Sight Access
by Sight Sciences

2025
Reimbursement Guide

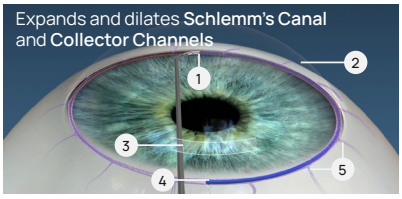
OMNI® Surgical System
SION® Surgical Instrument

About Sight Sciences®

We aim to provide eyecare providers with transformative, clinically-proven technologies that are intuitive, less invasive, and more intelligent.

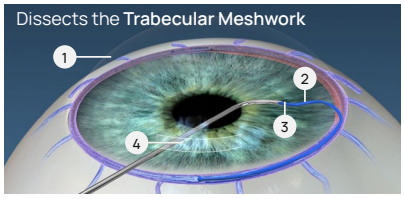
OMNI

About OMNI: OMNI is an insertable device that enables a comprehensive trabecular outflow procedure: canaloplasty (microcatheterization and transluminal viscodilation of Schlemm's canal) followed by trabeculotomy (cutting of trabecular meshwork) to reduce intraocular pressure (IOP) in adult patients with primary open-angle glaucoma (POAG).[1] OMNI targets three areas of resistance intended to lower IOP[2] and has been shown in published clinical trials to achieve sustained long-term IOP reduction.[3]



1 Cannula Tip
2 **Schlemm's Canal**
3 Clear Corneal Microincision
4 Microcatheter
5 **Collector Channels**

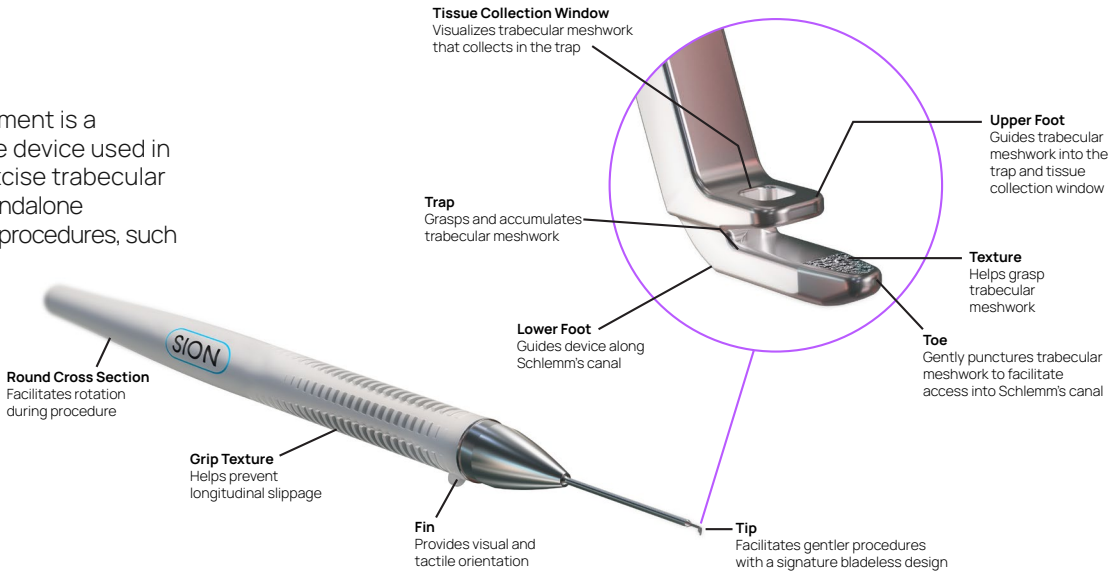
&



1 **Trabecular Meshwork**
2 Microcatheter
3 Cannula Tip
4 Clear Corneal Microincision

SION

About SION: The SION Surgical Instrument is a manually operated, sterile, single-use device used in ophthalmic surgical procedures to excise trabecular meshwork. SION can be used as a standalone procedure or in combination with other procedures, such as cataract surgery.



Coding Resources: Canaloplasty and Goniotomy

IMPORTANT: Providers are responsible for selecting the code that most closely represents the procedure performed. The correct code will be based on the medical record documentation, the operative report, payor coding guidelines, and publicly available coding guidance. Sight Sciences does not provide coding guidance, but instructs providers to follow American Medical Association (AMA) CPT [4] Codebook guidelines, AMA CPT Assistant articles, Medicare National Correct Coding Initiative (NCCI) edits, and Society Coding Fact Sheets for appropriate coding guidance.

CPT Code[5]	Descriptor	Short Descriptor	Coding Guidance
66174	Transluminal dilation of aqueous outflow canal (e.g., canaloplasty); without retention of device or stent	Canaloplasty	When CPT 66174 and 65820 are performed during the same session, only code 66174 should be reported. This procedure includes incising through the trabecular meshwork, which is a goniotomy and thus incidental to code 66174.[5,6,7]
65820	Goniotomy	Goniotomy	Code 65820 should not be separately reported if the incision into the trabecular meshwork is minimal or incidental to another ophthalmic procedure.[8]

Additional Coding Resource

American Academy of Ophthalmic Executives® Fact Sheet: Goniotomy As of February 2025:[9] CPT code 65820 is appropriate for trabeculotomy ab interno when the trabecular meshwork is opened for at least 3 contiguous clock hours or when multiple incisions are performed opening the trabecular meshwork over an area of at least 90 degrees.

2025 Medicare Payment Rates: National Averages

Pseudophakic Glaucoma Patients (standalone)

CPT Code	Short Descriptor	Hospital Outpatient Department (HOPD)[10]	Ambulatory Surgery Center (ASC)[11]	Physician[12]
66174	Canaloplasty	$4,023	$2,094	$600
65820	Goniotomy	$4,023	$2,094	$786
66984	Routine Cataract	$2,281	$1,214	$522
66982	Complex Cataract	$2,281	$1,214	$715

Canaloplasty and Goniotomy with Cataracts

CPT Code	Descriptor	Hospital Outpatient Department (HOPD)[10]	Ambulatory Surgery Center (ASC)[11]	Physician[12]
66174 + 66984	Canaloplasty + routine cataract	$4,023	$2,701	$861
66174 + 66982	Canaloplasty + complex cataract	$4,023	$2,701	$958
65820 + 66984	Goniotomy + routine cataract	$4,023	$2,701	$1,047
65820 + 66982	Goniotomy and complex cataract	$4,023	$2,701	$1,144

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

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HCPCS C-Code: C1889[13, 14]

The Centers for Medicare & Medicaid Services (CMS) uses C-Codes to track and determine future APC payment rates. The OMNI Surgical System, a single-use medical device, is surgically inserted during a canaloplasty followed by a trabeculotomy (goniotomy) procedure. OMNI is reported with C1889 (Implantable/insertable device, not otherwise classified) to reflect the cost associated with the procedure (e.g., CPT 66174)[13] under the appropriate Revenue Code. The SION Surgical Instrument, a single-use medical device, is surgically inserted during a goniotomy procedure. SION is reported with C1889 (Implantable/insertable device, not otherwise classified) to reflect the cost associated with the procedure (e.g., CPT 65820) under the appropriate Revenue Code.

Medicare encourages hospital outpatient departments to report C1889 on the claim with the appropriate CPT code (e.g., CPT 66174 or CPT 65820). While this C-code does not trigger additional Medicare facility payment, it is reported to establish future facility rates.[14]

It is important to appropriately track hospital charges to identify the Medicare costs of OMNI or SION under the appropriate revenue code and associated HCPCS C1889.[15]

OMNI – Example of a claim billed with CPT 66174:

Revenue Code Description	Revenue Code	HCPCS Code	HCPCS Short Description	Service Date	Units	Total Charges
General Operating Room Services	360	66174	Canaloplasty	XX/XX/XX	1	$X,XXX
Sterile Supply, Medical/ Surgical Supplies and Devices	272, 278	C1889	Implantable/insertable device, not otherwise classified	XX/XX/XX	1	$X,XXX

Choose the appropriate revenue code (e.g., 272 or 278) to report the insertable device (e.g., OMNI).

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

Use to accurately report device costs. Set an appropriate charge based on the hospital's usual methodology that includes the cost of the device such as OMNI

SION – Example of a claim billed with CPT 65820

Revenue Code Description	Revenue Code	HCPCS Code	HCPCS Short Description	Service Date	Units	Total Charges
General Operating Room Services	360	65820	Goniotomy	XX/XX/XX	1	$X,XXX
Sterile Supply, Medical/ Surgical Supplies and Devices	272, 278	C1889	Implantable/insertable device, not otherwise classified	XX/XX/XX	1	$X,XXX

Choose the appropriate revenue code (e.g., 272 or 278) to report the insertable device (e.g., SION)

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

Use to accurately report device costs. Set an appropriate charge based on the hospital's usual methodology that includes the cost of the device such as SION

HCPCS C-Codes are tracking codes established by the Centers for Medicare & Medicaid Services (CMS) to assist Medicare in establishing future APC payment rates. They only apply to Medicare hospital outpatient claims and do not trigger additional Medicare payment to the facility. For device-dependent procedures like OMNI and SION, when performed in the hospital outpatient setting, include C1889 on the claim. This is necessary to help ensure appropriate costs are captured for use in setting future hospital outpatient APC payment levels. ASCs billing with CMS-1500 forms are not required to report C-codes.

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. Any delegation of a surgeon's postoperative responsibilities to another non-operating practitioner and any payments to either party should be completely transparent to the patient and only done after obtaining the patient's informed consent in writing. 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]

Before entering into a co-management arrangement ensure to:

- Consult legal counsel before entering into any co-management or referral arrangement to ensure it complies with all applicable state and federal laws.*
- Confirm payor policies and reimbursement for co-management arrangements with a particular payor.
- Obtain patient's informed consent to the co-management arrangement in writing. Retain a copy of the informed consent in the patient's medical record.
- Complete a written co-management agreement outlining the specific co-management protocols for the patient. Retain a copy in the patient's medical record.
- Understand that the operating ophthalmologist determines whether/if transfer of postoperative care is clinically appropriate and is responsible to discuss potential co-management arrangements with the patient.[17]
- Be aware that it is the responsibility of the operating ophthalmologist to identify a qualified provider to which they would delegate the postoperative care of their patient.
- Cite appropriate co-management modifiers on both providers' claim forms.
- Confirm that both providers ensure completeness and accuracy of claim forms, including date of surgery, date that postoperative care is relinquished/assumed, and number of postoperative care days.[17]

* For example, make sure the co-management arrangement complies with federal Stark law and the Anti-kickback Statue as well as any state laws concerning fee splitting and patient brokering.

NOTE: Providers are responsible for reviewing their scope of practice, as determined by statutes, state legislatures, state medical boards, and other entities when considering co-management of canaloplasty and other procedures. Please reference state legislatures and rules adopted by the appropriate licensing entity.

OMNI SION

2025 Medicare Coverage Summary

OMNI Coverage

As outlined in the Medicare Coverage table below, the MACs (Medicare Administrative Contractors) cover OMNI outside of a Local Coverage Determination (LCD) or National Coverage Determination (NCD) for patients who meet medical necessity criteria. Five of the seven MACs cover a single micro-invasive glaucoma surgery (MIGS) procedure at the same time of service in the same eye (see Limitations of Coverage). The remaining two MACs (Novitas Solutions and First Coast Service Options) have not added the limitation of coverage to a single MIGS.

For specific MACs (Palmetto, NGS, CGS, WPS and Noridian) cataract surgery performed with multiple MIGS procedures (eg., cataract surgery, stent and canaloplasty or goniotomy) at the same time in the same eye is considered not covered as per LCDs. Additionally, a combination of a surgical MIGS procedure and an aqueous shunt cannot be performed at the same time of service in the same eye. This limitation does not apply to FCSO and Novitas.

Medicare Administrative Contractor (MAC)[18]	Local Coverage Determination (LCD) Number	Medicare covers OMNI for patients who meet documented medical necessity criteria	Limitation of 1 MIGS per procedure at the same time of service in the same eye(e.g., cataract + stent + canaloplasty or goniotomy)
CGS Administrators, LLC (CGS)[19]	L37578	✓	✓
First Coast Service Options, Inc. (FCSO)[20]	L38233	✓	
National Government Services, Inc. (NGS)[21]	L37244	✓	✓
Noridian Healthcare Solutions (Noridian)[22]	L38301	✓	✓
Novitas Solutions, Inc. (Novitas)[23]	L38223	✓	
Palmetto GBA (Palmetto)[24]	L37531	✓	✓
Wisconsin Physician Services Corporation (WPS)[25]	L39907	✓	✓

SION Coverage

The SION procedure is eligible for coverage for traditional Medicare beneficiaries when used as a standalone procedure or combined with cataract surgery. Check with your Medicare Administrative Contractor (MAC) to confirm medical necessity and coverage details before the procedure. A goniotomy is not covered or billable with a stent procedure by the MACs.

As outlined in the table below, the MACs cover goniotomy outside of a Local Coverage Determination (LCD) or National Coverage Determination (NCD) for patients who meet medical necessity criteria.

A goniotomy with cataract procedure is not covered or billable with a stent procedure (goniotomy + stent + cataract). Refer to the table below for links to the Local Coverage Determinations (LCD) and related Local Coverage Articles (LCA).[26]

Additionally, the American Academy of Opthalmologic Executives (AAOE) has published guidance indicating that goniotomy should not be coded in addition to other angle surgeries, stent insertion(s) or Schlemm canal implants, if the incision into the trabecular meshwork is minimal or incidental to those procedure(s).[9]

Medicare Administrative Contractor (MAC)[26]	Local Coverage Determination (LCD) Number[9,27]	Medicare covers SION for patients who meet documented medical necessity criteria
CGS Administrators, LLC (CGS)[19]	L37578	✓
First Coast Service Options, Inc (FCSO)[20]	L38233	✓
National Government Services, Inc (NGS)[21]	L37244	✓
Noridian Healthcare Solutions (Noridian)[22]	L38301	✓
Novitas Solutions, Inc (Novitas)[23]	L38223	✓
Palmetto GBA (Palmetto)[24]	L37531	✓
Wisconsin Physician Services Corporation (WPS)[25]	L39907	✓

About the MACs Micro-Invasive Surgical Glaucoma (MIGS) LCD Coverage Indications, Limitations, and Medical Necessity

Each Medicare Administrative Contractor (MAC) has established a Micro-invasive glaucoma surgery (MIGS) Local Coverage Determinations (LCD).

MAC	MACS with limitation to one single MIGS at the same time of surgery in the same eye	MACS with limitation to one single MIGS for goniotomy (CPT 65820)
CGS	✓	✓
FSCO[28]		✓
NGS	✓	✓
Noridian	✓	✓
Novitas[28]		✓
Palmetto	✓	✓
WPS	✓	✓

Indications of Coverage[28]

The following is considered reasonable and necessary and covered for the following MACS: CGS, NGS, Noridian, Palmetto, and WPS.

Phacoemulsification/intraocular lens placement can be performed with a single MIGS procedure.

Limitations of Coverage

A combination of a surgical MIGS procedure and an aqueous shunt cannot be performed at the same time of service in the same eye.

Phacoemulsification/intraocular lens placement performed with a combination of a MIGS procedure (e.g., cataract + stent + canaloplasty or goniotomy) at the same time of service in the same eye is non-covered.

Goniotomy and Canaloplasty

The 5 MAC LCD changes do not impact coverage positions for goniotomy or canaloplasty procedures but instead clarify that:

"phacoemulsification/intraocular lens placement performed with a combination of a MIGS procedure (e.g., cataract + stent + canaloplasty or goniotomy) at the same time of service in the same eye is not covered and risks denial of the entire claim."

For the 5 MACs with LCDs effective on November 17, 2024, below are appropriate coding examples under the LCDs by CPT[29] Code:

- CPT 66174: Canaloplasty
- CPT 65820: Goniotomy
- CPT 66984: Routine Cataract Removal
- CPT 66991: Stent and Routine Cataract Removal
- CPT 66988: Routine cataract and ECP
- CPT 66711: Standalone ECP

Covered	Not Covered	Rationale
	66991 + 66174	Phacoemulsification/intraocular lens placement performed with a combination of a MIGS procedure (e.g., cataract + stent + canaloplasty or goniotomy) at the same time of service in the same eye is non-covered and risks denial of the entire claim.
	CPT 66991 + CPT 65820	Phacoemulsification/intraocular lens placement performed with a combination of a MIGS procedure (e.g., cataract + stent + canaloplasty or goniotomy) at the same time of service in the same eye is non-covered and risks denial of the entire claim.
66174		LCD changes do not impact coverage positions for goniotomy or canaloplasty
65820		LCD changes do not impact coverage positions for goniotomy or canaloplasty
66174 + 66984		LCD changes do not impact coverage positions for goniotomy or canaloplasty and cataracts.
65820 + 66984		LCD changes do not impact coverage positions for goniotomy or canaloplasty and cataracts.
	66991 + 66984	66991 is already combined with cataract surgery
66174 + 66711		LCD changes do not impact coverage positions for ECP
66174 + 66988		LCD changes do not impact coverage positions for ECP

Disclaimer

This information is provided for educational purposes only to provide context around the reimbursement environment and processes. Reimbursement information provided herein is not an affirmative instruction regarding billing or reporting of codes or modifiers for a particular service, supply, procedure, or treatment, and does not constitute advice regarding coverage, coding or payment for Sight Sciences products. Actual codes and/or modifiers used are at the sole discretion of the treating physician and/or facility. Sight Sciences does not guarantee medical benefit coverage or payment. Providers, physicians, and suppliers should always contact their third-party payers for specific and current information on coverage, coding and payment policies. Detailed product information, including indications for use, contraindications, effects, precautions and warnings, may be found in the product's Instructions for Use (IFU). Any information provided herein is without any other warranty or guarantee of any kind, expressed or implied, as to completeness, accuracy or otherwise.

Common ICD-10-CM 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, payor 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 accurately code to the highest level of specificity.

ICD-10-CM[29]	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

ICD-10-CM[29]	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

Common Modifiers

Modifier[16]	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	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

Coverage Overview

Commercial and Medicare Advantage Payors

Commercial: Most payors cover canaloplasty (CPT 66174), including Anthem, BCBS plans, CIGNA, and Humana. Before the procedure, payor policies and medical necessity criteria must be checked to determine benefits and coverage. Prior authorization is recommended. Check medical necessity and coverage criteria requirements by accessing our **Payor Medical Necessity Criteria tool**.

Aetna: Aetna covers canaloplasty for primary open-angle glaucoma, but does not cover canaloplasty and trabeculotomy ab interno with the OMNI System combined with cataract surgery for the treatment of POAG. Despite the non-coverage, many providers experience favorable pre-determination requests before performing the procedure.

UnitedHealthcare: Although UnitedHealthcare currently has a formal non-coverage policy for canaloplasty (CPT 66174) and goniotomy in adults (CPT 65820), many providers experience positive outcomes by submitting pre-determination before performing the procedure. **Click here for a step-by-step process**.

Insurance	Canaloplasty Policy Overview	Medicare Advantage Coverage for Canaloplasty
Anthem	✓ Yes, standalone canaloplasty ✓ Yes, canaloplasty plus cataracts	✓ Yes, confirm benefits and medical necessity with your Medicare contractor.
aetna®	✓ Yes, standalone canaloplasty ✗ Note: OMNI in combination with cataract removal is not a covered procedure currently. Seek approval on a case-by-case through the authorization process.	✓ Yes, standalone canaloplasty is covered. Confirm benefits and medical necessity with your Medicare contractor. ✗ Note: For OMNI in combination with cataract removal, confirm coverage and medical necessity criteria with your Medicare contractor. Seek approval on a case-by-case through the authorization process.
BlueCross BlueShield	✓ Yes, standalone canaloplasty ✓ Yes, canaloplasty plus cataracts	✓ Yes, confirm benefits and medical necessity with your Medicare contractor.
Humana	✓ Yes, standalone canaloplasty ✓ Yes, canaloplasty plus cataracts	✓ Yes, confirm benefits and medical necessity with your Medicare contractor.
Cigna	✓ Yes, standalone OMNI ✓ Yes, OMNI plus cataracts	✓ Yes, confirm benefits and medical necessity with your Medicare contractor.
United Healthcare	✗ For standalone canaloplasty (or in combination with cataract removal), the procedure is not covered. Seek approval on a case-by-case through the authorization process. A pre-determination via the UHC Provider Portal is required prior to surgery for CPT 66174. **Click here for a step-by-step process**.	✗ For standalone canaloplasty or OMNI in combination with cataract removal, seek approval on a case-by-case through the authorization or appeal process. A pre-determination via the UHC OneHealth port is required prior to surgery for CPT 66174.

*The majority of BCBS plans cover canaloplasty. Check with the specific plan for coverage and medical necessity.

Coverage policies for goniotomy are often silent. A prior authorization is recommended when performing a goniotomy as standalone or in combination with cataract surgery.

OMNI SION

Frequently Asked Questions

Do commercial payors require prior authorization for OMNI? If so, what information is required?

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, if required.
- Checking the payor's medical policy (if available) to understand coverage criteria including documentation and chart notes that list any previous medical and surgical history.
- Outlining treatments along with outcomes, patient-specific treatment goals or comorbidities, and target IOPs for patient.
- Including a letter of medical necessity describing the patient's condition (contact your Market Access Team for more information or sample templates).

When do I report HCPCS C1889 (implantable/insertable device, not otherwise classified)?

For Medicare cases in the hospital outpatient setting, CMS requires the reporting of C1889 under revenue code 278. Check your ASC payor contracts to determine the appropriate billing.

Is OMNI used to perform viscocanalostomy?

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

May gonioscopy (92020) be billed with the claim for the surgery?

No. Gonioscopy is required during surgery to insert the OMNI Surgical System 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.

Is the procedure using the SION Surgical Instrument covered by insurers?

Coverage may vary by payor, or even by health plan within a particular payor. To determine coverage for a particular patient, a benefit verification should be conducted and the payor policy should be reviewed. Coverage is typically based on medical necessity and may require a pre-authorization or pre-determination. Once a patient is identified, the practice or the facility should allow enough time to complete these steps prior to scheduling a patient for surgery.

Is a prior authorization required for SION, and what documentation should be provided with a prior authorization request?

Traditional Medicare does not allow prior authorizations. Other health plans may require them as part of the conditions for coverage. Conducting a benefit investigation prior to treatment can uncover this information. Prior Authorization submissions to the payor generally include the following:

- Include the payor specific prior authorization form, if required
- Check the payor's medical policy to understand coverage criteria, if available
- Include documentation and chart notes that support medical necessity which might include diagnostic testing results, previous treatment(s) along with outcomes, patient specific goals like target IOP, and reason for current treatment selection
- Include a letter of medical necessity describing the specific patient story

Is there an NCCI edit in place for 65820 and other angle procedures?

At this time, there is not, but there are medical policies in place which may change throughout the year. It is recommended to regularly review the insurance medical policy prior to patient treatment. There are some Medicare Administrative Carriers (MACs) that include language in their MIGS policy around the definition of a goniotomy procedure and how it would be billed or not billed with procedures. For more questions around a particular payor policy, please reach out to our Market Access team for more information.

Notes

[1] U.S. Food & Drug Administration (FDA) 510(k)-cleared Instructions for Use [Traditional 510(k) K202678] https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm?ID=K202678

[2] Trabecular meshwork (trabeculotomy), Schlemm's canal (canaloplasty), and collector channels (canaloplasty).

[3] Williamson BK, Vold SD, Campbell A, Hirsch L, Selvadurai D, Aminlari AE, Cotliar J, Dickerson JE. Canaloplasty and Trabeculotomy with the OMNI System in Patients with Open-Angle Glaucoma: Two-Year Results from the ROMEO Study. Clin Ophthalmol. 2023 Apr 6;17:1057-1066. doi: 10.2147/OPTH.S407918. PMID: 37056792; PMCID: PMC10086214. https://pubmed.ncbi.nlm.nih.gov/37056792/

[4] CPT codes, descriptions, and other data only are copyright 2024 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

[5] CPT CodeBook Guidelines: Do not report 66174 in conjunction with 65820. 2025 CPT Professional Edition, page 513, parenthetical notation.

[6] CMS established a claim edit prohibiting separate payment of CPT 65820 with CPT 66174. If both codes are submitted, only 66174 will be paid. CMS National Correct Coding Edits. Procedure to Procedure Edit File as of 12/09/24. https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits

[7] AMA CPT Assistant. May 2022 page 14; September 2019 page 10-11; December 2018 page 9.

[8] AMA CPT Assistant,. Coding Clarification: Reporting Goniotomy (65820). August 2022 pages 1-2.

[9] American Academy of Ophthalmic Executives® Fact Sheet: Goniotomy As of February 2025. https://www.aao.org/practice-management/news-detail/how-to-bill-migs

[10] CMS-1809-FC Hospital Outpatient Prospective Payment- Notice of Final Rulemaking (NFRM) 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc

[11] CMS-1809-FC Ambulatory Surgical Center Payment- Notice of Final Rulemaking (NFRM) 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices/cms-1809-fc

[12] CMS-1807-F. 2025 Final Rule CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f

[13] HCPCS Quarterly Update.https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update

[14] Hospitals are encouraged to report all applicable C codes regardless of payment status. C-codes are critical when CMS determines charges to outpatient hospital payment rates. Medicare claims data has shown that very few hospitals appropriately report implantable or insertable device costs when used. This is necessary to help capture appropriate costs for setting future hospital outpatient APC payment levels.

[15] CMS-1809-FC. Hospital Outpatient Prospective Payment- Notice of Final Rulemaking (NFRM) 2025 https://www.cms.gov/license/ama?file=/files/zip/2025-nfrm-opps-addenda.zip3

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

[17] AAO 2016 Position Paper titled, Comprehensive Guidelines for the Co-Management of Ophthalmic Postoperative Care. https://www.aao.org/education/ethics-detail/guidelines-comanagementpostoperative-care

[18] Medicare coverage for CPT 66174 is outside of a formal national coverage determination (NCD) or a local coverage determination (LCD). Providers are to follow Medicare guidelines on medical necessity, which include: - Treatment is appropriate for individual patients based on approved label. - Treatment is within accepted standards of medical practice for the patient's condition.

[19] CGS effective 11/17/2024: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=37578&ver=27&bc=0

[20] FCSO effective 12/30/2019: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=38233

[21] NGS effective 11/17/24: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=37244&ver=39&bc=0

[22] Noridian effective 11/17/2024: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38301&ver=22&bc=0

[23] Novitas effective 12/30/2019: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38223

[24] Palmetto effective 11/17/2024: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=37531&ver=20&bc=00

[25] WPS effective 11/17/2024: https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f

[26] Medicare coverage for CPT 65820 is outside of a formal national coverage determination (NCD) or a local coverage determination (LCD). Providers are to follow Medicare guidelines on medical necessity, which include: - Treatment is appropriate for individual patients based on approved label. - Treatment is within accepted standards of medical practice for the patient's condition.

[27] Goniotomy should not be coded in addition to other angle surgeries, stent insertion(s) or Schlemm canal implants, if the incision into the trabecular meshwork is minimal or incidental to those procedure(s).

[28] For Novitas and First Coast Service Options, the 2 MACs that maintained the 2019 MIGS LCDs, the policies indicate that a goniotomy performed in conjunction with the insertion of a glaucoma drainage device is not medically necessary and may be subject to a focused medical review.

[29] About ICD-10-CM:https://www.cdc.gov/nchs/icd/icd-10-cm/index.html

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The OMNI® Surgical System is FDA 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. Visit omnisurgical.com/instructionsforuse for the indications for use, contraindications, warning, and potential adverse events. The SION® Surgical Instrument is a sterile, single use, manually operated device used in opthalmic surgical procedures to excise trabecular meshwork. Visit sionsurgical.com/instructionsforuse for the indications for use, contraindications, warnings, and potential adverse events.

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