

UPDATES FOR RETINA CODING: 2016

Pointers for avoiding confusion and steering clear of problems.

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This year, two main areas will affect coding for retinal physicians: Current Procedural Terminology (CPT) and ICD-10-CM coding. This article addresses both and includes a selection of case studies that should be mastered as templates for this coming year.

CPT CHANGES

Descriptors Changed

The following codes have had their descriptors changed to read “including when performed” in lieu of “with or without.” Nothing has to be altered in your coding patterns; it is part of the CPT standardization of descriptors. The 2016 code descriptions (with changes in italics) are as follows:

- 67101** Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, *including drainage of subretinal fluid, when performed*
- 67105** Repair of retinal detachment, one or more sessions; photocoagulation, *including drainage of subretinal fluid, when performed*
- 67107** Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), *including when performed* implant, cryotherapy, photocoagulation, and drainage of subretinal fluid
- 67108** Repair of retinal detachment; with vitrectomy, any method, *including when performed* air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique
- 67113** Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, *including when performed* air, gas, or silicone oil tamponade, cryotherapy,

endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens

Descriptor Deletion of “1 or More Sessions”

Two CPT codes previously contained the phrase “1 or more sessions.” They now read as follows:

- 67227** Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), cryotherapy, diathermy
- 67228** Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation

The significance of this change is that the global period has been reduced from 90 days to 10 days, so that each treatment session may be billed as long as the procedure is performed outside of the global period. In actuality, the total global period is 11 days because the 10-day countdown begins the day after surgery.

The advent of the new the global period changes the classification of the procedure from major to minor. The Centers for Medicare and Medicaid Services regulations package payment of the office visit with that of the minor procedure. Caution is warranted when using modifier 25 to obtain payment for the office visit and should only be used if there is a separate and significant condition.¹ This is rarely valid when performing repeat treatments and there would be no medical necessity for using the comprehensive eye code.

Code Deleted

- 67112** Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques

CPT states, “67112 has been deleted. To report see 67107, 67108, 67110, 67113.” When performing a repeat retinal detachment repair on a patient who had prior surgery in the global period, code the procedure being performed and use the appropriate modifier (58, 78, or 79). If the surgery is not being performed in the global period, then no modifier is needed.¹

Clarifications

The following now appears before all destruction codes (ie, using such techniques as cryotherapy, diathermy, photocoagulation, and ocular photodynamic therapy): “Codes 67208, 67210, 67218, 67220, 67229 include treatment at one or more sessions that may occur at different encounters. These codes should be reported once during a defined treatment period.”

ICD-10-CM CODING MISHAPS

Although fewer problems than anticipated have emerged with ICD-10-CM, some have occurred. Many electronic health record (EHR) systems provide some degree of coding, but not necessarily the correct or pertinent code(s). The accuracy of the EHR is dependent upon the physician’s chart documentation provided in the record, particularly in the “Impression and Plan” areas. Following is a brief review of some issues that have arisen that may also require your attention.

- When listing your diagnoses for an encounter, start with the most serious. Claims are often paid based on the primary diagnosis, although others may be required. Thus, it is critical to put them in order of importance.

- Clinical problems for which a colleague is treating a patient should not be part of your office visit code diagnosis selection.
- With the organization and wording of ICD-10-CM, it may be difficult for your billing department to pick the correct code. Physicians who work with their staffs on these issues will have better claims processing results.
- For trauma/injury/complications of implanted material codes (T codes for Injury, Poisoning, and Certain Other Consequences of External Causes), it is important to add the A, D, or S and use the “x” placeholder when needed to ensure putting the A, D, or S in the 7th character position.
- The Local Coverage Determinations (LCDs) that Medicare Administrative Contractors (MACs) have issued may be missing ICD-10-CM diagnoses. Your claim will be denied if the diagnosis is not on the LCD list. The physician or staff member should notify the MAC of this problem; the MAC will be happy to fix it if it is legitimate. It is probably easier to work through your state’s ophthalmic society or a member of the MAC’s Carrier Advisory Committee.

CASE STUDIES

The following case studies combine the more difficult aspects of CPT and ICD-10-CM coding.

Case No. 1

History

Patient presented with retinal detachment and epiretinal membrane (ERM) in the right eye. Prior retinal detachment repair had been performed, but the surgery had not been performed in the global period. There also was silicone oil droplet coating of a previously inserted intraocular lens. Surgery consisted of (i) pars plana vitrectomy (PPV) repair of retinal detachment with endolaser; (ii) peeling of the ERM using indocyanine green (ICG) dye; (iii) removal of the dislocated IOL from the posterior segment; (iv) insertion of anterior chamber IOL; and (v) suture fixation of IOL under scleral flaps. Code all procedures.

Diagnosis Codes

1. H33.001 Retinal detachment with retinal break, right eye
2. H35.371 Puckering of macula, right eye
3. T85.22xA Displacement of intraocular lens
4. H27.01 Aphakia, right eye
5. Z98.89 Personal history of surgery

Tips

Laterality determination (eg, right eye, left eye) has to be designated for each CPT code as well as the ICD-10-CM code. The fact that there is laterality designation on the ICD-10-CM code does not serve both sets of codes.

CPT CODE	MODIFIERS	ICD-10-CM CODE(S)
67113 Repair of complex retinal detachment by vitrectomy etc.	-RT	1, 2, 5
67121 Removal of implanted material, posterior segment, intraocular	-51-RT	3, 5
66985 Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal	-51-RT	4, 5
66682 Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)*	-51-RT	4, 5

*CPT formerly had a note that this code should be coded additionally for suture fixation of secondary intraocular lens implant. The code is not bundled with CPT code 66985; however, because ophthalmology has not removed the “separate procedure” designation, some coders would be reluctant to use it.

Case No. 2**History**

Patient presented with a retinal detachment, proliferative vitreoretinopathy, and ERM in the left eye. Prior retinal detachment repair had consisted of vitrectomy with endolaser photocoagulation, silicone oil, etc. Surgery performed in the global period consisted of (i) PPV repair of retinal detachment with endolaser photocoagulation; (ii) peeling of the ERM using ICG dye; and (iii) removal of silicone oil. Note that the first procedure had been coded 67108-LT (Repair of retinal detachment with vitrectomy...). Code all procedures.

Diagnosis Codes

1. H33.42 Traction detachment of retina, left eye
2. H35.372 Puckering of macula, left eye
3. T85.698A Other mechanical complication of other specified internal prosthetic devices, implants and grafts

Case No. 3**History**

Patient had sustained severe ocular trauma to his left eye and stated that broken glass had flown into the eye. Preoperative evaluation revealed a full thickness corneal laceration, traumatic cataract, posteriorly located retained intraocular foreign body, and vitreous hemorrhage. Surgery consisted of: (i) removal of glass foreign body located on the posterior aspect of the retina using forceps; (ii) PPV with endolaser and cryopexy; (iii) lensectomy for removal of traumatic cataract; (iv) repair of full thickness corneal laceration without uveal repositioning; and (v) anterior vitrectomy for removal of vitreous in anterior chamber. Code all procedures.

Diagnosis Codes

1. S05.52xA Penetrating wound with foreign body, left eye
2. H.26.102 Traumatic cataract, left eye
3. S05.32xA Ocular laceration without prolapse or loss of intraocular tissue, left eye

Tips

- Trauma cases are inherently unique and thus require an individualized approach to coding.
- For removal of intraocular foreign bodies, always distinguish between magnetic and nonmagnetic for both the CPT and ICD-10-CM codes.
- For repair of corneal/scleral lacerations, the code choice is between whether or not there was prolapse of uveal tissue.
- Follow CPT guidelines when coding for lensectomy when performed with PPV: use 66850 and not 66852.²
- Chapter 20. External Causes of Morbidity (V00 – Y99) of ICD-10-CM is where one finds all the other miscellaneous codes caused by environmental events and circumstances. Happily, its use is not mandatory on a national requirement

CPT CODE	MODIFIERS	ICD-10-CM CODE(S)
67113 Repair of complex retinal detachment by vitrectomy, etc.	-58-LT	1, 2, 4
67121 Removal of implanted material, posterior segment, intraocular	-51-58-LT	3, 4

4. Z98.89 Personal history of surgery**Tips**

- Not all MACs require modifier 51.
- Modifier 58 is used with 67113 because it is a case of a more complicated procedure following a lesser procedure.
- Modifier 58 is used because the procedure is planned prospectively.

CPT CODE	MODIFIERS	ICD-10-CM CODE(S)
65265 Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction	-LT	1
67039 Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation	-51-LT	1
66850 Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacofragmentation), with aspiration	-51-LT	2
65280 Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue	-51-LT	3

basis; however, ICD-10-CM cautions that there may be state-based reporting or individual payer mandate.

- Both an anterior vitrectomy for removal of vitreous present in the anterior chamber (CPT code 67010 for its removal mechanically) and a posterior vitrectomy were performed; however, because the two codes are bundled under the National Correct Coding Initiative, it is wisest not to code for the anterior vitrectomy, which would entail breaking the bundle. ■

1. Asbell RL. Coding for surgical procedures in the global period. *Retina Today*. 2014;9(6):35-37.

2. Asbell RL. Solutions for a pair of puzzling surgical coding issues. *Retina Today*. 2015;10(3):31-33.

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