

GLAUCOMA BILLING BASICS AND CODING CONSIDERATIONS



Ensure you're receiving the appropriate reimbursement for the care you're providing.

BY THOMAS R. CHEEZUM, OD, CPC, COPC

As more ODs incorporate glaucoma treatment as part of the medical eye care portion of their practice, it is critical they understand how to use the correct CPT and ICD-10 codes. Without proper coding, a practice will not receive correct or timely payment for their services. Helpful resources include the CPT and ICD-10 code books and the CMS National Coverage Determination and Local Coverage Determination publications.¹⁻³ Frequent changes in codes require providers and their billing staff to stay updated on the latest versions.

STAGING

The stages of glaucoma are glaucoma suspect and mild, moderate,

or severe glaucoma. Included in the glaucoma ICD-10 codes are "Unspecified" and "Indeterminate" codes for staging. Avoid the

"Unspecified" code because most payors will deny payment for them. If the stage of glaucoma has not yet been determined, apply the

AT A GLANCE

- ▶ If the stage of glaucoma has not yet been determined, apply the "Indeterminate" code.
- ▶ A patient is classified as a low- or high-risk glaucoma suspect based on risk factors.
- ▶ When billing for glaucoma office visits, the 992xx E/M codes should be used. In the case of an initial or annual examination, a 992x4 code is usually the most appropriate.

PROVIDERS WHO UNDERSTAND THE PROPER USE OF CPT AND ICD-10 CODES IN GLAUCOMA CARE, AS WELL AS HOW TO DETERMINE THE APPROPRIATE TESTING AND FREQUENCY OF TESTING FOR BILLING PURPOSES, WILL FIND THE CARE OF PATIENTS WITH THIS DISEASE TO BE BOTH PROFESSIONALLY AND FINANCIALLY REWARDING.

“Indeterminate” code. Based on the type and stage of glaucoma, the most specific ICD-10 code(s) within the H40 to H42 code set should be billed. The ICD-10 codes for at-risk patients fall in the H40.01* to H40.03* range.

A patient is classified as a low- or high-risk glaucoma suspect based on risk factors (eg, African American or Hispanic, family history of glaucoma, diabetes, thin central corneal thickness, elevated IOP, pseudoexfoliation or pigment dispersion, and/or abnormal anterior chamber angles). Those with two or fewer risk factors are considered low risk; those with three or more are considered high risk.

Medicare will pay for annual screenings for high-risk glaucoma suspects if the evaluation includes IOP measurement and dilated fundus examination. The two screening codes are G0117 (when performed by an OD or MD) and G0118 (when performed under the direct supervision of an OD or MD). Glaucoma evaluation tests must be medically necessary independent of and in conjunction with each other in order to qualify for reimbursement.

BILLING

An important consideration when billing for testing is both the frequency of testing and the quantity of same-day testing. Medicare suggests the frequency of visual field testing be based on the stage of glaucoma: one time per year for patients with borderline/stable glaucoma, two times per year for those with moderate glaucoma, and four times per year for patients with severe/advanced glaucoma.⁴ When performing multiple tests on the same date of service, a payment policy called Multiple Procedure Payment Reduction comes into play, under which the highest-paying test is paid in full and each subsequent test payment is reduced by approximately 20%. Medicare and commercial insurers adhere to this policy.

When billing for glaucoma office visits, the 992xx E/M codes should be used. In the case of an initial or annual examination, a 992x4 code is usually the most appropriate. For periodic progress visits to monitor the efficacy of a patient's treatment, 99213 (stable) or 99214

(progression) should be used. If social determinants of health play a role in a patient's care, 99214 is usually appropriate to apply to all office visits for glaucoma. These health factors, such as homelessness, financial instability, and transportation barriers, should be documented accordingly, and the appropriate ICD-10 code from the Z55 to Z65 code set should be applied, with the Z code(s) listed after the ICD-10 code(s).

Add-on code G2211 was recently adopted by Medicare and is usually accepted by commercial insurers. The G2211 code can be used when a provider offers continued care for a single serious or complex problem over a period of time, and it supplies additional reimbursement for the care. It is appropriate to bill this code, in addition to the appropriate 992xx code, for every glaucoma visit.

WIN-WIN

Providers who understand the proper use of CPT and ICD-10 codes in glaucoma care, as well as how to determine the appropriate testing and frequency of testing for billing purposes, will find the care of patients with this disease to be both professionally and financially rewarding. As billing and coding in the ocular space are constantly changing, be sure to take advantage of available resources to stay updated on the information you are providing and applying ■

1. CPT 2025 Professional Edition. American Medical Association; 2025.
2. ICD-10-CM Expert for Physicians. American Academy of Professional Coders; 2025.
3. Centers for Medicare and Medicaid Services. Accessed December 5, 2024. www.cms.gov
4. Local Coverage Determination. Centers for Medicare and Medicaid Services. Accessed December 5, 2024. www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=34394&ver=26

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