Corcoran Consulting Group

A Division of Ardare Corporation

Medicare Reimbursement

for the

Hydrus® Microstent

Prepared for

Alcon

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Medicare Reimbursement for the Hydrus® Microstent

by

Corcoran Consulting Group
A Division of Ardare Corporation
560 E. Hospitality Lane ~ Suite 360
San Bernardino, California 92408

(800) 399-6565
www.corcoranccg.com

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Objective: *This report is provided as a general discussion of billing and documentation for combined cataract and glaucoma surgery with the Hydrus® Microstent and related issues. Variations in coverage and payment policies among Medicare Administrative Contractors (MACs) may occur which are not described here. Other non-Medicare payers may promulgate policies that differ from those of Medicare and its contractors. The user is strongly encouraged to review federal and state laws, regulations and official instructions of the Centers for Medicare & Medicaid Services (CMS), the MACs, and other third-party payers.*

Notice: *All fee schedule amounts noted in this document are the national Medicare allowed amounts. Actual fee schedule amounts and payments vary by locality.*

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INTRODUCTION

This monograph describes reimbursement for surgery to implant the Alcon Hydrus® Microstent for primary open-angle glaucoma.

Much of the information in this document is taken from official publications of the Medicare program. The reader is encouraged to check with the local Medicare Administrative Contractor (MAC) for additional information and instructions. For other third-party payers, we have used the coding concepts contained in CPT and published by the American Medical Association; diagnosis codes are from ICD-10-CM.

Documentation of surgery, and the medical rationale for it, is key to reimbursement so we describe the required elements in detail. For added perspective, we discuss the utilization trends for glaucoma surgery as well as the current Medicare payment rates.

THE DEVICE

The Hydrus Microstent is a small, elastic device made of a biocompatible nickel-titanium alloy known as nitinol. Alcon notes that, "*Nitinol has been used extensively in a variety of implantable devices for its proven properties of flexibility, strength and biocompatibility. As a shape memory alloy, nitinol has super-elastic properties making it suitable as a support structure in Schlemm's canal. The Hydrus Microstent implant is laser cut from nitinol tubing to a proprietary design with alternating 'spines' for structural support and 'windows' to provide outflow pathways for aqueous humor. After laser cutting, the shape of the implant is heat-set to a curvature that matches the curvature of Schlemm's canal and is electro-polished to create a smooth biocompatible surface. The microstent is approximately 8mm in overall length with major and minor axes of 292µm and 185µm, respectively. The length and curvature of the implant are designed to occupy approximately 90° or 3 clock hours of Schlemm's canal.*"

It is designed to be inserted via a proprietary delivery system into the trabecular meshwork and Schlemm's canal, where it functions as a trabecular bypass device and an "*intracanalicular scaffold*" to allow for aqueous drainage from the anterior chamber to facilitate lowering intraocular pressure (IOP).[1] The proximal portion of the implant exits the canal through the trabecular meshwork to allow inflow of aqueous humor from the anterior chamber. Alcon notes that, "*the delivery system was designed to provide smooth tracking and controlled delivery of the microstent into Schlemm's canal. The delivery system is an ergonomic design for use in either the right or left hand, allowing for surgeon individual preference and hand position.*" They also note that the delivery system can

[1] Alcon. The Hydrus Microstent. Link here. Accessed 08/01/22.

"*accommodate a wide range of hand positions, a rotatable sleeve at the distal end allows positioning and alignment of the cannula by the surgeon into the trabecular meshwork to direct the implant into Schlemm's canal. The tracking wheel on the delivery system serves as the control mechanism to advance the implant into the canal or retract the implant into the cannula.*"

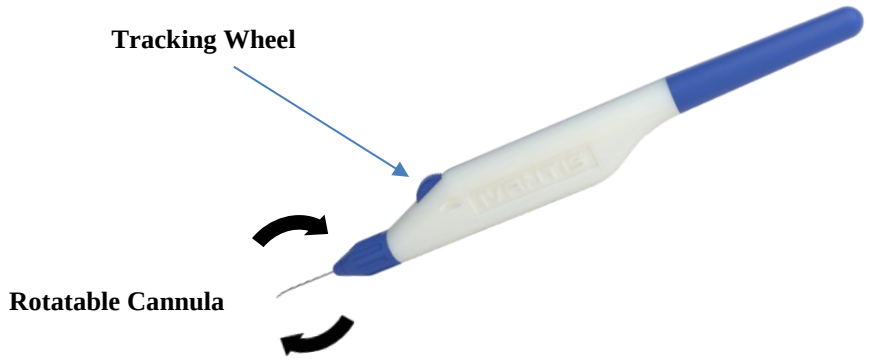
Actual insertion is noted by Alcon as follows:

> "*To deliver the microstent into Schlemm's canal, the cannula of the delivery system is inserted through a clear corneal incision (approximately 1.5 mm in length). The cannula tip is then advanced into and through the trabecular meshwork until it enters Schlemm's canal and the entry point into the meshwork is coincident with the end of the cannula bevel. The target tissue is visualized using a gonioscopic prism. After observing that the distal cannula tip is properly positioned through the trabecular meshwork into Schlemm's canal, the tracking wheel on the delivery system is used to advance and release the microstent.*"

The 5-year results of the HORIZON clinical trial in the US and overseas comparing intracanalicular Hydrus Microstent with cataract surgery and cataract surgery alone found greater intraocular pressure reduction, fewer glaucoma medications, reduced need for postoperative incisional glaucoma filtration surgery, and no difference in endothelial cell loss with combined glaucoma-cataract surgery.[2]

Figures 1 and 2 show the Hydrus Microstent Delivery System and the Hydrus Microstent, respectively.[3]

Figure 1 **Hydrus Microstent Delivery System**



[2] Ahmed, IK, DeFrancesco, T, Rhee, D, et al. Long-term outcomes from the HORIZON randomized trial for a Schlemm's canal microstent in combination cataract and glaucoma surgery. Ophthalmol 2022; 1-10 Link here. Accessed 08/01/22

[3] All images courtesy of Alcon.

Figure 2 **Hydrus Device (Magnified View)**

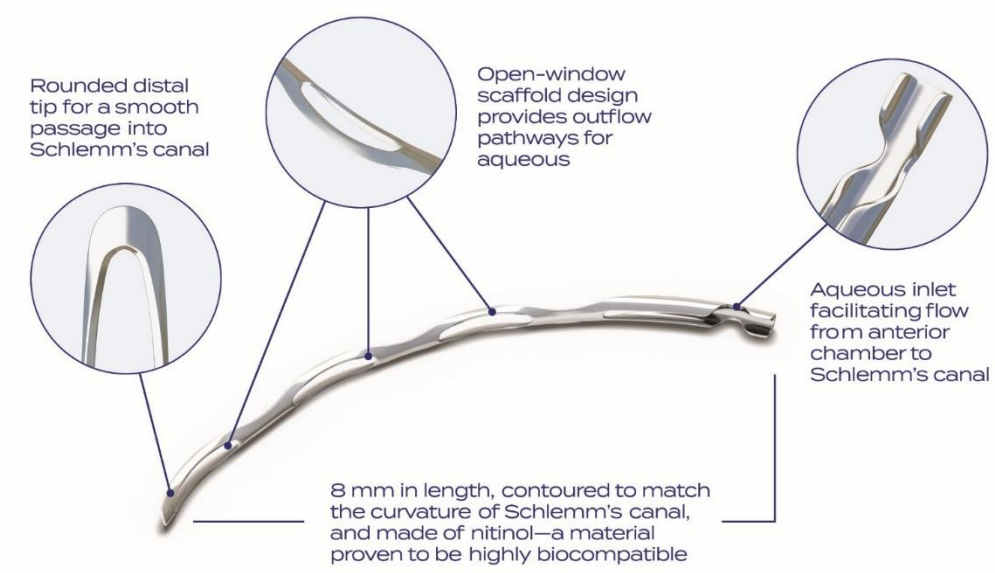


Figure 3 shows the device in preferred position with the expected locations of the corneal incisions. Figure 4 shows the device with the proximal end (at right) accessing the aqueous humor from the anterior chamber.

Figure 3 **Hydrus Microstent with Preferred Positions of Incisions and Target Placement**

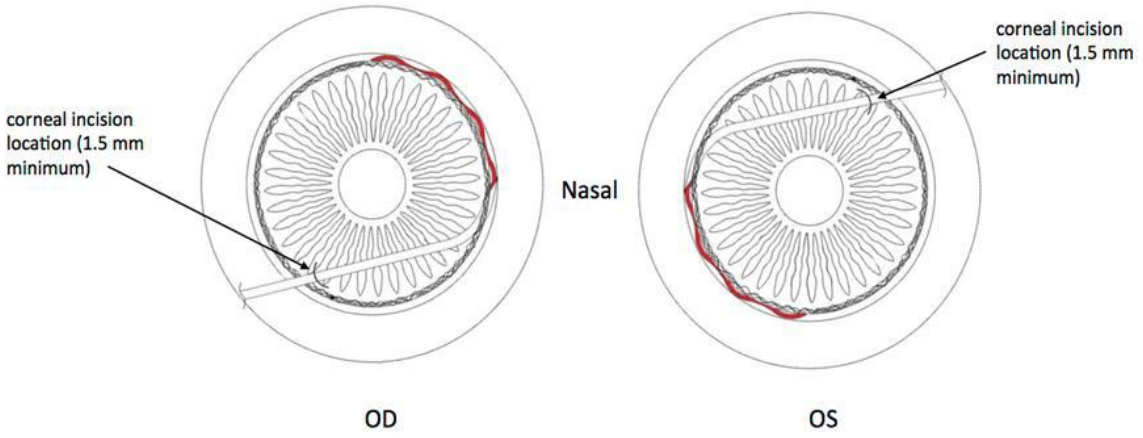
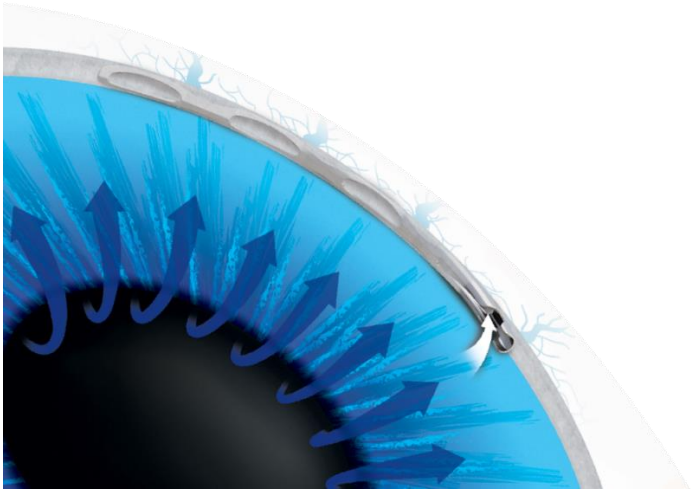


Figure 4 **Hydrus Microstent in Schlemm's Canal**



INDICATIONS

The Hydrus Microstent "*…is indicated for use in conjunction with cataract surgery for the reduction of intraocular pressure (IOP) in adult patients with mild to moderate primary open-angle glaucoma (POAG).*"[4] Clear media and an adequate direct gonioscopic view of the anterior chamber angle is required for insertion and follow-up, and intracameral miotic is recommended to improve visibility at insertion. Alcon also advises not to place the device in the superior temporal quadrant to avoid any possible interference with later trabeculectomy or tube shunt if needed.

It is contraindicated in the following circumstances or conditions:

- "*eyes with angle closure glaucoma, or*
- *eyes with traumatic, malignant, uveitic, or neovascular glaucoma or discernible congenital anomalies of the anterior chamber angle.*"

The American Academy of Ophthalmology (AAO) publishes its Preferred Practice Pattern (PPP) for primary open-angle glaucoma, most recently in 2020.[5] In most cases, IOP-lowering medications are the first line therapy. Yet many glaucoma patients do not do well with medications for many reasons including:

- medications are not tolerated (*e.g.,* allergy, hypersensitivity),

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[4] Directions for use. Link here. Accessed 08/01/22

[5] American Academy of Ophthalmology. Primary Open-Angle Glaucoma PPP 2020 Link here Accessed 06/13/22.

- patients cannot or will not comply with instructions for use, or
- medication(s) is not affordable so patient does not fill prescription(s).

When medical therapy fails, the result is usually disease progression requiring surgical intervention.

This PPP states, "*Potential benefits of a combined procedure (cataract extraction with IOL implantation and glaucoma surgery) are protection against the IOP rise that may complicate cataract surgery alone, the possibility of achieving long-term glaucoma control with a single operation, and elimination of the risk of bleb failure with subsequent cataract surgery when glaucoma surgery is performed first.*"

MIGS Coverage Guidelines

CGS Administrators (CGS), the MAC for Kentucky and Ohio, in their LCD L37578 on Micro-Invasive Glaucoma Surgery (MIGS), notes,

> "*The goal in POAG is to reduce the IOP to slow the development of optic nerve damage. The IOP can be reduced by medical treatment or surgery, alone or in combination. IOP above 21 mmHg has been shown to increase rates of visual field loss. However, because of the differences in susceptibility to pressure-related disc damage among POAG patients, pressure-lowering treatments are aimed at achieving a lower 'target' pressure individualized to each patient's baseline IOP in which glaucomatous damage occurred. … When the maximum tolerated medical therapy fails to control progression of glaucomatous optic neuropathy, surgical care is considered the next treatment option …*"[6]

CGS goes on to add,

> "*The term micro-invasive or minimally invasive glaucoma surgery (MIGS) refers to a group of newer surgical procedures that are performed by using an ab interno (from inside the eye) approach via gonioscopic guidance and involve minimal trauma to ocular tissues. In contrast to external filtration surgeries such as trabeculectomy and aqueous tube shunt, these procedures are categorized as internal filtration surgeries. Compared with traditional filtration surgery, MIGS holds the promise of faster recovery time and less severe complications.*"

[6] CGS Administrators, LLC. LCD L37578. Micro-Invasive Glaucoma Surgery (MIGS). Kentucky and Ohio. Revision Effective Date 05/05/22. Link here. Accessed 06/13/22.

National Governmental Services, Inc. (NGS), in their LCD L37244,[7] notes similar guidance.

There are many individual MIGS coverage policies but no single universal policy; however, third-party payers state that MIGS is not covered for a number of reasons including:

- the absence of glaucoma,
- for types of glaucoma that are not responsive to MIGS,
- where tolerated medication provides adequate IOP control,
- for off-label (not FDA approved) use of an aqueous drainage assist device,
- during a clinical study of an experimental and investigational device.

DOCUMENTATION

A claim for reimbursement is assumed to be supported by adequate and complete documentation in the beneficiary's medical record that describes the procedure and the medical rational for it. Because several therapeutic options exist for glaucoma and the severity of the disease determines which therapy is appropriate, it is important to establish the gravity of the condition and the effectiveness of earlier treatments, and include all relevant information in the medical record. Adequate chart documentation includes (at a minimum) all of the following items. Every page of the record must be legible and include appropriate patient identification information (*e.g.*, complete name, date(s) of service).

- Eye exam with description of medical justification for a MIGS procedure and absence of contraindications for the surgery.
- Documentation of glaucoma findings and inability to maintain target IOP with medication therapy and/or documentation of inability to comply with medication therapy such as cost, memory problems, difficulty with instillation, or intolerance to the medication.
- Documentation if previous glaucoma surgery was performed.
- Allied diagnostic testing with physician's order, medical rationale, findings, interpretation and report supporting medical necessity for MIGS (*e.g.*, VF, OCT).
- Clearance for surgery (*e.g.*, history and physical) by the surgeon or other qualified health care professional.

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[7] National Governmental Services, Inc. (NGS). LCD L37244. Micro-Invasive Glaucoma Surgery (MIGS). Revision Effective Date 12/01/19. Link here. Accessed 06/13/22.

- Detailed operative report that incorporates:
    - Indications
    - Procedure description
    - Make, model, serial number(s) of aqueous drainage device
    - Discharge instructions
- Services provided/ordered must be authenticated by the author. The method used shall be handwritten or electronic signature.[8]

In addition to evidence in the medical record that supports medical necessity for MIGS, concurrent cataract surgery must also be justified.[9] Adequate chart documentation includes (at a minimum) all of the following items:

- Eye exam with description of medical justification for cataract surgery and absence of contraindications for the surgery.
- Questionnaire about hindrance of activities of daily living (*e.g.*, VF-8 or VF-14)[10,11]
- Allied diagnostic testing with physician's order, medical rationale, findings, interpretation and report (*e.g.*, biometry and IOL calculation).
- Clearance for surgery (*e.g.*, history and physical) by the surgeon or other qualified health care professional
- Detailed operative report that incorporates:
    - Indications
    - Procedure description including make, model, and power of IOL
    - Discharge instructions

BILLING

Procedure Codes

Prior to 2022, implantation of the Hydrus Microstent was reported as Category III CPT code 0191T (*Insertion of anterior segment drainage device, without extraocular reservoir,*

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8 For more expansive and detailed information on this topic, refer to the Medicare Program Integrity Manual (Pub. 100-08), §3.3.2.4 – Signature Requirements. Link here. Accessed 06/13/22

9 American Academy of Ophthalmology. Cataract in the Adult Eye PPP 2021. Link here. Accessed 06/13/22.

10 Novitas Solutions, Inc. LCD L35091. Cataract Extraction. Revision Effective Date 07/11/21. Link here. Accessed 06/13/22.

11 Aetna. Cataract Removal Surgery, Policy 0508. Revision Effective Date 02/15/22. Link here. Accessed 06/13/22.

internal approach, into the trabecular meshwork; initial insertion). Effective January 1, 2022, 0191T is deleted from CPT and there are two new Category I CPT codes to report combined cataract surgery and implantation of the Hydrus Microstent: 66989 and 66991. In addition, there is a new Category III CPT code, 0671T, to describe implantation of the Hydrus Microstent without concurrent cataract surgery.[12]

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.*

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.*

0671T ….. *Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more*).

Modifiers

Modifiers provide additional information about the services provided. Following are some modifiers frequently associated with surgical claims. Check your Medicare bulletins and the CPT handbook for additional modifiers and expanded descriptions.

22 ….. Unusual procedural services

50 ….. Bilateral procedure

51 ….. Multiple procedures (*rarely used by Medicare*)

52 ..... Reduced services

53 ..... Discontinued procedure

[12] Current Procedural Terminology (CPT) 2022 Professional Edition.

54 ..... Surgical care only

55 ..... Postoperative care only

58 ….. Staged or related procedure or service during the postoperative period

59 ….. Distinct procedural service (see also X-modifiers)

78 ….. Return to the operating room/procedure room for a related procedure during the postoperative period

79 ….. Unrelated procedure during the postoperative period

GA …. Medicare probably does not cover this service; Advance Beneficiary Notice of Non-coverage (ABN) signed, as required by payer policy

GX …. Medicare probably does not cover this service. Advance Beneficiary Notice (ABN) signed, voluntary notice given under payer policy

GY …. Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit (used to obtain a denial)

GZ …. Item or service expected to be denied as not reasonable and necessary (no ABN on file) (*Medicare only*)

LT ….. Left eye (OS)

RT ….. Right eye (OD)

XE …. Separate encounter (use in lieu of modifier 59)

XS …. Separate structure (use in lieu of modifier 59)

XP …. Separate practitioner (use in lieu of modifier 59)

XU …. Unusual non-overlapping service (use in lieu of modifier 59)

Sample Claims

Example Cataract Surgery with Concurrent Hydrus Microstent

A patient has significant nuclear cataracts in both eyes (OD>OS) that affect activities of daily living. Current intraocular pressure is uncontrolled with medication and exceeds the target IOP for moderate open-angle glaucoma OU. After a thorough discussion of risks, benefits, and alternatives, the patient consents to cataract surgery and concurrent implantation of a Hydrus Microstent in the right eye. An uncomplicated procedure took place in the hospital outpatient department (HOPD). The surgeon's claim will read as follows.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890

19 ADDITIONAL CLAIM INFORMATION

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0

A. H25.11 B. H40.1112 C. D.

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		22		66991	RT	A,B	xxx xx	1		NPI	1234567890

Note: ICD-10 codes for open-angle glaucoma have stages and laterality; cataract only has laterality.

The HOPD claim for the facility fee is shown in the Appendix.

One week later, during the postoperative period of the initial surgery, the fellow eye is operated in the same way and in the same facility. The surgeon's claim for the second (left) eye is shown below.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890

19 ADDITIONAL CLAIM INFORMATION

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0

A. H25.12 B. H40.1122 C. D.

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		22		66991	79 LT	A,B	xxx xx	1		NPI	1234567890

Note: Modifier 79 denotes that surgery took place within a global period and is unrelated to the first surgery (fellow eye).

Prohibited Code Combinations

In 1996, CMS developed the National Correct Coding Initiative (NCCI)[13] to control improper coding leading to inappropriate payments in Part B claims.[14] NCCI consists of a series of edits to analyze codes reported on claims for reimbursement. They ensure the most comprehensive groups of codes are billed rather than the component parts; this is the concept informally known as "bundles". Additionally, the edits check for mutually exclusive code pairs – procedures that are medically incompatible – so just one of the pair may be reimbursed. New edits are published quarterly by the National Technical

[13] CMS. National Correct Coding Initiative Edits. Link here. Accessed 06/13/22.

[14] Medicare Claims Processing Manual, Chapter 23, §20.9. Correct Coding Initiative. Link here. Accessed 06/13/22.

Information Service (NTIS). Of note, you may not use an ABN to circumvent the NCCI edits. The edits for 66991 and 66989 include cataract procedures and some glaucoma procedures. As of January 1, 2022, there are no published edits for 0671T.

Financial Waivers

An Advance Beneficiary Notice of Non- Coverage (ABN, CMS-R-131)[15] is a written notice a health care provider gives to a Medicare beneficiary when the provider believes that Medicare will not pay for items or services. It applies to both assigned and non-assigned claims. By signing an ABN, the Medicare beneficiary acknowledges that he or she has been advised that Medicare will not pay and agrees to be responsible for payment, either personally or through another insurance plan. For an ABN to have any utility, it must be signed before providing the item or service.

The format of an ABN cannot be modified to any significant degree. You must add your name, address and telephone to the header. You may add your logo and other information if you wish. The "Items or Services," "Reason Medicare May Not Pay," and "Estimated Cost" boxes are customizable, so you can add pre-printed lists of common items and services or denial reasons. Anything you add in the boxes must be high contrast ink on a pale background. Blue or black ink on white paper is preferred. You may not make any other alterations to the form. It must be one page, single-sided, although an addendum is allowed.

The patient must *sign* and *date* the form; an unsigned or undated form is not valid. Once the patient has signed the completed form, he or she must receive a legible copy. The same guidelines apply to the copy as to the original: blue or black ink on white paper is preferred; a photocopy is fine. You keep the original in your files.

You must complete your portion of the form before asking the beneficiary to sign. Fill in the beneficiary's name and identification number (but not HIC number) at the top of the form. Complete the "Items or Services" box, describing what you propose to provide. Use simple language the beneficiary can understand. You may add CPT or HCPCS codes, but codes alone are not sufficient without a description. Complete the "Reason Medicare May Not Pay" box with the reason(s) you expect a denial. The reason(s) must be specific to the particular patient; general statements such as "medically unnecessary" are not acceptable. The "Estimated Cost" field is required.

The beneficiary must *personally* choose from Option 1, 2 or 3.

[15] Advance Beneficiary Notice of Noncoverage. Link here. Accessed 06/13/22.

- ☐ Option 1 I *want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but* ***I can appeal to Medicare*** *by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.*
- ☐ Option 2 I *want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and* ***I cannot appeal if Medicare is not billed.***
- ☐ Option 3 I *don't want the items or services listed above. I understand with this choice I am* ***not*** *responsible for payment, and* ***I cannot appeal to see if Medicare would pay.***

If the beneficiary chooses Option 1, you must file a claim and append an appropriate modifier to the reported item(s) or service(s). Option 2 applies to situations where Medicare is precluded from paying for the item or service and the beneficiary does not dispute the point; you are not required to file a claim. If the beneficiary chooses Option 3, there is no claim to file or charge to make; the service is not provided because the patient declines.

You do not need an ABN for items or services that are statutorily (*i.e.*, by law) non-covered by Medicare. Statutorily non-covered services in an eye care practice include refractions and cosmetic procedures such as refractive surgery. Instructions, published on September 5, 2008, allow the use of an ABN *voluntarily* for items excluded from Medicare coverage. At your discretion, you may choose to notify a beneficiary that these services are never covered using the ABN. Written notification is strongly recommended to avoid confrontations with beneficiaries about payment.

In CMS Transmittal R1921CP,[16] effective April 1, 2010, two modifiers were updated to distinguish between *voluntary* and *required* use of liability notices.

- Modifier GA is now defined as "Waiver of Liability Statement Issued as Required by Payer Policy". It applies when you believe Medicare will consider a service not medically necessary in a particular situation. Ask the patient to sign an ABN and submit your claim with modifier GA, allowing the payer to decide if the service is covered.
- Modifier GX is defined as "Notice of Liability Issued, Voluntary Under Payer Policy". It applies when a service is always noncovered; it addresses the fact that most beneficiaries will elect Option 1 in the hope that Medicare might pay, despite

[16] CMS. Transmittal R1921CP. Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs). February 19, 2010. Link here. Accessed 06/13/22.

your assurances to the contrary. Therefore, if the patient selects Option 1, append modifiers GX and GY to that claim to obtain a denial.

- Modifier GY is defined as "Item or service statutorily excluded or does not meet the definition of any Medicare benefit".

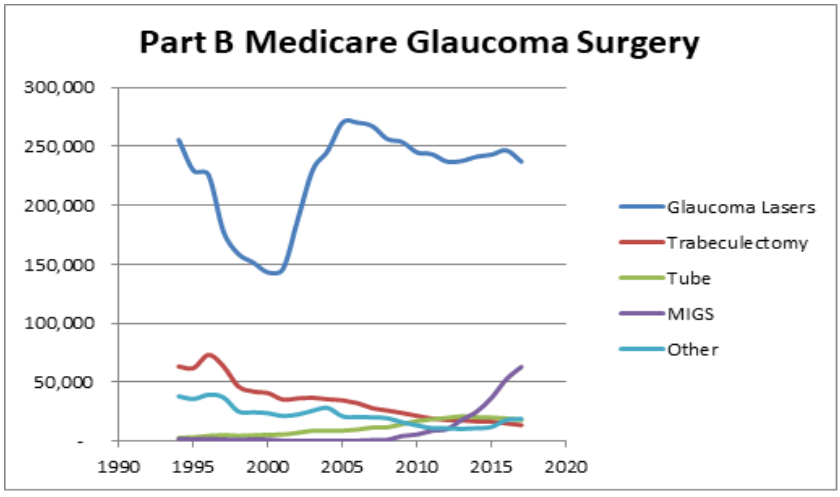
Note that Medicare Advantage plans (Medicare Part C) are prohibited from using the regular Medicare ABN form but may still require prior financial notice. In many cases, they are required to provide a coverage or non-coverage determination in advance. Check plan websites for appropriate instructions.

For non-Medicare beneficiaries, some of the principles outlined above are just as applicable. While the concept of waiver of liability may not be present, or at least not as vigorously, it is still prudent to ensure that patients appreciate the distinction between covered and non-covered services and accept financial responsibility for the latter.

UTILIZATION

Figure 5 describes utilization trends in glaucoma surgery within the traditional Medicare program from 1994 to 2018, the most recent information available.

Figure 5 **Part B Medicare Glaucoma Surgery**



Compared with other glaucoma surgeries, it is noteworthy that the MIGS category, including a variety of procedures, is rapidly increasing, beginning in 2009.

PAYMENT

The 2022 national Medicare Physician Fee Schedule allowed amount for 66991 is $683, and $857 for 66989. These amounts are adjusted in each area by local wage indices. There is no defined allowed amount in the MPFS for 0671T. Other payers set their own fees, which may differ significantly from the Medicare published fee schedule.

The Medicare Outpatient Prospective Payment System contains allowed amounts for an ambulatory surgery center (ASC) and hospital outpatient department (HOPD) as shown in Table 1. These amounts are adjusted in each area by local wage indices. Other payers set their own rates, which may differ significantly from the Medicare published fee schedule.

Table 1 **2022 National Medicare Facility Payment**

Code	ASC	HOPD
66991, 66989	$3,246	$4,251
0671T	$1,601	$2,121

CONCLUSION

This discussion is meant to assist the reader to better understand the rules and regulations regarding reimbursement for the Hydrus Microstent, however the responsibility for appropriate usage, adequate documentation and proper coding are always the physician's.

APPENDIX

SAMPLE UB-04 CLAIM FORM - CATARACT & MIGS

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
250	Pharmacy				$$ $$		
272	Sterile Supplies				$$ $$		
276	Intraocular Lens	V2632			$$ $$		
278	Aqueous Drainage Assist Device	C1783			$$ $$		
360	Operating Room	66991			$$ $$		
370	Anesthesia	00142			$$ $$		
710	Recovery Room				$$ $$		

HYDRUS

PAGE _____ OF _____ CREATION DATE

Cataract

Glaucoma

66 DX	A	B	C	D	E	F	G	H	68
	H25.XXX	H40.XXX							
	I	J	K	L	M	N	O	P	Q

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee

LIC9213257