Medico-Legal Considerations and Coding and Billing of Laser Procedures

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Invasive Patient Procedures

- First Do No Harm

Informed Consent

- Part of any medical procedure no matter how minor
  - Even routine parts of an ophthalmic exam require explanation to the patient prior to being performed
- Invasive procedures
  - Require written informed consent
  - Protection of the patient
  - Protection of the provider
  - Opportunity to make sure patient is at ease and all questions are answered
Components of Informed Consent
- Patient must have the capacity to make a decision
- Provider must disclose information on test or procedure
  - Should include:
    - Expected benefits
    - Risks
    - Likelihood or probability that the benefits and risks occur
- Patient must comprehend the relevant information
- Patient must voluntarily grant consent without coercion or duress

Decision Making Capacity
- Decision making capacity legally referred to as “competency”
- May be competent on some decisions and not others
- Components of Decision Making Capacity
  - Ability to understand options
  - Ability to understand consequences of choosing each option
  - Ability to evaluate personal cost and benefit of each consequence and relate to own set of values

Lack of “Competence”
- If not all components are met then
  - Family members, court-appointed guardians or other surrogate decision-makers may make decision
    - Depends on State Laws
  - Competence does not mean that all decisions are good decisions
  - Making a bad decision does not mean that patient is incompetent
Decision-making capacity, or competency, simply means that you can understand and explain the options, their implications, and give a rational reason why you would decide on a particular option instead of others.

Disclosure

- Provider must give (or disclose) enough information so that the patient can make an informed decision
- Not necessary to explain all detail
- Information should be enough for a reasonable person to make an intelligent decision
- Should include Risks and Benefits
- All questions should be answered
  - Opportunity for questions

The more invasive, the more need for written consent

- An explanation of the medical condition that warrants the test, procedure, or treatment
- An explanation of the purpose and benefits of the proposed test, procedure, or treatment
- An explanation or description of the proposed test, procedure, or treatment, including possible complications or adverse events
- A description of alternative treatments, procedures, or tests, if any, and their relative benefits and risks
- A discussion of the consequences of not accepting the test, procedure, or treatment
- Consent form should be signed and dated by both patient and doctor
- Patients are entitled to a copy
Competency is a legal term used to indicate that a person has the ability to make and be held accountable for their decisions. The term is often used loosely in medicine to indicate whether a person has decision-making capacity, as described previously. Technically, a person can only be declared "incompetent" by a court of law.

Doctor/Patient Decision Making
Laser Coding and Billing

- Billed with 60000 level surgical codes
- Carry a surgical global period
- Possible to bill additionally with the use of modifiers

Unilateral vs Bilateral Procedures

- It's possible but not preferred
  - Patient safety should dictate course
  - Watch to see how first eye responds
  - Reimbursement only 50% on second eye if done on the same day

Argon Laser Trabeculoplasty

- Selective Laser Trabeculoplasty
  - Requires glaucoma ICD9 (soon ICD10) code
  - CPT 65855
  - Global Period 10 days
  - Provider Reimbursement CMS $303.83
  - CMS Facility Fee $184.99
    - Aetna $714.40
    - BCBS $238.75
Laser Iridotomy

- Requires glaucoma ICD9 (soon ICD10) code
- CPT 66761
- Global Period 10 days
- Provider Reimbursement CMS $240.91
- CMS Facility Fee $183.78
- Cigna $1120

Laser Iridoplasty

- Requires glaucoma ICD9 (soon ICD10) code
- CPT 66762
- Global Period 90 days
- Provider Reimbursement CMS $434.88
- CMS Facility Fee $243.09

Posterior Capsulotomy

- CPT 66830
- Global Period 90 days
- Provider Reimbursement CMS $727.56
- CMS Facility Fee $912.49
1. **QUESTION:** Does Medicare cover selective laser trabeculoplasty (SLT)?

   **ANSWER:** Yes. Trabeculoplasty performed with a frequency doubled Nd:YAG laser (also known as SLT) is a covered procedure when it is medically necessary and supported in the patient's medical record.

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2. **QUESTION:** Should I consider SLT as a primary treatment for glaucoma?

   **ANSWER:** Sometimes. When a patient cannot tolerate anti-glaucoma medications or cannot comply with instructions for use, then SLT should be seriously considered. When anti-glaucoma meds are not affordable, SLT is a cost-effective alternative. Oftentimes, SLT supplements current medications as an adjunctive therapy to prevent glaucomatous damage.

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3. **QUESTION:** What CPT code do we use to report SLT for glaucoma?

   **ANSWER:** CPT code 65855, Trabeculoplasty by laser surgery, one or more sessions (defined treatment series) is used to report the service. This is the same code used for argon laser trabeculoplasty (ALT); CPT does not specify the type of laser. Also, report the location modifiers RT, LT, or 50 as appropriate.
**SLT FAQs**

**4. QUESTION:** What is the Medicare reimbursement for SLT?

**ANSWER:** When SLT is performed in the ophthalmologist’s office, the first quarter 2015 national Medicare Physician Fee Schedule allowed amount is $344.82 for participating providers. No facility fee is reported, the payment includes use of the laser.

When SLT is performed in an ambulatory surgery center (ASC) or hospital outpatient department (HOPD), the surgeon’s Medicare allowable is reduced to $300.70. Medicare fee schedule amounts are adjusted by local wage indices so actual payment amounts vary.

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**5. QUESTION:** Does Medicare allow a facility fee to an ASC or HOPD for SLT?

**ANSWER:** Yes. Under current Medicare regulations, 65855 is eligible for a facility fee. It is paid under APC 247. The 2015 national ambulatory surgery center (ASC) allowed amount is $188, in the hospital outpatient department (HOPD), the allowable is $445. Allowed amounts are adjusted by local indices.

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**6. QUESTION:** What is the global surgery period for SLT?

**ANSWER:** CMS assigned CPT 65855 a 10-day global period, so it is classified as a minor procedure for reimbursement purposes. Most payers agree.
**SLT FAQs**

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**QUESTION:** Is an office visit billable on the same day as SLT?

**ANSWER:** Sometimes. The visit on the day of a minor surgery is regarded as part of the global surgery package unless there is a separately identifiable reason for the visit. If such a reason exists, the exam may be reportable with modifier 25. If the only reason for the visit is to determine the need for SLT, that visit is not separately billable. For more information, see our FAQ on this subject.

Corcoran Consulting Group, January 26, 2015

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**QUESTION:** Is an office visit billable for a postoperative IOP rise in the treated eye within the 10-day global period?

**ANSWER:** No. The IOP spike in the treated eye is related to the SLT so the eye exam is considered to be postoperative care.

Corcoran Consulting Group, January 26, 2015

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**QUESTION:** Can I be reimbursed for a repeat SLT on the same eye?

**ANSWER:** Usually. As a general rule, the effectiveness of SLT can only be evaluated after 1-2 months, which is far beyond the 10-day global period. When the surgeon believes additional treatment is medically necessary, outside of the global period, it is covered. Repeat treatments are supported in the literature.

Corcoran Consulting Group, January 26, 2015
YAG FAQs

Q. What are the indications for YAG laser capsulotomy?
A. Ophthalmologists/Optometrists are quite familiar with the process of using a YAG laser to cut through an opacified posterior lens capsule and/or adjacent hyaloid membrane to restore clear vision in postop cataract patients.

Most Medicare coverage policies are very similar and require the following:
- An impaired ability to carry out activities of daily living due to decreased vision.
- Decreased BCVA of 20/30 or worse or a decrease of two lines of visual acuity.
- Other eye diseases have been excluded as the primary cause of visual disability.
YAG FAQs

Q. What diagnoses support a claim?
A. Appropriate ICD-9 diagnosis codes may vary from one Medicare policy to another, but most policies include the following:
• 366.50 After-cataract, unspecified
• 366.51 Soemmering's ring
• 366.53 After-cataract, obscuring vision
• 996.53 Mechanical complication of ocular lens prosthesis
Note that the use of these codes does not guarantee reimbursement. The patient's medical record must document that coverage criteria have been met.

Ophthalmology Management, Suzanne Corcoran, 12/1/10

YAG FAQs

Q. How should this procedure be documented in the medical record?
A. The indications for YAG laser capsulotomy should be clearly identified in the notes for the exam prior to the surgery. Regardless of the place of service (office, ASC or hospital), a consent form and operative note are expected.
• The key components of an operative report are: operated eye, indications, pre-op instructions and medications, type of laser (only FDA-approved lasers are appropriate), laser setting (wavelength, power setting), treatment details (size and number of applications, duration of laser, placement of spots) and discharge instructions.

Ophthalmology Management, Suzanne Corcoran, 12/1/10

YAG FAQs

Q. Are repeat YAG procedures during the global surgery period covered?
A. There is no separate payment, but repeat lasers are covered as part of the global surgery fee for the original procedure. Occasionally, the capsular opening is not large enough, or constricts slightly during the postoperative period, and the surgeon will perform a second procedure to remedy this. This is considered a continuation of the initial, failed treatment.

Ophthalmology Management, Suzanne Corcoran, 12/1/10
YAG FAQs

● Q. Is reimbursement made for YAG capsulotomy performed in the global surgery period following cataract surgery?
   A. Sometimes. Most Medicare contractors allow payment for this procedure if the visual criteria are met, but expect it to happen rarely. The location where the YAG is performed affects the answer. Related surgical procedures performed in the office during the global period are considered part of the postoperative care and are not separately billable.

   Procedures requiring a return to the operating room are reimbursed in the postoperative period; claims are submitted with modifier 78. Note that a dedicated laser suite in the surgeon’s office is considered an operating room in this context (MCPM, Ch. 12, §40.1B).

   Recently, there has been an increase in early YAG capsulotomy in patients who receive presbyopia-correcting IOLs (PC IOL). Oftentimes, the patient is symptomatic yet does not meet the visual requirements for YAG outlined in Medicare’s policies. These laser surgeries are not covered; however, the surgeon may be compensated for them as part of the “upgrade” package for implanting a PC IOL.

Ophthalmology Management, Suzanne Corcoran, 12/1/10

YAG FAQs

● Q. Is 66821 appropriate for YAG laser of the anterior capsule or to remove specks from the surface of the IOL?
   A. No. CPT 66821 is specifically defined as treatment on the “opacified posterior lens capsule.” There is no specific code to identify procedures on the anterior capsule or IOL. Use CPT 66999 (unlisted procedure, anterior segment) to describe these services.

Ophthalmology Management, Suzanne Corcoran, 12/1/10

Example of Laser Procedure Treatment Report

2014
Corcoran Consulting Group (800) 399-6565
### Practice Management Tips

- An office visit on the same day as SLT is only eligible for reimbursement, using modifier 25, if it is performed for a reason unrelated to the surgery.
- Retain a detailed operative note in the patient’s medical record.
- Document in the medical record your rationale for SLT instead of antiglaucoma pharmaceuticals.
- Notify the patient prior to surgery of financial responsibility if there is reason to believe SLT is not covered by Medicare; document acceptance on an Advance Beneficiary Notice of Non-Coverage form.
- If a subsequent treatment is performed as part of the initial plan, it is part of the initial treatment and not billed again.
- If the surgeon performs SLT in a facility, including a hospital (HOPD) or ambulatory surgery center (ASC), the surgeon’s Medicare payment rate is lower than when it is performed in the office.