OMNI®
SURGICAL SYSTEM

2022 FACILITY REIMBURSEMENT GUIDE

Surgical procedures performed in a facility require two claim submissions to the payer. This quick claim submission guide will help you submit facility-specific claims.

DISCLAIMER

This Reimbursement Guide is provided for informational purposes only. This Guide describes codes that may be applicable to the OMNI® Surgical System. It does not constitute legal or reimbursement advice or recommendations regarding clinical practice. Sight Sciences makes no guarantee that use of this information will result in coverage or payment or prevent disagreement by payers regarding billing, coverage, or amount of payment. Sight Sciences reminds providers of their responsibility to submit accurate and appropriate claims. Coding, coverage, and payment policies are complex and are frequently updated. Sight Sciences recommends that you consult with your legal counsel, applicable payers' policies, or reimbursement experts regarding coding, coverage, and reimbursement.

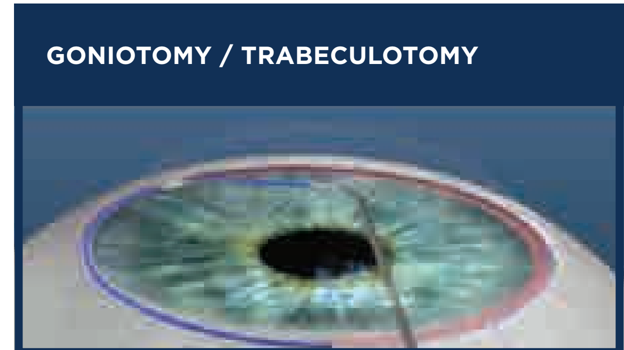
CODING AND MEDICARE PAYMENT WHEN USING OMNI® TO PERFORM A STANDALONE PROCEDURE

INDICATION

The OMNI® Surgical System is indicated for canaloplasty (microcatheterization and transluminal viscodilation of Schlemm's canal) followed by trabeculotomy (cutting of trabecular meshwork) to reduce intraocular pressure in adult patients with primary open-angle glaucoma.[1]

CANALOPLASTY / TRANSLUMINAL VISCODILATION

GONIOTOMY / TRABECULOTOMY



CPT[2] CODING FOR OMNI®

CPT	DESCRIPTION
66174	Transluminal dilation of aqueous outflow channel; without retention of device or stent

Note: Physicians should note that AMA CPT Assistant and NCCI edits advise that it is not appropriate to report both 66174 and 65820 (goniotomy) when a canaloplasty and goniotomy (ab interno trabeculotomy) are performed on the same eye during the same treatment session. According to CPT Assistant and NCCI edits, only 66174 should be reported.[3,4]

1. U.S. Food & Drug Administration (FDA) Indications for Use [Traditional 510(k) K202678]

2. CPT Copyright 2021 American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the American Medical Association.

3. https://www.cms.gov/Medicare/Coding/NCCI-Coding-Edits

4. Surgery: Eye and Ocular Adnexa. CPT® Assistant. December 2018, p 9; Surgery: Eye and Ocular Adnexa. CPT® Assistant. September 2019, p 12.

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OMNI® STANDALONE PROCEDURES 2022 MEDICARE PAYMENT[5]

FACILITY TYPE	CPT	NATIONAL AVERAGE REIMBURSEMENT RATE
Ambulatory Surgical Center (ASC)	66174	$1,917.31
Hospital Outpatient Procedure Department (HOPD)	66174	$3,999.59

Note: The payment information listed does not guarantee coverage or payment. Actual payment may vary by location. Commercial and Medicare Advantage payments are based on contractual agreements or negotiated fees between the physician and the health plan. Questions regarding your contracted payment rates should be directed to your health plan's provider representative.

ADDITIONAL HOPD CODING FOR OMNI®

For a claim submitted on a UB-04 form, the codes listed below are required to report the device costs to Medicare. There is no CPT code used. Commercial payor requirements vary. Questions regarding specific payor requirements should be directed to your payor provider representative.

CODING SYSTEM	CODE	DESCRIPTOR
HCPCS	C1889	Implantable / insertable device, not otherwise classified
Revenue Code	278	Medical / surgical supplies: other implants

5. 2022 CMS OPPS/ASC Final Rule, Addendum B (available on CMS website), 86 Fed. Reg. 218 (Nov. 16, 2021).

CODING AND MEDICARE PAYMENT WHEN USING OMNI® IN COMBINATION WITH CATARACT SURGERY

OMNI® Surgical System is indicated for use in standalone canaloplasty with trabeculotomy or in conjunction with cataract surgery. If these procedures are performed concomitantly, it is appropriate to bill/report the CPT code 66174 (for the canaloplasty followed by trabeculotomy) and the specific CPT code for the cataract procedure performed.

OMNI® IN COMBINATION WITH COMPLEX CATARACT

PROCEDURES	CPT CODE	PHYSICIAN PAYMENT**	ASC PAYMENT**	HOPD PAYMENT**
OMNI®	66174	$760.99	$1,917.31	$3,999.59
	C1889 (rev code 0278)			No additional payment
Complex Cataract	66982	$746.11 x 50% = $373.06*	$1,062.68 x 50% = $531.34*	No payment due to comprehensive APC
Totals		**$1,134.05**	**$2,448.65**	**$3,999.59**

OMNI® IN COMBINATION WITH ROUTINE CATARACT

PROCEDURES	CPT CODE	PHYSICIAN PAYMENT**	ASC PAYMENT**	HOPD PAYMENT**
OMNI®	66174	$760.99	$1,917.31	$3,999.59
	C1889 (rev code 0278)			No additional payment
Routine Cataract	66984	$544.70 x 50% = $272.35*	$1,062.68 x 50% = $531.34*	No payment due to comprehensive APC
Totals		**$1,033.34**	**$2,448.65**	**$3,999.59**

* Payment reduced due to multiple procedure reduction rules.

** Rates listed are national unadjusted allowable amounts, and the local rates may vary. Check your local MAC site for the specific reimbursement rate for your market.

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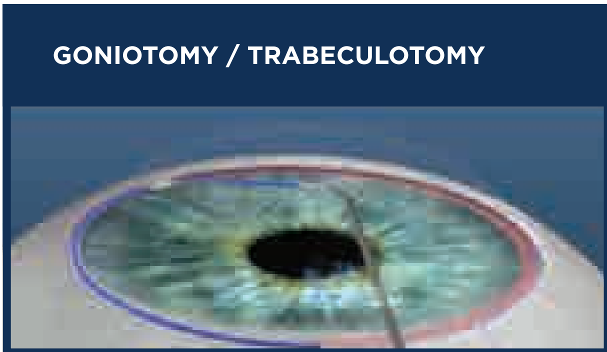
CODING AND MEDICARE PAYMENT WHEN USING OMNI® TO PERFORM A GONIOTOMY / TRABECULOTOMY



Trabeculotomy devices are Class I exempt per FDA regulations.[6]

OMNI® CODING FOR GONIOTOMY ALONE

CPT	DESCRIPTION
65820	Goniotomy

OMNI® USED TO PERFORM GONIOTOMY ALONE 2022 MEDICARE PAYMENT[7]

FACILITY TYPE	CPT	NATIONAL AVERAGE REIMBURSEMENT RATE
Ambulatory Surgical Center	65820	$1,917.31
Hospital Outpatient Procedure Department	65820	$3,999.59

Note: This payment information listed does not guarantee coverage or payment. Actual payment may vary by location. Commercial and Medicare Advantage payments are based on contractual agreements or negotiated fees between the physician and the health plan. Questions regarding your contracted payment rates should be directed to your health plan's provider representative.

6. See FDA's product classification page: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPCD/classification.cfm?ID=HNK
7. 2022 CMS OPPS/ASC Final Rule, Addendum B (available on CMS website), 86 Fed. Reg. 218 (Nov. 16, 2021).

COMMON ICD-10-CM DIAGNOSIS CODING FOR OMNI®[8]

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes are used to report patient diagnoses and health conditions for visits/services in all health care settings. Providers should consult the ICD-10-CM code set and coverage policies or other payer guidelines when determining the appropriate diagnosis code(s) to submit to health plans. Coding is a clinical decision, and providers should code to the highest level of specificity.

ICD-10-CM[8]	CODE DESCRIPTION
H40.1110	Primary open-angle glaucoma, right eye, stage unspecified
H40.1111	Primary open-angle glaucoma, right eye, mild stage
H40.1112	Primary open-angle glaucoma, right eye, moderate stage
H40.1113	Primary open-angle glaucoma, right eye, severe stage
H40.1114	Primary open-angle glaucoma, right eye, indeterminate stage
H40.1120	Primary open-angle glaucoma, left eye, stage unspecified
H40.1121	Primary open-angle glaucoma, left eye, mild stage
H40.1122	Primary open-angle glaucoma, left eye, moderate stage
H40.1123	Primary open-angle glaucoma, left eye, severe stage
H40.1124	Primary open-angle glaucoma, left eye, indeterminate stage
H40.1130	Primary open-angle glaucoma, bilateral, stage unspecified
H40.1131	Primary open-angle glaucoma, bilateral, mild stage
H40.1132	Primary open-angle glaucoma, bilateral, moderate stage
H40.1133	Primary open-angle glaucoma, bilateral, severe stage
H40.1134	Primary open-angle glaucoma, bilateral, indeterminate stage

8. American Medical Association (2022). ICD-10-CM 2022 The Complete Official Codebook.

COMMON MODIFIERS[9]

Modifiers are designed to provide additional information to the payor regarding the procedure that may be needed to process the claim. This list is not all-inclusive. Providers should consult reimbursement experts or the payors directly for questions regarding the use of modifiers.

MODIFIER	DESCRIPTION	DEFINITION
-RT	Right side	Indicates procedure was performed on the right eye
-LT	Left side	Indicates procedure was performed on the left eye
-50	Bilateral procedure	Indicates procedure was performed on both eyes that day
-51	Multiple procedures	Indicates procedure was performed with other procedures that day
-73	Discontinued HOPD/ASC	Discontinued procedure prior to administration of anesthesia
-74	Discontinued HOPD/ASC	Discontinued procedure after the administration of anesthesia
-79	Unrelated procedure	Unrelated procedure or service by the same physician during the postoperative period

9. https://med.noridianmedicare.com/web/jeb/topics/modifiers

SAMPLE UB-04 FORM

CPT 66174 for canaloplasty followed by trabeculotomy/CPT 65820 for trabeculotomy alone

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0360	Transluminal dilation eye channel	66174	XX/XX/XX	1	XXXXXX		
0278	Other medical / surgical supplies	C 1889	XX/XX/XX	1	XXXXXX		

Revenue code 0278 is used to report insertable/ implantable devices (e.g., OMNI® device)

HCPCS code C1889 is used to report insertable/implantable devices (e.g., OMNI® device) that do not have a more specific HCPCS code

The cost of the OMNI® device is assigned to the line item for device reporting (i.e., C1889 and 0278)

CREATION DATE

TOTALS

Prior authorization/ predetermination Information if applicable

63 TREATMENT AUTHORIZATION CODES

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SAMPLE CMS-1500 FORM

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

RANCE 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? YES NO ***If yes***, complete items 9, 9a, and 9d.

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.

SIGNED DATE

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

Prior authorization/ predetermination information if applicable

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)

A. HXX.XX B. E. F. I. J.

Include appropriate modifiers, if applicable

22. RESUBMISSION CODE ORIGINAL REF. NO.

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. #
XX XX XX			66174	XX		SXXX XX	1		NPI	
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	

CPT 66174 for canaloplasty followed by trabeculotomy/CPT 65820 for trabeculotomy alone

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. **NPI** b.

33. BILLING PROVIDER INFO & PH # ( )

a. **NPI** b.

NUCC Instruction Manual available at: www.nucc.org ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-1197 FORM 1500 (02-12)

FREQUENTLY ASKED QUESTIONS

DO PAYERS REQUIRE PRIOR AUTHORIZATION FOR OMNI®? WHAT INFORMATION IS REQUIRED?

Medicare does not require prior authorization for these procedures. Other health plans may require preauthorization as part of the conditions for coverage. Performing a benefit verification prior to treatment may provide insight into prior authorization criteria. Please consider:

- Including a payor-specific prior authorization form with your request
- Checking the payor's medical policy (if available) to understand coverage criteria
- Including documentation and chart notes that list any previous medical and surgical treatments along with outcomes, patient-specific treatment goals or comorbidities, and target IOPs for patient
- Including a letter of medical necessity describing the overall case (contact Sight Access or your Reimbursement Account Representative for more information)

IF PRIOR AUTHORIZATION IS NOT REQUIRED, IS SUBMITTING A PREDETERMINATION RECOMMENDED?

If prior authorization is not required, we typically encourage a predetermination be submitted, especially if the payer policy is unfavorable or unclear regarding CPT code 66174. Please note that some payers do not allow or accept predeterminations.

IS OMNI® COVERED BY INSURERS?

Coverage may vary by payer or even by health plan within a particular payer. In order to determine coverage for a particular patient, a benefit verification should be conducted, and the payer policy should be reviewed prior to treatment. Coverage will be based on medical necessity. Once the provider identifies that a patient is an appropriate candidate for OMNI®, the practice should allow enough time to verify the patient's benefits and coverage, check the payer's policy, and obtain prior authorization before scheduling the patient for surgery.

IS OMNI® USED TO PERFORM VISCOCANALOSTOMY?

No, viscocanalostomy is a different procedure entirely from canaloplasty. OMNI® is FDA cleared for canaloplasty followed by trabeculotomy. It is not indicated to perform a viscocanalostomy. Any reference to OMNI® as a viscocanalostomy device is incorrect.

WHAT CPT CODE(S) DO FACILITIES USE TO BILL FOR OMNI®?

CPT code 66174 is reported for the transluminal viscoelastic delivery procedure (aka canaloplasty) in conjunction with a trabeculotomy (aka goniotomy) during the same treatment session. When these two procedures are performed concomitantly, per AMA CPT Assistant, it is appropriate to report only CPT code 66174. The CPT for the trabeculotomy (65820) is bundled into the primary canaloplasty procedure.
CPT code 65820 is reported for the trabeculotomy/goniotomy when performed without a transluminal viscoelastic delivery procedure. We do, however, realize that the reporting of actual codes used is at the sole discretion of the treating physician and/or facility.

CAN OMNI® BE PERFORMED AS A STANDALONE PROCEDURE?

Yes. OMNI® Surgical System is indicated for use as a standalone procedure or in conjunction with cataract surgery. If both procedures are performed, it is appropriate to bill/report the CPT code 66174 (for the canaloplasty followed by trabeculotomy).

HOW DO I BILL OMNI® WHEN PERFORMED WITH CATARACT SURGERY, AND WHAT WOULD I BE REIMBURSED?

OMNI® Surgical System is indicated for use in standalone canaloplasty with trabeculotomy or in conjunction with cataract surgery. If these procedures are performed concomitantly, it is appropriate to bill/report the CPT code 66174 (for the canaloplasty followed by trabeculotomy) and the specific CPT code for the cataract procedure performed (see payment examples on page 4).

SHOULD HCPCS CODE C1889 BE USED TO REPORT THE OMNI® SURGICAL SYSTEM IN THE ASC SETTING?

In most cases, the HCPCS code C1889 would not be needed on ASC claims; however, there could be a commercial payer that may ask for it to be included in order to receive appropriate payment.

SIGHT ACCESS

A reimbursement support program to help you and your patients understand patient coverage details and payor-specific requirements for Sight Sciences products.

- **Benefit Verification**
- **Prior Authorization and Appeal Requirements**
- **Track Clinic Submitted Forms and Letters**
- **Billing and Coding Support**
- **Letter of Medical Necessity Templates**
- **Reimbursement Support Materials**

Reimbursement Support Is Available Across the Nation

SIGHT ACCESS OFFERS A SIMPLIFIED ENROLLMENT PROCESS

1. Fill and Fax Single-Page Enrollment Form or Fill and Submit from the Online Enrollment Portal (www.sightaccess.com)

UNDERSTAND ELIGIBILITY AND POTENTIAL COST-SHARING

2. Benefit Verification Summaries Are Faxed Back within 24-48 hours

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REIMBURSEMENT ACCOUNT EXECUTIVE (RAE)

The RAE is a Sight Sciences regional field reimbursement representative who can help minimize reimbursement barriers and support access for Sight Sciences products.

- **Personalized Reimbursement Support**
- **Review Documentation Considerations**
- **Provide Payor Policy Links and Policy Review**
- **Provide Published Reimbursement Rates for Specific Markets**
- **Discuss Payor Contracting Considerations**
- **Educate on Advocacy Initiatives**

Do you want to be connected with your local reimbursement account executive?

Ask your sales representative or email **sightaccess@sightsciences.com** to request a call or visit.

SIGHT SCIENCES REIMBURSEMENT SUPPORT LINE

Reimbursement staff are available to help answer coverage, coding, and payment questions and provide reimbursement support for the OMNI® Surgical System (e.g., preauth requests, claims assistance, appeals) Monday through Friday, 8 am - 8 pm EST.

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FAX (844) SIGHT13 OR 844-744-4813

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OMNI®

SURGICAL SYSTEM

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