# 2023 Reimbursement Guide

This guide offers guidance and support to assist with proper coding of CPT® code 66174 and reimbursement policies.

## 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 payors 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 payors' policies, or reimbursement experts regarding coding, coverage, and reimbursement. Sight Sciences, the Sight Sciences logo, and OMNI are registered trademarks of Sight Sciences.

## How to Use This Guide

### For Providers

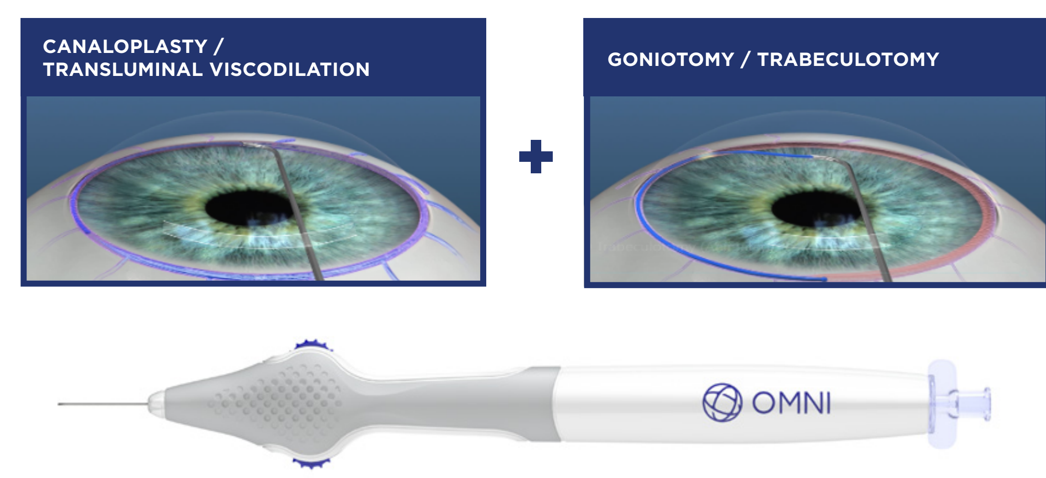
This icon indicates sections that are important for the provider's professional claim.

### For Facilities

This icon indicates sections that are important to the facility's claim.

## 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]




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

# CPT®[2] Coding and 2023 Medicare Payment When Using OMNI® to Perform a Standalone Procedure

| CPT Code | Description[3] | Global Period | RVUs | Physician Payment*[4] | ASC Payment*[5] | HOPD Payment*[6] |
|---|---|---|---|---|---|---|
| 66174 | Transluminal dilation of the aqueous outflow canal (eg, canaloplasty); without retention of device or stent | 90 | 18.36 | $622.17 | $1,968.66 | $3,995.58 |

* 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.

**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. Questions regarding your contracted payment rates should be directed to your health plan's provider representative. [7, 8]

**NOTE:** The payment information listed does not guarantee coverage or payment. Actual payment may vary by location. Commercial and Medicare Advantage may be based on 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 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 |

**NOTE:** CMS updated these codes to represent both implantable and insertable devices. The OMNI Surgical System is an insertable system.


2. CPT Copyright 2021 American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the American Medical Association.
3. Code description 66174. Find-A-Code: https://www.findacode.com/cpt/66174-cpt-code.html. Accessed January 2023.
4. Physician Fee Schedule - January 2023 release. RVU23A - Updated 01/05/23 (ZIP) (available on CMS website), https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu23a. Accessed on January 6, 2023.
5. January 2023 ASC Approved HCPCS Code and Payment Rates - Updated 01/09/2023. https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/11_addenda_updates. Accessed on January 9, 2023.
6. 2023 CMS OPPS Final Rule, Addendum B. 2023 January Web Addendum B.12212022 (available on CMS website). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates. Accessed on January 3, 2023.
7. https://www.cms.gov/Medicare/Coding/NCCI-Coding-Edits
8. Surgery: Eye and Ocular Adnexa. CPT® Assistant. December 2018, p 9 & 12.

## CPT Coding and 2023 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 or 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*[9] | ASC Payment*[10] | HOPD Payment*[11] |
|---|---|---|---|---|
| OMNI | 66174 | $622.17 x 50% = $311.09** | $1,968.66 | $3,995.58 |
| | C1889 (rev code 0278) | | | No additional payment |
| Complex Cataract | 66982 | $741.79 | $1,101.05 x 50% = $550.53** | No payment due to comprehensive APC |
| Totals | | $1,052.88 | $2,519.19 | $3,995.58 |

### OMNI in combination with routine cataract

| Procedures | CPT Code | Physician Payment* [9] | ASC Payment*[10] | HOPD Payment*[11] |
|---|---|---|---|---|
| OMNI | 66174 | $622.17 | $1,968.66 | $3,995.58 |
| | C1889 (rev code 0278) | | | No additional payment |
| Routine Cataract | 66984 | $541.86 x 50% = $270.93** | $1,101.05 x 50% = $550.53** | No payment due to comprehensive APC |
| Totals | | $893.10 | $2,519.19 | $3,995.58 |

* 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.

** Payment reduced due to multiple procedure reduction rules.


9. Physician Fee Schedule - January 2023 release. RVU23A - Updated 01/05/23 (ZIP) (available on CMS website), https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu23a. Accessed on January 6, 2023.
10. January 2023 ASC Approved HCPCS Code and Payment Rates - Updated 01/09/2023. https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/11_addenda_updates. Accessed on January 9, 2023.
11. 2023 CMS OPPS Final Rule, Addendum B. 2023 January Web Addendum B.12212022 (available on CMS website). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates. Accessed on January 3, 2023.

## CPT Coding and 2023 Medicare Payment When Using OMNI® for Goniotomy Alone

Trabeculotomy devices are Class I exempt per FDA regulations.[12]

| CPT Code | Description[13] | Global Period | RVUs | Physician Payment*[9] | ASC Payment*[10] | HOPD Payment*[11] |
|---|---|---|---|---|---|---|
| 65820 | Goniotomy | 90 | 24.41 | $827.19 | $1,968.66 | $3,995.58 |

## Common ICD-10 Diagnosis Coding

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 healthcare settings. Providers should consult the ICD-10-CM code set and coverage policies or other payor 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.

| Modifier[14] | 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 |

| Modifier[14] | Description |
|---|---|
| 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 |

12. FDA's product classification for "Probe, Trabeculotomy": https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPCD/classification.cfm?ID=HNK. Accessed January 3, 2023.
13. Code description 65820. Find-A-Code: https://www.findacode.com/cpt/66174-cpt-code.html. Accessed January 3, 2023.
14. American Medical Association (2022). ICD-10-CM 2022 The Complete Official Codebook.

## Common Modifiers

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 outside reimbursement consultations for questions regarding the use of these modifiers.

| Modifier[15] | Description | Definition[15] |
|---|---|---|
| -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 | Indicates surgical portion of the procedure |
| -55 | Postoperative management only | Indicates the postoperative management portion of the procedure |
| -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 |

15. AAPC. What are medical coding modifiers? https://www.aapc.com/modifiers/. Accessed January 3, 2023

## 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.[16]

**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 payor policies and reimbursement for co-management arrangements with a particular payor.
- 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.

If you have further questions, please reference the 2023 Co-management Reimbursement Guide provided by Sight Sciences.

16. 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 | 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) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other

7. INSURED'S ADDRESS (No., Street) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code) ( )

8. RESERVED FOR NUCC USE

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? PLACE (State) YES NO

c. OTHER ACCIDENT? YES NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. OTHER CLAIM ID (Designated by NUCC)

RANCE PLAN NAME OR PROGRAM NAME

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 services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

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 FRO... YY

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

18. HOS...VICES FRO... YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUT... YES NO

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

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

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Prior authorization / Predetermination information if applicable

Include appropriate modifiers if applicable

| | 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 | | SXXX 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

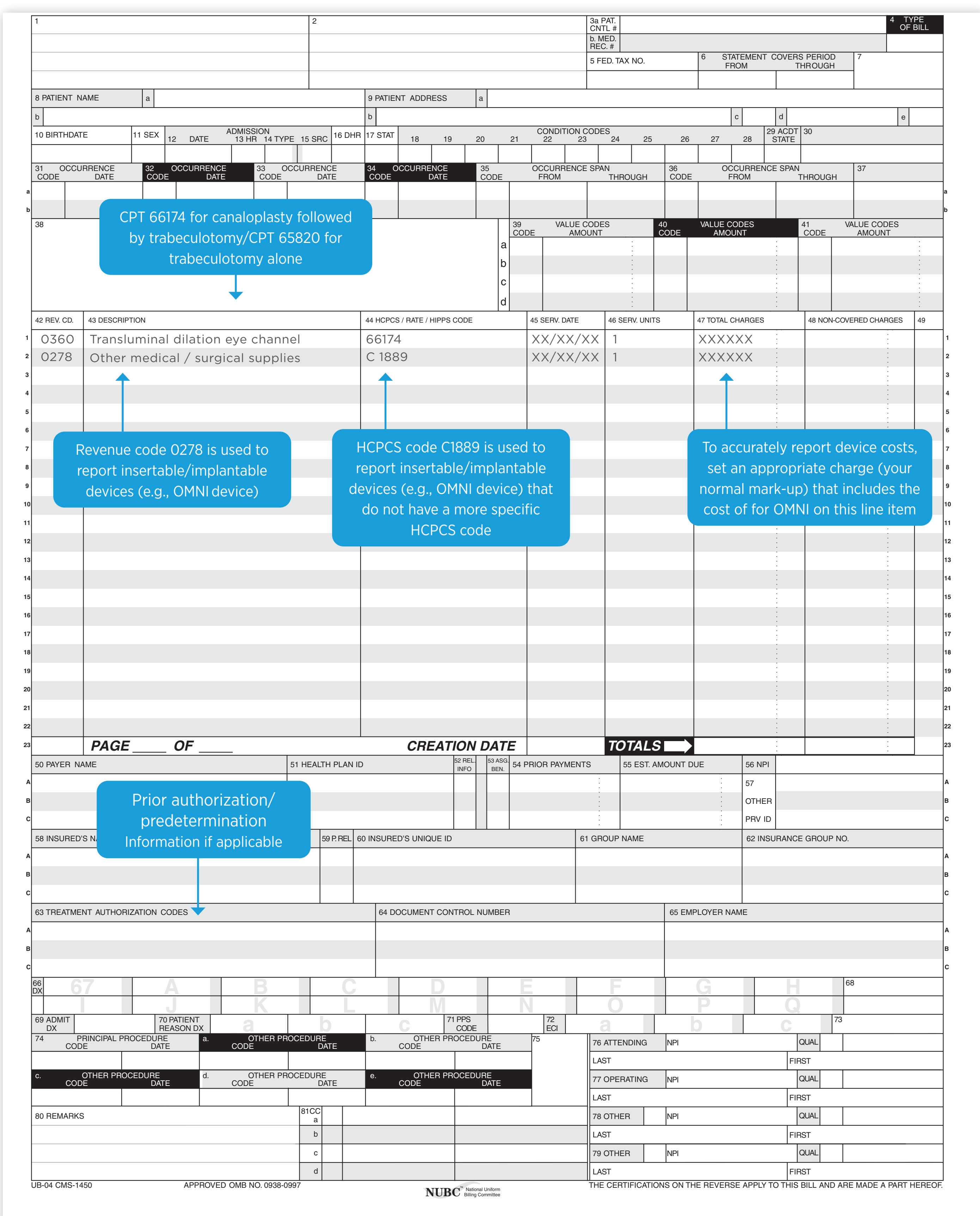
32. SERVICE FACILITY LOCATION INFORMATION — a. **NPI** b.

33. BILLING PROVIDER INFO & PH # ( ) — a. **NPI** b.

PHYSICIAN OR SUPPLIER INFORMATION

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

# Sample UB-04 Form



1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 4 TYPE OF BILL | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME a b | 9 PATIENT ADDRESS a b c d e

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

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

To accurately report device costs, set an appropriate charge (your normal mark-up) that includes the cost of for OMNI on this line item

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 | 57 OTHER PRV ID

58 INSURED'S NAME | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

Prior authorization/ predetermination Information if applicable

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 A B C D E F G H I J K L M N O P Q | 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75 | 76 ATTENDING NPI QUAL LAST FIRST

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE | 77 OPERATING NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d | 78 OTHER NPI QUAL LAST FIRST | 79 OTHER NPI QUAL LAST FIRST

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.

## Frequently Asked Questions

### Do payors require prior authorization for OMNI? If so, 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 your Reimbursement Account Representative for more information or sample templates)

### 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 payor policy is unfavorable or unclear regarding CPT code 66174. Please note that some payors do not allow or accept predeterminations.

### What is the professional work RVU for CPT code 66174?

7.62

### 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.

### Do I bill both CPT 66174 and CPT 65820 when performing 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.

### 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 payor that may ask for it to be included in order to receive appropriate payment.

17. Corcoran Consulting Group. Medicare reimbursement for OMNI Surgical System. January 1, 2022. https://www.corcoranccg.com/digital_files/FAQs/FAQ_OMNI_Sight%20Sciences_010122.pdf. Accessed December 16, 2022.

18. Physician Fee Schedule - January 2023 release. RVU23A - Updated 01/05/23 (ZIP) (available on CMS website), https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu23a. Accessed on January 6, 2023.

### May gonioscopy (92020) be billed with the claim for the surgery?[17]

No. Gonioscopy is required during surgery to insert the OMNI instrument and is an incidental part of the service. CPT instructs that a code designated as a "separate procedure", such as gonioscopy, should not be reported in addition to the code for the total procedure of which it is considered an integral component.

### Are there other NCCI edits for CPT 66174?[17]

Yes. Medicare's National Correct Coding Initiative (NCCI) edits include paracentesis, iridotomy, iridectomy, and scleral reinforcement. Cataract extraction is not among the edits. NCCI edits are updated quarterly. Most third-party payers follow NCCI edits, but not all; check your payer contracts.

### What are my options when there is an existing canal implant?

### Am I able to utilize OMNI with an existing implant in the canal?

- Yes, if you deem it medically necessary to choose to keep the implant in the canal and you use the OMNI Surgical System per its instructions for use (IFU), do not use the OMNI Surgical System in quadrants with previous MIGS implants.

### Am I able to utilize OMNI if I've made a clinical decision to remove an existing implant first before performing a canaloplasty followed by trabeculotomy procedure?

- Yes, if you deem it medically necessary to remove the implant and, after the removal, you use the OMNI Surgical System per its IFU.

### Are there CPT® codes and reimbursement for the removal of an existing implant followed by the canaloplasty and trabeculotomy procedures?

| Procedure | CPT | Physician[18] | ASC[19] | Hospital[20] |
|---|---|---|---|---|
| OMNI | 66174 | $622.17 x 50% = $311.09* | $1,968.66 | $3,995.58 |
| Removal of implanted material | 65920 | $790.59 | $1,101.05 x 50% = $550.53* | No payment due to comprehensive APC |
| | | $1,101.68 | $2,519.19 | $3,995.58 |

* Multiple procedure payment reduction (MPPR) may apply in which full reimbursement is made to the procedure with the highest value, and subsequent procedures reimbursed at 50 percent of the fee schedule value.

**NOTE:** The payment information listed above is provided for illustrative purposes and this information does not guarantee coverage of payment. Please also note actual payment may vary by location. Commercial and Medicare Advantage payments are based on contractual agreements or negotiated fees between physician and the health plan. Questions regarding your contracted payment rates should be directed to your health plan's provider representative.

19. January 2023 ASC Approved HCPCS Code and Payment Rates - Updated 01/09/2023. https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/11_addenda_updates. Accessed on January 9, 2023.

20. 2023 CMS OPPS Final Rule, Addendum B. 2023 January Web Addendum B.12212022 (available on CMS website). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates. Accessed on January 3, 2023.

sightaccess.com

Reimbursement support is available to help answer coverage, coding, and payment questions and provide reimbursement support (e.g., pre-auth requests, claims assistance, appeals).

**EMAIL** sightaccess@sightsciences.com

## Sight Access Partners

Sight Access Partners include a field-based team of Reimbursement Account Executives (RAEs) that provide personalized reimbursement support.

## Sight Access Resources

Our library of resources to support your practice and increase access for your patients.

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01/2023 RE-1360-US.v6 (v6.1)