Codify
BY AAPC

Optometry Coding & Billing Alert

Answers to the Post-Op Care Quiz

1. C. Append modifier -55 (Postoperative management only) to the surgery CPT code to report your postoperative care of the patient, says **Jesse Brinson**, administrator for Carrboro Family Vision in Carrboro, N.C.

Modifier -52 (Reduced services) tells the provider that you did the surgery, but not all of the surgery, which is not the case in postoperative management. The surgeon should report the CPT code for the procedure appended with modifier -54 (Surgical care only). In the rare case that you treat another problem, unrelated to the original surgery, during the global period, you would append modifier -24 (Unrelated evaluation and management service by the same physician during a postoperative period) to the E/M code. As of now, there is no modifier -67.

2. B. To make the claims match up better to Medicare, you should always use the same diagnosis code that the surgeon used to file the surgical claim. A phone call to the surgeon after you see the patient is a great way to remind that office to code properly as well - and to find out how many days he is filing for.

3. B. For all three procedures, Medicare considers the 90-day period following cataract surgery reimbursable at 20 percent of the overall procedure charge. Preoperative care earns 10 percent, and intraoperative care earns 70 percent.

4. A. You may bill for all the days you were responsible for the patient's care, starting from the day the surgeon transferred care, including any days prior to the first day you actually saw the patient. However, you should not bill Medicare for postoperative care until you actually see the patient in your office. Don't submit your claim until the patient actually presents in your office for care.

5. D. To determine the fee, first calculate 20 percent of the global fee, $700. Divide the result, $140, by 90 to find the per-day charge for postoperative care. Multiply that result (1.555~) by the number of days you are managing the patient postoperatively (45) to get the result, which, rounded to the nearest penny, is $70.

Remember: The "global fee" concept applies to Medicare carriers only. If the patient has any other insurance, providers usually bill per visit, just like any other medical diagnosis.