

Tips on Glaucoma Surgical Coding for Medicare

**Riva Lee Asbell
Philadelphia, PA**

INTRODUCTION

Glaucoma surgical coding is usually rather straightforward, but occasionally some problems occur. Although the surgical codes not as extensive as in the other ophthalmic subspecialties, there are still some pitfalls to be avoided.

MEDICARE'S GLOBAL PERIOD AND GLOBAL FEE

Medicare's global fee for ophthalmology surgery allocates 10% of the fee for preoperative work, 70% of the fee for intraoperative work and 20% of the fee for postoperative work.

The global period for a surgical procedure is 90, 10 or 0 days. Major surgical procedures are defined as those having a global period of 90 days, while minor surgical procedures have a global period of 10 or 0 days. Office visits for diagnoses related to the surgery may not be billed during the global period.

In order to be paid for surgical procedures performed within the global period, a modifier must be appended.

Use modifier 78 if the subsequent operation is related to the original surgery.

Use modifier 79 if the subsequent surgery is unrelated to the first operation.

Use modifier 58 for subsequent procedures that could be considered a greater or more extensive procedure than the original one, is staged or is therapeutic following a diagnostic procedure.

Another useful modifier is 59, which is used to indicate a different site or location and is also used to break the edits of code pairs in the National Correct Coding Initiative (CCI).

LASER GLAUCOMA SURGERY

All glaucoma laser surgeries that have the description “one or more sessions” include all laser sessions performed within the global period. With the exception of cyclophotocoagulation, all glaucoma laser surgeries include this description. Laser trabeculoplasty is considered as being performed in sessions; if not done all at one time, the sessions should not be billed separately.

Selective laser trabeculoplasty may be billed the same as argon laser trabeculoplasty by using Current Procedural Terminology (CPT) procedure code 65855 (trabeculoplasty) by laser surgery, one or more sessions). This is part of the defined treatment series.

Remember that procedure code 65855 has a global period of 10 days and office visits may be billed after that time.

66170 vs. 66172

These CPT codes represent trabeculectomy ab externo in absence of previous surgery vs. trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents).

CPT procedure code 66172 may be used when billing a trabeculectomy if any type of ocular surgery had not been previously performed on that eye, not only glaucoma surgery. However, there should be some conjunctival scarring, and this code should not be used when only laser surgery preceded the open surgery. Procedure code 66172 has a modestly higher payment rate than 66170.

Do not bill CPT code 66250 (revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure) in addition to code 66172. The difficulty of the wound revision has already been accounted for in calculating the payment of 66172.

Both codes include the use of an antifibrotic agent such as mitomycin. Use of such a substance during the surgery cannot be billed additionally. However, 5FY injections are not included in the payment of these procedures and, if performed in the global period, are additionally payable by appending modifier 79 or 58, depending on your local Medicare carrier’s instructions.

If 66172 is repeated in the global period, it should be billed with modifier 78.

NEEDLING OF THE BLEB

Needling of the bleb in the global period of a trabeculectomy may be paid if the procedure is performed in an operating room. The appropriate code of 66250 (revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure) and modifier 78 should be appended. However, if the needling is performed at the slit lamp in a patient examination lane, it is considered to be a component of postoperative care and does not warrant additional payment.

The rationale is that modifier 78 mandates return to the operating room for a problem encountered with the original procedure. Medicare defines an operating room as an OR in hospital or ambulatory surgery center, an endoscopy suite or a laser suite (devoted exclusively to laser surgery). A problem that can be managed in the office would not warrant extra payment.

Of course, outside the global period the site of service does not apply.

SHUNTS/TRABECULECTOMY/SCLERAL REINFORCEMENT PROCEDURES

The following CPT codes are used with insertion/revision of aqueous shunts:

66180: Aqueous shunt to extraocular reservoir (eg, Molteno, Shocket, Denver-Krupin).

66185: Revision of aqueous shunt to extraocular reservoir.

67255: Scleral reinforcement (separate procedure); with graft

Scleral reinforcement is bundled in the NCCI with the trabeculectomy codes (66170, 66172) but is not bundled with the shunt codes (66180, 66185). Providers are reimbursed by Medicare carriers for the reinforcement when it is performed with the shunt operations.

When billing for two shunts, such as placement of a Baerveldt and an Ahmed shunt at the same time, the procedure code can be

billed twice, as can the scleral reinforcement. However, a double plate shunt cannot be billed twice.

When coding for revision of the shunt (66185), do not additionally bill code 66250 (wound revision), and do not bill for a conjunctivoplasty.

CODING WORKSHOP

Case 1. Patient required insertion of both Baerveldt and Ahmed valves in the left eye. Accompanying donor scleral patch grafts were also placed. Code all procedures.

Diagnosis: 1) 365.89 Uncontrolled glaucoma

Surgery:	Diagnosis	Procedure Code(s)	Modifiers
	1) 1	66180 Insertion of aqueous shunt	-LT
	2) 1	66180 Insertion of aqueous shunt	-51-59-LT
	3) 1	67255 Scleral reinforcement	-51-LT
	4) 1	67255 Scleral reinforcement	-51-59-LT

TIP: To break CCI bundles or show different site, use modifier 59. This coding is to be used for separate shunts and not a double-chambered shunt.

Case 2. Patient underwent laser trabeculoplasty in the right eye and within the global period had the same procedure performed in the left eye. Code all procedure(s).

Diagnosis: 1) 365.10 Open angle glaucoma

Surgery:	Diagnosis	Procedure Code(s)	Modifiers
	1) 1	65855 Laser trabeculoplasty	-RT

Diagnosis: 1) 365.10 Open angle glaucoma

Surgery:	Diagnosis	Procedure Code(s)	Modifiers
	1) 1	65855 Laser trabeculoplasty	-79-LT

TIP: Use modifier 79; the procedure is unrelated because it is in the other eye. Medicare pays 100% of the allowable for the second procedure.

Case 3. Patient previously had an aqueous shunt placed in the left eye. The shunt seemed to be malfunctioning and a revision was necessary in the global period. Some conjunctival revision was also necessary. Code all procedure(s)

Diagnosis: 1) 996.59 Complication of mechanical device or implant

Surgery:	Diagnosis	Procedure Code(s)	Modifiers
1) 1		66185 Revision of aqueous shunt	-78-LT

TIP: Use modifier 78; the procedure is related because it is a complication related to the original surgery. Medicare pays 70% of the allowable.

Case 4. Patient had trabeculectomy surgery in the left eye. Within the global period it was necessary to perform insertion of an aqueous shunt with scleral reinforcement. Code all procedure(s).

Diagnosis: 1) 365.89 Mixed mechanism glaucoma

Surgery:	Diagnosis	Procedure Code(s)	Modifiers
1) 1		66180 Aqueous shunt placement to extraocular reservoir	-58-LT
2) 1)		67255 Scleral reinforcement	-51-58-LT

TIP: Use modifier 68; the procedure is a more extensive one than the original surgery. Medicare pays 100% of the allowable for the first procedure and 50% of the allowable for the second procedure (multiple surgery payment rules).

Notes: Modifier 51 is used for multiple surgeries performed at the same session. Medicare's multiple surgery reimbursement rules state the first procedure is paid at 100% of the allowable. Each of the next four procedures are paid at 50% of the allowable for each procedure

and after five procedures the case is evaluated by a medical advisor and given individual consideration.

CPT codes copyright 2002 American Medical Association

© 2003 Riva Lee Asbell

Reviewed March 2005

Ocular Surgery News August 1, 2003

