



iStent *inject*[®]W: BILLING AND CODING GUIDE



The iStent *inject*[®]W Trabecular Micro-Bypass System Model G2-W 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[®]) 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

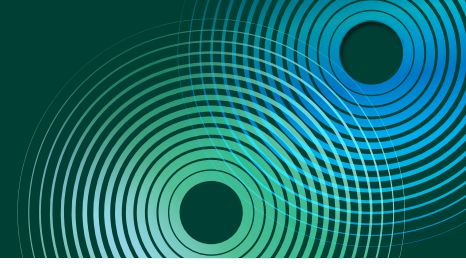
The iStent *inject*[®]W procedure must be billed on the same claim with the appropriate cataract procedure code.

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*[®]W:

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*[®]W:

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*[®] W 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® W Sample CMS-1500 for Physicians



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA PICA <input type="checkbox"/>									
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) Smith, John E.						3. PATIENT'S BIRTH DATE MM DD YY 02 23 45		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:		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 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>	
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	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.						23. PRIOR AUTHORIZATION NUMBER			
A. H40.XXXX B. H25.XXX C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____						F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
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									
1 09 01 20 09 01 20 24 0191T RT A XXXX. XX 1 NPI									
2 09 01 20 09 01 20 24 0376T RT A XXX. XX 1 NPI									
3 09 01 20 09 01 20 24 66984 RT B XXXX. XX 1 NPI									
4 _____ NPI									
5 _____ NPI									
6 _____ NPI									
25. FEDERAL TAX ID. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>						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. NPI		a. NPI b.	

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 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

iStent inject® W Sample CMS-1500 for Facilities



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#) (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					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										
ZIP CODE 12345			TELEPHONE (Include Area Code) (123) 456-7890		CITY			STATE							
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>								
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						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.															
A. H40.XXXX			B. H25.XXX			C. _____			D. _____						
E. _____			F. _____			G. _____			H. _____						
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) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF CRT UNITS	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 <input type="checkbox"/> <input type="checkbox"/>															
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 _____						SIGNED _____			
DATE _____						DATE _____						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 21D
Report 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® W Sample UB-04 for Facilities

BOX 44
Report 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® W 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. CNTL. #		4. TYPE OF BILL	
b. MED. REC. #		5. FED. TAX NO.		6. STATEMENT COVERS PERIOD FROM		7. THROUGH	
9. PATIENT NAME				9. PATIENT ADDRESS			
10. BIRTHDATE		11. SEX		12. DATE OF ADMISSION		13. HR. 14. TYPE 15. SRC. 16. DHR.	
17. STAT.		18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30.		CONDITION CODES		30. ACDT STATE	
31. OCCURRENCE DATE		32. OCCURRENCE DATE		33. OCCURRENCE DATE		34. OCCURRENCE DATE	
35. CODE		36. CODE		37. CODE		38. CODE	
39. VALUE CODES AMOUNT		40. VALUE CODES AMOUNT		41. VALUE CODES AMOUNT		42. VALUE CODES AMOUNT	
43. DESCRIPTION		44. HCPCS / RATE / HPPS 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		2 XXXX XX	
3 0360 Operating Room Services		66984-RT		09/01/20		3 XXXX XX	
4 0278 Other Implants		C1783		09/01/20		4 XXXX XX	
5 0276 IOL Implants		XXXXX		09/01/20		5 XXXX XX	
PAGE OF		CREATION DATE		TOTALS			
50. PAYER NAME		51. HEALTH PLAN ID		52. REL. INQ.		53. ADJ. BEN.	
54. PRIOR PAYMENTS		55. EST. AMOUNT DUE		56. NPI		57. OTHER PRV ID	
58. INSURED'S NAME		59. P. REL.		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		67. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z		68.			
69. ADMIT DEX		70. PATIENT REASON DEX		71. FPS CODE		72. ECI	
73.		74. PRINCIPAL PROCEDURE DATE		75. OTHER PROCEDURE DATE		76. ATTENDING NPI	
77. OTHER PROCEDURE DATE		78. OTHER PROCEDURE DATE		79. OTHER NPI		QUAL	
80. REMARKS		81. OCC. a. b. c. d.		76. LAST FIRST		77. LAST FIRST	
				78. LAST FIRST		79. LAST FIRST	
				76. QUAL		77. QUAL	
				78. QUAL		79. QUAL	
				76. FIRST		77. FIRST	
				78. FIRST		79. FIRST	

INDICATION FOR USE. The iStent inject® W Trabecular Micro-Bypass System Model G2-W 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. **CONTRAINDICATIONS.** The iStent inject W is contraindicated in eyes with angle-closure glaucoma, traumatic, malignant, uveitic, or neovascular glaucoma, discernible congenital anomalies of the anterior chamber (AC) angle, retrolental tumor, thyroid eye disease, or Sturge-Weber Syndrome or any other type of condition that may cause elevated episcleral venous pressure. **WARNINGS.** Gonioscopy should be performed prior to surgery to exclude congenital anomalies of the angle, PAS, rubeosis, or conditions that would prohibit adequate visualization of the angle that could lead to improper placement of the stent and pose a hazard. **MRI INFORMATION.** The iStent inject W is MR-Conditional, i.e., the device is safe for use in a specified MR environment under specified conditions; please see Directions for Use (DFU) label for details. **PRECAUTIONS.** The surgeon should monitor the patient postoperatively for proper maintenance of IOP. The safety and effectiveness of the iStent inject W have not been established as an alternative to the primary treatment of glaucoma with medications, in children, in eyes with significant prior trauma, abnormal anterior segment, chronic inflammation, prior glaucoma surgery (except SLT performed > 90 days preoperative), glaucoma associated with vascular disorders, pseudoexfoliative, pigmentary or other secondary open-angle glaucomas, pseudophakic eyes, phakic eyes without concomitant cataract surgery or with complicated cataract surgery, eyes with medicated IOP > 24 mmHg or unmedicated IOP < 21 mmHg or > 36 mmHg, or for implantation of more or less than two stents. **ADVERSE EVENTS.** Common postoperative adverse events reported in the iStent inject® randomized pivotal trial included stent obstruction (6.2%), intraocular inflammation (5.7% for iStent inject vs. 4.2% for cataract surgery only), secondary surgical intervention (5.4% vs. 5.0%) and BCVA loss ≥ 2 lines ≥ 3 months (2.6% vs. 4.2%). **CAUTION:** Federal law restricts this device to sale by, or on the order of, a physician. Please see DFU for a complete list of contraindications, warnings, precautions, and adverse events.

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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