

A POTPOURRI OF COMPLICATED SURGICAL CODING CASES

These coding tips and examples can help minimize common problems related to claim denials.

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Medical coding is the tool that one uses to facilitate payment, track health data, and measure performance and efficiency. Although much of it is straightforward, selecting the appropriate corresponding codes and modifiers for some retina procedures can be tricky. This issue's column

offers information that will hopefully prove helpful in making the coding of complicated surgical cases less daunting in the future.

CONFUSED OVER CLAIM DENIAL

The inquiry below came to me from a biller/coder in Florida regarding an issue coding a complicated surgical case. Errors made when submitting the claim that contributed to denials of the claim are in bold. My response to the inquiry follows.

*When the doctor does pars plana vitrectomy (PPV), removal of posterior chamber intraocular lens (PCIOL), and suture of IOL for dislocated PCIOL, we have always coded 67036 and **66985-51**. We have never had any problems getting paid for both by any insurance company including Medicare. I billed this combination of codes for two patients who had this type of surgery on January 21, 2016. In both cases, Medicare denied the PPV and paid only the **IOL suture**.*

*I called Medicare today to find out why. According to the rep I spoke with, it turns out it is not a bundling issue, but a medically necessary issue based on the diagnosis **T85.29XD** (other mechanical complication of IOL, subsequent encounter). She referred me to the National Coverage Determination (**NCD**) for PPV, which states that, "Vitrectomy may be considered reasonable and necessary for the following conditions: vitreous loss incident to cataract surgery, vitreous opacities due to vitreous hemorrhage or other causes, retinal detachments secondary to vitreous strands, proliferative retinopathy, and vitreous retraction."*

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How do you advise billing for “PPV, removal of PCIOL, and suture of IOL for dislocated PCIOL” for T85.29XD (other mechanical complication of intraocular lens, subsequent encounter)?

Without operative notes, the case cannot be coded. However, despite the lack of operative notes, some problems are apparent:

- Incorrect Current Procedural Terminology (CPT) code: 66985 is used for insertion of a secondary IOL, not for suturing the IOL. Potentially correct CPT codes that were not used in the above case include possible combinations of the following: 67121 (removal of implanted material, posterior segment); 66986 (exchange of IOL); 67036 (PPV); 66682 (suturing of IOL), etc.
- The information is insufficient to determine which CPT codes should have been used. *See Case No. 3 below for different approaches in a similar case.*
- Suturing of an IOL is coded with CPT code 66682 (suture of iris, ciliary body with retrieval of suture through small incision).
- ICD-10-CM code T85.29xD (other mechanical complication of IOL) is the wrong diagnosis and the wrong 7th character, most likely the main reason the claim was

denied. The correct code is T85.22xA (displacement/malposition of IOL), and the correct 7th character is A because the patient is receiving active treatment for the condition.¹

- There is an obscure and outdated NCD on vitrectomy (bit.ly/asbell0716) that may benefit from attention by the ophthalmology and retina societies. Interestingly, First Coast Service Options, the Medicare Administrative Contractor (MAC) for Florida, does not have a Local Coverage Determination (LCD) for vitrectomy.

CASE STUDIES

Clinical information is generally not available to the coder when coding is outsourced, so any assistance provided in the operative note itself can be helpful. This is particularly true for trauma cases (Case No. 1 and Case No. 2 below). Basic material that facilitates accurate coding and optimal payment includes the following:

- Brief history (eg, patient was involved in automobile accident and sustained lacerations of right eye with intraocular foreign body)
 - Correct and corresponding diagnosis for each procedure performed
 - Whether patient is in global period from another procedure
 - Listing of prior procedures if patient is in global period
 - Whether concurrent surgery was performed by another surgeon and the ophthalmic subspecialty of that surgeon.
- The case studies below were coded using operative notes.

CASE NO. 1

History

This patient sustained severe ocular trauma to his right eye while working on machinery, resulting in a corneal laceration with a metallic foreign body. Inspection of the sclera revealed multiple posterior rupture sites. There was a corneoscleral limbal entry site where a large metallic foreign body was situated. The corneoscleral laceration was vertically oriented to the cornea and turned somewhat superonasally on the sclera, extending approximately 2 mm on the sclera and 2 mm to 3 mm on the cornea. The anterior capsule had been compromised, leading to the decision to perform a pars plana lensectomy.

Surgery, First Procedure

Surgery consisted of an attempted removal of the metallic foreign body with an 18-gauge magnet; however, it ultimately had to be removed using large retinal forceps. Further surgery involved primary open globe repair, PPV, pars plana lensectomy, and anterior chamber washout. Cultures were taken and intravitreal antibiotics injected.

Diagnosis Codes

1. S05.51xA Penetrating wound with foreign body
2. H26.101 Traumatic cataract
3. S05.31xA Ocular laceration without prolapse or loss of intraocular tissue
4. W31.1xxA Contact with metalworking machines

CASE 1 CPT CODES, FIRST PROCEDURE	MODIFIERS	ICD-10-CM CODES
65265: Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction	-LT	1, 4
66850: Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacofragmentation), with aspiration	-51-LT	2, 4
65280: Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue	-51-LT	3, 4

Tips

- CPT code 67036 (PPV) is bundled in the National Correct Coding Initiative (NCCI) with CPT code 65265 and is therefore not listed.
- Magnetic and nonmagnetic foreign body removal codes are bundled; therefore, the code that represented the final method of extraction was selected.
- Because enough information is present on how the metallic foreign body and laceration occurred, the external cause can be coded. Chapter 20 of ICD-10-CM contains the external codes, and the practice felt it might be desirable to include them in this case. Keep in mind, however, that use of these codes is not mandatory for Medicare.

Surgery, Second Procedure

A second procedure was necessitated by the presence of hypotony on the postoperative visit. The patient was scheduled for examination under anesthesia, and slow anterior corneal and scleral wound leaks were found, necessitating additional sutures. The previous sclerotomy sites were also sutured, and it was necessary to reinflate the globe with balanced salt solution.

Diagnosis Codes

1. T81.33xA Disruption of traumatic injury wound repair
2. H44.431 Hypotony of eye due to other ocular disorders
3. Z98.89 Personal history of surgery, not elsewhere classified

CASE 1 CPT CODES, SECOND PROCEDURE	MODIFIERS	ICD-10-CM CODES
66250: revision or repair of operative wound of anterior segment, any type, early or late, major or minor	-78-RT	1, 2, 3
67025: injection of vitreous substitute, pars plana or limbal approach	-51-78-RT	2, 3

Tip:

- Because the surgery was performed within the global period of a *related* major procedure, modifier 78 must be used in order to be paid for this surgery. The procedures will be paid at 70% of the allowed fee and will be subject to multiple procedure payment rules (100% of the first procedure and 50% of the following four procedures). Generally, try to list only five procedures because there is no written Medicare policy for paying for a claim that lists more than five procedures, and it will not be processed directly but rather will be submitted by Medicare to an expert for individual consideration.

CASE NO. 2*History*

This patient previously had a retinal detachment (RD) repaired using vitrectomy and silicone oil (CPT code 67108). Within the global period, the patient developed proliferative vitreoretinopathy, tractional retinal detachment (TRD), subretinal fibrosis, and epiretinal membrane (ERM). Silicone oil was present in the anterior chamber of the left eye.

Surgery

Surgery in the global period consisted of repair of TRD by PPV with ERM peeling, removal of subretinal bands, use of indocyanine green dye, removal of the internal limiting membrane, and removal of the silicone oil from the anterior chamber with anterior chamber washout.

Diagnoses

1. H33.42 Traction detachment of the retina
2. H35.372 ERM
3. T85.698A Other mechanical complication of other specified internal prosthetic devices, implants and grafts
4. Z98.89 Personal history of surgery, not elsewhere classified

CASE 2 CPT CODES	MODIFIERS	ICD-10-CM CODES
67113: Repair of complex RD with vitrectomy and membrane peeling	-58-LT	1, 2, 4
65920: Removal of implanted material, anterior segment of eye	-51-78-LT	3, 4
65800: Paracentesis of anterior chamber of eye	-51-78-LT	3, 4

Tips

- Modifier 58 is used to engender payment in the global period because a greater procedure (67113) is being performed after a lesser procedure (67108).
- The complex repair code mandates use of ERM peeling. Without it, CPT code 67113 cannot be used.
- Increasingly, anterior segment surgery is being performed along with posterior segment surgery. The silicone oil had migrated to the anterior chamber, so 65920 is used rather than CPT code 67121 (removal of implanted material posterior segment). Because the surgery is not only related to the first surgery (the original RD repair) but is also a complication of that first surgery, modifier 78 is used.

CASE NO. 3*History*

This patient had undergone a trabeculectomy in the left eye and presented with a leaking bleb. At this visit, a dislocated IOL was noticed to be posterior to the iris.

Surgery

A first attempt to remove the IOL was made using an anterior approach, but the flap from the trabeculectomy prevented access, and the IOL fell back into the vitreous. It was then decided to use a posterior approach. The leaking bleb was repaired. A PPV was performed, vitreous traction from the IOL was severed, and the IOL was brought into the anterior chamber and removed. A secondary IOL was inserted, and an iridectomy was also performed.

Note: Coding is not always straightforward. Two options for coding this complicated case are offered below.

*Option 1**Diagnoses:*

1. T85.22xA Displacement (malposition) of IOL
2. T85.9xxA Unspecified complication of internal prosthetic device (vitreous strands to IOL)
3. H27.02 Aphakia
4. H59.89 Other postprocedural complications and disorder of eye and adnexa

5. H40.10x0 Primary open-angle glaucoma, stage unspecified
6. H44.432 Hypotony
7. Z98.83 Filtering (vitreous) bleb after glaucoma surgery
8. Z98.89 Personal history of surgery

CASE 3 OPTION 1 CPT CODES	MODIFIERS	ICD-10-CM CODES	COMMENTS
67121: Removal of implanted material, posterior segment	-LT	1, 8	CPT code originally developed for removing IOL from posterior segment
66985: Insertion of secondary IOL	-51-LT	3, 8	Note, aphakia diagnosis coordinates with CPT code 67121 versus 66986 used in Option 2
66250: Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure	-51-59-LT	4, 5, 6, 7, 8	Modifier 59 is used to break the NCCI bundles for anterior segment procedures vs. posterior segment procedures
66625: Iridectomy with corneoscleral or corneal section; peripheral for glaucoma	-51-59-LT	5	See notes above on Modifier 59 usage

Option 2

Diagnoses:

1. T85.22xA Displacement (malposition) of IOL
2. T85.9xxA Unspecified complication of internal prosthetic device (vitreous strands to IOL)
3. 59.89 Other postprocedural complications and disorder of eye and adnexa
4. H40.10x0 Primary open-angle glaucoma, stage unspecified
5. H44.432 Hypotony
6. Z98.83 Filtering (vitreous) bleb after glaucoma surgery
7. Z98.89 Personal history of surgery

CASE 3 OPTION 2 CPT CODES	MODIFIERS	ICD-10-CM CODES	COMMENTS
66986: Exchange of IOL	-LT	1, 7	This code is more commonly used when removal and insertion occur at the same time in the anterior segment
67036: PPV	-51-LT	3, 8 2, 7	None
66250: Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure	-51-59-LT	3, 4, 5, 6, 7	This code is used for repair of the bleb. It is bundled with 66986. The NCCI thinking is that, just because another incision was made in the same area, it should not be coded separately. However, in this case it was not performed in conjunction with the retinal portion of the surgery.
66625: Iridectomy with corneo-scleral or corneal section; peripheral for glaucoma	-51-59-LT	4, 6	Code 66625 is bundled with 66250. Again, this is not a normal part of IOL exchange surgery, and it is unbundled because the iridectomy was performed as treatment for active glaucoma

SUMMARY

Generally, the main causes of payment problems include errors in CPT code selection; incorrect application of or lack of modifiers; and improper use of ICD-10-CM diagnosis codes, especially the use of the mandatory 7th character for injury diagnoses and a different set of 7th characters for glaucoma staging codes. Some helpful take-away points are listed on the next page.

Teamwork

- Do:** Participate with your coders and billers and review with them complicated cases such as those shared in this article. A layperson may have difficulty understanding what procedures were performed, the correlating diagnoses, and the relationship of the previous procedures to the current one. Diagnosis selection itself is much more difficult with ICD-10-CM than with ICD-9-CM for individuals without a clinical background.
- Don't:** Do not use modifier 59 in judiciously. Be sure a physician approves its use. Overuse of this modifier triggers audits.

ICD-10-CM Updates

- Do:** Review and share the March 2016 *Retina Today* article "Troubleshooting the 7th Character."¹ The Centers for Medicare and Medicaid Services revised the interpretation of the guidelines for the use of this character in December 2015 for injury/trauma cases.
- Don't:** Do not neglect physician and staff continuing education on this subject. Rules change regarding ICD-10-CM, as do interpretations.

Operative Notes

- Do:** Make sure your operative notes describe all procedures performed. This may sound obvious, but I have seen cases in which ERM peeling was listed in the operative note section of "surgery performed" but not dictated in the body of the operative notes, resulting in the case not qualifying for coding as complex. I usually can tell from the diagnosis and surgery description, and I ask for a rediction in order to capture all the codes that render the RD repair as complex. Review the dictation format that your residents and fellows use to ensure that it follows that of the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations). A sample can be found online at: bit.ly/dictationsample.
- Don't:** Do not let your staff code from the top section of the operative note, but rather make them learn how to read the description of the surgery, verify which procedures were performed, and code those. In case of an inadvertent omission, the operative notes should be redictated. ■

1. Asbell RL. Troubleshooting the 7th character. *Retina Today*. 2016; 11(2):22-24.

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