HOW TO IMPROVE CODING FOR ASC PROCEDURES – A DISCUSSION OF ORTHOPEDIC, GI AND OPHTHALMOLOGY PROCEDURES

Speaker: Stephanie Ellis, R.N., CPC
President, Ellis Medical Consulting, Inc.

ORTHOPEDICS

KNEE/LEG ORTHO. PROCEDURES

Diagnosis Coding in Orthopedic Conditions

Removal of Hardware procedures have different diagnosis codes, depending on the reason the hardware/implant is being removed. Use diagnosis code 996.78 for the removal of painful hardware. Use code V54.01 for the removal of hardware in the absence of symptoms.

Arthropathies

Arthropathies include disorders of the joint. Codes are 5-digits in the 716 section. They do not include injuries to the joint. These codes do not include any disorders of the spine.

Loose Bodies

For a Loose Body in the Knee, just code 717.6.

Articular Cartilage Disorder

Articular Cartilage covers the bone surfaces of joints and serves as a shock absorber to enable weight-bearing by the joint. Articular cartilage is compromised/injured by trauma and the wear and tear of aging. Use code 718.08 for Articular Cartilage Disorder, other specified site for an Articular Cartilage Disorder of the Knee.

Traumatic Arthropathy

Arthopathy may be related to previous injuries. In this instance, the coder will first code the arthropathy and then add an additional code to show that this is a late effect of an injury. Codes are 5-digits in the 716.1X section. It was not necessarily an injury to the joint.

Internal Derangement of the Knee

Degeneration, ruptures, and old tears of the knee are coded from category 717 for Chronic problems and the 836 section for Current Injuries. The coder must clarify if this is a Current Injury, or treatment for a previous condition/Chronic problem.

Bucket Handle Tears

Bucket Handle Tears are coded 836.0 for a Current Injury Tear of the Medial cartilage or Meniscus of the Knee. Chronic problem Bucket Handle Tears are coded 717.0 for a Medial Meniscus Tear or 717.41 for a Lateral Meniscus Tear.

Chondromalacia

Chondromalacia of the Patella is coded 717.7. For Chondromalacia occurring in the Medial or Lateral Compartment of the Knee, use code 733.92, which would also be the code for use for the Chondromalacia condition occurring in joints other than the Knee.

Hypertrophy of Fat Pad

When a patient has the condition of Hypertrophy of the Fat Pad in the Knee, it is coded 726.91.

Malunion/Nonunion

Occasionally, fractures fail to heal or heal improperly and require additional attention. Each of these codes should be accompanied by a "late effect" code, showing that the principal diagnosis is the result of a previous fracture. Use code 733.81 for a Malunion occurring anywhere in the body. Use code 733.82 for a Nonunion occurring anywhere in the body.

Injuries

Avoid Upcoding of Injury Diagnosis Coding

It is very important, when coding Injury claims, not to "Upcode" the diagnosis codes for these cases. Upcoding of the diagnoses occurs when you choose a diagnosis code from the 800-section, which are codes for CURRENT Injuries, when the injury is an old injury or the problem is Chronic in nature. The codes for CHRONIC Injuries are in the 700-section, which should be used if the injury occurred more than 6 months prior to the surgical procedure being performed. Six months is only a "rule of thumb" to have some guide to go by. When coding, if you cannot derive the age of the injury from the OP Report, review the H & P for this information and if it is still not clear, consult the physician's office for the Date of Injury (DOI) they have on file in their records. The Exception: It is usually necessary to continue using the Current Injury codes from the 800-section on an ongoing basis for Workers' Comp. claims.

Dislocations

Determine whether the injury is a "closed" or "open" dislocation. The dislocation codes are only used with current injuries. If the condition is old, recurrent or

pathological, the code will be found in the other musculoskeletal system diagnosis codes.

Other Ortho./Neuro. Diagnoses

Synovitis involves the inflammation of the synovial lining that keeps foreign matter out of joints and produces joint fluid for lubrication of joints such as the knee, shoulder, hip, elbow, wrist, or ankle. The usual type of Synovitis conditions found, for which orthopedic procedures are commonly performed (Synovectomy procedures or Plica Resections) are coded with the 727.00 Synovitis or Tenosynovitis code. If the Synovitis condition occurs in the hand or wrist area, use code 727.05. If the Synovitis condition occurs in the foot or ankle regions, use code 727.06.

Villonodular Synovitis conditions sometimes seen should not be confused and coded for most Synovitis conditions, as that is another condition (where there is pigmenting of the tissue and the joint lining swells, retaining fluid), which should be coded from the 719.2X section – that is only to be coded when the OP Report or Path. Report specifically states the patient has the *Villonodular* Synovitis condition.

Plica Syndrome is coded 727.83. In this condition, folds in the synovium (plicae) become irritated, red and thick, causing pain and inflammation. Usually, it is the inner (medial) plicae which is affected by Plica Syndrome and women have this problem more than men.

Knee Procedures

Knee Anatomy

The knee joint is the largest joint in the body, and it is one of the body's most complex structures. The three main Compartments of the Knee joint are the inner (medial), the outer (lateral), and the kneecap (patella or also called patello-femoral), which includes the Trochlear Groove.

Arthroscopic Procedures

In Arthroscopic procedures, the physician visualizes the interior of the knee (or another) joint by inserting an arthroscope through small incisions and uses a camera to transmit images onto a monitor. These minimally-invasive procedures offer a quicker rehabilitation time for patients.

When both a Diagnostic and Surgical Arthroscopy procedure are performed in the same Joint area, the Diagnostic Arthroscopy is included in the Surgical Arthroscopy, and would not be billed separately. For procedures involving both an Arthroscopy and an Arthrotomy, both may be billed, as long as the procedures are in different compartments for different diagnoses, and the OP Note clearly documents this fact. Those CPT codes which list the procedure as being performed "by any method" may be used for either

open or arthroscopic procedures. Those procedures performed arthroscopically for which there is no specific CPT code should be billed with the Unlisted CPT code from the Arthroscopy section, and it is advisable to send the OP Report with the claim. Coding an Open Procedure for an Arthroscopic one is considered Fraudulent by Medicare and most other payors.

The American Academy of Orthopedic Surgeons (AAOS) has issued guidance that if an arthroscopic procedure is performed using an Arthocare Wand, it does not change the coding and the regular code can still be used.

- Knee Joint Manipulations procedures (code 27570) should only be billed when it is the only procedure performed. If a surgical arthroscopy is performed on the same joint, the Manipulation should not be billed. When a Manipulation procedure is performed in the same case with a Joint Injection (code 20610), both procedures are billable, unless Unbundled.
- A Knee Lateral Release performed Arthroscopically should be billed with code 29873. The Open Lateral Release code is 27425.
- If CPT codes 29875-29881 are billed, and the surgeon also performs Arthroscopic Removal of Loose or Foreign Bodies (CPT code 29874) in the same compartment, the 29874 code would be considered bundled and not separately billable. If the 29874 procedure occurred in a different compartment, it might be separately-billable with a –59 Modifier or the G0289-GZ code for Medicare. The G0289 code is not presently on the Medicare list of covered procedures.
- Open ACL Reconstruction procedures
  While most ACL Reconstruction procedures are performed Arthroscopically (29888), when that procedure is instead performed as an Open procedure, there are three codes to choose from, which vary by whether the procedure is performed outside of the joint (Extra-articular), in the joint (Intra-Articular) – or both.
  - Use code 27427 for a Ligamentous Reconstruction (augmentation) of the Knee; Extra-articular, which is the most common procedure of the three.
  - Use code 27428 for a Ligamentous Reconstruction (augmentation) of the Knee; Intra-articular.
  - Use code 27429 for a Ligamentous Reconstruction (augmentation) of the Knee; Intra-articular and Extra-articular.

- Dislocating Patella
  When the patient has a chronically Dislocating Patella, the Reconstruction procedures for correction of that condition are in the 27420-27424 codes.
  - Use code 27420 for the Reconstruction of a Dislocating Patella; (also referred to as the Hauser procedure).
  - Use code 27422 for a Reconstruction of a Dislocating Patella when an Extensor Realignment and/or Muscle Advancement/Release are performed (also referred to as the Campbell or Goldwaite procedures).
  - Use code 27424 when the Reconstruction of a Dislocating Patella procedure is performed with a Patellectomy.

- Use code 27437 for an Open Abrasion Arthroplasty, patella; (without prosthesis) – this is the closest code to an open debridement or chondroplasty procedure.

Synovectomy Procedures

For coding Synovectomy procedures, the following applies:

1. The 29875 code for a Limited Synovectomy includes the partial resection of synovium or plica from one knee compartment. Code 29875 is considered a "Separate Procedure", thus if this Limited Synovectomy is performed in the same compartment with another procedure, it is not billable. If the procedure is performed in a separate compartment, is a separate procedure, is carried out independently, or is considered unrelated (different compartment) from the other procedure from which the 29875 code is Unbundled, it could be billed with a –59 Modifier.
2. The 29876 code for a Major Synovectomy involves removal of the synovium and plicae from 2 or more knee compartments.
3. If a multiple compartment Synovectomy is performed in the same compartment where another procedure from which the 29875 code is Unbundled, the Synovectomy would be included in the other procedure and would not be separately-billable using the 29876 code. However, if the Synovectomy was performed in another compartment and was the only procedure performed in that compartment, it would be billable with the 29875 code using the -59 Modifier.
4. The Synovectomy codes are used for the Excision of Plica and Resection of Fat Pad in the Knee procedures.

OATS Procedures

When the surgeon performs Mosiacplasty procedures, these codes are used. OATS procedures performed Arthroscopically are coded as follows:

- Use code 29866 for an Arthroscopic Osteochondral Autograft.
- Use code 29867 for an Arthroscopic Osteochondral Allograft.
- Use code 29868 for an Arthroscopic Meniscal Transplantation procedure.
- Use Unlisted Scope code 29999 or HCPCS code S2112 for an Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells) when the surgeon is harvesting the cartilage for later use in the implant/transplant procedures listed above. Use code J7330 for the Genzyme Kit used in that procedure.

Abrasion Arthroplasty (also called PICK Arthroplasty) Procedures (CPT code 29879) are usually performed to promote the regeneration of cartilage by creating access to blood and nutrients by smoothing the cartilage and/or drilling holes to create microfractures. The AAOS Guidelines state that the OP Report documentation must state that the procedure was performed "down to bleeding bone" or to the "subchondral level". The 29879 code includes a Chondroplasty (bill separately only if performed in a different compartment), Resection of Osteophytes, and Removal of Loose or Foreign Bodies, when performed in the same compartment.

Meniscus Procedures

- Meniscectomy procedures are performed for Meniscal Tears. A motorized cutter or shaver is used through the arthroscope to remove the meniscus in either the Medial OR Lateral Compartments of the Knee and is billed with code 29881.
- If a Meniscectomy procedure is performed in both the Medial AND Lateral Compartments arthroscopically, use code 29880.
- Meniscal Repairs are billed with code 29882 for an arthroscopic repair in the Medial OR Lateral Compartment. If an arthroscopic Meniscal Repair is performed in both the Medial AND Lateral Compartments, it is coded 29883.
- If an arthroscopic Meniscal Transplant procedure is performed in the Medial OR Lateral Compartment, use code 29868.
- If an Open Arthrotomy procedure is used to Excise the Meniscus in either the Medial OR Lateral Compartment, use code 27332.
- If an Open Arthrotomy procedure is used to Excise the Meniscus in both the Medial AND Lateral Compartments, use code 27333.
- An Open Meniscal (Inside Out) Repair is coded 27403.

ACL Reconstructions

Acromioclavicular Clavicular Ligament (ACL) Repair/Reconstruction procedures include the removal of synovium for the surgical approach, notchplasty, removal of the ACL stump, a partial synovectomy, resection of the fat pad, reconstruction of the intra-articular ligament, the harvesting and insertion of a tendon, fascial or bone graft with internal fixation, lysis of adhesions, and joint manipulation.

- Arthroscopic ACL Repair/Reconstruction procedures are coded 29888.

- Use code 27407 for an Open ACL Repair procedure.

- If a procedure is performed on the ACL to Drill the Ligament to enhance the healing response, bill code 29888-52 for Reduced Services.

- If the ACL is Debrided, but not Repaired, use code 29999, the Unlisted Arthroscopy code. Unlisted codes are not covered by Medicare.

- The code for a Re-do ACL Reconstruction procedure is 29888.

- Hamstring Autografts harvested from the back of the same Knee are not separately billable. Bill purchased Allografts with code L8699 or other appropriate implant code.

Arthroscopic Ankle procedures

There are two sets of Ankle Arthroscopy codes. Those performed on the Tibiotalar and Fibulotalar Joints (which is up higher on the ankle) and those performed on the Subtalar Joint, which is lower on the ankle.

The Subtalar Joint lies between the calcaneus (heel bone) and talus, which is lower down in the ankle joint than the 298XX Ankle Arthroscopy codes performed at the Tibiotalar and Fibulotalar Joints. These procedures are for intra-articular calcaneus fractures, sinus tarsi syndrome, rheumatoid arthritis and synovitis conditions.

- Codes for Arthroscopic Ankle procedures performed in the Tibiotalar and Fibulotalar Joints:
  - Use code 29894 for an Ankle Arthroscopy for the Removal of Loose or Foreign Bodies in the Tibiotalar and Fibulotalar Joints
  - Use code 29895 for an Ankle Arthroscopic Partial Synovectomy in the Tibiotalar and Fibulotalar Joints
  - Use code 29897 for an Ankle Arthroscopic Limited Debridement in the Tibiotalar and Fibulotalar Joints
  - Use code 29898 for an Ankle Arthroscopic Extensive Debridement in the Tibiotalar and Fibulotalar Joints

- Codes for Arthroscopic Ankle procedures performed in the Subtalar Joint:
  - Use code 29904 is for the Arthroscopic Removal of a Loose or Foreign Body from the subtalar joint of the ankle
  - Use code 29905 for an Arthroscopic Synovectomy of the Ankle performed in the Subtalar Joint, which removes the synovial lining of the joint
  - Use code 29906 for an Arthroscopic Ankle Debridement performed in the Subtalar Joint
  - Use code 29907 for an Arthroscopic Subtalar Arthrodesis, which is a joint Fusion, usually done with Morcellized bone grafting and internal fixation with screws in the Subtalar Joint.

Subtalar Arthroereisis Procedure

The Arthroereisis condition involves the limitation of excessive movement across a joint. Podiatrists often perform a Subtalar Arthroereisis procedure, in which they place an implant in the sinus tars (a canal located between the talus and the calcaneus) of the foot, which is designed to correct excessive talar displacement and calcaneal eversion. This procedure is usually performed for Flexible Flatfoot, which can be a Congenital condition, or it may be acquired in adulthood due to posterior tibial tendon dysfunction, which may be caused by trauma, overuse, and inflammatory disorders.

Use HCPCS code S2117 or Unlisted Foot CPT code 28899 for an open Subtalar Arthroereisis procedure, which is not covered by Medicare or BC/BS. You may want to

head this procedure off to another place of service at the time of scheduling if in doubt it will be reimbursed.

Post-Operative Knee Surgery Pain Control Injection Procedures

When a patient is to receive an Injection or has a Catheter placed during an Arthroscopic Knee surgical procedure for control of post-operative pain, there are certain requirements which must be met in order to bill the Injection/Catheterization procedure separately.

- The Injection/Catheterization procedure must be performed by a *different physician* (usually the anesthesiologist) from the surgeon who performs the Knee surgery.
- There must be a *separate* Procedure Report for the Post-Op Injection/ Catheterization procedure (it cannot be part of the surgeon's OP Report or part of the Anesthesia Record).
- The Block must not be the only anesthesia for the case.
- Codes for billing Injection/Catheterization post-operative pain procedures:
    1. 64447 code for a Femoral Nerve Block Injection
    OR
    2. 64448 for a Femoral Block with a Catheter/Pump
- Do not bill to Medicare.

Coding of Other Orthopedic Procedures

Injection Procedures in Orthopedics

Trigger Point Injections

Trigger Point Injection (TPI) CPT Codes:

- Use code 20552–Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
- Use code 20553–Injection(s); single or multiple trigger point(s), 3 or more muscle(s)
- Do not bill trigger point injection as a local anesthetic for surgery
- Medical record documentation for all tendon sheath, ligament, or trigger point injections is expected to indicate the clear and concise medical necessity should be documented. Reports should list how many or which muscles are injected – in addition to how many injections are performed.
- Since Medicare does cover these procedures, but reimburses at a low amount, we recommend performing TPIs as an Add-on Procedure only and not as the only procedure performed.

Joint Injections

- Use code 20600 for an Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes).

- Use code 20605 for an Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa).
- Use code 20610 for an Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa).

Radiology Services

Prior to 2008, Medicare did not reimburse ASC facilities for radiology services, however, under the present Medicare payment system, some radiology services are covered. Check the Medicare "Ancillary Services" ASC List for codes which are covered. Fluoroscopy is still not covered by Medicare.

Implants/Devices

While not all Implants are covered by Medicare, some Implants are separately reimbursed when billed as a separate line item with a CPT or HCPCS code. For a few procedures, the related Implants are reimbursed as part of the surgical CPT code itself (which cannot be billed separately). An example of these procedures would include Brachytherapy sources used for cancer treatments and Spinal Cord Neurostimulator devices.

Unfortunately, some Implantable devices (such as stents and mesh) are not covered under the Medicare payment system. Bill implants to payors other than Medicare, unless your facility's contract with the payor specifically prohibits it.

Commonly used codes for Orthopedic Implants include:

C1713 – Anchor/Screw
L8630 – Metacarpophalangeal Joint Implant
L8631 – Metacarpophalangeal Joint Replacement Implant
L8641 – Metatarsal Joint Implant
L8642 – Hallux Implant
L8699 or 99070 – Misc. Implants
Q4116 – Alloderm
Q4104, Q4105 & Q4108 – Integra Wound Matrix
Q4107 – Graft Jacket
J7330 – Genzyme (Autologous cultured chondrocytes)
C2634-C2699 - Brachytherapy source codes

SHOULDER/HAND ORTHOPEDICS

Diagnosis Coding in Orthopedic Conditions

Removal of Hardware procedures have different diagnosis codes, depending on the reason the hardware/implant is being removed. Use diagnosis code 996.78 for the removal of painful hardware. Use code V54.01 for the removal of hardware in the absence of symptoms.

Arthropathies

Arthropathies include disorders of the joint. Codes are 5-digits in the 716 section. They do not include injuries to the joint. These codes do not include any disorders of the spine.

Loose Bodies

For a Loose Body in the Shoulder, just code 718.11.

Bankart Lesion

Use code 831.00 (or another code in that section) for a Closed Dislocation of the Shoulder, unspecified site, for a Current Bankart Lesion. Use code 718.31 for a Recurrent Dislocation of the Shoulder Joint for a Chronic Bankart problem.

Bursitis

Use code 726.10 for Shoulder Bursitis.

Articular Cartilage Disorder

Articular Cartilage covers the bone surfaces of joints and serves as a shock absorber to enable weight-bearing by the joint. Articular cartilage is compromised/injured by trauma and the wear and tear of aging. Use code 718.01 for an Articular Cartilage Disorder of the Shoulder.

Chondromalacia

For Chondromalacia use code 733.92.

Rotator Cuff Problems

1. Impingement Syndrome, which occurs when swelling of the rotator cuff and subacromial bursa causes a narrowing of the space between the humeral head and the acromion process and ligament that lie above it. Assign ICD-9 code 726.2, for Other Affections of the Shoulder Region, not elsewhere classified.
2. **Current** Rotator Cuff Tear/Rupture - Can be coded as 840.4, if the condition is a CURRENT Traumatic Injury (appears in the 840 section, sprains and strains of the Rotator Cuff Capsule). Use code 840.5 for a Current Injury to the Subscapularis area. If that Current Injury is to the Supraspinatus Tendon, use code 840.6.

3. **Chronic** Rotator Cuff Problems - For *Complete* Nontraumatic Rotator Cuff Ruptures, which are CHRONIC in nature, use code 727.61. This code can only be used when the OP Report is detailed about the extent of the injury and at least 3 of the 4 rotator cuff tendons are involved. For a Partial Chronic Rotator Cuff Tear (involving less than 3 tendons or an unspecified number of tendons) or Chronic Rotator Cuff problem, use code 726.10 for Disorders of Bursae and Tendons in the Shoulder Area, Unspecified.
4. Tendinitis and Shoulder Bursitis can also be coded using ICD-9-CM code 726.10, for Disorders of Bursae and Tendons in the Shoulder Region, Unspecified.
5. Use code 726.0 for Adhesive Capsulitis of the Shoulder.

SLAP Lesion

Superior Glenoid Labrum Lesion (SLAP Tears or SLAP Lesions), which is a detachment injury of the superior aspect of the glenoid labrum (the ring of fibrocartilage attached to the rim of the glenoid cavity of the scapula) is coded 840.7 for a Current Injury and use code 726.2 for a Chronic SLAP problem. The 718.01 code can be used for an Articular Cartilage Disorder of the Shoulder Region.

Tennis Elbow

Tennis Elbow (also, Golfer's Elbow) is the inflammation of the tendinous origin of the muscles of the forearm. It is caused by strong, repetitive gripping motions. Assign ICD-9-CM code 726.32 for Lateral Epicondylitis of the Elbow for this condition.

Trigger Finger

Trigger Finger is an irritation of the sheath which surrounds the flexor tendons that prevents the tendons from gliding smoothly. This condition is coded 727.03 for Trigger Finger, Acquired.

Other Ortho./Neuro. Diagnoses

deQuervain's Syndrome is a condition brought on by irritation or swelling of the tendons running along the thumb side of the wrist. This condition is coded 727.04 for Radial Styloid Tenosynovitis.

Dupuytren's Contracture is a hereditary condition involving a thickening of the fascia that lies just below the skin and can pull the fingers towards the palm. This condition is coded 728.6 for Contracture of the Palmar Fascia.

Synovitis involves the inflammation of the synovial lining that keeps foreign matter out of joints and produces joint fluid for lubrication of joints such as the shoulder, hip, elbow or wrist. The usual type of Synovitis conditions found, for which orthopedic procedures are commonly performed are coded with the 727.00 Synovitis or Tenosynovitis code. If the Synovitis condition occurs in the hand or wrist area, use code 727.05.

Villonodular Synovitis conditions sometimes seen should not be confused and coded for most Synovitis conditions, as that is another condition (where there is pigmenting of the tissue and the joint lining swells, retaining fluid), which should be coded from the 719.2X section – that is only to be coded when the OP Report or Path. Report specifically states the patient has the *Villonodular* Synovitis condition.

SHOULDER/HAND ORTHOPEDIC PROCEDURES

Shoulder Procedures

Shoulder Anatomy

The shoulder is the most moveable joint in the human body, due to its unique structure of three bones, muscles, ligaments and tendons, which is why chronic shoulder problems can become a nightmare for some patients.

The three bones which make up the shoulder are the clavicle (collarbone), humeral head (upper arm bone), and the scapula (shoulder blade), which meet at the top of the shoulder joint. The scapula is an unusually-shaped bone, which extends up and around the shoulder joint in the back and over the shoulder joint, creating a "roof" at the shoulder joint (called the acromion), and around the front to the coracoid process. The clavicle forms the front of the shoulder girdle and extends from the sternum to the scapula. The humeral head is joined to the scapula in the glenohumeral joint, which is a ball-and-socket type of joint. The *ball* (the head of the humerus) fits into the part of the scapula known as the *socket* (or glenoid), which is lined with the labrum. The labrum is a ring of fibrous cartilage that makes the glenoid more "cuplike". The capsule, which is lined with synovium, encircles the glenohumeral joint. It is these muscles, tendons, and ligaments that hold the shoulder bones in place. It is a complicated structure, which can experience problems that can cause patients to have impingement, weakness and/or tingling extending down the arm, limited motion, and severe pain.

The AAOS recognizes 3 areas/regions of the Shoulder: The Glenohumeral joint, the Acromioclavicular joint, and the Subacromial Bursal Space – which are clearly separate areas.

Shoulder Manipulations

Manipulations (code 23700) should only be billed when it is the only procedure performed. If a surgical arthroscopy is performed on the same joint during the same case, the Manipulation procedure should not be billed. It is billable when the Manipulation procedure is performed in the same case with a Joint Injection (code 20610). This procedure is usually performed for Adhesive Capsulitis, for post-shoulder replacement stiffness and for "frozen shoulder" conditions.

Rotator Cuff Tears

The largest muscle of the shoulder is the deltoid muscle, which lies above the rotator cuff. The rotator cuff consists of a group of flat tendons which cover the front, back and top of the shoulder joint, like the cuff of a shirt sleeve, which, along with other muscles, holds the top of the humerus in the glenoid socket and provides mobility and strength to the shoulder joint. The rotator cuff tendons are attached to four muscles: The supraspinatous, the subscapularis, the infraspinatous, and the teres minor.

An arthroscopic repair of the rotator cuff would be coded 29827. An open repair would be coded using either 23412 for a chronic condition or 23410 for an acute condition, unless the tear is considered to be "Complete".

Reconstructive procedures for Complete Rotator Cuff Tears or Ruptures are coded 23420, which includes an acromioplasty procedure. According to the AAOS, conditions which justify the use of this code would include:

1. When the physician performs multiple or extensive releases during the procedure
2. If the physician performs mobilization during the rotator cuff release
3. When a fascial graft or synthetics are used in the repair
4. A large tear or avulsion with extensive retraction
5. All 3 major muscles/tendons of the cuff must be repaired.

Some arthroscopic repairs require a conversion to an open procedure. When this occurs, report only the code for an Open (or a "Mini-Open") procedure. Also use the V-code V64.43 for an Arthoscopic surgical procedure converted to an Open procedure (as the last diagnosis code on the claim form).

When an Arthroscopic procedure is converted to an Open procedure in the same area/for the same problem, only the Open procedure would be billed. If an Arthroscopic procedure starts out as a Diagnostic procedure only (where the surgeon is looking into the joint only, but he/she is not performing any surgical or therapeutic procedure) and the surgeon converts the Diagnostic procedure to a Surgical procedure, only the more extensive surgical procedure is billed.

Acromioclavicular Conditions

The Acromioclavicular (AC) joint is located between the acromion and the clavicle and is held together with the support of the acromioclavicular and coracoclavicular ligaments. Spurs projecting from the bones may develop around the joint, which usually causes pain and swelling, which can limit the motion of the arm.

The arthroscopic procedure (code 29826) used to repair this condition is a Subacromial Decompression with Partial Acromioplasty, with or without Coracoacromial Release. Open procedures would be coded 23130 for an Acromioplasty or Acromionectomy, Partial, with or without Coracoacromial Ligament Release <u>or</u> 23415 for a Coracoacromial Ligament Release, with or without Acromioplasty.

The AAOS considers Acromionectomy procedures to be separately-billable from Rotator Cuff Repair procedures (whether performed arthroscopically or as open procedures), except in the case of the Complete Repair procedure, since the 23420 code includes the verbiage "includes Acromionectomy" in the code descriptor. If there is a CCI Unbundling edit encountered, consider the payor's guidelines and whether or not it is allowable to bill the Acromionectomy procedure using a –59 Modifier. Do not bill 29826 or 23130 with Open Rotator Cuff Repair procedures to Medicare, due to CCI Edits.

Synovectomy Procedures

Joint Capsules, which are lined with a synovial membrane, which produces synovial fluid, encases the joint and protects the cartilage, muscle, and connective tissue. Because of the unique range of motion of the shoulder joint, there is a greater chance of capsular injury. The arthoscopic removal of synovium from the shoulder would be coded as either 29820 or 29821, depending on whether it is a partial or complete removal. The AAOS directs that the 29821 Complete Synovectomy procedure is not to be billed unless the surgeon documents removal of the entire intra-articular synovium. The open code for a shoulder synovectomy procedure would be 23105 or 23106, and is coded based on which joint is involved in the procedure - the glenohumeral or the sternoclavicular joint.

Instability of the Shoulder Joint

When a patient suffers from Instability of the shoulder joint, it can be the result of a Bankart Lesion (which is a defect at the insertion of the capsule, where it enters the rim of the glenoid) or a problem with an unstable or loose capsule. Bankart Lesions can occur in the glenoid at the posterior, inferior, or anterior/inferior (most common) areas. Bankart repairs are coded as 29806 for an arthroscopic procedure or 23455 for an open procedure.

For an arthoscopic repair to the capsule, code 29806 would be used. There are 6 codes for OPEN capsular repairs: Codes 23450, 23455, 23460, 23462, 23465, or 23466. The open shoulder codes are specific for anterior, posterior, or multi-directional instability, so read the code descriptors carefully. There is no code for an Arthroscopic Thermal Capsulorrhaphy, so two possibilities are codes S2300 or the Unlisted code 29999.

SLAP Tears

The biceps tendon, which comes from the muscle on the forearm, goes through the shoulder joint and attaches to the top of the labrum. A SLAP (Superior Labrum Anterior to Posterior) tear can occur when there is damage to the labrum, where the biceps tendon attaches. There are several different types of SLAP lesions, which can affect the type treatment performed. The AAOS directs that if Debridement is the only procedure performed to treat a SLAP I Lesion and no repair is performed, use the 29822 or 29823 Debridement codes, as appropriate. The arthroscopic code for a SLAP repair of a type II or type IV SLAP lesion is 29807. There is **no** corresponding open code. Type III SLAP lesions (called Bucket-handle tears) are coded using either the 29822 or 29823 Arthroscopic Debridement codes or the 29807 Arthroscopic Repair code, as appropriate.

Clavicle Procedures

The Clavicle (the collar bone) runs from the scapula or shoulder blade to the sternum. The arthroscopic procedure for a partial distal claviculectomy (involving removal of approximately 1 cm. of bone) is coded 29824, while the open procedure for a partial procedure would be coded as 23120. The open code for a total claviculectomy procedure would be 23125. Claviculectomy procedures may be referred to as the Mumford procedure. The AAOS guidelines direct that the surgeon should document that at least 1 cm. of the distal clavicle was removed. If only bone spurs are removed from the clavicle area, it is not separately billable.

Shoulder Debridements

There are two codes for the arthroscopic Debridement of the Shoulder. Code 29822 would be used for Limited Debridement and code 29823 would be used for Extensive Debridement. Read the OP report carefully to ascertain how extensive the procedure was, to know which code to select. The AAOS directs that the 29822 code is used for Limited Labral Debridements, Limited Rotator Cuff Debridements, or the Removal of Degenerative Cartilage and Osteophytes. The 29823 Extensive Arthroscopic Debridement code is only justified when the physician performs Debridements in both the front *and* back areas of the shoulder. The 29823 code includes a Chondroplasty of the Humeral Head or Glenoid and Osteophytes or the Debridement of multiple structures including the Labrum, Subscapularis and Supraspinatus areas.

Post-Operative Shoulder Surgery Pain Control Injection Procedures

When a patient is to receive an Injection or has a Catheter placed during an Arthroscopic Shoulder surgical procedure for control of post-operative pain, there are certain requirements which must be met in order to bill the Injection/Catheterization procedure separately.

- The Injection/Catheterization procedure must be performed by a *different physician* (usually the anesthesiologist) from the surgeon who performs the Shoulder surgery.
- There must be a *separate* Procedure Report for the Post-Op Injection/ Catheterization procedure (it cannot be part of the surgeon's OP Report or part of the Anesthesia Record).
- The Block must not be the only anesthesia for the case.
- Codes for billing Injection/Catheterization post-operative pain procedures:
  1. 64415 – Brachial Plexus Block (also use this code for an Interscalene Block) for a Single Injection
     OR
  2. 64416 – Brachial Plexus Infusion by Catheter

    - Do not bill to Medicare.

Tenodesis Procedures

Tenodesis procedures are performed on the long tendon of the biceps, which can become frayed or rupture from Impingement and other degenerative conditions of the shoulder. Tenodesis involves suturing the end of a tendon to a bone and/or shaving the frayed portion of the tendon for repair.

- Use code 23430 for an Open Tenodesis of the long tendon of the Biceps.
- Use code 29828 for an Arthroscopic Shoulder Biceps Tenodesis procedure. Use the 29828 code for Biceps Tendon Repairs of tears, tendinosis, and subluxation conditions.

- **Lipoma Removals**

  Lipomas are benign fatty tumors in the subcutaneous or deeper tissues. They can be of varying depth into the tissues, which is what dictates how you code their removal.

  While there are diagnosis codes for Lipomas (214.X section), there are no specific CPT procedure codes for Lipoma Excisions. Lipomas can be as superficial as the subcutaneous tissue or extend deep into the intramuscular tissues. Therefore, it is very important to code these accurately – using the appropriate code from the 10000-section (11400-11446), if the Lipoma is located just under the skin. Code from the 20000-section codes if the lipoma is removed from a deep subcutaneous, subfascial or deep intramuscular tissue area, as long as a layered closure was performed.

- **Hardware Removals**

  Use code 20680 for **Deep** Pin Removal procedures, which are usually done in an ASC. To define, the physician makes an incision overlying the site of the implant. Deep dissection is carried down to visualize the implant, which is usually below the muscle level and within bone. The physician uses instruments to remove the implant from the bone. The incision is repaired in multiple layers using sutures, staples, etc.

  CPT Assistant and the AAOS (American Academy of Orthopedic Surgeons) direct that the 20680 code is to be billed once per operative or fracture site, rather than based on the number of incisions made to remove the hardware from one fracture site or original area of injury. Billing the 20680 code more than once is only appropriate when hardware removal is performed in a different anatomical site unrelated to the first fracture site or area of injury.

- **Platelet Rich Plasma**

  Orthopedic surgeons (as well as those for some other specialties) use Platelet Rich Plasma in some procedures to aid in post-operative healing. In 2011, CPT issued a new code for billing of this procedure. Use code 0232T for the Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed, which is covered by Medicare at a low reimbursement.

GASTROENTEROLOGY

Diagnosis Coding for GI Conditions

- Blood in Stool, Hematochezia, Melena or Rectal Bleeding – Code 569.3
- Change in Bowel Habits – Code 787.99
- Diarrhea – Code 787.91
- Constipation – Code 564.00
- Stricture/Stenosis of Esophagus or Esophageal Ring (Schatzki's Ring) – Code 530.3
- Esophageal Varices – with Bleed – Code 456.0 / w/o Bleeding – Code 456.1
- Barrett's Esophagus – Code 530.85
- Gastritis – Code 535.50
- Reflux Esophagitis/GERD – Code 530.11
- Hiatal Hernia – Code 553.3
- Nausea – Code 787.02 / Vomiting – Code 787.03 / Nausea & Vomiting – Code 787.01
- Weight Loss (Abnormal) – Code 783.21
- Diverticulosis – Code 562.10 / Diverticulitis – Code 562.11
- Colon Polyp – Code 211.3 / Rectal Polyp – Code 211.4 / Stomach Polyp – Code 211.1
- Anal/Rectal Polyp – Code 569.0
- Anemia – Codes 281.9 or 280.9
- Anal or Rectal Pain – Code 569.42
- Dysphagia – Code 787.20
- Dyspepsia – Code 536.8
- Heartburn – Code 787.1
- Gas/Flatulence – Code 787.3
- H. pylori – Code 041.86
- Arteriovenous Malformation (AVM) – Code 569.84 w/o Bleed / Code 569.85 w/Bleeding
- Gastroparesis – Code 536.3
- Morbid Obesity – Use code 278.0
- Abnormal GI Exam/X-ray – Code 793.4
- Gastrostomy Complications – Use code 536.40
- Anal/Rectal Pain – Use code 569.42
- Hemorrhoids – Use codes from section 455
- Gallbladder Problems – Use codes from sections 574-575
- Attention to Gastrostomy – Use code V55.1
- Attention to Ileostomy – Use code V55.2
- Attention to Colostomy – Use code V55.3
- Mechanical Complication of a Device or Implant – Use code 996.59
- Digestive System Complications – Use code 997.4

- Personal History of Lower Digestive System Cancer – Codes V10.05 for Colon and V10.06 for Rectum
- Family History of Gastrointestinal Cancer – Code V16.0
- Personal History of Colon Polyps – Code V12.72
- Family History of Colon Polyps – Code V18.51
- Screening Colonoscopy – Use code V76.51
- Intestinal Bypass Status/Colon Resection – Code V45.3
- Bariatric Surgery Status – Code V45.86
- Suspected Lesions – Use code V71.1 for Observation of Suspected Malignant Neoplasms

GI PROCEDURES

- The key to accurately coding endoscopic procedures depends on knowing exactly what the surgeon did and the final destination of the scope.
- A "Separate Site", for definition purposes, can be a separation between lesions of 1 centimeter.
- A Surgical Endoscopy always includes a Diagnostic Endoscopy. The Diagnostic Endoscopy is billed only when a surgical procedure was **not** performed.
- An Esophagoscopy is a study of the esophagus **only.** Use the EGD codes when the endoscope crosses the pyloric channel and the Esophagogastroscopy codes when the endoscope passes the diaphragm.
- A Colonoscopy examines the entire colon from rectum to splenic flexure and may include the terminal ileum.
- A Proctosigmoidoscopy examines the rectum and sigmoid colon.
- Sigmoidoscopy examines the entire rectum and sigmoid colon and may include some of the descending colon.
- If a single lesion (or multiple biopsies from the same or different lesion) is biopsied but not excised, use the biopsy code (report this code once regardless of the number of biopsies). If a lesion is biopsied and then excised, code only for the excision. You can bill both the excision and biopsy codes if the biopsy is taken from a different lesion than excised and the excision code does not include "with or without biopsy". If the code for the excision uses this verbiage, do not code separately for the biopsy. The –59 modifier needs to be appended to the second code billed, if you are billing for the biopsy and excision. If both a biopsy and a polypectomy are taken from separate lesions by Cold Biopsy Forceps, use the 45380 code once for all of the procedures performed using this method.

Esophagogastroduodenoscopy (EGD) Procedures

An EGD is a common endoscopic procedure performed for upper GI symptoms, diagnoses, suspected and proven lesions of the upper gastrointestinal tract – EGDs are NOT performed for "screening" purposes, like Colonoscopy procedures can be. Medical necessity must be proven for Medicare patients. There is a Medicare LCD which has many rules for coverage of these procedures.

- The 43238 code is for an Upper Gastrointestinal Endoscopy including the esophagus, stomach, and either the duodenum and/or jejunum, as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) of the esophagus (includes endoscopic ultrasound examination limited to the esophagus).
- Two Upper Gastrointestinal Endoscopy procedures such as code 43239 for Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple and code 43245 for

Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum, as appropriate; with dilation of gastric outlet for obstruction (e.g., balloon, guidewire, bougie) performed at the same setting would both be billable using the –59 modifier appended to the procedure with a lower billing weight.

- If an EGD is done with a CLO/H. Pylori test, since the test typically involves obtaining a tissue biopsy through the endoscope, the Biopsy code should be used. Use CPT code 43239 to code the EGD procedure (includes a biopsy, which would describe the CLO/H. Pylori test situation). If the test is positive, the diagnosis code 041.86 for Helicobacter pylori (H. pylori) infection should be also used.
- If an EGD is performed with a biopsy, and then the physician removes the scope and performs an Esophageal Dilation by unguided sound, it should be billed using two CPT codes – CPT code 43239 for the scope with biopsy and code 43450 for the Esophageal Dilation (Maloney).
- Use CPT code 43248 if the patient has an EGD procedure with a flexible-tipped guidewire passed through the endoscope, the endoscope is withdrawn and the guidewire is left in place for dilators to be passed over the guidewire to dilate the Esophagus. If the guidewire is passed under fluoroscopic guidance for esophageal dilation, without the use of an endoscope, use CPT code 43453.
- The control of bleeding is included in biopsy (and most other) endoscopic procedures, and is not separately-billable. Control of bleeding can be obtained through means of injections, as well as cauterizations. Injections of Epinephrine through an endoscope are coded as 43255. This injection would be included in the ASC facility fee, and would not be reimbursed separately from the EGD procedure, unless the EGD case is completed and the patient is in the PACU and has a bleed, necessitating a return to the OR to treat the hemorrhage.
- The most common EGD code is 43239 for an EGD with a Biopsy.

Upper GI Dilations

Dilation procedures must sometimes be performed for those patients whose esophagus becomes closed because they suffer from such problems as esophageal varices, achalasia, reflux esophagitis (GERD), problems after radiation therapy for esophageal cancer, scarring from drinking of poisons, certain medications that can cause ulcerations, and esophageal “webs”. Some dilation procedures are done with endoscopy – coded from the appropriate Endoscopy codes, and some are not (when they are not, they are called Manipulations – codes 43450-43458). Bougies are flexible dilators, which have different sizes increasing in thickness.

Bougie Dilations – If an EGD is performed prior to a bougie dilation (where the physician removes the endoscope), the endoscopy would also be coded as 43235. For the dilation, use code 43450 for a Dilation of the Esophagus by unguided sound or bougie, single or multiple passes, or code 43453 for a Dilation of the Esophagus over a Guidewire. For Dilation procedures performed with a Balloon, use codes 43456, 43458 or 43460, as appropriate.

- Pustow Dilator – this dilator is used with a guidewire and is coded as 43453.
- Bougie Dilations - dilations with bougies are coded as 43450. If an Endoscopy is performed prior to the bougie dilation, the Endoscopy would also be coded as 43235.
- Dilations using a Guidewire are usually coded as 43248.
- Balloon Dilators – usually inserted by Endoscopy, which would be coded as 43249.
- Dilation of the Esophagus for Achalasia with a Balloon is coded 43458.
- For an Upper Gastrointestinal Endoscopy of the esophagus, stomach, and either the duodenum and/or jejunum, as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), which includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum, use code 43242.
- For an Upper Gastrointestinal Endoscopy of the esophagus, stomach, and either the duodenum and/or jejunum, as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum, use code 43259.

PEG Tubes

- Percutaneous Endoscopic Gastrostomy (PEG) Tubes or J-Tubes (which can also be referred to as "buttons") codes are as follows:

  - Placement procedures:
    Code 43246 - Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube.
    Code 49440 - Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s).
    Code 49441 - Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s).

  - Change/Adjustment of Tube procedures:
    Code 43760 - Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance.
    Code 43761 - Repositioning of the gastric feeding tube, through the duodenum for enteric nutrition.

  - Replacement procedures:
    Code 49450 - Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s).
    Code 43760 - Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance.

- Mechanical Removal of Tube Obstructions:
  Code 49460 - Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed.

- Tube Removal:
  Code 43870 - Closure of gastrostomy, surgical – there MUST be stitches placed, with a surgical closure to use this code.
  If NO stitches are placed and the tube is just pulled and steri-strips are put over the gastrostomy opening, use the 49999 Unlisted GI code.

- For the endoscopic treatment/removal of a Foreign Body in the Tube, use code 43247 for an Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body.

Colonoscopy Procedures

- A Colonoscopy is a visual examination of the lining of the large intestine with a flexible fiberoptic endoscope. The Colonoscope is inserted anally and is advanced through the large intestine under direct vision, using the scope's optical system. To qualify as a Colonoscopy procedure, the scope must move beyond the splenic flexure of the colon.

There is likely a Local Carrier Determination (LCD) Policy detailing the full coverage policy (including CPT codes and **billable ICD-9 diagnosis codes**) on this procedure for your state. If your claim is billed to Medicare with any diagnosis codes not on the LCD list, your claim is likely to be denied. If you cannot locate a covered diagnosis in the procedure report, review the H & P for a covered symptom. The patient must be notified of their financial responsibility PRIOR to services being rendered.

- **Documentation of Colonoscopy Procedures**

  1. If the physician attempts – but fails – to remove a polyp by one technique, however, he/she is successful at removing the polyp via another technique only bill the CPT code for the procedure that was successful.
  2. If the physician removes two polyps from separate sites using the same technique (Snare removal, in this case), the CPT code 45385 may be billed only once, as the coding descriptor specifically states Removal of Tumor(s), Lesions(s), or Polyp(s). Close attention needs to be paid to the wording in the scope codes, as other Colonoscopy codes are worded in this same manner, and this will have a definite effect on coding of these procedures.

Medicare's special coding guidelines for Colonoscopy procedures:

- Use CPT code 45378 for a Diagnostic Colonoscopy. There will be a symptom prompting the test and this is not a screening procedure for Medicare. However, you may use this code for screening procedures billed to payors other than Medicare.
- CPT code G0105 is to be used for a Colonoscopy done for Cancer Screening on an Individual at High Risk. These procedures are covered every 24 months for Medicare patients.
    - *High risk* is defined as a personal history of any of the following:
        1. Colorectal cancer;
        2. Personal history of adenomatous polyps;
        3. Some Inflammatory Bowel disorders, such as Crohns Disease or Ulcerative Colitis;
        4. The patient has a close relative (sibling, parent or child) who has had colorectal cancer or an adenomatous polyposis;
        5. Family History of Colon Polyps - the patient has a family history of familiar adenomatous polyposis; or
        6. The patient has a family history of nonpolyposis colorectal cancer.
- The G0121 procedure code is to be used for a Screening Colonoscopy done on an Individual not meeting the criteria for High Risk. Colonoscopies for Medicare patients of average risk (not at high risk) are covered by Medicare once every 10 years.
- Do not use G-codes for non-Medicare patients, unless the payor requires their use.
- If, during the course of a Screening Colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, it should be billed with a Biopsy or Polypectomy code pertaining to what was performed, instead of as a Screening procedure. Use –PT Modifier for Medicare and bill V76.51 as the first diagnosis.
- If the physician intends to perform a Diagnostic Colonoscopy (CPT code 45378), but he/she cannot complete the procedure (due to medical complications), the 45378 code should be billed, appending the –74 Modifier for Terminated Procedure. Some payors prefer the use of the -52 Reduced Services Modifier, instead of the -74 for a Terminated procedure.
- To qualify for billing a Colonoscopy code, the scope must move beyond the Splenic Flexure of the Colon. If the scope is not able to move that far, and is only used to examine as far as the Sigmoid Colon and a portion of the Descending Colon, it should be coded as 45378 with a –52 Modifier.
- If the patient has a particularly long GI tract, and the physician runs out of scope before viewing the entire colon, (for example, the scope goes past the Splenic Flexure, but does not extend all the way to the Cecum) – these procedures should have a –52 Modifier appended for billing purposes.
- Failed Colonoscopies are also referred to as "incomplete". This occurs when the scope is not able to be advanced past the splenic flexure. Causes of this problem include incomplete preps, unusual patient anatomy, the patient has an obstructing lesion, or the provider performing the procedure is inexperienced. These

procedures are coded as 45378-74, with the – 74 Modifier indicating a Discontinued Procedure. Some payors might prefer the use of the -52 Modifier, instead of the -74 Modifier.

- ***The latest Medicare guidance for the situation where a Colonoscopy is scheduled as a Screening Colonoscopy, but a Polyp is Removed and/or a Biopsy is taken is to not bill the G-code for a Screening study, but bill the appropriate CPT codes for the procedure(s) performed (45385, etc.) and on the claim listing of the diagnoses in field 21, list the Screening V-code first, followed by the 211.3 Polyp or other diagnosis code. When linking the diagnosis to the procedure in field 24E, only link the 211.3 Polyp code with the 45385 or other Colonoscopy code and do NOT link the Screening V-code in field 24E to any procedure code. You also need to append the –PT Modifier to all of the CPT codes billed to indicate the case was scheduled as a Screening Study.

Colonoscopy Techniques

1. Diagnostic Colonoscopy procedures without a biopsy or removal of a polyp are coded 45378. This is also the code to use for a Screening Colonoscopy for payors other than Medicare (with whom you would use the appropriate G-code). Use this code for Medicare patients <u>with</u> symptoms for studies not being done as screening tests. This code is designated as a "Separate Procedure" in the CPT book.
2. Decompression – Code 45378. Decompression procedures are performed by the GI physician to relieve pressure in the colon. They are considered to be a standard component of colonoscopies, and are not separately-billable when other procedures (such as a polypectomy) are being performed.
3. Biopsies – Code 45380. Use this code for the removal of a portion of a polyp or an entire polyp by cold biopsy forceps, in which disposable forceps is used. This is referred to as "cold", since no electric current is running to the instrument and no cauterization of bleeding takes place during the removal of the tissue. Tissue samples (biopsies) are taken.
4. Submucosal Injection – Code 45381. For Submucosal Injections of Saline, India Ink, Botox, or Steroids, or for the Tattooing of Lesions.
5. Control of Bleeding – Code 45382. The only time the control of bleeding is separately-billable (it is included in the procedure most of the time), is when the bleeding occurs at a different site and was not caused by the actions of the physician performing the procedure.
6. Ablation Technique – Code 45383. A polyp is removed using the APC, laser, heat probe, or other device to cauterize it or the remnants of a polyp previously removed during a colonoscopy procedure. This is the code for use if the surgeon states in the procedure report that polyps were Fulgurated.
7. Hot Biopsy Technique – Code 45384. A polyp is removed during a colonoscopy where the polyp is snipped off and cauterized at the same time. Bipolar cautery may be billed using this same code.
8. Snare Technique – Code 45385. A polyp is removed during a colonoscopy where a wire loop (which heats up) is used to shave off the polyp. It is the most

common method of removal, especially with larger lesions. This procedure may also be referred to as “hot snare” or “cold snare” technique. Monopolar and bipolar snares can be used.

9. If the Snare instrument is used to fulgurate a flat polyp, which is NOT removed but destroyed, use code 45383 instead of 45385.

Colonoscopy procedures performed through Stomas (Ileostomy and Colostomy patients) are coded from a different section, as follows:

- Code 44388 for Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- Code 44389 for Colonoscopy through stoma; with biopsy, single or multiple
- Code 44390 for Colonoscopy through stoma; with removal of foreign body
- Code 44391 for Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
- Code 44392 for Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- Code 44393 for Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
- Code 44394 for Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- Code 44397 for Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)
- If a Colonoscopy is also performed through the Rectum during the same case as a stoma scope, the regular Colonoscopy code for that procedure should also be billed.

OPHTHALMOLOGY

Diagnosis Coding in Ophthalmology Conditions

- Strabismus – Use codes from the 378.XX section
- Esotropia (Convergent concomitant Strabismus) – Use codes from the 378.0X or 378.2X sections
- Exotropia (Divergent concomitant Strabismus) – Use codes from the 378.1X section
- Diplopia (Double Vision) – Use code 368.2
- Cataracts – it is important to code Cataract conditions based on the medical record documentation, and not code all Cataract diagnoses the same. Some potential codes to use include the following:
    - Unspecified Nonsenile Cataract – Code 366.00
    - Nuclear Cataract/Nonsenile Cataract – Code 366.04
    - Unspecified Senile Cataract – Code 366.10
    - Nuclear Sclerosis – Code 366.16
    - Total or Mature Senile Cataract – Code 366.17
    - Other Cataract – Code 366.8
    - Unspecified Cataract – Code 366.9 (Most commonly used)

  When billing the 66982 ("Difficult" Cataract) CPT procedure code, also code the underlying condition causing the use of this code, such as Glaucoma, Small Pupils (code 379.40), Uveitis (code 360.11), etc., in addition to the Cataract code.

- Cataract Fragments left in the Eye after a Cataract Extraction – Code 998.82
- Mechanical complication due to ocular lens prosthesis – Code 996.53
- Subluxation of Lens – Code 379.32
- Posterior dislocation of Lens – Code 379.34
- Anterior dislocation of Lens – Code 379.33
- Floppy Iris – Code 364.81
- Miotic Pupil – Code 379.42
- Small Pupils – Code 364.75
- Glaucoma (involves an elevated intraocular pressure [IOP], which restricts bloodflow) – Use codes from the 365.XX section. When you see the word "Gonio-" in the medical record, it means an Open Angle Glaucoma, where the trabecular meshwork is blocked or not working correctly. Angle-Closure Glaucoma involves misplacement of the iris where it blocks the anterior chamber and the aqueous cannot drain properly.
- Eyelid Ptosis (drooping of the eyelid) – Code 374.30 for an Unspecified condition
- Mechanical Ptosis – Code 374.33
- Blepharochalasis (loss of elasticity of the eyelid skin with recurrent edema and tissue atrophy) – Code 374.34
- Dermatochalasis (connective tissue disorder causing loss of elasticity in the skin of the eyelid [associated with aging]) – Code 374.87
- Visual Field Defect – use Code 368.40

- Acute Dacryocystitis (inflammation of the lacrimal passages) – Code 375.32
- Chronic Dacryocystitis – Code 375.42
- Disorder of the Lacrimal System – Code 375.89
- Stenosis of the Nasolacrimal Duct (Acquired) – Code 375.56
- Ectropions (turning outward [eversion] of the eyelid edge, exposing the conjunctiva and causing dryness and irritation) – Use codes from the 374.1X section
- Entropions (turning inward of the eyelid edge toward the eyeball) – Use codes from the 374.0X section
- Trichiasis without Entropion (ingrowing eyelashes, which irritate the eye and can cause a distortion of sight) – Code 374.05
- Other Disorders of the Eyelid – Code 374.89
- Other Plastic Surgery for Unacceptable Cosmetic Appearance – Code V50.1
- Fitting and Adjustment of an Artificial Eye – Code V52.2

OPHTHALMOLOGY PROCEDURES

Eyelid Lesions

On Lid Lesion procedures, don't leave money on the table by first turning to the 114XX Lesion Excision codes. Use code 67840 for the Excision of a lesion of the eyelid (except chalazion) without closure or with simple direct closure, if the code fits what was documented – it reimburses at a higher rate than the Skin codes (11440-11443). For larger lesion excisions, code 67961 for the Excision and repair of the eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to 1/4 of lid margin may be used - particularly if a reconstructive procedure is performed. For just a Biopsy of the Eyelid procedure, use code 67810.

It is very important with eye surgery claims to append the appropriate –LT or –RT Modifiers to codes for all eye procedures performed unilaterally. If a claim is submitted with no modifier, and the patient has an identical procedure on the other eye later, the subsequent claim is likely to be denied by the payor as a Duplicate.

Cataract Extractions

There are more Cataract procedures performed each year in the U.S. than any other procedure. It is the highest volume procedure performed in ASCs.

To define, a Cataract is an opacity (or cloudiness) of the lens of the eye, the lens capsule, or both. A Capsulotomy is a surgical incision into the lens capsule. Phacoemulsification is a disintegration (or breaking up) of the cataract, followed by its aspiration and removal. Most Cataract procedures done currently utilize the Extracapsular technique. Extracapsular Cataract surgery may be performed by aspiration and expression or by phacofragmentation techniques. The phacoemulsification or phacofragmentation method uses a cutting instrument to chop the lens into fragments, or an ultrasonic instrument (called phacoemulsification) to shatter the lens into fragments using sound energy. The cataract is then removed in a piecemeal manner, usually leaving the posterior capsule behind. The surgical technique or approach guides the selection of the appropriate CPT code for billing Extracapsular Cataract surgery when no IOL lens implant is used. If no lens is implanted following the phacoemulsification in an extracapsular procedure, the correct code for use is 66850. For an Extracapsular Cataract surgery where an intraocular lens (IOL) is implanted (the most billed procedure), the 66984 code is used.

Many Medicare Carriers have Local Carrier Determination policies (LCDs) for Cataract and YAG Laser After-Cataract procedures. If your state has one, review it carefully for the documentation requirements and billing instructions required for billing these procedures.

Cataract procedures usually include the following procedures, which are not separately-reportable:

1. Lateral Canthotomy
2. Iridectomy
3. Iridotomy
4. Anterior Capsulotomy
5. Posterior Capsulotomy
6. Use of Viscoelastic Agents
7. Enzymatic Zonulysis
8. Use of other pharmacologic agents
9. Subconjunctival or Sub-Tenon Injections

Be Sure You are Billing IOLs for Cataract Cases Correctly

When your ASC facility has a Medicare patient who requests a Presbyopia-Correcting (PC) or Astigmatism-Correcting (AC) IOL lens (instead of a regular/standard IOL), there are special guidelines that must be followed to stay in compliance with Medicare guidelines. It is critical that these guidelines are followed. This can be an important compliance problem if not handled correctly at your facility.

Billing Correctly
Medicare reimburses $150.00 for IOL Cataract procedures, which is included in the payment of the usual 66984, 66982, etc. cataract extraction procedure codes. You need to indicate on the claim form that an Astigmatism-Correcting Lens (AC IOL) or a Presbyopia-Correcting Lens (PC IOL) was used in the case. Bill these special IOLs using the V2788 code for the PC IOL (Crystalens, ReSTOR® and ReZoom®) or code V2788 for AC IOLs (Toric Lenses). AcrySof ReSTOR® lens model numbers are SN6AD1 and SN6AD3. AMO ReZoom lens models are Tecnis ZMB00, ZM900 and ZMA00. Crystalens® models are AT-50AO and AT-52AO. Toric Lenses by Alcon are models SN6ATT, SN6AT3, SN6AT4 and SN6AT5. It is advisable to append the –GZ Non-Covered Modifier and/or the -GA Modifier to the V-code to indicate you have had the patient sign an Advanced Beneficiary Notice (ABN form or waiver). While it is not mandatory to have the patient sign an ABN, since the PC IOLs are *never* covered by Medicare, but it is a good idea, so that there will be no misunderstandings with patients as to his/her owing portion.

Compliance Issues
The compliance issues which can come up with these types of cases are outlined as follows:

1. When the surgeon wants to purchase an AC or PC IOL for the case and bring it into the ASC for the case, it is a compliance issue. Why? Because Medicare does not allow the ASC to bill for cataract extraction procedures with placement of an IOL with the -52 Reduced Services Modifier or use any other billing method to convey to Medicare that the ASC did not supply the IOL and should not be

reimbursed for the IOL supply. Since there is no provision to allow the ASC to break out the implant portion of the procedure from the cataract extraction, **Medicare requires the ASC facility to supply (purchase) the IOL for these and ALL cataract cases - always.** Medicare considers it to be a False Claim for the ASC to submit a cataract extraction claim for which they are receiving payment for the IOL when the ASC is not supplying the IOL.

2. Medicare does not allow the ASC facility to reimburse the physician for the IOL if the IOL was supplied by the physician in these cases. The IOL must be purchased and supplied by the ASC facility for these and all cataract cases billed to Medicare.

3. What you charge patients for the use of AC and PC IOLs can be another compliance issue, as Medicare directs what you can charge patients for these IOLs. Overcharging patients for these lenses can be a compliance issue. Medicare allows you only a modest mark-up ($25-$50) on the IOL cost for handling on AC and PC IOLs.

   Following is an example of how to correctly charge a Medicare patient on an AC or PC IOL case:

$1,100.00	Lens Cost
- $150.00	Medicare reimbursement for regular IOL
$950.00	
+ $50.00	ASC's cost for handling of lens
$1,000.00	Final suggested Maximum amount ASC can charge patient

"Difficult" Cataracts

Use CPT code 66982 to bill "Difficult" Cataract procedures. This Complex Cataract Extraction procedure requires the use of devices or techniques not used in routine Cataract surgery, such as:

- Iris Expansion Devices
- Pupil Stretcher
- Use of a Capsular Ring
- Lysis of Adhesions with a spatula
- Use of Dye in the procedure for staining the anterior capsule for an anterior capsulotomy
- Suture Support for the IOL / suturing of IOL Haptics
- Insertion of two IOLs at the same time **OR**
- Primary Posterior Capsulorrhexis

The patient population who will more likely have "Difficult" Cataracts usually includes the following:

Pediatric patients (under age 8)

Performed on patients in the Amblyogenic Developmental Stage

Patients with weakened or absent lens support structures, usually resulting from:

- Glaucoma (code section 365)
- Small pupils or other Pupil Abnormality (diagnosis code 379.40 or 364.75)
- Floppy Iris (diagnosis code 364.81)
- Subluxated lens
- Pseudoexfoliation
- Trauma
- Marfan Syndrome
- Uveitis
- Male patients taking Flomax

Special coding provisions **when using the 66982 code require that you usually use the code for surgical problems the physician identified *prior to the surgery*.** The code cannot be used for difficulty with a normal cataract procedure or obstacles that come up (unexpectedly) *during* the normal cataract surgical procedure. Bill Cataract code 1st then the appropriate diagnosis code (i.e., Glaucoma, etc.) for the reason the surgery fell into the "difficult" category as the second diagnosis code on the claim.

- When a patient has to have a subsequent procedure performed to remove cataract fragments left in the eye after a Cataract Extraction procedure, use code 66840 for the Removal of lens material; aspiration technique, 1 or more stages with diagnosis code 998.82.

- If a patient has previously had cataract surgery and had an IOL placed at that time, which must be removed and exchanged for a different IOL, use code 66986 for the Exchange of an Intraocular Lens. The usual codes to use for diagnoses in this situation would be 996.53 for a Mechanical Complication due to ocular lens prosthesis and/or 379.34 for the Posterior Dislocation of the IOL lens.

YAG Laser Procedures

YAG Laser Capsulotomy procedures (CPT code 66821) are performed to treat posterior capsule opacification (cloudiness), usually occurring after cataract surgery. This procedure can also assist in the diagnosis and treatment of retinal detachments, macular disease, diabetic retinopathy, posterior pole tumors, and to evaluate the optic nerve head. The Medicare Carrier in your state is likely to have a Local Carrier Determination policy (LCD) for this procedure, which must be followed, if one exists. The usual diagnosis code to use for billing this procedure is 366.53 for After-cataract, Obscuring Vision.

Vitrectomy Procedures

A Vitrectomy is a microsurgical procedure for removing an opacity (usually old blood and protein) from the vitreous cavity of the eye.

- If a Vitrectomy procedure (CPT codes 67005, 67010, or 67036) is performed at the same time as a Cataract Extraction for a vitreous loss incident, it is separately-billable.

Complicated Vitrectomy Procedures Performed with Other Procedures for Diabetic Retinopathy, Macular Holes, Retinal Detachment, Vitreous Hemorrhage, etc.

- Use code 67039 for a Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation, which is a less extensive procedure for smaller defects.
- Use code 67040 for a Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation, which is a more extensive procedure for larger defects.
- Use code 67041 for a Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker). In this procedure, the surgeon removes a cellular membrane from the anterior surface of the macula, which is the center of the retina. Epiretinal Membranes and Macular Pucker are the same thing and might be some verbiage you would see in the OP Reports for this procedure being performed.
- Use code 67042 for a Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina, which includes (if performed) intraocular tamponade (ie, air, gas or silicone oil). This procedure would usually be performed for patients with macular holes or diabetic macular edema.
- Use code 67043 for a Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation. This is a commonly performed procedure and is relatively complex compared to the other procedures. This procedure would usually be performed for patients with proliferative vitreoretinopathy, diabetic traction, retinal detachments, retinal tears.

Retina Procedures

- Use code 67101 for a Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid.
- Use code 67105 for a Repair of retinal detachment, one or more sessions; photocoagulation, with or without drainage of subretinal fluid.
- Use code 67107 for a Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation, and drainage of subretinal fluid. This is the most common procedure.

- Use code 67108 for a Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique.
- Use code 67110 for a Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy).
- Use code 67112 for a Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques.
- Use code 67113 for a Repair of complex retinal detachment with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens. This procedure is usually done for patients with proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of premature babies, and retinal tears of greater than 90 degrees.
- Use code 67115 for a Release of encircling material in the posterior segment. This procedure is performed to release tension in a previously placed scleral buckle by adjusting the buckle.
- Use code 67120 for the Removal of implanted material, posterior segment; extraocular to Remove a Scleral Buckle.
- Use code 67121 for the Removal of implanted material, posterior segment; intraocular.
- Use code 65265 for the Removal of a Foreign Body, intraocular; from posterior segment, nonmagnetic extraction for the Removal of Silicone Oil placed in a retina procedure.

Miscellaneous Eye Procedures

1. **Ocular Surface Reconstruction Procedures**

    - Use CPT code 65780 for Ocular Surface Reconstruction using Amniotic Membrane Transplantation. In this procedure, the physician debrides diseased epithelium and stroma and then places and sutures down amniotic membrane in 1 or more layers. HCPCS code V2790 for the Amniotic Membrane used in the procedure.
    - Use code 65781 for Ocular Surface Reconstruction done using a Limbal Stem Cell Allograft (eg, cadaveric or living donor).
    - Use code 65782 for Ocular Surface Reconstruction using a Limbal Conjunctival Autograft (includes obtaining graft).

- **Amniotic Membrane Codes**
  CPT recently added two new codes for the use of Amniotic Membranes in wound healing (below). ASCs can use HCPCS code V2790 for the Amniotic Membrane for the purchase of the implant.

  Code 65778 is for the Placement of amniotic membrane on the ocular surface for wound healing; self-retaining.

  Code 65779 is for the Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured.

2. **Procedures to Treat Glaucoma**
   Trabeculectomy procedures are often used to treat Glaucoma conditions. These procedures reduce intraocular pressure of the fluid in the Anterior Segment of the eye by creating a new opening between the anterior chamber and the external eye (between the sclera and conjunctiva).

- Use CPT code 66170 for Fistulization of the Sclera for Glaucoma done as a Trabeculectomy Ab Externo procedure in those patients who have not had previous surgery.
- Use CPT code 66172 for Fistulization of the Sclera for Glaucoma done as a Trabeculectomy Ab Externo in those patients who have had previous surgery or trauma and are experiencing problems with scarring. This code also includes injection of antifibrotic agents.
- Use CPT code 66174 for Transluminal dilation of aqueous outflow canal; without retention of device or stent.
- Use code 66175 for Transluminal dilation of aqueous outflow canal; with retention of device or stent. This procedure is also called a Canaloplasty / Tensioning of Schlemm's Canal.
- Trabeculotomy ab externo – Use CPT code 65850 for this procedure, which involves an incision into the trabecula. The Ophthalmologist cuts from the outside of the eye inward to reach the Schlemm's Canal, the trabecular meshwork, and the anterior chamber of the eye to increase drainage of aqueous in a Glaucoma patient's eye.
- Use code 66180 for the Insertion of a Molteno Shunt procedure. Use HCPCS code L8612 for the Aqueous Shunt supply. The ICD-9 Procedure Code for this procedure is 12.79.
- Category III code 0192T for the Insertion of Anterior Segment Aqueous Drainage Device without Extraocular Reservoir, performed via an External Approach. The ICD-9 Procedure Code for this procedure is 12.79. Use HCPCS code L8612 for the Aqueous Shunt supply. There is likely to be a Medicare LCD policy with limited diagnosis codes approved for this procedure.

3. **Procedures to Repair Strabismus**

Strabismus is a condition caused by an imbalance in the muscles of the eyeball that control movement of the eyeball. Sometimes, surgery on one or more of the Extraocular Muscles to realign the eyes so they are both aimed in the same direction, which restores single vision, expands the patient's visual field, and restores depth perception, can be done to improve the patient's problem. Strabismus can be a congenital condition, it can be caused by Thyroid Disorders, or by other conditions.

- The CPT codes for Strabismus (which run in the section of codes 67311-67345) refer to *each* eye. Thus, the –RT and –LT modifiers should be used. If the identical procedure is performed on both eyes (during the same surgical session), a –50 modifier should be appended to the muscle code for the procedure.
- There are many "Add-on" + codes in this section, so use care with coding these surgeries. The applicable add-on code may not necessarily follow just under the primary code, so you might need to check the CPT codes in this section carefully to locate the correct add-on code for use.
- In these procedures, the eyes are rolled into the most optimal position for the procedure and an incision is made through the conjunctiva over the sclera. The surgeon may lengthen the muscle (recession) or shorten the muscle (resection).
- Patients whose eyes are turned outward suffer from Exotropia. Those with eyes which turn inward suffer from Esotropia.
- There are notations on some codes in the Strabismus surgery section referring to patient with *previous* surgery and injury, so use care with coding these surgeries.
- The position of each eye is controlled by six eye muscles contained in the Orbit. These muscles move the eye.
- The structures involved in Strabismus surgery include:

  <u>4 Vertical Muscles</u>
  Superior Rectus
  Inferior Rectus
  Superior Oblique
  Inferior Oblique

  <u>2 Horizontal Muscles</u>
  Lateral Rectus
  Medial Rectus

- Sometimes, fibrous adhesions can form between the extraocular muscle and the orbital contents or the walls of the orbital cavity after the patient has had strabismus surgery. The procedure done to release the scar tissue as coded as 67343.

4. **Iridectomy procedures** – Use CPT codes 66600 through 66635 for these procedures, which involve the surgical removal of some portion of the iris tissue. Several of these codes are designated as "Separate Procedures", so check your CCI Unbundling material closely.

5. **Cyclectomy** – Use CPT code 66605 for the surgical removal of a portion of the ciliary body, done with the removal of a portion of the iris of the eye.

6. **Tarsorrhaphy** – Patients suffering from corneal conditions can have problems from the constant action of the eyelid opening and closing, causing a need for them to have a temporary closure of the eyelids. This procedure is coded using codes 67880 and 67882. Code 67875 is for what is commonly referred to in OP Reports as a Frost Suture or Temporary Tarsorrhaphy – 67875 for the Temporary closure of eyelids by suture (eg, Frost suture).

Blepharoplasty Procedures

The goal of Blepharoplasty procedures is to restore normalcy to a structure that has been altered by trauma, age, infection, inflammation, degeneration, neoplasms, or developmental problems. The 1582X Blepharoplasty codes in the Skin section are less extensive procedures, which involve only the removal of excess skin/subcutaneous tissue, whereas, the 6790X codes involve surgery on the muscle structures.

Some conditions that may necessitate Blepharoplasty procedures (often called Blephs.) include:

1. Dermatochalasis – Excessive skin, usually resulting from the normal aging process and its related loss of elasticity.
2. Blepharochalasis – Excessive skin, usually associated with the disease of Chronic Blepharoedema, which stretches the skin.
3. Blepharoptosis – Drooping of the upper eyelid, which relates to the position of the eyelid margin, with respect to the eyeball and visual axis.
4. Pseudoptosis – A "false ptosis" (drooping of the eyelid), where the eyelid margin (which is usually in an appropriate position, with respect to the eyeball and visual axis) has an excessive amount of skin overhanging it, creating its own ptosis.

- Blephs. are coded from the 15820-15823 section or 67900-67924 section, as appropriate. The 60000 section codes are more involved procedures.
- The 67903 Tarso Levator Resection (Internal Approach) procedure is done from the inside of the eye.
- The 67904 Tarso Levator Resection (External Approach) procedure is more commonly used.
- Medicare frequently has Local Carrier Determination policies (LCDs) describing the (very limited) coverage of Blepharoplasty procedures, with very strict billing guidelines, which should be reviewed prior to scheduling the patient. The appropriate lid modifiers should be appended to the CPT code(s) billed.

Ectropions

An Ectropion is a turning outward of the eyelid margin.

- Use code 67914 for a Simple Suture Repair of an Ectropion
- When a Tarsal Wedge Excision is performed to repair an Ectropion, use code 67916
- When an Extensive Tarsal Strip procedure is performed to repair an Ectropion, use code 67917

Entropions

An Entropion is an inversion of the eyelid margin.

- Use code 67921 for a Simple Suture Repair of an Entropion
- When a Tarsal Wedge Excision is performed to repair an Entropion, use code 67923
- When an Extensive Tarsal Strip or Capsulopalpebral Fascia Repair procedure is performed to repair an Entropion, use code 67924

If Scar Excisions or Skin Grafts are performed to repair Ectropions or Entropions, use code 67961, if applicable.

Corneal Transplant Procedures

Corneal Transplants (called Keratoplasties) involve the replacement of a diseased or scarred cornea with healthy corneal tissue from a donor. The codes run in section 65710-65755.

- The 65710 code refers to an Anterior Lamellar type procedure, which refers to replacement of the thin part of the outermost layers of the cornea.
- The 65730-65755 codes refer to a "Penetrating" type procedure, which refers to replacement of the full thickness of the cornea. The difference between these 3 codes is the lens status of the patient.

    1. Use the 65730 code for those patients who are phakic (except in aphakia or pseudophakia) and still have a natural lens.
    2. Use the 65750 code for those patients who are aphakic and who have had cataract surgery (without an IOL) in the past (they do not have a natural lens). Aphakia is the absence of the crystalline lens of the eye.
    3. Use the 65755 code for those patients who are pseudoaphakic, who have had cataract surgery, and who have an artificial lens in place (they do not have a natural lens). Pseudophakia is the state of having an IOL implant as a replacement for an opaque lens (with a cataract).
    4. Use code 65756 for an Endothelial Keratoplasty, which is not a penetrative keratoplasty, but is only a partial-thickness transplant, which involves the replacement of only the innermost layer of the cornea containing the corneal endothelium. This is the code to use when the OP Report refers to a DSAEK procedure.

5. Use code 65757 (which is an Add-on Code) for the Backbench Preparation of the Corneal Endothelial Allograft prior to the transplantation. This code is not covered by Medicare.
6. Use HCPCS code V2785 for the Processing, Preserving and Transporting of the Corneal Tissue used in these procedures. Use diagnosis code V42.5 for Re-do procedures.

Lacrimal Procedures

- Use code 68420 for a Dacryocystotomy or Dacryocystostomy procedure done to drain the Lacrimal Sac.
- Use code 68520 for a Dacryocystectomy procedure done to Excise the Lacrimal Sac.
- Dacryocystorhinostomy procedures, which provides a Fistulization of the Lacrimal Sac to the Nasal Cavity, are coded 68720.
- Use code 68815 when a Stent or Tube is inserted for drainage.
- Use code 68801 for a Dilation of the Lacrimal Punctum, with or without irrigation.
- Use code 68810 for the Probing of Nasolacrimal Duct, with or without irrigation (performed with the patient under local anesthetic only).
- Use code 68811 for the Probing of Nasolacrimal Duct, with or without irrigation performed under General Anesthesia.
- Use code 68815 for the Probing of Nasolacrimal Duct with the insertion of a Tube or Stent.
- Use code 68816 for the Probing of Nasolacrimal Duct, with Transluminal Balloon Catheter Dilation. In this procedure, the surgeon inserts a balloon device into the patient's tear ducts to clear an obstruction in the opening of the duct and in the ductal canal.

CPT codes are copyrighted by the AMA

Information compiled by:
Stephanie Ellis, R.N., CPC
Ellis Medical Consulting, Inc.
(615) 371-1506
www.ellismedical.com