract removal. The code was developed for primary cataract extraction using a pars plana approach wherein incidental vitreous may be removed, but a core or complete vitrectomy is not intentionally performed. Furthermore, CPT code 66852 is bundled with the pars plana vitrectomy codes in the National Correct Coding Initiative bundling lists.

Suggested Reading

- Asbell RL. Coding Reassessment for Complex Retinal Detachment Repair. *The Ophthalmic ASC*; May 2018. Available at: https://bit.ly/2Oe2GJd.
- Asbell RL. Anterior Segment Surgery by Posterior Segment Surgeons. *Retina Today*; September 2016. Available at: https://bit.ly/2TPF5V1.

3 Glaucoma

Minimally invasive glaucoma surgery (MIGS) has always been fraught with errors, beginning with the original CPT descriptors, and the confusion continues. Here are three important areas of which you should be cognizant:

- ***Removal of MIGS devices:*** Erroneous advice has been put forth regarding removal of implanted MIGS devices, such as Hydrus (Ivantis), Xen (Allergan), CyPass (Alcon), and the various iStent (Glaukos) products. The correct CPT code is 65920 (removal of implanted material, anterior segment of eye). ASCs have no means of being reimbursed for CPT code 66999 (unlisted procedure of anterior segment of the eye) — so it is a good idea to check with the surgeon/practice to ascertain if they are using CPT code 65920.
- ***Repositioning of MIGS devices:*** There is no CPT code for repositioning of a MIGS device. The ASC and surgeon must use the unlisted CPT code 66999, and this is not reimbursable in an ASC. It is recommended that these cases are not scheduled in an ASC for Medicare patients.
- ***Off-label use of MIGS devices as a second stent in the same procedure:*** CPT code +0376T technically reads: "Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; +0376T each additional device insertion (List separately in addition to code for primary procedure)." This is an off-label use when used with iStent; thus, all rules for off-label use must be followed.

Suggested Reading

- Asbell RL. A MIGS Compliance Compendium. *The Ophthalmic ASC*; October 2018. Available at: https://bit.ly/2UKBfsU.
- Asbell RL. CyPass Device Removal/Revision: Coding & Reimbursement Challenges. RivaLeeAsbell.com; October 2018. Available at: https://bit.ly/2YaVT7B.
- Asbell RL. ASC & Physician Medicare Audits: Cataract & MIGS Surgery. *The Ophthalmic ASC*; February 2018. Available at: https://bit.ly/2TP5EKh.

4 Oculoplastic Surgery

Ophthalmic plastic surgery coding is fraught with coding mistakes, sadly, sometimes intentionally. Three of the most difficult areas are listed here.

- ***Coding for blepharoplasty and ptosis surgery:*** In 2017 and 2018, Medicare enacted some very stringent regulations regarding coding for reimbursement of these procedures. ASC coders should read the guidelines on this and carefully adhere to them. Fraudulent coding could include billing for the removal of the nasal fat pad as a cosmetic procedure (billing the patient) when performing a functional upper eyelid blepharoplasty or coding lower eyelid blepharoplasties as ectropion repair. Neither of these types of surgery practices should be allowed, as each would be considered fraudulent by Medicare.
- ***Not differentiating between cosmetic and functional surgery:*** When the surgeon is performing both cosmetic and functional surgery (e.g., functional upper eyelid bilateral blepharoplasties and cosmetic lower eyelid blepharoplasties) during the same operative session, it is imperative to differentiate the functional and cosmetic portions of the surgery to ensure that the cosmetic portions are not billed to Medicare. This applies to the ASC fees, the anesthesia fees, and the surgeon's fees.
- ***Excisional biopsies and the biopsy revisions in CPT 2019:*** The February 2019 issue of *The Ophthalmic ASC* contains a comprehensive listing of the CPT changes in biopsy coding for 2019. ASCs should not permit the ambiguous and erroneous term excisional biopsy to appear in the charts. A given procedure is described as either one or the other, but not both together. If a lesion is biopsied and sent for pathological diagnosis, then it is a biopsy, whereas if the lesion is completely excised and sent to pathology for a report, it is an excision. All ASC staff, including the surgeons and practices, must be made aware of this.

Suggested Reading

- Asbell RL. Biopsies in Ophthalmology: Myths & Mysteries. *The Ophthalmic ASC*; February 2019. Available at: https://bit.ly/2Tn6WXT.
- Asbell RL. Medicare's New ASC Regulations for Ptosis & Blepharoplasty. *The Ophthalmic ASC*; October 2016. Available at: https://bit.ly/2FfseBv.
- Asbell, RL. 2017-2018 Update on CMS Blepharoplasty Policy. RivaLeeAsbell.com; August 2017. Available at: https://bit.ly/2HvLgXR.

5 Compliance and Billing Issues

This area may be the least familiar, and, thus, the most difficult for readers. It is imperative that both ASC personnel and surgeons be cognizant of Medicare's regulations regarding given procedures when asking Medicare to pay for the service.

- *The ASC chart documentation must be self-contained:* If Medicare audits a given ASC chart, that chart has to withstand scrutiny as an independent document regardless of what may be in the surgeon's chart. This is the Achilles' heel for most ASCs. Medical necessity for the procedure should be readily apparent in the ASC chart. Additional informed consents should be used when a procedure is off-label, cosmetic, or otherwise not under the ordinary protection of your standard informed consent. A copy of the office notes supporting the medical necessity of the procedure should be standard procedure for your charts. Most ASCs are only concerned with adhering to the Conditions for Coverage and not medical necessity issues.
- *Medicare Administrative Contractors' Local Coverage Determinations (LCDs):* An LCD is the determinant of how and when certain procedures are covered. If a procedure is not covered on the physician side, scheduling in the ASC should not be permitted. An example of this is a MIGS procedure using the XEN 45 Gel Stent. For providers under NGS Medicare, this MIGS procedure is only reimbursed when used in conjunction with a diagnosis of refractory glaucoma — other diagnoses that the FDA approved for use are not covered. Both ASCs and surgeons should keep up with these LCDs in order to avoid many errors.
- *Proper use of CPT modifiers:* It is imperative that both physician and ASC coders have an in-depth mastery of modifiers. However, the usage vastly differs between the two types of surgical coding. Appendix A in the CPT book (titled "Modifiers Approved for Ambulatory Surgery Center Hospital Outpatient Use") is a dedicated appendix for modifiers to be used in coding ASC claims. But … Medicare does not approve usage of all the modifiers listed, so ASC coders must be very careful to use only the ones that will not be rejected. Some of the problem results from the ASC and Hospital Outpatient usages being combined so that office visit modifiers are included on the list. It is best to check with your MAC or CMS to determine which ones may be used. Keeping in mind that this is facility coding, the following modifiers have been listed as Medicare approved by different sources — including one from Verywell Health (verywellhealth.com/asc-billing-basics-2317426). The modifiers are also listed in Table 1. Keep in mind that each insurer may have its own list, and there may be variations among the various MACs and other insurers.

TABLE 1. MEDICARE MODIFIERS FOR USE IN ASCS

(Note: approximate list only – may vary by MAC and time frame)

*(Note: **Boldface** indicates those most common in ophthalmic ASC usage)*

Modifier RT	**Right side (used to identify procedures performed on the right side of the body)**
Modifier LT	**Left side (used to identify procedures performed on the left side of the body)**
Modifier TC	Technical component
Modifier 52	**Reduced services**
Modifier 59	**Distinct separate procedure**
Modifier 73	**Procedure discontinued after prep for surgery**
Modifier 74	**Procedure discontinued after anesthesia administered**
Modifier FB	Device furnished at no cost/full credit
Modifier FC	Device furnished at partial credit
Modifier PA	Wrong body part
Modifier PB	Surgery wrong patient
Modifier PC	Wrong surgery on patient
Modifier PT	Colorectal screening converted to diagnostic or therapeutic procedure/surgery
Modifier GW	Surgery not related to hospice patients' terminal condition

Suggested Reading

- Noridian Healthcare Solutions website. ASC Documentation Requirements. Available at: https://bit.ly/2YbDTtD.
- Chidester-Palmer B. ASC Coding and Billing Fundamentals. AAPC website. Article available at: https://bit.ly/2u8TyMJ. ■

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