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Modifier -25 and Billing a Foreign Body Removal: What you have always done may not be correct.

A 34-year-old WM presents to your office with pain of the right eye for the past 3 days. It is red, watering, and photophobic. He was working on his car's exhaust system a few days ago and his eye has been irritated ever sense. You perform a slit lamp exam and find a metallic foreign body imbedded in the cornea with a rust ring. You remove the foreign body with a 27G needle and use an Alger brush to remove the rust ring. A bandage contact lens is inserted and you schedule the patient for a follow up in two days.

How do you code this encounter?
This is one of the most misunderstood coding situations I encounter, yet most doctors I speak with think they have it figured out. The first concept we need to understand is that a surgical code includes an office visit. That means in most situations, it is inappropriate to bill both an office visit (99000 or 92000) on the same day as you do a surgical code like a FB removal (CPT 65222). The exception is when the office visit is a "significant, **separately identifiable** evaluation and management [E/M] service. Meaning…if the office visit is **unrelated** to the surgery, then you can bill both by adding -25 to the office visit code. For example, you could bill both if a patient is in the office for a 6-month glaucoma check and they happen to also have a FB that needs to be removed. The office visit would have the glaucoma diagnosis code and the FB removal would have the FB diagnosis code. But if the office visit's diagnosis code is for any reason related to the diagnosis used for the surgery, it would not holdup in a review. During a review and auditor would look at a diagnosis like "pain in and around the eye" and very easily determine that it was caused by the piece of metal that was removed. And as a result, they would recoup the office visit payment.

Modifier 25	significant, **separately identifiable** evaluation and management [E/M] service by the same physician on the same day of the procedure or other service

The next very common error in this situation is that the doctor will also bill 65435 (removal of the corneal epithelium) on the same day if they use an Alger brush. This part does get a little more confusing, but most sources will state that if this is done at the same time as the FB removal it is bundled together and you should only bill 65222. If a rust ring is removed a few days later and you perform the debridement at that time, you may bill 65435 at that point. However, some sources (CPT Assistant) states in one reference that you should simply bill 65222 again because the rust ring is technically a foreign body. The point here is that you should not bill them both on the same day. A foreign body removal does have a zero-day global period, so if a rust ring removal is performed on another day you can bill for it at that point. Because the reference material has conflicting information, it is up to the provider to choose which code they feel is the most appropriate. If they are ever audited, they would at least be able to say they are aware of the controversy and explain why they chose the code they did. I know many of you are thinking, "But I have billed both of these the same day many times and they have always been paid." Remember, just because it got paid, does not mean you did it right. Using a different diagnosis code for each surgical procedure may get it past the computer system, but an auditor may not be as forgiving.

Finally, the bandage contact lens (92071). If a bandage contact lens is used, you may bill for it along with the surgical code…usually. Some payers might consider a bandage CL as part of the wound care that is covered under the FB removal code. But the majority do not. Another gray area here is that most payers (like Medicare) bundle the cost of the actual lens with the fee paid for 92071. Therefore, you do not bill separately for the materials. If the payer does reimburse for the materials, you would bill for them with 99070 *Supplies and materials,* or 92326 *Replacement of contact lens,* or the appropriate V code such as V2523 (contact lens, hydrophilic, extended wear). The only way to know is to find a Local Coverage Determination or to call the specific payer.

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So, how would I typically code for the above case?

Initial Visit

CPT: 65222 - RT (Removal of foreign body, external eye; corneal, with slit lamp)

- ICD-10: T15.01A (Foreign body in cornea, right eye, **initial** encounter)

CPT 92071 – RT (Fitting of contact lens for treatment of ocular surface disease)

- ICD-10: T15.01A (Foreign body in cornea, right eye, **initial** encounter)

Follow Up

99000 or 92000 code that best describes the care provided.

Sorry this tip is not a simple "Do it this way" kind of article. The situation has so many "ifs and "buts" that you need to understand it in its entirety to make the proper coding decision.