Primary Open-Angle Glaucoma

Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

Coding Specifications

Codes required to document patient has primary open-angle glaucoma and a visit or procedure for ophthalmologic services occurred:

A line item ICD-9-CM diagnosis code for primary open-angle glaucoma and a CPT service code are required to identify patients to be included in this measure.

All measure-specific coding should be reported ON THE SAME CLAIM.

Primary open-angle glaucoma line item ICD-9-CM diagnosis codes

- 365.10, 365.11, 365.12, 365.15 (open angle glaucoma)

AND

CPT service codes

- 92002, 92004 (ophthalmological services — new patient),
- 92012, 92014 (ophthalmological services — established patient),
- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult),
- 99307, 99308, 99309, 99310 (nursing facility),
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 (domiciliary)

Quality codes for this measure:

CPT II Code descriptors

(Data collection sheet should be used to determine appropriate code or combination of codes.)

- ***CPT II 3284F:*** Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level
- ***CPT II 3285F:*** Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level
- ***CPT II 3284F–8P:*** IOP measurement not documented, reason not otherwise specified
- ***CPT II 0517F:*** Glaucoma plan of care documented
- ***CPT II 0517F–3P*** [1]***:*** Glaucoma plan of care not documented for system reason(s)
- ***CPT II 0517F–8P:*** Glaucoma plan of care not documented, reason not otherwise specified

[1]The system reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for primary open-angle glaucoma.