CPT Coding: It's All in the Modifiers

How to get the best reimbursement possible for your oculoplastic procedures.

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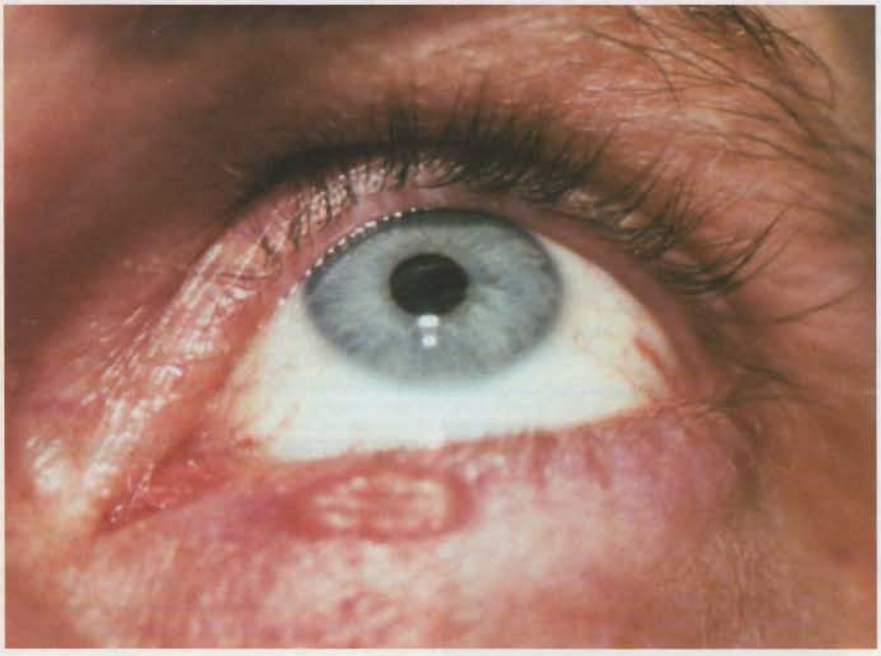
GETTING A FAIR REIMBURSEMENT FOR your services can be a challenge, when the myriad of codes and coding procedures are taken into account. Since fraud and compliance infractions can cost a practitioner up to $10,000 per occurrence, compliance is not to be taken lightly. Here's how you can get a fair shake and play fair, at the same time.

Part of the challenge in the ophthalmic realm is that the specialty is progressive and there are multiple codes for specific procedures, particularly lesions and reconstructions near the eyelid margin. An example of this is a full-thickness wedge excision of the eyelid. If the excision encompasses less than a quarter of the width of the lid, the surgeon uses code 67961. However, if the resection involves more than that, the correct code is 67966. These codes also include primary closure of the defect. If the closure is more extensive, then reconstructive procedures are coded in addition to the primary code. Lateral canthotomy is coded separately, as is flat reconstruction of a defect that can't be coded primarily. For example, if you use a tarsoconjunctival flap from the opposing lid, the codes that apply are 67971-67975.

However, a lot of periorbital plastic surgery involves lesion-removal and closure-of-local-flap codes, which are more commonly used in plastic surgery. Next, I'll explain some of the nuances of coding for these.

If a lesion, such as this basal cell carcinoma, involves an excision of less than a quarter of the lid's width, use code 67961.



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CPT/ICD-9 Matching

The remuneration for CPT codes is not driven by procedures, but rather by the ICD-9 codes. Provider computer programs that don't associate a particular CPT Code with the utilized ICD-9 code line will reject that submitted bill. As an example, take the 11600 codes used for removal of malignant eyelid lesions. An ICD-9 code must be used that reflects either a primary malignancy (173.1), a secondary malignancy (198.2), *in situ* (232.1) or uncertain behavior (238.2). If you use a benign lesion code, such as 216.1 (benign tumor) or 702.0 (actinic keratosis), the claim will be rejected.

E/M Coding

As remuneration has increased for the cognitive portion and decreased for the procedural portion, it's imperative that the surgeon make the most of evaluation and management codes (E/M). One challenge is that E/M codes aren't paid if applied on the same day as a procedure. This proviso

wasn't inserted to penalize surgeons who make the decision for surgery and the procedure on the same day. Rather, its intent is that E/M codes not be used to pay for routine history and physical visits that are performed within 24 hours. If an E/M visit leads to the decision for surgery within 24 hours, then a 57 modifier will legitimize the code.

RVU or not RVU? That Is the Question

Relative Value Units (RVU) are the key to the order that codes should be submitted. Since providers discount multiple procedures when they're listed chronologically or alphabetically, it's best to list them by RVU. The discounting usually runs 80 percent of the allowable charge for the first procedure, 50 percent for the second and third, and 25 percent for each subsequent procedure. This being the case, you don't want the first one in your list, for which you'll get full reimbursement, to be a $10 charge, while the second pays $1,000, because the second will be discounted. For instance, say you've got to remove a 9-mm basal cell carcinoma in a senile ectropion patient who requires canthopexy, excision of the tumor and intermediate closure. In this case, it would be best to list the procedures on the billing statement in this way:

1. Correction of lid retraction (RVU code 12.3)
2. Lesion excision (CPT 11641; RVU 4.91)
3. Layered closure of lid under 2.5 cm (RVU 4.02)

Don't Unbundle Your Worries

Unbundling is when a practitioner submits multiple CPT codes for subunits of a larger procedure. This practice is inappropriate, highly frowned upon and can approach the level of fraud. However, even when you toe the line and submit the appropriate codes, some computer programs and/or their operators may disallow them on the grounds that you were unbundling.

For example, say you remove two lesions. The first is on the upper eyelid of the left eye (CPT 11402) and is closed primarily. The other is on the lower right lid, and is closed with a rotation flap (CPT 14060). Normally, you would apply modifier 51 for a primary procedure to the excision code 11402. However, the 14060 local tissue advancement code includes removal of the primary lesion. The computer program won't identify two separate lesions and the 11402 will be disallowed. The solution is to use the 59 modifier, which recognizes separate and identifiable procedures.

Hints on Lesion Excision

Don't code the size of the excision. Rather, code for the maximal clinical dimension of the lesion *in situ*, prior to excision. The lesion excision codes include simple one-layered repair. If you excise a lesion and close a defect with intermediate or complex repair, code for both of them.

Removal of a malignant lesion includes removal of a margin of normal tissue. Simple undermining to close a wound, especially if it's smaller than 1.0 cm, is not classified as adjacent tissue transfer. To use it would be considered upcoding—which would rapidly "downcode" your integrity.

Flap or Transfer?

A question often arises in plastics procedures: When is a procedure considered an adjacent tissue transfer 14060 code, or flap closure?

First, the difference in remuneration is extremely small. Local adjacent tissue transfer includes rotation, transposition and advancement flaps, as well as W-plasty and Z-plasty. The excision of a lesion or scar is included in this code, so the benefit you derive from using a specific ocular flap (Code 67971) is appropriate if you describe the flap, since it allows you to bill for an additional excision code.

Not-So-Simple Closure

Repair of lacerations and defects are coded as simple, intermediate, or complex—though deciding which is which can be more complex than simple. This is especially true currently, as HCFA has decided not to follow CPT guidelines.

To simplify matters, don't use an intermediate closure for benign lesions or lacerations smaller than 5.0 mm. Placing a single suture in the subcutaneous tissue isn't multi-layer closure, but the closing of another layer, such as the preseptal orbicularis or the SMAS layer of the cheek, is considered intermediate closure. Complex closure requires additional work, such as debridement, extensive undermining or tension sutures.

In summary, to receive the most fair level of reimbursement possible while being completely in compliance with the law, make sure you code for what you did, organize the CPT codes by RVU, don't unbundle and be educated on modifiers. Follow these guidelines, and you'll be sure to receive equitable reimbursement every time.

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