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Optometry Coding & Billing Alert

Glaucoma Evaluation: Determine Eligibility Before Looking to G0117 or G0118

The answers to the 2 questions below could bring $135 in to your practice.

Choosing the correct code for a glaucoma screening can be tricky -- add in Medicare's complicated eligibility requirements and you could be seeing red every time your optometrist performs a screening service. Let our expert answers to your two top glaucoma screening questions put you on the right track for screening reimbursement you can rely on.

Question 1: Which Patients Qualify for Glaucoma Screenings?

Make sure you know the definition of "high-risk patients" and how to determine if a patient is eligible for Medicare coverage for glaucoma screenings before reporting your optometrist's services to Medicare. Patients who are considered high-risk are eligible for a screening glaucoma exam once every 12 months.

Since Jan. 1, 2002, Medicare has reimbursed practices for screening patients who meet the definition of high-risk for the disease. Currently, there are four high-risk categories the patient could fall into.

Those eligible for the screening now include:

- people with a family history of glaucoma
- people with diabetes mellitus (250.xx)
- blacks age 50 and older
- Hispanics age 65 and older.

Remember: An optometrist or ophthalmologist who is legally authorized to perform such services in the state where the services are furnished must perform or supervise the screening.

This is not a routine exam, notes **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas. The patient is presenting with an actual concern about the health of his eyes. The exam is also not medical since the patient hasn't ever been diagnosed with the illness or had another eye-related problem to deal with, Gibson explains.

What's involved: According to Medicare's guidelines, a qualifying glaucoma screening exam consists of:

- a dilated eye examination with an intraocular pressure measurement and
- a direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination.

Tip: Visit www.cms.hhs.gov/glaucomascreening to read more on Medicare's glaucoma screening guidance.

Question 2: Which CPT Codes Should I Report?

You have two coding options for reporting glaucoma screenings to Medicare:

G0117 (Glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist) and G0118 (Glaucoma screening for high-risk patient furnished under the direct supervision of an optometrist or ophthalmologist).

Caution: Remember that using code G0117 or G0118 means you're unable to report several other services. If any other item (an exam or any diagnostic tests like a visual field) is billed on the same day as the screening, the screening will bundle into that code and will not be paid separately.

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Codes G0117 and G0118 both include a dilated examination (DE), intraocular pressure (IOP) measurement, a test for visual acuity, and direct ophthalmoscopy or a slit-lamp biomicroscopic exam.

The National Correct Coding Initiative bundles G0117 and G0118 with E/M services 99201-99215, 99241-99245, 99315-99316, 99341-99345, 99347-99350 (all with an indicator of 1) and eye exam codes 92002-92014 (all with a 0 indicator) because the glaucoma screening and an ophthalmic evaluation are not payable on the same day.

Remember: A 0 indicator means that you may not unbundle the edit combination under any circumstances, according to NCCI guidelines. An indicator of 1 means that you may use a modifier to override the edit if the procedures are distinct from one another, such as on a separate encounter on the same date, on a separate anatomical site, or for a separate indication, explains **Maggie M. Mac, CPC,** CEMC, CHC, CMM, ICCE, director of Best Practices-Network Operations at Mount Sinai Hospital in New York City.

You also can't report the following codes with a glaucoma screening: 92100 (Serial tonometry [separate procedure] with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day [e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure]),

92120 (Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method),

92130 (Tonography with water provocation) and 92140 (Provocative tests for glaucoma, with interpretation and report, without tonography).

Tip: You cannot report another office visit or consultation for a patient on the same day you're reporting the glaucoma screening. When your optometrist diagnoses or suspects glaucoma, you may want to report an E/M code instead of the glaucoma screening code if the provider documented all of the elements for reporting an E/M service. This allows the provider to order and perform diagnostic tests at this same session. Medicare allows around $46 for the glaucoma screening, compared with $135 for a 92004 or $110 for a 92014.

If, after a finding of glaucoma, the provider decides to perform a complete evaluation and management service at the same encounter, then the glaucoma screening is included in the work performed for the E/M code and not separately reportable.

Note: Payers other than Medicare don't recognize G0117 and G0118. Check with your individual payers on how they want you to report glaucoma screenings and if they will even pay for them.