2025 Baerveldt™ Billing & Coding Guide

Johnson&Johnson | Vision

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Billing and coding guides

The information provided in this guide is general information only and is not legal advice nor is it advice about how to code, complete, or submit any particular claim for payment for health care services or goods.

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It is not intended to increase or maximize reimbursement by any payer.

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For inquiries or request of any additional information, please contact us at: JJSVHEMA@its.jnj.com.

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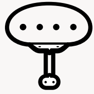

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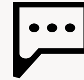

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Abbreviations

ABN	Advance Beneficiary Notice of Non-coverage	MPFS	Medicare Physician Fee Schedule
APC	Ambulatory Payment Classification	NCCI	National Correct Coding Initiative
ASC	Ambulatory surgery center	NTIS	National Technical Information Service
CMS	Centers for Medicare & Medicaid Services	OCT	Optical coherence tomography
CPT®	Current Procedural Terminology	OPPS	Outpatient Prospective Payment System
HCPCS	Healthcare Common Procedure Coding System	MIGS	Minimally invasive glaucoma surgery
HOPD	Hospital outpatient department	MPFS	Medicare Physician Fee Schedule
IOP	Intraocular pressure	US	United States
MIGS	Minimally invasive glaucoma surgery	VF	Visual field

Baerveldt™ reimbursement considerations

Baerveldt™ Glaucoma Implants

- The Baerveldt™ glaucoma implants are tube shunts indicated for use in patients with medically uncontrollable glaucoma and poor surgical prognosis.[1,a]
  - Provide a therapeutic alternative when anti-glaucoma medications, laser trabeculoplasty, trabeculectomy, and other surgical procedures have failed; notably, aggressive treatment with an aqueous shunt and similar devices may be the preferred approach in cases involving neovascular glaucoma and buphthalmos.[2]
- Two models (BG101-350, BG103-250) are designed for implantation in the anterior chamber, whereas a third model (Pars Plana BG102-350) is designed for insertion in the posterior chamber during or following a pars plana vitrectomy.[1]

Medicare Reimbursement Considerations for Baerveldt™

- In the United States (US), the standard of care for glaucoma is medical intervention with anti-glaucoma medications as the initial course of treatment except in extraordinary cases; the need for surgical intervention is determined on a patient-by-patient basis.[2]
- Because the appropriate therapeutic option for glaucoma is determined by the severity of the condition, a reimbursement claim must be supported by adequate documentation.[2]

Minimum requirements[a] for chart documentation[2]

- ✓ Eye exam with description of medical justification for an aqueous shunt 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 aqueous shunt (e.g., VF, OCT)
- ✓ 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; make, model, serial number(s) of aqueous drainage device; discharge instructions
- ✓ Services provided/ordered must be authenticated by the author (handwritten or electronic signature)[3]
- ✓ Eye exam with description of medical justification for an aqueous shunt procedure and absence of contraindications for the surgery

Note: Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, date(s) of service).

[a] Indication: For use in patients (with prior vitrectomy for Pars Plana) with medically uncontrollable glaucoma and poor surgical prognosis, such as, but not limited to: neovascular glaucoma, aphakic/pseudophakic glaucomas, patients who have failed conventional surgery, congenital glaucomas and secondary glaucomas due to uveitis, epithelial downgrowth, etc. Abbreviations: IOP = intraocular pressure; OCT = optical coherence tomography; VF = visual field.

Baerveldt™ Billing & Coding

Applicable Procedure Codes

CPT® Code	Description
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft
66184	Revision of aqueous shunt to extraocular plate reservoir, external approach; without graft
66185	Revision of aqueous shunt to extraocular plate reservoir, external approach; with graft

Modifiers

- Modifiers provide additional information about the services provided. The following are some modifiers associated with surgical claims. Please check your Medicare bulletins and the CPT® handbook for additional modifiers and expanded descriptions.

Modifier	Description
-22	Unusual procedural services
-50	Bilateral procedure
-52	Reduced services
-53	Discontinued procedure
-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

Modifier	Description
-GA	Medicare probably does not cover this service; ABN signed, as required by payer policy
-GX	Medicare probably does not cover this service. 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)

Abbreviation: ABN = Advance Beneficiary Notice of Non-coverage.

Baerveldt™ Billing & Coding

Billing & Coding Considerations

MULTIPLE PROCEDURES

- When performing a Baerveldt™ procedure in conjunction with another surgery (e.g., posterior vitrectomy or lens surgery), standard rules governing multiple procedures apply:[2,a]
  - The primary procedure is reimbursed at 100% of the payer's allowance; the subsequent procedure is reimbursed at 50% of the allowed amount (note that the primary procedure is always the service with the highest allowable value).

PROHIBITED CODE COMBINATIONS

- To address improper coding in Part B claims, CMS developed the National Correct Coding Initiative (NCCI)—a series of edits to analyze codes reported in reimbursement claims that:[5,6]
  - Ensure that the most comprehensive groups of codes (i.e., "bundles") are billed rather than the component parts.
  - Check for mutually exclusive code pairs (i.e., procedures that are medically incompatible).
- Notably, several ophthalmic procedures may not be billed concurrently with the codes listed on Pg. 6, particularly other glaucoma procedures, including minimally invasive glaucoma surgery (MIGS).[2]
- An ABN may not be used to circumvent the NCCI edits.[2]
- For a complete listing of NCCI edits, please refer to the CMS website.[5]

Payment

- The allowed Medicare payment amounts are reported in the Medicare Physician Fee Schedule (MPFS) (for surgeons) and the Medicare Outpatient Prospective Payment System (OPPS) (for ambulatory surgery centers [ASCs] and hospital outpatient departments [HOPDs]).[2]
- Other payers set their own rates, which may differ significantly from Medicare fee schedules.[2]

CPT® Code	Surgeon	ASC	HOPD
66179	$1,036.71	$3,313.87	$5,159.71
66180	$1,091.69	$3,423.86	$5,159.71
66184	$760.47	$1,214.31	$2,280.73
66185	$816.43	$1,214.31	$2,280.73

Note: These amounts are adjusted in each area according to local wage indices.

REIMBURSEMENT FOR THE PROSTHETIC DEVICE

- The HCPCS code for an aqueous shunt implant is L8612; it is packaged in the payment for the primary procedure (i.e., reimbursement is included in the facility fee for both HOPD and ASC).[2]
  - N status indicator (HOPD) and N1 payment indicator (ASC) within the Medicare fee schedule mean that there is no additional payment for the implant.
- When a patch graft is used to cover the tube, it is reimbursed as part of the facility fee.[2]
  - Do not use HCPCS code V2785 for donor cornea; this HCPCS code is reimbursed separately only when used in a keratoplasty.

[a] Note: The multiple procedure rule does not apply to procedures with a J1 indicator (comprehensive Ambulatory Payment Classification [APC]) performed in a HOPD; instead, when a procedure with this indicator is performed in the same operative session as another major ophthalmic surgery, payment is based on the allowed amount for the comprehensive APC.

Baerveldt™ Reimbursement FAQs

Frequently Asked Questions

DOES MEDICARE COVER IMPLANTATION OF THE BAERVELDT™™ GLAUCOMA IMPLANT?
IF SO, WHAT CPT® CODES CAN BE USED TO DESCRIBE THE PROCEDURE?

- Yes, Medicare covers Baerveldt™ implantation for medically necessary indications.
  The Baerveldt™ glaucoma implant is intended to reduce intraocular pressure in severe and complex cases where medical and conventional surgical treatments have not been successful to control disease progression.[7]
- Two CPT® codes may be used to describe the implantation of the Baerveldt™ glaucoma implant depending on whether a patch graft is used: 66179 (Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft) and 66180 (Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft).[7]

HOW IS A HOPD PAID FOR THESE PROCEDURES?

- Under OPPS, 66179 and 66180 are assigned to APC 5493 and status indicator J1 (comprehensive APC).[7]
- Note that when a procedure with the J1 indicator is performed in the same operative session as another major ophthalmic surgery in a HOPD, then the multiple procedure rule does not apply and payment is based on the allowed amount for the comprehensive APC.[7]

IS THERE SEPARATE PAYMENT FOR THE IMPLANT?

- No. The shunt is supplied by the facility; reimbursement is included in the facility fee for both HOPD and ASC.[7]

IS THERE SEPARATE REPORTING AND PAYMENT FOR A PATCH GRAFT?

- No. The graft is supplied by the facility and reimbursement is included in the facility fee for both ASC and HOPD. The surgeon may choose donor cornea or sclera or other suitable material. Do not report V2785 for donor cornea; this HCPCS code is reimbursed only when used in keratoplasty.[7]

IF A REVISION PROCEDURE IS PERFORMED, IS IT COVERED?

- Yes. When medically necessary, Medicare will pay for revision of a tube shunt. There are two specific codes depending on whether a graft is used: 66184 (Revision of aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft) and 66185 (Revision of aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft).[7]
- These procedures are included in APC 5491.[7]

References

1. Johnson & Johnson Vision (2019). Baerveldt™™ Glaucoma Implant. Indications for use. Available at: https://www.jnjvisionpro.com/en-us/products/baerveldt-glaucoma-implants/

2. Corcoran Consulting Group (2022) Medicare Reimbursement for Baerveldt™ Glaucoma Implants.

3. Centers for Medicare & Medicaid Services (2022) Medicare Program Integrity Manual (Pub. 100-08), §3.3.2.4 – Signature Requirements. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf

4. Gandhi, A, Miller, DM, Zink, JM (2014). Analysis of long-term outcomes for combined pars plana vitrectomy (PPV) and glaucoma tube shunt surgery in eyes with advanced glaucoma. *Eye*; 28(3): 290-295.

5. Centers for Medicare & Medicaid Services (2022). National Correct Coding Initiative (NCCI) Edits. Available at: https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare?redirect=/nationalcorrectcodinited/

6. Centers for Medicare & Medicaid Services (2021) Medicare Claims Processing Manual. Chapter 23 §20.9 – National Correct Coding Initiative (NCCI). Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

7. Corcoran Consulting Group (2022) FAQs – Reimbursement for Baerveldt™ Glaucoma Implants. PP2022CT5137.

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