BY RIVA LEE ASBELL

# OOSS ASC Benchmarking: Thoughts from a Coding/ Compliance Perspective

The cover story for this issue is based on the Ophthalmic Outpatient Surgical Society's (OOSS) benchmarking study and the importance of tracking ophthalmic ASC data. I have taken some of the benchmarking results as a starting point for various reimbursement issues that plague ASC coders. Coding follows Medicare guidelines.

## RETURN TO ASC OR FOR SURGICAL PROCEDURES OOSS FINDING: 28% OF FACILITIES SURVEYED HAD POSTSURGICAL ADMISSIONS

Modifiers control Medicare surgical payment. Each Medicare Administrative Contractor (MAC) has different instructions for the use of modifiers and it's important to familiarize yourself with them.

There are two different lists of ASC modifiers: the MAC's and the Current Procedural Terminology (CPT) appendix "Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use." A given MAC and the CPT Appendix have different lists and a MAC pays on their lists that generally exclude use of 58, 78 and 79 modifiers.

Physicians and facilities are paid on a different basis — physician payment is essentially based on work (plus practice expense and malpractice expense to a lesser degree) whereas facility payments are based on costs. The physician is paid at 70 to 80% of the allowable when modifier 78 is appended to the procedure on the claim whereas the facility does not experience a comparable reduction in reimbursement.

Readmissions to an ASC may be on the same day or at a later date.

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When the readmission occurs on the same day, there may be problems with getting paid for both procedures. Use two separate claims because if both procedures are on the same claim both surgeries may be interpreted as being performed in the same session and paid according to Medicare's multiple surgery rules wherein the second through fifth procedures are paid at 50% of the allowable amount. On the second claim, you can try appending a narrative statement stating that the second surgery was due to a complication of the first surgery that day and was actually performed during a separate session.

If the readmission occurs on a separate date then there should be no problem with the claim going through as a clean one. Just code the procedures performed and do not append modifiers 58, 78 or 79.

## CODING FOR CANCELED OR DISCONTINUED SURGERIES OOSS FINDINGS: 1% OF CASES SCHEDULED HAD SAME-DAY CANCELLATIONS

Physicians and ASCs use different modifiers to indicate that a procedure was canceled or discontinued. When coding for physicians, use modifier 53 to indicate that a procedure was canceled after it was started. Medicare cannot be billed for elective cancellations or if the surgery has not commenced.

Two modifiers that are specific for ASC coding are 73 and 74. Modifier 73 engenders payment at 50% of the allowable and modifier 74 at 100%.

The 2014 CPT definitions are given in full.

**"73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia:** Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but canceled can be reported by its usual procedure number and the addition of modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53."

WPS Medicare gives the following examples. I highly recommend you visit their website and read the entire modifier fact sheet, particularly the comments on modifiers 58, 78 and 79.

## An Example of Coding for Returns to the ASC OR

**A cataract extraction with insertion of an intraocular lens and corneal transplant had been performed in the right eye. The intraocular lens dislocated, had to be removed, and a new one was inserted. A mechanical anterior vitrectomy was performed to remove all the vitreous in the anterior chamber. An intraocular lens exchange was performed with suturing of the intraocular lens. This surgery was performed during the global period of the first surgery.**

**DIAGNOSIS:** 1) 996.53 Subluxated intraocular lens
2) 379.26 Vitreous prolapse
3) V45.69 Previous intraocular surgery

**SURGERY:**

| Diagnosis Codes | CPT Procedure Code(s) | Modifiers |
|---|---|---|
| 1, 3 | 66986 Exchange of intraocular lens | -RT |
| 1, 3 | 66682 Suturing of intraocular lens | -51-RT |
| 2, 3 | 67010 Anterior mechanical vitrectomy | -51-RT |

TIPS: **CPT code 66986 encompasses both removal of the old and insertion of the new intraocular lens. Formerly two codes were used. Not all Medicare contractors specify use of modifier -51 any longer. The physician would use modifier 78; the ASC would not.**

**Modifier 73: Example of payable case:**

*The ASC prepped the patient and took them to the procedure room. The patient's blood pressure increases suddenly or the physician determines the patient is not able to complete the procedure.*

**Modifier 73: Example of cases that should not be billed.**

*Patient complained of cold or flu upon intake. The surgeon canceled the procedure due to patient condition.*

**"74 Discontinued Out-Patient/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia:** Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53."

WPS Medicare's example of a case eligible for payment: The patient developed uncontrolled bleeding and the procedure was terminated.

### CODING FOR COMPLICATIONS THAT OCCUR DURING A SURGICAL PROCEDURE OOSS FINDINGS: 0.5% OF FACILITIES SURVEYED HAD UNPLANNED VITRECTOMY REPORTED (2013 DATA)

One of the main complications of cataract surgery is rupture of the posterior capsule. The occurrence rate ranges from 3 to 30% as reported in various studies; however, not all cases require performance of a vitrectomy. As Thomas John, MD, has stated, "Posterior capsular tear during a phacoemulsification procedure is an unwelcome event in the operating room for any ophthalmic surgeon. However, proper decision making in the technique for handling the vitreous and retaining the violated capsule, removing the lens remnants, and stable positioning of the lens implant will all contribute to an optimal postoperative result and minimize potential complications such as dropped nucleus, cystoid macular edema or retinal detachment. Anterior vitrectomy may be performed via a wound that is anterior to the iris plane or behind the iris plane (i.e., pars plana vitrectomy). Both approaches have associated risks and benefits. Familiarity with one or both vitrectomy techniques and being prepared as a team will be beneficial for the cataract surgeon."[1]

The CPT codes for vitrectomy surgery are classified as anterior vitrectomy or posterior vitrectomy. Coders frequently have difficulty making the choice. The codes are:

**67005 Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal**

**67010 subtotal removal with mechanical vitrectomy**

**67036 Vitrectomy, mechanical, pars plana** approach;

**Note:** *This code is followed by a series of codes that involve other techniques in* addition to the vitrectomy.

CPT code 67005 is for a manual technique such as excision of the vitreous using a Weck-Cel technique at the incision wounds to make sure no vitreous is incarcerated in the incision. This is often performed in conjunction with an anterior mechanical vitrectomy as well as by itself in trauma cases. CPT code 67010 is used when a mechanical vitrector is utilized. CPT code 67036 and the series of codes that follow are used only for coding posterior vitrectomy that uses a pars plana approach.

The National Correct Coding Initiative (NCCI) bundles are in place for the cataract extraction codes with insertion of intraocular lens (66982, 66984) and 67005 and 67010, but are not in place for 67036. No bundles are in placed for the cataract extraction codes when no intraocular lens is used. ■

### References

1 John, Thomas MD, Successful anterior vitrectomy requires effective management. Ocular Surgery News, US Edition, March 10, 2012.

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## An Example of Coding for Surgical Complications

**The anterior segment surgeon performed a planned cataract extraction in the right eye and during the lens extraction a posterior capsular rupture occurred and the nucleus dropped into the posterior vitreous. A retina surgeon from a different practice was called in and removed the retained lens fragments by phacofragmentation as well as having performed a pars plana vitrectomy. Code all procedure(s) performed by retina surgeon.**

**DIAGNOSIS:** 1) 998.82 Retained lens fragments
2) V45.69 Previous intraocular surgery

**SURGERY:**

| Diagnosis Codes | CPT Procedure Code(s) | Modifiers |
|---|---|---|
| 1, 2 | 66850 Phacofragmentation of lens | -RT |
| 1, 2 | 67036 Pars plana vitrectomy | -51-RT |

TIPS: CPT code 66850 is used rather than 66852 per CPT instructions even though an anterior segment approach is not used by the retina surgeon.

CODING NOTES: The anterior segment surgeon would code 66894-53 if the IOL pack was opened and the ASC would code 66984-74. If the IOL pack was not opened, then use 66850-53 for physician coding and 66850-74 for the ASC coding. The retina surgeon's procedures do not require modifier 74.