

Coding Clarifications for Pediatric Ophthalmology

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Coding in pediatric ophthalmology is often quite difficult, particularly since the examination and surgical techniques may vary from those used in adults. Furthermore, Medicare is seldom the primary payer and the rules vary from insurer to insurer. Nevertheless, some standards need to be in place, and Medicare benchmarks are good ones.

CHART DOCUMENTATION OF OFFICE VISITS/CONSULTATIONS

Most practitioners are familiar with the rules for Evaluation and Management (E/M) services as well as the eye codes. It is important to document all the elements (14) of an E/M examination when billing the higher levels, even if the given element is not performed. For example, if it is not possible to perform confrontation fields because the child is too young or non-cooperative, then stating that will usually allow credit for the element.

A forced entry form that enables a quick check-off of normal findings facilitates this type of documentation. A copy of such a form may be seen in Figure 1.*

Many initial encounters may be classified as an E/M consultation, thus it is critical that all the requirements as specified in CPT (Current Procedural Terminology) be adhered to, including documentation of the requester, performing all the elements of the examination and sending a written report back to the requester. A telephone call does not fulfill the requirement. These requirements are not just Medicare requirements, but are also listed in CPT.

When performing inpatient consultation on babies with ROP (Retinopathy of Prematurity) a low level E/M in patient consultation (CPT code 9952X) may be billed in addition to the extended ophthalmoscopy. The level will depend on the extent of the examination and billing for the extended ophthalmoscopy mandates having an appropriate sized drawing and interpretation and report (not just a summary of the findings).

EXAMINATIONS UNDER GENERAL ANESTHESIA

When an infant or child is examined under general anesthesia the correct procedure code to use is either 92018 or 92019, depending on the extent of the examination. Diagnostic tests such as A scans or B scans may be billed additionally. If the physician is doing an A-scan just for axial length measurement and not intraocular lens power calculation, the correct code is 76516. Please note that this is a bilateral code which means it is billed once for both eyes and modifier -52 is applied if there is only medical necessity for one eye. Be sure there is medical necessity for each eye.

DIAGNOSTIC TESTS IN CONJUNCTION WITH OFFICE VISITS/CONSULTATIONS

There are many special ophthalmological services listed in CPT that can be billed in addition to the office visit or consultation. Among them are refractions, gonioscopy, fitting of contact lens for treatment of disease, visual field examinations, orthoptic/pleoptic training and sensorimotor examination.

Sensorimotor examination is less clear cut in its definition than the others are and the CPT definition is as follows: "Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report". In order to fulfill the requirements of the test, it is necessary to perform cardinal fields and a head tilt test when indicated. Measurements of primary gaze alignment alone would not suffice to bill this code in addition to the office visit or consultation since it is included, by definition, in the description of single organ systems E/M codes. The comprehensive eye codes require "basic sensorimotor evaluation" in CPT, and more extensive requirements would have to be described by each insurer.

The requirement "with interpretation and report" must be fulfilled. Medicare has described the requirements as addressing the findings, relevant clinical issues, and comparative data (when available). There must be a *written* report that becomes part of the patient's medical record and this should state the findings and then continue to describe how this test is going to aid or influence the clinical management of the patient.

SURGICAL CODING

Surgical coding in pediatric ophthalmology involves strabismus for the most part, but also can involve anterior segment, glaucoma, and retina.

Modifier –63 may be appended to the billing of surgeries that are performed on infants weighing less than 4 kilograms. You may receive a higher reimbursement in these instances.

Procedure codes 67311 versus 67312 and 67314 versus 67316.

This remains confusing to many coders. If a recession or resection of a muscle is performed in both eyes, such as a bilateral lateral rectus recession, the proper coding would be 67311-50 or 67311-RT combined with 67311-51-LT. The terms “one horizontal muscle” or “one vertical muscle” refers to each eye. When more than one muscle is operated on in the same eye, procedure code 67312 (two horizontal muscles, ie, recession and resection in the same eye) or 67314 (two or more vertical muscles [excluding superior oblique]) should be used.

Add-on codes. These codes designated in CPT by a + sign and, by definition, are procedure codes that cannot be billed alone and must be billed with another CPT code (in strabismus coding the instruction is to use them in conjunction with CPT codes 67311 – 67334). If the add-on code is not added to another designated regular code and is billed by itself, it will not be paid. Therefore, you must bill either another procedure with it, such as a recession or resection, in order to be paid.

Add-on procedure codes 67332 (Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) and 67331 (Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles) cannot be used if the the previous surgery or medical condition applies to the fellow eye and not the eye being operated on. These codes reimburse for more difficulty encountered physically, and in an eye that has not been previously traumatized, either by injury or surgery, use of the codes would not apply.

Transposition codes. Procedure code 67320 is only to be used for transposition of muscles for paretic muscles. It is an add-on code and regular surgery code must be used with it. Raising or lowering the insertions for correction of an A or V pattern when the muscles are

being recessed or resected for correction of a horizontal deviation, is incidental to the main procedure and should not be billed separately.

Adjustable sutures. Although there are many instances when multiple adjustable sutures are placed on the same side, you can only bill the add-on code once for each side. The actual reimbursement is for adjusting the sutures, whether or not the adjustment is performed, in the postoperative period and not for the actual insertion of the sutures.

Pediatric cataract surgery. By definition, all pediatric cataract with intraocular lens insertion surgery qualifies for CPT procedure code 66982 (Extracapsular cataract extraction with insertion of intraocular lens prosthesis...performed on patients in the amblyogenic developmental stage). The obtuse wording derives from CPT policy of not having ages in the code description whenever possible. Capsulotomy is included in all cataract surgeries by CPT definition and cannot be billed additionally. If an intraocular lens is not inserted, then one of the other cataract extraction codes should be used. If a pars plana approach is used CPT procedure code 66852 (Removal of lens material; pars plana approach, with or without vitrectomy) may be appropriate. This code is for primary cataract extraction by pars plana approach and is not a retinal surgeon's core or complete vitrectomy code.

* The pediatric form is part of the Examination Form Portfolio and is available for purchase – see Products.

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