iStent® Trabecular Micro-Bypass Stent

Reimbursement Guide
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Overview

This guide provides coding and billing information for facilities and physicians submitting claims for procedures using the iStent Trabecular Micro-Bypass Stent (the "iStent").

Approved Indication

The iStent® Trabecular Micro-Bypass Stent Model GTS100R/L is indicated for use in conjunction with cataract surgery for the reduction of intraocular pressure (IOP) in subjects with mild to moderate open-angle glaucoma currently treated with ocular hypotensive medication.

Disclaimer

This reimbursement resource is intended to provide health care professionals with information related to billing, coding, and reimbursement requirements that may apply to Glaukos® products. This guide is provided for general informational and educational purposes only, and is not intended, nor does it constitute, reimbursement or legal advice. Using codes identified here does not guarantee coverage or payment at any specific level and is not intended to increase or maximize payment by any payer¹. Laws, regulations and coverage policies are complex and updated frequently. Reimbursement policies also vary widely from payer to payer and will reflect different patient conditions. You should check current laws and regulations, as well as different payer policies to confirm the most current coverage, coding or billing requirements. Any questions should be directed to your attorney or reimbursement specialist. The health care professional is responsible for all aspects of reimbursement, including using codes that accurately reflect the patient's condition, procedures performed, and products used, and ensuring the veracity of all claims submitted to third party payers.

¹ Payers include private insurance companies and the Centers for Medicare and Medicaid (CMS).
Coding

Coding Overview

Medical billing codes convert a narrative description of a procedure, device, drug or disease into an alphanumeric or numeric code. Healthcare providers use these codes on payers’ claim forms to report medical services rendered to patients. When submitting claims to Medicare and other third party payers, facilities (e.g., hospitals and ASCs) and physicians list codes that describe a patient’s condition and procedures performed.

The following sections of this guide will review codes that may be appropriate for billing the iStent and associated procedures. However, providers are ultimately responsible for choosing diagnosis and procedure codes that accurately describe the patient’s condition, underlying disease and treatment. The key to coding and billing payers to reimburse providers for services rendered is to fully disclose how a product was used and what procedures were necessary to deploy and remove products.

Table 1 provides an overview of the types of codes most commonly used when billing for the iStent and associated procedures.

Table 1: Reimbursement Code Overview

<table>
<thead>
<tr>
<th>CODE TYPES</th>
<th>CODE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Procedural Terminology (CPT) codes</td>
<td>Describes procedures performed. Used on claims submitted by physicians, Ambulatory Surgical Centers (ASC) and Hospital Outpatient Departments (HOPD)</td>
</tr>
<tr>
<td>Healthcare Common Procedure Coding System (HCPCS)</td>
<td>Describes items used in a patient’s treatment, such as devices or drugs</td>
</tr>
<tr>
<td>International Classification of Diseases Clinical Modification (ICD-9-CM) diagnosis codes</td>
<td>Describes patient condition or underlying disease</td>
</tr>
<tr>
<td>Revenue codes</td>
<td>Describes the location where a procedure was performed, and the type of item, if applicable</td>
</tr>
</tbody>
</table>

Procedure Coding

**Category I CPT codes** are 5-digit numeric, permanent codes used to describe established procedures or services.

**Category III CPT Codes** are temporary codes that describe emerging technologies or services. Category III CPT Codes allow for data collection and tracking for these specific services/procedures and if available, Category III CPT Codes must be reported instead of unlisted Category I CPT codes. Physicians and facilities need to establish a charge amount to be submitted with a Category III CPT code.

Both Category I and Category III CPT Codes are eligible for coverage and reimbursement by payers.

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2 CPT is a registered trademark of the American Medical Association.

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When submitted on claims, Category III CPT Codes are often subject to manual review by payers because they need to make a determination regarding medical necessity and therefore payment. Coverage and reimbursement are not guaranteed, and using such codes often requires that additional documentation be submitted to payers in order to prove the medical necessity of the procedure performed.

Using Category III CPT Codes may require submitting additional documentation to payers to assess medical necessity and determine appropriate payment levels. Such documentation may include:

- A letter of medical necessity
- Product description, including FDA approval letter
- The patient’s medical records
- A copy of the surgical/operative report with clear documentation of the procedure in question having been performed
- Clinical literature

**iStent Procedure Coding (Physicians and Facilities)**

Table 2 identifies possible CPT code(s) that may be used to describe the iStent implantation procedure. Category III CPT Code 0191T, which describes the insertion of glaucoma drainage devices using an *ab interno* approach, became effective for use July 1, 2008.

CPT 0376T became effective January 1, 2015. Since this is a new code it is listed as Non-Covered by all Medicare Administrative Contractors. For facilities this code is listed with a payment indicator of "N1" – packaged service/item; no separate payment made. Since they are considered temporary codes, it may be necessary to submit additional documentation proving medical necessity for the procedure. It is important to remember physicians and facilities are responsible for accurately selecting CPT procedure codes to describe the procedures performed. If there are any uncertainties providers are encouraged to check with the patient’s health plan before providing services.

**Table 2: Potential CPT Code(s)**

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0191T</td>
<td>Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork</td>
</tr>
<tr>
<td>0376T</td>
<td>Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork, each additional device insertion (List separately in addition to code0191T for primary procedure)</td>
</tr>
</tbody>
</table>

**Cataract Procedure Coding (Physicians and Facilities)**

The iStent device is indicated for use in conjunction with cataract surgery. Standard cataract surgery with implantation of an IOL is most commonly reported with CPT code 66984, although a number of other CPT codes may apply depending on the actual services performed. When implanting the iStent in conjunction with cataract surgery described by a code other than 66984, check with the payer in advance to determine coverage and request a prior authorization if possible.

Table 3 (next page) identifies Category I CPT codes that may be used to describe cataract surgery procedure(s) performed in conjunction with the iStent insertion procedure

**Table 3: Potential CPT Code(s)**
<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>66982</td>
<td>Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage</td>
</tr>
<tr>
<td>66983</td>
<td>Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1-stage procedure)</td>
</tr>
<tr>
<td>66984</td>
<td>Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)</td>
</tr>
</tbody>
</table>

Device Coding (Facilities Only)

Level II HCPCS codes are 5-character alphanumeric codes that include a single letter followed by four numbers. They are primarily used to identify a variety of medical supplies, drugs and equipment. HCPCS codes are billed by facilities and should not be included on claims for physician services only.

Table 4 below identifies the possible HCPCS code(s) that may be used by ASCs and HOPDs to report the iStent device. Facilities are ultimately responsible for determining the appropriate code to report the iStent device.

Table 4: Potential HCPCS Code(s)

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1783</td>
<td>Ocular implant, aqueous drainage assist device</td>
</tr>
<tr>
<td>L8699</td>
<td>Prosthetic implant, not otherwise specified</td>
</tr>
</tbody>
</table>

Additional Coding Information

Modifiers

Depending on the actual procedure(s) performed with the iStent, it may be necessary to append certain modifiers to procedure codes indicated on claim forms. Modifiers are designed to provide payers with additional information that may be necessary in order to process claims.

Modifiers are used to clarify the intent, duration, or scope of a billed procedure. Modifiers are 2-digit alphanumeric codes appended to CPT codes when necessary to indicate the procedure performed was modified in some way from its original definition.

Using modifiers when not necessary may actually disrupt claim payment. There are two modifiers that are commonly misused to describe multiple procedures:

**Modifier -51** is used to indicate that multiple procedures were performed during the same surgical session.³ This modifier is not applicable for outpatient hospitals and ASCs under Medicare⁴;

⁴ CPT Assistant, Coding Communication: Hospital Outpatient Reporting Part V, Use of CPT Modifiers -25, -27, -50, -51 and HCPCS Level II Modifiers, May 2003

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however, Modifier -51 may be applicable for use on the physician claim. Providers should always check with payer for local guidance on the proper use of modifiers.

Modifier -59 is used in circumstances that require the provider to indicate when separate procedures are performed on more than one anatomical location/site of the body. This modifier would not be appropriate when billing for cataract surgery and the iStent procedure. Providers should always check with payer for local guidance on the proper use of modifiers.

**Discontinued Use Cases**

Sometimes iStent® cases have to be cancelled intraoperatively due to unforeseen clinical conditions that occur after the iStent® package has been opened. There are modifier codes that may be used for coding a cancelled or discontinued procedure.

**For the Facility:**

**Modifier -74 Discontinued Out-Patient/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia:** Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc.). Under these circumstances, the procedure started but terminated and can be reported by its usual procedure number and the addition of modifier -74.

**Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

**For the Surgeon:**

**Modifier -53 Discontinued Procedure:** Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure.

**Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

Healthcare providers may consider the coding options listed in Table 5 (next page) and select appropriate modifiers based on the procedure(s) performed. Please note that commercial payers may have different billing requirements.

**Table 5: Potential Modifiers**

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>RT</td>
<td>Used to indicate that the procedure was performed on the right side of the body</td>
</tr>
</tbody>
</table>

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5 CMS, *Proper Use of Modifier “-59” (SE0715)*, August 2012
*This table is not inclusive. Modifier use will differ based on the clinical scenario and procedures performed.

Revenue Codes

Revenue codes are three-digit numeric codes reported on a UB-04 facility claim form to describe general categories of provided services and items furnished to a patient in a facility setting. Facilities are required to report revenue codes to provide a description of the specific service or item related to each revenue code reported. Revenue codes are used for tracking purposes and are not reimbursable.

Table 6 identifies possible revenue code(s) that may be used to report the iStent device in the HOPD setting of care.

Table 6: Potential Revenue Code(s)

<table>
<thead>
<tr>
<th>SETTING OF CARE</th>
<th>DEVICE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Outpatient</td>
<td>274</td>
<td>Prosthetic /Orthotic Devices</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>278</td>
<td>Other prosthetic implant</td>
</tr>
</tbody>
</table>

Diagnosis Codes

Note: While ICD-10-CM supersedes ICD-9-CM for Medicare claims some commercial payers, Medicaid, Personal Injury and Worker’s Compensation plans/companies may continue to use ICD-9-CM Diagnosis codes. It is suggested that the provider confirm which code system is required prior to submitting Prior Authorization or Claims.

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-9-CM) diagnosis codes are listed on hospital and physician claims to report a patient’s medical condition. Payers use this information to evaluate the episode of care and determine whether or not a treatment was appropriate. ICD-10-CM diagnosis codes are used in all settings of care.

Table 7 includes ICD-10-CM diagnosis codes that describe conditions that may be reported on iStent claim forms.

Table 7 Potential ICD-10-CM Glaucoma Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H40.11X1</td>
<td>Primary open-angle glaucoma, mild stage</td>
</tr>
<tr>
<td>H40.11X2</td>
<td>Primary open-angle glaucoma, moderate stage</td>
</tr>
</tbody>
</table>

The ICD-10-CM diagnosis codes listed in this table may be commonly associated with iStent patients but are not intended to be an exhaustive list of all possible diagnosis codes. Please refer to the ICD-10-CM book for a comprehensive list of diagnosis codes. For specific payers, other diagnosis codes may support medical necessity. Always check with each individual Payer to determine which diagnosis codes support medical necessity for 0191T.

Note that in all cases, it is ultimately the provider’s responsibility to report the ICD-10-CM diagnosis code that most accurately describes the patient’s condition.

Coverage
To be a covered service, iStent use must meet the requirements established by Medicare and other third party payers. Their coverage policies are available in either benefit policy manuals (Medicare) or insurance contracts (private payers) which identify the products and services eligible for payment. Health insurers generally provide coverage for services when they are medically reasonable and necessary for treatment or diagnosis of illness or injury.

The iStent represents the latest technology in treating glaucoma and, like other new technologies, is in the early stages of securing widespread coverage from payers. Currently all Medicare Administrative Contractors have established positive coverage guidelines for the iStent. United Healthcare, Aetna, several local Blue Cross Blue Shield plans and other local carriers have also established positive coverage guidelines for the iStent. Glaukos continues to work with payers to obtain specific guidance on the iStent for its customers. Please check with your local Glaukos Regional Business Manager for the latest updates on coverage policies in your area.

In the absence of established coverage policies, payers will review claims and determine coverage on a case-by-case basis. Private payers may need to be contacted to obtain prior authorization before performing procedure(s). Additionally, because Category III CPT codes are often used to identify emerging technology, insurers unfamiliar with the iStent may request additional materials to support coverage when submitting claims.

For information regarding payer coverage in your area, please consult with your Glaukos Regional Business Manager.

Payment

Payment Overview

Healthcare providers are granted payment for products and services they provide to patients during an episode of care. Two types of payments are generally made: a payment for facility resources and a
payment for professional services. Facilities such as hospitals and ambulatory surgery centers are paid for the resources used in an episode of care. Physicians are paid for the services they provide in treating patients.

**Medicare Payment**

**Physician Payment**

Medicare provides payment to physicians for services based on a fee schedule called the Medicare Physician Fee Schedule (MPFS). CMS assigns national payment rates on the MPFS for Category I CPT codes. Since Category III CPT Codes typically reflect new and emerging technologies, CMS does not establish national payment rates on the MPFS for these types of procedures.

Payment for Category III CPT Codes will be determined by individual Medicare contractors on a case-by-case basis. Physicians need to establish a charge amount to submit with these types of codes. Claims for professional services submitted under Category III CPT Codes are often manually reviewed by payers.

The payment methodology for a procedure submitted under a Category III CPT code varies. In some instances, Medicare will calculate payment based on the amount charged on the claim. In other cases, payment will be determined by comparing work involved with implantation of the iStent to other similar procedures.

To determine the payment amount for specific codes on the MPFS, visit the Medicare MPFS Lookup feature on the CMS website: [http://www.cms.gov/PFSlookup/](http://www.cms.gov/PFSlookup/)

**Facility Payment**

Medicare pays ASCs for services under a prospective payment system called the ASC Payment System. Under this payment system, Medicare assigns procedure codes, which may be performed in the ASC setting of care, to an ASC payment group. This group determines the amount a facility will be paid by Medicare for services provided.

To determine the payment amount for the iStent procedure and associated cataract procedure in the ASC and to obtain additional information related to the ASC Payment System, visit the CMS website: [http://www.cms.gov/center/asc.asp](http://www.cms.gov/center/asc.asp)

Medicare pays hospitals for outpatient services under a prospective payment system: Hospital Outpatient Prospective Payment System (HOPPS).

HOPPS is a system that groups payment for drugs and services into ambulatory payment classifications (APCs). The HOPPS provides a fixed, bundled payment for hospital outpatient procedures or services that are assigned to a particular APC (See Table 8). The system only determines the hospital payment and does not affect payment to physicians who perform services in the hospital outpatient setting.

To determine the payment amount for the iStent procedure and associated cataract procedures in the HOPD and to obtain additional information related to HOPPS, visit the CMS website: [http://www.cms.gov/HospitalOutpatientPPS/01_overview.asp](http://www.cms.gov/HospitalOutpatientPPS/01_overview.asp)

**Table 8: HOPD Payment Classifications for 2016**

In 2015, in an effort to reduce costs and simplify beneficiary understanding, CMS implemented a new payment system for hospital outpatient surgery departments called Comprehensive APC’s (C-APC’s). C-APCs were initially device-intensive, however, CMS has expanded to include payment for the primary procedure (iStent) and adjunctive procedures performed on the same day as the primary procedure (cataract) resulting in one comprehensive payment. The multiple procedure rule in the HOPD is no
longer applicable for procedures associated with APC5492. What is important to understand is that CMS consolidated many APC’s into comprehensive APC’s (i.e. assigning more procedures into fewer APC’s).

In 2015, there were five intraocular procedures, which was reduced to four levels in 2016. In 2016 APC 0673 which 0191T is in was renamed C-APC 5492, and are assigned “J1” status indicator. APC 0233 which 66984 is in was renamed APC 5491 and are assigned “T” status indicator. It is important to note that APC 5491 is not a comprehensive APC in 2016.

<table>
<thead>
<tr>
<th>CPT</th>
<th>2015 APC</th>
<th>2016 APC</th>
<th>2016 APC Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0191T</td>
<td>0673</td>
<td>5492</td>
<td>$3,380.70</td>
</tr>
<tr>
<td>66984</td>
<td>0273</td>
<td>5491</td>
<td>$1,745.70</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>$3,380.70</td>
</tr>
</tbody>
</table>

For purposes of payment CMS has packaged the two procedures into a C-APC and will pay one lump sum for the two procedure performed on the same date of service and includes the cataract costs in the comprehensive payment rate.

**HCPCS Codes**

Although there is a HCPCS code that can be used to bill for the iStent device itself (i.e., C1783), Medicare does not provide separate payment for the device. Under Medicare, payment for the iStent and other implantable devices is bundled into the payment for the implantation procedure itself in the ASC and HOPD. **It is still important that HOSPITALS include the iStent device on their claim forms to payers as this permits appropriate tracking of the full costs of the procedure(s). C1783 should not be reported by ASCs on Medicare claim forms as this may cause the entire claim to be denied.**

It is recommended that both HOPDs and ASCs report C1783 – or other appropriate HCPCS code – on claim forms submitted to commercial carriers. Depending on the terms of the contract between the payer and the facility, the cost of the iStent device may be reimbursed.

**Private Payer Payment**

**Physician Payment**

Private payers typically establish their own payment rates for services and procedures and may provide this information on a publicly accessible fee schedule.

As with Medicare, payment for Category III CPT Codes is determined by private payers on a case-by-case basis. Physicians need to establish a charge amount to submit with these types of codes. Claims for professional services submitted under Category III CPT Codes are often manually reviewed by payers.

The payment methodology for a procedure submitted under a Category III CPT code varies. In some instances, private payers will calculate payment based on the amount charged on the claim. In other cases, payment will be determined by comparing work involved with the iStent to other similar procedures.

Payment rates for specific CPT codes may be obtained from the payer’s published physician fee schedule or by contacting the payer directly.

**Facility Payment**

Individual private payers will employ their own methodology to determine payment amounts for facility services based on the CPT, ICD-9 and HCPCS codes billed on the claim. Facility billing departments should check service contracts with individual private payers or contact each payer directly to verify payment amounts.
applicable reimbursement methodologies and/or amounts for the iStent implantation, the associated cataract procedure and for the iStent device itself. As with Medicare, it is important that facilities include the iStent device on their claim forms to payers in order to capture the full cost of providing the service.
Setting Charges

Providers must determine a charge for Category III CPT Codes. There are many variables that may account for the determination of a charge for a particular service, which should all be addressed when submitting claims. For example, the American Academy of Orthopedic Surgeons suggests providers consider the following when establishing a charge to submit for a Category III CPT code:

- Time, effort, equipment, RVUs, and cost related to geographic variability of the procedure
- Referencing another CPT code of similar complexity to that of the procedure
- Comparing preoperative, intraoperative, and postoperative services to those of a similar procedure
- Contrasting factors that differentiate the services (more difficult or less difficult) and setting the charges accordingly\(^6\)

Furthermore, the Practice Management Information Corporation\(^7\) suggests that the following additional resources may also be helpful when determining appropriate charges:

- Payer policies
- Current coding books
- Relative value data for existing Category I CPT codes
- Medicare Fee Schedules for existing Category I CPT codes

Whichever process the provider uses, it should be described in the supporting documentation that accompanies the claim.

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\(^7\) Practice Management Information Corporation. *Medical Fees*. Los Angeles, CA; 2011.
Frequently Asked Questions

Q1. How can I tell whether a private payer will cover the iStent implantation procedure? 
I can’t tell from their coverage policies.

A1. When it is unclear whether a private payer will cover the iStent, the provider should obtain prior 
authorization for the patient’s iStent implantation procedure.

Q2. How can I tell whether Medicare will cover the iStent implantation procedure? I can’t tell 
from their local coverage determinations.

A2. Since Medicare does not have a definitive process wherein they review prior authorization 
requests, it is up to the provider to determine coverage guidelines either by checking the payer’s 
website or contacting the payer directly. Currently, all Medicare Administrative Contractors, at 
minimum, cover iStent implantation in conjunction with routine cataract surgery (CPT Code 
66984) for patients diagnosed with Primary Open-Angle Glaucoma (ICD-9 Code 365.11). 
Providers should contact their local Medicare contractor to determine coverage guidelines for 
other types of cataract surgery and other diagnosis codes.

Finally, please check with your Glaukos Regional Business Manager for the most current 
information regarding coverage for iStent implantation by your local Medicare contractor.

Q3. Can I bill for the implant of the iStent (0191T) and cataract surgery (66982, 66983 or 66984) 
on the same day for the same patient?

A3. The National Medicare Correct Coding Initiative (CCI) edits do not prohibit billing 0191T and 
66982, 66983 or 66984 on the same day for the same patient.

Q4. My claim for the iStent procedure was denied. What should I do?

A4. Since Category III CPT Codes represent newer – and lesser-known – technologies, payers may 
request additional documentation showing medical necessity before paying a claim with a 
Category III CPT code.

Providers should pursue an appeal via the appeals process, which usually involves providing 
product information, clinical literature, and an explanation describing why the procedure was 
medically necessary for the patient. Contact the payer in question to get information on their 
appeals process and the materials they require to show medical necessity.

To see whether you qualify for Glaukos assistance with your iStent medical necessity appeal, 
contact your Glaukos Regional Business Manager.

Q5. How do I bill Medicare for the iStent when used in the hospital outpatient setting of 
care?

A5. Hospital outpatient facilities may use revenue code 274 or 278 and HCPCS supply code C1783 
on the UB-04 claim form to bill for the iStent in this setting. Medicare reimbursement for hospital 
outpatient departments is based on the APC payment system. CPT code 0191T maps to APC 
0673.
Q6. What diagnosis codes are covered for use with the iStent? I have a patient who I think would be a good candidate but I don’t know whether his condition would result in on- or off-label use of the iStent.

A6. Providers should check with a patient’s insurer to determine which indications are currently covered, and the appropriate course of action when submitting claims for non-covered indications.

Q7. What procedure code should I use to report the implantation of the iStent?

A7. Providers should bill for the iStent implantation procedure using the Category III CPT code 0191T. As payers typically flag claims with Category III CPT Codes for manual review, you should be prepared to provide product information, clinical literature, and an explanation describing why the procedure was medically necessary for the patient.

Q8. Do I need to use Modifier -51 or -59 to indicate that multiple procedures were performed during the surgical session?

A8. Modifier -51 is not applicable for outpatient hospitals and ASCs under Medicare\(^8\); however, Modifier -51 may be applicable for use on the physician claim. Providers should always check with payer for local guidance on the proper use of modifiers.

Modifier -59 is used in circumstances that require the provider to indicate when separate procedures are performed on more than one anatomical location/site of the body.\(^9\) This modifier would not be appropriate when billing for cataract surgery and the iStent procedure. Providers should always check with payer for local guidance on the proper use of modifiers.

Using modifiers, when it is not necessary, may actually be an impediment to prompt claims payment.

Q8. Is CPT 0376 covered by any payers?

A8. It is expected that 0376T will be placed on the Non-Covered Category III CPT Non-payment list by all Medicare Administrative Contractors. For facilities this code is listed with a payment indicator of “N1” – packaged service/item; no separate payment made. If you are uncertain you are encouraged to check with the patient’s health plan before providing services.

\(^8\) CPT Assistant, Coding Communication: Hospital Outpatient Reporting Part V, Use of CPT Modifiers -25, -27, -50, -51 and HCPCS Level II Modifiers, May 2003
\(^9\) CMS, Proper Use of Modifier “-59” (SE0715), August 2012