Article - Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS) (A57863)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	American Samoa California - Entire State Guam Hawaii Nevada Northern Mariana Islands

Article Information

General Information

Article ID **AMA CPT / ADA CDT / AHA NUBC Copyright**

A57863

Article Title
Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS)

Article Type
Billing and Coding

Original Effective Date
03/23/2020

Revision Effective Date
10/03/2022

Revision Ending Date
N/A

Retirement Date
N/A

CMS National Coverage Policy

N/A

Article Guidance

Article Text

This article contains coding and other guidelines that complement the Local Coverage Determination (LCD) for Micro-Invasive Glaucoma Surgery (MIGS).

Coding Information:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

Specific Coding Guideline:

According to Current Procedural Terminology (CPT), in this setting a 'device' is a 'stent'. Therefore, to comply with coverage requirements set forth in the Local Coverage Determination the stent(s) must be inserted on the same date of service as the cataract surgery and billed accordingly on the same claim.

Insertion of these devices not in conjunction with cataract surgery services is considered investigational and will be denied.

For insertion of the XEN45 bill 0449T. Insertion of more than one XEN45 device per eye in a given surgical session (each additional device represented by CPT 0450T) is considered investigational and not covered.

Since there is no specific CPT® code for goniopuncture or so-called microgoniotomy procedures, the unlisted CPT® code 66999 (unlisted procedure, anterior segment of the eye) should be reported in these instances.

Any procedures performed which consists of single or multiple small punctures and/or injections of small amounts of viscoelastic, or other limited interventions should be reported using unlisted CPT® code 66999.

Specifically, goniotomy (CPT® code 65820) should not be coded in addition to other angle surgeries, stent insertions or Schlemm canal implants or if the incision into the trabecular meshwork is minimal or simply incidental to another procedure.

In order to report a goniotomy, an extensive incision of the trabecular meshwork around the eye, at the least and generally more than 3 clock hours, must have been performed.

Documentation regarding the reasonable and necessary premise for the work must be present. Noridian may request additional documentation on a case-by-case basis.

Documentation Requirements: The patient's medical record must contain documentation that fully supports the medical necessity for services included in the LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. The medical record and/or test results documenting medical necessity should be maintained and made available on request. iStent, iStent inject, and Hydrus must be performed in conjunction with cataract surgery on the same date of service and documented in the medical record.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

The CPT codes in Group 1 are considered medically necessary when the Indications of Coverage are met. The 90 day global period applies.

Group 1 Codes: (3 Codes)

CODE	DESCRIPTION
66989	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1-STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION), COMPLEX, REQUIRING DEVICES OR TECHNIQUES NOT GENERALLY USED IN ROUTINE CATARACT SURGERY (EG, IRIS EXPANSION DEVICE, SUTURE SUPPORT FOR INTRAOCULAR LENS, OR PRIMARY POSTERIOR CAPSULORRHEXIS) OR PERFORMED ON PATIENTS IN THE AMBLYOGENIC DEVELOPMENTAL STAGE; WITH INSERTION OF INTRAOCULAR (EG, TRABECULAR MESHWORK, SUPRACILIARY, SUPRACHOROIDAL) ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, ONE OR MORE
66991	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1 STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION); WITH INSERTION OF INTRAOCULAR (EG, TRABECULAR MESHWORK, SUPRACILIARY, SUPRACHOROIDAL) ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, ONE OR MORE
0449T	INSERTION OF AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUBCONJUNCTIVAL SPACE; INITIAL DEVICE

Group 2 Paragraph:

The CPT code(s) in Group 2 are considered not medically necessary

Group 2 Codes: (2 Codes)

CODE	DESCRIPTION
0450T	INSERTION OF AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUBCONJUNCTIVAL SPACE; EACH ADDITIONAL DEVICE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0474T	INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITH CREATION OF INTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUPRACILIARY SPACE

CPT/HCPCS Modifiers

Group 1 Paragraph:

N/A

Group 1 Codes:

N/A

ICD-10-CM Codes that Support Medical Necessity

Group 1 Paragraph:

N/A

Group 1 Codes: (52 Codes)

CODE	DESCRIPTION
H40.10X1	Unspecified open-angle glaucoma, mild stage
H40.10X2	Unspecified open-angle glaucoma, moderate stage
H40.10X3	Unspecified open-angle glaucoma, severe stage
H40.10X4	Unspecified open-angle glaucoma, indeterminate stage
H40.1111	Primary open-angle glaucoma, right eye, mild stage
H40.1112	Primary open-angle glaucoma, right eye, moderate stage
H40.1113	Primary open-angle glaucoma, right eye, severe stage
H40.1114	Primary open-angle glaucoma, right eye, indeterminate stage
H40.1121	Primary open-angle glaucoma, left eye, mild stage
H40.1122	Primary open-angle glaucoma, left eye, moderate stage
H40.1123	Primary open-angle glaucoma, left eye, severe stage
H40.1124	Primary open-angle glaucoma, left eye, indeterminate stage
H40.1131	Primary open-angle glaucoma, bilateral, mild stage
H40.1132	Primary open-angle glaucoma, bilateral, moderate stage
H40.1133	Primary open-angle glaucoma, bilateral, severe stage
H40.1134	Primary open-angle glaucoma, bilateral, indeterminate stage
H40.1211	Low-tension glaucoma, right eye, mild stage
H40.1212	Low-tension glaucoma, right eye, moderate stage
H40.1213	Low-tension glaucoma, right eye, severe stage
H40.1214	Low-tension glaucoma, right eye, indeterminate stage
H40.1221	Low-tension glaucoma, left eye, mild stage
H40.1222	Low-tension glaucoma, left eye, moderate stage
H40.1223	Low-tension glaucoma, left eye, severe stage

CODE	DESCRIPTION
H40.1224	Low-tension glaucoma, left eye, indeterminate stage
H40.1231	Low-tension glaucoma, bilateral, mild stage
H40.1232	Low-tension glaucoma, bilateral, moderate stage
H40.1233	Low-tension glaucoma, bilateral, severe stage
H40.1234	Low-tension glaucoma, bilateral, indeterminate stage
H40.1311	Pigmentary glaucoma, right eye, mild stage
H40.1312	Pigmentary glaucoma, right eye, moderate stage
H40.1313	Pigmentary glaucoma, right eye, severe stage
H40.1314	Pigmentary glaucoma, right eye, indeterminate stage
H40.1321	Pigmentary glaucoma, left eye, mild stage
H40.1322	Pigmentary glaucoma, left eye, moderate stage
H40.1323	Pigmentary glaucoma, left eye, severe stage
H40.1324	Pigmentary glaucoma, left eye, indeterminate stage
H40.1331	Pigmentary glaucoma, bilateral, mild stage
H40.1332	Pigmentary glaucoma, bilateral, moderate stage
H40.1333	Pigmentary glaucoma, bilateral, severe stage
H40.1334	Pigmentary glaucoma, bilateral, indeterminate stage
H40.1411	Capsular glaucoma with pseudoexfoliation of lens, right eye, mild stage
H40.1412	Capsular glaucoma with pseudoexfoliation of lens, right eye, moderate stage
H40.1413	Capsular glaucoma with pseudoexfoliation of lens, right eye, severe stage
H40.1414	Capsular glaucoma with pseudoexfoliation of lens, right eye, indeterminate stage
H40.1421	Capsular glaucoma with pseudoexfoliation of lens, left eye, mild stage
H40.1422	Capsular glaucoma with pseudoexfoliation of lens, left eye, moderate stage
H40.1423	Capsular glaucoma with pseudoexfoliation of lens, left eye, severe stage
H40.1424	Capsular glaucoma with pseudoexfoliation of lens, left eye, indeterminate stage
H40.1431	Capsular glaucoma with pseudoexfoliation of lens, bilateral, mild stage
H40.1432	Capsular glaucoma with pseudoexfoliation of lens, bilateral, moderate stage
H40.1433	Capsular glaucoma with pseudoexfoliation of lens, bilateral, severe stage
H40.1434	Capsular glaucoma with pseudoexfoliation of lens, bilateral, indeterminate stage

ICD-10-CM Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

Any ICD-10-CM code not listed in Group 1 "ICD-10 Codes that Support Medical Necessity" section

Group 1 Codes: (1 Code)

CODE	DESCRIPTION
XX000	Not Applicable

ICD-10-PCS Codes

N/A

Additional ICD-10 Information

N/A

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

Other Coding Information

Group 1 Paragraph:

N/A

Group 1 Codes:

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
10/03/2022	R6	Effective 8/2/2022 due to new FDA approved devices, 0671T is being removed from Group II CPT/HCPCS codes.
10/03/2022	R5	Under article text, *Specific coding Guideline:* added verbiage regarding billing and reporting of goniopuncture.
01/01/2022	R4	Effective 1/1/2022 - CPT 68841 has been removed from the Billing and Coding Article, CPT 0671T has been moved to Group 2. Under **Specific Coding Guidelines**: verbiage changes were made.
01/01/2022	R3	Per 2022 Annual CPT/HCPCS Updates, effective 12/31/2021 Category III CPT codes 0191T and 0376T are deleted from Group 1. Effective 1/1/2022 CPT Codes 0671T, 66989, 66991 and 68841 are being added to Group 1.
10/03/2021	R2	Typographical and verbiage changes were made throughout the document for clarification.
02/15/2021	R1	**Under Article Text/Specific Coding Guideline: Removed:** 2-stent device, and therefore, is adequately described by 0101T. Billing of 0376T (an additional device) in addition to 0191T is inappropriate. **Added:** an insertion device that contains two aqueous drainage devices. Bill 0191T for the insertion of the first device and bill 0376T for insertion of the second device on the same date of service. Insertion of a second device on a different date of service will be subject to medical review. Use 0449t for insertion of the Hydrus stent. More than one Hydrus device per eye is considered investigational and not covered. **Under Group 2 Codes:** Removed code 0376T and added to Group 1 codes

Associated Documents

Related Local Coverage Documents

Articles

DA57863 - (MCD Archive Site)

A58855 - Response to Comments: Micro-Invasive Glaucoma Surgery (MIGS)

LCDs

L38299 - Micro-Invasive Glaucoma Surgery (MIGS)

Related National Coverage Documents

N/A

Statutory Requirements URLs

N/A

Rules and Regulations URLs

N/A

CMS Manual Explanations URLs

N/A

Other URLs

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
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Keywords

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