CORNEA Q & A

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Q. Can I use CPT (Current Procedural Terminology) codes 65420 (Excision or transposition of pterygium; without graft) and 68320 (Conjunctivoplasty; with conjunctival graft or extensive rearrangement) when I perform pterygium excision and free conjunctival autograft instead of CPT code 65426 (Excision or transposition of pterygium; with graft).

A. No, you cannot. CPT code 65426 was designed to encompass placement of the free conjunctival autograft.

Q. What are the new cornea codes for 2004?

A. The new codes for 2004 are:

- 65780 Ocular surface reconstruction; amniotic membrane transplantation
- 65781 Limbal stem cell allograft (eg, cadaveric or living donor)
- 65782 Limbal conjunctival autograft (includes obtaining graft)
- 68731 Harvesting conjunctival allograft, living donor

Q. How do I pick the codes for keratoplasty?

A. The following are the CPT codes for keratoplasty:

- 65710 Keratoplasty (corneal transplant); lamellar
- 65730 penetrating (except in aphaka)
- 65750 penetrating (in aphakia)
- 65755 penetrating (in pseudophakia)

When selecting a CPT code for surgical coding, the code(s) selected represent what was done at the end of the case. However, with keratoplasty the opposite rule prevails. One selects the code based on the status of the eye at the beginning of the operation.

For example, if a repeat penetrating keratoplasty is being performed in a patient with failed graft along with exchange of an intraocular lens - then the correct CPT code would be 65755. On the other hand, if the penetrating keratoplasty is performed on a patient who is aphakic with insertion of a secondary intraocular lens, then the correct code for the keratoplasty would be 65750.
Q. Can AK/LRI surgeries performed along with cataract surgery be billed using CPT code 65772 (Corneal relaxing incision for correction of surgically induced astigmatism)?

A. No, absolutely not. AK (astigmatic keratectomy) and LRI (limbal relaxing incisions) surgical procedures that are performed at the time of the cataract surgery are non-covered procedures and cannot be billed to Medicare unless the astigmatism was present at the time of surgery and was induced from prior surgery or trauma. Therefore, many providers are now charging the patient for these procedures. This practice requires close scrutiny on the part of the practice to ascertain if there is medical necessity for the procedure and when it should be performed. Surgical techniques, the amount of preoperative planning and the amount of pre-surgical astigmatism should all be considered before the patient is charged.

Q. How would you code deep lamellar endothelial keratoplasty?

A. From a coder's perspective the word lamellar refers to a thin layer, and in reference to the cornea is usually applied the outermost layers. Penetrating, on the other hand, refers to the thickness of the cornea indicating that it is full thickness. This interpretation may be at variance with a physician's perspective. I would code these operations as a lamellar keratoplasty (CPT code 65710). An alternative would be to use CPT code 66999 - the unlisted code.

Q. How can I code for insertion of a temporary keratoprosthesis? I work at a major academic medical center and often perform combined operations with other ophthalmology subspecialists. This takes a lot of work and effort and we don't seem to be able to get reimbursed for this.*

A. Unfortunately, there is no code for the insertion of a temporary keratoprosthesis, so it can only be billed using the unlisted CPT code 66999. However, perhaps your academic medical center billing people could work with your local Medicare carrier or third party payor personnel and try to obtain approval for reimbursement for this procedure using CPT code 66999 when the claims are submitted with proper documentation.
Q. The cornea specialist in our practice did an excisional biopsy of a cornea lesion - do I use CPT code 65410 (Biopsy of cornea), 65400 (Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium) or both?

A. Physicians often use the term excisional biopsy which always presents coding dilemmas. What the physicians generally are trying to convey is that a lesion with suitable margins was excised and the material was sent to pathology for definitive diagnosis. When this type of situation occurs, whether in cornea, oculoplastics or other specialty, code the excision and not the biopsy.

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*Some providers have reported using 65772 with modifier 52 (reduced services). It is recommended you have written approval of your insurer before doing this.
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