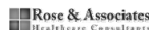


Surgical Coding Clearing Up the Confusion

ASCRS-ASOA Symposium & Congress
Practice Management Program
San Diego, California
April 17-21, 2015

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Financial Interest

*I acknowledge a financial interest
in the subject matter of this
presentation.*



What Will Be Covered

- Review the basic premises of coding
 - CPT Manual – conventions & rules
 - Code bundling
 - Modifier application
- Address some of the most common questions
 - Both major and minor surgeries
- Look for details to determine the code



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CPT Conventions & Rules

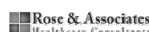
- Most Ophthalmic Surgical CPT codes are 65091 – 68899
 - Primary category is by anatomical region: Anterior Segment, Posterior Segment, Conjunctiva, Ocular Adnexa, etc. (Red Print)
 - Subcategory is by structure within the region: cornea, anterior chamber, vitreous, retina or choroid, eyelids, extraocular muscles, etc. (Blue Print)
 - Sub - Subcategory is by process: Incision, Implant, Destruction, Excision, Repair, etc. (Black Print)



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CPT Conventions & Rules

- Some of the “code sets” have an introductory paragraph or statement that defines the parameters
 - Example: “Code Set” 67930-67975
 - *Has an introductory paragraph “codes for blepharoplasty involve more than skin (ie, involving lid margin, tarsus, and/or palpebral conjunctiva).”*



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CPT Conventions & Rules

- Semicolon is key
 - What is to the left of the “;” is the main procedure
 - What is to the right of the “;” is how, where or extent the procedure was performed
 - The codes tend to become more complex



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CPT Conventions & Rules

- Example:
 - 65205 - Removal of foreign body, external eye; conjunctival superficial
 - 65210.....conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
 - 65220.....corneal, without slit lamp
 - 65222..... corneal, with slit lamp

Separate Procedure

- Defined in the “Surgery Guidelines” CPT
 - “are commonly carried out as an integral component of a total service or procedure”
 - *Don't bill it in addition to the primary procedure*
 - “is carried out independently or considered to be unrelated or distinct from other procedures / services provided at the time, it may be reported by itself, or in addition to other procedures/ services by appending the -59 modifier”

CCI Edits

- National Correct Coding Initiative (NCCI)
 - Developed by CMS for Medicare
 - *Most commercial payers follow CCI as well*
 - Published Quarterly
 - Lists codes that cannot be billed together (in most cases)
 - *Bundled – one code is a part of a larger procedure (but not always)*
 - *Mutually Exclusive – two codes cannot reasonably be performed at the same time*

Operative Reports

- Code from the body of the operative report not the intended surgery
- Beware of canned operative reports
 - Not in chronological order
 - Lack details specific to a given case
 - May not include amendments detailing changes in procedures

Surgery Related Modifiers

- Most common -24, -25, -53, -58, -78, -79
 - Learn the definitions of each
 - Know global fee periods
 - Understand the purpose of the procedure
 - Recognize known complications

Surgery Related Modifiers

- Modifier -24 – appended to exam
 - Is the exam in the global fee period really unrelated to the original surgery?
 - What does the history say on the exam?
- Modifier -25 – appended to exam
 - Is the exam really “above and beyond” what was necessary to be prepared the patient for the minor procedure?

Surgical Modifiers

- Modifier -53
 - Was the actual surgery started before it was discontinued?
- Modifier -58
 - Is the procedure more extensive than the previous procedure?
 - Is the procedure and additive course of treatment?

Surgical Modifiers

- Modifier -78
 - Is the reason the patient is returning to surgery a complication of the previous surgery?
 - Is the additional procedure being performed in an HOPD, ASC or designated procedure room?
- Modifier -79
 - Is the current procedure truly unrelated to the previous surgery?

Most Common Surgeries

Lid Lesions

Know the Terminology & Anatomy

- Shaving
- Biopsy
- Excision
- Destruction
- Full Thickness
- Partial Thickness
- Debridement
- Closure
- Dermis
- Conjunctiva
 - Palpebral
 - Bulbar
- Lid Margin
- Tarsus

Lid Lesions

- If removal of lesion involving mainly skin, code must be found in integumentary section of CPT
 - 11200 - +11201 – Removal of skin tags
 - 11310 - 11313 – Shaving epidermal or dermal lesion
 - 11440 - 11446 – Excision of benign lesion
 - 11640 - 11646 – Excision of malignant lesion
 - 17000 - 17004 – Destruction, benign or premalignant lesion

Lid Lesions

- 67840 - Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure
 - Introductory paragraph for the code set:
 - “Codes for removal of lesion include more than skin (ie, involving lid margin, tarsus, and/or palpebral conjunctiva)”

Complex Cataract Surgery

- Code 66982 definition
 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, require devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage

Complex Cataract Surgery

- Appropriate use of code 66982:
 - Capsular tension rings (CTR) for weak zonules noted prior to surgery
 - Pupil manipulation for poor dilation noted prior to surgery (iris hooks or CTR)
 - Suture of IOL as part of the primary surgery
 - Cataract surgery on babies
 - Staining of the anterior capsule for dense cataract noted prior to surgery

Complex Cataract Surgery

- Inappropriate use of code 66982:
 - Managing intraoperative complication (eg, vitrectomy, evacuating hemorrhage)
 - Severing adhesions (separate procedure)
 - “Dropless” cataract surgery
 - Presbyopia/Astigmatism correcting IOLs
 - “Blended Vision”
 - LRIs, CRIs or astigmatic keratotomy

Corneal Relaxing Incisions

- 65772 - Corneal relaxing incision for correction of surgically induced astigmatism
 - Usually iatrogenic (eg, following PKP)
 - Large amount of astigmatism >~3 diopters
- 66999 - Unlisted procedure of anterior segment of the eye
 - For refractive procedures

Corneal Transplants

- Codes 65730, 65750, 65755 - Keratoplasty
 - Status of patient’s lens determines proper code
 - *Natural* - Code 65730
 - *Aphakic* - Code 65750
 - *Pseudophakic* - Code 65755
 - If performed with cataract surgery, it becomes the primary procedure

Paracentesis

- Code 65800 - Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous
 - Used to relieve elevated IOP, often in post-operative period
 - *Requires return to OR and -78 modifier*
 - *Document instrumentation used - tuberculin syringe, 20 gauge needle, etc.*
 - Is never billed at the same time as an intravitreal injection

Removal of Anterior Adhesions

- Codes 65865-65880 - Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure)
 - As “separate procedures” bundled with other anterior segment procedures
 - *If performed with posterior segment procedure, is not bundled*
 - Requires return to OR in post-operative period of cataract or glaucoma surgery

Aqueous Shunt

- 66179 - Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft
- 66180 - with graft
 - *Do not report 66180 in conjunction with 67255*
 - ASCs can now bill separately for cornea allograft tissue used for codes 66180 and 66185
 - *Must report V2785 (same code as corneal tissue)*

Aqueous Shunt

- Primary purpose of the graft is to prevent exposure of the shunt through the conjunctiva
 - Billing 65778 & 65779 – amniotic membrane is inappropriate
 - *Intended to be office based procedure*

Aqueous Shunt

- 67250 - Scleral reinforcement (separate procedure); without graft
- 67255.....with graft
 - These codes fall under the sub-categories “Posterior Sclera” and “Repair”

Wound Repair

- Code 66250 – Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure
 - Requires return to OR and -78 modifier
 - Is used to describe:
 - *Needling of bleb – ICD-9 V45.6*
 - *Suturing corneal flap – ICD-9 998.3*
 - *Wound leakage – ICD-9 998.3*
 - Is not used to describe just suture removal

IOL Exchange

- Code 66986 - Exchange of intraocular lens
 - Should have patient complaint of continued visual disability
 - Also performed for dislocated IOL
 - Vitrectomy, code 67010, is not bundled
 - Requires return to OR when performed in global fee period of same eye

Vitreous Tap

- Code 67015 - Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach
 - Usually for diagnosing endophthalmitis
 - Also used for simple removal of silicone oil
 - *Intravitreal injection of medication, 67028, is now bundled*
 - *Requires return to OR and -78 modifier*
 - *Has an ASC facility fee*



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Endolaser With Vitrectomy

- Codes 67039, 67040 - Vitrectomy with focal or panretinal endolaser
 - Requires documentation that endolaser used
 - *op report states laser in posterior segment through sclerotomy*
 - If op report documents use of indirect laser, only codes 67210 or 67228 can be billed
 - When followed by indirect in global fee period, indirect considered additional laser session



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Focal Laser

- Code 67210 - Destruction of localized lesion of retina (eg, macular edema, tumors, (1 or more sessions); photocoagulation
 - Bundled in post-op period when the PRP performed first
 - Number of shots usually 400 or less
 - Treatment of localized area of retina
 - Usually for macular edema, CRVO/BRVO
 - Requires -79 & -RT/-LT modifiers for fellow eye in global fee period



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PRP Laser

- Code 67228 - Treatment of extensive or progressive retinopathy, 1 or more sessions (eg, diabetic retinopathy)
 - For treatment of proliferative retinopathy
 - Number of shots usually 600 or more & covering peripheral retina
 - When following 67210 in global fee period, use modifier -79
 - Requires -79 & -RT/-LT modifiers for fellow eye in global fee period



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Epilation Trichiasis

- Code 67820 - Correction of trichiasis; epilation, by forceps only
 - Use of a Weck sponge or cotton swab for simple epilation is not billable in addition to the eye exam
 - If forceps are needed, bill this service with code 67820
 - *Clinical record must indicate the actual method used - forceps, laser, etc.*



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Epilation Trichiasis

- Document patient complaint of FB or painful, irritated eye
- Adnexa section of examination needs to identify presence of trichiasis
- Particular eyelid must be noted in the chart
- Some carriers permit billing the service only once per encounter



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Ptosis Repair

- Codes 67901 – 67908 – Repair of blepharoptosis
 - Involves muscles other than the orbicularis, such as the frontalis, levator, Muller's
 - Not usually considered cosmetic
 - No special criteria published; varies by carrier
 - Patient complaint of visual disability is helpful

Punctum Plug Insertion

- Code 68761 – Closure of the lacrimal punctum; by plug, each
 - Medical necessity must be in the chart
 - *DES patient documented as trying conservative methods & failed, e.g., artificial tears, unguents, changed medication causing symptoms*
 - *Recurrent corneal ulcer from insufficient tear film*
 - *Results of any testing, e.g., TBUT, Schirmer's, rose bengal stain*

Punctum Plug Insertion

- Chart must identify each punctum occluded
- Type of plug used during procedure should be noted, e.g., collagen or silicone
- Supply of plugs no longer billable separately
- Dilation of lacrimal punctum, code 68801, is not billable in addition to the insertion

Questions



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