Segment vs. Chamber

- Contains both the anterior & posterior chambers
- Lens – focuses light onto the retina for image clarity
- Zonules – muscles of ciliary body that shape lens (accommodation)
- Ciliary body – produces aqueous humor that fills both chambers
Segment vs. Chamber

- The vitreous – gelatinous substance filling posterior segment
- The vitreous membrane (or hyaloid membrane or vitreous cortex) is a layer of collagen separating the vitreous humor from the rest of the eye.
- The anterior hyaloid membrane separates the front of the vitreous from the lens.
- The posterior hyaloid membrane separates the rear of the vitreous from the retina.

Membrane peel consisting of hyaloid only is considered part of the vitrectomy.
Pars Plana

- Limbus – aka. The corneoscleral junction
- 2mm posterior to the limbus is the pars plicata (vascularized area prone to bleeding).
- Posterior to the pars plicata is the pars plana which runs for 4-6mm to the anterior edge of the retina (ora serrata)
Pars Plana Vitrectomy

- 67036 – Vitrectomy, *mechanical*, pars plana approach (*use when vitrectomy is the only procedure performed*)

Mechanical - Vitrector, Microvit, Ocutome or retractor
Non-mechanical - Weck-cel sponges or scissors)
Pars Plana Vitrectomy

- 67039 – with focal endolaser photocoagulation *(small localized area is treated)*
- 67040 – with endolaser panretinal photocoagulation *(treatment over a large area of the retina - usually 360 degrees)*
- 67041 – with removal of preretinal cellular membrane (eg, macular pucker) *(vitrectomy procedure for removal of a cellular membrane from the anterior surface of the macula)* *(Aka - Epiretinal membrane - Preretinal fibrosis)*

As the vitreous ages and pulls away from the retina, cells will converge in the macular area to protect the retina.
• **POSTOPERATIVE DIAGNOSIS:** Macular pucker, OD.

• **PROCEDURE:** Pars plana vitrectomy with membrane peel, OD.

• **DESCRIPTION OF OPERATION:** The right eye and periocular area were prepped and draped. A 2 cc of sub-Tenon's anesthetic was injected inferonasally. A #25-gauge plus vitrectomy system was used, with the ports being placed in the inferotemporal and superior quadrants, 3 mm posterior to the limbus. A pars plana vitrectomy was performed. There was a posterior vitreous detachment. Intraocular forceps were used to grasp and peel an epiretinal membrane away from the macula. This was then removed with a vitrectomy instrument. The peripheral retina was checked for breaks and there were none noted. A partial air fluid exchange was performed. The ports were removed. There were no wound leaks. The eye was patched.
Pars Plana Vitrectomy

- 67042 – with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)

(Vitrectomy procedure with removal of the internal limiting membrane (noncellular, very adherent, and microscopically thin) from the surface of the macula)

*Internal limiting membrane separates the vitreous from the retina*

- Macular hole is caused by contraction of detached vitreous strands around the macula
- Diabetic macular edema is swelling of retina due to a release of fluid from blood vessels within the macula
POSTOPERATIVE DIAGNOSIS: Macular hole, left eye.

PROCEDURE: Pars plana vitrectomy, membrane peel, and gas-fluid exchange, left eye.

Three trocars were placed supratemporal, supranasal, and infratemporal 3.75 mm posterior to limbus. The infusion cannula was placed infratemporally, verified through the pupil, found to be patent, and turned on. A pars plana vitrectomy was carried out in a core fashion. The hyaloid was lifted and peeled off the surface of the retina and vitrectomized down to the periphery. The internal limiting membrane was removed off the surface of the macular hole with the help of a Tano diamond dusted scraper. An air-fluid exchange was carried out and then exchanged for 23% SF6. The intraocular pressure was perfect at the end of the case with a totally flat retina. The trocars were removed and all found to be self-sealing.
Pars Plana Vitrectomy

- 67043 – with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation

- Pars plana vitrectomy with retinotomy (incision into the retina) to expose and peel the subretinal membrane – neovascularization is treated with laser
Choroidal Neovascularization

**Definitions**

- Neovascularization – neo (new) vascularization (blood vessels)
- Choroidal neovascularization (CNV) involves the growth of new blood vessels that originate from the choroid through a break in the Bruch membrane into the subretinal space.
- There are two types of age related macular degeneration - wet and dry. Wet macular degeneration gets its name from leaking blood vessels in the retina.
- CNV causes degeneration around the area of the macula
Retinal Detachment

- Rhegmatogenous – retinal tear with vitreous access to subretinal space peeling sensory retinal from pigmented epithelium

- Traction – attachment of vitreous strands to retina that pull and detach retina from pigmented epithelium

- Exudative – collection of fluid beneath the sensory retina without the presence of hole or tear
Posterior Vitreous Detachment (PVD)

- Vitreous shrinks and pulls away from the retina
- When “traction” occurs the attached vitreous pulls on the retina which can cause small breaks in the retina
- Vitreous can then seep under the retina causing retinal detachment
Repair/Prophylaxis

- **67101** – *Repair* of retinal detachment, *1 or more sessions*; cryotherapy or diathermy, *with or without drainage* of subretinal fluid

- **67105** – photocoagulation, *with or without drainage* of subretinal fluid

- **67141** – *Prophylaxis* of retinal detachment, (eg. retinal break, lattice degeneration) *without drainage*, *1 or more sessions*; cryotherapy or diathermy

- **67145** – photocoagulation, *(laser or xenon arc)*

“Prophylaxis describes the treatment of a retinal break which attempts to prevent retinal detachment”
Coding Tip

One or More Sessions

- These codes should be reported only one time for a “defined treatment period” that may occur over the course of several encounters.

- The defined treatment period is determined by the physician and will vary depending on the patient, diagnosis, and, often, the area being treated.

- If the patient experiences a recurrence (several months after initial treatment because of disease progression) and retreatment is necessary, those subsequent retreatment periods would not be included in the first treatment period.

- The retreatment would be reported with the appropriate code, as it represents a new defined treatment period of “one or more sessions” performed to treat the problem.

CPT Assistant Oct. 08
Scleral Buckling

67107 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.

67108 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.

67112 by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques.

(For aspiration or drainage of subretinal or subchoroidal fluid, use 67015)
(For use of ophthalmic endoscope with 67112, use 66990)

Repair of Retinal Detachment 67107
The retinal tear is treated externally by placing a hot or cold probe over the sclera and then depressing it. The burn seals the choroid to the retina at the site of the tear. The healing scar is supported by the encircling band, which buckles the eye.
Scleral Buckling

POSTOPERATIVE DIAGNOSIS: Retinal detachment, left eye.

PROCEDURE PERFORMED: Scleral buckle, cryopexy, SF6 gas injection in the left eye.

A 360-degree conjunctival peritomy was then performed and the four rectus muscles were isolated with silk sutures. Cryopexy was performed at about 9 o'clock position where there was a single horseshoe tear. Next, 5-0 Mersilene suture was then placed in a horizontal mattress fashion in the superonasal and inferonasal quadrants with the anterior bite along the muscle insertion line and the posterior bite 10 mm posterior to it. Next, #511 silicone sponge was then slid under the superior rectus, inferior rectus, middle rectus, and the two horizontal mattress suture after a scleral incision and subretinal drainage was performed at about 8 o'clock position. The two Mersilene sutures were then tied and the ends of the scleral buckle were tied to the sclera with 5-0 Mersilene suture temporal to the superior rectus and inferior rectus muscles. Then, 0.4 cc of SF6 gas was injected prior to that to normalize intraocular pressure. The concentration of SF6 gas was 100%. A 20-diopter indirect ophthalmic examination revealed good optic disc perfusion, good buckle effect, complete flattening of the retina. There was good intraocular pressure at the completion of this
Scleral Buckling

- 67108 – vitrectomy, any method
  With or Without
  - Air or gas tamponade
  - *Focal endolaser* photocoagulation
  - Cryotherapy
  - Drainage of subretinal fluid
  - *Scleral buckling*
  - Removal of lens

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• The physician documents in his operative report the components of code 67108; however, instead of the focal endolaser photocoagulation, he performs a panretinal endolaser photocoagulation. Is it appropriate to report codes 67108 and 67040 because code 67108 does not specify endolaser panretinal photocoagulation?

• It is appropriate to report code 67108, 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, and 67040, Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation, for panretinal endolaser photocoagulation procedures

• Although this reporting method reflects the intent of CPT coding guidelines, third-party payers may request that these services be reported differently. Individual third-party payers may have specific reporting and reimbursement policies that govern the reporting of this procedure.
• **Question:** May code 66940 be reported in addition to code 67112 in the following surgical circumstance? At the same session, an extracapsular lensectomy (patient's natural lens) is performed in addition to repair of retinal detachment by scleral buckling on a patient having a previous retinal detachment repair in the same eye.

• **Answer:** *Yes, it is appropriate to report CPT code 67112, Repair of retinal detachment; by scleral buckling or vitrectomy, on a patient who had a previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques, along with CPT code 66940, Removal of lens material; extracapsular (other than 66840, 66850, 66852).*

67113 – Complex Retinal Repair

- 67113 – Repair of complex retinal detachment (e.g., proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), 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

67113 – Complex Retinal Repair

- **Proliferative vitreoretinopathy** – disease secondary to rhegmatogenous detachment. Mixture of retinal and vitreous cells combine to allow proliferation of RPE. The RPE has fibrotic membrane (scar) that contracts and pulls on the retina causing secondary detachment
  - PVR is divided into three grades A, B, and C
  - Grade A is limited to the presence of vitreous cells or haze.
  - Grade B is defined by the presence of rolled or irregular edges of a tear or inner retinal surface wrinkling/contraction
  - **Grade C** is recognized by the presence of preretinal or subretinal membranes. Grade C is further delineated as being anterior to the equator (grade Ca) or posterior to the equator (grade Cp) and by the number of clock hours involved (1 to 12).
67113 – Complex Retinal Repair

- Diabetic traction retinal detachment - traction detachment of a diabetic patient with ophthalmic manifestation

- Retinopathy of Prematurity (ROP) - abnormal blood vessel development in the retina of a “premature infant”

- Retinal tear of greater than 90 degrees
POSTOPERATIVE DIAGNOSIS: Persistent vitreal hemorrhage and traction, O.D.


INDICATIONS FOR THE PROCEDURE: This 68-year-old diabetic has proliferative retinopathy addressed with panretinal photocoagulation. Despite treatment, his right eye went on to develop dense and persistent vitreal hemorrhage.

The two superior trocars were positioned at the usual ten and two o'clock locations in the usual fashion. The Microvit was introduced superotemporally. After a generous anterior vitrectomy, a light pipe was placed in the eye along with the use of an irrigating contact lens. The vitrectomy was continued posteriorly and peripherally in the usual fashion. All membranous adhesions were easily stripped from the retinal surface.

The superior trocars were plugged after which 560 indirect laser burns were placed in a fill in pattern into the far periphery via scleral depression. Intensities were adjusted for moderate blanches. The IOP was lowered. The two superior trocars were removed.

WHAT’S MISSING???
Treatment of Retinopathy

- 67228 – Treatment of extensive or progressive retinopathy, 1 or more sessions; (eg, diabetic retinopathy), photocoagulation

- 67036 – Vitrectomy, mechanical, pars plana approach
Injection/Aspiration

- 67110 – *Repair of retinal detachment*; by injection of air or other gas *(e.g. pneumatic retinopexy)*

(For aspiration or drainage of subretinal or subchoroidal fluid, use 67015)

- 67015 – Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)

- 67025 – Injection of vitreous substitute, pars plana or limbal approach (fluid-gas exchange), with or without aspiration (separate procedure)
Cornea - Anatomy

- Cornea – dome shaped covering over iris and pupil
- Limbus – area where cornea and sclera meet
- Conjunctiva – transparent membrane covering sclera
Keratoplasty

1. Epithelium
2. Stroma
3. Descemet's membrane and endothelium (cornea)
4. Anterior chamber
5. Iris
6. Lens
7. Ciliary body
8. Sclera
Keratoplasty

- 65710 – Anterior lamellar, *only a portion of the cornea is removed* (*anterior stroma & Bowman’s membrane*)

- 65730 – Penetrating (except in aphakia or pseudophakia) – *patient has their natural lens in place*

- 65750 - Penetrating (in aphakia) – *patient’s natural lens is absent* (*previously removed*)

- 65755 – Penetrating (in pseudophakia) – *false lens* (*usually an IOL has been previously placed*)

*Lens status is determined by how the patient presents for surgery*
Laser Treated Cornea

+ 0289T
Corneal incisions in the donor cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (List separately in addition to code for primary procedure)
Sunset January 2017
CPT Changes: An Insider’s View 2012
(Use 0289T in conjunction with 65710, 65730, 65750, 65755)

+ 0290T
Corneal incisions in the recipient cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (List separately in addition to code for primary procedure)
Sunset January 2017
CPT Changes: An Insider’s View 2012
(Use 0290T in conjunction with 65710, 65730, 65750, 65755)
Endothelial Keratoplasty

- 65756 – Keratoplasty; endothelial

- + 65757 – backbench prep of endothelial allograft (Do not report with other penetrating keratoplasty codes)

aka - DSEK, DSAEK or DLEK
Descemet’s Stripping Endothelial Keratoplasty
Descemet’s Stripping Automated Endothelial KP
Deep Lamellar Endothelial Keratoplasty
PK vs. DSEK

- Penetrating keratoplasty
  65730, 65750, 65755

- DSEK – small incision near limbus, stripping of Descemet’s membrane

- Graft placement on inside of eye

- V2785 for corneal tissue allograft
Pterygium

• Use 65426 for pterygium excision with amniotic membrane graft

• V2790 – amniotic membrane
  (coverage determined by individual carriers)

*Do not report 65420 – Excision pterygium; without graft and ocular surface reconstruction code*
Pterygium

June 09 CPT Assistant

- In some surgical procedures, amniotic membrane is used after the removal of a conjunctival growth known as pterygium graft. In those situations, the correct code to report is:

- 65426 – Excision or transposition of pterygium; with graft

Medicare CCI Edit Guidelines

- CPT codes 65420 and 65426 describe excision of pterygium without and with graft respectively. Graft codes and the ocular surface reconstruction CPT codes 65780-65782 should not be reported separately with either of these codes for the ipsilateral eye.

(For placement of amniotic membrane using tissue glue, use 66999)
Dec 07 CPT Assistant

• If pterygium excision was performed with conjunctival rearrangement without a graft, and the conjunctival rearrangement is substantial, then code:

68320 - Conjunctivoplasty; with conjunctival graft or extensive rearrangement, is separately reportable.
Glaucoma

- Caused by inadequate drainage of aqueous humor from anterior segment
- Leads to increased intra-ocular pressure damaging optic nerve
- Open angle glaucoma's
  - Most common type
  - Chronic, of long duration
- Angle closure, closed angle, narrow angle (acute sudden onset)
Glaucoma Procedures

**Trabeculectomy**

**Laser Surgery**
Trabeculectomy

- 66170 – Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery

- 66172 - ;trabeculectomy ab externo w/scarring from previous ocular surgery or trauma

**Question:** When a bleb fails after a trabeculectomy procedure, is it appropriate to report the revision of that bleb with code 66250 - Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure?

**Answer:** Yes, it is appropriate to report code 66250 to describe the revision of the bleb following a trabeculectomy procedure.
Aqueous Shunt

- 66180 - *Aqueous shunt to extraocular reservoir*

- To prevent the drainage tube from eroding through the conjunctiva, the surgeon may place a piece of processed, dehydrated human pericardial allograft over the drainage tube before closing the conjunctival flap. The allograft is cut to size and secured in place with nylon sutures, anchoring its edges to the sclera. *(Application of the allograft is not coded separately.)*

*CPT Assistant Sep. 03*
Aqueous Shunt/Graft Update

CPT Assistant Aug. 2012

Question
• May codes 66180 and 67255 be reported for placement of the “Ahmed Glaucoma Valve (AGV™)” with scleral reinforcement?

Answer
• Yes. It is appropriate to report code 66180, Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin), for placement of the “Ahmed™ Glaucoma Valve (AGV™).” In addition, code 67255, Scleral reinforcement (separate procedure); with graft, should also be reported to describe the scleral graft procedure. As code 67255 is designated as a “separate procedure,” it is recommended that the modifier 59, Distinct Procedural Service, be appended to indicate a distinctly separate procedure was performed in addition to that represented by code 66180.
Microstent

- 0191T – Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork
- 0192T – external approach
- 0253T – internal approach, into suprachoroidal space

*NOT LISTED ON LCD L32789*

*Mini ex-press shunt*  *iStent – Trabecular Micro-Bypass*
Microstent with Trabeculectomy

Question
• May CPT codes 66170 and 66172 trabeculectomy ab externo be reported in addition to 0191T and 0192T for insertion of anterior segment aqueous drainage device without extraocular reservoir?

Answer
• No. It would not be appropriate to report either Category I code 66170 or 66172 (trabeculectomy codes) in addition to either Category III code 0191T or 0192T (insertion of anterior segment aqueous drainage device, without extraocular reservoir)

CPT Assistant Dec. 2012
Microstent with Trabeculectomy

Description of Procedure (0192T)
A limbal- or fornix-based conjunctival incision is prepared. Next, a partial-thickness scleral flap is formed with a base at the limbus. Aqueous flow from the anterior chamber is produced by an incision into the anterior chamber beneath the scleral flap or by excising the inner wall of Schlemm’s canal. The aqueous drainage device is implanted under the scleral flap in order to maintain the aqueous flow out of the eye. The scleral flap is secured with sutures, and the conjunctiva is repositioned over the wound site and closed with sutures to create a watertight seal.

Codes 0191T, 0192T and 0253T are on the ASC List of Approved Procedures
“Canaloplasty”

- 66174 – *Transluminal dilation of aqueous outflow canal; without retention of device or stent*
- 66175 – *with retention of device or stent*
Canaloplasty

- Following this a 250 micron cannula was placed within the opening of Schlemm's canal and advanced in a clockwise direction. Progress of the advancement was followed by the blinking red light at the tip of the cannula. Approximately 300 degrees of advancement went quite easily but then the cannula deviated through one of the feeder vessels into a more temporal position. Several attempts were made to coax the cannula back into Schlemm's canal to complete the 360 degrees but this could not be done. Consequently the cannula was withdrawn and reinserted in the opposite direction. This time cannula was advanced for 360 degrees without difficulty and exited back into the wound site. The #9-0 Prolene suture was tied to the tip of the cannula and the cannula was then withdrawn. As the cannula was withdrawn, aliquots of Healon were deposited within Schlemm's canal to dilate it and once the cannula had been withdrawn completely it was cut free from the Prolene suture which had pulled through with it. The Prolene suture was then tied together so as to create inward pressure on the Schlemm's canal.
Complex Cataract 66982

• A miotic pupil which will not dilate sufficiently to allow adequate visualization of the lens in the posterior chamber of the eye and which requires one or more of the following techniques: *the insertion of multiple iris retractors through multiple additional incisions, pupil expansion device or technique, a sector iridectomy with or without subsequent suture repair of iris sphincter, or sphincterotomies created with scissors.*

• The presence of a disease state that produces lens support structures that are abnormally weak or absent. This *requires the need to support the lens implant with permanent intraocular sutures or when a capsular support ring is necessary to allow placement of an intraocular lens.*

• Pediatric cataract surgery may be more difficult intraoperatively because of an anterior capsule which is more difficult to tear, cortex which is more difficult to remove, and the need for a primary posterior capsulotomy or capsulorrhexis. Furthermore, there is additional postoperative work associated with pediatric cataract surgery.

• The *use of capsular dye* for the assisted visualization of the anterior capsule in performing capsulorrhexis.
Iris Hooks

Iris hooks are left in during surgery and removed at the end of the procedure. *Merely stretching the pupil does not constitute a complex cataract extraction.*
Pupil Expansion Device
(Malyugin Ring)

- Ring inside of injector
- Ring deployed into anterior chamber
- Lateral margin of pupil engaged
- Remaining pupillary margins engaged
- Expansion device in place
- Device removed at end of procedure
Capsular Support/Tension Rings
Cataract with Other Procedures

- Iridectomy and/or anterior vitrectomy may be performed in conjunction with cataract extraction. If an iridectomy is performed in order to complete a cataract extraction, it is an integral part of the procedure and is not separately reportable. Similarly, the minimal vitreous loss occurring during routine cataract extraction does not represent a vitrectomy and is not separately reportable. If an iridectomy or vitreectomy that is separate and distinct from the cataract extraction is performed for an unrelated reason at the same patient encounter, the iridectomy and/or vitreectomy may be reported separately with an NCCI-associated modifier. The medical record must document the distinct medical necessity for each procedure.

- A trabeculectomy is separately reportable with a cataract extraction if performed for a purpose unrelated to the cataract extraction. For example, if a patient with glaucoma requires a cataract extraction and a trabeculectomy is the appropriate treatment for the glaucoma, the trabeculectomy may be separately reportable. However, performance of a trabeculectomy as a preventative service for an expected transient increase in intraocular pressure postoperatively, without other evidence for glaucoma, is not separately reportable.
# Proposed Quality Measures

## Complications within 30 days of Cataract Surgery
- Denominator: total number of patients aged 18 years and older who had cataract surgery and no significant preoperative ocular conditions impacting the surgical complication rate
- Numerator: number of patients who had one or more specified operative procedures for any of the following major complications within 30 days following cataract surgery

**Key definitions: post-operative patients who had major complications:**
- Retained nuclear fragments
- Endophthalmitis
- Dislocated or wrong power intraocular lens (IOL)
- Retinal detachment
- Wound dehiscence

## Cataract: Improvement in Patients Visual Function within 90 days
- Denominator: number of patients aged 18 years and older in sample who had cataract surgery
- Numerator: number of patients 18 years and older in sample who had improvement in visual function achieved within 90 days following cataract surgery, based on completing a pre-operative and post-operative visual function instrument
Lipshitz Macular Implant

- Lens design uses two miniature mirrors to enhance the telescopic image
- Greatly magnifies images for patients with significant central retinal disease (macular degeneration, diabetic retinopathy, macular holes)

In AMD, photoreceptor cells on the center of the macula do not function and cannot detect light, but photoreceptor cells in the more peripheral area are still functioning.

By increasing central visual field using two to three times magnification on the macula, enough photoreceptor cells are used to create an image that can be seen by the patient.
Telescopic Intraocular Lens

Billing Instructions

• Effective July 1, 2012, device pass-through category C1840 (Lens, intraocular (telescopic) must be billed with CPT code 0308T (Insertion of ocular telescope prosthesis including removal of crystalline lens) to receive pass-through payment, because C9732 is deleted effective June 30, 2012.

MLN Matters Number: MM7847

HCPCS code C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens) was deleted June 30, 2012, and replaced with CPT code 0308T effective July 1, 2012.
Blepharoplasty vs. Blepharoptosis

AMA Guidelines

• The instruction reported in the September 2000 issue of the CPT Assistant Newsletter remains correct, it is still appropriate to report code 15823, Blepharoplasty, upper eyelid; with excessive skin weighting down lid, in addition to code 67904, Repair of blepharoptosis; (tarso) levator resection or advancement, external approach, when both procedures are performed on the same eyelid.

Third-party payer guidelines may differ from CPT coding guidelines - For reimbursement please contact the applicable payer.

CCI Edit Guidelines

• CMS payment policy does not allow separate payment for a blepharoptosis procedure (CPT code 67901-67908) and blepharoplasty procedure (CPT codes 15822, 15823) on the ipsilateral upper eyelid.

15822/15823 ($833) bundles into 67901/67904 ($755)
ASC List of Drugs/Biologicals

- **F4** - Corneal tissue acquisition, hepatitis B vaccine; *paid at reasonable cost*
  
  **V2785** Processing, preserving and transporting corneal tissue

- **K2** - Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate
  
  **J3300** Injection, triamcinolone acetonide, preservative free, 1 mg ($3.91) – use for Trivaris, Triesence

  **J7315** Mitomycin, ophthalmic, 0.2mg ($379.24) - use for Mitosol

  *HCPCS Code J7315 should only be used for Mitosol and should not be used for compounded mitomycin or other forms of mitomycin.*

- **J7** – OPPS pass through device paid separately when provided integral to a surgical procedure on ASC list; *payment contractor-priced.*
  
  **C1840** Telescopic intraocular lens
Thank You

pcadorette@mdstrategies.com
CEU’s

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