

ECP: What Can It Do For Me?

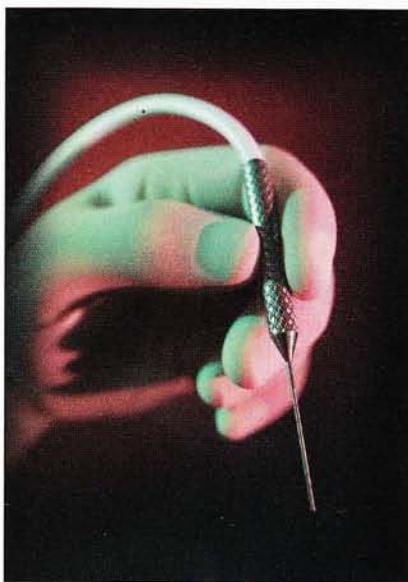
Reducing dependence on medications will improve patient satisfaction, a proponent says.

BY FARRELL TYSON, II, M.D.

A few years ago, we integrated endoscopic cyclophotocoagulation (ECP) into our practice to treat medically-controlled glaucoma. ECP diminishes aqueous production by photocoagulating the pigmented epithelium of the ciliary processes. I have found the ideal candidates are pseudophakes or those with well-controlled glaucoma who are undergoing a cataract procedure; ECP is also well-suited for patients in which other glaucoma procedures have previously failed. ECP is a great way for a doctor to set the practice apart from the competition by reducing or eliminating the need for prescription medications, as well as its cost effectiveness and the ease of the treatment.

With ECP, the endoscope allows a view of the eye that has not been seen before. The laser endoscope is a 20-gauge instrument that incorporates a 10,000-pixel image guide with wide view, a plurality of light fibers, and a single laser fiber. This instrument permits delivery of image, illumination and laser to the target tissue. As a result of this technology, the learning curve is certainly lowered a bit by allowing us to see everything we are doing and assures us that over-treatment will not be the issue if performed correctly.

ECP is done easily in conjunction with cataract surgery because it can be used through the same limbal or clear corneal incisions used in cataract removal. Once inserted, the probe delivers laser energy that selectively ablates ciliary processes to decrease aqueous production, reducing IOP without causing excessive damage to uveal tissue or sclera and with minimal to no inflammation.



The Benefits of ECP

During cataract surgery, ECP can be administered to treat the patient's glaucoma and adds only about five minutes to the procedure. In my experience, roughly 95% of the ECP procedures that I have performed have been done in conjunction with cataract surgery. Most patients prefer to have their ocular procedures done in as small amount of time as possible. Therefore, the patient will not need separate OR visits to treat each problem. Consolidating two visits in one also limits the risk of endophthalmitis. There is a wide range of eligible candidates for ECP, and the procedure is successful as a stand-alone as well.

When performed with phacoemulsification, ECP can lower a patient's IOP, along with the amount of medications needed to maintain control of glaucoma. Patients are grateful to reduce or eliminate the use of medications, which in turn can generate positive word of mouth. In my experience not all patients respond immediately to ECP, as it takes a few days to two months for their pressure to drop. Because ECP is likely to reduce post-operative medication use, it saves patients from paying for these regimens — a financial benefit to the patient with the added benefit of better compliance.

The idea of cost effectiveness also comes with an element of surgical convenience. Performing approximately 180 ECP procedures a year, I have found it to be a first-line surgical procedure, and one that allows for review if ECP doesn't reduce IOP in an immediate fashion. If the process doesn't prove to be effective, it is always feasible to go back

CONTINUED ON PAGE 72

Medicare Tips for Endoscopic Cyclophotocoagulation Coding

By Riva Lee Asbell

The codes for cyclophotocoagulation were revised in 2004 when the new CPT code for endocyclophotocoagulation was established. The codes now read:

66710 — *Ciliary body destruction; cyclophotocoagulation, transscleral*

66711 — *Ciliary body destruction; cyclophotocoagulation, endoscopic*

At that time and continuing until today, various misleading suggestions were promulgated for enhancing reimbursement including using additional codes for injection of air/medication, synechiolysis and vitrectomy. The end result was that most of these procedures were bundled in the National Correct Coding Initiative.

Here are some tips for staying away from the Medicare auditor when coding these procedures:

- **Endocyclophotocoagulation and transscleral cyclophotocoagulation do *not* contain the words “one or more sessions.”** Thus, additional procedures may be billed with the appropriate modifier if performed within the global period.

- **National Correct Coding Initiative (NCCI) bundles include the following categories, which should *not* be coded additionally:**

- Injection of air or medication (CPT codes 66020, 66030)
- Iridotomy and peripheral, sector or optical iridectomy codes (CPT codes 66500, 66825, 66630, 66635)
- Paracentesis codes (CPT codes 65800, 65805, 65815)
- Goniotomy, trabeculotomy, trabeculoplasty by laser surgery (CPT codes 65820, 65850, 65855)
- Severing of adhesions by laser or incisional techniques, or anterior or posterior synechiae or corneal-vitreous adhesions (CPT codes 65860, 65865, 65870, 65875, 65880). Lysing synechiae with viscoelastic material does not qualify as lysing anterior or posterior adhesions.

- The other NCCI codes for ciliary body destruction are bundled mutually exclusively, which means if you bill the two codes together you will be paid for the *lesser paying code*. These codes include ciliary body destruction by diathermy, transscleral cyclophotocoagulation, cryotherapy, cyclodialysis, and destruction of cyst or lesion of iris or ciliary body. (The CPT codes are 66700, 66710, 66720, 66740, 66770.)

- **In order to obtain payment for any of the additional codes, you will have to break the NCCI bundle by using modifier 59.** This is not advised, particularly since this usage is a current focus of the OIG (Office of the Inspector General).

and implement SLT, a trabeculectomy or shunt. The safety record of ECP also saves us time and money because complications are unlikely and the procedure requires minimal post-op care. Not having to deal with postoperative hypotony, bleb leaks or laser suture lysis allows for an uneventful postoperative period.

ECP has enhanced my practice. Because my patients are happy with their results (which improves loyalty and trust), it attracts new patients. Additionally, more time can be allotted for new patients because ECP adds little time to cataract surgery and, again, the post-op care is minimal.

Myths of ECP

Many doctors fall into the habit of undertreating patients, which creates a need for retreatments. I believe this often happens because doctors fear they will overtreat patients with ECP. This is a common misconception. The fact of the matter is that you will not cause hypotony when treating 360 degrees with ECP. Other doctors seem to be reluctant to use ECP because it is an inflow laser treatment. Several surgeons are hesitant to perform ECP because they believe it is a “destructive” treatment — as if performing a trabeculectomy is a benign procedure.

People may believe ECP can lead to increased patient complications. Some common misconceptions of ECP

include the following: patients can get hypotony or phthisis; inflammation is extreme; there is an increased incidence of CME; it is unpredictable; takes too long or costs too much; or that it just “doesn’t work.”

Like all eye surgeries, inflammation can be a side effect. Usually, this is no worse than what is seen in typical cataract surgery. However, medications are prescribed to patients to reduce inflammation and to increase the comfort in the eye pre- and postoperatively. There is a slight increase in PCO and CME rates but these are under 15% and 5%, respectively, in my patient population, and both are treatable.

For five years, I have used the ECP method for all standard glaucoma surgery cases. Although most MDs prefer to reserve ECP for severe cases, follow-up studies from the European Cataract and Refractive Society meeting, as well as my active service and experience in the field, lead me to believe it is still a primary tool for treating glaucoma and lowering IOP. **OM**

Farrell Tyson, II, M.D. is Medical Director of the Cape Coral Eye Center in Florida. Certified by the American Board of Ophthalmology, Dr. Tyson has revolutionized eye care in Southwest Florida by providing specialized treatment methods for cataracts, glaucoma, refractive disorders and other ocular diseases. He is the inventor of the Tyson Bimanual Microphaco/ECP Diamond Knife, used worldwide in cataract surgery.