

# 2018 iStent® Trabecular Micro-Bypass Stent Reimbursement and Coding Fact Sheet

Effective January 1, 2018

## Medicare National Average Rates and Allowances

		Hospital Outpatient					Ambulatory Surgical Center
CPT® HCPCS Code	Procedure Description	APC Classification	HOPD Status Indicator	APC Descriptor	APC Rate <sup>1</sup>	APC Status Indicator	ASC Rate <sup>2</sup>
0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion	C-5492	J1	Level II Intraocular Procedures	\$3,610.75	T	\$2,573.27

### Physician reimbursement

Because RVUs (Relative Value Units) are not assigned to Category III CPT Codes, the physician reimbursement for iStent (0191T) is at the Medicare Administrative Contractor's (MAC's) discretion. Consult the local MAC fee schedule for physician reimbursement information.

### Comprehensive APC

Status indicator "J1" indicates that hospital Part B services are paid through a Comprehensive APC (C-APC). C-APCs package payments for services and supplies rather than providing separate multiple payments for each individual service. Under a C-APC, CMS packages payment for adjunctive and secondary items, services, and procedures into the most costly primary procedure under the OPSS at the claim level. CMS only makes a single payment to the facility for the primary service and considers all other items and services reported on the hospital outpatient claim as being integral, ancillary, supportive, dependent, adjunctive and therefore packaged into the primary service.

### Device-intensive designation

In 2017, CMS modified the methodology for assigning device-intensive status to all procedures that require the implantation of a device and have an individual HCPCS code-level device offset of greater than 40 percent, regardless of APC assignment. CMS payment methodology is based upon the HCPCS code level rather than the APC level because groupings of clinically similar procedures do not necessarily factor in device cost similarity.

### Preauthorization

Traditional Medicare does not require preauthorization. Preauthorization by commercial payers may or may not be required for this service, but a written pre-determination review may be requested.

### Multiple procedure discounting

Multiple procedure payment reduction discount for surgical procedures performed by a single physician on the same patient furnished during the same operative session are reduced 50%. The above National Average APC and ASC (freestanding) rates represent the reimbursement amounts paid directly to the facility for the technical portion of the procedure. The physician (surgeon) would separately receive the professional fee (MPFS allowable) for the procedure performed. Multiple procedure discounting does NOT apply to C-APCs and therefore does not affect services provided in the hospital outpatient department. Multiple procedure discounting also does not apply to physician services reported with a Category III CPT Code.

## Coding for iStent

Possible ICD-CM Diagnostic Codes <sup>3</sup>	
Possible ICD-10 Code	Description
H40.1111	Primary open-angle glaucoma, right eye, mild stage
H40.1112	Primary open-angle glaucoma, right eye, moderate stage
H40.1121	Primary open-angle glaucoma, left eye, mild stage
H40.1122	Primary open-angle glaucoma, left eye, moderate stage
H40.1131	Primary open-angle glaucoma, bilateral, mild stage
H40.1132	Primary open-angle glaucoma, bilateral, moderate stage

## Modifiers

The appropriate –LT (left) or –RT (right) modifier should always be appended to code 0191T and the cataract procedure code. Medicare no longer requires the use of modifier -51 to indicate multiple procedure.

## HCPCS Codes

While Medicare and some commercial payers package the reimbursement for the iStent implant with the facility reimbursement, some commercial payers may pay separately for the device. Consult your payer/provider contract or contact the specific payer’s representative for guidance.

Code	Description	Ambulatory Surgery Center	Hospital Outpatient Department*
<b>C1783</b>	Ocular implant, aqueous drainage device.	Use for commercial payer claims only.	Use for Medicare and commercial payer claims.
<b>L8612</b>	Aqueous shunt.	May be required by commercial payers that do not recognize C1783.	May be required by commercial payers that do not recognize C1783.

\*All hospital outpatient departments must report all items and supplies using the correct HCPCS code. Failure to report the iStent device may result in incorrect payment.

## Revenue Codes

Certain facility claims require the use of revenue codes to provide a description of the service or item provided.

CPT HCPCS Code	Description	Revenue Code	Description
<b>0191T</b>	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork, initial insertion...	<b>0360</b>	Operating room services; general
<b>C1783</b>	Ocular implant, aqueous drainage assist device.	<b>0278</b>	Other implants
<b>L8612</b>	Aqueous shunt.	<b>0278</b>	Other implants

Current Procedural Terminology (CPT®) is the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs. CPT is copyrighted by the American Medical Association (AMA). CPT does not include fee schedules, relative values or related listings.

Glaukos provides this coding guide for informational purposes only. This guide is not an affirmative instruction as to which codes and modifiers to use for a particular service, supply, procedure or treatment. It is the provider’s responsibility to determine and submit the appropriate codes and modifiers for any service, supply, procedure or treatment rendered. Actual codes and/or modifiers used are at the sole discretion of the treating physician and/or facility. Contact your local payer for specific coding and coverage guidelines. Glaukos cannot guarantee coverage or reimbursement for the codes listed in this guide.

REFERENCES: 1. Center for Medicare and Medicaid Services. CMS-1678-FC: Hospital Outpatient Prospective Payment–Final Rule with Comment Period and Final CY2018 Payment Rates. 2. Center for Medicare and Medicaid Services. CMS-1678-FC: January 2018 ASC Approved HCPCS Codes and Payment Rates (Addendum AA, BB, DD1, DD2, EE). 3. Center for Medicare and Medicaid Services. ICD-10-CM Diagnosis and Procedure Codes: Abbreviated and Full Code Titles, Version 32 (10-1-14, International Classification of Diseases, 10th Revision, Clinical Modification, 2017).

GLAUKOS CORPORATION  
 229 Avenida Fabricante • San Clemente, CA • 92672 • USA  
 tel 800.GLAUKOS (452.8567) • fax 949.367.9838 • Glaukos.com

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 PM-US-0014



# iStent® Sample Physician Claim Form

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>											PICA <input type="checkbox"/>
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Smith, John E.</b>				3. PATIENT'S BIRTH DATE MM DD YY <b>02 23 45</b>		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) <b>123 Main Street</b>				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY <b>Anytown</b>		STATE <b>AA</b>		8. RESERVED FOR NUCC USE			CITY		STATE		
ZIP CODE <b>12345</b>		TELEPHONE (Include Area Code) <b>(123) 456-7890</b>					ZIP CODE		TELEPHONE (Include Area Code) <b>( )</b>		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____		b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>					
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary for the payment of government benefits either to myself or to the party who accepts assignment						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
SIGNED _____						SIGNED _____					
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below)						22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. <b>H40.XXXX</b> B. <b>H25.XXX</b> C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____						23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 17 01 01 17 22				0191T RT		A	XXXX.	X	1	NPI	
2 01 01 17 01 01 17 22				66984 RT		B	XXXX.	XX	1	NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ( )			
SIGNED _____ DATE _____				a. <b>NPI</b>		b. _____		a. <b>NPI</b>		b. _____	

Report the appropriate ICD-10 code specific to the patient's condition. A list of codes specific to Primary Open Angle Glaucoma is included on page 2.

Report the appropriate ICD-10 code for the cataract procedure.

Report iStent: 0191T, Insertion of anterior segment aqueous drainage device...

Report the cataract procedure using the appropriate CPT code, for example: 66984 or 66982.

Append the appropriate modifier (-LT or -RT). Medicare no longer requires -51 to indicate multiple procedures.

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# iStent® Sample ASC Claim Form

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Smith, John E.</b>		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX <b>02/23/45 M</b> <input checked="" type="checkbox"/> <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) <b>123 Main Street</b>		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY <b>Anytown</b> STATE <b>AA</b>		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE <b>12345</b> TELEPHONE (Include Area Code) <b>(123) 456-7890</b>		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. RESERVED FOR NUCC USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>	
11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX		b. OTHER CLAIM ID (Designated by NUCC)	
11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX		c. INSURANCE PLAN NAME OR PROGRAM NAME	
11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary for the payment of government benefits either to myself or to the party who accepts assignment

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  
FROM MM/DD/YY TO MM/DD/YY

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  
FROM MM/DD/YY TO MM/DD/YY

20. OUTSIDE LAB?  YES  NO \$ CHARGES

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below)

A. **H40.XXXX** B. **H25.XXX** C. \_\_\_\_\_ D. \_\_\_\_\_ E. \_\_\_\_\_ F. \_\_\_\_\_ G. \_\_\_\_\_ H. \_\_\_\_\_ I. \_\_\_\_\_ J. \_\_\_\_\_ K. \_\_\_\_\_ L. \_\_\_\_\_

1	A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From MM/DD/YY	To MM/DD/YY	MM/DD/YY			CPT/HCPCS	MODIFIER						
1	01	01	17	01	01	17	22	0191T RT	A	XXXX.	XX	1	NPI
2	01	01	17	01	01	17	22	C1783	A	XXXX.	XX	1	NPI
3	01	01	17	01	01	17	22	66984 RT	B	XXXX.	XX	1	NPI
4													NPI
5													NPI
6													NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)  YES  NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION  
a. **NPI** b. \_\_\_\_\_

33. BILLING PROVIDER INFO & PH # ( )  
a. **NPI** b. \_\_\_\_\_

Report the appropriate ICD-10 code specific to the patient's condition. A list of codes specific to Primary Open Angle Glaucoma is included on page 2.

Report the appropriate ICD-10 code for the cataract procedure.

Report iStent: 0191T, Insertion of anterior segment aqueous drainage device...

For commercial payers, include HCPCS code C1783, ocular implant, aqueous drainage assist device. For Medicare claims, do not report C1783.

Report the cataract procedure using the appropriate CPT code, for example: 66984 or 66982.

Append the appropriate modifier (-LT or -RT). Medicare no longer requires -51 to indicate multiple procedures.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

# iStent® Sample Hospital Claim Form

1		2		3a PAT CNTRL #		4 TYPE OF BILL	
				b. MED REC. #			
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM		7 THROUGH	
8 PATIENT NAME		a		9 PATIENT ADDRESS			
b		b		c		d	
10 BIRTHDATE		11 SEX		12 DATE		13 HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31		32		33	
34		35		36		37	
38		39		40		41	
a		b		c		d	
e		f		g		h	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1		2		3		4	
5		6		7		8	
9		10		11		12	
13		14		15		16	
17		18		19		20	
21		22		23		24	
25		26		27		28	
29		30		31		32	
33		34		35		36	
37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	

This list of services is for example only and is not intended to be inclusive of all services and items that may be provided. HOPD providers should report all appropriate supplies and pharmacy items.

Report iStent: 0191T, Insertion of anterior segment aqueous drainage device...

Report the cataract procedure using the appropriate CPT code, for example: 66984 or 66982.

For Medicare claims, report the iStent device with HCPCS code C1783. Other payers may require the use of L8612.

Append the appropriate modifier (-LT or -RT). Medicare no longer requires -51 to indicate multiple procedures.

Report the appropriate ICD-10 code specific to the patient's condition. A list of codes specific to Primary Open Angle Glaucoma is included on page 1.

Report the appropriate ICD-10 code for the cataract procedure.