

BY RIVA LEE ASBELL

Coding for Complications of Cataract Surgery

Cataract surgery is the most frequent ophthalmic procedure performed in most ASCs. Although complications occur in only a small percentage of cases, it's imperative that the staff be prepared to handle them when they arise and be aware of how reimbursement may be affected. This article discusses some of the reimbursement issues that may be apparent — or not so obvious.

DIFFERENTIAL BETWEEN COMPLEX CATARACT EXTRACTION AND COMPLICATIONS THAT OCCUR DURING THE PROCEDURE

The definition of complex cataract includes the following qualifiers in Current Procedural Terminology (CPT):

... requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage.

According to the American Medical Association's publication titled *CPT Changes 2001, An Insider's View*, the following rationale was originally given for this then-new code:

66982 has been added to delineate procedural differences associated with the removal of extracapsular cataract(s) and lens insertion performed in the pediatric age group, on patients who present with diseased states, prior intraocular surgery, or with dense, hard and/or white cataracts. The presence of trauma, or weak or abnormal lens support structures caused by numerous conditions (e.g., uveitis) and disease states (e.g., glaucoma, pseudoexfoliation

syndrome, Marfan syndrome) require additional surgical involvement, and utilization of additional techniques and surgical devices. A small pupil found in a patient with glaucoma or a past surgical history may not dilate fully, and will require iris retractors through additional incisions. Capsular support rings to allow the placement of an intraocular lens may be required in the presence of weak or absent support structures.

Pediatric anatomy contributes to the complexity of cataract surgery. The anterior capsule tears with great difficulty and the cortex is difficult to remove from the eye because of intrinsic adhesion of the lens material. Additionally, a primary posterior capsulotomy or capsulorrhexis is necessary, which further complicates the insertion of the intraocular lens.

Clinical Application. Here are some of the clinical situations in which the complex code can be used:

- **Dense white cataracts removed in conjunction with application of dye** (e.g., Trypan Blue). Note that the use of dye alone is not mentioned and this was further substantiated in CPT Assistant in March 2016. It states: "... the additional work of instilling and removing Trypan Blue dye from the anterior segment though an additional surgical step does not reach the threshold of physician time, work, or intensity necessary to report the complex cataract code."
- **Pupillary enlargement procedures.** The precise procedures that would qualify for using this code are dependent on your Medicare Administrative Contractor's (MAC) Local Coverage Determination (LCD). The various authorities at the ophthalmology societies believe that both the use of iris retractors and pupillary stretching should enable the use of 66982. However, one should defer to the Medicare authorities.

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- **Synechiolysis** cannot be additionally billed. The definition of 66982 includes “requiring devices or techniques not generally used in routine cataract surgery.” The intent of the code is to include any form of synechiolysis. Both codes 66984 and 66982 were bundled with the various synechiolysis codes in Version 7.2 of the National Correct Coding Initiative effective July 1, 2000.
- **Vitrectomies** occasionally can be coded and billed as an additional procedure. If CPT code 67005 - removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal, or 67010 - subtotal removal with mechanical vitrectomy, is used, each is ordinarily bundled by the National Correct Coding Initiative (NCCI). However, in pediatric cataract surgery, when a limited pars plana vitrectomy is performed, it may be billed additionally. It is recommended that modifier -52 usually be applied since this is usually a limited pars plana posterior vitrectomy. Also, modifier -59 would have to be used due to the bundles with all cataract and retina/vitreous procedures (except 66850 – lensectomy).
- **Management of intraoperative complications**, such as vitreous loss and iris prolapse, do not qualify for the use of code 66982. The intent is that CPT code 66982 only be used when the physician plans prospectively and documents in the preoperative plan that a complex cataract procedure is to be performed.
- **Pediatric cases** cannot be coded as complex (CPT code 66982) when an IOL is NOT inserted. An IOL must be inserted to use this code, even though pediatric cataract extraction is more difficult than adult cataract extraction.

NOTE: The description of the code was changed to remove “endocapsular rings” in 2001 because, technically, a device that does not have FDA approval cannot be included in CPT code descriptors. Now that most of these devices do have FDA approval, their use would qualify the case to be coded using CPT code 66982.

The use of high-technology instrumentation doesn't necessarily qualify the procedure as complex. Examples would include use of the Fugo blade for anterior capsulorrhexis or performing laser ablation of the lens rather than phacoemulsification.

ASC PAYMENT CONSIDERATIONS WHEN COMPLICATIONS OCCUR

Surgical complications do occur and when trying to code a case, the focus may be on the various salvaging procedures rather than the original procedure. This often happens when cataract surgery with insertion of an IOL is being performed. Those responsible for setting up the codes (CPT Editorial Panel and National Correct Coding Initiative) are focused on physician reimbursement and, thus, the ASC reimbursement may be neglected. Extreme examples of this are found with the bundles between retinal detachment repair and cataract extraction with insertion of an intraocular lens. How is the ASC going to be reimbursed when the retinal and anterior segment surgeries are bundled?

Common complications that occur in which this situation can be problematic include:

- Vitreous loss precipitating an anterior, posterior, or combination vitrectomy
- The intraocular lens being dropped into the posterior segment, necessitating referral to a retina specialist (**See Case 1**)
- Rupture of the posterior capsule leading to other complications, such as vitreous loss and other possible disastrous complication (**See Case 2**).

Modifier Issues. In this context, it is worthwhile to review my column from the October 2015 issue of *The Ophthalmic ASC*.¹ Because this addresses facility billing for Medicare coding, there is no requirement for modifiers to demonstrate that the surgery for a complication is or is not related to any prior procedure, thus, there is no issue of global period.

QUALITY MEASURE: ASC-14: UNPLANNED ANTERIOR VITRECTOMY

For those of you who may have missed the column in the February 2017 issue of *The Ophthalmic ASC*, one of the final quality reporting measures for ASCs in 2017 will assess the percentage of unplanned anterior vitrectomies performed in conjunction with cataract surgery in an ASC.²

The assignment of a vitrectomy to the unplanned category and its associated type of cataract surgery, focusing on occurrences with complex cataract extraction as well as potential difficulties in abstracting the information, is discussed in the article. The import of these cases that need to be reported is that it is unplanned, thus, being a complication of the surgery (**See Case 3**).

REIMBURSEMENT OPTIMIZATION

One of the basic principles generally expounded is that the ASC surgery coding should match that of the physician's; however, sometimes this is not possible. If a better alternative exists that differs, but is accurate, then use it.

A seemingly obvious principle, but one that may be overlooked when coding, is the objective of the coding in cataract extraction with insertion of an intraocular lens is to get the facility charge covered that covers the procedure as well as the cost of the intraocular lens if it has been opened and cannot be used again or was specially ordered, and so on.

CASE STUDIES

The following cases are those that would be considered complications of cataract or other surgery and none fit into the category of complex.

Case 1

Operative Note excerpts: "This patient had had secondary lens insertion and suturing done elsewhere by another surgeon, including a McCannel suture. These have all failed, and the intraocular lens had dislodged into the vitreous cavity. The latest intraocular lens had broken into two pieces, with one haptic floating into the vitreous cavity, while the lens had dislodged and hung posteriorly.

A limbal peritomy was performed temporally and nasally. Partial thickness scleral flaps were raised approximately 4 mm in length extending 2 mm posterior from the limbus, which were limbus based nasally and temporally.

... A partial thickness scleral flap was raised about 1 mm posterior to the limbus and then a keratome was used to enter the anterior chamber ... The light pipe was used to raise the remaining portion of the intraocular lens and placed it into the anterior chamber. Forceps were then used to grasp the intraocular lens and remove from the eye. An Akreos (Bausch + Lomb) lens was secured using GORETEX CV-8 sutures and hung from the nasal and temporal sides, respectively. The lens was well centered. The sutures were tied temporarily while the intraocular lens was centered, and then tied permanently after the ports have been removed.

The 25-gauge ports were then placed outside of the scleral flap beds superonasally and superotemporally. Closed vitrectomy was carried out. The retained haptic was found lodged in the inferior vitreous space. This was removed using intraocular end-grasping forceps."

Diagnosis: 1) T85.22xA Malposition of intraocular lens; 2) H27.02 Aphakia, left eye; 3) Z98.89 Personal history of surgery

CASE 1		
DIAGNOSES	PROCEDURE CODES	MODIFIERS
1) 1, 3	67121 Removal of implanted material, posterior segment	-LT
2) 1, 3	67036 Pars plana vitrectomy	-51-59-LT
3) 2, 3	66895 Insertion of secondary intraocular lens	-51-LT
4) 1, 2, 3	66682	-51-LT
Notes: 1. This case would NOT qualify for Quality Measure: ASC—14 Unplanned Vitrectomy.		

Case 2

Operative Note excerpts: "... Trypan blue was injected through the paracentesis followed by epi shugarcaine to further stabilize the pupil and irrigate out the trypan blue then followed by [Viscoat] to fill the anterior chamber ... create a two-step full-thickness clear corneal incision ... The cystotome and Utrata forceps were used to create a continuous capsulorhexis in the anterior capsule. BSS on a hydrodissection cannula was used to perform gentle hydrodissectin and the lens was rotated.

The lens was noted to have significant phacodonesis at this point. Phacoemulsification was performed to groove the nucleus and attempts at cracking and chopping the nucleus were made. At this point, due to excessive movement by the patient during the surgery and difficulty with safely cracking and chopping the lens, a decision was made to convert the case to an extracapsular cataract extraction.

A 10-0 nylon suture was placed through the main wound. The surgeon moved superiorly and performed a superior peritomy and made an 8-mm scleral tunnel wound after applying bipolar wet-field cautery to the superior sclera to achieve hemostasis.

Attempts at bringing the lens out of the bag using viscoelastic and hydration with BSS on a cannula were made. A lens loop and muscle hook were used to then express the lens nucleus from the capsular bag. The lens and capsular bag flipped upside down during this process.

The superior wound needed to be widened using cornea-scleral scissors to allow extraction of the lens ... the eye was reformed with balanced salt solution ...The remaining cortical material was attempted to be removed with coaxial irrigation through the initial temporal clear corneal incision; however, at this point, it was noted that there was vitreous in the anterior chamber. Kenalog was injected into the anterior chamber to visualize the vitreous. Bimanual anterior vitrectomy was performed ... A small amount of remaining cortical material and nuclear material in the anterior chamber was successfully removed using the anterior vitrector. Additional vitrectomy was performed as needed until there was no more vitreous found extending into the wounds..."

[Note: per conversation with surgeon both lens and capsule were removed.]

Diagnosis: 1) H25.811 Combined forms of age-related cataract, right eye; 2) H21.81 Floppy iris syndrome; 3) H43.01 Vitreous prolapse, right eye

CASE 2		
DIAGNOSES	PROCEDURE CODES	MODIFIERS
1) 1, 2	66920 Intracapsular cataract extraction, right eye	RT
2) 3	67010 Mechanical anterior vitrectomy	-51-RT
Notes: 1. This case would qualify for Quality Measure: ASC—14 Unplanned Vitrectomy. 2. A very complicated case that ended up being coded as an intracapsular cataract extraction. 3. Not all MACs require modifier 51		

Case 3

Operative Note excerpts: "... A temporal clear cornea tunnel was then created ... A continuous curvilinear capsulorrhexis was performed, followed by hydrodissection. At this point, the anterior chamber deepened suddenly and iris prolapsed out of the wound. Posterior capsular rupture during hydrodissection was suspected. The iris was initially repositioned successfully, but immediately prolapsed with any slight manipulation of the eye. Therefore, it was repositioned, and the main wound was closed with two interrupted 10-0 nylon sutures.

During this time, the lens was seen to slowly sublux

into the vitreous ... Bimanual anterior vitrectomy was then performed to clear back all the prolapsed vitreous, and further vitrectomy was performed at the plane of the posterior capsule and [then] the remaining cortical material beneath the anterior lens capsule was carefully stripped away. There was about a half of a clock hour of cortex beneath the incision that could not be removed without threatening the anterior capsule and so this was left in place..."

Diagnosis: 1) H25.811 Combined forms of age-related cataract, right eye

CASE 3		
DIAGNOSES	PROCEDURE CODES	MODIFIERS
1) 1	66984 Phacoemulsification of cataract with insertion of IOL	74-RT
Note: This case would qualify for Quality Measure: ASC—14 Unplanned Vitrectomy.		

CONCLUSION

Some of these complications may be anticipated by the physician, so the more extensive the chart documentation in the patient chart and operative notes, the better it is, especially in case of untoward circumstances. ■

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References & Resources

1. Asbell RL. ASC Surgical Coding/Claims Processing. The Ophthalmic ASC; October 2015.
2. Asbell RL. Ophthalmic Quality Measure ASC-14: Unplanned Anterior Vitrectomy and Its Relationship to Cataract Surgery. The Ophthalmic ASC; February 2017.