

iStent *inject*[®]: 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^{®1}) codes may be reported when insertion of an anterior segment aqueous drainage device is performed:

| CPT Code | Description | Modifiers | Revenue Codes |
|----------|--|-------------------------------------|--|
| 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) | HOPD: 0360 , Operating room services; general |
| +0376T | each additional device insertion (List separately in addition to code for primary procedure) | | ASC: 0490 , 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 | 0278 , 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 |

2020 NATIONAL AVERAGE UNADJUSTED MEDICARE PAYMENT²

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. 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 | \$2,717 Device intensive procedure paid at an adjusted rate (J8) | \$3,818 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.

iStent inject® Sample CMS-1500 for Physicians



HEALTH INSURANCE CLAIM FORM

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

| | | | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|---|--|--------------------|--|-----------------------|
| <input type="checkbox"/> PICA <input type="checkbox"/> 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#)</small> | | | | | 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 CITY Anytown STATE AA | | | | | 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 STATE ZIP CODE TELEPHONE (Include Area Code) 12345 (123) 456-7890 | | | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME 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 to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____ | | | | | 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 _____ | | | | | | | | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. | | | | | 15. OTHER DATE MM DD YY QUAL. | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____ | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | 20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | | | 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. | | 22. RESUBMISSION CODE ORIGINAL REF. NO. | | | | | | |
| 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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSONI Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. # | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | |
| 09 01 20 09 01 20 24 | | | | | 0191T RT | | A XXXX. XX 1 NPI | | | | | | |
| 09 01 20 09 01 20 24 | | | | | 0376T RT | | A XXX. XX 1 NPI | | | | | | |
| 09 01 20 09 01 20 24 | | | | | 66984 RT | | B XXXX. XX 1 NPI | | | | | | |
| 25. FEDERAL TAX ID. NUMBER SSN EIN | | | | | 26. PATIENT'S ACCOUNT NO. | | 27. ACCEPT ASSIGNMENT? (For gov. claim, see back) | | 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. NPI | | b. NPI | | a. NPI | | b. NPI | | |

BOX 21A
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.

BOX 21B
Report the appropriate ICD-10 code for the cataract procedure.

BOX 24D
Report iStent inject with 0191T and 0376T.

BOX 24D
Report the cataract procedure using the appropriate CPT code, for example: 66984 or 66982.

BOX 24D
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

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

iStent inject® Sample CMS-1500 for Facilities



HEALTH INSURANCE CLAIM FORM

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

| | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|---|-------------------------------|--|
| <input type="checkbox"/> PICARE <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 <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small> | | | | | | | | | | <input type="checkbox"/> PICA | |
| 1. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, John E. | | | | | 3. PATIENT'S BIRTH DATE MM DD YY 02 23 45 | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | | |
| 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 | | |
| ZIP CODE 12345 | | | TELEPHONE (Include Area Code) (123) 456-7890 | | 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | 10. IS PATIENT'S CONDITION RELATED TO: | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | |
| b. RESERVED FOR NUCC USE | | | | | b. AUTO ACCIDENT? PLACE (State) <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"/> | | | | |
| c. RESERVED FOR NUCC USE | | | | | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | b. OTHER CLAIM ID (Designated by NUCC) | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | 10d. CLAIM CODES (Designated by NUCC) | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. | | | | | | | | | | | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | | | | 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 | | | | | | |
| DATE | | | | | DATE | | | | | | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. | | | | | 15. OTHER DATE QUAL. MM DD YY | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | 17a. | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | |
| 17b. NPI | | | | | 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 (24E) ICD Ind. | | | | | | |
| A. H40.XXXX B. H25.XXX C. D. | | | | | 22. RESUBMISSION CODE ORIGINAL REF. NO. | | | | | | |
| E. F. G. H. | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | |
| I. J. K. L. | | | | | 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) E. DIAGNOSIS F. \$ CHARGES G. DAYS OF CARE H. EPSON Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. # | | | | | | |
| 09 01 20 09 01 20 24 | | | | | 0191T RT | | A XXXX. XX 1 | | NPI | | |
| 09 01 20 09 01 20 24 | | | | | 0376T RT | | A XXX. XX 1 | | NPI | | |
| 09 01 20 09 01 20 24 | | | | | L8612 RT | | A XXXX. XX 2 | | NPI | | |
| 09 01 20 09 01 20 24 | | | | | 66984 RT | | B XXXX. XX 1 | | 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 | | | | | SIGNED | | | | | | |
| DATE | | | | | DATE | | | | | | |
| a. NPI | | | | | a. NPI | | | | | | |
| b. NPI | | | | | b. NPI | | | | | | |

BOX 21A
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.

BOX 21B
Report the appropriate ICD-10 code for the cataract procedure.

BOX 21D
Report iStent inject with 0191T and 0376T.

BOX 24D
For commercial payers, include HCPCS code L8612, ocular implant, aqueous drainage assist device. For Medicare claims, do not report a HCPCS code.

BOX 24D
Report the cataract procedure using the appropriate CPT code, for example: 66984 or 66982.

BOX 24D
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

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

iStent inject® Sample UB-04 for Facilities

BOX 44
Report iStent *inject* with 0191T and 0376T.

BOX 42
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.

BOX 42
HOPDs use Rev Code 0360, ASCs use Rev Code 0490.

BOX 44
Report the cataract procedure using the appropriate CPT code, for example: 66984 or 66982.

BOX 44
For Medicare claims, report the iStent *inject* device with HCPCS code C1783. Non-Medicare payers may require the use of L8612.

BOX 44
Append the appropriate modifier (-LT or -RT). Medicare no longer requires -51 to indicate multiple procedures.

BOX 66
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.

BOX 66
Report the appropriate ICD-10 code for the cataract procedure.

| | | | | | | | |
|-------------------------|--------|----------------------------------|-----------------|------------------------------|----------|--------------------------------|---------|
| 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 | | | |
| a | | | | a | | | |
| b | | | | c | | | |
| d | | | | e | | | |
| 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 | 30 | 30 | | |
| 31 OCCURRENCE CODE | | 32 OCCURRENCE DATE | | 33 OCCURRENCE CODE | | 34 OCCURRENCE DATE | |
| 35 OCCURRENCE SPAN FROM | | 36 OCCURRENCE SPAN THROUGH | | 37 | | | |
| 38 | | 39 VALUE CODES AMOUNT | | 40 VALUE CODES AMOUNT | | 41 VALUE CODES AMOUNT | |
| a | | b | | c | | d | |
| 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 | 09/01/20 | 1 | XXXX XX |
| 2 | 0360 | Operating Room Services | | 0376T-RT | 09/01/20 | 1 | XXX XX |
| 3 | 0360 | Operating Room Services | | 66984-RT | 09/01/20 | 1 | XXXX XX |
| 4 | 0278 | Other Implants | | C1783 | 09/01/20 | 2 | XXXX XX |
| 5 | 0276 | IOL Implants | | XXXXX | 09/01/20 | 1 | XXXX XX |
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| PAGE | | OF | | CREATION DATE | | TOTALS | |
| 50 PAYER NAME | | 51 HEALTH PLAN ID | | 52 REL. INPC. | | 53 ADJ. BEN. | |
| 54 PRIOR PAYMENTS | | 55 EST. AMOUNT DUE | | 56 NPI | | 57 OTHER PRV ID | |
| 58 INSURED'S NAME | | 59 P.PREL. | | 60 INSURED'S UNIQUE ID | | 61 GROUP NAME | |
| 62 INSURANCE GROUP NO. | | 63 TREATMENT AUTHORIZATION CODES | | 64 DOCUMENT CONTROL NUMBER | | 65 EMPLOYER NAME | |
| 66 DX | | H40.XXXX | | H25.XXXX | | 68 | |
| 69 ADMIT DX | | 70 PATIENT REASON DX | | 71 PPS CODE | | 72 ECI | |
| 73 | | 74 | | 75 | | 76 ATTENDING NPI | |
| 77 OPERATING NPI | | 78 OTHER NPI | | 79 OTHER NPI | | 80 REMARKS | |
| 81CC a | | b | | c | | d | |

Glaukos Reimbursement and Appeals Support Program (GRASP)

GRASP is available to provide reimbursement information and assistance related to the iStent *inject*® and iStent® Trabecular Micro-Bypass Stents.

GRASP can simplify access to reimbursement information and support for iStent *inject* or iStent procedures including:

- Authorization guidance
- Letter templates
- General billing and coding recommendations
- Medicare Advantage, Tricare and Commercial plan denials
- Appeals for low-paid or denied claims
- Referrals for assistance with contracting questions

To engage GRASP services, you may contact a case manager via phone, e-mail, and/or fax. They are committed to helping our customers navigate the complex reimbursement environment.

Phone: 866-GRASP77 (866-472-7777)

Fax: 866-257-5614

Email: grasp@guidehouse.com

Hours of operation: GRASP Case Managers are available to support providers Monday – Friday, 9am – 5pm PST, except for major holidays.*

For additional information, contact your Glaukos Sales Representative or Field Reimbursement Director.

GRASP services are provided by Guidehouse, a third party reimbursement assistance provider.

INDICATION: 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.

IMPORTANT SAFETY INFORMATION: The iStent *inject* is contraindicated in eyes with angle-closure glaucoma, traumatic, malignant, uveitic, or neovascular glaucoma, discernible congenital anomalies of the anterior chamber (AC) angle, retrolubar tumor, thyroid eye disease, or Sturge-Weber Syndrome or any other type of condition that may cause elevated episcleral venous pressure.

INDICATION: The iStent® Trabecular Micro-Bypass Stent (Models GTS100R and GTS100L) is indicated for use in conjunction with cataract surgery for the reduction of intraocular pressure (IOP) in adult patients with mild to moderate open-angle glaucoma currently treated with ocular hypotensive medication.

IMPORTANT SAFETY INFORMATION: The iStent Trabecular Micro-Bypass Stent is contraindicated in eyes with primary or secondary angle closure glaucoma, including neovascular glaucoma, as well as in patients with retro bulbar tumor, thyroid eye disease, Sturge-Weber Syndrome or any other type of condition that may cause elevated episcleral venous pressure. Please see the Directions for Use for complete information at www.glaukos.com.

*Observed holidays include: New Year's Day, President's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and the day after, and Christmas Day.

REFERENCES:

1. CPT is a registered trademark of the American Medical Association (AMA). Copyright 2020 AMA. All rights reserved. 2. Medicare fee schedules are available at cms.gov.

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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