CPT Changes Effective January 1, 2011

December 10, 2010

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It doesn't seem possible that another year has flown by! We only have about three weeks left in 2010 and it is time to get ready to implement the 2011 *CPT* changes. Most ophthalmologists will need to update their superbills before January 1, 2011 to ensure accurate coding. Keep in mind, these changes are effective for dates of service (DOS) on or after January 1, 2011 and are applicable to all payers.

We attended the American Medical Association's (AMA) "*CPT* and RBRVS 2011 Annual Symposium" in November. George A. Williams, MD, representing the American Academy of Ophthalmology, and L. Neal Freeman, MD, representing the American Society of Ophthalmic Plastic and Reconstructive Surgery, presented the ophthalmology portion of the symposium. Some of the information below is based on their excellent presentation.

Deleted Code - New Code Assigned – Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

Anterior Segment		
Deleted	**0187T**	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral
Replaced	92132	– Scanning computerized ophthalmic diagnostic imaging, anterior segment with interpretation and report, unilateral or bilateral

Posterior Segment		
Deleted	**92135**	Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral
Replaced	92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
	92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina

First thing we should note is that the new codes are considered "unilateral or bilateral." The addition of this phrase represents a significant change from 92135. The new codes are bilateral and are not separately reported and paid for each eye (unilateral). One unit of service equals one or both eyes. Thus, the new codes should not be reported with the RT/LT modifiers or with more than one (1) unit of service in Item 24g (or its electronic equivalent).

NCI believes one of the reasons 92135 was split into two codes is to allow separate tracking of SCODI performed for the optic nerve and retina. It will be much easier for Medicare and other payers to establish utilization frequencies based on the reason SCODI is performed, e.g., glaucoma vs retinal disease.

As you review your *CPT* manual, you will find that 92133 and 92134 cannot be reported together for the same patient during the same encounter. If both tests are obtained during the encounter, you will only report one code.

Further, when the 2011 Medicare fee schedule is available, we will find 92133 and 92134 have slightly higher fee schedules when these tests are performed unilaterally; however, there will be a substantial loss when these tests are performed bilaterally.

Not applying any Geographical Practice Cost Indices (GPCI), using the total relative value units for the codes multiplied by the 2010 Medicare conversion factor which will be continued for 2011, we find the following gross fee schedules

***CPT* Codes**	**Total RVUs**	**2010/2011 Conversion Factor**	**Unilateral Gross Medicare Physician Fee Schedule**	**Bilateral Gross Medicare Physician Fee Schedule**
92135	1.22	$36.8729	$44.98	$89.86
92133 (both eyes)	1.28	$36.8729	$47.20	$47.20
92134 (both eyes)	1.28	$36.8729	$47.20	$47.20

NCI anticipates the National Correct Coding Initiative (CCI) will continue the bundling edits assigned to 92135 for the new codes 92133 and 92134. The "1" indicator means under certain circumstances the codes can be "unbundled" and billed separately. Except for visit codes, when we find a "1" indicator for ophthalmology services, it typically means we can unbundle the codes when one service is performed unilaterally and it is medically necessary to perform the other service in the contralateral eye.

Type of Edit	**Payable Code**	**Bundled Code**	**Edit Indicator**
Mutually Exclusive	92135	92250	1
Column 1/Column II	92135	0187T (2011 code 92132)	1
Column 1/Column II	92135	99211	1

When unbundling visit codes and tests, the documentation must support a medically necessary separately identifiable visit. 99211 is typically referred to as the nurse or technician code. There must be a physician service that connects to the technician's visit, e.g., the physician's plan states the patient is to return to the office in 2 weeks for a 30-2 Humphry Visual Field in the right eye and the technician is to remove the dressing on the left eye dressing if the patient is still having drainage. The patient should return in 4 weeks to see the physician.

At the 2 week visit, the technician obtains a history of the present illness that describes what the patient has noticed since their last encounter, removes the dressing and assesses the left eye for drainage noting it is necessary to reapply the dressing. He redresses the left eye. He then performs a 30-2 visual field of the right eye and reminds the patient to schedule a visit in 2 weeks. All services are documented in the patient's medical record.

To bill Medicare, the billing physician must be physically present in the office suite, and immediately available if needed, during the time the technician is performing these services. The ordering physician's name and national provider identifier (NPI) are shown in Items 17 and 17b (or their electronic

equivalents). The technician's visit is reported using 99211 and the supervising physician is shown as the "rendering provider" in Item 24j (or its electronic equivalent). 92083 is used to report the visual field. The NPI of the physician interpreting the test is typically shown as the "rendering provider" in Item 24j (or its electronic equivalent).

New Codes for Remote Imaging – Retinal Disease

The following two codes have been established for remote imaging to screen patients for retinal disease (e.g., glaucoma) and to remotely monitor and manage active retinal disease (e.g., diabetic retinopathy). With the exception of ophthalmologists providing interpretations of these tests performed by another provider, e.g., primary care physician (PCP), these two codes will NOT be used to describe services rendered by ophthalmologists.

92227 Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) with analysis and report under physician supervision unilateral or bilateral

92228 Remote imaging for monitoring and management of active retinal disease (e.g., diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral

According to the American Medical Association (AMA), these codes were added to *CPT* to meet the needs of diabetic retinopathy screening programs, which provide remote imaging and data submission to a centralized reading center

Due to the nature of service being provided (screening vs active disease management), the codes will never be reported for the same patient on the same date of service. These codes should not be reported in conjunction with eye codes (92002-92014) and E/M codes (99201-99350). Finally, these codes should not be reported with the code for fundus photography (92250).

Three possible scenarios for using these codes were presented during the Symposium:

1. A separate entity, such as a reading center, owns the imaging system which is placed in a primary care office and images are relayed back for review
    - The PCP provides the staff taking the photos, while the staff in a reading center under MD supervision provides the interpretation. In this scenario, the –TC and -26 modifiers will apply for the two entities
2. The imaging service could be performed in a retinal imaging center
3. The image can be sent directly to an ophthalmologist for interpretation and report

The Final Rule clearly indicates 92227 and 92228 are considered "active" codes. This means they can be paid as covered services. At this time, there is no indication that Medicare Contractors are in the process of establishing Local Coverage Decisions for these codes.

Although code 92228 has relative value units for all three coding scenarios (global and professional or technical components), code 92227 does not. At this time, we do not have an answer to the question of how to code and who can bill when remote imaging is performed for the detection of retinal disease (92227) when the imaging center provides the PCP with imaging equipment and the image is sent to the imaging center's technicians for interpretation.

New and Revised Codes for Placement of Amniotic Membrane on the Ocular Surface

The existing code for ocular surface reconstruction including amniotic membrane transplantation has been revised.

- 65780 Ocular surface reconstruction; amniotic membrane transplantation multiple layers
  - This code was revised to indicate multiple layers
  - 65780 continues to have a 90-day postoperative period

CPT 2011 includes a new parenthetical statement under this code:

> For placement of amniotic membrane without reconstruction using self-retaining or single layer suture technique, see 65778, 65779

CPT codes 65778 and 65779 have been added to describe the placement of amniotic membrane on the ocular surface for wound healing. Code assignment is based on how the membrane is attached to the ocular surface. The following codes have 10-day postoperative periods.

- 65778 Placement of amniotic membrane on the ocular surface for wound healing; self-retaining
- 65779 Placement of amniotic membrane on the ocular surface for wound healing; single layer sutured

Another parenthetic statement directs the coder to use the unlisted procedure code 66999 to describe the placement of amniotic membrane using tissue glue.

Finally, *CPT 2011* instructs coders that the following codes include placement of amniotic membrane. Thus, 65778 and 65779 should not be separately reported with:

- 65430 Scraping of cornea, diagnostic, for smear and/or culture
- 65435 Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)
- 65780 Ocular surface reconstruction; amniotic membrane transplantation, multiple layers

Changes in Coding Glaucoma Procedures

Transluminal Dilation of Aqueous Outflow Canal – New CPT Codes (Deleted CPT Category III Codes)

CPT Category III codes 0176T and 0177T have been deleted and replaced with new codes in *CPT* 2011. Both codes include a 90-day postoperative period. The following codes are used to report treatment of open-angle glaucoma involving accessing and dilating the Schlemm's canal to augment aqueous outflow. Decision of which code to use will be based on whether the device or stent is retained following the procedure.

- 66174 Transluminal dilation of aqueous outflow canal; without retention of device or stent
- 66175 Transluminal dilation of aqueous outflow canal; with retention of device or stent

Insertion of Anterior Segment Aqueous Drainage Device – New and Revised CPT Category III Codes

CPT 2011 includes three codes for the insertion of an anterior segment aqueous drainage device. The changes relate to the internal approach and where the device is placed.

- 0191T – Revised Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork

- 0253T – New Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the suprachoroidal space

- Note 0253T is out of sequence

- 0192T – Same Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach

Changes to Iridotomy/Iridectomy Code Requires Change to "Minor" Procedure Designation
Before January 1, 2011, 66761 was defined as a "one or more sessions" code with a 90-day postoperative period making it a "major" procedure. *CPT* 2011 changes the code to a "per session" code with a 10-day postoperative period. The distinction is very important when determining whether you can bill a visit on the same day as an iridotomy/iridectomy. The -57 visit code modifier is not applicable for visits performed on the same day as a minor surgical procedure.

- 66761 Iridotomy/iridectomy by laser surgery (e.g., for glaucoma) (per session)

According to CMS' explanation of services included in the global surgical package, the "initial evaluation is always included in the allowance for a minor surgical procedure." Chapter 12 §30.6.6 of the *Medicare Claim Processing Manual* includes the following:

> ***CPT* Modifier -25** - Significant Evaluation and Management Service by Same Physician on Date of Global Procedure
> Medicare requires that *Current Procedural Terminology* (*CPT*) modifier -25 should only be used on claims for evaluation and management (E/M) services, and only when these services are provided by the same physician (or same qualified nonphysician practitioner) to the same patient on the same day as another procedure or other service. Carriers pay for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work of the procedure. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier -25 is added to the E/M code on the claim.
>
> Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified nonphysician practitioner in the patient's medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.
>
> ***CPT* Modifier -57** - Decision for Surgery Made Within Global Surgical Period
> Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses *CPT* modifier -57 to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the *CPT* modifier -57 if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.

Deleted *CPT* Category III Codes
CPT Category III codes are considered temporary and used to describe emerging technology, services, and procedures. According to *CPT*, "if a Category III code is available, it must be reported instead of an unlisted *CPT* code." *CPT* Category III codes are archived five years from its date of publication or conversion to a *CPT* Category I code. When Category III codes are archived after five years, the services/procedures must be reported using the appropriate *CPT* Category I unlisted code.

The following *CPT* Category III codes were deleted for 2011. Coders will use the unlisted code 67299 when these procedures are performed on or after January 1, 2011.

- 0016T Destruction of localized lesion of choroid (e.g., choroidal neovascularization), transpupillary thermotherapy (TTT)
- 0017T Destruction of macular drusen, photocoagulation

2011 RVU Changes

This list is not all-inclusive, but identifies a few codes with substantial changes in RVUs. We multiplied the total RVUs (listed in the Final Rule) by the 2011 Medicare Conversion Factor calculate the Gross Medicare Physician Fee Schedule allowances do not take into account the Geographic Practice Cost Indices (GPCI).

15823 Blepharoplasty, upper eyelid; with excessive skin weighting down lid
66761 Iridotomy/iridectomy by laser surgery (e.g., for glaucoma) (per session)
67028 Intravitreal injection of a pharmacologic agent (separate procedure)
92081 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
92082 Visual field examination, unilateral or bilateral, with interpretation and report;intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92285 External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)

***CPT* Codes**	**2010 Total RVUs**	**2010 Conversion Factor**	**2010 Gross Medicare Physician Fee Schedule**	**2011 Total RVUs**	**2011 Conversion Factor**	**2011 Gross Medicare Physician Fee Schedule**
15823	16.42	$36.8729	$605.45	16.23	$36.8729	$598.45
66761	11.23	$36.8729	$414.08	9.30	$36.8729	$342.92
67028	5.30	$36.8729	$195.43	3.79	$36.8729	$139.75
92081	1.39	$36.8729	$ 51.25	1.43	$36.8729	$ 52.73
92082	1.86	$36.8729	$ 68.58	2.00	$36.8729	$ 73.75
92285	1.10	$36.8729	$ 40.56	1.27	$36.8729	$ 46.83