One of the most difficult dilemmas in surgical coding is determining whether to bill per extraocular muscle versus per session, per eyelid versus per side, per lash versus per eyelid per side. Help! Please get your CPT books out before continuing and pull up Medicare’s Physician Fee Schedule Data Base (MPFSDB) (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/PhysicianFeeSched/). MPFSDB overrules CPT instructions for payment for Medicare.

**Medicare**

MPFSDB lists various indicators in category columns that might be considered funny places. The indicators for diagnostic tests and sides in surgery are listed in the column entitled “Bilateral Surgery” and use the following system:

- **0** = Payment adjustment for bilateral procedures does not apply. Bilateral modifier is inappropriate for reasons such as (a) physiology; (b) code descriptor specifically states a unilateral procedure; or (c) procedure is not performed as a bilateral procedure.
- **1** = Payment adjustment applies if billed with modifier 50 (payment based on billed amount or 150% of the fee schedule amount). (Example: 67810 Biopsy of eyelid)
- **2** = Payment adjustment does not apply. Payment already based on procedure being a bilateral proce-
The codes with indicator 0 for Medicare include 65756, 66990; the lesion excision codes 67800, 67801, 67805, 67808; ocular photodynamic therapy 67221, 67225; the remainder (67320, 67331, 67332, 67334, 67335, 67340) are add-on codes. The chalazion excision codes carry this indicator, thus explaining the importance of selecting the right code. The codes are billed per session. These rules may differ for other insurers.

**Strabismus surgery.** When coding for strabismus surgery, pay attention to these three guidelines.

1. **Adjustable sutures.** CPT code 67335 Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) was developed for the adjustment of the sutures; the physician is not really being paid for the insertion of the sutures. CPT Assistant states, “Code 67335 does not represent the operating room performance of the strabismus surgery. Rather it is used to code for the adjustment procedure, regardless of the number of adjustable sutures placed.” You may code it once per session but not per eye.

2. **Add-on codes.** Add-on codes do not stand alone and must be appended to another code as listed in CPT. They were developed to compensate surgeons for extra difficulty that may be encountered due to previous surgery, trauma, or various medical conditions. Previously, they could be coded per side. This applies to codes 67320, 67331, 67332, 67334, 67335, and 67340. You may code it once per session but not per eye.

3. **Transposition procedure.** CPT Assistant states, “A transposition procedure (67320) is performed when a patient has lost functioning in one of the extraocular muscles … An add-on code is not used for minor transpositions of a muscle coincident to a recession or resection.” Transposition procedures are coded when the surgical procedure is for correction of a paretic/paralyzed muscle—not for raising or lowering the insertions of muscles for correction of A or V pattern. You may code it once per session but not per eye.

**Trichiasis.** One of the most frequently asked questions is “Do I code for lash removal per lash, per eyelid, or what?” CPT Assistant specifies, “Codes 67820 and 67825 are intended to be reported per procedure, not per eyelash or per eyelid.” However, for Medicare, the indicator is 1 so you may bill the code per eyelid but not per lash.

**Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm).**

The code was developed and priced for the typical patient receiving this procedure per side—not per muscle, nor per number of injections on that side. You may code it per side but not per muscle nor per number of injections nor per eyelid.

**Getting paid**

These coding guidelines are often not well known and therefore not followed. For Medicare, payments are calculated by RVUs (relative value units) that take into consideration the work and expenses involved for the typical patient or case—and that is why the specific examples we discussed are paid per eye or per side and not per muscle or per injection. Getting paid for a procedure does not equate to correct coding, however, and payers can ask for their money back.

**Notes**

1. CPT Assistant March 1997 issue, page 5
2. CPT Assistant April 2001 issue, page 1
3. CPT Assistant July 1998 issue, page 10

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