

Surgery: Eye and Ocular Adnexa

This section contains information to help providers bill for eye and ocular adnexa surgical procedures. Additional information about eye surgeries is located in the *Ophthalmology* sections of this manual.

Retinal Surgery: Repetitive Services

Descriptors for CPT-4 codes 67141, 67145, 67208, 67210, 67218, 67220, 67227 and 67228 include all sessions in a defined treatment period. Therefore, these codes must not be billed more than one time in a 90-day period for services rendered on an individual eye, regardless of the number of sessions, except in the case of retinoblastoma. When treating both the left and right eyes within the 90 days, providers must include documentation in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim to substantiate surgery for the contralateral eye. The following are guidelines for billing repetitive retinal surgery:

- Code 67208 (destruction of localized lesion of retina [eg, macular edema, tumors], one or more sessions; cryotherapy, diathermy) or 67210 (...photocoagulation) and 67227 (destruction of extensive or progressive retinopathy [eg, diabetic retinopathy], one or more sessions; cryotherapy, diathermy) or 67228 (...photocoagulation [laser or xenon arc]) will not be separately reimbursed for the same eye on the same date of service.
- Code 67208 or 67210 may be performed on and reimbursed for one eye and code 67227 or 67228 may be performed on and reimbursed for the contralateral eye on the same date of service.
- Code 67208 or 67210 will not be reimbursed within the 90-day period following reimbursement of 67227 or 67228 on the same eye.
- Code 67227 or 67228 may be performed and reimbursed within the 90-day period following reimbursement of 67208 or 67210 performed on the same eye.
- Retinoblastoma: The 90-day billing frequency restriction does not apply for codes 67208 or 67210 when billed in conjunction with ICD-9-CM diagnosis code 190.5 (malignant neoplasm of the eye, retina) or if a *Treatment Authorization Request* (TAR) or Service Authorization Request (SAR) is present.

Reimbursement for ophthalmoscopy procedures (CPT-4 codes 92225 – 92240, 92250, 92260 – 92287) is included in the reimbursement for the repetitive eye surgery procedure codes as part of the follow-up care. Instructions for billing these procedures (CPT-4 codes 92225 – 92240, 92250, 92260 – 92287) when not performed with repetitive eye surgery procedure codes are located in the *Ophthalmology* section of this manual. Reimbursement for the ophthalmoscopy procedure codes is denied if billed within the 30-day follow-up period.

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**Retinal Surgery:
Vitrectomy**

Providers are not required to submit an invoice when billing for CPT-4 code 67040 (vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation). CPT-4 code 67040 is payable to both surgeon and assistant surgeon. Providers must bill with the appropriate surgical modifier.

**Cataract Extraction
Surgery**

Provider must submit a *Treatment Authorization Request* (TAR) for cataract extraction surgery (CPT-4 codes 66840, 66850, 66852, 66930, 66940, 66982, 66983, 66984, 66985). The TAR must demonstrate medical necessity for approval. Required documentation for TAR submission is indicated below:

Note: Assistant surgeons are not required to submit a TAR for cataract extraction surgery.

Medical Documentation

One of the following conditions must be documented on the TAR:

- Documentation of the patient's symptoms such as blurred vision, visual distortion, and/or glare with associated functional impairment such as diminished ability to perform instrumental activities of daily living (such as, reading, writing, driving, etc.)
AND
 - That the cataract is the cause for Snellen best-corrected visual acuities (BCVA) of 20/50 or worse in the affected eye
OR
 - For patients with Snellen BCVA acuity of 20/40 or better, providers must submit documentation of one of the following symptoms:
 - ◆ Fluctuation of vision function due to glare or dim illumination (complaints of glare should be confirmed with Brightness Acuity Testing (BAT) or another suitable test)
 - ◆ Complaints of monocular diplopia or polyopia
 - ◆ Visual Disparity between the two eyes
- Documentation of lens induced disease such as phacomorphic glaucoma or phacolytic glaucoma
- Documentation that a clear media is required to adequately diagnose or treat other ocular conditions in the posterior segment of the eye (for example, diabetic retinopathy)

Bilateral Cataract Surgery

Cataract surgery is rarely performed on both eyes at the same time. The interval between surgeries should be based on the following factors:

- Patient’s ability to provide informed consent for surgery on the second eye after evaluating the visual results and postoperative course of surgery of the first eye
- Adequate passage of time (3 – 4 weeks) to establish that vision in the operated-on eye has recovered sufficiently so that the patient is not at risk of injury due to functional impairment during cataract surgery of the second eye

If the TAR is requested for bilateral cataract surgery, the TAR may be approved with the “from/through” interval of six months if both eyes meeting criteria for cataract surgery as indicated in the *Medical Documentation* section. The TAR may only be approved for the worse eye if the better eye does not meet the criteria for cataract surgery. Providers will have to submit a new TAR for the better eye once it meets the criteria for surgery specified previously.

Reasons for TAR Denial

Cataract surgery is not considered medically necessary, even if a cataract is present, under the following conditions:

- If the recipient declines surgery,
- When the recipient’s life-style is not compromised,
- When eyeglasses or visual aids provide satisfactory functional vision, OR,
- When the recipient is medically unfit for surgery

Examples of recipients considered medically unfit for surgery include those patients who are comatose, have organic brain syndrome, end stage Alzheimer’s, or other conditions in which cataract surgery will not improve the recipient’s independence.

ICD-9-CM Codes

Providers must document one of the following ICD-9-CM diagnosis codes on the TAR to support medical necessity:

366.00 – 366.9	743.32
379.31	743.33
379.32	743.34
379.33	743.35
379.34	996.53
743.30	V43.1
743.31	V45.61

Note: Although one of the above diagnosis codes must be documented on the TAR for approval, it is not required to be included with the claim for reimbursement.

**Supplies and Drugs with
Cataract Surgery**

Outpatient hospital departments and surgical clinics should include the following modifiers when billing supplies and drugs used during cataract extraction surgery procedures (CPT-4 codes 66830 – 66986):

- UA (surgical or non-general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code)
- UB (surgical or general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code)

Refer to the *Supplies and Drugs* section in this manual for more information.

**Intra-Ocular Lens
with Cataract Surgery**

The following medical policies have been established for certain multiple surgeries when billed for a recipient, by the same provider, for the same date of service. Note the following information:

- Insertion of intra-ocular lens with cataract extraction (CPT-4 codes 66982 – 66984) includes cataract removal as well as insertion of the intra-ocular lens.
- Secondary insertion of intra-ocular lens, subsequent to lens extraction (CPT-4 code 66985), is reimbursable only as a second stage procedure on a date of service other than that of the cataract extraction.
- If CPT-4 code 66982, 66983, 66984 or 66985 is billed on the same date of service as a cataract extraction (CPT-4 codes 66830 – 66940), only one procedure is separately reimbursable.

All surgical procedure codes require a modifier. Failure to submit a modifier with a surgical procedure code will result in the claim being returned to the provider for correction. Providers may refer to the *Surgery: Billing With Modifiers* section of the appropriate Part 2 manual for further billing information.

Posterior Capsulotomy

Surgical intervention is not often indicated less than 90 days after cataract surgery. If capsulotomy surgery is performed within 90 days of cataract surgery on the same eye, documentation justifying the need for the procedure must be included with the claim. Indication for a capsulotomy procedure performed less than three months after cataract surgery includes:

- Significant visual debility as defined on a following page under “Medical Documentation”
- Preoperative uveitis
- Chronic glaucoma
- Diabetes mellitus
- Prolonged use of pilocarpine hydrochloride

When a series of procedures is performed for the management of a secondary cataract, it will be covered as a single procedure.

Payment will only be allowed for the same physician or group once per patient per eye per 90 days, no matter how many YAG laser treatment sessions occur.

Medical Documentation

Capsulotomy is covered when all of the criteria listed below are met and clearly documented in the medical record. Documentation justifying the medical need for this procedure should be made available upon request by the Department of Health Care Services (DHCS).

- Objective evidence shows that a secondary cataract is present and impairs the patient's vision, and other eye disease, including but not limited to macular degeneration or diabetic retinopathy, has been excluded as the primary cause of visual functional disability.
- The patient has a significant visual debility defined as:
 - Best-corrected visual acuity of 20/40 or worse at distance or near; or additional testing shows one of the following:
 - ❖ Consensual light testing decreases visual acuity by two lines.
 - ❖ Glare testing decreases visual acuity by two lines.
- Visual impairment from secondary cataract affects the patient's ability to perform activities of daily living (such as reading, writing or driving).
- The patient has determined that he/she is no longer able to function adequately with the current level of visual function.
- Physician concurrence with significant patient-defined improvement in visual function can be expected as a result of capsulotomy.
- The patient has been educated about the risks and benefits of capsulotomy and the alternatives to surgery (such as the avoidance of glare or use of optimal eyeglasses prescription).
- The patient has undergone an appropriate preoperative ophthalmologic evaluation.

Capsulotomy is not covered:

- If performed concurrently with cataract surgery
- If performed prophylactically
- If scheduled routinely after cataract surgery without regard to whether there is clinically significant opacification of the posterior capsule

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Billing Requirements

Posterior capsulotomy is reimbursable using the following CPT-4 codes:

- 66820 Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife).
- 66821 Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages).

To support medical necessity for capsulotomy, claims must be submitted with one of the following ICD-9-CM diagnosis codes:

- 366.50 After-cataract, unspecified
- 366.51 Soemmering's ring
- 366.53 After-cataract, obscuring vision
- 996.53 Due to ocular lens prosthesis

Claims must be submitted with either modifier LT (left eye), modifier RT (right eye) or modifier 50 (both eyes) on a single claim line.

If either code 66820 or 66821 is performed within 90 days of cataract surgery (defined as CPT-4 codes 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984, or 66985) on the same eye, a copy of the operative report for the cataract extraction must be submitted and one of the following indications must be documented on the capsulotomy claim or on an attachment:

- Significant visual debility as defined on a previous page under "Medical Documentation"
- Preoperative uveitis
- Chronic glaucoma
- Diabetes mellitus
- Prolonged use of pilocarpine hydrochloride

**Blepharoplasty and/or
Repair for Blepharoptosis**

Blepharoplasty procedure and/or a repair for blepharoptosis is reimbursable when it is considered medically necessary. The service is considered medically necessary when performed as functional/reconstructive surgery to correct one of the following:

- Impairment of near or far vision or visual field defect due to dermatochalasis, blepharochalasis or blepharoptosis
- Symptomatic redundant skin weighing down or upper lashes
- Chronic, symptomatic dermatitis of pretarsal skin caused by redundant upper lid skin
- Prosthesis difficulties in an anophthalmic socket

A blepharoplasty procedure and/or a repair for blepharoptosis is not a benefit when performed for cosmetic purposes.

ICD-9-CM Codes

ICD-9-CM diagnosis codes that support medical necessity include the following (not required for claim reimbursement):

239.2	374.20	374.41	378.55	744.9
351.0	374.22	374.46	378.72	870.1
351.8	374.30	374.50	701.8	951.0
368.40	374.31	374.87	701.9	V52.2
374.01	374.32	374.89	709.2	
374.03	374.33	376.21	743.61	
374.11	374.34	376.36	743.62	

TAR Requirements

A *Treatment Authorization Request* (TAR) is required for a blepharoplasty procedure and/or a repair for blepharoptosis. When requesting a TAR or a Service Authorization Request (SAR), providers must include documentation of the patient complaints and either a photograph or the visual field examination printout.

Patient complaints must include one or more of the following:

- Interference with near or distance vision or visual field;
- Difficulty seeing at distance and/or near due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin; or
- Chronic blepharitis or dermatitis

Photographs must demonstrate one or more of the following:

- The upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex.
- The upper eyelid skin rests on the eyelashes.

- The upper eyelid indicates the presence of dermatitis.
- The upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmic socket.

Visual field examination must demonstrate a minimum of 12 degree or 30 percent loss of upper field of vision with upper lid skin and/or lid margin in repose and elevated (by taping the lid) to demonstrate potential correction by the proposed procedure or procedures.

Providers must conform to the following standards when submitting photographs:

- Prints not slides must be frontal, canthus-to-canthus with the head perpendicular to the plane of the camera (not tilted) to demonstrate a skin rash or position of the true lid margin or the pseudo-lid margin.
- The photos must be of sufficient clarity to show a light reflex on the cornea.
- If redundant skin coexists with true lid ptosis, additional photos must be taken with the upper lid skin retracted to show the actual position of the true lid margin (needed if both CPT-4 code 15822 and 15823 are required and planned in addition to codes 67901 – 67908).
- Oblique photos are only needed to demonstrate redundant skin on the upper eyelashes when this is the only indication for surgery.
- If both a blepharoplasty and a ptosis repair are planned, both must be individually documented. This may require two sets of photographs, showing the effect of drooping of redundant skin (and its correction by taping) and the actual presence of blepharoptosis.

Providers must conform to the following standards when submitting visual field examination printout:

- Record using either a Goldmann Perimeter (III 4-E test object) or a programmable automated perimeter (equivalent to a screening field with a single intensity strategy using a 10dB stimulus) to test a superior (vertical) extent of 50 to 60 degrees above fixation with targets presented at a minimum 4 degree vertical separation starting at 24 degrees above fixation while using no wider than a 10 degree horizontal separation.
- Each eye should be tested with the upper eyelid at rest and repeated with the lid elevated to demonstrate an expected “surgical” improvement meeting or exceeding the criteria.
- A tangent screen visual field is also acceptable and must be performed at 1 meter with a 2 mm to 5 mm white test object.

Keratoplasty

The following new CPT-4 code must be billed “By Report.”

<u>CPT-4 Code</u>	<u>Description</u>
65757	Backbench preparation of corneal endothelial allograft prior to transplantation

Keratoprosthesis

Keratoprosthesis (CPT-4 code 65770) is reimbursable for the treatment of corneal blindness after standard corneal transplant involving tissue transplanted from human donors has failed or when such a transplant would be unlikely to succeed.

Documentation Requirements

CPT-4 code 65770 requires a *Treatment Authorization Request* (TAR). Providers must include the following documentation when submitting a TAR request:

- History of multiple (two or more) failed corneal grafts, with poor prognosis for further grafting; or
- History of bilateral blindness; best-corrected visual acuity less than 20/400 in affected eye and additionally with lower than optimal vision in the opposite eye for which corneal transplantation is not an option.

TAR Diagnosis Code Requirement

The TAR for CPT-4 code 65770 must include one of the following ICD-9-CM diagnosis codes to support medical necessity (not necessary for claim reimbursement):

076.1	371.11	371.50 – 371.54	871.6
139.1	371.16	371.60 – 371.62	871.9
264.6	371.20	371.82	906.5
370.06	371.23	694.61	918.1
370.63	371.31	743.41 – 743.43	921.3
370.8	371.42	871.0 – 871.2	940.2 – 940.4
371.00 – 371.05	371.46	871.5	996.51

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Placement of Amniotic Membrane

The following CPT-4 codes should be used for placement of amniotic membrane on the ocular surface for wound healing:

<u>CPT-4 Code</u>	<u>Description</u>
65778	Without sutures
65779	Single layer, sutured

Note: Do not report codes 65778 and 65779 with codes 65430, 65435 and 65780.

Diagnosis Restrictions

CPT-4 codes 65778 and 65779 are restricted to the following ICD-9-CM diagnosis codes:

053.21	370.8	373.00 – 373.02
053.22	371.23	374.04
053.29	371.24	379.60 – 379.63
054.42	371.40	694.61
054.43	371.42	695.13 – 695.15
054.44	371.43	757.39
054.49	371.48	940.0 – 940.9
055.71	371.49	941.12
190.0 – 190.9	371.82	941.22
239.89	372.10 – 372.15	998.32
365.10	372.40 – 372.45	998.33
365.11	372.63	
365.9	372.64	
370.00 – 370.07	372.81	

Insertion of Ocular Telescope Prosthesis

The insertion of an ocular telescope prosthesis with removal of crystalline lens is reimbursable with CPT-4 code 66999 (unlisted procedure, anterior segment, eye) when billed in conjunction with HCPCS code C1840 (lens, Intraocular, [telescopic]).

When billed for this service, unlisted code 66999 is not reimbursable with CPT-4 codes 65800 – 65815, 66020, 66030, 66600 – 66635, 66761, 66825, 66982 – 66986 or 69900 on the same day for any provider. Reimbursement is determined case-by-case and is based on the submitted invoice. A copy of the operative report is required for code C1840.

Documentation Requirements

CPT-4 code 66999 requires a TAR. Providers must document all of the following:

- Patient has irreversible, end-stage Age-Related Macular Degeneration (ARMD) resulting from either dry or wet ARMD in both eyes with vision stable, but severe visual impairment (best-corrected Snellen equivalent distance acuity of 20/160 to 20/800) in both eyes, and
- Patient is not responding to drug treatment of ARMD, and
- Patient has no history of cataract surgery in the eye in which the ocular telescope prosthesis will be implanted, and
- Patient is 75 years of age or older, and
- Patient's vision improves with external telescope and has adequate peripheral vision in non-operative eye, and
- Patient has been diagnosed with qualifying macular degeneration (ICD-9-CM diagnosis codes 362.50 – 362.52).

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Reasons for TAR Denial

Ocular telescope prosthesis is not considered medically necessary, even if end-stage non-treatable ARMD is present, under the following conditions:

- If the recipient declines surgery,
- When the recipient's quality of life is not compromised,
- When eyeglasses or other external visual aids provide satisfactory functional vision, or
- When the recipient is medically unfit for surgery

Phakic Intraocular Lens

HCPCS code S0596 (phakic intraocular lens for correction of refractive error) requires authorization. Documentation of a bilateral procedure is required.