Try This for Medicare Fraud
(Well, At Least Abuse)
Part I

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Introduction

A title that shocks! In many cases, in an attempt to maximize reimbursement, creative coding pushes and even exceeds the limit of acceptability. This occurs in surgical coding as well as office coding and diagnostic testing. It may be committed wittingly or unwittingly. And finally, if it is not actually fraud, it can certainly be considered abuse - the difference being one of intent for Medicare.

Since Medicare serves as a benchmark for other insurers, I suggest you adhere to its guidelines unless the other insurer has published definitive instructions otherwise.

Surgical Coding

***Global Period and Global Fee*.** One of the least understood concepts by most physicians is that of the global period and the global fee

. For Medicare, each surgical procedure has a global period of zero, ten or 90 days during which additional services or procedures will not be paid unless there is an explanatory modifier attached to the CPT (Current Procedural Terminology) code**.** These are modifiers 24 for office visit/consultation procedures and 58, 78, and 79 for surgical procedures. Whether or not one should append the modifier (and consequently get paid - and how much one gets paid) depends on what the problem/condition is and whether or not it would normally be considered part of the global fee.

For ophthalmology in Medicare, the global surgical fee (the allowable) usually is composed of three parts: 10 % is dedicated to preoperative work; 70 % is dedicated to the intraoperative portion; 20 % is dedicated to the postoperative care. Thus, one would not append modifier 24 for evaluation of a minor problem that frequently occurs in the postoperative period just to engender payment for that service. Medicare states that miscellaneous services such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; et cetera are included in the surgical fee.

National Correct Coding Initiative. The code edit pairs in the NCCI (affectionately known as the bundles) were, to a large extent, implemented due to fragmenting of codes when billing and other abusive practices. Never unbundle a code simply because you do not agree with it. There are mechanisms to do this (use of modifiers 25 and 59), but there should be a valid medical reason.

Unlisted Codes. For the varying categories in ophthalmology for CPT there are unlisted codes such as 67599, unlisted procedure, orbit; 67399 unlisted procedure, extraocular muscle etc.

The CPT instructions were modified in 2002 to read as follows: *Select the name of the procedure or service that accurately identifies the service performed.* ***Do not select a CPT code that merely approximates the service provided. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code.*** *In surgery, it may be an operation; in medicine, a diagnostic or therapeutic procedure; in radiology, a radiograph.*

As unappealing as it may be due to the many problems associated with using unlisted codes, one must, nevertheless, use them when appropriate.

Retina. One of the more creative little fraudulent coding tricks I have come across is billing for the second session of panretinal photocoagulation as the first session in order to bill the focal laser on the first session, even though both were performed at the first session. Focal and panretinal photocoagulation are bundled when performed on the same eye at the same session and that bundle should not be broken.

Another area that is very grey is the when to bill for a diagnostic test as bilateral and when as unilateral. This depends on medical necessity. Special ophthalmoscopic diagnostic tests may be unilateral (each eye is paid separately), such as extended ophthalmoscopy (CPT procedure codes 92225, 92226) or bilateral (one amount is paid for both eyes - 92250 fundus photography). There must be medical necessity (i.e. symptoms, findings, complaints) for each eye if the test is going to be billed for each eye. For example, there is medical necessity for examination by extended ophthalmoscopy for following a choroidal nevus in the given eye; however, in the absence of symptoms there would be no medical necessity for performing the test in the other eye (even though it is good medical practice).

Most retinal lasers include the phrase "one or more sessions". Do not unbundle the second or following sessions when performed in the global

period (90 days except for ocular photodynamic therapy which has a global period of zero days).

Oculoplastics. There is probably more erroneous creative coding in oculoplastics than in any of the other subspecialties in ophthalmology - and, for several reasons.

First, the societies have been tardy in obtaining new procedure codes for the work being performed, so when someone attempts to code these complicated procedures the codes simply are not there. Using a rhytidectomy code for a SMAS procedure will render the procedure not paid by Medicare since it is considered a cosmetic surgery code. No one likes to use the unlisted codes since it pulls the claim out of the queue for payment and you wait and wait and wait some more. Example: CPT code for insertion of a gold weight was just given a code in 2004 even though the procedure has been performed for 25 years or so.

Next, there is a marked scarcity of good coding courses in oculoplastics and many put out a lot of erroneous information - well intended but erroneous. So most of the information is passed down from preceptors in fellowships or colleagues who are really not trained in coding and are judging by the fact that they have been paid.

Lastly, complex oculoplastic procedures are among the most difficult to code in ophthalmology and often unfairly under-compensated (at least in my opinion) - tending to spawn even more Acreativeness@. Don not fall into the trap! Here are some things to watch out for:

-Billing orbitotomies with fracture repairs (now bundled for Medicare due to abusive practices)

-Using the high level reconstructive codes for procedures which are not those being performed (ie, 15732 Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae) and 15756 Free muscle or myocutaneous flap with microvascular anastomosis)**.** Most of the time that I have seen these codes used the proper codes would have been for a rotation flap (14060), eyelid reconstruction procedures (67961, 67966) and Hughes and/or Cutler-Beard procedures (67971, 67973, 67974).

Cornea. Pterygium surgery is so undervalued and now the use of amniotic membrane is bundled with it and cannot be billed separately. There is supposed to be a re-evaluation this year and we will have to hope for the best. Meanwhile, do not bill 65420 (Excision or transposition of pterygium, without graft) + 68320 (Conjunctivoplasty, with conjunctival

graft or extensive rearrangement) when a conjunctival graft is performed with pterygium surgery. The correct code is 65426 (Excision or transposition of pterygium; with graft)

Do not use code 68371 (Harvesting conjunctival autograft, living donor) with the above mentioned surgeries. This code is for harvesting limbal stem cell grafts from a donor (not the patient).

Do not use the term excisional biopsy. In coding terms it is either a biopsy or an excision - and it is better to code the excision. This applies to all lesions when there is a code for biopsy and other code(s) for excision. For Medicare, the codes 65400 and 65410 are bundled; however, if a lesion other than the lesion being excised is being biopsied, then you need to append modifier 59 to differentiate them.

Pediatrics. Using the transposition code (67320 Transposition procedure eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure) for raising or lowering the insertions of muscles when correction of A or V patterns is an improper use of the code. This is for procedures used to aid functioning when there is a paretic muscle(s).

Procedure code 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) should not be used unless the surgery or trauma occurred on the eye being operated on. Although bilateral surgery may be performed, it does not necessarily follow that the code should be used for each eye, even though it may be when applicable.

Glaucoma. I have had innumerable inquiries on whether one can use both 66172 and 66250 when performing a trabeculectomy in the presence of scarring. No, you should not. Reimbursement for code 66172 encompasses the difficulties encountered from previous surgery in that area.

There is no CPT code for suture lysis - and do not use 66250. In fact, it=s probably not a good idea to bill it at all since any type of suture removal by the surgeon is considered part of the global surgery, but since there is no appropriate code one would have to use 66999.

When a CPT description includes the phrase “one or more sessions” or “one or more stages” do not bill for additional repeat procedures within the global period.

Also remember that needling of the bleb is considered part of the global package if done in the global period. In order to be reimbursed during the global period you must append modifier 78 to the procedure code and the place of service must be an operating room as defined by Medicare (an operating room of a hospital, ambulatory surgical center, endoscopy or laser suite). Neither a minor treatment room nor a patient examination lane meets the definition of Aoperating room@ - so if the needling is performed in one of those sites, do not bill for it. It is considered part of the 20 percent of the global fee dedicated to postoperative care.

Conclusion

In Part II we will continue with fraudulent/abusive practices as they relate to office visits and consultations and in Part III we conclude with diagnostic tests.

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