



Ophthalmology Coding Alert

Your practical adviser for ethically optimizing coding, payment, and efficiency in ophthalmology practices

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In this issue

ICD-10 Countdown

Get Ready or Get Fined —
That's the CMS Message **p82**
▶ Explore 6 FAQs to ramp up your
ICD-10 coding know-how.

Diagnosis Coding

6 Tips Help Keep Your ICD-9
Coding on Track **p83**
▶ Cheat sheets come with a
warning label.

Visual Fields

92081-92083 With Modifier 50?
Not So Fast **p84**
▶ Careful with those modifiers
and dx codes, or you could be
heading towards VF denials.

You Be the Coder **p85**

▶ Cataract Removal With Pupil
Stretching

Reader Questions

92285 Requires 'Track or Treat'
Evidence **p85**

92225-92226: Apply Initial EO
Code to New Condition **p85**

68761 With E/M? Check
Documentation First **p86**

Specify Refraction Exclusion to
Clarify ABN Confusion **p87**

CPT® 2012 Update

0289T, 0290T Shape Your Options for Intralase-Assisted Keratoplasty

Use two new temp codes to represent the emerging laser corneal incision technology.

If your ophthalmic surgeon is one of the trailblazers putting aside his trephine in favor of an advanced laser to perform corneal incisions and transplants, take heart. CPT® 2012 features two temporary codes that describe this emerging technology.

CPT® Category III codes 0289T (*Corneal incisions in the donor cornea created using a laser, in preparation for penetrating or lamellar keratoplasty [List separately in addition to code for primary procedure]*) and 0290T (*Corneal incision in the recipient corneal created using a laser, in preparation for penetrating or lamellar keratoplasty [List separately in addition to code for primary procedure]*) will debut in your 2012 CPT® manuals, effective January 1, 2012.

These codes cover the incisions made by a laser, such as the IntraLase FS Laser, into the donor cornea and the recipient site, during a keratoplasty (corneal transplant). By creating custom, unique, matching edges in the donor cornea and recipient site, Intra-Lase Enabled Keratoplasty (IEK) may provide a higher accuracy of fitting and a stronger graft, reducing healing time and improving visual recovery.

You would report 0289T and 0290T in conjunction with the code for the primary corneal procedure:

- » 65710 (*Keratoplasty [corneal transplant]; anterior lamellar*)
- » 65730 (... *penetrating [except in aphakia or pseudophakia]*)
- » 65750 (... *penetrating [in aphakia]*)
- » 65755 (... *penetrating [in pseudoaphakia]*)

Medicare has not yet assigned relative value units (RVUs) to 0289T and 0290T, so it is unclear how much insurers will reimburse for these codes.

CPT® creates Category III codes for emerging technology, services, or procedures that might not be widely performed.

CPT® requires you to bill with the codes in order to track their usage and effectiveness. If a technology (and therefore a code) becomes more widely used, it has the potential to become a Category I. "Codes in this section of the CPT® may or may not eventually receive a Category I CPT® code," says **Lisa Center, CPC**, a billing professional with Mt. Carmel Regional Medical Center in Pittsburg, Kan.

Category III codes are temporary codes. "They are archived five years from the date of their publication or revision in the CPT® code book, unless it is demonstrated that a temporary code is still needed," Center says. □

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ICD-10 Countdown

Get Ready or Get Fined — That's the CMS Message

Explore 6 FAQs to ramp up your ICD-10 coding know-how.

Denials aren't the only thing you have to fear if your practice doesn't implement ICD-10 by the Oct. 1, 2013 deadline. You could face fines, too, according to CMS.

Based on comments from CMS representatives in recent CMS ICD-10 teleconferences, we've broken down six FAQs that promise to help you ramp up ICD-10 coding for your ophthalmology practice.

Prepare for Medicare and Other Payers

CMS has no intention of delaying the implementation of ICD-10 beyond the Oct. 1, 2013, date, according to CMS's **Kyle Miller**. However, not all entities are prepared for the conversion, he noted.

Question 1: Only entities covered by HIPAA must make the transition to ICD-10 — does that mean workers' compensation insurers will still use ICD-9, even after the rest of the industry transitions to ICD-10 on Oct. 1, 2013?

Answer: The response to that is unclear, but CMS has heard murmurs that workers' comp. insurers will switch over to ICD-10.

"We've heard anecdotally that even though they're not required to transition to ICD-10, that many of them are planning to, just because it's more practical to do so and they see that it's the way the rest of the industry is going," said CMS's **Denise Buening, MsM**.

Question 2: What about Medicaid?

Answer: CMS provided rankings for state Medicaid preparedness: As of July, 11 state Medicaid programs are at high risk for not meeting the ICD-10 implementation date, while 21 states are at moderate risk. Fifteen states are at low risk, and four states have not let CMS know where they are in the process. "It's important to note there are still two years to go," Miller added, and CMS is working with the high-risk states to ensure that they get ready on time.

Question 3: What are the penalties for entities that are covered under HIPAA who choose not to use ICD-10 codes as of Oct. 1, 2013?

Answer: Your claims will be denied — and you technically could face fines since use of the ICD-10 codes falls under the HIPAA transaction code set regulations, CMS reps noted.

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Denials: “From a practical standpoint, as of service dates of Oct. 1, 2013, if you don’t use ICD-10 codes, most likely your claims will be returned and will be asked to transition to ICD-10,” Buenning said.

Fines: “The penalties are the same penalties that any HIPAA entity would be subject to,” Buenning noted. “I think most of you are familiar with the ongoing HIPAA transaction codeset penalty that calls for a maximum of \$25,000 per covered entity per year, but the HITECH legislation of last year actually upped those transaction and codeset penalties, and they can be as much as \$1.5 million per entity per year. So obviously it behooves everybody — Medicare and Medicaid inclusive — to make sure we are compliant with these ICD-10 codes by the Oct. 1, 2013 date,” she added.

Keep Up With Codesets and Coverage

Your ophthalmology practice can’t get ready for ICD-10 all alone. Study the following questions to see how others’ preparations can help or hinder you.

Question 4: The Medicare local coverage decisions (LCDs) currently list the payable ICD-9 codes that correspond to all Medicare-payable procedures. Will contractors issue updated LCDs to the public prior to the Oct. 1, 2013 implementation date to show the payable ICD-10 codes for the procedures?

Answer: The answer to that isn’t yet crystal clear. “The LCDs will be translated because they will need to be translated, [but] as it relates to having them available to the public prior to the implementation date, that I’m not sure of, because we are working fast and furious on all of our ICD-10 implementation efforts,” said CMS’s **Lisa Eggleston, RN, MS**.

Question 5: When can we expect a final ICD-10 code set?

Answer: As of this October, you’ll see an ICD-10 code set that’s pretty close to how the final will look.

“We will have the last major update in FY 2012, but we’re warning you that we could add some more codes because of new technology and new procedures,” said CMS’s **Pat Brooks, RHIA**.

Question 6: What can our practice do to get ready for the ICD-10 conversion?

Answer: One thing you won’t need to do is remember a bunch of new codes — “in fact, most practitioners probably don’t know many ICD-9 codes by heart, so they won’t be expected to memorize ICD-10 codes either,” said **Daniel Duvall, MD**, medical officer with CMS’s Hospital and Ambulatory Policy Group.

Do this: “You may need to look at those codes that you see most commonly in your practice,” Duvall said. He advises physicians to pick the top 30 diagnoses that they see and concentrate on knowing how to code those appropriately. Then you should create new job aids or superbills for those procedures.

(Continued on next page)

Diagnosis Coding

6 Tips Help Keep Your ICD-9 Coding on Track

Cheat sheets come with a warning label.

To help ensure your coding complies with ICD-9 guidelines, there are several tactics you can use:

1. Always read the notes in the ICD-9 manual that apply to the code you’re considering, says **Denae M. Merrill, CPC**, HCC coding specialist in Michigan.
2. Read the ICD-9 official guidelines that apply to your “specialty periodically as a refresher. If we only read them when the codes change once a year, it is difficult to absorb and retain that information for an entire year,” says **Lisa S. Martin, CPC, CIMC, CPC-I**, chargemaster specialist for OSF Healthcare System in Peoria, Ill.
3. Don’t be afraid to write a lot of notes and make good use of your highlighters, says Martin. “I even make notes in the index because where you initially expect to find something is where you will search again in the future.”
4. After using your usual coding resource, occasionally switch to a different resource to see if you come to the same conclusion about the proper code, says Martin.
5. Take care when using cheat sheets, says Merrill. They can be helpful as long as you don’t rely on them too heavily. And you absolutely must be sure you update them regularly, she says.
6. The last point in number 5 bears repeating and applies across the board. “Regardless of the resource, the most important factor is that it is up to date,” says Martin. Using an invalid code will trigger a denial. With that in mind, be sure everyone in the office follows through on updates. Consider the example of an office where a cheat sheet is copied and passed out to multiple coders. If any of the codes become invalid, the office will instantly have multiple coders at risk of reporting codes that payers won’t accept. □

Strategy: Use your list of the top diagnoses that your practice sees to find the corresponding ICD-10 codes, and “you’ve got your cheat sheet,” Duvall said. Then, ensure that your coders are trained, that your claims are form 5010 compliant, and that your claim submission

system supplier is ICD-10-ready. In addition, if you have an electronic medical record or you plan to get one, make sure it can handle ICD-10. “If you’re starting to bring in an EMR, you want to convert to ICD-10 first, not bring one in under ICD-9 and then convert,” Duvall added. □

Visual Fields

92081-92083 With Modifier 50? Not So Fast

Careful with those modifiers and dx codes, or you could be heading towards VF denials.

Ophthalmologists usually spend a lot of time and effort helping patients who they suspect might have glaucoma. When a patient returns to your office for visual field examinations, can you code and bill the tests individually per eye? Can you bill for another visit to the office — including the actual test, verifying the results, and discussing them with the patient? How do you determine which diagnosis code to report for glaucoma suspects? Our experts provide the answers.

Appending 50? Not So Fast

When deciding whether to bill for services “unilaterally,” per eye, or “bilaterally,” for both eyes, the first thing to do is read the code description in CPT®. All of the visual field testing codes have in their description the phrase “unilateral or bilateral”:

- » 92081 — *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)*
- » 92082 — *... intermediate examination (e.g., at least 2 isopters on Goldmann perimeter; or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)*
- » 92083 — *... extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30o, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2.*

This means that the payment that has been established for the service is for one or two eyes, and you should only submit a bill for one service — even if the ophthalmologist performed it on both eyes.

Don't Code for Routine Office Visit

Whether you can bill an office visit in addition to the testing services depends on what services the ophthalmologist renders to the patient and what had been established as being medically necessary. If the physician sees the patient to discuss the test results and treatment options, you can definitely bill a visit in addition to the testing service. If the only service rendered is the technician’s pretesting *routine* of obtaining or verifying the patient’s visual acuity and intraocular pressure, you cannot bill an office visit in addition.

Let Symptoms or Tests Determine Diagnosis

How you assign diagnosis codes for diagnostic tests really depends on whether you submit the claim for the ordered test before or after the physician has received and interpreted the test results.

If the ophthalmologist who ordered the test has not received the results, the patient’s diagnosis code should reflect the signs and symptoms with which the patient presented. If the ophthalmologist has the results of the test before submitting the claim and those results are negative, you should still code the signs and symptoms that prompted the physician to order the test. But if the same ophthalmologist who orders a test receives and interprets the results as positive before the claim has been sent to the carrier, report the diagnosis codes for the positively identified condition — for example, glaucoma as the primary diagnosis.

You may also report the symptoms as secondary diagnoses, notes **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE**, Director of Ambulatory Hospital & Network Oversight at the Mount Sinai Medical Center Compliance Department in New York City.

For a glaucoma suspect, you will more than likely need to report a code for a threshold field: 92083. You should

link this service to a primary diagnosis of either 365.00 (*Borderline glaucoma [glaucoma suspect]; preglaucoma, unspecified*) or 365.01 (... *open angle with borderline findings*), if the results of the field are normal.

If a patient is glaucoma suspect by pressure, history or disk appearance, and the results of the field are normal,

link 92083 to 365.01. Private insurers, on the other hand, may prefer that you link the VF code to 365.00, even when the results of the field are normal.

When the results are abnormal and confirm the presence of glaucoma, link the VF code to the appropriate glaucoma diagnosis code. □

Reader Questions

92285 Requires ‘Track or Treat’ Evidence

Question:

Our ophthalmologist performs external ocular photography for a Medicare patient with a malignancy on her left eyeball. Is this a covered service?

New York Subscriber

Answer:

Based on the patient’s diagnosis, Medicare should cover the external photography — if your ophthalmologist is taking the photos to “track or treat” the disease. Medicare will typically cover 92285 (*External ocular photography with interpretation and report for documentation of medical progress*) if the ophthalmologist is either:

- » tracking the progression of the disease, or
- » checking the effectiveness of a particular course of treatment for the disease.

If the ophthalmologist performs the photography for either of these purposes, you can report 92285 to Medicare. If you are unsure about your individual policy, contact your local Medicare carrier before filing the claim.

If the ophthalmologist obtains the photography to “track or treat” the disease, most Medicare payers will deem 92285 medically necessary based on the patient’s diagnosis (190.0, *Malignant neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid*).

Other diagnoses that many Medicare carriers accept for 92285 include:

- » the 190.x series (*Malignant neoplasm of eye*)
- » the 364.5x series (*Degenerations of iris and ciliary body*)
- » the 370.6x series (*Corneal neovascularization*).

But not all Medicare carriers consider the same ICD-9 medically necessary guidelines for 92285, so check with your local carrier if you have any questions. □

92225-92226: Apply Initial E0 Code to New Condition

Question:

I’m confused about the extended ophthalmoscopy codes. Is 92225 for a new patient and 92226 for an established patient? Should I bill twice for both eyes?

California Subscriber

(Continued on next page)

You Be the Coder

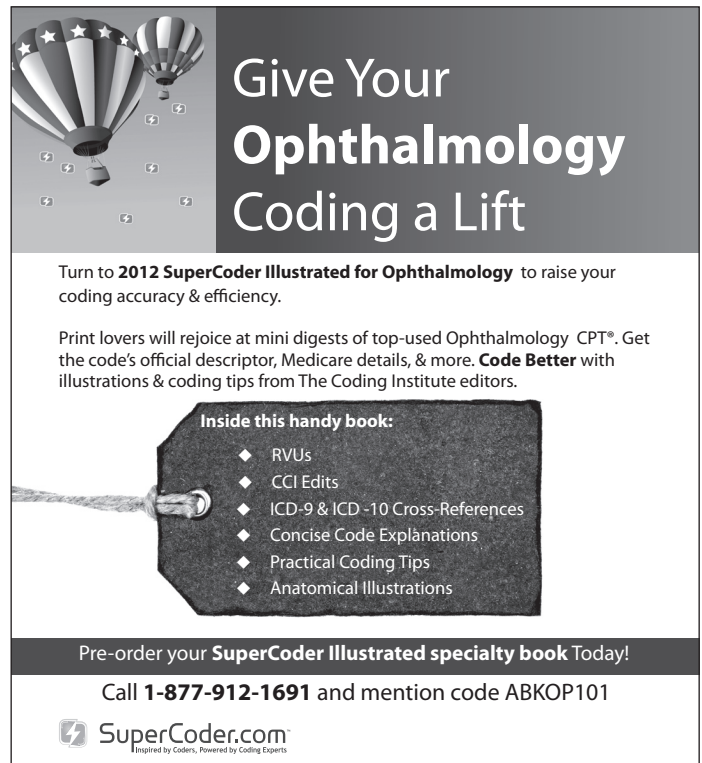
Cataract Removal With Pupil Stretching

Question:

Our ophthalmologist wants me to submit a claim for 66982, along with stretching of pupil with iris hooks and staining of anterior capsule with vision blue dye. Are there separate codes for those services? Are they bundled?

South Carolina Subscriber

Answer: See page 87. □



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Answer:

The extended ophthalmoscopy (EO) codes, 92225 (*Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial*) and 92226 (... *subsequent*), don't correspond to new and established patients. CPT® does not intend for 92225 to be a one-time-only code, only to be used with new patients. Rather, report 92225 for the initial EO associated with new *symptoms* of a nonchronic condition for each eye.

Example 1: The ophthalmologist sees a patient complaining of flashes and floaters in the right eye. He performs an initial EO (92225-RT), finding post vitreous detachment. He asks the patient to return in six weeks. At that visit, he performs a subsequent EO (92226-RT). A few weeks after that, the patient returns, now complaining of flashes and floaters in the left eye. Since this is a different eye and an initial EO was not performed, report 92225-LT.

Example 2: A physician refers a diabetic patient to your office for a consultation. The patient has diabetic retinopathy, a chronic condition. At the first appointment, the ophthalmologist performs an initial EO (92225-50). He asks the patient to return in a year for a dilated exam, at which point he performs a subsequent EO (92226-50). He returns again in another year for another subsequent EO (92226-50).

Medicare reimburses both 92225 and 92226 unilaterally, which means that if the ophthalmologist performs EO on both eyes, including the drawing and report, you can report the codes bilaterally and receive twice the payment you would have gotten for one procedure. Append modifier 50 (*Bilateral procedure*) or modifiers LT (*Left side*) and RT (*Right side*) to indicate the bilateral performance of the procedure.

Medicare may also have very specific policies about the requirements for these drawings. In most cases, you should have documented drawings that are 3-4 inches, using 4-6 standard colors with findings that are labeled. In addition, if a patient has glaucoma, the record should have a separate drawing with the optic nerve detailed.

Crucial: Before an ophthalmologist performs an extended ophthalmoscopy, the medical record must

support documentation of having performed a general ophthalmoscopy with findings that are indicative of medical necessity to perform the extended test. A general ophthalmoscopy is included in the eye examination and not separately billable. However, reporting an extended ophthalmoscopy without the general exam and subsequent need to perform the extended exam would likely trigger a denial or recoupment of monies following an audit.

Watch for: Occasionally, it may be necessary to append modifier 79 (*Unrelated procedure or service by the same physician during the postoperative period*) to 92226, as this code is not considered “diagnostic,” if performed during a post-op period for an unrelated diagnosis. □

68761 With E/M? Check Documentation First

Question:

When my ophthalmologist does a comprehensive exam (92004) and decides to insert punctal plugs on the same day, do I need the 25 modifier on the exam?

Texas Subscriber

Answer:

If you plan to report 92004 (*Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient ...*) separately, then yes, you would need to append modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*).

You should first check that your chart note supports billing the E/M with modifier 25. You have to prove that the E/M was a significant, separate service from the punctal plug insertion (68761, *Closure of the lacrimal punctum; by plug, each*) because every procedure has a small amount of E/M service already built into it.

Tip: Ask yourself whether the E/M documentation — which should also indicate medical necessity for the E/M and subsequent procedure — would stand alone for payment if you hadn't inserted the punctal plugs.

Watch for: You may determine that another coding option, such as ophthalmic exam codes 92002-92014, suits

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a particular service better than an E/M code. Always report the code that is most appropriate for your service.

Most important: There is a 10-day global period for punctal plug insertions. If the patient reports improvement later, and returns within 10 days to have permanent plugs placed, you may only bill for the insertion — not a separate office visit — because the plug insertion is the only reason for that visit.

However, if the patient returns after 10 days, you can bill an E/M code only if it is necessary for your provider to perform another E/M service. □

Specify Refraction Exclusion to Clarify ABN Confusion

Question:

Are patients undergoing keratoconus workup or contact lens fitting still required to sign an advance beneficiary notice (ABN)? Why is it necessary when Medicare won't pay for it anyway?

Nebraska Subscriber

Answer:

According to CMS, the ABN is necessary “for the physician to bill a Medicare beneficiary for services which are always denied for medical necessity (e.g., visual fields for a patient without a covered diagnosis), frequency limited items (repeat of visual fields or other test more frequently than covered by the carrier or contractor), denial of advanced determination of Medicare coverage (ADMC), and certain instances of upgrades.

The ABN is voluntary for items that are statutorily excluded (never covered by Medicare, such as refraction) or do not meet the definition of a Medicare benefit.

A patient undergoing a keratonocus workup or contact lens fitting needs to sign an ABN from Medicare informing him that he is responsible for the payment, although it may already appear redundant.

The ABN is a waiver signed by the patient to clarify that he needs to pay for the service. The patient's signature on the document is important because it is assumed that once he signs it he has read and understands it and thus he can be held financially liable for the services. .

In the case of refraction for the purpose of keratoconus workup or contact lens fitting, there have been debates if the ABN is still necessary since, some argue, that you can simply tell the patient that Medicare doesn't cover the procedure.

However: Some Medicare patients don't know the refraction is not a benefit. If they sign the ABN, it can be explained to them in detail that refraction is not a benefit.

But Medicare has stated that the ABN is not needed for refraction because Medicare never pays for refraction whereas they do sometimes pay for the services stated in your example.

According to CMS, the situations that call for an ophthalmologist's patient to sign an ABN should remain the same when using the new form. “The ABN is only issued when the provider has an expectation of noncoverage,” CMS states. □

— *Advice for You Be the Coder and Reader Questions provided by Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE, Director of Ambulatory Hospital & Network Oversight, Mount Sinai Medical Center Compliance Department in New York City.*

You Be the Coder

Cataract Removal With Pupil Stretching

(Question on page 85)

Answer:

You can't claim them separately, but the use of iris hooks and blue dye in the anterior chamber will help back up your use of 66982 (*Extracapsular cataract removal ... complex ...*).

Key: According to CPT®, “devices or techniques not generally used in routine cataract surgery” distinguish complex cataract surgery from the other codes. The “iris expansion device” (e.g., iris hooks) is one of those devices. Any device or technique to gain access through a miotic pupil would also support your 66982 claim.

Some Medicare carriers' policies on 66982 also mention the use of dye for visualization of capsulorrhexis as a reason to report the code. Very young patients (who are still in the amblyogenic stage) or weak intraocular support necessitating permanent intraocular sutures also indicate complex cataract removal.

However: Don't report 66982 just because the ophthalmologist encountered a surgical complication, such as the need to perform a vitrectomy. A true complex cataract extraction is prospectively planned based on pre-existing conditions.

Report 66982 only if the ophthalmologist knows preoperatively that the procedure is necessary and meets the requirements of the code descriptor. Documentation in the medical record prior to the surgery will support this decision. □

Ophthalmology

CODING ALERT

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to *Ophthalmology coding* and reimbursement to the Editor indicated below.

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