Billing and Coding Article

Article - Billing and Coding: Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach (0192T 66183) (A52432)

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NOT AN LCD REFERENCE ARTICLE

This article is not in direct support of an LCD. Learn more

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
CGS Administrators, LLC	MAC - Part A	15101 - MAC A	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part B	15102 - MAC B	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part A	15201 - MAC A	J - 15	Ohio
CGS Administrators, LLC	MAC - Part B	15202 - MAC B	J - 15	Ohio

Article Information

General Information

Article ID
A52432

Article Title
Billing and Coding: Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach (0192T 66183)

Article Type
Billing and Coding

Original Effective Date
10/01/2015

Revision Effective Date
11/16/2023

Revision Ending Date
N/A

Retirement Date

N/A

CMS National Coverage Policy

N/A

Article Guidance

Article Text

Abstract:

Glaucoma filtering surgery is indicated when glaucomatous damage progresses despite pharmacological and/or surgical treatment. Trabeculectomy is the most widely used form of filtering surgical treatment for primary open-angle glaucoma. Glaucoma drainage implants designed to shunt the aqueous fluid posteriorly represent an alternative method for lowering intraocular pressure in glaucomatous patients and are commonly used in refractory glaucoma or after failure of filtration surgery.

Since the first mini shunt device was approved by the Food and Drug Administration (FDA) for marketing in March 2002, over 14,000 implantations have been performed. However, there has been disagreement in the ophthalmology community regarding the correct coding for this procedure. The majority of ophthalmologists billed Current Procedural Terminology (CPT) code *66180 (Aqueous shunt to extraocular reservoir [eg, Molteno, Schocket, Denver-Krupin]), with some using 66172 (Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma [includes injection of antifibrotic agents]) or 66999 (Unlisted procedure, anterior segment of eye).* Because of this disagreement, the American Medical Association (AMA) CPT Panel developed a new Category III CPT code, *0192T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach),* effective for services rendered on or after July 1, 2008 thru December 31, 2013. Effective January 1, 2014 CPT code 66183 should be used for the insertion of anterior segment aqueous drainage device.. The appropriate ICD-10-CM codes are listed below in the covered ICD-10 code section. The device used must be FDA approved, such as the Ex-PRESS™ mini shunt (Optonol).

Indications:

An anterior segment aqueous drainage device, without extraocular reservoir, implanted under a partial thickness scleral flap may be a safe alternative or adjunct to standard guarded trabeculectomy, especially for patients with advanced glaucoma in need of low intraocular pressures with a high risk for hypotonous complication.

Limitations:

Other indications for 0192T and/or 66183 remain investigational or not medically necessary.

Coding Guidelines:

General Guidelines for claims submitted to Part A or Part B MAC:

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.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, for complete instructions.

Effective from April 1, 2010, non-covered services should be billed with modifier –GA, -GX, -GY, or –GZ, as appropriate.

The –GA modifier ("Waiver of Liability Statement Issued as Required by Payer Policy") should be used when physicians, practitioners, or suppliers want to indicate that they anticipate that Medicare will deny a specific service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. Modifier GA applies only when services will be denied under reasonable and necessary provisions, sections 1862(a)(1), 1862(a)(9), 1879(e), or 1879(g) of the Social Security Act. Effective April 1, 2010, Part A MAC systems will automatically deny services billed with modifier GA. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Part A MAC, occurrence code 32 and the date of the ABN is required.

Modifier GX ("Notice of Liability Issued, Voluntary Under Payer Policy") should be used when the beneficiary has signed an ABN, and a denial is anticipated based on provisions *other* than medical necessity, such as statutory exclusions of coverage or technical issues. An ABN is not required for these denials, but if non-covered services are reported with modifier GX, Part A MAC systems will automatically deny the services.

The –GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier. An ABN is not required for these denials, and the limitation of liability does not apply for beneficiaries. Services with modifier GY will automatically deny.

The anatomic modifiers left (-LT) or right (-RT) should be appended to the procedure code. The -50 modifier is not to be appended to this code as two eyes should not be done on the same day.

Only CPT code 0192T should be reported for insertion of the anterior segment aqueous drainage device for dates of service July 1, 2008 thru December 31, 2013. Effective January 1, 2014 CPT code 66183 should be reported for insertion of the anterior segment aqueous drainage device. . Do not report CPT codes 66170, 66172, 66180 or other procedure codes formerly used for the insertion of this device.

For claims submitted to the Part B MAC:

Claims for 0192T/66183 are payable under Medicare Part B in the following places of service: office (11), inpatient hospital (21), outpatient hospital (22), ambulatory surgical center (24) and independent clinic (49).

For claims submitted to the Part A MAC:

Hospital Inpatient Claims:

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- The hospital enters ICD-10-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.
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- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

- *The hospital should report the full ICD-10-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67.* If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider *should report an ICD-10-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (Z00.00-Z13.9).*
- The hospital enters the full ICD-10-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes: (1 Code)

CODE	DESCRIPTION
66183	INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, EXTERNAL APPROACH

CPT/HCPCS Modifiers

N/A

ICD-10-CM Codes that Support Medical Necessity

Group 1 Paragraph:

N/A

Group 1 Codes: (44 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
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

CODE	DESCRIPTION
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
H40.151	Residual stage of open-angle glaucoma, right eye
H40.152	Residual stage of open-angle glaucoma, left eye
H40.153	Residual stage of open-angle glaucoma, bilateral
Q15.0	Congenital glaucoma

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

N/A

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.

CODE	DESCRIPTION
011x	Hospital Inpatient (Including Medicare Part A)
013x	Hospital Outpatient

CODE	DESCRIPTION
071x	Clinic - Rural Health
085x	Critical Access Hospital

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.

Revenue codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

CODE	DESCRIPTION
0360	Operating Room Services - General Classification
0490	Ambulatory Surgical Care - General Classification
0510	Clinic - General Classification
0960	Professional Fees - General Classification
0962	Professional Fees - Ophthalmology
0982	Professional Fees - Outpatient Services
0983	Professional Fees - Clinic

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
11/16/2023	R11	Revision Effective: 11/16/2023 Revision Explanation: Updated LCD Reference Article section.
10/06/2022	R10	Revision Effective date: 10/06/2022 Revision Explanation: Annual review, no changes were made.
09/30/2021	R9	Revision Effective date: 09/30/2021 Revision Explanation: Annual review, no changes were made.
01/01/2020	R8	Revision Effective date: n/a Revision Explanation: Annual review, no changes made.
01/01/2020	R7	Revision Effective date: 01/01/2020 Revision Explanation: Converted to new billing and coding article format.
10/01/2016	R6	Revision Effective date: N/A Revision Explanation: Annual Review, no changes made.
10/01/2016	R5	Revision Effective date: N/A Revision Explanation: Annual review no changes made at this time.
10/01/2015	R4	Revision Effective date: N/A Revision Explanation: Annual review no changes made at this time.
10/01/2016	R3	Revision Effective date: 10/01/2016 Revision Explanation: The following ICD-10 codes were deleted H40.11X1, H40.11X2, H40.11X3, and H40.11X4 and replaced with the following H40.1111, H40.1112, H40.1113, H40.1114, H40.1121, H40.1122, H40.1123, H40.1124, H40.1131, H40.1132, H40.1132, H40.1133, H40.1134.
10/01/2015	R2	Revision Effective date: N/A Revision Explanation: Annual review no changes made at his time.
01/01/2014	R1	Revision Effective date: N/A Revision explanation: Annual review, no changes made

Associated Documents

Related Local Coverage Documents

N/A

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
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		
11/07/2023	11/16/2023 - N/A	Currently in Effect (This Version)
09/26/2022	10/06/2022 - 11/15/2023	Superseded

Keywords

N/A