

Foreign Body Removal Coding

The optometric profession has at its disposal a significant number of minor surgical procedures for primary care of the eye. Although there is some variability from state to state, the removal of conjunctival and corneal foreign bodies is a reasonably universal service offered by optometry. With optometry's distribution in rural America, some optometrists see every foreign body sufferer from a broad radius.

The proper billing of the procedure to a patient's health care insurance carrier is critical to convey the treatment rendered. When minor surgical procedures are performed, the CPT guidelines clearly indicate that the provider should choose a code that most accurately reflects the treatment. The CPT surgical code includes the decision to provide the procedure, the encounter on the date of the procedure, and the immediate post-operative care.

For example, optometrists will commonly remove corneal foreign bodies under the view of the slit lamp. CPT code 65222 reflects that service, and the relative value unit for that procedure reflects the degree of the procedure, the care rendered, and the required instrumentation. An associated ICD-9 code must be billed, and corneal foreign body is 930.0 (keep in mind that the diagnosis code should always be carried out to the fifth digit when available, but in this case there is not a fifth digit.) The code is only used once per eye, even if there are multiple foreign bodies in the cornea. If there are foreign bodies in each cornea, the -50 modifier (bilateral procedure) would be applied. These basics of minor surgical coding are quite well known by most eye care providers.

Many doctors become confused about billing additional CPT codes for the office visit itself. On the day of that service, no other CPT code can be billed under that same diagnosis for "Evaluation and Management" of the foreign body or associated findings. In other words, the doctor codes the entire service for the foreign body evaluation, removal, and post-operative treatment under the CPT minor surgical code. Even if the patient has an associated anterior chamber reaction requiring cycloplegia, the doctor is not authorized to bill a 99000 E&M code for the foreign body diagnosis or this associated finding to the foreign body.

The only time a 99000 code could be billed on that same day is for an unrelated medical diagnosis. There are few instances when this would be possible. Examples that could be plausible would be a corneal abrasion evaluation for one eye due to some traumatic event that caused a corneal foreign body in the fellow eye. The eye that received the corneal foreign body care would be coded with the appropriate CPT minor surgical code, and the care of the abrasion in the other eye would be billed under an appropriate E&M code with the appropriate diagnosis.

The 65222 code (and related foreign body removal codes) have a zero-day global period. The follow-up care deemed necessary by the doctor as soon as the day following the procedure can be billed at an appropriate level 99000 E&M code. The diagnosis would change to fit the description of the medical condition of the eye at the subsequent visit, and would not be the foreign body diagnosis since it had been removed.

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On a final note, previous to 2004 a CPT code (99025) existed for the "initial visit with surgery" that provided the doctor with a billable code for a new patient who visited the office who underwent a minor surgical procedure at that initial visit. An example would be a foundry worker who just moved to town and had not yet visited the clinic, but was seen at the initial clinic appearance with the requirement of a minor surgical procedure like removal of a corneal foreign body. That code has been eliminated from the CPT list and is not anymore valid.

In summary, the proper coding of corneal foreign body removal involves use of only one CPT code for that visit, and most always is a 65000 level code used without an associated 99000 level code.