Coding Companion for Ophthalmology

A comprehensive illustrated guide to coding and reimbursement
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67412-67413

**67412**
Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of lesion

**67413**
with removal of foreign body

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**Explanation**

The physician removes a lesion or a foreign body from the orbit through a subciliary, frontal, or transconjunctival incision. In the subciliary incision, an incision is made in the lower eyelid. In the frontal approach, an incision is made in the lid crease with a further postseptal dissection for removal of a lesion or foreign body in this portion of the orbit. In the transconjunctival approach, the lower lid is everted and an incision is made over the infraorbital rim through the inferior cul-de-sac. In 67412, the lesion is excised. In 67413, the foreign body is removed. In either case, the incision is closed with layered sutures.

**Coding Tips**

For orbitotomy with bone flap to remove lesion, see 67420. For orbitotomy with bone flap to remove foreign body, see 67430. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

**ICD-9-CM Procedural**

16.09 Other orbitotomy

16.1 Removal of penetrating foreign body from eye, not otherwise specified

**Anesthesia**

00140

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**ICD-9-CM Diagnostic**

190.1 Malignant neoplasm of orbit

213.0 Benign neoplasm of bones of skull and face

216.3 Benign neoplasm of skin of other and unspecified parts of face

224.1 Benign neoplasm of orbit

228.01 Hemangioma of skin and subcutaneous tissue

228.09 Hemangioma of other sites

237.70 Neurofibromatosis, unspecified

237.71 Neurofibromatosis, Type 1 (von Recklinghausen’s disease)

237.72 Neurofibromatosis, Type 2 (acoustic neurofibromatosis)

237.73 Schwannomatosis

237.79 Other neurofibromatosis

238.8 Neoplasm of uncertain behavior of other specified sites

239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin

239.89 Neoplasms of unspecified nature, other specified sites

375.12 Other lacrimal cysts and cystic degeneration

376.01 Orbital cellulitis

376.6 Retained (old) foreign body following penetrating wound of orbit — (Use additional code to identify foreign body (V90.01-V90.9))

376.81 Orbital cysts

379.92 Swelling or mass of eye

802.8 Other facial bones, closed fracture

870.4 Penetrating wound of orbit with foreign body

930.8 Foreign body in other and combined sites on external eye

930.9 Foreign body in unspecified site on external eye

**Terms To Know**

**benign.** Mild or nonmalignant in nature.

**cellulitis.** Sudden, severe, suppurative inflammation and edema in subcutaneous tissue or muscle, most often caused by bacterial infection secondary to a cutaneous lesion.

**dissection.** Separating by cutting tissue or body structures apart.

**foreign body.** Any object or substance found in an organ and tissue that does not belong under normal circumstances.

**hemangioma.** Benign neoplasm arising from vascular tissue or malformations of vascular structures. It is most commonly seen in children and infants as a tumor of newly formed blood vessels due to malformed fetal angioblastic tissues.

**incision.** Act of cutting into tissue or an organ.

**neurofibroma.** Tumor of peripheral nerves caused by abnormal proliferation of Schwann cells.

**neurofibromatosis.** Autosomal dominant inherited condition with developmental changes in the nervous system, muscles, bones, and skin, producing coffee colored spots of pigmented skin (café au lait spots) and multiple soft tumor neurofibromas distributed over the entire body.

**orbitotomy.** Opening made into the orbital space for biopsy, abscess drainage, or tumor mass or foreign body removal.

**subcutaneous tissue.** Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

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**CCI Version 16.3**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

**Medicare Edits**

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**Medicare References:** 100-2, 15, 260; 100-4, 12, 30, 100-4, 12, 90.3; 100-4, 14, 10

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168 — Ocular Adnexa

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Coding Companion for Ophthalmology
Appendix

70030
70030  Radiologic examination, eye, for detection of foreign body

Explanation
X-rays of the eyes are obtained to determine the location of a foreign body in the eye. After positioning the patient, a one- or two-view x-ray is obtained. Transparent objects such as glass may not be good candidates for x-ray visualization. The physician supervises the procedure and interprets and reports the findings.

70140
70140  Radiologic examination, facial bones; less than 3 views

Explanation
X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, a complete series of x-rays of the facial bones are obtained. The physician supervises the procedure and interprets and reports the findings.

70150
70150  Radiologic examination, facial bones; complete, minimum of 3 views

Explanation
X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, a complete series of x-rays of the facial bones, with a minimum of three views, is obtained. The physician supervises the procedure and interprets and reports the findings.

70170
70170  Dacryocystography, nasolacrimal duct, radiological supervision and interpretation

Explanation
Dacryocystography is the radiographic evaluation of the lacrimal system to localize the site of an obstruction. One cc of a water-soluble contrast medium is injected through the lower canaliculus and x-rays of the excretory system are obtained. The physician supervises the procedure and interprets and reports the findings.

70190
70190  Radiologic examination; optic foramina

Explanation
Radiological examination of the optic foramina is useful in the evaluation of trauma, tumors, or foreign bodies. After positioning the patient, the radiologist obtains x-rays of the optic foramina. The physician supervises the procedure and interprets and reports the findings.

70200
70200  Radiologic examination; orbits, complete, minimum of 4 views

Explanation
Radiological examination of the orbits is useful in the evaluation of trauma, tumors, or foreign bodies. After positioning the patient, the radiologist obtains a minimum of four x-ray views of the orbits. Standard methods include posterioranterior (PA) exposures from two different positions, lateral views, optic canal projections, and oblique views of each side for comparison. The physician supervises the procedure and interprets and reports the findings.

70480-70482
70480  Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481  with contrast material(s)
70482  without contrast material, followed by contrast material(s) and further sections

Explanation
Computed tomography directs multiple narrow beams of x-rays around the body structure being studied and uses computer imaging to produce thin cross-sectional views of various layers (or slices) of the body. It is useful for the evaluation of trauma, tumor, and foreign bodies as CT is able to visualize soft tissue as well as bones. Patients are required to remain motionless during the study and sedation may need to be administered as well as a contrast medium for image enhancement. These codes report an exam of the orbit, sella, posterior fossa, or outer, middle, or inner ear. Report 70480 if no contrast is used. Report 70481 if performed with contrast and 70482 if performed first without contrast and then again following the injection of contrast.

70540-70543
70540  Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)
70542  with contrast material(s)
70543  without contrast material(s), followed by contrast material(s) and further sequences

Explanation
Magnetic resonance imaging (MRI) is a radiation-free, noninvasive technique to produce high-quality sectional images of the inside of the body in multiple planes. MRI uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electromagnetic field. These signals are processed and converted by the computer into high-resolution, three-dimensional, tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRI. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered, as well as contrast material for image enhancement. These codes report an exam of the orbit, face, or neck, or any combination of these. Report 70540 if no contrast is used; 70542 if performed with contrast; and 70543 if performed first without contrast and again following the injection of contrast.

75660
75660  Angiography, external carotid, unilateral, selective, radiological supervision and interpretation

Explanation
A local anesthetic is applied over the femoral, brachial, subclavian, or axillary artery. The artery is percutaneously punctured with a needle and a guidewire is inserted and selectively fed through the artery into the right or left external carotid. A catheter is threaded over the guidewire to the point of study and the guidewire removed. Contrast medium is injected and a series of x-rays is performed to visualize the vessels and evaluate any abnormalities. This code reports the radiological supervision and interpretation only. Use a separately reportable code for the catheterization.

75662
75662  Angiography, external carotid, bilateral, selective, radiological supervision and interpretation

Explanation
A local anesthetic is applied over the femoral, brachial, subclavian, or axillary artery. The artery is percutaneously punctured with a needle and a guidewire is inserted and selectively fed through the artery into the external carotid. A catheter is threaded over the guidewire to the point of study and the guidewire removed. Contrast medium is injected and a series of x-rays performed bilaterally to visualize the vessels and evaluate any abnormalities. This code reports the radiological supervision and interpretation only. Use a separately reportable code for the catheterization.

75665
75665  Angiography, carotid, cerebral, unilateral, radiological supervision and interpretation

Explanation
A local anesthetic is applied over the femoral, brachial, subclavian, or axillary artery. The artery is percutaneously punctured with a needle and a guidewire is fed through the artery into the right or left (cerebral) carotid. A catheter is threaded over the guidewire to the point of study and the guidewire removed. Contrast medium is injected into the cerebral arterial system and a series of x-rays is performed to visualize the vessels and evaluate any abnormalities. This code reports the radiological supervision and interpretation only. Use a separately reportable code for the catheterization.
Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $29 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician’s office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient’s encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient’s attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician “admitting” the patient for observation.

Codes 99224-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported. If the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99223, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting physician. (If a physician other than the admitting physician