

CyPass Device Removal/Revision Coding & Reimbursement Challenges

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INTRODUCTION

With the recent recall of the Minimally Invasive Glaucoma Surgery (MIGS) device, CyPass, there remain reimbursement issues for both surgeons and ASCs for coding subsequent surgeries.

This white paper presents guidance for coding subsequent procedures related to handling of complications related to the initial insertion, regardless of time frame.

REMOVAL OF THE DEVICE

Subsequent removal of the implant is correctly coded using CPT code 65920 and is paired with ICD-10-CM diagnosis codes as indicated.

Diagnosis: 1) T85.698A Other mechanical complications of other specified internal prosthetic devices, implants and grafts
2) Z98.890 Personal history of surgery not elsewhere classified

Diagnosis	Procedure Codes	Modifiers
1) 1, 2	65920 Removal of implanted material, anterior segment of eye	<i>Use location modifier RT or LT.</i>
Note: This is not to be used when insertion and removal are performed at the same session.		

REPOSITIONING/TRIMMING OF THE DEVICE

Since there is no specific CPT code for repositioning or trimming of any MIGS device, and CPT mandates that the code selected must be specific and not merely an approximation, an unlisted code (one that ends in "99") when a precise CPT code is not found must be used; thus, **both the surgeon and the ASC must use CPT code 66999.**

For physician reimbursement, the claim is sent for medical review to a physician and pricing is thus determined. When submitting claims using any unlisted code the physician should send in a clinical summary and operative notes

ASCs have no way to obtain pricing for unlisted codes and thus cannot accept these cases. **The cases would have to be performed in a hospital setting rather than an ASC.**