Priority Health	BILLING POLICY No. 096

MICRO-INVASIVE GLAUCOMA SURGERY

Date of origin: June 19, 2025	Review dates: None yet recorded

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Microinvasive glaucoma surgery (MIGS) is a minimally invasive surgery that employs microscopic implantable instruments and small incision surgery. This surgery option is safer to reduce intraocular pressure than standardized surgery.

The MIGS procedures are categorized into three types based on how they achieve reduced or normal intraocular pressure.

1. Improving the natural drainage system of the eye and simply referred to as trabecular meshwork
2. Redirecting or eliminating the excess ocular fluid from the eye
3. Reducing the production of the ocular fluid inside the eye

MEDICAL POLICY

- Vision care (#91538)

Find a list of all Priority Health medical policies in our Provider Manual.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

Reimbursement specifics

Bill type codes

Code	Description
013x	Hospital Outpatient
083x	Ambulatory Surgery Center
085x	Critical Access Hospital

Revenue codes

Code	Description
036X	Operating Room Services - General Classification
045X	Emergency Room - General Classification
049X	Ambulatory Surgical Care - General Classification

076X	Specialty Services - General Classification

Coding specifics

- Diagnosis should be coded to the highest level of specificity and laterality
- Medically Unlikely Edits (MUE) may be applicable to billed codes. Codes should be reviewed for units allowed by MUE prior to claim submission. Get more information on MUE from CMS.
- Only 1 unit per eye per date of service should be billed for CPT 66991 and 66989
- Even if multiple drainage devices are inserted into one eye in a day, the extra work or cost is minimal once the tool is used. Therefore, only one unit of codes 66991 and 66989 can be billed per eye, per day, no matter how many devices are inserted.
- Injecting an antibiotic, steroid or nonsteroidal anti-inflammatory drug during a cataract extraction (e.g., CPT codes 66820-66991) or other eye procedure cannot be billed separately.

See our General Coding billing policy for additional specific information.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

1. All documentation must be maintained in the patient's medical record and must support the medical necessity of the services as directed in this policy and be made available to Priority Health upon request.
2. The documentation must include previous treatments and response to the treatment.
3. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
4. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Get more information on modifier use in our Provider Manual.

- **50**: Bilateral Procedure (except when done in ASC)
- **54**: Surgical Care Only
- **55**: Postoperative Management Only
- **GA**: Waiver of liability statement issued as required by payer policy, individual case
- **GY**: Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit
- **GZ**: Item or service expected to be denied as not reasonable and necessary

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Resources

- What is Microinvasive Glaucoma Surgery?
- Article – Billing and Coding: Micro-Invasive Glaucoma Surgery (A59807) (CMS)
- Medicare NCCI 2025 Coding Policy Manual – Chapter 8 (CMS)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made