Coding, Billing, and Documentation for Glaucoma Patients Nov 8 2014

Jeffrey Restuccio, CPC, CPC-H, MBA
Memphis TN
(901) 517-1705
jeff@eyecodingforum.com
www.EyeCodingForum.com

Everything you ***ever*** wanted to know about coding and billing for glaucoma

- Miscellaneous Concepts
- Office Visits
- 920xx
- E & M
- MDM
- Related Concepts
- Diagnostics
- ICD-10

Educate your patients

- The Baltimore Eye Study proved that glaucoma can be hard to diagnose. 50% of all people found to have glaucoma during the study had seen an eye doctor within the past year and were unaware that they had glaucoma.
- The Early Manifest Glaucoma Trial demonstrated that 50% of patients with glaucoma, even if they had elevated IOPs most of the time, had screening IOPs below 22 mm Hg.
- The Beaver Dam Eye Study reported that nearly one-third of glaucoma patients can be classified as having NTG.

Educate your patients

- As of the year 2013, an estimated 2.2 million people in the United States had glaucoma and more than 120,000 are legally blind because of this disease.
- Studies estimate that 3-6 million people in the United States alone, including 4-10% of the population older than 40 years, have intraocular pressures of 21 mm Hg or higher, without detectable signs of glaucomatous damage using current tests.

Medical Necessity for Glaucoma

- Glaucoma is not difficult. A glaucoma suspect diagnosis will support most diagnostic tests.
- It the one-to-one linking of a diagnosis to a CPT code to support medical necessity.
- Some CPT codes require two diagnoses. (e.g., secondary glaucoma)
- Some CPT codes are paid only on a very specific diagnosis.
- The source for medical necessity information is the Medicare Local Coverage Determination.
- Without medical necessity, the procedure is a screening.
- This is the “catch 22” of healthcare.
- If unsure if paid, have the patient fill out an ABN (Medicare) or a similar private carrier form stating they are responsible if the carrier does not pay.

Screenings

- Any procedure performed in the absence of a diagnosis supporting medical necessity. Common examples would be:
- Fundus photography used as a baseline.
- Pachymetry when performed several years ago for glaucoma.
- Always link a routine vision exam (920xx code) to V72.0 if the patient has not current or chronic medical condition.

Advance Beneficiary Notice (ABN)

- Required by Medicare if you want to bill the patient for a non-covered service (does not meet medical necessity).
- Have the patient fill out the form. Explain that you may be paid, but if not they are responsible.
- Append **modifier GA** to the code.
- Use with pachymetry or any screening without medical necessity (e.g., fundus photography).
- Be sure you have the latest version. Download from the Medicare website.

Glaucoma Suspect vs Probable Glaucoma

- Glaucoma is one of the few diseases that's includes a formal "suspect" diagnosis code.
  - "those patients who have elevated intraocular pressure but no clinical signs of disease, or, alternatively, patients whose pressures are within range but who show other signs of concern."
- There is no cataract, dry eye, or foreign-body suspect code.
- It is listed as preglaucoma as well.
- If appropriate, report the ocular hypertension code: 365.04/H30.05*
- No other "suspected" condition can be reported. List only signs and symptoms for "likely", "probable" or "rule-outs."

Medicare Screening Codes

G0117	Glaucoma screening for high risk patients furnished **by an optometrist or ophthalmologist**
G0118	Glaucoma screening for high risk patient furnished under the **direct supervision** of an optometrist or ophthalmologist

Payment may be made for a glaucoma screening examination that is performed on an eligible beneficiary after at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed.

V80.1 Medicare beneficiaries with diabetes mellitus, family history of glaucoma, African-Americans aged 50 and older, or Hispanic-Americans aged 65 and older Annually for covered beneficiaries

- Copayment/ coinsurance applies
- Deductible applies

These codes are not commonly used.

G0117 RVU and Medicare Reimbursable

G0117	Medicare Non Facility
Allowed	$62.43
Reimbursement	$49.94
After Sequest	$48.95
RVUw [work]	0.45
RVUpe [practice expense]	1.08
RVUm [malpractice ins.]	0.03
RVU total	1.5

G0118 RVU and Medicare Reimbursable

	Medicare Non Facility
Allowed	$51.42
Reimbursement	$41.14
After Sequest	$40.31
RVUw	0.17
RVUpe	1.08
RVUm	0.01
RVU total	**1.26**

Vision Plans

- VSP, EyeMed, Davis, Spectera. Most combine a refraction exam (92015) with a routine vision exam (920xx). They make up their own rules, guidelines and interpretations.
- Be sure to explain to every patient that you are performing two, separate, discrete services.
- Check carrier manual if dilation is required.
- Check the **vision plan manual** to determine if they will pay a routine visit on a patient with a chronic illness such as **glaucoma.** Link the visit to V72.0 and add the glaucoma code second. Providing the routine visit is mainly a **customer satisfaction** and **contractual** issue with the vision plan.
- Determine your **clinic policy** on whether chronic-illness patients receive their routine vision visit once per year.

920xx Documentation Errors

- **Intermediate Exam**: 920x2: 3-8 exam elements
- Required: **external ocular adnexa**

- **Comprehensive**: 920x4: 9 -14 exam elements
- Required: **external ocular adnexa, Extra Ocular Motility, Confrontation Fields**
- **Dilation** not required in CPT but some Medicare carriers do require it ! **It is a carrier-specific rule.**
- Always perform review of family Hx; recommend proper HPI and ROS even though not specifically required. **MDM is not an issue**.
- Initiation of a diagnostic and therapeutic treatment as indicated. [see next slide]

Comprehensive Eye Exams (92004 & 92014)

A comprehensive exam always includes "initiation of diagnostic and treatment programs as indicated." At least one of the following **must** be included:

1. Prescription of medication*
2. Arranging for special ophthalmological diagnostic or treatment services
3. Consultations
4. Laboratory procedures
5. Radiological services

*a prescription for eyeglasses *was* included in a now retired LCD from Trailblazer MCR).

One option is to include documentation for the **initiation** of therapeutic anti-oxidants for ARMD and dry eyes (Even if you don't sell them the vitamins).

Office Visits: Eye Exam – Included Tests 1 -10

The following 20 procedures may be included as part of an intermediate or comprehensive ophthalmologic service :

1 Amsler Grid Test
2 Basic sensorimotor Exam
3 Brightness Acuity Test (BAT)
4 Corneal Sensation
5 Exophthalmometry
6 General Medical Observation
7 Glare Test
8 History
9 Keratometry
10 Laser Inteferometry

Office Visits: Eye Exam – Included Tests 11-20

The following procedures may be included as part of an intermediate or comprehensive ophthalmologic service :

11 Maddox Test
12 Routine Ophthalmoscopy
13 Phacometry
14 Potential Acuity Meter (PAM) [don’t bill separately]
15 Retinoscopy
16 Schirmer's Tear Test [don’t bill separately]
17 Slit lamp Exam
18 Slit Lamp Tear Film Adequacy
19 Tonometry (Basic)
20 Transillumination

Office visits new or established?

- Be very clear whether this is being reported as a new or established patient.
- Some providers use the terminology: “new to me” and this can be a little confusing to the auditor.
- Established: Have they seen anyone in the office within three years?
- New: Have not.
- **Applies to both E & M and 920xx codes.**
- E & M rules and levels are different for new versus established patients.

992xx E & M codes

- Evaluation and Management (E & M) Exam codes
- Key components are history, exam and medical decision making (MDM).
- Time **not a factor** except when counseling.
- Based on new or established.
- Based on level of service.
- **Same history and exam elements** as the 920xx codes.
- You can report either 920xx or 992xx codes for an office visit for a medical condition (not a refraction visit). Use what is supported by documentation, is paid by the carrier, and pays the highest.

Incident-To Services (E & M Code 99211)

- A minimal **Provider E & M visit** should be a 99212, not a 99211.
- 99211 does not require the presence of a Provider. Sometimes referred to as an **“Incident-To”** Service (Medicare Concept)
- Do not report this code whenever a tech performs a test (99211 plus 92083 or 99211 and pachymetry. It is highly unlikely the claim will be paid. That is a national NCCI edit violation.
- If a patient has an IOP check without seeing the provider then a 99211 could be reported.
- If a tech or nurse is providing nutrition-therapy services for ARMD patients including minimal exam elements and History.

RVU's 2014 (La CA)

E & M	Total RVU	Medicine Exam	Total RVU
99202	2.08		
99203	**3.02**	92002	2.32
99204	**4.64**	92004	4.22
99205	5.77		
99212	1.22		
99213	2.04	92012	**2.43**
99214	3.01	92014	**3.52**
99215	4.03		

Medicare Allowable 2014 (LA CA)
Conversion Factor: $35.822

E & M	Total	Medicine Exam	Total
99202	$81.46		
99203	**$117.59**	92002	$91.62
99204	**$179.36**	92004	$165.99
99205	$223.03		
99212	$48.07		
99213	$79.63	**92012**	**$96.02**
99214	$117.26	**92014**	**$138.75**
99215	$156.62		

E & M: 2 of 3 rule; 3 of 3 rule

- For a **new patient**, to report a given level, **all three key components**, hx, exam, and MDM must be at the highest level. Missing 10 ROS on a comprehensive encounter (99204) is fatal.
- For an **existing patient**, either hx, or the exam, may be at a lower level, and the level is determined by MDM and the other key component. This is the 2 of 3 rule.
- Remember that MDM always determines the level and can never the lower of the three.
- I have seen some clinics either skip or document a minimal hx or exam for a level IV or V visit. While I must audit these as “correct” I do not recommend it unless there is a very good reason for it (patient is going to the ER or unconscious).

E & M Exam

These are the Medicare 1997 E & M Guidelines for Eyecare

- 14 elements; 12 vision and 2 Psych.
- 1-5: Problem Focused (PF)
- 6: Expanded Problem Focused (EPF)
- 9: Detailed
- 12 + 1 is comprehensive exam (note same name as 92014 exam!)

- **2 additional elements for children** (VSP and Medicaid) not part of 14 above and not required by Medicare.
- **Binocularity** (stereo vision) and **color vision**. Be sure to include them in your progress notes or EMR. I, as well as most Eyecare professionals consider the cover test and/or phorias to be a subset.

992xx Examination Components - Eye

Selecting Exam Elements (14) - Example

	PF 1-5	EPF 6	Det 9	Comp 12+1
1. VA	1	1	1	1
2. CF		1	1	1
3. EOM		1	1	1
4. Conjunctiva		1	1	1
5. Pupils/Iris			1	1
6. IOP	1	1	1	1
7. Adnexa	1	1	1	1
8. Cornea			1	1
9. Lens			1	1
10. A/C			1	1
11. Disks (Dil.)				1
12. Retina (Dil.)				1
13. A+OX3	1	1	1	1
14. Mood	1	1	1	1

A Word about Time

- While not part of this presentation, if the MDM clearly does not support a higher level, if the documentation supports, you might consider using **Counseling and/or Coordination of Care** and **Time** to determine the Level of E & M**.**. That is better than **upcoding.**
- Always document **two times**: total time ***and*** counseling time and be very specific to *that* patient and *that* Date of Service on what was discussed. No cloned notes!

Encounter Dominated by Counseling or Coordination of Care

Include specifics for this DOS and patient.

Diagnostic results, impressions, and/or recommended diagnostic studies.
Prognosis.
Risks and Benefits of management (treatment) options
Instructions for management (treatment) and/or follow-up.
Importance of compliance with chosen management (treatment) option.
Risk factor reduction.
Patient and family education

Using Time: Encounter Dominated by Counseling or Coordination of Care

Always document two times:
Total Time
Counseling Time (> 50% of total)
Always something unique to the patient and this individual encounter on this Date of Service (DOS) in your notes.
Don't copy the exact same note from date to date or patient to patient. That is a "cloned note."
Don't just document:
We discussed risks . . . (what specific risks?)
We discussed options . . . (what specific options?)
We discussed medications (List medications)

Using Time – New patient

99201	10 min Face Time
99202	20 min Face Time
99203	30 min Face Time
99204	45 min Face Time
99205	60 min Face Time

Using Time – Est. patient

99211	5 min Face Time
99212	10 min Face Time
99213	15 min Face Time
99214	25 min Face Time
99215	40 min Face Time

Medical Decision Making

MDM – What does this all mean?

First in very general terms (more than one element required):

1. Straightforward: Resolved problem; follow-up on acute conjunctivitis
2. Low: Two est. chronic problems; two self limited problems.
3. Moderate: New problem; Three chronic illnesses
4. High: Decision for emergency surgery; severe exacerbation; four or more chronic diseases – but that is not enough.

Medical Decision Making Components

A) Number of Diagnoses/Management Options.

B) Amount and/or Complexity of Data to be Reviewed.

C) Table of Risk of Significant Complications, Morbidity and/or Mortality.

Only two of the three components need to be at a given level.
Sometimes you will see these listed as Tables 1,2 and 3

Key MDM documentation Points (1)

Always clearly document:

1. Whether a condition is stable, improving, worsening or “not responding as expected to treatment.”
2. Chronic versus Acute conditions.
3. New diagnoses or conditions.
4. Abrupt changes or exacerbations
5. Need for additional tests (work-up)

Key MDM Documentation Points (2)

Always clearly document:

6. Any new prescription medications or change in medication.
7. Rule-outs when presented with vague symptoms (itching, tearing and burning of eyes, red eyes)
8. Review (visualization) of any tests or image data (pachymetry, fundus photo, GDX) performed or reviewed by *another physician*.
9. Discuss with your staff and other Providers categories of Dx: (e.g., acute illness w/ systemic symptoms or the difference between a mild exacerbation and a severe exacerbation.)

Key MDM Documentation Points (3)

Use the same *Assessment* **verbiage** as Medicare if possible:

- New problem; Existing problem
- Reviewed records taken on Jan 15 2014 obtained from John Smith, primary care provider (or neurologist).
- Mild exacerbation; severe exacerbation.
- Document any risk factors of any surgery, this includes co-morbidities such as glaucoma for a cataract patient, DM I, malignant HTN, or previous heart attack.
- Use stable, improved, worsening, no workup or additional workup planned, not responding to treatment as expected.

Medical Decision Making Components

Type (Level)	(A) # of Dx	(B) Data	(C) Risk
Straightforward	Minimal	Minimal	Minimal
Low	Limited	Limited	Low
Moderate	Multiple	Multiple	Moderate
High	Extensive	Extensive	High

Medical Decision Making - Example

Type (Level)	# of Dx	Data	Risk
Straightforward	Viral conj - resolved	None	One self-limited prob
Low	POAG	Pachymetry	1 stable chronic illness
Moderate	HTN, DM II, POAG	1 lab, 1 X-Ray, 1 Dx Test	2 or more stable chronic ill
High	Acute glaucoma	Eye/Brain Trauma	Emerg Surgery

Table A) Number of Dx and Management Options Point System

Description	Limitations	Pts
Self-Limited (minor)	Max of 2 Points	1
Est. Previous Dx	1 Point Each 3 Prev Dx = 3 = Moderate	1
Undiagnosed New Problem	Max of 3 points Need 3 for Moderate (99214)	3
Undiag New problem. Need add'l Tests	One new prob = Extensive	4

Table B) Amt and Complexity of DATA Point System (need 3 for Moderate)

Lab Tests (83891, 82040, 86777)	1 (max)
Radiology Test (76514, 76516, 76519)	1 (max)
Medicine Section Tests (92225, 92250, 92135)	1 (max)
Visualization of image, tracing or specimen previous interpretation by other physician.	2
Discuss of results w/ phys who performed study.	1
Decision to obtain old records and/or add'l Hx	1
Sum of review of old records and/or add'l Hx to supplement info from pt.	2

Table of Risk - Overview

Only Need Highest One !	Minimal	Low	Moderate	High
(1) Presenting Problem				**X**
(2) Dx Tx		X		
(3) Mgmt Options			X	

This table is in the CPT manual. Note that it is divided into three rows and four levels above.
What Table of Risk level is depicted above?

C) Table of Risk

1) Presenting Problems

Minimal	Low	Moderate (99214)	HIGH
Self-Limited NS +1	2 self-limited	1 or more chronic w/ exacerb (NS +3)	1 or more chronic w/ severe exacerb
	1 stable chronic	2 or more stable chronic	Pose threat to eyesight
	Acute uncompl illness	Acute problems w/ systemic symptoms	Abrupt change
		Acute Complicated Injury	

C) Table of Risk
2) Dx Procedures

Minimal	Low	MOD (99214)	HIGH
Labs	GDX/OCT	Cerebrospinal fluid analysis	Anterior Chamber Tap
Pachymetry	A-Scan	MRI of the brain (RU MS)	
Serial Tonometry	B-Scan		
Fundus Photo			

This is a difficult category for Eyecare because most procedures are non-invasive and minor

C) Table of Risk
3) Management Options

Minimal	Low	MOD (99214/ 99204)	HIGH (99215/ 99215)
Rest No Tx	OTC (Artificial Tears)	Prescription drugs; YAG Laser	Repair of Retinal Tear – macula
		Cataract surgery w/ no risk factors	Repair of Rupture of globe
		Trabeculoplasty	Any Major Surgery w/ risk factors
		Non-penetrating deep sclerectomy (NPDS)	

MDM Takeaway

- Stable glaucoma, alone, established, will never support moderate MDM or a 99214 or 99204 level E & M code.
- 90% of the time, Table A and C will support MDM. Table B is rare.
- Three diagnoses, with at least two chronic will always support moderate MDM.
- Recommend reporting three diagnoses with all 99214 or 99204 level E & M codes when appropriate.
- Be clear if the disease/condition is newly diagnosed; then it is three points (Table A) and could support moderate MDM.

Suite of Diagnostic Tests

- Visual field exam
- Fundus photography
- Posterior segment OCT/GDX
- Anterior segment OCT/GDX (narrow angle glaucoma)
- Pachymetry
- Gonioscopy
- Serial Tonomotry

Diagnostic Tests

- In the Medicine section of CPT.
- There is no global period.
- There is no E & M component–but many insurance companies want a Mod-25 on the E & M code.
- Always include the interpretation and report.
- You cannot report an office visit based on discussing the results of a test. The Hx, Exam, and MDM must support the level. You might report a 99212 and report at least one exam element.
- **Many insurance companies deny** a visual field exam or anterior segment photography on the same day as an office visit. This is not an NCCI edit. It should always be challenged. Ask them to show you where it is a non-covered service in their manual or an official bulletin.

Common Billable Office Diagnostic Procedures

It's important to know which diagnostic tests or procedures are **not included** with the intermediate or comprehensive eye exam codes (920xx) or the E & M codes (992xx).

Included	Exam Elements	Billable
BAT	Extra Ocular Motility	Gonioscopy
PAM	Confrontation Fields	Pachymetry
Shirmers	IntraOcular Pressure (IOP)	Fundus Photo

Fundus Photography (92250)

During this procedure the entire inner surface of the eyeball (fundus) is photographed. A picture of the inner surface permits an accurate record of its condition which can be reviewed later when looking for evidence of change.

Optomap Plus, a new diagnostic procedure code is reported with this code. It takes retinal images using a non-mydriatic camera. Since dilation is not necessary, many patients prefer this procedure.

This is an inherently bilateral procedure. Some carriers require MOD-52 when performed on one eye (RT or LT)

Gonioscopy (92020)

Test for Glaucoma

This procedure is not included with the comprehensive Ophthalmological exam.

During this procedure a special lens is used to examine the mesh-like drains in the eye to see if they are blocked or unblocked. Blocked drains cause eye pressure to build. Information about these drains is required to correctly diagnose the kind of glaucoma present and the appropriate treatment.

Visual Field Exams

92081 Visual Field Examination: limited examination

92082 Intermediate ... Humphrey test or Octopus 33

92083 Extended ... Humphrey Visual Field Analyzer, Octopus program G-1, 32 or 4

If your specific test is not on the CPT code list, contact your manufacturer and they should provide assistance.

OCT, GDX HRT, SCODI

Scanning Computerized Ophthalmic Dx Imaging

This procedure has three codes.

92132 – SCODI, anterior segment

92133 – SCODI, posterior segment, optic nerve.

92134 – SCODI, posterior segment, retina

- Optical Coherence Tomography (OCT) (Zeiss Humphrey)
- Also referred to as GDX (GDx Nerve Fiber Analyzer from laser Dx Technologies)
- Confocal Laser Scanning (HRT: Heidelberg Retina Tomograph from Heidelberg Engineering.

SCODI – NCCI Edits.

The following codes would generally not be necessary with SCODI. When necessary on the same day, documentation must justify the procedures; append mod-59 to the **second code**.

92250 Fundus photography with interpretation and report

92225 Ophthalmoscopy, extended with retinal drawing (e.g., for retinal detachment, melanoma) with interpretation and report; initial

92226 Subsequent ophthalmoscopy

76512 B-scan (with or without superimposed non-quantitative A-scan)

Serial tonometry (92100)

- Tonometry is considered serial when you measure IOP at least **three separate times** during the course of **a single day**. This test is most commonly used in patients who have suspected **normal tension glaucoma** (365.12).

Corneal Pachymetry 76514

- Corneal pachymetry is a measurement of the thickness of the cornea.
- A pachymeter measures the central cornea, although certain diseases warrant a "patchette" or pachymetry grid across a wide area.
- Eye care practitioners customarily order corneal pachymetry when a patient's diseased cornea is edematous or ectatic. It is also used before LASIK surgery to help plan the photoablation.

Bilateral surgery Indicator

- 1 = Unilateral: means you are paid for one eye only. Use a modifier when performed on both eyes. (Paid 150% for both eyes)
- 2 = Bilateral: this means you are paid for both eyes. Never use MOD-50.
- 9 = Concept does not apply
- 3 = 150 % rule does not apply (paid 200% for both eyes)
- These flags are in the Medicare PFSRVU database.
- Some diagnostic codes are inherently bilateral such as fundus photography and visual field exams.
- **Not i**n the CPT manual.

Bilateral Surgery Modifier = 2

Paid for both eyes; no modifier necessary.

92250	Bilat	92133	Bilat
92081	Bilat	92134	Bilat
92082	Bilat	92100	Bilat
92083	Bilat	76514	Bilat

Documentation for the Interpretation and Report

1. Clinical Findings.

- The interpretation and report should succinctly summarize your clinical findings. This discussion needs to be clear and concise and include any pertinent findings. It is recommended that this portion be separate from the office exam notes on that day (Assessment and Plan) and clearly labeled as an Interpretation and Report/Clinical Findings.

Interpretation and Report

2. Comparative Data.

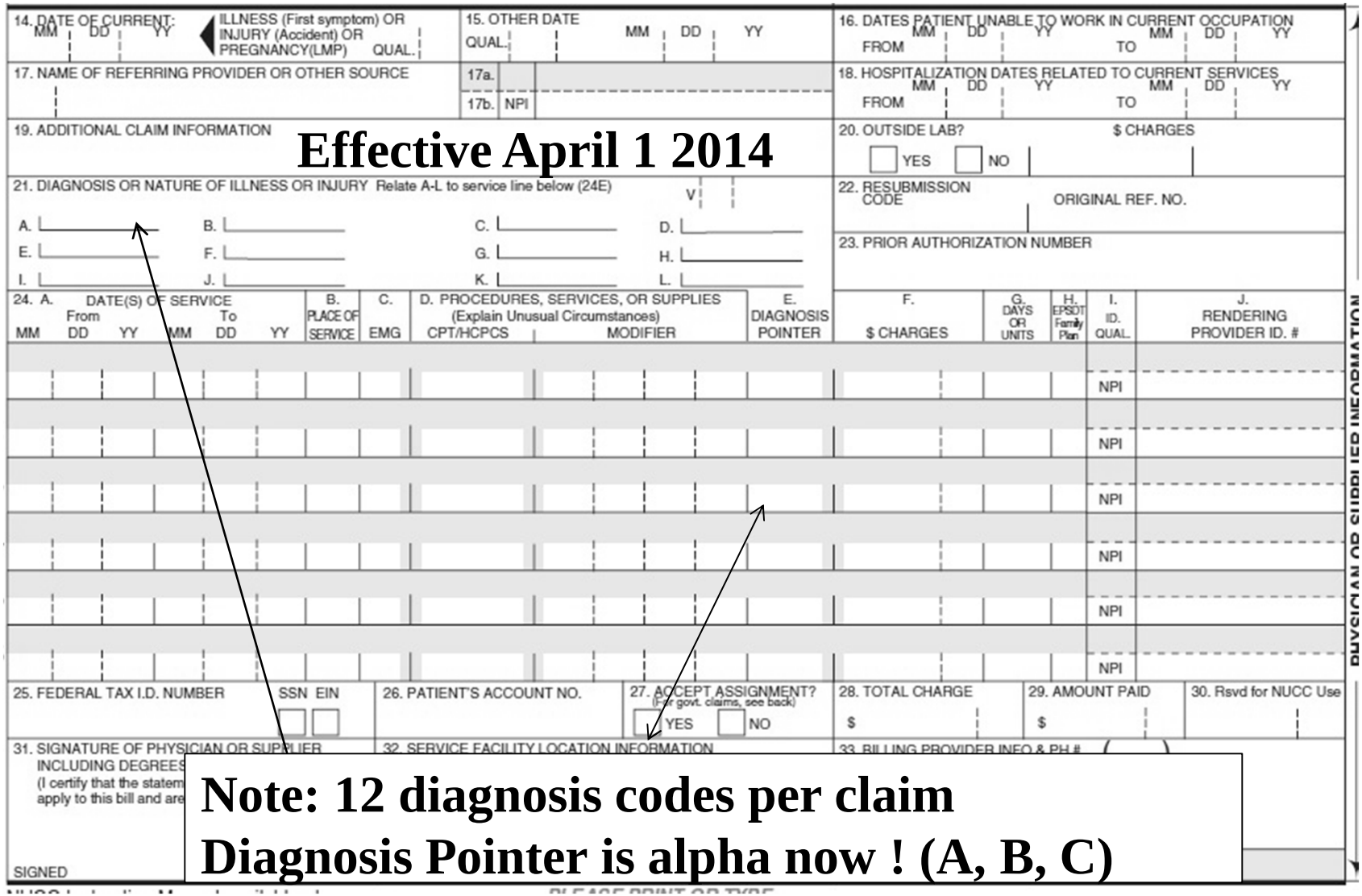
- It is recommended to always document whether a condition is improving, worsening or “Not responding to Treatment as Expected (which is considered a worsening). And this is true for interpretation and report requirements. Always document clearly and succinctly if drusen are found, if the cup to disk ratio has changed or the Intraocular pressure has not changed but should have because of a new prescription. Always document to be read by anyone.

Interpretation and Report

3. Clinical Management.

- Always document why the test was performed (what condition) and what was discovered or ruled out as a result of performing the test. It should always be clear why the additional tests: extended ophthalmoscopy, visual field exam, fundus photography, pachymetry, topography, was performed.
- Address how the diagnostic test is impacting your clinical management. Are you going to change/increase/stop medications? Are you going to recommend surgery? Are you suggesting further diagnostic testing? Include these findings in your written report.

New claim form supports up to 12 diagnoses



ICD-10 Coding for Glaucoma

Glaucoma Suspect: Laterality **Only**. No stage. All four codes are listed. This is a six-digit code.

H40.001		Preglaucoma, unspecified, right eye
H40.002		Preglaucoma, unspecified, left eye
H40.003		Preglaucoma, unspecified, bilateral
H40.009		Preglaucoma, unspecified, unspecified eye

ICD-9 Glaucoma Stage Codes

- In ICD-9, report both the glaucoma type and a separate stage code, below, when appropriate.

ICD-9	Stages	ICD-10
365.70	glaucoma stage, **unspecified**	0
365.71	glaucoma stage, mild	1
365.72	glaucoma stage, moderate	2
365.73	glaucoma stage, severe	3
365.74	glaucoma stage, **indeterminate stage**	4

Glaucoma stage codes

- Determine the severity of the glaucoma in **the worse eye**, based on the new ICD-9 staging definitions:
- **365.71 Mild or early-stage glaucoma** (defined as optic nerve abnormalities consistent with glaucoma but no visual field abnormalities on any white-on-white visual field test, or abnormalities present only on short-wavelength automated perimetry or frequency-doubling perimetry)
- **365.72 Moderate-stage glaucoma** (optic nerve abnormalities consistent with glaucoma and glaucomatous visual field abnormalities in one hemifield, and not within 5 degrees of fixation)

Glaucoma stage codes

- **365.73 Severe-stage glaucoma**, advanced-stage glaucoma, end-stage glaucoma (optic nerve abnormalities consistent with glaucoma and glaucomatous visual field abnormalities in both hemifields, and/or loss within 5 degrees of fixation in at least one hemifield).
- **365.74 Indeterminate** (***visual fields not performed yet***, or patient incapable of visual field testing, or unreliable/uninterpretable visual field testing)
- **365.70 Unspecified, stage *not recorded in chart***
- It is important to document the stage in the patient's medical record.

ICD-10 Glaucoma Stage Codes

- Stage codes will not be reported separately and in addition to the primary glaucoma codes. The codes are combined, and ICD-10 Glaucoma stage codes will now be a seventh digit character.
- Note there is **no laterality** for POAG below.
- The **seventh-digit** stage options are 0, 1, 2, 3 and 4.

H40.11X**0**		Primary open-angle glaucoma, stage unspecified
H40.11X**1**		Primary open-angle glaucoma, mild stage
H40.11X**2**		Primary open-angle glaucoma, moderate stage
H40.11X**3**		Primary open-angle glaucoma, severe stage
H40.11X**4**		Primary open-angle glaucoma, indeterminate stage

GEMS Crosswalk
Pseudoexfoliation glaucoma

Pseudoexfoliation syndrome is a systemic disorder in which a flaky, dandruff-like material peels off the outer layer of the lens within the eye. Worldwide, it is a common cause of secondary glaucoma.

H40.14**13** Capsular glaucoma with pseudoexfoliation of lens, right eye, **severe stage**
ICD-9: 365.52 Pseudoexfoliation glaucoma **and** ICD-9: 365.73 Severe stage glaucoma [**two codes**]
ICD-10 Eye Code: Sixth digit: (1,2,3,9) **Laterality (Right, Left, Bilateral and unspecified.** Seventh digit: (0,1,2,3,4) **Glaucoma stage code**

Pseudoexfoliation glaucoma (20 codes)

1	H40.1410	Capsular glaucoma with pseudoexfoliation of lens, **right eye,** stage unspecified
2	H40.1411	Capsular glaucoma with pseudoexfoliation of lens, right eye, mild stage
3	H40.1412	Capsular glaucoma with pseudoexfoliation of lens, right eye, moderate stage
4	H40.1413	Capsular glaucoma with pseudoexfoliation of lens, right eye, severe stage
5	H40.1414	Capsular glaucoma with pseudoexfoliation of lens, right eye, indeterminate stage
6	H40.1420	Capsular glaucoma with pseudoexfoliation of lens, **left eye**, stage unspecified
7	H40.1421	Capsular glaucoma with pseudoexfoliation of lens, left eye, mild stage
8	H40.1422	Capsular glaucoma with pseudoexfoliation of lens, left eye, moderate stage
9	H40.1423	Capsular glaucoma with pseudoexfoliation of lens, left eye, severe stage
10	H40.1424	Capsular glaucoma with pseudoexfoliation of lens, left eye, indeterminate stage
11	H40.1430	Capsular glaucoma with pseudoexfoliation of lens, **bilateral,** stage unspecified
12	H40.1431	Capsular glaucoma with pseudoexfoliation of lens, bilateral, mild stage
13	H40.1432	Capsular glaucoma with pseudoexfoliation of lens, bilateral, moderate stage
14	H40.1433	Capsular glaucoma with pseudoexfoliation of lens, bilateral, severe stage
15	H40.1434	Capsular glaucoma with pseudoexfoliation of lens, bilateral, indeterminate stage
16	H40.1490	Capsular glaucoma with pseudoexfoliation of lens, **unspecified eye**, stage unspecified
17	H40.1491	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, mild stage
18	H40.1492	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, moderate stage
19	H40.1493	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, severe stage
20	H40.1494	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, indeterminate

Glaucoma Made Easy !

No Stage code, with laterality (sixth-digit code required)

1. H40.0* Glaucoma suspect
2. H40.01* Open angle with borderline findings, low risk
3. H40.02* Open angle with borderline findings, high risk
4. H40.03* Anatomical narrow angle
5. H40.04* Steroid responder
6. H40.05* Ocular hypertension
7. H40.06* Primary angle closure without glaucoma damage

Glaucoma Made Easy !

No Stage code, with laterality (a sixth-digit code) (4 each)

8. H40.15* Residual stage of open-angle glaucoma
9. H40.21* Acute angle-closure glaucoma
10. H40.23* Intermittent angle-closure glaucoma
11. H40.24* Residual stage of angle-closure glaucoma
12. H40.81* Glaucoma with increased episcleral venous pressure
13. H40.82* Hypersecretion glaucoma
14. H40.83* Aqueous misdirection

Glaucoma Made Easy !

Stage Codes, no laterality (five codes each)

[Note **Placeholder code**]

1. H40.10X* Unspecified open-angle glaucoma
2. H40.11X* Primary open-angle glaucoma
3. H40.20X* Unspecified primary angle-closure glaucoma

Glaucoma Made Easy !

Stage Codes plus laterality (20 codes each!)

1. H40.12** Low-tension glaucoma
2. H40.13** Pigmentary glaucoma
3. H4014** Capsular glaucoma with pseudoexfoliation of lens
4. H40.22** Chronic angle-closure glaucoma

Glaucoma Made Easy !

Nothing: **no stage**, **no laterality**, **no placeholder**. short codes.

1. H40.89 Other specified glaucoma [Neovascular Glaucoma]
2. H40.9 Unspecified glaucoma
3. H42 Glaucoma in diseases classified elsewhere

Glaucoma Made Easy - Secondary !

Stage Codes plus **laterality** in the **fifth-digit location**, **note placeholder code plus second code**! (20 codes each!)

1. H40.3*X* Glaucoma secondary to eye trauma, right eye **[note fifth digit is laterality]**
2. H40.4*X* Glaucoma secondary to eye inflammation
3. H40.5*X* Glaucoma secondary to other eye disorders
4. H40.6*X* Glaucoma secondary to drugs

Secondary glaucoma

- Secondary glaucoma may be caused by an eye injury, inflammation, certain drugs such as steroids and advanced cases of cataract or diabetes.
- Remember, to **report two codes, not just one !**
- **Traumatic Glaucoma** — Injury to the eye may cause traumatic glaucoma. This form of open-angle glaucoma can occur immediately after the injury or develop years later. It can be caused by blunt injuries that bruise the eye (called blunt trauma) or by injuries that penetrate the eye.

Glaucoma Codes (Trauma)

- **Angle-recession glaucoma**: This glaucoma is secondary to elevated IOP from reduction in aqueous outflow through the trabecular meshwork.
- Secondary glaucoma after trauma=late effect=sequelae (ICD-10)
- Angle recession is reported to occur in 20 to 94 percent of eyes after **blunt trauma**. 5 to 20 percent of eyes with angle recession develop **angle-recession glaucoma**.
- **Indications** include: iris sphincter tears, mydriasis, iris atrophy, iridoschisis, iridodonesis, phacodonesis and a subluxated lens.

Secondary glaucoma

- **Neovascular Glaucoma** (NVG) is a severe form caused by the abnormal formation of new blood vessels on the iris and over the eye's drainage channels. Rarely occurring on its own, it is always associated with other abnormalities, most often diabetes. The new blood vessels block the eye’s fluid from exiting through the trabecular meshwork, causing an increase in eye pressure (365.63/H40.89 [Other specified glaucoma])
- **Other names** include: hemorrhagic glaucoma, congestive glaucoma, thrombotic glaucoma, and rubeotic glaucoma.

Secondary Glaucoma

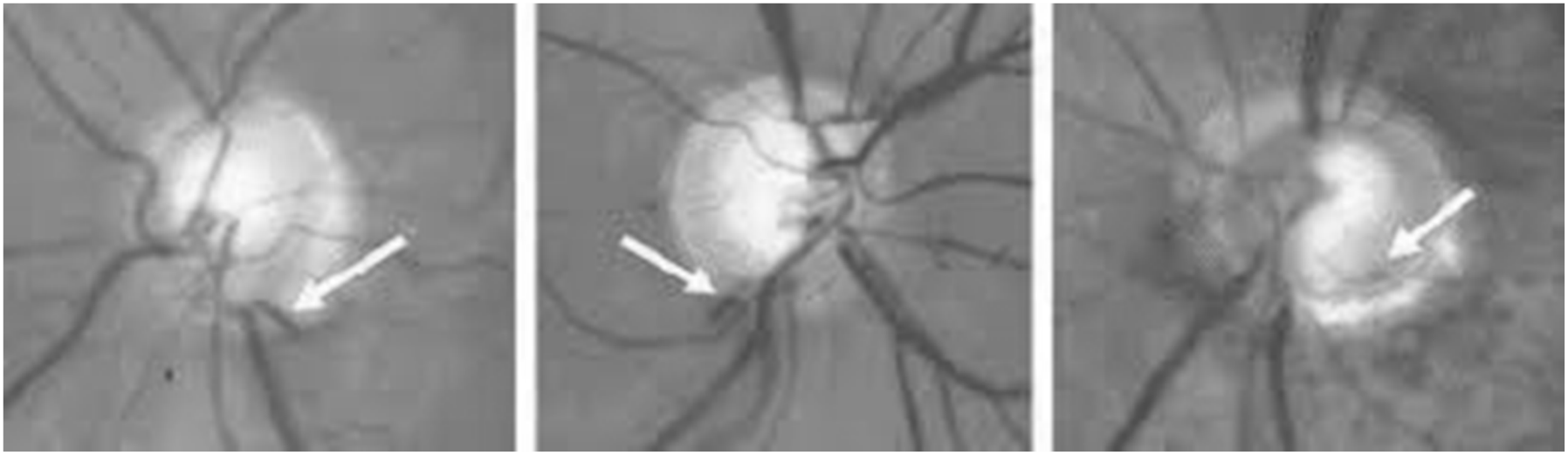
- **Exfoliative Glaucoma** (aka pseudoexfoliative glaucoma) occurs when a flaky, dandruff-like material peels off the outer layer of the lens within the eye. The material collects in the angle between the cornea and iris and can clog the drainage system of the eye, causing eye pressure to rise.
- **Pigmentary Glaucoma** occurs when the pigment granules that are in the back of the iris (the colored part of the eye) break into the clear fluid produced inside the eye. These tiny pigment granules flow toward the drainage canals in the eye and slowly clog them, causing eye pressure to rise.

Secondary Glaucoma

- **Uveitic Glaucoma** — Uveitis is swelling and inflammation of the uvea, which provides most of the blood supply to the retina. Increased eye pressure in uveitis can result from the inflammatory process itself or the medication (steroids) used to treat it. (365.62/H40.41)
- **Congenital Glaucoma** occurs in babies when there's incorrect or incomplete development of the eye's drainage canals during the prenatal period. This is a rare condition that may be inherited. When uncomplicated, microsurgery can often correct the structural defects. Other cases are treated with medication and surgery. (743.21/Q15.0)

Drance Heme

- Drance hemes are a risk factor for glaucoma and are **disc hemorrhages** that lie within the peripapillary retinal nerve fiber layer. They occur often in patients with **normal-tension glaucoma**.



How do I report a Drance heme?

- The term is **not** in ICD-9 nor ICD-10.
- 377.42 Hemorrhage in optic nerve sheaths
- But more certified coders listed this condition as:
- **362.81 Retinal Hemorrhage**
- **H35.6* is the ICD-10 crosswalk.**
- A few listed 379.21: Vitreous degeneration (I don't think so)

- Yes, Virginia, there will be disagreement among experts, certified coders, and providers!

Family and Personal History Codes

- **Z83.****: Report a family history code for those patients with a refraction Dx and a family history of eye disease; it's proper coding.

Z65.2		**Malingerer** [person feigning illness **[V65.2]**
Z83.3		**Family history of diabetes mellitus**
Z83.49		Family history of other endocrine, nutritional and metabolic diseases
Z83.511		**Family history of glaucoma**
Z91.19		**Patient's noncompliance with other medical treatment and regimen [V15.81]**

Reporting Glaucoma and Dry Eye Syndrome

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN **NPI Number**

19. RESERVED FOR LOCAL USE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **365.02 anat. narrow angle glaucoma**
3. **375.15 DES**
2. **333.81 blepharospasm**
4. **250.00 DM Type II, controlled**

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	Units
10/15/2012		11		99214	25	1, 2, 4	1
10/15/2012		11		68761	E1	3	1
10/15/2012		11		68761	51 E2	3	1

MOD-51 is added to second procedure on other eyelid.

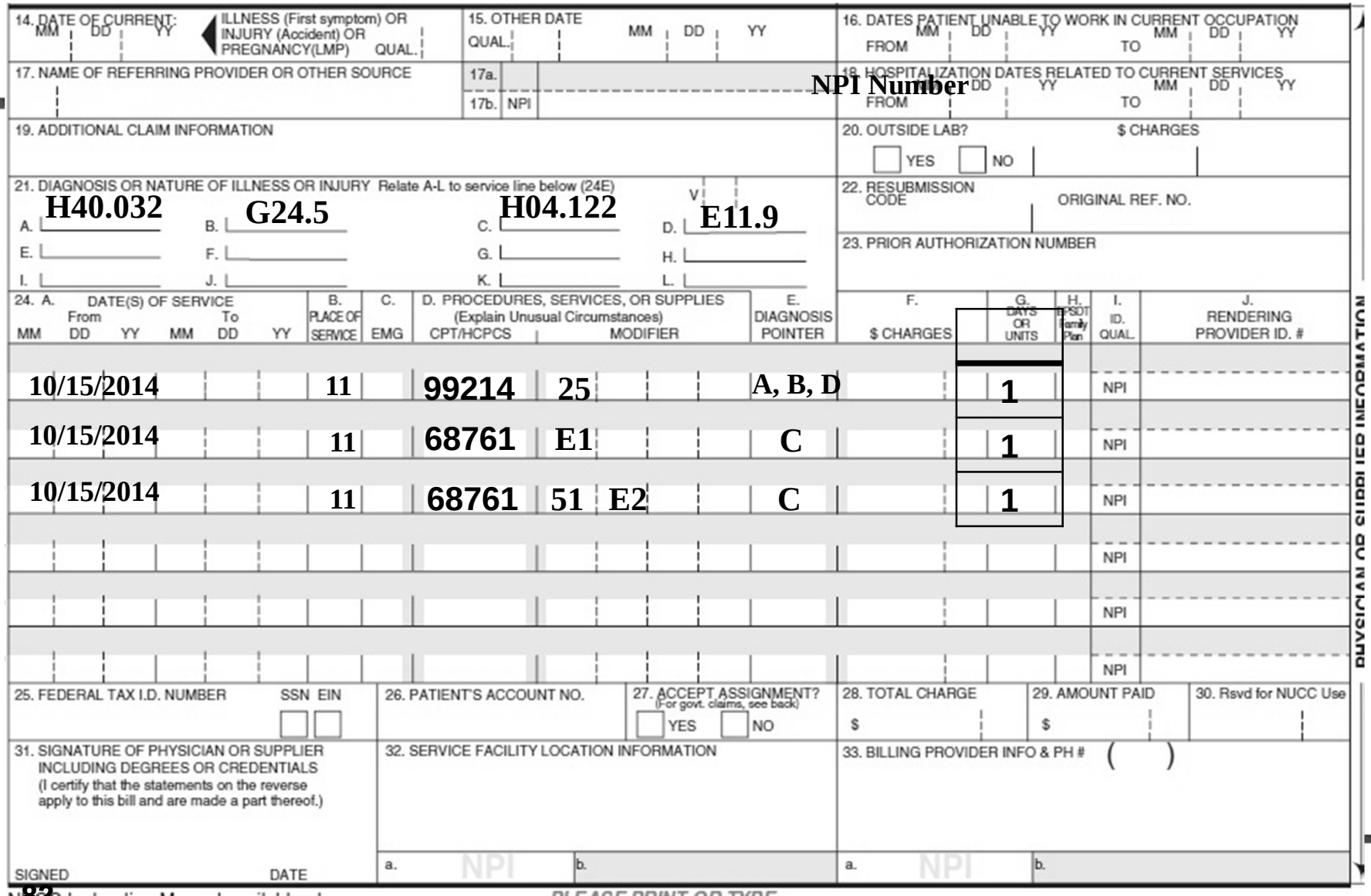
(For govt. claims, see back) YES NO

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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Reporting Glaucoma and Dry Eye Syndrome



ICD-9 to ICD-10 Conversion

- 365.02 anat. narrow angle glaucoma
- (A) H40.032 anat. narrow angle glaucoma, left eye
- 333.81 Blepharospasm
- (B) G24.5 Blepharospasm [no laterality]
- 375.15 Tear Film insufficiency (DES)
- [C] H04.122 Dry Eye Syndrome of left lacrimal gland.
- 68761-E1 punctal plug insertion upper left [Linked]
- 68761-E2 punctal plug insertion lower left [Linked]
- 250.00 DM II, controlled
- (D) E11.9 DM II, w/o complications

OCT performed as Technical component only

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN
19. RESERVED FOR LOCAL USE	

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) →

1. 365.11 POAG
2. 365.72 Moderate stage
3. ____.__
4. ____.__

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	Units
10/15/2012		11		92133	TC	1,2	1

Note: Other clinic performs and reports technical component.

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO
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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	

E & M and OCT: Professional component only

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

19. RESERVED FOR LOCAL USE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 365.11 POAG
2. 365.72 Moderate stage
3. ____.__
4. ____.__

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	Units
10/15/2012		11		99213	25	1, 2	1
10/15/2012		11		92133	26	1, 2	1

Note: Other clinic performs and reports technical component.

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

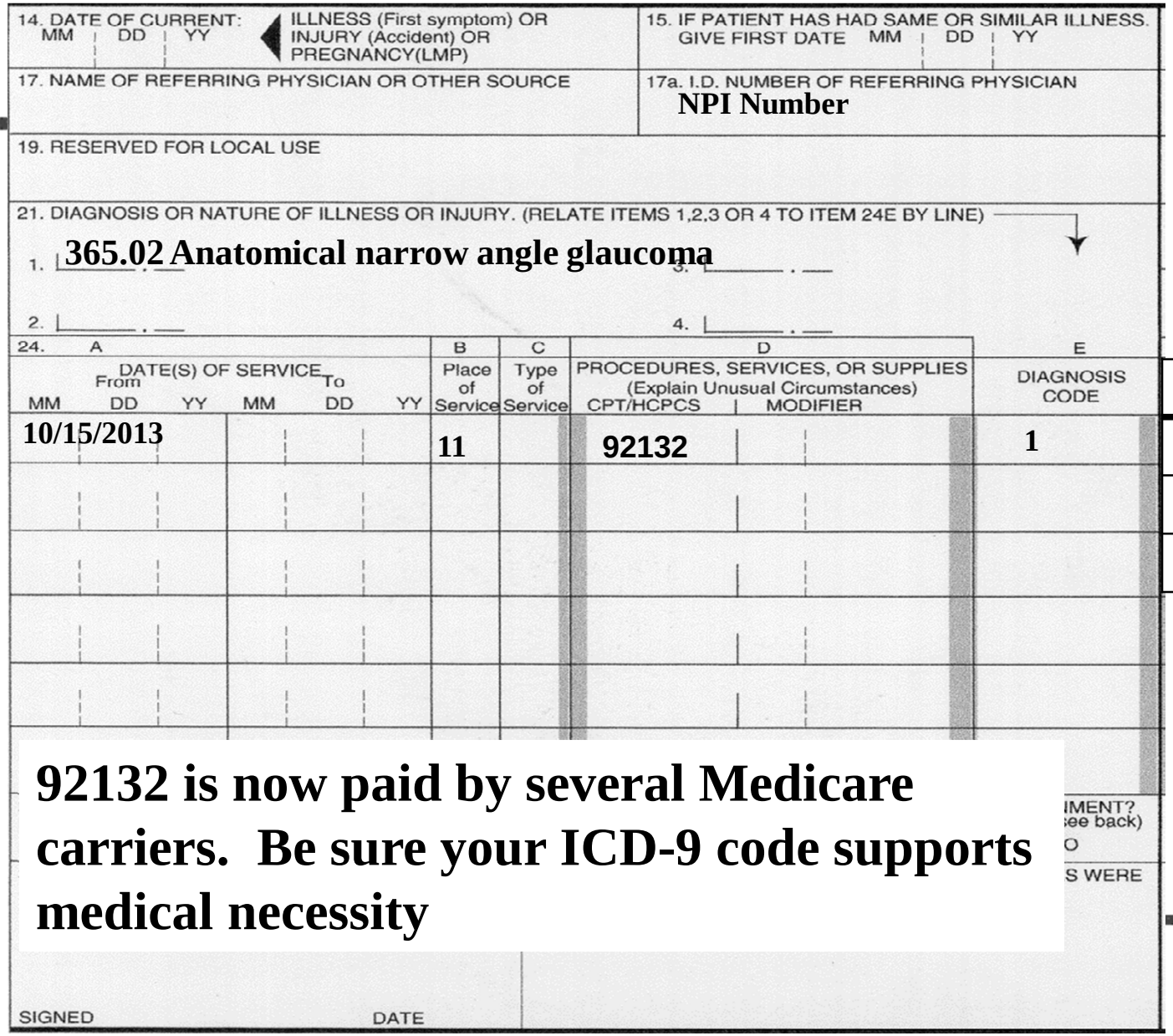
92132 – **Anterior Segment OCT**

- Anterior segment OCT is rapidly becoming a valuable tool for managing some glaucoma patients.
- Assess angle structure in glaucoma patients with **narrow** or suspicious angles.
- Ability to perform scans in the dark.
- Use OCT as a complement to gonioscopy.

92132 – **Anterior Segment OCT**

- Get an ABN waiver signed in case of denial. Append MOD-GA to the CPT code. More carriers may pay on this in 2014. Several Medicare Jurisdictions pay on it.
- 365.02 Anatomical narrow angle

92132 – Anterior Segment OCT – ICD-9



14. DATE OF CURRENT: MM | DD | YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

NPI Number

19. RESERVED FOR LOCAL USE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **365.02 Anatomical narrow angle glaucoma**

2. ____ . __

3. ____ . __

4. ____ . __

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	Units
10/15/2013						**11**		**92132**		**1**	1

92132 is now paid by several Medicare carriers. Be sure your ICD-9 code supports medical necessity

IMENT? (see back)

S WERE

SIGNED DATE

92132 – Anterior Segment OCT – ICD-10

14. DATE OF CURRENT: MM | DD | YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

NPI Number

19. RESERVED FOR LOCAL USE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

H40.033, Anatomical narrow angle glaucoma bilateral

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	Units
10/15/2015						**11**		**92132**		**1**	1

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

92132 – **Anterior Segment OCT**

- **ICD-10 Code**
- H40. 033, Anatomical narrow angle glaucoma bilateral

I am teaching ICD-10 for Eyecare

- It is a full, six-hour training session. It is ARBO, COPE approved for six-hours of CE credit.

- Nov 11 Reno Nevada
- Nov 12 **Sacramento CA**
- **Very likely LA and San Diego sometime next year.**
- Contact Cross Country Education for more information. Phone number is 800.397.0180. E-mail is customerservice@CrossCountryEducation.com

- The complete course is also available as on-demand, recorded video 24/7 through the EyeCodingForum.com website.

Coding, Billing, and Documentation for Glaucoma Patients
Nov 8 2014

Any Questions?

Jeffrey Restuccio, CPC, CPC-H, MBA
Memphis TN
(901) 517-1705
jeff@eyecodingforum.com
www.EyeCodingForum.com

Additional Information

- Glaucoma Resources
- Miscellaneous Concepts
- Documentation Recommendations
- Visual Evoked Potential Information

Medicare Educational Training (MLN)

- **Medicare Vision Services** – This fact sheet is designed to provide education on Medicare coverage and billing information for vision services. **PDF**
- **(MLN Product) Glaucoma Screening** - This brochure provides a basic overview of Medicare's glaucoma screening benefit. **PDF**

Ophthobook.com

- This is a Basic Medical Eyecare manual. Organized by ten chapters (134 pgs). The PDF files below are free to download:

1. History and Physical
2. Basic Eye Anatomy
3. **Glaucoma**
4. Retina
5. Infection
6. Neurology
7. Pediatrics
8. Trauma
9. Optics
10. Lens & Cataract

Medicare PFSRVU database

- Physician Fee Service and Relative Value Unit database. An ASCII/excel file on the Medicare website. It is free to download.
- Includes:
  - RVU data
  - Bilateral surgery modifier
  - Global Days
  - Breakable or not breakable NCCI edit flag.
  - Professional and Technical Component
  - Much more.

Relative Value Units (RVU's)

- Relative Value Unit
- All reimbursable procedures/services have an RVU value.
- E & M codes, surgical procedures, diagnostics, labs, radiology.
- Small procedures have low RVU
- Large procedures have high RVU's
- Determines your reimbursement.
- EyeCodingForum Coding Advisor has RVU's
- Coding specialty manuals
- List CPT codes in decreasing RVU value.
- **Not i**n the CPT manual.

Keys to accurate documentation

- Be consistent.
- A good Progress Note or Surgical Operative Report **form** = good documentation. Don't assume your EMR covers everything you need (e.g., binocularity).
- Strive for consistent terminology and explanations of procedures when providers are from different schools or countries.
- Be careful of using abbreviations or acronyms.
- Have a master document that clarifies terms for common, unusual or difficult procedures.
- Avoid any contradictions or inconsistencies in the documentation. The ROS and Exam should not contradict one another.

Documentation Basics

- Always use an ink pen (black is preferred).
- Never document with a pencil.
- Your notes must be legible! Illegible notes are the same as no documentation.
- Be sure to record documentation as soon as possible during or after the procedure (in a timely manner).
- Be sure to date and time entries.
- If it is not documented, it did not happen.

Acronyms and Abbreviations

- Avoid illegal abbreviations.
- Don’t use any abbreviations that someone in your specialty would not immediately recognize.
- Create a master list of commonly used abbreviations by specialty.
- See List of Prohibited Abbreviations (US).
- JCAHO will have a list of prohibited abbreviations as well (e.g., OD and OS).

Visual Evoked Potential

- Most often performed in a neurologist office some optometrists, nationwide, are using this technology. It is reimbursed by Medicare and other insurance carriers. Recently the Texas Optometric Association conducted a seminar on the topic. The full presentation is available at:
- http://texas.aoa.org/Documents/TX/2013%20Convention/OD%20Handouts/112_Growing%20Your%20Practice%20With%20Electrodiagnostic%20Testing_Craig%20Thomas.pdf
- Or google “VEP Texas Optometric Association”.
- Following is an edited excerpt.

Visual evoked potential (VEP)

- A visual evoked potential or evoked response is an electrical potential recorded from the nervous system of a human following presentation of a visual stimulus. Use to evaluate the following:
- Optic nerve atrophy
- Primary optic atrophy – 371.11
- Glaucomatous optic atrophy – 377.14
- Partial optic atrophy – 377.15
- Ischemic optic neuropathy
- Papilledema
- Optic disc drusen
- Identification and follow-up for conversion disorder
- To evaluate persons reporting subjective blindness or loss of vision with no known physiological cause.

Types of VEP

- Monocular pattern reversal (most common)
- Sweep visual evoked potential
- Binocular visual evoked potential
- Chromatic visual evoked potential
- Hemi-field visual evoked potential
- Flash visual evoked potential
- LED Goggle visual evoked potential
- Motion visual evoked potential
- Multifocal visual evoked potential
- Multi-channel visual evoked potential
- Multi-frequency visual evoked potential
- Stereo-elicited visual evoked potential
- Steady state visually evoked potential

Open-Angle Glaucoma: Risk Factors

- Vertically elongated cup-to-disc ratios
- Asymmetric cup-to-disc ratios
- IOPs greater than 21 mm Hg, risk begins to increase at IOPs above 16 mm Hg
- Intraocular pressure asymmetry > 5 mm Hg
- Advancing age
- Black or Hispanic race
- Thin corneas, if IOP is elevated
- Family history
- Medical history (e.g., metabolic syndrome)

VEP

- Electrophysiological studies suggest that glaucoma must not be considered as a disease exclusively involving ocular structures, but is a pathology in which brain structures are also damaged.
- **First indication** involves the early impairment of the ganglion cells of the outer retina
- **Second indication** involves the impairment of the brain's postretinal visual pathways secondary to transynaptic degeneration.
- **Third indication** involves impairment of brain.

Billing

Procedure	CPT Code	Diagnosis	Fees
Examination	92014	365.01	$100
Refraction	92015	365.01	$ 20
Visual Field Exam	92083	368.40	$ 70
Fundus Photography	92250	377.15	$ 70
Visual Evoked Potential	**95930**	**377.32**	**$ 130**

VEP Waveform in Glaucoma

- Delayed P100 peak time of the low-contrast VEP response is the usual finding in patients with glaucoma.
- Decreased P100 amplitude of the low-contrast and/or high-contrast VEP response and wave shape perturbation may be found in patients with glaucoma.
- Ocular hypertensives who develop glaucoma do not consistently have abnormal VEP waveforms.
- **Recent research suggests that glaucomatous changes can be detected with VEP testing before measurable visual field defects are detected.**