OMNI®
SURGICAL SYSTEM

2022 PROVIDER REIMBURSEMENT GUIDE

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

DISCLAIMER

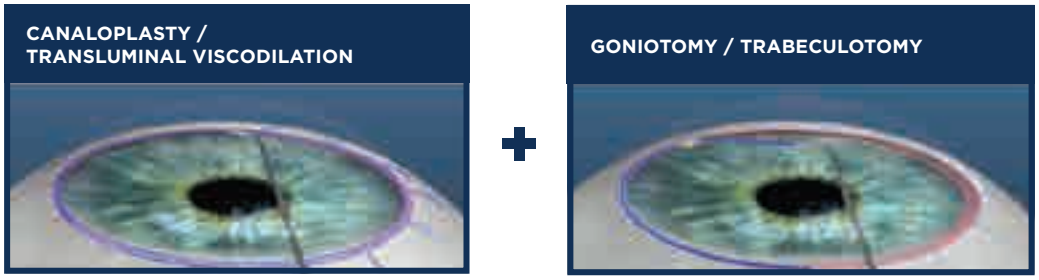
This Reimbursement Guide is provided for informational purposes only. This Guide describes codes that may be applicable to the OMNI® Surgical System. It does not constitute legal or reimbursement advice or recommendations regarding clinical practice. Sight Sciences makes no guarantee that use of this 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.

SIGHT SCIENCES

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]



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]

OMNI® STANDALONE PROCEDURES 2022 MEDICARE PAYMENT[5]

CPT	GLOBAL PERIOD	TOTAL RVUS	NATIONAL AVERAGE REIMBURSEMENT RATE
66174	90	21.99	$760.99

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.

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.
5. 2022 CMS PFS Final Rule, Addendum B (available on CMS website), 86 Fed. Reg. 221 (Nov. 19, 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*	$1,063.42 x 50% = $531.71*	No payment due to comprehensive APC
Totals		**$1,134.05**	**$2,448.65**	**$3,999.59**

OMNI® IN COMBINATION WITH ROUTINE CATARACT

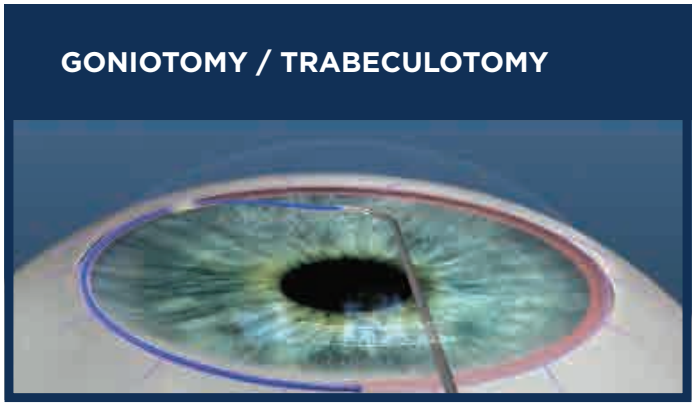
PROCEDURES	CPT CODE	PHYSICIAN PAYMENT**	ASC PAYMENT**	HOPD PAYMENT**
OMNI®	66174	$760.99	$1,917.31	$3,999.59
	C1889 (rev code 0278)			No additional payment
Routine Cataract	66984	$544.70 x 50% = $272.35*	$1,062.68 x 50% = $531.34*	No payment due to comprehensive APC
Totals		**$1,033.34**	**$2,448.65**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

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]

CPT	GLOBAL PERIOD	TOTAL RVUS	NATIONAL AVERAGE REIMBURSEMENT RATE
65820	90	24.22	$838.16

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 PFS Final Rule, Addendum B (available on CMS website), 86 Fed. Reg. 221 (Nov. 19, 2021).

ICD-10-CM DIAGNOSIS CODING[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
-54	Surgical care only	This modifier is submitted when one physician performs a surgical procedure and another provides preoperative and/or postoperative management
-55	Postoperative management only	This modifier is used to indicate that payment for the postoperative care is split between two or more physicians
-79	Unrelated procedure	Unrelated procedure or service by the same physician during the postoperative period

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

CALL (844) SIGHT12 OR 844-744-4812 FAX (844) SIGHT13 OR 844-744-4813

CO-MANAGEMENT OF OPHTHALMIC SURGERY POSTOPERATIVE CARE

In clinically appropriate situations, an operating ophthalmologist and patient may determine that a co-management arrangement is medically appropriate based on the patient's individual circumstances or needs. A co-management arrangement is a relationship between an operating ophthalmologist and a non-operating practitioner where they have shared responsibilities for a patient's postoperative care (e.g., patient request, unavailability of the operating ophthalmologist, patient's inability or unwillingness to return to the operating ophthalmologist, changes in follow-up plans). The operating ophthalmologist is ultimately responsible for the care of the patient, from the initial determination of the need for surgery through completion of postoperative care and medical stability of the patient.[10]

PLEASE CONSIDER:

- Consulting legal counsel before entering into any co-management or referral arrangements to ensure it complies with all applicable state and federal laws.
- Confirming payer policies and reimbursement for co-management arrangements with a particular payer.
- Obtaining patient's informed consent to the co-management arrangement in writing. Retain a copy of the informed consent in the patient's medical record.
- Completing a written co-management agreement outlining the specific co-management protocols for the patient. Retain a copy in the patient's medical record.
- Operating ophthalmologist determines whether/if transfer of postoperative care is clinically appropriate and discusses potential co-management arrangement with the patient.
- Operating ophthalmologist identifies a qualified provider to which they would delegate the postoperative care of their patient.
- Both providers cite appropriate co-management modifiers on claim forms.
- Both providers confirm completeness and accuracy of claim forms, including date of surgery, date that postoperative care is relinquished/assumed, and number of postoperative care days.

10. AAO Comprehensive Guidelines for Co-Management of Ophthalmic Postop Care, Sept 7, 2016. https://www.aao.org/ethics-detail/guidelines-comanagement-postoperative-care

SAMPLE CMS-1500 FORM

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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. #
1 XX XX XX				66174	XX		$XXX XX	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

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)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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 PROVIDERS 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 2).

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

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**

Need to connect 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.

CALL (844) SIGHT12 OR 844-744-4812
MON - FRI 8 AM - 8 PM EST

FAX (844) SIGHT13 OR 844-744-4813

EMAIL SIGHTACCESS@SIGHTSCIENCES.COM

VISIT WWW.SIGHTACCESS.COM

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