**Glaucoma surgical coding remains a challenge**

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Glaucoma affects over two million Americans. Although only the minority of these patients requires surgery, the overall volume of these procedures is still relatively high. The number of trabeculectomies alone performed on Medicare beneficiaries approximates 40,000 annually. Coding and reimbursement for glaucoma surgery therefore has a significant impact nationally, as well as for many ophthalmology practices.

Glaucoma surgery is an evolving field. Generally speaking, the "tried and true" glaucoma procedures are designated in CPT as "Category I" codes. Payment for these procedures is largely standardized. Category I codes include not only trabeculectomy, iridotomy, and laser trabeculoplasty, but also glaucoma seton procedures such as placement of Molteno and Baerveldt valves (coded as CPT 66180). Wrapping a valve is coded as CPT 67255, Scleral reinforcement (separate procedure); with graft, which is also a Category I code.

Some of the recently-developed glaucoma procedures have been granted "Category III" CPT status, which means that the involved technology is judged to be "new." Unlike the situation for Category I codes, payment for Category III codes is not standardized.

There is disparity between payers' coverage policies for glaucoma surgery, especially with regard to newer procedures. Certain payers will consider glaucoma surgery medically necessary only for patients that are progressing despite specified levels of medical treatment.

Modifiers pay a particularly significant role when coding for glaucoma surgery. One reason is because additional operations and services performed within a 90 day period are frequently included in the payment for the major surgery. This rule is part of the concept known in the Medicare program as the "global surgical package."

There are many services, however, that do not fall within global surgical restrictions. Testing (e.g., visual fields, fundus photography), for example, is billable at any point postoperatively. No modifier is required.

It is crucial to understand modifiers thoroughly in order to receive payment postoperatively when indicated. Modifier -58 is "Staged or Related Procedure or Service by the Same Physician During the Postoperative Period." This modifier is used for 5-FU injections provided in the global period of trabeculectomy, assuming the injections were planned preoperatively.

The code for subconjunctival injection is CPT 68200. If this code is billed without the -58 modifier, it will be kicked out by the payer's computer since the service is within the

postoperative period of the trabeculectomy. Correct coding would be 68200-58 in addition to the HCPCS supply code J9190 with the correct number of fluorouracil units.

Modifier -78 was changed in 2008 to read: "Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period." This is the "complications" modifier.

Assume there is a conjunctival leak following trabeculectomy that requires suturing in the operating room within the global period of the trabeculectomy. The repair code CPT 66250, Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure, will require the -78 modifier in order to be paid under Medicare's rules.

Another -78 modifier situation arises when drainage of a choroidal effusion is performed within the global period of a trabeculectomy. Appropriate coding for the second procedure is CPT 67015, Aspiration or release of vitreous, subretinal, or choroidal fluid, pars plana approach (posterior sclerotomy), with the -78 modifier.

Newer interventions for glaucoma include canaloplasty with iScience's iTrack illuminated microcatheter. This is reported with Category III CPT code 0177T, Transluminal dilation of aqueous outflow canal; with retention of device or stent. The new (2009) Category III code 0192T, Insertion of anterior segment aqueous drainage

device, without extraocular reservoir, external approach, is used to report both the AquaFlow Collagen Glaucoma Drainage Device and the Ex-PRESS mini glaucoma shunt.

Other Category III codes relevant to glaucoma surgery include 0176T, Transluminal dilation of aqueous outflow canal; without retention of device or stent, and 0191T, Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach.

Laser surgery is reported very frequently in both the Medicare and non-Medicare populations. Both argon laser trabeculoplasty and selective laser trabeculoplasty are coded to CPT 65855. For Medicare and selected other payers, the global period associated with trabeculoplasty is ten days.

Payers sometimes impose limitations on proceeding to, and billing for, trabeculoplasty. Many doctors have used the results of the Glaucoma Laser Trial of the 1990s to support early treatment with laser.

It is somewhat common to measure persistently high pressures despite a recent trabeculoplasty. If a Medicare patient goes to the operating room for a trabeculectomy within 10 days of a trabeculoplasty, the trabeculectomy code (CPT 66170 or 66172) should be paid if the -58 modifier is used. This scenario fits one of the applications for

the -58 modifier, namely a “lesser procedure” followed by a “greater procedure” within the global period of the first procedure.

Be sure to check the global period associated with trabeculoplasty for different payers, as not all adhere to the ten day global period assigned by Medicare. This illustrates the point that payers are generally free to set their own policies.

Coding for glaucoma surgery is not always straightforward, but can be rewarding when approached with fundamental concepts in mind. Make the effort to learn the rules.