BY RIVA LEE ASBELL

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◀

DELETED CPT CODES

66165 Fistulization of sclera for glaucoma; iridencleisis or iridostasis

Category III Codes

The Category III codes are Emerging Technology Codes and are actually updated every 6 months. They can be accessed online at the AMA website (http://www.ama-assn.org). This is somewhat confusing due to the vagaries of the system. The implementation date occurs 6 months after the release date. The appearance of the code in the CPT book depends on the cycle. You may begin using the code on the implementation date even though it does not appear in that year's CPT. On Jan.1, 2015 codes were released that you may begin using July 1, 2015.

The following changes for Category III glaucoma codes appear in CPT 2015.

The + sign always signifies that it is an add-on code and can only be used with a primary code and not by itself.

▲**0191T** 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◀

▲**0253T** Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space

Microinvasive Glaucoma Surgery (MIGS)

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

ASC CODING EXAMPLES

PROCEDURE	CPT CODE(S)
Surgery consists of placement of aqueous shunt (tube inserted) with Tutoplast (IOP Ophthalmics)graft.	**CPT code 66180** (Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft).
Surgery on patient with neovascular glaucoma. Prior operation consisted 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.	**CPT code 66184** (Revision of aqueous shut to extraocular equatorial plate reservoir; without graft).
Surgery on patient for cataracts and mild to moderate open angle glaucoma (phacoemulsification with insertion of intraocular lens + insertion of initial iStent).	**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).

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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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 channeled 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 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.

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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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