CODING ADVISOR
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ASK THE EXPERT: COMMON RETINA CODING QUESTIONS

Knowing the answers could mean the difference between a successful claim and a denial.

BY JOY WOODKE, COE, OCS, OCSR

Retina coding can often feel complex and challenging, but it doesn't have to be. Here, I share a few of the most important questions that have been asked, and the answers that can help you expand your coding knowledge.

Q: IS IT APPROPRIATE TO UNBUNDLE AN ANTERIOR CHAMBER (AC) TAP—CPT CODE 65800, PARACENTESIS OF AC OF EYE (SEPARATE PROCEDURE), WITH REMOVAL OF AQUEOUS—WHEN PERFORMED IN THE SAME SESSION AS AN INTRAVITREAL INJECTION, CPT CODE 67028?

A: CPT code 65800 is bundled with 67028 under the National Correct Coding Initiative. It should not be unbundled when performed on the same eye during the same encounter, as it does not meet the criteria for using modifier -59 because the AC tap is typically prophylactic.

Q: IS IT APPROPRIATE TO ORDER OCT ANGIOGRAPHY IN ADDITION TO RETINA OCT ON ALL PATIENTS AND BILL THE HIGHER REIMBURSING CODE, CPT CODE 92137, EVEN THOUGH THE RETINA OCT GUIDES DECISION MAKING?

A: OCT alone can typically be used to monitor anti-VEGF treatment, so an additional test (CPT code 92137) requires additional documentation that supports medical necessity and explains how this test will guide medical decision making and the patient's treatment. For example, OCT angiography can be medically necessary in some instances to document the progression of choroidal neovascularization.

Q: DOES THE MEDICARE ADMINISTRATIVE CONTRACTOR PALMETTO GBA REQUIRE A PATIENT WITH DIABETES TO BE DIAGNOSED WITH RETINOPATHY TO BILL AN ANNUAL FUNDUS PHOTOGRAPH?

A: Palmetto has both a local coverage determination (LCD) and a local coverage article (LCA) for fundus photography. Copies of current LCDs/LCAs can be found on each payer's website and at aao.org/lcds.

Palmetto's LCD (L33467) states that fundus photography is not covered for routine screening and provides guidelines to meet medically necessary coverage. However, the policy does confirm that fundus photography is considered medically necessary when "monitoring potential progression of a disease process" such as diabetes.

The LCA (A53060) confirms that fundus photography can be medically necessary to monitor diabetes without retinopathy or diabetic macular edema and provides ICD-10-CM codes that support medical necessity, including E10.9, type 1 diabetes without complications, and E11.9, type 2 diabetes without complications.

Q: DUE TO OUR COMPOUNDING PHARMACY'S SHORTAGE OF COMPOUNDED ANTIBIOTICS, WE ADMINISTER INJECTIONS OF VANCOMYCIN AND CEFTAZIDIME FROM RECONSTITUTED POWDER-FILLED VIALS. HOW DOES THIS AFFECT OUR CODING?

A: After being reconstituted, the drug has a shorter shelf life. Bill as single-use vials per the label. Bill each medication's specific HCPCS code and include the National Drug Code (NDC) from the vial.

When reporting reconstituted medications, the unit of measure (UOM) reported in item 24a following the NDC should be the total number of vials used (eg, UN1 = one vial used). This is different than a liquid vial of medication where the UOM is reported in terms of volume (eg, 2 mg/0.05 mL = ML0.05).

The HCPCS dosage (unit) for ceftazidime is 500 mg. Any amount up to 500 mg is reported as one billing unit.

OCT ALONE CAN TYPICALLY BE USED TO MONITOR ANTI-VEGF TREATMENT, SO AN ADDITIONAL TEST (CPT CODE 92137) REQUIRES ADDITIONAL DOCUMENTATION THAT SUPPORTS MEDICAL NECESSITY AND EXPLAINS HOW THIS TEST WILL GUIDE MEDICAL DECISION MAKING AND THE PATIENT'S TREATMENT.

If a single-use vial has 500 mg, bill one unit injected and report the -JZ modifier because the remaining drug is less than one unit. Documentation should include the actual dosage in mg/mL injected and state that the remaining medication less than one unit was discarded. Medicare (as well as other payers) has policies that state to purchase the vial size that minimizes waste.

Effective July 1, 2025, HCPCS code J3370—injection, vancomycin, 500 mg—was discontinued, and a new code, J3373—injection, vancomycin, 10 mg—was added. If the dosage is 10 mg or less, bill one unit.

Q: WE HAVE A PATIENT WHO WAS GIVEN AN INTRAVITREAL INJECTION OF COMPOUNDED GANCICLOVIR–CPT CODE 67028. IT WAS PREPARED IN A PRE-FILLED SYRINGE BY A COMPOUNDING PHARMACY. THE DOSAGE WAS 2 MG, WHICH IS DIFFERENT THAN THE GANCICLOVIR IMPLANT. HOW DO WE CODE THE MEDICATION?

A: Report as HCPCS code J7999—compounded medication—and include the medication name, dosage, and invoice amount in item 19 of the CMS-1500 form.

Q: WE PURCHASED BEVACIZUMAB (AVASTIN, GENENTECH/ROCHE) FROM A COMPOUNDING PHARMACY. FOR BILLING PURPOSES, SHOULD WE USE THE NDC NUMBER ON THE REPACKAGED SYRINGE OR THE NDC NUMBER FOR THE MEDICATION?

A: Report NDC 50242-0060-01. Correct billing is based on the medication NDC prior to repackaging. The NDC from a compounding pharmacy is for tracking, not billing, purposes. Reporting it on a claim will prompt a denial.

Q: WHEN BILLING FOR SILICON-FREE REPACKAGED BEVACIZUMAB, THE SYRINGES COME WITH 2.5 MG/0.1 ML, BUT ONLY 1.25 MG IS INJECTED INTO THE EYE. SHOULD THE REMAINING 1.25 MG BE BILLED WITH THE APPROPRIATE HCPCS CODE AND MODIFIER -JW?

A: The silicone-free syringes are prepared with overfill to allow the needle to be primed prior to the injection. Overfill, according to Medicare, is not considered wastage and should not be reported with modifier -JW. Include in your documentation the dosage injected and that the overfill medication was discarded.

Q: WHEN CPT CODE 67105–LASER REPAIR OF A RETINAL DETACHMENT–IS PERFORMED THE SAME DAY AS THE EXAMINATION, WHICH MODIFIER SHOULD BE APPENDED, -25 OR -57?

A: Modifier -57 is appended to office visits the same day as or a few days prior to a major surgery (90-day global period). It indicates that the office visit includes the decision for the major procedure.

Modifier -25 is appended to an office visit the same day as a minor surgery (0- or 10-day global period) if it is a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

CPT code 67105—repair of retinal detachment, including drainage of subretinal fluid when performed, photocoagulation—has a 10-day global period. If the examination meets the definition of modifier -25, then append it to the office visit code.

Q: DOES THE 28-DAY FREQUENCY LIMITATION APPLY TO INTRAVITREAL INJECTIONS, CPT CODE 67028, ONLY WHEN ONE EYE IS BEING TREATED OR WHEN BOTH EYES ARE BEING TREATED BUT ON DIFFERENT DATES OF SERVICE?

A: Treatment frequency is based on the FDA label of each drug, which isn't always 28 days. When treating both eyes, injections can occur on different days within the same limited period if performed on opposite eyes. Newer drugs have varied frequency limitations per indication and can have dosing flexibility.

LEARN MORE

To find more information on retina coding, visit the AAO's dedicated site, aao.org/coding, and check out the *Retina Coding: Complete Reference Guide*. ■

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