BY RIVA LEE ASBELL

Coding for Current Concepts in Glaucoma Surgery

GLAUCOMA SHUNT SURGERY

As witnessed in many queries on various listservs, there remains a significant amount of confusion regarding the Current Procedure Terminology (CPT) codes that were presented last year in conjunction with the revision of existing codes for aqueous shunts with and without grafts. The outcome was the final four codes listed as follows:

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)

Scleral reinforcement procedures (CPT code 67255) should no longer be coded as an additional procedure. For these procedures, the two codes (glaucoma procedure code + graft code) should not be coded together and, in fact, are bundled in the National Correct Coding Initiative (NCCI). There have been many queries about whether it is acceptable to "unbundle" the code pairs by using modifier 59 — it is not. Furthermore, the Centers for Medicare and Medicaid Services (CMS) has packaged ASC payments for all tissue used as patch grafts with glaucoma shunt surgery.

MEDICARE CODING TIPS

- Regardless of the graft material used, the cost of the graft material is bundled into the payment for the procedure
- Here are the national averages from the Medicare ASC 2016 fee schedule for the codes mentioned above:

66179	$1793.90
66180	$1793.90
66184	$ 976.17
66185	$ 976.17

- Medicare rescinded the policy of paying for corneal tissue used in conjunction with aqueous shunt procedures, effective January 1, 2016.

CORNEAL AND OTHER GRAFT MATERIALS

Materials used for grafting with aqueous shunt procedures include pericardium, sclera, fascia lata, dura, and cornea. In 2015, CMS announced that it would reimburse for cornea tissue when used in conjunction with aqueous shunt procedures.

In Transmittal 3234 (also explained in Medicare Learning Network [MLN] article 9100), the following information was communicated on April 15, 2015:

MLN 9100 04.15.2015

"5. Billing Guidance for Corneal Allograft Tissue
ASCs can bill for corneal allograft tissue used for coverage (CPT code 66180) or revision (CPT code 66185) of a glaucoma aqueous shunt with HCPCS code V2785. Contractors pay for corneal tissue acquisition reported with HCPCS code V2785 based on acquisition/invoice cost."

This has been rescinded by CMS for 2016.

For 2016, CMS limits the separate payment policy for corneal tissue acquisition costs in the hospital outpatient department and ASC to **only corneal tissue that is used in corneal transplant procedures.** Thus, CMS no longer makes separate payments for corneal tissue when used in non-transplant procedures.

The Medicare Claims Processing Manual Chapter 4 §200 states, "Corneal tissue will be paid on a cost basis, not under OPPS. To receive cost-based reimbursement,

hospitals [or ASCs] must bill charges for corneal tissue using HCPCS code V2785." The invoice to the facility from the Eye Bank will reflect the handling charges for harvesting corneal tissue as well as any additional processing of the tissue to prepare the endothelial graft.

MIGS – SURGICAL AND REIMBURSEMENT ISSUES

MIGS is the acronym for either minimally invasive or micro invasive glaucoma surgery. The concept implies that the surgery is minimally traumatic to ocular tissue and is coupled with utilization of smaller devices that work by channeling or facilitating aqueous outflow to what may be considered another anatomic site; for example Schlemm's canal, suprachoroidal space, or subconjunctival space. The discussions in this review are limited to those procedures that use microstent implantation.

ASC Medicare Coverage Determinations. In various publications CMS has stated this most basic precept:

> *"The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Your MAC determines whether a drug, device, procedure, or other service meets all program requirements for coverage; for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment."*

The importance of this lies in that a procedure may have a code, may or may not have FDA approval for a particular usage, and still can be determined to be payable or nonpayable in the ASC by the Medicare Administrative Contractor (MAC). For example, CPT code 0191T used for iStent is a Category III code, has FDA approval for a certain usage. However, the use of an additional stent is packaged in the ASC reimbusement. (**See next section and Table 1 for more information.**)

Off-label Usage. The ASC should make sure that all of the compliance requirements for physicians are in order before scheduling an off-label procedure. Currently, this applies to multiple iStents (not the same as iStent Inject) when a second stent is implanted at the same session. It behooves the ASC to ascertain the following are in order:

- An addendum to the iStent informed consent form if you use the one OMIC (Ophthalmic Mutual Insurance Company) provides, or any other that specifies the use of multiple stents at the same session;
- A separate informed consent for using the second device as off label if the primary device has FDA approval;
- A written confirmation informing the patient of financial responsibilities for the procedure/device and having a signed Advanced Beneficiary Notice when applicable.

CPT CODES FOR MIGS IMPLANTED DEVICES

See Table 1 for an overview of MIGS implanted devices. Note that coding a new procedure sometimes qualifies for using an already existing CPT code. However, any device must have FDA approval in order for the procedure to be billed to Medicare.

The current Category III codes are:

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

The following are temporary codes that were issued during the February 2016 meeting of the CPT Editorial Panel and have yet to be finalized:

> *"**Accepted addition of** Category III codes 0X46T, 0X47T for an aqueous drainage device for the subconjunctival space to lower intraocular pressure." It is best to verify the final codes online at the AMA website before using them (ama-assn.org).*

0X46T Code to be finalized

0X47T Code to be finalized

Category III code 0191T should be used for coding those devices, such as iStent, wherein the stent is inserted into Schlemm's canal, bypasses the trabecular meshwork and channels the aqueous from the anterior chamber into

TO READ MORE ABOUT THE STATUS OF PERFORMING GLAUCOMA PROCEDURES IN THE ASC, SEE DIMINISHING RETURNS ON PAGE 12

TABLE 1
A SNAPSHOT OF THE CURRENT STATUS OF MIGS IMPLANTED DEVICES*

BRAND NAME	MANUFACTURER	MECHANISM OF ACTION	CPT CODE	FDA APPROVALS**	COMMENTS
CyPass Micro-Stent	Transcend Medical (Purchased by Alcon, February 2016)	Shunts aqueous from the anterior chamber to the suprachoroidal space.	0253T[1]	No	➔Requires performance in conjunction with cataract extraction. ➔For use with mild to moderate glaucoma. ➔Current treatment with ocular hypotensive medication.
Hydrus Microstent	Ivantis	Implanted within Schlemm's Canal to facilitate aqueous outflow by stretching the wall and scaffolding the canal, potentially allowing for a larger area of flow within the aqueous outflow distal system.	No code at this time	No	➔Requires performance in conjunction with cataract extraction. ➔For use with mild to moderate glaucoma. ➔Current treatment with ocular hypotensive medication.
InnFocus Microshunt	InnFocus	Shunts fluid from anterior chamber to subconjunctival space under a subconjunctival-subTenon's flap.	66183[2]	No	➔Can be performed in conjunction with or without cataract surgery. ➔A minimally invasive stand-alone procedure for mild, moderate, and severe stages of open angle glaucoma patients.
iStent	Glaukos	Stent creates bypass of aqueous through the trabecular meshwork from the anterior chamber into the Canal of Schlemm.	0191T[3]	Yes	➔Requires performance in conjunction with cataract extraction. ➔For use with mild to moderate glaucoma. ➔Current treatment with ocular hypotensive medication.
iStent Supra Micro-Bypass Stent	Glaukos	Shunts aqueous into the suprachoroidal space to facilitate aqueous outflow.	0253T[1, 3]	No	➔Can be performed in conjunction with or without cataract surgery. ➔For use with mild to moderate glaucoma.
iStent Inject	Glaukos	Two stents are implanted sequentially using an injector into the Canal of Schlemm.	0191T[3] +0376T	No	➔Can be performed in conjunction with or without cataract surgery. ➔For use with mild to moderate glaucoma.
XEN Gel Stent	Aquesys (Purchased by Allergan)	Shunts aqueous from the anterior chamber to subconjunctival space creating an ab interno bleb that becomes, over time, a low-lying drainage area.	Approved for Category III codes February 2016 CPT meeting. Final codes pending. 0X46T 0X47T	No	➔Can be performed in conjunction with or without cataract surgery. ➔For use with mild to moderate and severe glaucoma. ➔For use when medical and surgical therapy has failed.

* Data as of April 2016
** Procedures cannot be billed until clinical trials are complete and device receives FDA approval
[1]Code suggested on basis of procedure description matching CPT code
[2]Code(s) suggested by company
[3]Code is paid for ASC and Physician services by Medicare on a national basis

Schlemm's canal. The ASC payment for the second stent is packaged with that of 0191T. It has a N1 Payment Indicator (PI) and no extra payment is made to an ASC for packaged items. The January 2016 national ASC payment amount for procedure code 0191T is $1,793.90.

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; however, iStent Supra and CyPass would fit into this category for coding.

When the aqueous is channeled ab interno into the subconjunctival space, one of the yet-to-be finalized new codes will apply (final versions of 0X46T and 0X47T).

When a surgery not fully covered by Medicare is performed in an ASC, the patient would be responsible for all aspects: physician's, facility (including cost of the device), and anesthesia fees. However, a patient cannot be charged for packaged items such as a second iStent. This can change as the various companies complete their clinical trials and obtain FDA approval or obtain new CPT codes.

MEDICARE CODING TIPS

- For both ASC and Physician Coding, CPT code 0191T should be coded first on the claim, before the cataract surgery code, because it is the highest-paying code.
- The codes for aqueous shunt placement (CPT code 66179 or 66185) + scleral reinforcement (CPT code 67255) + modifier 59 to break the NCCI bundles should *not* be used. Medicare would consider it improper coding, as the intent would be to gain unwarranted reimbursement for procedures performed Jan. 1, 2015 or after.
- Always abide by your Medicare Administrative Contractor's Local Coverage Determination 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. ■

All CPT codes © 2015, American Medical Association

Riva Lee Asbell is principal of Riva Lee Asbell Associates, an ophthalmic reimbursement firm specializing in Medicare reimbursement and compliance. She may be contacted at RivaLee@RivaLeeAsbell.com.