

INGENIX®

Coding Companion for Ophthalmology

A comprehensive illustrated guide to coding and reimbursement

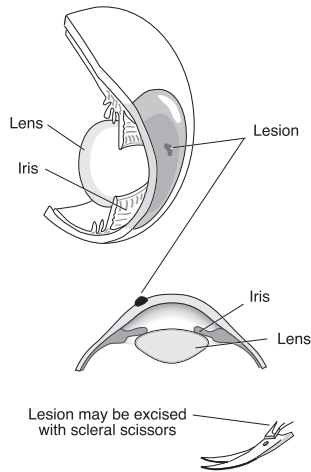
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65400-65410

65400 Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium

65410 Biopsy of cornea



Report 65410 if only a portion of the lesion is removed or 65400 if the entire lesion is excised

Explanation

The physician removes the entire corneal lesion (e.g., 65400) using a blade and forceps or scleral scissors. The edges of the lesion are undermined following a superficial incision in the cornea. Sutures are not required. Antibiotic ointment and possibly a 24-hour pressure patch is applied. The lesion is superficial; the cornea is not perforated by the excision. Sometimes, only a portion of the lesion is removed for diagnostic purposes (e.g., 65410).

Coding Tips

An excision reports the removal of an entire defect while a biopsy reports a sampling of the defect prior to its possible excision. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. These procedures are generally performed with a topical anesthetic rather than general anesthesia. If specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For excision or transposition of pterygium, without graft, see 65420; with graft, see 65426. For diagnostic scraping of the cornea, see 65430. For destruction of a corneal lesion by cryotherapy, photocoagulation, or thermocauterization, see 65450. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-9-CM Procedural

- 11.22 Biopsy of cornea
- 11.49 Other removal or destruction of corneal lesion

Anesthesia

00140

ICD-9-CM Diagnostic

- 190.4 Malignant neoplasm of cornea
- 198.4 Secondary malignant neoplasm of other parts of nervous system
- 224.4 Benign neoplasm of cornea
- 234.0 Carcinoma in situ of eye
- 238.8 Neoplasm of uncertain behavior of other specified sites
- 239.89 Neoplasms of unspecified nature, other specified sites
- 370.01 Marginal corneal ulcer
- 370.03 Central corneal ulcer
- 370.55 Corneal abscess
- 371.00 Unspecified corneal opacity
- 371.10 Unspecified corneal deposit
- 371.11 Anterior pigmentations of cornea
- 371.12 Stromal pigmentations of cornea
- 371.13 Posterior pigmentations of cornea
- 371.14 Kayser-Fleischer ring
- 371.15 Other deposits of cornea associated with metabolic disorders
- 371.16 Argentous deposits of cornea
- 371.70 Unspecified corneal deformity
- 371.89 Other corneal disorder

Terms To Know

argentous deposits of cornea. Silver deposits in the cornea.

benign. Mild or nonmalignant in nature.

biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

corneal abscess. Pocket of pus and inflammation on the cornea.

fluorescein stain. Fluorescein dye is instilled into the eye to stain local defects that are visible with cobalt blue illumination.

Kayser-Fleischer ring. Condition found in Wilson's disease in which deposits of copper cause a pigmented ring around the cornea's outer border in the deep epithelial layers.

keratotomy. Surgical incision of the cornea.

posterior pigmentations of cornea.

Color deposits in the innermost layers of the cornea.

pterygium. Benign, wedge-shaped, conjunctival thickening that advances from the inner corner of the eye toward the cornea.

secondary. Second in order of occurrence or importance, or appearing during the course of another disease or condition.

stromal pigmentations of cornea. Color deposits in the middle layer of the cornea.

CCI Version 15.3

36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64470, 64475, 64479, 64483, 64505-64530, 67250, 67500, 69990, 92018-92019, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 65400: 65410, 68371, J2001

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

	Fac	Non-Fac		
	RVU	RVU	FUD	Assist
65400	16.18	17.92	90	N/A
65410	2.93	3.8	0	☐

Medicare References: 100-2,15,260; 100-4,12,30; 100-4,12,90.3; 100-4,14,10

0016T

0016T Destruction of localized lesion of choroid (eg, choroidal neovascularization), transpupillary thermotherapy

Explanation

Transpupillary thermotherapy is a sub-threshold laser photocoagulation technique that can result in closure of choroidal neovascularization (CNV) while sparing the neurosensory retina. Treatment is typically done without retrobulbar anesthesia, though topical anesthesia may be applied. The laser HeNe aiming beam is set at low to moderate intensity and the ophthalmologist bisects the retina by a moderate-to-high slit beam to visualize the retina and the RPE. Treatment is stopped at the first sign of retinal color change.

0017T

0017T Destruction of macular drusen, photocoagulation

Explanation

Laser treatment in patients with dry age-related macular degeneration (AMD) has been shown to cause resorption of drusen, which may benefit the natural course of the disease. There are ongoing clinical trials that utilize sub-threshold diode laser treatment that minimizes damage to the retina and is not perceptible to the patient or to the clinician. The method consists of placing a grid of 48 ophthalmoscopically invisible diode laser spots around the macula. The ophthalmologist administers photocoagulation as a grid in four concentric rings that spares the fovea.

0099T

0099T Implantation of intrastromal corneal ring segments

Explanation

Intrastromal corneal ring segments are prescription corneal inserts implanted for surgical treatment of mild myopia. The rings are made of ultra-thin, biocompatible polymethylmethacrylate. The corneal ring is inserted between layers of the outer edge of the cornea, causing flattening of the center of the cornea to gently reshape the contour of the eye. Insertion is done under topical anesthesia and only takes about 15 minutes. The incision positions and segment placement are marked on the cornea and a radial incision is made with a diamond blade on the marked zone. Micro fine nylon interrupted sutures are placed to close the initial incision.

0100T

0100T Placement of a subconjunctival retinal prosthesis receiver and pulse generator,

and implantation of intra-ocular retinal electrode array, with vitrectomy

Explanation

An electronic retinal prosthesis is implanted to restore some lost vision and create visual perception by electronically stimulating the retina. Diseases such as retinitis pigmentosa and age-related macular degeneration destroy vision by degenerating the rod and cone photoreceptors in the eye. These electronically conducting devices help patients detect light or distinguish between objects such as a cup or plate. The retinal prosthesis is a sliver, or tiny chip, of silicone and platinum attached to and sitting on top of the retina.

0123T

0123T Fistulization of sclera for glaucoma, through ciliary body

Explanation

The physician creates a new tract or pathway for filtering aqueous fluid from the posterior chamber of the eye. Using an operating microscope, a small conjunctival flap is first created. An electromagnetic plasma ablation device creates a tiny pit through the sclera above the ciliary body and behind the iris. The metal tip creates a pore or a tract through the ciliary body into the posterior chamber of the eye beginning at the base of the scleral pit created above. The conjunctival flap is reattached.

0124T

0124T Conjunctival incision with posterior extrascleral placement of pharmacological agent (does not include supply of medication)

Explanation

The physician performs a conjunctival incision and places medication into the posterior segment of the eye for treatment of conditions of the choroid and retina, such as macular degeneration. After placing a lid speculum and administering lidocaine, the physician makes a small 2 to 3 mm conjunctival incision into the Tenon's capsule in the upper, outer quadrant a few millimeters from the limbus. A blunt tipped, curved cannula is inserted into the posterior area of the globe through the Tenon's space and positioned with the tip near the macula. The medication is injected, and the cannula is removed. Pressure is applied, and the speculum is removed. Sutures are not usually required to close the conjunctiva. This code does not include supply of the medication itself.

0173T

0173T Monitoring of intraocular pressure during vitrectomy surgery (List separately in addition to code for primary procedure)

Explanation

The physician monitors intraocular pressure (IOP) during vitrectomy surgery. IOP monitoring may be

accomplished indirectly by placing disposable blood pressure transducers into the line tubing utilized for vitrectomy infusion. It may also be monitored by inserting a catheter pressure transducer directly into the vitreous via an extra pars plana incision. In either approach, pressure measurements are obtained simultaneously during the various stages of the vitrectomy, including air-fluid exchange and gas-forced fusion.

0176T-0177T

0176T Transluminal dilation of aqueous outflow canal; without retention of device or stent

0177T with retention of device or stent

Explanation

The physician dilates the aqueous outflow canal (canaloplasty) for the treatment of glaucoma. Via scleral cutdown, the physician dilates the circular canal in the eye that drains aqueous humor from the anterior chamber into the anterior ciliary veins (Schlemm's canal) using a flexible microcatheter and viscoelastic. Intraoperative ultrasound imaging guidance is frequently used to ensure proper catheterization. Report 0177T if a polypropylene suture is placed within the canal to improve aqueous outflow and preserve canal patency.

0181T

0181T Corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report

Explanation

The physician determines corneal hysteresis (CH) by air impulse stimulation. The physician applies force to the cornea by rapid air pulse. The cornea moves inward, reaches the point of being flat (applanation), and then continues in to form a slight concavity. Milliseconds after applanation, the air pump is turned off and the pressure to the eye decreases. As this pressure decreases, the cornea returns to its natural shape while passing through the applanated state. Utilizing an advanced electro-optical system, two intraocular pressure (IOP) measurements are obtained during this process, the first as the cornea moves inward and the second as it returns to its baseline. The difference between these two values is corneal hysteresis.

0186T

0186T Suprachoroidal delivery of pharmacologic agent (does not include supply of medication)

Explanation

The physician performs suprachoroidal delivery of a pharmacologic agent. In one method, the physician uses a microcannulation system. Under appropriate sedation, the physician makes a pars plana incision and exposes the suprachoroidal space. The microcannula is inserted, threaded through the suprachoroidal space, and directed toward the targeted posterior segment tissues under direct

Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately \$29 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services
- Hospital inpatient services—initial care

- Hospital inpatient services—subsequent care
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as "observation status" in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician "admitting" the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and