2015 ASC Coding Update for Glaucoma Surgery

In 2015, the Current Procedural Terminology (CPT) codes for aqueous shunts were revised so that there are now four codes for aqueous shunts — two with grafts and two without grafts. As noted in “CPT Changes: An Insider’s View for 2015,” the insertion of an aqueous graft (prior CPT code 66180) and scleral reinforcement (67255) were reported together 73% of the time. It is now mandated that the two codes no longer should be coded together and, in fact, are bundled in the National Correct Coding Initiative. Medicare has very specific changes and new rules for coding and billing the new glaucoma codes.

2015 CPT Code Changes

Here are the changes in glaucoma coding for 2015. For a given year, CPT nomenclature indicates a new code for that year by placing a red bullet (●) before the code. Comments that are printed in green with text inserted between ▶ are added new material. The blue triangle symbol (▲) indicates the code description has been revised from the previous year.

NEW CPT CODES

**Category I Codes**

- 66179  Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft
- 66180  with graft
  ▶ Do not report 66180 in conjunction with 67255
- 66184  Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft
- 66185  with graft
  ▶ Do not report 66185 in conjunction with 67255

**Category II Codes**

- 0376T  Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion
- ▶ 0376T  each additional device insertion
  (List separately in addition to code for primary procedure)
  ▶ Use 0376T in conjunction with 0191T

**Category III Codes**

- 66165  Fistulization of sclera for glaucoma; iridecleeisis or iridostasis

**Deleted CPT Codes**

- 0191T  Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach, into the trabecular meshwork; initial insertion

**Microinvasive Glaucoma Surgery (MIGS)**

MIGS is commonly used to refer to both Microinvasive or Minimally Invasive Glaucoma Surgery, but either way...
ASC CODING EXAMPLES

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>CPT CODE(S)</th>
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<tbody>
<tr>
<td>Surgery consists of placement of aqueous shunt (tube inserted) with Tutoplast (IOP Ophthalmics) graft.</td>
<td>CPT code 66180 (Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft).</td>
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<tr>
<td>Surgery on patient with neovascular glaucoma. Prior operation of repair of retinal detachment (including use of gas) and placement of an aqueous shunt, but with the tube placed in the subconjunctival space underneath the Tutoplast graft. The tube was identified and freed from underlying sclera. The pars plana port was opened and the tube was placed in the pars plana.</td>
<td>CPT code 66184 (Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft).</td>
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<tr>
<td>Surgery on patient for cataracts and mild to moderate open angle glaucoma (phacoemulsification with insertion of intracocular lens + insertion of initial iStent).</td>
<td>CPT codes 0191T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork, initial insertion) + 66984 (phacoemulsification cataract extraction with insertion of intraocular lens).</td>
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When coding for a device that channels aqueous into the suprachoroidal space, use Category III code 0253T. At this time, there are no FDA approved devices that fit into this category.

When the aqueous is channelled into the subconjunctival space, the coding is problematic since at this time there is no Category III code and, in ASC coding, unlisted CPT codes (in this case 66999) cannot be used. The surgery is thus not covered for Medicare when performed in an ASC and the patient would be responsible for all aspects: physician’s, facility (including cost of the device) and anesthesia fees. Usually, these cases are referred to another type of facility.

The current FDA approval of iStent is for initial insertion of a single stent at a given session. The use of an iStent as an additional stent at the same session (new code 0376T) is not FDA approved. The ASC payment is packaged with that of 0191T. It has an N1 Payment Indicator (PI) and no extra payment is made to an ASC for packaged items. The January 2015 national ASC payment amount for procedure code 0191T is $1,711.02.

For physician coding it would be incumbent upon the physician to follow proper protocols regarding off-label use when inserting multiple iStents. This includes the following: an addendum to the iStent informed consent form if you use the one Ophthalmic Mutual Insurance Company (OMIC) provides, or any other one, regarding the use of multiple stents at the same session; a separate informed consent for using the second device as off-label; and a written confirmation informing the patient of financial responsibilities for the surgical procedures involve the use of less invasive and traumatic surgery coupled with utilization of smaller devices that work by channeling aqueous outflow to what may be considered as another anatomic site: Schlemm’s canal, suprachoroidal space or subconjunctival space.

Category III code 0191T, should be used for coding those devices, such as iStent (Glaukos Corp.), wherein the stent is inserted to bypass the trabecular meshwork and channel the aqueous from the anterior chamber into Schlemm’s canal. The only FDA approved stent at this time is iStent and the only approved usage is for the initial insertion when the surgery is performed for treating mild to moderate glaucoma in conjunction with cataract surgery.

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the procedure/device and having a signed Advanced Beneficiary Notice (ABN). It's a good idea for the ASC to make sure all of the above are in order before scheduling multiple stent procedures.

"FOR PHYSICIAN CODING IT WOULD BE INCUMBENT UPON THE PHYSICIAN TO FOLLOW PROPER PROTOCOLS REGARDING OFF-LABEL USE WHEN INSERTING MULTIPLE ISTENTS."

**Medicare Coding Tips**

- For both ASC and Physician Coding, CPT code 0191T should be coded first on the claim, before the cataract surgery code, since it is the highest paying code.
- The codes for aqueous shunt placement (CPT code 66179) + scleral reinforcement (CPT code 67255) + modifier 59 to break the NCCI bundles should not be used. Medicare would consider it improper coding for any procedures performed January 1, 2015 or after since it would be done with the intent of gaining unwarranted reimbursement.
- From the physician's perspective, use any of the MIGS stents that are not FDA approved constitutes an off-label use, and the ASC should ascertain that the physician has completed all protocols mandated for such use. Seek help from your malpractice insurer or health care attorney if necessary.
- Always abide by your Medicare Administrative Contractor's Local Coverage Determination (LCD) regarding guidelines and regulations for use of these codes.
- CPT code 0376T is an add-on code, which means it is used for multiple stents that are inserted at the same session. Add-on codes are always attached to a primary code and cannot be billed alone.

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