

# iStent *inject*<sup>®</sup>: BILLING AND CODING GUIDE

The iStent *inject* Trabecular Micro-Bypass System Model G2-M-IS is indicated for use in conjunction with cataract surgery for the reduction of intraocular pressure (IOP) in adult patients with mild to moderate primary open-angle glaucoma.

## CODING

**PROCEDURE:** The following possible Current Procedural Terminology (CPT<sup>®1</sup>) codes may be reported when insertion of an anterior segment aqueous drainage device is performed:

CPT Code	Description	Modifiers	Revenue Code
0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion	-LT (left side) or -RT (right side)	<b>HOPD: 0360</b> , Operating room services; general
+0376T	each additional device insertion (List separately in addition to code for primary procedure)		<b>ASC: 0490</b> , Ambulatory surgical care; general

The iStent *inject* procedure must be billed on the same claim with the appropriate cataract procedure code.

**DEVICE:** Healthcare Common Procedure Coding System (HCPCS) codes are used, among other things, to describe medical devices provided to patients. C-codes are unique temporary HCPCS codes established by the Centers for Medicare and Medicaid Services (CMS) for the Hospital Outpatient Prospective Payment System (HOPPS) and are only valid for Medicare on claims for hospital outpatient department services and procedures. Although other payers may also accept C-codes, they are not required to do so. The following HCPCS codes may be reported to describe iStent *inject*:

HCPCS Code	Description	Revenue Code
C1783	Ocular implant; aqueous drainage assist device	<b>0278</b> , other implants
L8612	Aqueous shunt	

**DIAGNOSIS:** The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is the coding system used to report all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States. The following possible ICD-10-CM diagnosis codes may describe conditions that are consistent with the FDA labeled indication for iStent *inject*:

ICD-10-CM 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

## 2019 NATIONAL AVERAGE UNADJUSTED MEDICARE PAYMENT<sup>2</sup>

**PHYSICIAN:** Contractor-priced. Check your local MAC fee schedule.

CPT Category III codes such as 0191T and 0376T are temporary codes that allow data collection for emerging technologies, services, procedures, and service paradigms. CPT Category III codes are not referred to the AMA-Specialty RVS Update Committee (RUC) for valuation because no relative value units (RVUs) are assigned to these codes.<sup>3</sup> As a result, CMS does not establish payment levels for these services or procedures in the annual physician fee schedule, but leaves it to Medicare contractors to determine the rates.

Currently, 0191T is included in all Medicare Administrative Contractor (MAC) physician fee or carrier-priced published fee schedules. Please consult your local MAC's website for applicable physician payment rates. As utilization of iStent *inject* increases, payers will begin to incorporate 0376T into their fee schedules and coverage policies. Like all Category III CPT Codes, physician payment rates for CPT codes 0191T and 0376T will be at each MAC's discretion.

CPT Code	Descriptor	Ambulatory Surgical Center	Hospital Outpatient Department
0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion	\$2,680 Device intensive procedure paid at an adjusted rate (J8)	\$3,640 Comprehensive APC 5492 (J1)
+0376T	each additional device insertion (List separately in addition to code for primary procedure)	Packaged service or item (N1)	Items and Services Packaged into APC Rates; Paid under OPPS; payment is packaged into payment for other services (N)

**HOSPITAL OUTPATIENT DEPARTMENT:** CPT code 0191T has a status indicator of "J1" and is assigned to a comprehensive APC, APC 5492 (Level 2 Intraocular Procedures). CPT code 0376T has a status indicator of "N" which indicates that the facility payment for this code is packaged into the APC rate for other services – in this instance, presumably APC 5492. CPT code 0376T is not a separately paid service for the facility.

Hospital outpatient departments must also report the appropriate device HCPCS code on all Medicare claims to ensure appropriate reimbursement. For more information on this, please see the "Device" paragraph in the "Coding" section above.

**AMBULATORY SURGICAL CENTER:** CPT code 0191T has a status indicator of "J8" and is designated as a device intensive procedure. CPT code 0376T has a status indicator of "N1" which indicates that the payment for this code is packaged.

ASCs do not report HCPCS codes to report implanted devices on claims sent to Medicare. Payment for a device is typically "packaged" into the payment for the ASC procedure. However, some commercial payer contracts may allow a carve-out for the device when a HCPCS code is reported.

For additional assistance, please contact  
Glaukos Reimbursement and Appeal Support Program  
(GRASP)

(866) GRASP77  
grasp@navigant.com

**GLAUKOS**<sup>®</sup>  
Transforming Glaucoma Therapy

**REFERENCES:**

1. CPT is a registered trademark of the American Medical Association (AMA). Copyright 2017 AMA. All rights reserved. 2. Medicare fee schedules are available at cms.gov. 3. AMA, CPT Category III Codes, January 16, 2019 available at <https://www.ama-assn.org/sites/default/files/media-browser/public/physicians/cpt/cpt-category3-codes-long-descriptors.pdf>.

Glaukos provides this coding guide for informational purposes only and it is subject to change without notice. This guide is not an affirmative instruction as to which codes and modifiers to use for a particular service, supply, procedure or treatment and does not constitute advice regarding coding, coverage, or payment for Glaukos products. It is the responsibility of providers, physicians and suppliers to determine and submit appropriate codes, charges and modifiers for products, services, supplies, procedures, or treatment furnished or rendered. Providers, physicians and suppliers should contact their third-party payers for specific and current information on their coding, coverage, and payment policies. For further detailed product information, including indications for use, contraindications, effects, precautions and warnings, please consult the product's Instructions for Use (IFU) prior to use. The information provided herein is without any other warranty or guarantee of any kind, expressed or implied, as to completeness, accuracy, or otherwise. This information is intended only to help estimate Medicare payment rates and product costs in the hospital outpatient department setting. All rates shown are national average Medicare rates and have not been adjusted for geographic variations in payment or other factors, such as sequestration.

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PM-US-0116



# iStent inject® Sample Physician Claim Form

## HEALTH INSURANCE CLAIM FORM

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

PICA										PICA																			
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) ( )																
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? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					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>										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary for the treatment of government benefits either to myself or to the party who accepts assignment										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		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. #									
From MM DD YY To MM DD YY		SERVICE																											
1 09 01 19 09 01 19		24				0191T RT				A		XXXX. XX		1				NPI											
2 09 01 19 09 01 19		24				0376T RT				A		XXX. XX		1				NPI											
3 09 01 19 09 01 19		24				66984 RT				B		XXXX. XX		1				NPI											
4																		NPI											
5																		NPI											
6																		NPI											
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For gov't. 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 potential codes specific to Primary Open Angle Glaucoma is included on page 1.

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

Report iStent inject with 0191T, +0376T.

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 inject® Sample ASC Claim Form

## HEALTH INSURANCE CLAIM FORM

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

PICA										PICA																			
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) Smith, John E.										3. PATIENT'S BIRTH DATE MM DD YY 02 23 45					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) 123 Main Street										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 Anytown					STATE AA					8. RESERVED FOR NUCC USE										CITY					STATE				
ZIP CODE 12345					TELEPHONE (Include Area Code) (123) 456-7890															ZIP CODE					TELEPHONE (Include Area Code) ( )				
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>									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary for the treatment 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.																			
<p>Report the appropriate ICD-10 code specific to the patient's condition. A list of potential codes specific to Primary Open Angle Glaucoma is included on page 1.</p>										<p>Report the appropriate ICD-10 code for the cataract procedure.</p>										SIGNED									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										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									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. H40.XXXX B. H25.XXX										<p>Report iStent inject with 0191T, +0376T.</p>										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. EPSTD Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																													
1 09 01 19 09 01 19 24										0191T RT A										XXXX. XX 1 NPI									
2 09 01 19 09 01 19 24										0376T RT A										XXX. XX 1 NPI									
3 09 01 19 09 01 19 24										L8612 RT A										XXX. XX 2 NPI									
4 09 01 19 09 01 19 24										66984 RT B										XXXX. XX 1 NPI									
5																													
25. FE										27. ACCEPT (For govt. clg) <input type="checkbox"/> YES <input type="checkbox"/> NO INFORMATION										29. AMOUNT PAID \$ 30. Rsvd for NUCC Use									
31. SIGNATURE (I apply to this bill and are made a part thereof.)										<p>Report the cataract procedure using the appropriate CPT code, for example: 66984 or 66982.</p>										<p>Append the appropriate modifier (-LT or -RT). Medicare no longer requires -51 to indicate multiple procedures.</p>									
SIGNED										a. NPI										a. NPI									
DATE										b.										b.									

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

# iStent inject® 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										9 PATIENT ADDRESS												
b										c												
10 BIRTHDATE		11 SEX	12 DATE		ADMISSION 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

33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37	
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39 CODE		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT	
a		b		c		d	
b		c		d		e	
c		d		e		f	

**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 inject with 0191T, +0376T.**

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

**For Medicare claims, report the iStent inject device with HCPCS code C1783. Non-Medicare payers may require the use of L8612.**

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

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	0360 Operating Room Services	0191T-RT	09/01/19	1	XXXX XX		1
2	0360 Operating Room Services	0376T-RT	09/01/19	1	XXX XX		2
3	0360 Operating Room Services	66984-RT	09/01/19	1	XXXX XX		3
4	0278 Other Implants	C1783	09/01/19	2	XXXX XX		4
5	0276 IOL Implants	XXXXX	09/01/19	1	XXXX XX		5

PAGE \_\_\_\_ OF \_\_\_\_ CREATION DATE TOTALS

50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	
A		B		C	D	E		F		G	
B		C		D	E	F		G		H	
C		D		E	F	G		H		I	

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

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

58		59 P.REL		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.	
A		B		C		D		E	
B		C		D		E		F	
C		D		E		F		G	

63 TREATMENT AUTHORIZATION CODES				64 CONTROL NUMBER				65 EMPLOYER NAME			
A				B				C			
B				C				D			
C				D				E			

66 DX		H40.XXXX		H25.XXXX		68	
A		B		C		D	
B		C		D		E	
C		D		E		F	

69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73	
A		B		C		D		E	
B		C		D		E		F	
C		D		E		F		G	

74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75		76 ATTENDING NPI		QUAL	
A		B		C		D		E		F	
B		C		D		E		F		G	
C		D		E		F		G		H	