

Glaucoma Coding

Glaucoma management involves a keen clinical sense and definitive decision making abilities. And so does the appropriate coding of the professional services rendered in care of the glaucoma patient. First, glaucoma care involves a degree of care that can be identified by general ophthalmological service codes (92000's) or evaluation and management codes (99000's). In addition, the doctor must cautiously choose special ophthalmological service codes to match the unbundled procedures that are appropriate for the patient's diagnosis and clinical needs.

Many sources are available for the use of the 92000 codes versus the 99000 codes and that matter will not be covered ad nauseum here. One particular area that deserves attention is that the 92004 and 92014 codes. Often misused by eye care professionals as "routine eye examination" codes, they are truly broader codes. Very few eye doctors have taken the time to read CPT to find the true definition of these codes.

In the current 2006 CPT, page 298 includes the descriptions of these codes. As it applies to coding glaucoma care, keep in mind that the 92000 codes are integrated services where medical decision making cannot be separated from the procedures done. Therefore, per CPT, "itemization of service components, such as... tonometry... is not applicable." While serial tonometry, 92100, is additionally billable if there are multiple measurements taken over an extended period of time and a specific interpretation and report is noted in the chart, it is never appropriate to add 92100 to any billing for just one or two IOP readings that might be taken a few minutes apart.

Finally, keep in mind that 92004 and 92014 must include initiation of a diagnostic and treatment program that includes the prescription of medication and arranging for special ophthalmological diagnostic or treatment services (amongst other options.) In that regard, it is entirely appropriate to use these codes in the care of a glaucoma patient. However, it would be very unlikely that these "general evaluation" codes would be used frequently, and most ongoing care would be best reflected with the 99000 evaluation and management codes or the intermediate ophthalmic code 92012.

Special service codes for glaucoma are billable with 92000 or 99000 codes to demonstrate a special evaluation of the visual system. They include:

92020 -- Gonioscopy

92083 -- Visual field examination, unilateral or bilateral, with interpretation and report, extended examination including automated threshold perimetry

92100 -- Serial tonometry with multiple measurements of intraocular pressure over an extended period of time with interpretation and report, same day

92135 -- Scanning computerized ophthalmic diagnostic imaging with interpretation and report, unilateral

92250 -- Fundus photography with interpretation and report

92285 -- External ocular photography with interpretation and report

The last code 92285, would be limited to diagnoses such as secondary glaucomas (pigmentary glaucoma, pseudoexfoliative glaucoma). Gonioscopy (92020) is billable on a periodic basis, certainly not monthly or quarterly but typically annually. In narrow angle Glaucoma patients, the frequency of Gonioscopy may approach every six months or in the event of a significant change in status, IOP or anterior segment appearance.

92083 must be applied with caution to avoid overuse. CPT specifically lists instruments such as the Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2, although there are other instruments available today that clearly meet the 92083 definition. The patient record must support the use of this "extended examination" of the visual field as opposed to screening-level fields.

92135 is a unilateral code and can be supported by any instrument that provides diagnostic imaging of the optic disc (in glaucoma patients, that is.) Instruments such as the GDx, HRT, RTA and OCT can perform tests that are covered by this definition.

Finally CPT has some interpretations that are made by payers such as Medicare that must be recognized. The National Correct Coding Initiative shows that CPT codes 92135 and 92250 are "mutually exclusive." The determination is that it is improbable that these procedures would be performed in the same session for the same diagnosis. Only in special circumstances would a case of medical necessity result in these two codes being paid on the same day of service.

Most importantly, coding for procedures related to care of glaucoma must be supported by excellent recordkeeping. Documentation of procedure results, interpretation of the results, and written notes/reports about how the test results affect the patient's care and doctor's decision making must be done thoroughly.

Given the complex nature of Glaucoma, the frequency of follow up care, which is typically equal to or greater than most other ophthalmic diseases, there are certainly multiple patient interactions per year. While this translates into significant professional fees and financial compensation, it also results in an enhanced need for proper record keeping and coding and billing.