ALCON REIMBURSEMENT SERVICES

Alcon®

a Novartis company

EX-PRESS® Glaucoma Filtration Device Coding and Reimbursement Fact Sheet

EX-PRESS® Glaucoma Filtration Device Description and Indication

The EX-PRESS® Glaucoma Filtration Device received FDA clearance on March 26, 2002. The device is a miniature surgical implant and is intended to reduce intraocular pressure in glaucoma patients where medical and conventional surgical treatments have failed.[1]

Coding

Category I CPT® Code, 66183, insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach, is effective for dates of service on or after January 1, 2014.

Physician and Surgical Facility Coding

	Physician	Ambulatory Surgery Center	Hospital Outpatient Department
Medicare	66183	66183	66183 and C1783, Ocular Implant
Commercial	66183	66183 and L8612, Aqueous shunt	66183 and L8612, Aqueous shunt

Reimbursement

Medicare and many commercial payers package reimbursement for the EX-PRESS® device with the facility payment. Facilities are encouraged to proactively review and negotiate their commercial payer contracts for payment of L8612.

2015 Medicare National Unadjusted Payment Rates

Physician	Ambulatory Surgery Center[2]	Hospital Outpatient Department
$1,041.53	$1,711.02	$3,122.56

Global Period

66183 has an assigned global period of 90 days. The reimbursement for 66183 includes services provided on the day of and 90 days following the procedure.

1. See Instructions for use and back page for Important Safety Information.
2. Medicare fee schedules are available at cms.gov. Inclusion in fee schedule is not a guarantee of payment.

Common Glaucoma Diagnosis Codes

Diagnosis and procedure coding are at the discretion of the physician based upon the clinical condition of the patient, the nature of the physician's findings, and the procedural steps dictated in the patient's medical record. Only the physician can determine a diagnosis. Because policies vary, verification of covered diagnosis is recommended.

Some examples could be:

ICD-9-CM	Description
365.10	*Unspecified open-angle glaucoma*
365.11	*Primary open angle glaucoma*
365.12	*Low tension open-angle glaucoma*
365.13	*Pigmentary glaucoma*
365.15	*Residual stage of open angle glaucoma*

Because coverage criteria varies by payer (e.g., Aetna covers 365.11 and WellPoint covers 365.10 -365.15), providers are encouraged to check with the plan for specific covered diagnosis codes. Individual benefit plans may vary.

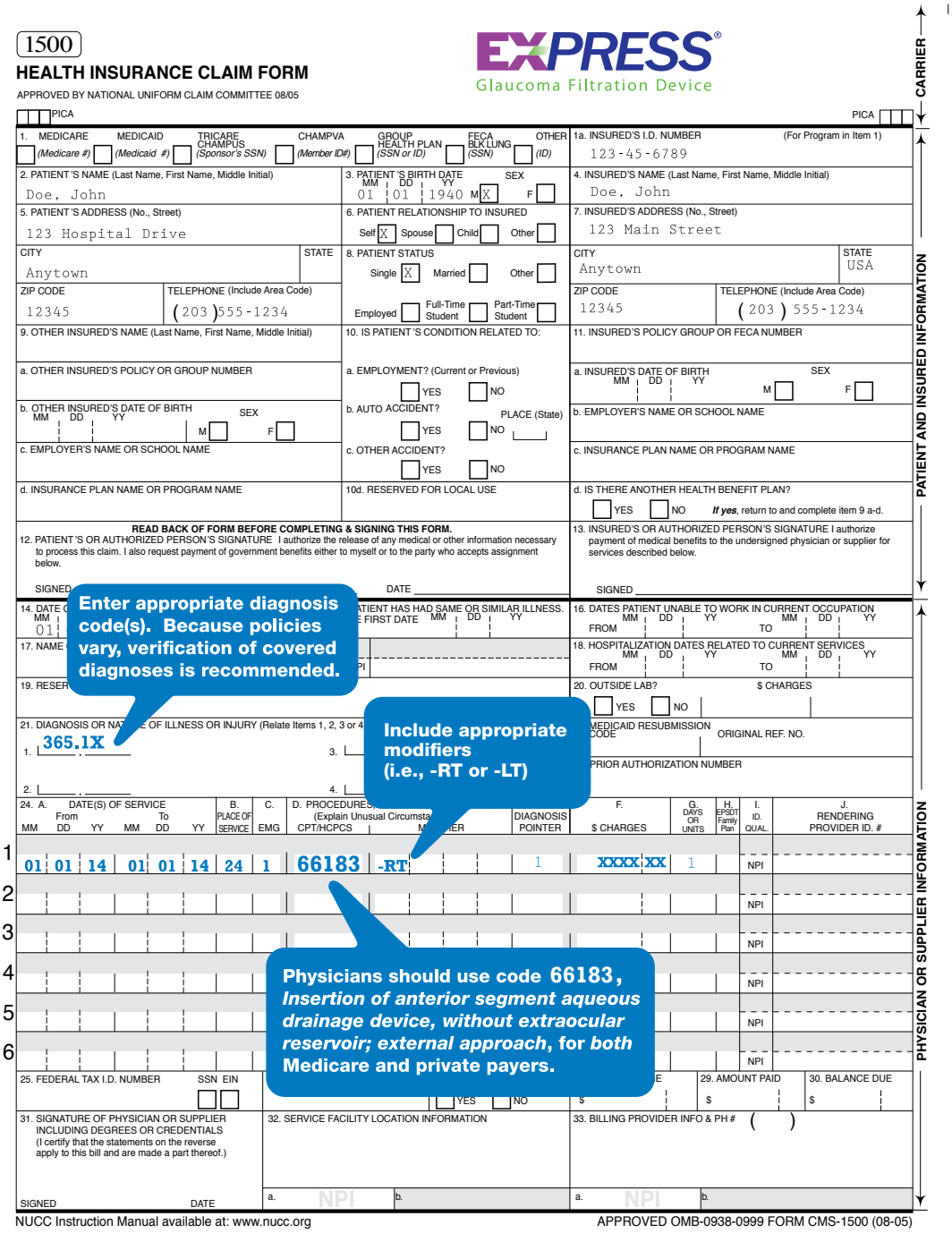
Commercial Payer Reimbursement

Payment from private payers will be contingent upon individual contracts that may need to be updated to include CPT® code 66183. Like Medicare, many commercial payer contracts package the cost of the EX-PRESS® device with facility payment for CPT® code 66183, while other commercial payers may allow an additional payment for HCPCS L8612. Individual contracts are always proprietary to the provider.

Note: If a provider does not proactively negotiate an update to their existing contracts, commercial payers may reimburse at a significantly lower than expected rate or may deny the procedure without an appeal option.

Physician Office

Sample CMS - 1500 Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

EXPRESS® Glaucoma Filtration Device

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123-45-6789

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

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1940 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 123 Hospital Drive

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Main Street

CITY: Anytown STATE:

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: Anytown STATE: USA

ZIP CODE: 12345 TELEPHONE (Include Area Code): (203)555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 12345 TELEPHONE (Include Area Code): (203) 555-1234

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. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

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

14. DATE OF CURRENT: MM DD YY 01 ... ATIENT HAS HAD SAME OR SIMILAR ILLNESS. E FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME ... PI

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

19. RESER...

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 ... MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

1. 365.1X 3. ... PRIOR AUTHORIZATION NUMBER

2. ... 4. ...

Enter appropriate diagnosis code(s). Because policies vary, verification of covered diagnoses is recommended.

Include appropriate modifiers (i.e., -RT or -LT)

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	14	01	01	14	24	1	66183	-RT	1	XXXX XX	1		NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

Physicians should use code 66183, *Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach*, for *both* Medicare and private payers.

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

... YES [ ] NO [ ]

29. AMOUNT PAID $

30. BALANCE DUE $

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.

CARRIER

PATIENT AND INSURED INFORMATION

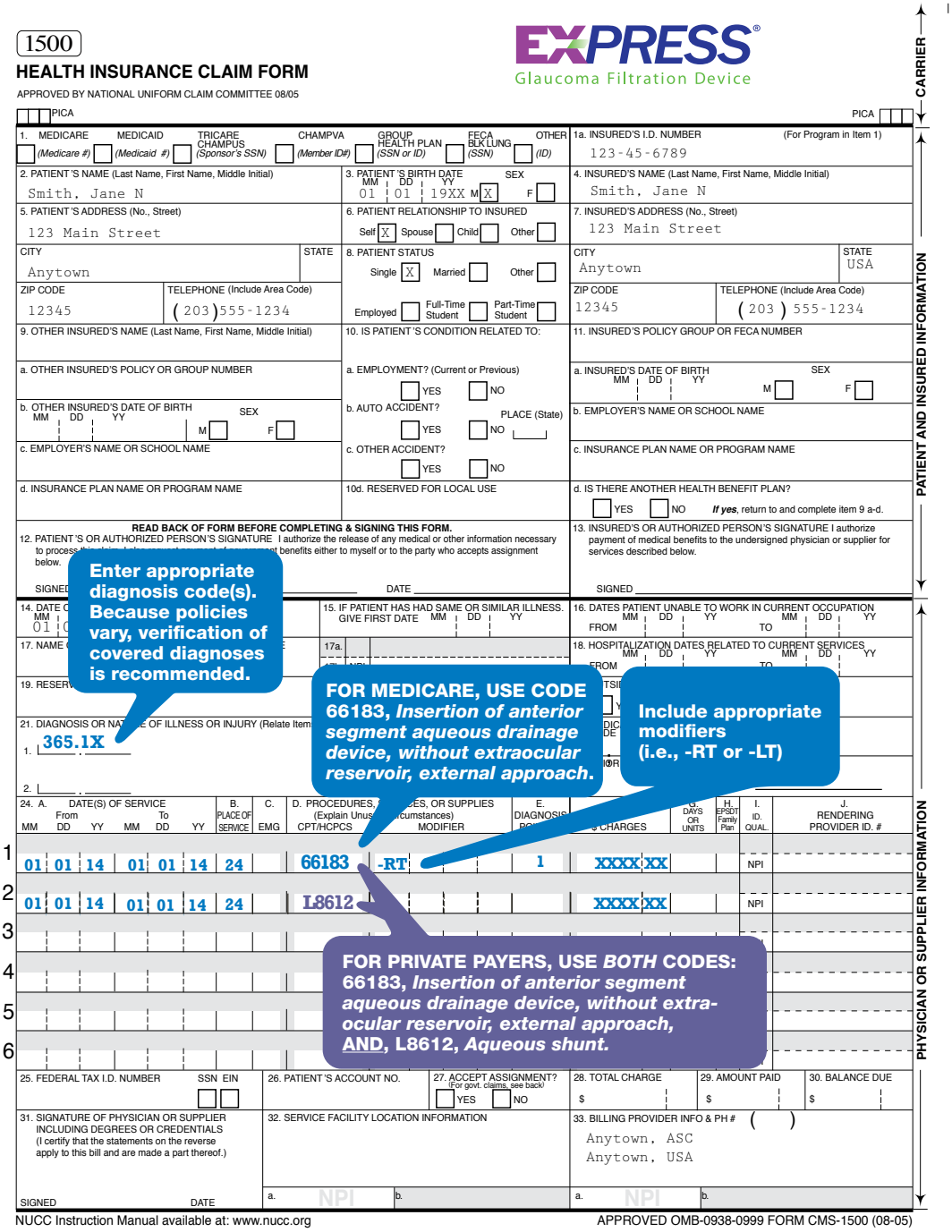
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Ambulatory Surgery Center

Sample CMS - 1500 Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

EXPRESS® Glaucoma Filtration Device

CARRIER

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123-45-6789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Smith, Jane N	01 01 19XX M[X] F[ ]	Smith, Jane N
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 Main Street	Self [X] Spouse [ ] Child [ ] Other [ ]	123 Main Street
CITY: Anytown / STATE	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]	CITY: Anytown / STATE: USA
ZIP CODE: 12345 / TELEPHONE (Include Area Code): (203)555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: 12345 / TELEPHONE (Include Area Code): (203) 555-1234
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. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M[ ] F[ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

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: 01 (0

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME (

17a.

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

19. RESER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 365.1X

2.

Enter appropriate diagnosis code(s). Because policies vary, verification of covered diagnoses is recommended.

FOR MEDICARE, USE CODE 66183, *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach.*

Include appropriate modifiers (i.e., -RT or -LT)

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 01 01 14	01 01 14	24		66183	-RT	1	XXXX XX			NPI	
2 01 01 14	01 01 14	24		L8612			XXXX XX			NPI	
3											
4											
5											
6											

FOR PRIVATE PAYERS, USE *BOTH* CODES: 66183, *Insertion of anterior segment aqueous drainage device, without extra-ocular reservoir, external approach,* AND, L8612, *Aqueous shunt.*

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. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. NPI b.	Anytown, ASC Anytown, USA a. NPI b.

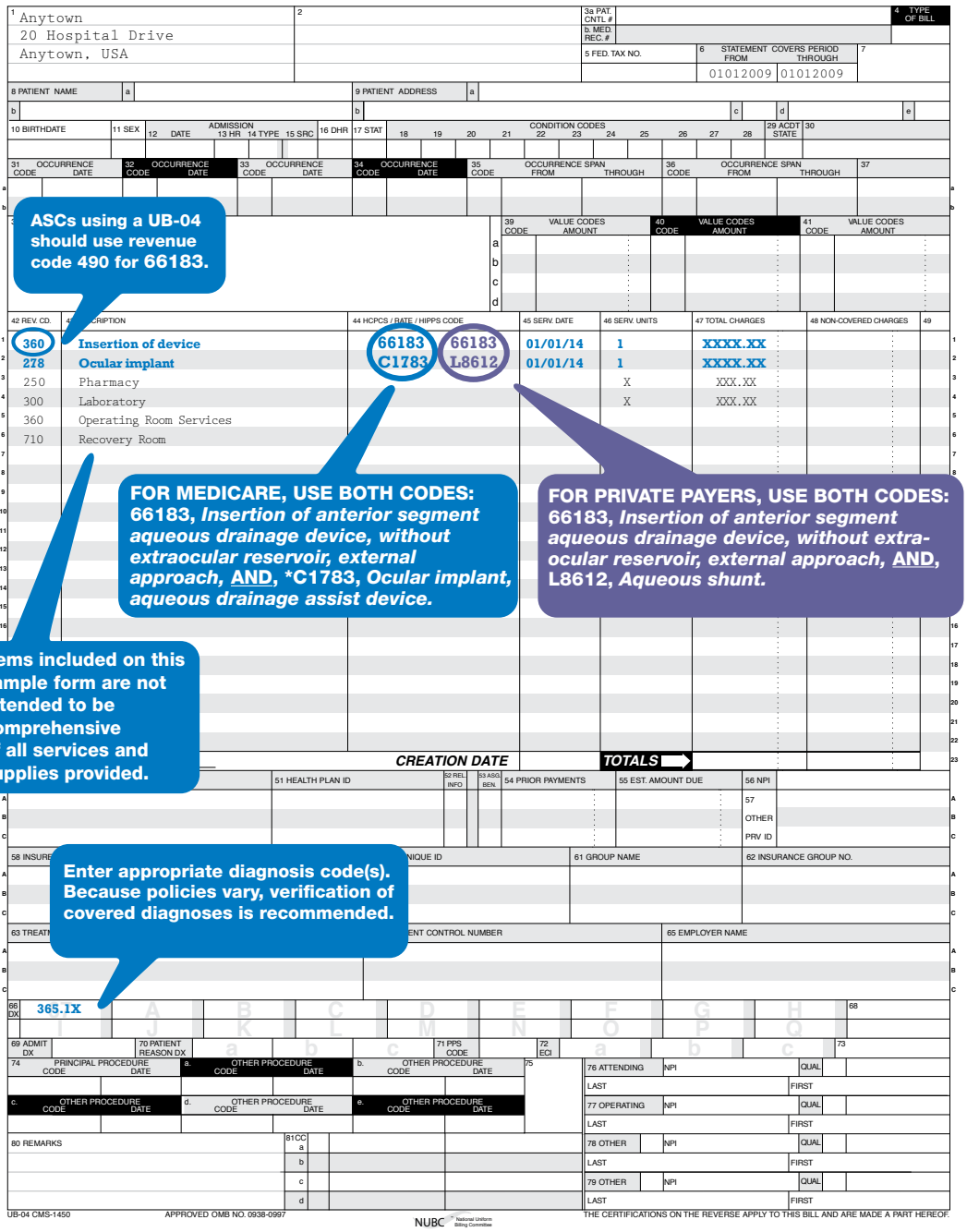
NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Hospital Outpatient Fact Sheet

Sample UB-04 Paper Claim Form

EXPRESS®
Glaucoma Filtration Device



* Medicare relies on proper coding for year-end payment review. When billing Medicare for EX-PRESS® device, it is imperative to always include the appropriate HCPCS code (C1783). Failure to include code C1783 may result in reduced payment rate.

CAUTION: Federal (USA) law restricts this device to sale by, or on the order of, a physician.

INDICATION: The EX-PRESS® Glaucoma Filtration Device is intended to reduce intraocular pressure in glaucoma patients where medical and conventional surgical treatments have failed.

GUIDANCE REGARDING THE SELECTION OF THE APPROPRIATE VERSION: Prior clinical studies were not designed to compare between the various versions of the EX-PRESS® Glaucoma Filtration Device. The selection of the appropriate version is according to the doctor's discretion.

CONTRAINDICATIONS: The use of this device is contraindicated if one or more of the following conditions exist:

- Presence of ocular disease such as uveitis, ocular infection, severe dry eye, severe blepharitis.
- Pre-existing ocular or systemic pathology that, in the opinion of the surgeon, is likely to cause postoperative complications following implantation of the device.
- Patients diagnosed with angle closure glaucoma.

WARNINGS/PRECAUTIONS:

- The surgeon should be familiar with the instructions for use.
- The integrity of the package should be examined prior to use and the device should not be used if the package is damaged and sterility is compromised.
- This device is for single use only.
- MRI of the head is permitted, however not recommended, in the first two weeks post implantation.

ATTENTION: Reference the Directions for Use labeling for a complete listing of indications, warnings, precautions, complications and adverse events.

ALCON REIMBURSEMENT SERVICES

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(866) 457-0277 – ARS.SupportUS@alcon.com
http://ars.alcon.com