Corcoran
Consulting
Group

A Division of Ardare Corporation

Reimbursement for Balloon Catheter Lacrimal Procedures

Prepared For

QUEST Medical, Inc.

May 2005

Reimbursement for Balloon Catheter Lacrimal Procedures

by

Corcoran Consulting Group
A Division of Ardare Corporation
1845 Business Center Drive ~ Suite 108
San Bernardino, California 92408

(800) 399-6565
www.corcoranccg.com

© Copyright 1997 – 2005 All rights reserved.

Except as permitted under the United States Copyright Act of 1976, no part of this publication may be reproduced or distributed in any form or by any means, or stored in a database or retrieval system, without the prior written permission of the author. From time to time, changes may occur in the content of this report and it is the user's responsibility to assure that current issues of this report are utilized. This additional information is also copyrighted as expressed above.

Other copyright: *CPT and all CPT codes are copyrighted by the American Medical Association with all the rights and privileges pertaining.*

Objective: *This report is provided as a general discussion of Medicare reimbursement for balloon catheter lacrimal procedures and related issues. Local variations between carriers may occur which are not described here. The user is strongly encouraged to review official instructions promulgated by the Centers for Medicare and Medicaid (CMS), the agency formerly known as the Health Care Financing Administration (HCFA) and their Medicare carriers; this document is not an official source nor is it a complete guide on all matters pertaining to reimbursement. In addition, users should check with their local insurance carriers for approved diagnosis codes and usage guidelines for the services discussed.*

Acknowledgement: *This paper was underwritten by a grant from QUEST Medical Inc. as an aid to customers and other interested parties.*

® LacriCATH is a registered trademark of QUEST Medical, Inc.

Disclaimer: *The reader is reminded that this information can and does change over time, and may be incorrect at any time following publication.*

INTRODUCTION

This monograph addresses the reimbursement issues associated with lacrimal surgery using the LacriCATH® balloon catheter. This includes both the surgeon and the facility.

We identify the applicable CPT codes to describe the procedures as well as the ICD-9 codes that identify those diagnoses that justify reimbursement. Applicable modifiers are noted as well.

Much of the information is taken from official publications of the Medicare program, however the reader is encouraged to check with the local carrier for additional information and instructions. In the case of other third party payers, we have used the coding concepts contained in CPT and published by the American Medical Association; diagnosis codes are from ICD-9-CM.

As a matter of principle, physicians should establish their own fees based on reasonable levels for their communities and payers. Medicare's national allowed amounts are provided for reference.

SURGICAL PROCEDURES

Balloon Dacryoplasty

The LacriCATH® balloon catheter may be used in both adult and pediatric patients with nasolacrimal duct (NLD) obstructions. The dacryoplasty (DCP) procedure involves probing of the lacrimal apparatus twice; once with a Bowman's probe and then, secondarily, with the LacriCATH® balloon catheter. In children, the primary indication for DCP is congenital NLD obstructions. In adults, DCP is usually performed for partial acquired NLD obstructions as a primary procedure before considering a dacryocystorhinostomy (DCR). Table 1 includes the ICD-9 codes most often used on claims for reimbursement.

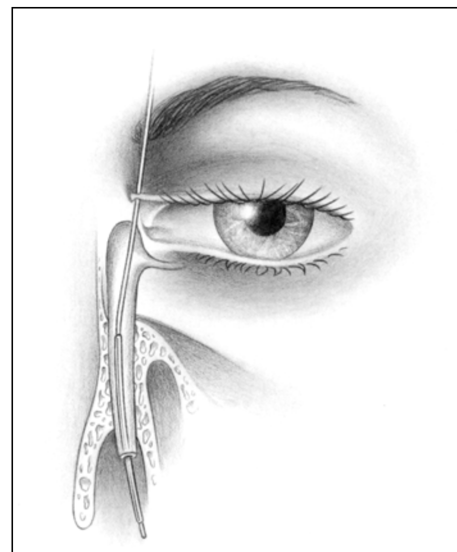
Table 1 **Diagnosis Codes**

ICD-9	Description
375.55	Obstruction of NLD, neonatal
375.56	Stenosis of NLD, acquired
743.65	Congenital anomalies of lacrimal passages

Selection of an appropriate CPT code to report this procedure was based on communication with the American Academy of Ophthalmology as well as the expanded coding instructions in the Professional Edition of CPT. The American Academy of Ophthalmology confirmed in writing that CPT code 68815 (*Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent*) is appropriate to describe DCP rather than 68810 (*probing of nasolacrimal duct, with or without irrigation*) or 68811 (*probing of NLD requiring general anesthesia*). Further, the discussion of this procedure in the Professional Edition of CPT reads *"a balloon catheter is inserted in the nasolacrimal duct"*. We recognize that a Jones tube or stent remains in place after the surgery while a balloon catheter does not, although the placement of these devices have a lot in common.

Figure 1 depicts the use of the LacriCATH® balloon catheter.

Figure 1 **Placement of Balloon Catheter**



Although the description in CPT does not indicate the type of anesthesia, 68815 applies to procedures performed under general, regional or topical anesthesia.

On claims for reimbursement, use modifier RT or LT for procedures performed on one eye; use modifier 50 for bilateral procedures.

Fracture Turbinate

During DCP, fracture of the turbinate is occasionally performed to cope with bony obstructions. Use 30930 (*fracture of nasal turbinate(s), therapeutic*) to report this additional procedure.

Endoscopy

In 2003, 66990 (*use of ophthalmic endoscope*) was added to CPT. This add-on code may only be used with specified procedures including: 65820, 65875, 65920, 66985, 66986, 67038, 67039, 67040. No lacrimal procedures are included in this short list. Consequently, avoid using 66990 for any lacrimal surgery with the balloon catheter.

During DCP, nasal endoscopy is occasionally performed to visualize the distal end of the balloon catheter. The family of CPT codes that describes diagnostic nasal endoscopy includes 31231-31235; these procedures are much more extensive than is needed for a lacrimal procedure. Consequently, we do not believe they apply.

Balloon Catheter DCR

The endoscopic balloon catheter DCR is a more extensive procedure performed in cases of lacrimal stenosis where prior treatment failed or was only partially successful. The procedure is usually performed under general anesthesia. The lacrimal apparatus is probed and the lacrimal fossa is punctured with a reinforced Bowman probe to create an opening to the nasal cavity from the nasolacrimal sac. A nasal endoscope is used to visualize the ostomy. The LacriCATH® balloon catheter is used to enlarge the ostium prior to placement of the silicone tube. Use CPT code 31239 *"nasal/sinus endoscopy, surgical; with dacryocystorhinostomy"* to describe this procedure. If both eyes are operated on, use 31239-50, or use 31239-RT and 31239-LT. In the event a balloon catheter DCR is performed without nasal/sinus endoscopy, code only 68720 (*Dacryocystorhinostomy [fistulization of lacrimal sac to nasal cavity]*). No other procedure codes are required to describe this fistulization with placement of a tube. Do not use:

- 30130-excision of turbinate (part of DCR)
- 30930-fracture nasal turbinate (part of DCR)
- 31231-nasal endoscopy, diagnostic (not surgery, "separate procedure")
- 68750-conjunctivorhinostomy with stent (conjunctiva not operated)
- 68825-probing of NLD (part of DCR)

PHYSICIAN REIMBURSEMENT

The surgeon's reimbursement for these procedures varies by payer and by site of service (where the service is rendered). For reference purposes, Table 2 contains Medicare's physician payment based on both the *non-facility* and *facility* allowables. The column labeled *non-facility* contains the allowable amount assigned when the procedure is performed in the physician's office. The column labeled *facility* contains the allowable amount assigned when the procedure is performed in a setting other than the physician's office or clinic (*i.e.,* ambulatory surgery center, hospital, nursing facility). Note that in some instances, the professional fee for the surgeon is reduced when the procedure is performed in a setting outside of the physician's office. This reduction represents an offset for physician overhead expense that was not incurred.

The comparable reimbursement for other third party payers is generally higher than Medicare; Table 2 contains representative values. The

column labeled "commercial" contains payment rates that are in the 50th percentile of commercial carrier fee schedules. The 50th percentile identifies the middle value in a series of payments (*i.e.,* 50% of all values are equal to or less than the value listed as the 50th percentile). This information is collated and published annually by several publishers, including the Practice Management Information Corporation (PMIC).

Table 2 **Physician Reimbursement**

	Medicare Rates*		Commercial
CPT	Non-Facility (in office)	Facility	50%
68815	$440	$225	$707
30930	$114	$114	$239
31239	$656	$628	$1,379
68720	$656	$629	$1,926

*Medicare physician fee schedule effective January 1, 2005

The ophthalmic surgeon may sometimes request the assistance of another physician or surgical assistant with lacrimal procedures, particularly those necessitating an endoscope. In some of these cases, both the surgeon and assistant may claim reimbursement. Table 3 identifies the procedures for which Medicare allows payment for the assistant surgeon; other payers establish their own guidelines. Consult the bulletins or your contractual agreement for each payer to determine eligibility for reimbursement for an assistant surgeon.

The assistant must be involved in the actual performance of the procedure and not just ancillary services. A modifier is appended to the procedure code on claims for a surgical assistant. Most frequently, modifier -80 is used. In teaching institutions, modifier -82 may apply when a qualified resident is not available. For additional information regarding the use of modifiers, review your carrier instructions and state statutes.

Table 3 **Assistant Surgeon**

CPT	Procedure	Assist	Rate
68815	Balloon DCP	No	--
30930	Fracture Turbinate	No	--
31239	Endoscopic Balloon DCR	Yes	$105
68720	Balloon DCR	Yes*	$105

*Payment restrictions apply to CPT code 68720 unless supporting documentation is submitted to establish the medical necessity of the assistant

Postoperative Periods

The global surgery package includes most medical care during a specified postoperative time period. Table 4 contains the Medicare postop periods. Other third party payers are not required to adhere to Medicare's policy and may establish their own postop periods.

Table 4 **Postoperative Periods**

CPT	Procedure	Postop Days
68815	Minor surgery	10 days
30930	Minor surgery	10 days
31239	Minor surgery	10 days
68720	Major surgery	90 days

FACILITY REIMBURSEMENT

These procedures are commonly performed in a hospital or ambulatory surgery center (ASC) where general anesthesia can safely be administered. In most cases, these procedures can be performed on an outpatient basis and do not require an overnight stay. In those cases that do not require general anesthesia, the procedure may be performed in the physician's office. Reimbursement for the facility differs dramatically depending on which location is involved.

Hospital

Medicare uses two different fee schedules to reimburse hospitals. For inpatient procedures, the reimbursement is based on Diagnosis Related Groups (DRGs). For outpatient procedures, the reimbursement is based on Medicare's outpatient prospective payment system (OPPS). "Prospective payment" means that a hospital will receive a fixed amount for its services and the amount is known in advance. Since 2000, if a hospital can provide services for less than the payment amount, the institution is allowed to keep the excess payment.

Table 5 **Medicare HOPD Rates**

CPT	APC	Reimbursement *
68815	240	$1030
30930	253	$911
31239	075	$1,193
68720	242	$1,723

* APC rates for hospitals effective January 1, 2005

Table 5 lists the ambulatory payment classifications (APCs) and Medicare's national payment rates for hospital outpatient departments (HOPDs) in 2005. These values are adjusted by wage indices to compute local reimbursement levels. The APC represents the payment group under which each procedure is reimbursed. The APC covers *all* elements of a procedure, including supplies and labor; the LacriCATH® balloon catheter is one of those elements.

Ambulatory Surgery Center

All of the procedures that utilize the LacriCATH® balloon catheter are eligible for a facility fee in the ambulatory surgery center (ASC). Like HOPDs, the facility fee covers all supplies including the LacriCATH® balloon catheter. The Medicare ASC facility fee rates vary according to local wage indices. The rates are updated annually. Refer to Table 6 for Medicare's current national ASC rates under the existing group designations.

Table 6 **Medicare ASC Rates**

CPT	Group	Reimbursement *
68815	2	$446
30930	4	$630
31239	4	$630
68720	4	$630

*ASC rates effective April 1, 2004 (no change was made for 2005)

Commercial carriers are attracted to ASCs by their lower costs and generally lower charges. More and more, outpatient procedures that were formerly performed exclusively in a hospital setting have migrated to ASCs if they can be safely performed there. Lacrimal procedures are good candidates.

When more than one procedure is performed during an operative session (*e.g.,* bilateral surgery), the second procedure is also accorded a facility fee, albeit at 50% of the regular rate for that group. This concept applies to both ASCs and HOPDs.

CONCLUSION

The LacriCATH® balloon catheter is an innovative surgical instrument designed for use in lacrimal surgery in adults and children. The primary procedure for congenital or acquired NLD obstructions is usually DCP; use 68815 to identify this procedure. If fracture of turbinate is also performed at the time of DCP, use 30930 in addition to 68815 to identify the procedures. If DCP is performed with the assistance of endoscopy, do not report it with 66990 or with 31231-31235.

For those patients where DCP failed or was only partially successful, the ophthalmologist may elect to perform balloon catheter DCR, with or without endoscopy. Use 68720 to describe balloon DCR and 31239 to describe endoscopic balloon DCR. Do not use 66990 to report endoscopy with any lacrimal surgery.

DCP and DCR are customarily performed in a HOPD or ASC. A DCP may be performed in-office if general anesthesia is not used. Medicare reimbursement for hospitals and ASCs is based on fee schedules, although the payment rates differ by the site of service. In all cases, the facility fee covers all supplies including the LacriCATH® balloon catheter.

Commercial carriers make independent reimbursement determinations separate from Medicare rules and regulations. Frequently the claims submission procedures differ from Medicare conventions. Generally, the payments exceed Medicare rates, but the values assigned are highly variable.

This discussion describes general rules and regulations regarding reimbursement for these procedures, however the responsibility for appropriate usage, adequate documentation and proper coding are always the physician's. Our sources included Medicare, CPT and ICD-9. No attempt was made to address all the individual differences between payers. That task is beyond the scope of this treatise.

Accurate coding of medical and surgical procedures requires special consideration of the factors involved. Providers are expected to understand and abide by the definitions in CPT as well as the published bundles and local medical review policies. Additionally, basic coding principles provide a general instruction to code for the anticipated procedure (the surgical goal) and not necessarily itemize each surgical step with its own code. History has shown us that providers continue to be paid on claims that are not accurate. Receipt of payment does not guarantee the accuracy of the claim.

© 2005 Corcoran Consulting Group (800) 399-6565 www.corcoranccg.com