New Glaucoma Staging Codes: Is It Worth Adding Them?

Stratifying the disease may improve communication between physicians and their patients and educate payors.

BY RONALD L. FELLMAN, MD

Why should we clinicians go through the hassle of figuring out a staging code for glaucoma? Many physicians feel these codes create extra work for their staff without improving patients' care. On the flip side, some of the giants in glaucoma care argue that a staging system is worthwhile and necessary. According to Shields and Spaeth, staging codes for glaucoma offer several benefits. They (1) group patients according to the severity of their disease, (2) better explain to patients the severity of their disease, (3) evaluate clinical effectiveness at various levels of the disease, and (4) develop a useful framework to accommodate expanding knowledge.[1] Considering that Friedman and colleagues found physician-patient communication lacking with regard to education about potential visual loss from glaucoma,[2] a glaucoma staging system may contribute to a much-needed dialogue with patients about the stage of their disease and the consequences of poor adherence.

At this time, there is no universally accepted staging system for glaucoma. Brusini and Johnson assert it is useful to stage glaucoma to distinguish between healthy and diseased individuals, to provide a reliable prognosis of the disease, and to adjust patients' treatment on the basis of disease severity as well as for medical-legal purposes.[3] Pasquale et al found the costs of caring for patients with ocular hypertension and primary open-angle glaucoma (POAG) are considerable and may place a significant burden on health care resources.[4] According to Lee et al, the cost of glaucoma care for POAG is roughly 10% of health care costs per person per year.[5] Without a doubt, glaucoma costs are on the radar for health care providers.

AN OPPORTUNITY TO CREATE A FAIR SYSTEM

Staging a disease and documenting it with a code are inherently difficult, controversial, and likely imperfect. Nonetheless, various subspecialties have made progress. For example, there are codes for mild, moderate, and severe nonproliferative diabetic retinopathy. Why not just group them into one code? If only one code were available, there would be a vast difference in health care expenditures for the management of the disease. This leads to confusion when policymakers try to understand the cost of health care associated with diabetic retinopathy, because expenditures vary, and there is a significant difference in outcomes and patients' satisfaction—all the buzzwords of value-based medicine. It is not fair to lump all diabetic retinopathies

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1. Do you currently use staging codes for your glaucoma patients?
☐ Yes
☐ No

2. After reading this article, would you consider using the add-on codes?
☐ Yes
☐ No

together, and the same holds true for glaucoma. Prior to October 2011, we did not have separate codes for mild, moderate, and severe glaucoma, but now, we have add-on codes that give us the option to stage the disease.

The stratification of glaucoma should help us better understand the variability in costs of care, recognize resource utilization based on the stage of disease, and improve our negotiations with health care providers by knowing our costs of doing business. None of the staging systems is perfect. When evaluating practice patterns compared to claims data, Quigley et al found that claims-based data overestimate the severity of glaucomatous damage and fail to distinguish patients who are new to treatment.[6] These systems will evolve, and research will continue to point out better ways in which to analyze glaucoma care. We need to convey meaningful information to health policymakers concerning glaucoma care, or they will create a task force to review the situation and make their own recommendations. I think input from ophthalmologists is important. At this time, staging glaucoma is not mandatory, but changes in health care will require us to think differently.

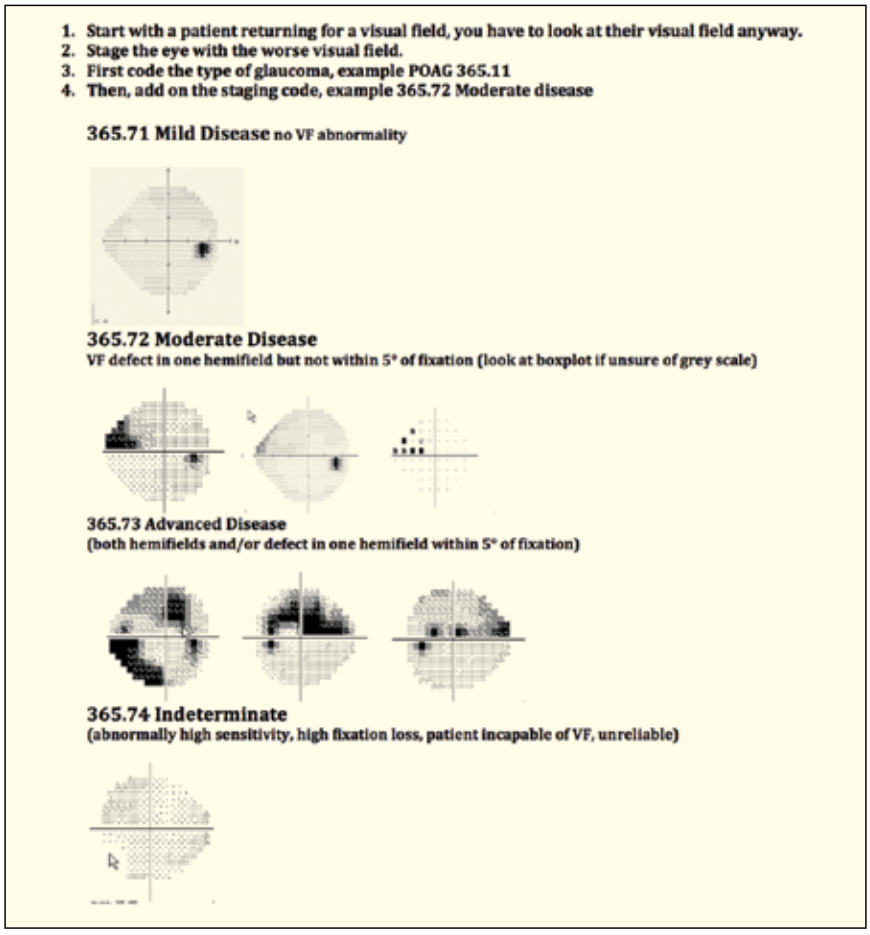

Figure. Summary of glaucoma staging codes with examples of visual field examinations.

In light of economic profiling by insurance companies that flag physicians for an excessive use of resources, it is imperative to have a fair system in place that rewards quality care for all disease stages. Lee and colleagues estimated a fourfold difference in the cost of care for patients with early versus advanced disease.[7] Mills et al found similar data and noted that the cost of glaucoma care rises as the severity of the disease increases.[8]

Glaucoma encompasses a wide spectrum of signs and symptoms. Affected patients may present with normal white-on-white visual fields and mild disc damage or advanced end-stage disease with high IOP and tunnel vision. Do we take care of these patients the same way? Of course not. How do we communicate these differences in treatment to health care providers and policymakers who mine claims-based data to assess value-based medicine and patients' satisfaction?

BEGIN WITH POAG PATIENTS

Several staging systems are very good, but they are complex; they were developed for research purposes and involve elaborate scoring systems. The preferred practice pattern for POAG developed by the American Academy of Ophthalmology in 2010 created a simplified staging classification system based on visual field data. The Health Care Policy Committee of the American Glaucoma Society used this as a basis for a coding system that was studied and validated by Joshua Stein, MD, MS, assistant professor of ophthalmology at the University of Michigan.

A successful staging system has to be simple; easy to teach, understand, and remember; and logical so that technicians can record it. Trying to code every patient during a first attempt at staging is inadvisable. Instead, I recommend starting with POAG patients who are returning for a visual field examination and informing the clinical staff of this decision (Figure and Table). Considering we have to look at the field to interpret it anyway, it only takes a few seconds to add on the stage. Targeting a specific group of patients

TABLE. GLAUCOMA STAGING CODES

Step 1: Code by type of glaucoma for any of the following:

365.10 Open-angle, unspecified
365.11 POAG (let's start with this)
365.12 Low-tension glaucoma
365.13 Pigmentary glaucoma
365.20 Primary angle-closure glaucoma, unspecified
365.23 Chronic or primary angle-closure glaucoma
365.31 Steroid-induced glaucoma
365.52 Pseudoexfoliation glaucoma
365.62 Glaucoma associated with inflammation
365.63 Glaucoma associated with vascular disorder
365.65 Glaucoma associated with trauma

Step 2: Add the staging code in the worse eye

Assume GON for all staging codes
365.71 Mild: GON and a normal white-on-white VF (SWAP or FDT may be abnormal)
365.72 Moderate: GON and VF loss in only one hemifield (but not within 5° of fixation)
365.73 Severe: GON and VF loss in both hemifields or one hemifield with loss within 5° of fixation
365.74 Indeterminate: Patient incapable of performing VF, unreliable VF, unable to determine the stage
365.70 Unspecified: Stage not recorded in chart

Abbreviations: GON, glaucomatous optic neuropathy; VF, visual field; SWAP, short-wavelength automated perimetry; FDT, frequency doubling technology

serves as a great starting point for the first month of transition to glaucoma staging codes. My advice is to add on the glaucoma staging code. Once the staff is comfortable with the process, I recommend expanding the add-on codes to the various types of glaucoma on the approved list. It is worth remembering that these staging codes do not apply to glaucoma suspects; there are new codes for suspects, but that is a subject for another article.

CLOSING THOUGHTS

It remains to be seen if staging systems will improve glaucoma care. It is a multifaceted issue. Staging may help us better understand the cost of the disease, better educate insurers and policy makers, improve physician-patient communication, and lay a foundation for more meaningful research. It is to be hoped that a staging system of the future will reflect not only the structure-function-cost side of the equation but also quality of life. Kulkarni et al found that patients' better-seeing eye better reflected how he or she functioned, as determined by evaluating activities of daily living.[9] In the long run, it is likely that patients' satisfaction scores will be tied to physicians' reimbursement, which certainly will pique physicians' interest in the subject. When the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) finally becomes available, I hope that it will be possible to stage both eyes, which would offer a more accurate representation of the glaucomatous process and patients' quality of life.

> "I think the add-on codes are worthwhile, and I have incorporated them into my practice with the hope that, ultimately, they will improve glaucoma care."

At the present time, it does not make sense to lump all of our POAG patients into one code without the ability to stratify the disease. I think the add-on codes are worthwhile, and I have incorporated them into my practice with the hope that, ultimately, they will improve glaucoma care.

More information about the glaucoma staging codes is available from the American Glaucoma Society's teaching module (www.americanglaucomasociety.net) and the American Academy of Ophthalmology's website (www.aao.org/aaoesite/promo/coding/glaucoma_staging_codes.cfm). ■

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