

Complex Cataract Surgery: Audit Considerations, Coding & Compliance

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INTRODUCTION

During the last week in May 2018 the Centers for Medicare and Medicaid Services (CMS) issued a reminder of the renewed interest in the Office of the Inspector General's September 2015 report "Questionable Billing for Medicare Ophthalmology Services".¹ There have been increased efforts on CMS's behalf to contain the excessive billing of the complex cataract code: Current Procedural Terminology (CPT) code 66982. External auditors, such as Supplemental Medical Review Contractor (SMRC) firms, have been engaged for several years now and have listed the auditing of complex cataract as one of their foci.

The problem facing ASCs, as well as physicians, is simply that both types of providers have not had sufficient training in the requirements for utilization of the code and corresponding chart documentation. In general, the CPT codes used in both facility and physician coding should coordinate, although this is not always possible—particularly when surgical complications arise. This review presents these original guidelines intended for using the complex cataract code as originally presented to the CPT Editorial Panel and issued upon receipt of the code. Modifications and further regulations are issued as Local Coverage Determinations (LCD) by the Medicare Administrative Contractors (MACs).

DEFINITION

The following is the CPT description of code 66982:

*Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage.*²

First issued in 2001, the code was modified in 2002 to eliminate the use of endocapsular rings from the description since they were not FDA (Food and Drug Administration) approved. Since then FDA approval has been obtained; their use once again qualifies the case as being coded complex.

According to the American Medical Association's publication entitled *CPT Changes 2001, An Insider's View*, the following rationale was originally given for this 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 (eg, uveitis) and disease states (eg, 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.³

Thus, it is very important that the code only be used for cases that are deemed to be complex. It should **not be used** for coding cataract surgeries where **complications** are encountered.

CLINICAL AND CODING ISSUES

Some of the many concerns regarding the use of the complex cataract code are addressed here.

Utilization. Physicians are concerned with what percentage of cases involving cataract extraction with IOL insertion should be classified as complex. In the last set of utilization statistics (2016) available from CMS (Centers for Medicare and Medicaid Services) there were approximately

3,465,749 cataract surgeries performed (CPT codes 66984 + 66982) and 7.96% of these were coded as complex.⁴

When the original pricing for CPT code 66982 was calculated, it was based on statistics collected and concluded that 1.5 % of all cataract cases would qualify for the use of this code. This was based on a 20% increase in physician work for in these cases. It is imperative that CPT code 66982 be used only for cataract procedures that meet the definition of this CPT code.

Use of Dye. Update for 2018: The percentage of cases coded as complex has increased and at first was thought to be mainly due to the identification of more complex cases, such as those with Intraoperative Floppy Iris Syndrome, that had not been identified in 2001.

However, I propose that one of the principal increases may be the result of some of the MACs (Medicare Administrative Contractor) Local Coverage Determinations (LCD) that state, or stated, the use of dye in itself qualifies a case to be coded complex. A policy that combines the phrasing "use of dye" with the presence of a mature or dense cataract often leads to the misinterpretation that the dye is the qualifier. This was never the intent of the code by definition and is nowhere found in any of the Current Procedural Terminology (CPT) publications. In fact, in CPT Assistant, an AMA publication, in March of 2016 it is stated: "...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."⁵ **So the use of dye in and of itself does not constitute sufficient extra work or intensity to qualify the case as being coded complex.**

Audit Environment. In 2015 CMS issued Comparative Billing Reports (CBR) and one of the issues was overutilization of CPT code 66982.⁶ The national average disclosed was 9%. My guesstimate is if you are over 9-10 percent you would do well performing an internal or external audit on this issue since the names of those found to be significantly higher than their peers were turned over to CMS and this usually heralds auditing. In fact, StrategicHealth Solutions was subsequently subcontracted by CMS and has commenced widespread auditing of complex cataract surgery as one of its main issues.⁷ It is important that *both* your chart notes and operative notes support the use of the code.

Clinical Application. Here are some of the clinical situations when the code **can or cannot** be used:

- Dense white cataracts removed in conjunction with application of a dye. *The use of dye alone does not qualify the case as complex.*
- Pupillary enlargement procedures. The precise procedures that would qualify for using this code is dependent on your local MAC's LCD that identifies various surgical techniques/instruments used for pupillary stretching that qualify the case to be coded as complex. MAC policies generally do not include manual or viscoelastic pupillary stretching.

Furthermore, pharmacological assistance with pupillary dilation/maintenance is not one of the criteria for a case qualifying for being coded as complex (eg, use of epi-Sugarcaine or Omidria).

- Synechiolysis **cannot** be additionally billed and is bundled under the National Correct Coding Initiative (NCCI). 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 7.3 of the NCCI effective July 1, 2001.
- In rare instances an anterior vitrectomy can be coded and billed as an additional procedure. Both CPT code 67005 (removal of vitreous, anterior approach [open sky technique or limbal incision]; partial removal) and CPT code 67010 (...subtotal removal with mechanical vitrectomy) are bundled with CPT codes 66982 and 66984 by the NCCI. However, in pediatric cataract surgery, a limited pars plana vitrectomy (CPT code 67036) may be billed additionally. Modifier 52 (reduced services) needs to be applied when less than a full posterior vitrectomy is performed.
- Management of *intraoperative complications*, such as vitreous loss, iris prolapse, and dropped nucleus or IOL does **not** qualify the case as complex. The original intent was that, for the most part, the complex cataract code 66982 should be used when the physician plans prospectively and documents that a complex cataract procedure is to be performed in the preoperative plan.
- Pediatric (or other) cases **cannot** be coded with 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.

- The description of code 66982 was changed to remove “endocapsular rings” in 2001 since, technically, a device that does not have FDA approval cannot be included in CPT code descriptors. Now that 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 does **not** necessarily qualify the procedure to be complex. Examples would include use of the Fugo blade for anterior capsulorrhexis or performing laser ablation of the lens rather than phacoemulsification.

CONCLUSION

Some physicians, by the nature of their practices, will have a higher percentage of these cases than others. In all instances, it is wise to have complete and precise chart documentation preoperatively and include documentation in the operative note itself. And, be sure to remember to document all the other details of cataract surgery management that need attention including written documentation of problems with ADL (Activities of Daily Living), use of proper coding and modifiers for the surgical procedures and diagnostic tests, and charting the medical necessity factors for the procedure(s).

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