
Surgery: Eye and Ocular Adnexa

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This section contains information to help providers bill for eye and ocular adnexa surgical procedures. Additional information about eye surgeries is located in the *Ophthalmology* sections of this manual.

Retinal Surgery: Repetitive Services

Descriptors for CPT® codes 67141, 67145, 67208, 67210, 67218, 67220, 67227 and 67228 include all sessions in a defined treatment period. Therefore, these codes must not be billed more than one time in a 90-day period for services rendered on an individual eye, regardless of the number of sessions, except in the case of retinoblastoma. When treating both the left and right eyes within the 90 days, providers must include documentation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim to substantiate surgery for the contralateral eye. The following are guidelines for billing repetitive retinal surgery:

- «Code 67145 and 67228: The 90-day billing frequency restriction does not apply. The reimbursement follow-up days for these codes are ten days.»
- Code 67208 (destruction of localized lesion of retina [eg, macular edema, tumors], one or more sessions; cryotherapy, diathermy) or 67210 (...photocoagulation) and 67227 (destruction of extensive or progressive retinopathy [eg, diabetic retinopathy], cryotherapy, diathermy) or 67228 (treatment of extensive or progressive retinopathy, photocoagulation) will not be separately reimbursed for the same eye on the same date of service.
- Code 67208 or 67210 may be performed on and reimbursed for one eye and code 67227 or 67228 may be performed on and reimbursed for the contralateral eye on the same date of service.
- Code 67208 or 67210 will not be reimbursed within the 90-day period following reimbursement of 67227 or 67228 on the same eye.
- Code 67227 or 67228 may be performed and reimbursed within the 90-day period following reimbursement of 67208 or 67210 performed on the same eye.
- Retinoblastoma: The 90-day billing frequency restriction does not apply for codes 67208 or 67210 when billed in conjunction with ICD-10-CM diagnosis code C69.20 thru C69.22 (malignant neoplasm of retina) or if a *Treatment Authorization Request* (TAR) or Service Authorization Request (SAR) is present.

Reimbursement for ophthalmoscopy procedures (CPT codes 92227 thru 92240, 92250, 92260 thru 92287) is included in the reimbursement for the repetitive eye surgery procedure codes as part of the follow-up care. Instructions for billing these procedures (CPT codes 92227 thru 92240, 92250, 92260 thru 92287) when not performed with repetitive eye surgery procedure codes are located in the *Ophthalmology* section of this manual. Reimbursement for the ophthalmoscopy procedure codes is denied if billed within the 30-day follow-up period.

Retinal Surgery: Vitrectomy

Providers are not required to submit an invoice when billing for Vitrectomy CPT code 67040 (vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation). CPT code 67040 is payable to both surgeon and assistant surgeon. Providers must bill with the appropriate surgical modifier.

«Insertion of Capsular Bag Prosthesis

CPT code 0996T (Insertion and scleral fixation of a capsular bag prosthesis containing an intraocular lens prosthesis, with vitrectomy, including removal of crystalline lens or dislocated intraocular lens prosthesis, when performed) is reimbursable for primary surgeon services.

TAR Requirements

A *Treatment Authorization Request* (TAR) is required for CPT code 0996T.>>

Cataract Extraction Surgery

Provider must submit a *Treatment Authorization Request* (TAR) for cataract extraction surgery (CPT codes 66840, 66850, 66852, 66930, 66940, 66982, 66983, 66984, 66985, 66989, 66991). The TAR must demonstrate medical necessity for approval. Required documentation for TAR submission is indicated below:

Note: Assistant surgeons are not required to submit a TAR for cataract extraction surgery.

Medical Documentation

One of the following conditions must be documented on the TAR:

- Documentation of the patient's symptoms such as blurred vision, visual distortion, and/or glare with associated functional impairment such as diminished ability to perform instrumental activities of daily living (such as, reading, writing, driving, etc.) and
 - That the cataract is the cause for Snellen best-corrected visual acuities (BCVA) of 20/50 or worse in the affected eye or

- For patients with Snellen BCVA acuity of 20/40 or better, providers must submit documentation of one of the following symptoms:
 - ❖ Fluctuation of vision function due to glare or dim illumination (complaints of glare should be confirmed with Brightness Acuity Testing (BAT) or another suitable test)
 - ❖ Complaints of monocular diplopia or polyopia
 - ❖ Visual Disparity between the two eyes
- Documentation of lens induced disease such as phacomorphic glaucoma or phacolytic glaucoma
- Documentation that a clear media is required to adequately diagnose or treat other ocular conditions in the posterior segment of the eye (for example, diabetic retinopathy)

Bilateral Cataract Surgery

Cataract surgery is rarely performed on both eyes at the same time. The interval between surgeries should be based on the following factors:

- Patient's ability to provide informed consent for surgery on the second eye after evaluating the visual results and postoperative course of surgery of the first eye
- Adequate passage of time (3 to 4 weeks) to establish that vision in the operated-on eye has recovered sufficiently so that the patient is not at risk of injury due to functional impairment during cataract surgery of the second eye

If the TAR is requested for bilateral cataract surgery, the TAR may be approved with the "from/through" interval of six months if both eyes meeting criteria for cataract surgery as indicated in the *Medical Documentation* section. The TAR may only be approved for the worse eye if the better eye does not meet the criteria for cataract surgery. Providers will have to submit a new TAR for the better eye once it meets the criteria for surgery specified previously.

Reasons for TAR Denial

Cataract surgery is not considered medically necessary, even if a cataract is present, under the following conditions:

- If the recipient declines surgery,
- When the recipient's life-style is not compromised,
- When eyeglasses or visual aids provide satisfactory functional vision, or
- When the recipient is medically unfit for surgery

Examples of recipients considered medically unfit for surgery include those patients who are comatose, have organic brain syndrome, end stage Alzheimer's, or other conditions in which cataract surgery will not improve the recipient's independence.

ICD-10-CM Codes:

Providers must document one of the following ICD-10-CM diagnosis codes on the TAR to support medical necessity:

E08.36	H28
E09.36	Q12.0
E10.36	Q12.3
E11.36	T85.21XA thru T85.29XS
E13.36	Z96.1
H25.011 thru H26.9	Z98.41 thru Z98.49
H27.00 thru H27.139	

Note: Although one of the above diagnosis codes must be documented on the TAR for approval, it is not required to be included with the claim for reimbursement.

Supplies and Drugs with Cataract Surgery

Outpatient hospital departments and surgical clinics should include the following modifiers when billing supplies and drugs used during cataract extraction surgery procedures (CPT codes 66830 thru 66986):

- UA (surgical or non-general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code)
- UB (surgical or general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code)

Refer to the *Supplies and Drugs* section in this manual for more information.

Intra-Ocular Lens with Cataract Surgery

The following medical policies have been established for certain multiple surgeries when billed for a recipient, by the same provider, for the same date of service. Note the following information:

- Insertion of intra-ocular lens with cataract extraction (CPT codes 66982 thru 66984, <<66989, 66991>>) includes cataract removal as well as insertion of the intra-ocular lens.
- Secondary insertion of intra-ocular lens, subsequent to lens extraction (CPT code 66985), is reimbursable only as a second stage procedure on a date of service other than that of the cataract extraction.
- <<If CPT code 66982, 66983, 66984, 66985, 66987, 66988, 66989 or 66991 is billed on the same date of service as a cataract extraction (CPT codes 66830 thru 66940), only one procedure is separately reimbursable.>>

All surgical procedure codes require a modifier. Failure to submit a modifier with a surgical procedure code will result in the claim being returned to the provider for correction. Providers may refer to the *Surgery: Billing With Modifiers* section of the appropriate Part 2 manual for further billing information.

Posterior Capsulotomy

Surgical intervention is not often indicated less than 90 days after cataract surgery. If capsulotomy surgery is performed within 90 days of cataract surgery on the same eye, documentation justifying the need for the procedure must be included with the claim. Indication for a capsulotomy procedure performed less than three months after cataract surgery includes:

- Significant visual debility as defined on a following page under “Medical Documentation”
- Preoperative uveitis
- Chronic glaucoma
- Diabetes mellitus
- Prolonged use of pilocarpine hydrochloride

When a series of procedures is performed for the management of a secondary cataract, it will be covered as a single procedure.

Payment will only be allowed for the same physician or group once per patient per eye per 90 days, no matter how many YAG laser treatment sessions occur.

Medical Documentation

Capsulotomy is covered when all of the criteria listed below are met and clearly documented in the medical record. Documentation justifying the medical need for this procedure should be made available upon request by the Department of Health Care Services (DHCS).

- Objective evidence shows that a secondary cataract is present and impairs the patient's vision, and other eye disease, including but not limited to macular degeneration or diabetic retinopathy, has been excluded as the primary cause of visual functional disability.
- The patient has a significant visual debility defined as:
 - Best-corrected visual acuity of 20/40 or worse at distance or near; or additional testing shows one of the following:
 - ❖ Consensual light testing decreases visual acuity by two lines.
 - ❖ Glare testing decreases visual acuity by two lines.
- Visual impairment from secondary cataract affects the patient's ability to perform activities of daily living (such as reading, writing or driving).
- The patient has determined that he/she is no longer able to function adequately with the current level of visual function.
- Physician concurrence with significant patient-defined improvement in visual function can be expected as a result of capsulotomy.
- The patient has been educated about the risks and benefits of capsulotomy and the alternatives to surgery (such as the avoidance of glare or use of optimal eyeglasses prescription).
- The patient has undergone an appropriate preoperative ophthalmologic evaluation.

Capsulotomy is not covered:

- If performed concurrently with cataract surgery
- If performed prophylactically
- If scheduled routinely after cataract surgery without regard to whether there is clinically significant opacification of the posterior capsule

Billing Requirements

Posterior capsulotomy is reimbursable using the following CPT codes:

Table of Reimbursable Codes for Posterior Capsulotomy

Code	Explanation
66820	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife).
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages).

To support medical necessity for capsulotomy, claims must be submitted with one of the following ICD-10-CM diagnosis codes:

Table of ICD-10-CM Diagnosis Codes

Code	Diagnosis
H26.40	Unspecified secondary cataract
H26.411 thru H26.419	Soemmering's ring
H26.491 thru H26.499	Other secondary cataract
T85.21XA thru T85.29XS	Mechanical complication of intraocular lens

Claims must be submitted with either modifier LT (left eye), modifier RT (right eye) or modifier 50 (both eyes) on a single claim line.

If either code 66820 or 66821 is performed within 90 days of cataract surgery (defined as CPT codes 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984, 66985, «66989 or 66991») on the same eye, a copy of the operative report for the cataract extraction must be submitted and one of the following indications must be documented on the capsulotomy claim or on an attachment:

- Significant visual debility as defined on a previous page under “Medical Documentation”
- Preoperative uveitis
- Chronic glaucoma
- Diabetes mellitus
- Prolonged use of pilocarpine hydrochloride

Blepharoplasty and/or Repair for Blepharoptosis

Blepharoplasty procedure and/or a repair for blepharoptosis is reimbursable when it is considered medically necessary. The service is considered medically necessary when performed as functional/reconstructive surgery to correct one of the following:

- Impairment of near or far vision or visual field defect due to dermatochalasis, blepharochalasis or blepharoptosis
- Symptomatic redundant skin weighing down or upper lashes
- Chronic, symptomatic dermatitis of pretarsal skin caused by redundant upper lid skin
- Prosthesis difficulties in an anophthalmic socket

A blepharoplasty procedure and/or a repair for blepharoptosis is not a benefit when performed for cosmetic purposes.

ICD-10-CM Codes

ICD-10-CM diagnosis codes that support medical necessity include the following (not required for claim reimbursement):

D49.2	H02.70	L57.4
G51.0	H02.831 thru H02.839	L66.4
G51.2 thru G51.8	H02.89	L85.8
H02.031 thru H02.049	H05.211 thru H05.219	L85.9
H02.131 thru H02.139	H05.89	L87.1
H02.201 thru H02.209	H49.40 thru H49.43	L87.8
H02.221 thru H02.229	H50.89	L87.9
H02.30 thru H02.36	H53.40	L90.3 thru L90.5
H02.401 thru H02.439	L11.8	L90.8
H02.521 thru H02.529	L11.9	
H02.531 thru H02.539	L57.2	

ICD-10-CM Codes (continued):

L90.9	L98.5 thru L98.7	S01.139A thru S01.139S
L91.8	L99	S01.149A thru S01.149S
L91.9	Q10.0 thru Q10.3	S01.159A thru S01.159S
L92.2	Q18.9	S04.10XA thru S04.12XS
L94.8	S01.119A thru S01.119S	
L94.9	S01.129A thru S01.129S	

TAR Requirements

A *Treatment Authorization Request* (TAR) is required for a blepharoplasty procedure and/or a repair for blepharoptosis. When requesting a TAR or a Service Authorization Request (SAR), providers must include documentation of the patient complaints and either a photograph or the visual field examination printout.

Patient complaints must include one or more of the following:

- Interference with near or distance vision or visual field;
- Difficulty seeing at distance and/or near due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin; or
- Chronic blepharitis or dermatitis

Photographs must demonstrate one or more of the following:

- The upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex.
- The upper eyelid skin rests on the eyelashes.
- The upper eyelid indicates the presence of dermatitis.
- The upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmic socket.

Visual field examination must demonstrate a minimum of 12 degree or 30 percent loss of upper field of vision with upper lid skin and/or lid margin in repose and elevated (by taping the lid) to demonstrate potential correction by the proposed procedure or procedures.

Providers must conform to the following standards when submitting photographs:

- Prints not slides must be frontal, canthus-to-canthus with the head perpendicular to the plane of the camera (not tilted) to demonstrate a skin rash or position of the true lid margin or the pseudo-lid margin.
- The photos must be of sufficient clarity to show a light reflex on the cornea.
- If redundant skin coexists with true lid ptosis, additional photos must be taken with the upper lid skin retracted to show the actual position of the true lid margin (needed if both CPT code 15822 and 15823 are required and planned in addition to codes 67901 thru 67908).
- Oblique photos are only needed to demonstrate redundant skin on the upper eyelashes when this is the only indication for surgery.
- If both a blepharoplasty and a ptosis repair are planned, both must be individually documented. This may require two sets of photographs, showing the effect of drooping of redundant skin (and its correction by taping) and the actual presence of blepharoptosis.

Providers must conform to the following standards when submitting visual field examination printout:

- Record using either a Goldmann Perimeter (III 4-E test object) or a programmable automated perimeter (equivalent to a screening field with a single intensity strategy using a 10dB stimulus) to test a superior (vertical) extent of 50 to 60 degrees above fixation with targets presented at a minimum 4 degree vertical separation starting at 24 degrees above fixation while using no wider than a 10 degree horizontal separation.
- Each eye should be tested with the upper eyelid at rest and repeated with the lid elevated to demonstrate an expected “surgical” improvement meeting or exceeding the criteria.
- A tangent screen visual field is also acceptable and must be performed at 1 meter with a 2 mm to 5 mm white test object.

Keratoplasty

The following new CPT code must be billed “By Report.”

<u>CPT Code</u>	<u>Description</u>
65757	Backbench preparation of corneal endothelial allograft prior to transplantation

Keratoprosthesis

Keratoprosthesis (CPT code 65770) is reimbursable for the treatment of corneal blindness after standard corneal transplant involving tissue transplanted from human donors has failed or when such a transplant would be unlikely to succeed.

Documentation Requirements

CPT code 65770 requires a *Treatment Authorization Request* (TAR). Providers must include the following documentation when submitting a TAR request:

- History of multiple (two or more) failed corneal grafts, with poor prognosis for further grafting; or
- History of bilateral blindness; best-corrected visual acuity less than 20/400 in affected eye and additionally with lower than optimal vision in the opposite eye for which corneal transplantation is not an option.

TAR Diagnosis Code Requirement

The TAR for CPT code 65770 must include one of the following ICD-10-CM diagnosis codes to support medical necessity (not necessary for claim reimbursement):

A18.59	H18.311 thru H18.319	S05.10XA thru S05.12XS
A71.1	H18.451 thru H18.459	S05.20XA thru S05.32XS
B94.0	«H18.501 thru H18.509»	S05.50XA thru S05.52XS
E50.6	«H18.521 thru H18.549»	S05.8X1A thru S05.92XS
H16.071 thru H16.079	«H18.591 thru H18.629»	T26.10XA thru T26.12XS
H16.441 thru H16.449	H18.821 thru H18.839	T26.60XA thru T26.62XS
H16.8	L12.1	T85.318A thru T85.398S
H17.00 thru H17.9	Q13.3	«T86.8401 thru T86.8419»
H18.011 thru H18.029	Q13.4	
H18.10 thru H18.20	S05.00XA thru S05.00XS	

Placement of Amniotic Membrane

The following CPT codes should be used for placement of amniotic membrane on the ocular surface for wound healing:

«Table of CPT Codes Used for Placement of Amniotic Membrane»

CPT Code	Description
65778	Without sutures
65779	Single layer, sutured

Note: Do not report codes 65778 and 65779 with codes 65430, 65435 and 65780.

Diagnosis Restrictions

CPT codes 65778 and 65779 are reimbursable with the following ICD-10-CM diagnosis codes:

B00.50 thru B00.59	H16.001 thru H16.079	L12.1
B02.30 thru B02.39	H16.8	L12.30
B05.81	H18.10 thru H18.13	L12.31
C69.00 thru C69.92	H18.211 thru H18.219	L12.35
D49.89	H18.40	L51.1 thru L51.3
H01.001 thru H01.02B	H18.421 thru H18.429	Q81.0 thru Q81.9
H02.011 thru H02.019	H18.461 thru H18.469	Q82.8
H10.401 thru H10.439	H18.49	Q82.9
H10.44 thru H10.45	H18.821 thru H18.829	T26.00XA thru T26.92XS
H11.001 thru H11.069	H40.10X0 thru H40.1194	T81.31XA thru T81.31XS
H11.231 thru H11.249	H40.9	T81.33XA thru T81.33XS
H11.821 thru H11.829	H59.40 thru H59.43	

Insertion of Ocular Telescope Prosthesis

The insertion of an ocular telescope prosthesis with removal of crystalline lens is reimbursable with CPT code 66999 (unlisted procedure, anterior segment, eye) when billed in conjunction with HCPCS codes C1839 (iris prosthesis) and C1840 (lens, intraocular, [telescopic]).

When billed for this service, unlisted code 66999 is not reimbursable with CPT codes 65800 thru 65815, 66020, 66030, 66600 thru 66635, 66761, 66825, 66982 thru 66986 or 69900 on the same day for any provider. Reimbursement is determined case-by-case and is based on the submitted invoice. A copy of the operative report is required for code C1840.

Documentation Requirements

CPT code 66999 requires a TAR. Providers must document all of the following:

- Patient has irreversible, end-stage Age-Related Macular Degeneration (ARMD) resulting from either dry or wet ARMD in both eyes with vision stable, but severe visual impairment (best-corrected Snellen equivalent distance acuity of 20/160 to 20/800) in both eyes, and
- Patient is not responding to drug treatment of ARMD, and
- Patient has no history of cataract surgery in the eye in which the ocular telescope prosthesis will be implanted, and
- Patient is 75 years of age or older, and
- Patient's vision improves with external telescope and has adequate peripheral vision in non-operative eye, and
- Patient has been diagnosed with qualifying macular degeneration (ICD-10-CM diagnosis codes H35.30 thru H35.3293).

Reasons for TAR Denial

Ocular telescope prosthesis is not considered medically necessary, even if end-stage non-treatable ARMD is present, under the following conditions:

- If the recipient declines surgery
- When the recipient's quality of life is not compromised
- When eyeglasses or other external visual aids provide satisfactory functional vision, or
- When the recipient is medically unfit for surgery

Phakic Intraocular Lens

HCPCS code S0596 (phakic intraocular lens for correction of refractive error) requires authorization. Documentation of a bilateral procedure is required.

Aqueous Shunt

CPT codes 66179 (aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft) and 66184 (revision of aqueous shunt to extraocular equatorial plate reservoir; without graft) are reimbursable for both primary and assistant surgeon services.

Implantation of Corneal Ring Segments

CPT code 65785 (implantation of intrasomal corneal ring segments) is reimbursable for the reduction or elimination of myopia and astigmatism in patients 21 years of age and older with keratoconus. This procedure requires a *Treatment Authorization Request (TAR)* documenting the following criteria:

- Progressive deterioration of vision such that the patient is unable to achieve adequate functional vision (at least 20/40 or better) with eyeglasses or contacts
- The patient is unable to perform activities of daily living or occupational functions due to progressive vision deterioration
- Corneal thickness greater than or equal to 450 microns at the proposed incision site
- Central cornea is clear
- Recipient's only alternative is corneal transplant

This procedure is not reimbursable for any indication except keratoconus.

Implantation of Retinal Prosthesis System

HCPCS code L8608 (miscellaneous external component, supply or accessory for use with the Argus II Retinal Prosthesis System) is limited to two in a lifetime, one per eye.

«Collagen Cross-Linking of the Cornea

HCPCS code J2787 (riboflavin 5'-phosphate, ophthalmic solution, up to 3 ml) is billed with CPT code 0402T (collagen cross-linking of cornea, including removal of the corneal epithelium, when performed, and intraoperative pachymetry, when performed) for beneficiaries 14 to 65 years old. Claims, for code J2787 only, must be submitted with modifier LT (left eye) or RT (right eye), and an approved *Treatment Authorization Request (TAR)* is required for reimbursement of HCPCS code J2787 and CPT code 0402T.»

«TAR Requirements

Providers must submit clinical documentation of the following on the TAR:

- HCPCS code J2787 must be used for FDA-approved indications and dosages
- HCPCS code J2787 must be prescribed by an ophthalmologist
- Patient must have a diagnosis of one of the following:
 - Progressive keratoconus
 - Corneal ectasia following refractive surgery
- Diagnosis was made by patient history and clinical exam
- HCPCS code J2787 is being used for corneal collagen cross-linkage in combination with ultraviolet light
- Patient must be between the ages of 14 and 65
- Patient does not have active or history of herpes simplex virus (HSV) keratitis, thin corneas, or corneal hydrops

The TAR is authorized for three months (one treatment).

Treatment is limited to once in a lifetime. Reauthorization is not approvable.

ICD-10-CM Codes

Providers must document one of the following ICD-10-CM diagnosis codes with HCPCS code J2787 to support medical necessity:

H18.601 thru H18.629

H18.711 thru H18.719

Prescribing Restrictions

Frequency of billing is once in a lifetime.

Maximum billing units for HCPCS code J2787 equals 6ml/2 units when performing the corneal cross-linking procedure.»

«Canaloplasty

CPT code 66174 (transluminal dilation of aqueous outflow canal [eg, canaloplasty]; without retention of device or stent) is considered medically necessary for the treatment of Primary Open-Angle Glaucoma (POAG), including normal-tension glaucoma, and for pseudo-exfoliation glaucoma. Furthermore, Canaloplasty is not considered medically necessary for all other indications. Canaloplasty may be considered medically necessary as a method to reduce intraocular pressure in individuals with chronic POAG under the following:

- Medical therapy has failed to adequately control intraocular pressure
- The individual is not a candidate for any other intraocular pressure lowering procedure (for example, trabeculectomy or glaucoma drainage implant) due to a high risk for complications. Surgical intervention becomes necessary in managing glaucoma if medication fails to sufficiently lower intraocular pressure. The standard surgical procedure used as a benchmark for comparison is trabeculectomy.
- Canaloplasty is considered investigational under all other conditions, including angle-closure glaucoma
- Canaloplasty is covered when all of the following criteria have been met:
 - Diagnosis of glaucoma with eye pressures inadequately controlled on maximum tolerated topical medications and laser treatment
 - Documented risk for greater problems with standard glaucoma surgery (trabeculectomy or valve implant) as defined by one of the following:
 - ❖ Myopic diopters greater than five
 - ❖ Moderate to severe dry eye
 - ❖ Blepharitis
 - ❖ Preservative allergy
 - ❖ Has allergy or side effects preventing the use of one or more of the standard glaucoma eye drops
 - ❖ Had problems with trabeculectomy or glaucoma valve implant surgery in the contralateral eye (such as bleb dysesthesia [chronic eye pain] or need for re-operation)
 - ❖ Surgical intervention may be indicated in patients with glaucoma when the target intraocular pressure cannot be reached pharmacologically

ICD-10-CM Codes

ICD-10-CM diagnosis codes that support medical necessity include the following (not required for claim reimbursement):

H40.1110 thru H40.1194»

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.