INTRODUCTION

There are many complicated issues when attempting to code for retina and vitreous surgery, particularly the more complex cases. If the physician remains unknowledgeable regarding the reimbursement issues, one can expect to experience a corresponding loss of revenue. This review is based on coding for Medicare and entails some of the more important issues and challenges that confront coding for these surgical procedures.

MODIFIER CHALLENGES

Most practices have competent billing personnel who are capable of attaching appropriate modifiers when indicated, such as those for location, multiple surgeries, and bilateral procedures. Prudence dictates that there are three modifiers that must be mastered by the surgeon in order to optimize surgical reimbursement. Prudence is often colored green. These modifiers are 58, 78 and 79. The full description of these modifiers are found in the accompanying sidebar. Modifier 59 is discussed under the National Correct Coding Initiative.

Complete modifier information is found in CPT (Current Procedural Terminology).

**Modifier 58 - Staged or Related Procedure or Service by the Same Physician**

Modifier 58 has three distinct uses. They are:

- Procedures planned prospectively at the time of the original procedure (staged)
  
  Examples: -Silicone oil removal in the global period
  -Vitrectomy followed by planned PDT (photodynamic therapy – Medicare calls this OPT – Ocular Photodynamic Therapy)

- Procedures that are more extensive than the original procedure
  
  Example: Repair of retinal detachment by vitrectomy (CPT code 67108) followed by PVR (proliferative vitreoretinopathy) with traction detachment and subsequent repair of retinal detachment with vitrectomy and epiretinal membrane peel (CPT codes 67108 + 67038)

- For therapy following a diagnostic procedure
  
  Example: Vitreous tap followed by complete vitrectomy

Modifier 58 pays at 100% of the allowable and a new global period starts. For Medicare, the global period is either 0, 10, or 90 days: procedures are classified as minor or major based solely on the global period, with those procedures having a global period of zero or ten days being minor and those having a global period of 90 days being major. Complexity of the procedure is irrelevant in determining the global period – it is fixed by Medicare and different carriers have different global periods.
**Modifier 78 - Return to Operating Room for a Related Procedure During the Global Period**

Modifier 78 is defined as the related procedure and is to be used when a procedure performed in the global period is related to the original procedure. Be careful. Medicare’s concept of related is not necessarily a physician’s medical concept of related. The occurrence of a retinal detachment in the global period of a cataract surgery may be considered related by the physician but is not considered related by Medicare.

Medicare’s definition of an Operating Room includes a laser suite, an endoscopy suite and an operating room in a hospital or ASC (Ambulatory Surgery Center). The physician is paid at the intraoperative value of the procedure which for most cases is 70% of the allowable. No new global period starts.

- **Example:** Retinal detachment repair by vitrectomy et cetera (CPT code 67108) followed by re-repair in the global period using the same technique (CPT code 67108).

- **TIP:** If you use the same CPT code for the subsequent operation you probably Should be using modifier -78

**Modifier 79 - Unrelated Procedure or Service by the Same Physician During the Postoperative Period**

Modifier 79 is defined as the unrelated modifier and is to be used for services and procedures that are not related to the original procedure. They can be nonrelated by virtue of a different location or a different diagnosis. Payment is made at 100% of allowable and a new global period starts.

- **Example:** Focal laser (CPT 67210) followed by PRP (CPT 67228) in the global period
- **TIP:** Be sure to tell billing people on all procedures if the right or left eye is being operated on. If you are doing an unrelated procedure on the opposite eye in the global period, payment can be seriously delayed if the 79 modifier is not appended.

- **TIP:** When two surgeons with different subspecialties in the same practice operate on the same person on the same day, in order to get paid for each surgeon independently use modifier -79 on each procedure code for each surgeon. Each surgeon should be paid 100% of the allowable for the first procedure and 50% of the allowable for the next four procedures.

When trying to decide which modifier to use it is sometimes helpful to think of a food chain analogy.

If you are going up the food chain, using more complicated surgical techniques and different procedure codes such as occurs with 67108 followed by 67108 + 67038, then, generally, modifier -58 is correct.

If you are stable (using the same procedure code again) or going down the food chain, use modifier -78. Example: 67108 + 67038 followed by 67036

In modifier application terms - in general, if you are using the same procedure code for the second operation in the global period that is the same procedure code as the first operation, you are in a modifier 78 situation. If you are coding for procedure(s) that are complications of
the original surgery it is modifier 78, whereas if you are coding for procedures that represent a progression of the disease process it is usually modifier 58.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

The National Correct Coding Initiative lists sets of code pairs, defined as either comprehensive or mutually exclusive, that cannot be used together for various reasons. Column 1 (formerly Comprehensive) code sets are defined as code set pairs that include all related services, most of which are listed in Column 2. When coding, one should not fragment one service into component parts in order to maximize reimbursement. Because this was being done in excess (ie, fraudulently), the NCCI was developed.

Let’s look at the following example of comprehensive bundled codes:

- Column 1 code 67108, Column 2 code 67107:
  - **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.
  - **Code 67107** Repair of retinal detachment; scleral buckling.

If both of these codes are billed together, only 67108 will be paid.

Mutually exclusive codes are those codes that cannot reasonably be done in the same session. This is based on the CPT definition of the medical impossibility or improbability that the procedures could be performed at the same session. Caution; the lowest paying code (code with lowest RVUs) is paid.

Here is an example of a mutually exclusive bundle:

- Column 1, code 67112; Column 2, code 67108:
  - **Code 67112** Repair of retinal detachment by scleral buckling or vitrectomy on patient having previous ipsilateral retinal detachment repairs.
  - **Code 67108** Repair of retinal detachment; with vitrectomy, any method.

Mistakes made by billing mutually exclusive codes can be costly because the code with the lowest RVUs is paid and the other is denied. Here is the reimbursement on a national average for 2005 on the above code pairs so you can get an idea of the impact.

- Code 67112 (29.47 RVUs\(^1\)) = $1116.83; code 67108 (39.33 RVUs) = $1373.02.

In January, 2005 all the bundles with the retinal detachment repair codes/vitrectomy codes were removed. In my opinion, if an insertion of an intraocular lens had been one of procedures performed, the code pair edit could have been legitimately unbundled. The process for doing this is application of modifier 59 on the bill for all the bundled procedures.

- **TIP:** Do not unbundle 67108 with cataract extraction (ie, lensectomy only).
- **TIP:** Familiarize yourself with the complex cataract code (CPT code 66982) - many of your cases may qualify.
• **TIP:** The bundles were in effect from April 1, 2003 until January 1, 2005. In order for claims within that time frame to be paid properly, you will have to unbundle the codes for Medicare. Claims can be processed for 12 months from date of service for clean claims and 18 months for corrected claims (small penalty).

**CODING FOR NEW TECHNOLOGY TREATMENTS**

Technology is advancing more rapidly than ever, particularly in the field of pharmacotherapy and the treatment of macular degeneration. The coding for pharmacotherapeutic treatments is not particularly difficult as can be seen from the table listed below.

### CPT CODING BY TREATMENT DELIVERY SYSTEM

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>How to Code (CPT Code)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intraocular Injections</strong></td>
<td>67028 Intravitreal injection of pharmacologic agent</td>
<td>-If an off-label use, be sure to have this in your informed consent and check your Medicare carrier’s LCD (Local Coverage Determination) for Off-Label Use of Drugs for Non Oncologic Conditions -For physician use of drugs be sure that the drug is on Medicare’s approved list of drugs</td>
</tr>
<tr>
<td><strong>Implantation of an intravitreal drug delivery system such as Retisert</strong></td>
<td>67027 Implantation of intravitreal drug delivery system (eg, ganciclovir implant), included concomitant removal of vitreous</td>
<td>-Use modifier 59 to unbundle 67036 (pars plana vitrectomy) if complete vitrectomy is performed – this is not to be done for incidental removal of vitreous that normally accompanies this type of surgery</td>
</tr>
<tr>
<td><strong>Ocular Photodynamic Therapy</strong></td>
<td>67221 Destruction of localized lesion of choroids (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion) 67255 photodynamic therapy, second eye, at single session</td>
<td>67255 is an add-on code and should not be billed using modifier 51</td>
</tr>
<tr>
<td><strong>Topical Therapy</strong></td>
<td>E/M or Eye Codes</td>
<td>Included in the office visit or consultation</td>
</tr>
<tr>
<td><strong>Systemic Therapy</strong></td>
<td>E/M or Eye Codes</td>
<td>Included in the office visit or consultation</td>
</tr>
<tr>
<td><strong>Posterior Juxtascleral Depot (Has received FDA approvable letter, but not FDA approval at time of publication)</strong></td>
<td>0124T Conjunctival incision with posterior juxtascleral placement of pharmacological agent (does not include supply of medication)</td>
<td>This is a Category III code released July 1, 2005 for implementation January 1, 2006. Whether Medicare pays for this is a local carrier decision as is true all Category III codes.</td>
</tr>
</tbody>
</table>
Combination Therapies. Sometimes different therapies are combined on the same day such as 67028 (Intravitreal injection) + 67221 (PDT). In this example both procedures have “0” days global period. Multiple surgery rules apply - you will be paid at 100 percent of PDT (6 RVU’s) and 50 percent of the injection (4.10 RVU’s). The math for payment on a national average is $227.38 + $77.68 = $305.06. No reduction for the second procedure occurs if they are performed on separate days. Be sure to use an appropriate modifier if the procedure is performed within the global period of another procedure. This is not necessary if the global period is “0” days.

CPT CODE SELECTION

CPT Code 67108 versus 67112. One of the most puzzling retinal detachment coding dilemmas concerns whether to use 67108 or 67112 (Repair of retinal detachment; by scleral buckling or vitrectomy on patient having ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques) for repair of a recurrent retinal detachment.

It seems that CPT code 67112 was originally developed for use with insurers who refused to pay CPT code 67108 more than once or twice (i.e., for recurrent retinal detachment). Remember, many third party payors do not recognize modifiers as Medicare does. Since the reimbursement for 67112 is significantly lower, a choice has to be made whether to use 67108 with the proper modifier (usually -78) or 67112. Unfortunately, this was not thought through when the values for code 67112 were developed. What should be apparent is that, for the most part, recurrent retinal detachment surgery is more complex, has a poorer prognosis, and is technically more difficult. Even if you are in a global period, it is financially advantageous in Medicare patients to use 67108 with a 78 modifier if that is the only procedure code being used.

CPT Code 66850 versus 66852. CPT code 66850 (Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration) is the one that is to be used when a lensectomy is performed in conjunction with a vitrectomy procedure. This is based on the instruction in the CPT manual. It seems a bit bizarre to retinal surgeons since an anterior approach is used and most want to use CPT code 66852 (Removal of lens material; pars plana approach, with or without vitrectomy). In fact CPT code 66852 is not your code! There is occasional use for it when coding for pediatric cataract removal. The code was developed for primary cataract extraction using a pars plana approach wherein incidental vitreous may be removed, but a core or complete vitrectomy is not performed.

Selective elimination of codes. Do not selectively eliminate codes when listing multiple codes just in order to obtain higher reimbursement. For example, if both CPT codes 67028 (Intravitreal injection of a pharmacological agent) (0 global) (4.08 RVU’s) and 67015 (Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)) (90 global) (13.39 RVU’s) are performed on the same day, you cannot ignore 67015 just to be able to capture the 0 day global period and bill for the postoperative visits. Use the NCCI bundles and list the comprehensive code for payment.
### CHALLENGING CASES – A MINIWORKSHOP

**Case 1.** Patient presented with a vitreous hemorrhage and cataract with pseudoexfoliation and loose lens zonules in the right eye. The vitreoretinal surgeon performs a vitrectomy and lensectomy and the anterior segment surgeon inserts and sutures in a posterior chamber intraocular lens. Code all procedures.

**Retinal Surgeon**

**Diagnosis:**
1) 379.23 Vitreous hemorrhage, right eye  
2) 366.17 Mature cataract, right eye

**Surgery:**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Procedure(s)</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) 1</td>
<td>67036 Vitrectomy, pars plana approach</td>
<td>-79-RT</td>
</tr>
<tr>
<td>2) 2</td>
<td>66850 Removal of lens material; phaco-fragmentation technique</td>
<td>-51-79-RT</td>
</tr>
</tbody>
</table>

**Anterior Segment Surgeon**

**Diagnosis:** 1) 379.31 Aphakia

**Surgery:**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Procedure(s)</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) 1</td>
<td>66985 Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal</td>
<td>-79-RT</td>
</tr>
<tr>
<td>2) 1</td>
<td>66682 Suturing of intraocular lens</td>
<td>-51-79-RT</td>
</tr>
</tbody>
</table>

**TIP:** Modifier 79 is used to indicate separate surgeon of different subspecialty and facilitates payment for each surgeon at multiple surgery rules

**Case 2.** Patient had cataract surgery in the left eye by an anterior segment surgeon and the posterior chamber intraocular lens dropped into the posterior vitreous space. Surgery consisted of retrieval of the intraocular lens, its removal from the eye and the placement of another intraocular lens in the posterior chamber which was sutured into position. Code all procedures.

**Diagnosis:** 1) 996.53 Mechanical complication of prosthetic device due to intraocular lens implant, left eye

**Surgery:**

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</tr>
</thead>
<tbody>
<tr>
<td>1) 1</td>
<td>67036 Vitrectomy, pars plana approach</td>
<td>-LT</td>
</tr>
<tr>
<td>2) 1</td>
<td>66986 Exchange of intraocular lens</td>
<td>-51-LT</td>
</tr>
<tr>
<td>3) 1</td>
<td>66682 Suturing of posterior chamber intraocular lens</td>
<td>-51-LT</td>
</tr>
</tbody>
</table>
TIP: If both surgeons are in the same practice, again use modifier 79. Codes 67036 and 66986 are no longer bundled.

Case 3. Patient had recurrent tractional retinal detachment in the right eye with vitreous membrane formation. This occurred within the global period. Current surgery consists of re-repair of retinal detachment by vitrectomy, removal of membranes, placement of silicone oil, fluid-gas exchange, and peripheral iridectomy. Code all procedures.

<table>
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<tr>
<th>Diagnosis</th>
<th>Procedures</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>361.81</td>
<td>Traction retinal detachment with vitreoretinal organization</td>
<td></td>
</tr>
<tr>
<td>V45.69</td>
<td>Previous retinal detachment surgery</td>
<td></td>
</tr>
</tbody>
</table>

Surgery: Diagnosis Procedures Modifiers

1) 1 67038 Vitrectomy with removal of epiretinal membranes -58-RT
2) 1, 2 67108 Repair of retinal detachment by vitrectomy, etc. -51-58-RT
3) 1 66625 Peripheral iridectomy -51-79-RT

TIP: Modifier 58 is used because you are going from a lesser to greater procedure in the global period due to disease progression. The 79 modifier is used because that procedure is unrelated to the earlier surgery. The RVU’s for 67038 became higher than 67108 in 2005 and 2006.

MANDATES FOR SUCCESS

In order to code correctly and optimize reimbursement here are some mandates:

- The **surgeon** must master the modifiers 58, 78 and 79
- The **surgeon** must choose when to break a NCCI bundle
- The **surgeon** must decide which off-label use of a drug meets the conditions for reimbursement set forth by your Medicare carrier
- The **surgeon** must develop a surgical encounter form that includes diagnoses, location and CPT procedure codes

Good Luck!

1 RVU = Relative Value Unit – the unit used to calculate payments. Each code has a RVU assigned to it that changes annually. The RVU (composed of physician work RVU’s, malpractice RVU’s and practice expense RVU’s) is multiplied by a conversion factor and then a geographic index to arrive at the payment.

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KEY SURGICAL CODING MODIFIERS

-58  Staged or Related Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier ‘-58’ to the staged or related procedure. Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier ‘-78’.

-78  Return to the Operating Room for a Related Procedure During the Postoperative Period: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier ‘-78’ to the related procedure. (For repeat procedures on the same day, see ‘-76’.)

-79  Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier ‘-79’.
(For repeat procedures on the same day, see ‘-76’.)

-59 DISTINCT PROCEDURAL SERVICE: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier ‘-59’ is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier ‘-59’. Only if no more descriptive modifier is available, and the use of modifier ‘-59’ best explains the circumstances, should modifier ‘-59’ be used.

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