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Procedures Performed on the Eye and Ocular Adnexa

Anterior Sclera Procedures: By Indication/Specific Area of Eye (66130–66250)

This subsection includes procedures of the anterior sclera, a dense fibrous tissue that forms the “white” of the eye. The sclera helps to maintain the shape of the eyeball and is where the extrinsic muscles of the eye are attached. It is covered with the vascular episclera, the Tenon capsule (fascial bulbi), and the conjunctiva. The sclera comprises five-sixths of the eye surface, with the remaining one-sixth covered by the cornea, which bridges the anterior scleral foramen, one of the two large openings in the sclera. Procedures in this part of the eye are performed primarily for glaucoma, using a variety of techniques including aqueous shunt procedures.

Procedure Differentiation

Removal of a sclera lesion by cutting through the conjunctiva is reported with 66130.

Codes from range 66150–66185 are reported when controlling the pressure of the aqueous fluid in the eyeball.

Codes 66150–66172 describe fistulization of the sclera. Each code listed below includes an additional procedure or a different technique to achieve the fistulization.

- Code 66150 reports procedures using a trephine to remove a circular portion of the sclera and iris.
- Code 66155 describes thermocauterization where a portion of the sclera and iris are destroyed by burning with a hot probe.
- Code 66160 reports a sclerectomy using a punch or scleral scissors and includes an iridectomy. Various methods of sclerectomy include Lindner’s, Lagrange, Knapp’s, Holth’s, and Herbert’s operations.
- Assign code 66170 for trabeculectomy performed in the absence of previous surgery.
- Assign code 66172 for trabeculectomy performed on a patient who has scarring from previous ocular surgery or trauma. This code is to be used only when a trabeculectomy is performed on an eye that has conjunctival scarring from previous ocular surgery or injury. Examples include history of cataract surgery, history of strabismus surgery, history of failed trabeculectomy ab externo, history of penetrating trauma to the eyeball, or conjunctival lacerations. This procedure includes the injection of antifibrotic agents, such as 5-Fluorouracil (5-FU). The technique of injecting 5-FU is recognized as effective in reducing the number of failed procedures caused by the formation of scar tissue and fistula closure.

Aqueous outflow canal transluminal dilation is reported with codes 66174–66175. Report 66175 if a polypropylene suture is placed within the canal to improve aqueous outflow and preserve canal patency. This procedure is usually performed for open-angle glaucoma.

Procedures that pertain to aqueous shunt to extraocular reservoirs are reported with 66179–66185. Shunt procedures are performed in the anterior segment of...
the eye to reduce and control intraocular pressure (IOP). Though aqueous is constantly flushed and renewed, its overall pressure is constant in a healthy eye’s anterior chamber. Too little or too much fluid can cause permanent damage. To enhance drainage, the physician places an ocular speculum in the patient’s eye and makes an incision in the conjunctiva. The physician then places tubing into the anterior portion of the eye at the juncture of the sclera and cornea (the limbus) and sutures tubing to the sclera. This improves the aqueous flow in the anterior chamber and is reported using 66179. The tube implant connects to an equatorial reservoir plate (a bleb) sutured into place behind the pars plana between the extraocular muscles. The physician stretches conjunctival tissue over the shunt and reservoir and sutures it into place. The physician then closes the incision with sutures and may restore the intraocular pressure with an injection of water or saline. A topical antibiotic or pressure patch may be applied. Report 66180 if the procedure includes a graft.

Code 66183 describes a procedure in which the physician treats a refractory, primary, open-angle glaucoma by draining aqueous humor from the anterior chamber directly into the Schlemm’s canal by shunting or stenting, lowering intraocular pressure (IOP) without the formation of a filtering bleb using an external approach. The physician inserts an implant via a superficial scleral flap through the trabeculum and into the anterior chamber. IOP is reduced by diverting the excess aqueous fluid from the anterior chamber to a subconjunctival bleb rather than to an extraocular reservoir.

When the documentation states that the physician revises a previously placed aqueous shunt to extraocular equatorial plate reservoir, report 66184. The physician places an ocular speculum in the patient’s eye and opens the previous incision in the conjunctiva. The tubing from the anterior chamber to the reservoir is revised or replaced. The physician then stretches conjunctival tissue over the shunt and reservoir and sutures it into place. The physician may restore the intraocular pressure with an injection of water or saline, and a topical antibiotic or pressure patch may be applied. Report 66184 for revision without graft and 66185 for revision with graft.

Repair of the sclera is reported with 66220–66225 and revision of an operative wound with 66250.

**Medical Necessity**
The following conditions may warrant these procedures (this list is not all inclusive):

- Essential or progressive iris atrophy
- Glaucoma
- Plateau iris syndrome

**Key Documentation Terms**
Documentation should indicate the surgical procedure that was performed. Terms such as excision, fistulization, revision, or repair provide the guidance needed to ensure correct code assignment. Above all else, the documentation should support the medical necessity of the procedure.

**Coding Tips**
- These procedures are generally performed with a subconjunctival injection, retrobulbar injection, or a topical anesthetic rather than general anesthesia.
• Codes 66180 and 66185 should not be reported with scleral reinforcement with graft procedures (67255).
• The use of an operating microscope (69990) is not reported separately.

Iris, Ciliary Body Procedures: Destruction/Iridectomy/Iridotomy/Repair (66500–66770)
The iris, which lies in front of the lens and ciliary body, separates the anterior chamber from the posterior chamber. The posterior portion of the iris rests on the front of the lens. It contains the pupil, which controls the amount of light that enters the eye.

The ciliary body is a ring of tissue, about 6 mm wide, that is primarily responsible for the production of aqueous humor, accommodation, and maintenance of the lens zonules. Many of the procedures performed on the iris and ciliary are for the treatment of glaucoma.

Procedure Differentiation
Incision into the iris, iridotomy, is reported with 66500 for stab incision; 66505 is reported for transfixion for iris bombe. Iris bombe is a condition where the iris balloons forward blocking aqueous outflow channels. In this procedure, the surgeon pierces the iris in two places.

Excision of the iris (iridectomy) codes (66600–66635) are selected according to the extent of the procedure and concomitant procedures. Codes 66625–66635 are separate procedures by definition and are usually a component of a more complex service and are not identified separately. When performed alone or with other unrelated procedures/services they may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59.

Code 66600 describes the excision of a full-thickness piece of the iris, which is usually accomplished with an argon laser.

In 66605, excision of a piece of the ciliary body (cyclectomy) is performed, the burn is deeper, and goes through the iris into the ciliary body.

Code 66625 is reported for a peripheral iridectomy. In the procedure, a piece of the iris is removed, providing a direct passageway for aqueous. This causes the intraocular pressure to fall as aqueous from behind the iris can flow forward and drain from the eye. This procedure is also called basal, buttonhole, or stenopeic iridectomy and is performed for glaucoma.

In 66630, a sector iridectomy is performed. An incision is made at the juncture of the cornea and sclera (the limbus). The physician removes a wedge piece from the iris leaving what is often referred to as a keyhole pupil.

Code 66635 describes an optical iridectomy. In this procedure an incision is made at the juncture of the cornea and sclera (the limbus). The physician trims the inner ring of iris as a means of widening an abnormally small pupil and improving vision. This is usually performed for pupillary abnormalities (e.g., Argyll Robertson pupil or miosis).

Repair of the iris is reported with 66680 or 66682. Report 66680 for tears at the base of the iris, separating it from the ciliary body; code 66682 for sutures of the iris or ciliary body. These procedures are also performed due to degenerative changes.
Examples of how the Auditors’ Desk Reference Solves Auditing Problems

**Auditing Problem:** A physician performs a sigmoidoscopy and places a transendoscopic stent during the same session. CPT code 45347 is reported for the procedure. The claims for Medicare patients are being denied and the office does not know why, because the documentation supports the procedure reported.

**Auditing Solution:** In 2015, the AMA made many revisions to the lower endoscopy code set, however, CMS has elected to not value the new codes in this range for 2015. This decision was made based on the fact the Agency will be making policy changes affecting moderate sedation and how it is valued, and since many of these codes are performed under moderate sedation, it would be better to value these new codes using the revised moderate sedation methodology which will be implemented beginning in 2016. Medicare contractors will not accept the new 2015 lower endoscopy procedures. Therefore, to enable physicians to report these services, CMS has created HCPCS level II codes that crosswalk directly to the 2014 CPT codes used to report these services that will be valued. The table below can be used to determine the appropriate HCPCS level II code that should be reported in 2015. Note, these codes are assigned using the same guidelines that would have been used to report the service using 2014 CPT.

The code in the above scenario 45347, replaced the 2014 code 45345. Looking at the table below it crosswalks code 45345 to G6022. This would be the appropriate code to report to Medicare.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>45339</td>
<td>G6022</td>
<td>Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesions(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>45345</td>
<td>G6023</td>
<td>Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)</td>
</tr>
<tr>
<td>45383</td>
<td>G6024</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>45387</td>
<td>G6025</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)</td>
</tr>
<tr>
<td>0226T</td>
<td>G6027</td>
<td>Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed</td>
</tr>
<tr>
<td>0227T</td>
<td>G6028</td>
<td>Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)</td>
</tr>
</tbody>
</table>

[Source, 2015 Auditors’ Desk Reference, page 369-371]
Auditing Problem: A provider frequently performs consultations for Medicare patients. All of the inpatient and outpatient consultations have been denied whether Medicare is primary or secondary. The documentation clearly supports the level of consultation reported but Medicare has failed to reimburse any of them stating that Medicare uses another code for reporting and payment of the service.

Auditing Solution: As a result of the confusion regarding the consultation guidelines many are reported inappropriately. Due to this, CMS adopted new policies regarding the use of consultation codes. Under these guidelines the inpatient and office/outpatient consultation codes contained in the CPT book will not be a covered service for CMS effective January 1, 2010. However, Medicare will cover telehealth consultations when reported with the appropriate HCPCS Level II G code, if applicable.

CMS implemented the following changes to these services in 2010. Physicians are instructed to report patient evaluation and management visits with E/M codes that represent the correct place of service and that identify the complexity of the visit performed. For services performed in the office or other outpatient setting codes 99201–99215 should be reported.

For inpatient hospital services the rules are more complex. All providers who perform an initial evaluation may bill the initial hospital care codes (99221–99223). The admitting or primary physician of record should append modifier AI Principal physician of record, in addition to the reported E/M code. The principal physician of record is identified as the physician who oversees the patient’s total care as opposed to other physicians who may be furnishing specialty specific care. Other guidelines affecting the assignment of consultations include:

- Providers performing low level inpatient consultations that do not meet the minimum requirements of the lowest level initial inpatient codes are instructed by CMS to report subsequent inpatient E/M services (99231-99233).
- Follow-up visits in the inpatient setting should be billed as subsequent hospital care visits (99231-99233).
- When Medicare is secondary consultations are also excluded from coverage. CMS offers the following guidance for billing these services.
- If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:

  Report an E/M code that is appropriate for the service to the primary payer, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due

OR

  Report a consultation code to the primary payer that is appropriate for the service performed, and then report the amount actually paid by the primary payer on the Medicare secondary claim form. On the same claim form change the code to an E/M code that is appropriate for the service and submit it to Medicare for determination of whether a payment is due.
Please note CMS redistributed the value of the consultation codes across the other E/M codes for Medicare services. The agency retained values for codes 99241–99255 in the Medicare physician fee schedule for those private payers who utilize this data for reimbursement. Note that private payers may choose to follow CMS or CPT guidelines and the use of consultation codes should be verified with the individual payers.

[Source, Auditors’ Desk Reference, page 193-196]

---------------------------------------------------------------------------------

Auditing Problem: A practice has received a number of notices from payers that services provided to children are not covered. But the services are not unusual or not medically necessary, and the child is covered by the parent’s insurance. What’s the problem? The insurance company is referencing Claim Adjustment Reason code 109 Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

Auditing Solution: This reason code signals that the payer receiving the claim believes that the patient has some other insurance that is primary. Several factors may be the cause of the confusion. A) Birthday Rule—If a payer believes that both parents have insurance that covers a child, the parent whose birthday occurs earliest in the ear is commonly regarded as the primary insurer. This “Birthday Rule” may apply, or just as likely, B) one parent is no longer employed and their insurance policy is no longer in effect.

[Source, Auditors’ Desk Reference, page 48]