Ophthalmology Coding Alert

Reader Question: Multiple Global Periods May Mean Multiple Modifiers

Question: A patient had cataract surgery in her right eye on August 4th. Surgery was scheduled on the left eye for August 18th. That morning, the patient arrived and mentioned to our receptionist that she felt irritation in the right eye. The operating physician examined her, epilated a lash, and continued with the cataract surgery. I used modifier -24 for the exam, and the claim was rejected. What did I do wrong?

Texas Subscriber

Answer: The first step to correct coding is to identify ALL of the procedures your doctor performed, according to AAO's panel of expert coders who presented at 2016's annual conference.

You're still within the post-op period for the right eye, and the patient's new complaint is unrelated to that surgery, so you were correct to append modifier 24 (Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period) to your exam code.

Second, the epilation is a minor procedure with its own global period, and as such, includes an office visit that is not separately billable. But in your case the epilation wasn't the reason for the patient's visit she came for her scheduled cataract surgery. Therefore, you would also append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to your exam code.

If the epilation was the only reason for the patient visit, modifier 25 wouldn't be appropriate. The exam would be included in the global period. Likewise, if the epilation occurred in the left eye the eye scheduled for cataract surgery the epilation would likely be considered pre-op care and wouldn't be billable since it would have been included in the global period for the cataract surgery.

Reimbursement is dependent upon clear documentation to describe the circumstances of the physician-patient encounter and the need for an assessment of a presenting problem different from or in addition to the planned surgery. Even with excellent documentation, the correct modifiers and the proper ICD-10 diagnoses, you may find it necessary to appeal denied claims, which may be a losing battle with the payer.