Glaucoma Care Pilot Payment Schedule

For Glaucoma Care Services Provided by an Optometrist

October 1, 2025

OVERARCHING PRINCIPLES

- The Ministry of Health (Ministry) and the Saskatchewan Association of Optometrists (SAO) have a joint interest in improving patient access and health outcomes through collaborative care closer to home, for the provision of care with and on behalf of patients.
- The provision of glaucoma care by optometrists strives to ensure that patients receive glaucoma care closer to home.
- Under the "Patient-Centered Model of Care", Saskatchewan optometrists have enhanced authority to prescribe Schedule I, II, and III Drugs of the Saskatchewan College of Pharmacists Drug Schedules (with the exception of narcotics and as amended or replaced from time to time) and the authority to independently diagnose, treat and manage glaucoma.
- The decision to diagnose, treat, co-manage or refer depends on the optometrist's level of competence and the type and severity of the patient's condition. Optometrists are regulated to practice within their level of comfort and expertise. Transfer of care to an ophthalmologist is required when the patient's condition exceeds the optometrist's scope of practice and/or level of expertise/training.
- The Ministry and the SAO are both supportive of compensating optometrists for glaucoma care in a manner that is fair, equitable, cost effective, and that will lead to better patient health outcomes for Saskatchewan residents.

PREAMBLE

For the purposes of this Glaucoma Care Pilot, glaucoma care is defined as the diagnosis, treatment, monitoring, and management of glaucoma or high-risk glaucoma suspect patients in Saskatchewan by Saskatchewan licensed optometrists. These services can include assessments, follow-up assessments, diagnostic testing services, and co-management services with ophthalmologists, such as referrals and transfer of care.

The services contained within this payment schedule are temporary service codes; they are not insured services as per *The Saskatchewan Medical Care Insurance Act*. In order to facilitate payment, the Medical Services Branch (MSB) has agreed to accept electronic submissions of Glaucoma Care pilot codes for services provided by the optometrist to Saskatchewan beneficiaries directly to MSB, and the billing optometrist agrees to submit billings and accept payment according to the conditions outlined in this payment schedule and the Automated Submission and *Direct Payment Agreement* that has been signed by MSB and the optometrist.

To facilitate billings, the existing explanatory codes will be used in the optometrist's payment list or return file, reject or pending file, or returned claim, as applicable. See the Payment Schedule for Insured Services provided by an Optometrist for The Ministry of Health Explanatory Codes.

Saskatchewan beneficiaries cannot be charged out of pocket for any aspect of a publicly funded Glaucoma Care Pilot service in an amount that exceeds the fee payable that is listed in the service description.

Compensation for glaucoma care services is limited to the parameters of the Glaucoma Care Pilot as agreed to by the Ministry and the SAO. For clarity:

- Glaucoma care services are payable only for Saskatchewan licensed optometrists providing services to Saskatchewan beneficiaries when both the optometrist and patient are located in Saskatchewan at the time of the service.
- Only those optometrists who have completed certification in all relevant continuing education courses determined by the SAO can offer or provide glaucoma care services.

Upon mutual agreement, the Ministry and the SAO may amend the Glaucoma Care Pilot Payment Schedule as required, including but not limited to reduce, suspend or cancel these services code items, or make changes to the fees to ensure financial accountability/feasibility and effectiveness of the Pilot.

INTRODUCTION

The Glaucoma Care Pilot Program Payment Schedule is effective for services provided on or after October 1, 2025. It lists a payment for each service, which will be paid at 100% unless the "Assessment Rules" indicate that payment for the service is:

a) included in the composite payment made for another service; or

b) subject to an adjustment when billed in addition to another service.

All services billed to the Medical Services Branch are the sole responsibility of the optometrist rendering the service with respect to appropriate documentation and billing (see "Documentation Requirements for the Purposes of Billing" below).

If a specific fee code for the service rendered is listed in the Payment Schedule for Insured Services Provided by an Optometrist, then that fee code must be used in claiming for the service, without substitution (e.g., optometrists must bill a 31U for tonometry for diabetic patients if the visit is for the diabetes eye exam and not the 320U for a tonometry performed with glaucoma).

BILLING INFORMATION

1. Glaucoma care services are payable only for Saskatchewan licensed optometrists providing services to Saskatchewan beneficiaries.
2. Both the optometrist and the patient must be located in Saskatchewan at the time the service is provided, with the exception of the border community of Lloydminster, where the optometrist holds Saskatchewan licensure and a Direct Payment Agreement with the Medical Services Branch, and the patient is a Saskatchewan Healthcare beneficiary.
3. Glaucoma care services are not billable to out-of-province beneficiaries or reciprocally by out-of-province optometrists.
4. Glaucoma care services must be medically required.
5. Glaucoma care services must be direct optometrist to patient contact in real time. With the exception of the diagnostic services performed by clinic staff and Virtual Glaucoma Assessment Follow Ups (801U/811U).
6. Services requiring physical in-person examination (300U/310U) are not eligible for payment under virtual care codes. If, during the course of a virtual visit (801U/811U), it becomes apparent that an in-person visit is necessary, only the higher in-person service code is payable. Unless indicated otherwise, no billings for any combination of in-person or virtual care service codes may exceed the individual service code billing limits/maximum units listed.
7. An optometrist may require more than one visit to complete a proper glaucoma or high-risk glaucoma suspect diagnosis, but only one payment will be made for Glaucoma Assessment (300U) or High-Risk Glaucoma Suspect Assessment (310U) within the defined period. Payment for follow up services (301U/801U/311U/811U) and corresponding tests/procedures in excess of the stated annual limits may be authorized on an exceptional basis when deemed to be medically required for the detection and management of glaucoma patient care.

   For instances where medically required glaucoma care services exceed the limit stated in the pilot payment schedule, optometrists must include a comment on their claim indicating, “Maximum exceeded due to medical necessity” for consideration of payment. Optometrists are required to retain a record of the service, including documentation of the medical necessity, to be produced upon request of the Medical Services Branch.
8. Unless otherwise indicated, glaucoma care services are not eligible for premiums or surcharges.
9. Optometrists are responsible to ensure appropriate documentation consistent with the “Documentation Requirements for the Purposes of Billing” below.

Documentation Requirements for the Purposes of Billing

Documentation is an integral and fundamental component of a medical service. An adequate record will enhance quality and accountability, and provide protection for the optometrist, the beneficiary, and the Ministry. Documentation requirements apply to both in-person and virtual care services.

For billing purposes, the optometrist is responsible for documenting and maintaining an adequate medical record(s) to support any service being provided and billed.

To be considered adequate, a medical record must be legible and contain the information specifically designated in the Optometry Payment Schedule(s) service codes depending on the classification of the service. The record must also establish that:

1. An insured service was provided; and
2. The service for which the account is submitted is the service that was rendered; and
3. The service was medically required.

Requirements

Visit Services (in-person and virtual)

- All listed service code criteria must be recorded.

Diagnostic testing:

- All relevant information must be recorded, i.e., assessment notes, diagnoses, test results, admission/discharge reports, etc.

Professional and Technical Components

- The optometrist is required to perform the professional (i.e., interpretation) component of any diagnostic service that has both a professional and technical component.
- For the technical component, payment listed offsets the costs related to providing the service, including but not limited to:
  a) If a technician/non-optometrist is involved in performing the service, the fee includes a component to cover their service.
  b) Amortization of cost or leasing costs of any special equipment needed to carry out the procedure (costs incurred by optometrist only);
  c) Equipment maintenance.
  d) Capital cost of replacement equipment.
  e) Expendable costs (specific to the procedure such as contrast media).
  f) Fixed and variable costs of the premises (space and time); and
  g) Production of radiographs.

Submission of Accounts

1. **Time Limit for Submission of Accounts**

   Accounts for services included in the pilot must be received by the Ministry of Health within 6 months following the date of service to be eligible for payment. The time limit applies to all persons submitting accounts to the Ministry of Health.

2. **Claim Submission**

   All claims must be electronic, automated submissions through an MSB approved billing software vendor or through the Customer Portal if no billing software vendor is contracted by the optometrist.

   The claims submission must contain:

   a) Patient's name in full;
   b) Patient's Health Services Number (HSN);
   c) Patient's month and year of birth, and sex;
   d) Location of service: office
   e) Three-digit ICD-9 diagnostic code: 365 (minimum);
   f) The service code corresponding to the service, visits or diagnostic performed (4-alpha numeric characters (ie. 190U);
   g) Date of each service;
   h) Amount charged for each service provided;
   i) Additional remarks if the nature of the service was unusual;
   j) Name of the person providing the service;
   k) Four-digit referring physician number, if applicable.

300U Glaucoma Assessment **$56.00**

Initial/annual assessment of the specific condition with ICD-9 365.
Must include:

a) Pertinent family history;
b) Patient History;
c) History of presenting complaint;
d) Functional enquiry and tests;
e) Examination of affected part(s) or systems;
f) Diagnosis and ICD-9 Code;
g) Assessment;
h) Necessary treatment;
i) Advice to the patient; and
j) Record of service provided.

Maximum one per 365 days per patient

310U High Risk Glaucoma Suspect Assessment **$56.00**

Initial/annual assessment of the specific condition with ICD-9 365.
Must include:

a) Pertinent family history;
b) Patient History;
c) History of presenting complaint;
d) Functional enquiry and tests;
e) Examination of affected part(s) or systems;
f) Diagnosis and ICD-9 Code;
g) Assessment;
h) Necessary treatment;
i) Advice to the patient; and
j) Record of service provided.

Maximum one per 365 days per patient.

301U Glaucoma Assessment Follow-up **$28.00**

Includes:

a) History review;
b) Functional enquiry;
c) Examination;
d) Reassessment;
e) Necessary treatment;
f) Advice to the patient; and,
g) Record of service provided.

Maximum two per 365 days per patient for any combination of 301U/801U/311U/811U.

801U **Virtual Glaucoma Assessment Follow-up** **$25.20**

Includes:

a) History review;
b) Functional enquiry;
c) Examination;
d) Reassessment;
e) Necessary treatment;
f) Advice to the patient; and,
g) Record of service provided.

Maximum two per 365 days per patient for any combination of 301U/801U/311U/811U.

311U **High Risk Glaucoma Suspect Assessment Follow-up** **$28.00**

Includes:

a) History review;
b) Functional enquiry;
c) Examination;
d) Reassessment;
e) Necessary treatment;
f) Advice to the patient; and,
g) Record of service provided.

If patient's diagnosis changes from High-Risk Glaucoma Suspect to Glaucoma within the same 365 days, subsequent follow-ups should be billed as a 301U.

Maximum two per 365 days per patient for any combination of 301U/801U/311U/811U.

811U **Virtual High Risk Glaucoma Assessment Follow-up** **$25.20**

Includes:

a) History review;
b) Functional enquiry;
c) Examination;
d) Reassessment;
e) Necessary treatment;
f) Advice to the patient; and,
g) Record of service provided.

Maximum two 365 days per patient for any combination of 301U/801U/311U/811U.

320U	**Tonometry – bilateral** Not to be used for routine screening of patients and only eligible when billed in conjunction with 300U, 301U, 801U, 310U, 311U, 811U. Maximum of 3 per 365 days per patient.	**$15.30**
325U	**Optical Coherence Tomography (OCT) - bilateral – professional fee** Maximum of 1 per 365 days per patient	**$21.20**
326U	**Optical Coherence Tomography (OCT) – bilateral – technical fee** Maximum of 1 per 365 days per patient	**$21.20**
328U	**Fundus Photography – bilateral – professional fee** Maximum of 1 per 365 days per patient	**$6.35**
329U	**Fundus Photography – bilateral – technical fee** Maximum of 1 per 365 days per patient	**$6.35**
322U	**Visual Field – bilateral** Maximum of 1 per 365 days per patient	**$31.80**
334U	**Corneal Pachymetry – bilateral** Maximum of 1 per patient	**$8.15**
336U	**Gonioscopy – bilateral** Maximum of 1 per 365 days per patient	**$12.50**

Explanatory Codes

Patient Identification

A plastic "Health Services Card" for registered beneficiaries is sent every third year, expiring December 31, 2026, and every third year thereafter, to their last reported postal address. Coverage depends on registration. Notification of changes is the beneficiary's responsibility.

The Health Services Card shows: the effective and ending coverage dates, Health Services Number, name, sex, month, and year of birth.

Health Registration, Phone: 1-800-667-7551 or 306-787-3251, 2130 11th Avenue, Regina, S4P 0J5, should be notified of:

a) Change of address.
b) Registration errors, i.e.: name, sex, or date of birth.
c) Changes in family.

All accounts should be sent to the Medical Services Branch, the Ministry of Health.

Residents who are members of the Canadian Forces and inmates of the Federal Penitentiaries are not provided with health care coverage under MSB. Their spouses and dependents, resident in Saskatchewan, must be registered for coverage.

The alphabetic code listed in the payment file/list, reject file or returned claim identifies the related explanation.

AA Not registered - the Health Services Number for this patient is incorrect. Please recheck the Health Services Card and verify your claim details in the Person Health Registration System (PHRS). If appropriate, correct your claim details and resubmit through your vendor system.

AC Incorrect sex indicated on claim - Medical Services Branch (MSB) has processed this claim. Please use the sex shown in the Person Health Registration System (PHRS) for future claim submissions.

AD Incorrect Health Services Number indicated on claim - Medical Services Branch (MSB) has processed this claim. Please use the number shown in Person Health Registration System (PHRS) for future claim submissions.

AE Incorrect date of birth indicated on claim - Medical Services Branch (MSB) has processed this claim. Please use the birth date shown in the Person Health Registration System (PHRS) for future claim submissions.

AF Incorrect first name and/or last name indicated on claim - Medical Services Branch (MSB) has processed this claim. Please use the name shown in the Person Health Registration System (PHRS)for future claims.

AH Please review this claim. Our records indicate that the beneficiary registered under this number died prior to the date of service.

AR Patient not registered for coverage on this date of service. Please check the effective and expiry dates on the Health Services Card. If the patient is a resident, they should immediately contact eHealth Registries, by phone at 1-800-667-7551 or 306-787-3251, 2130 11th Avenue, Regina, S4P 0J5, in order to have coverage updated. If the patient's coverage is updated as per the Person Health Registration System (PHRS), please resubmit the rejected claim through your vendor system.

AS Your account had to be split for processing. Payment for the listed services was approved based on the Ministry of Health Payment Schedule

AT Diagnosis and Payment Schedule item are not compatible.

AU To assist in the assessment of this claim, a copy of the operative report, medical record or a descriptive letter is required. PLEASE NOTE: If an operative report is being submitted, it must contain surgical start and end times. Submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

AV This service is not insured.

AZ
1) Please refer to correspondence sent to the optometrist or clinic. If you have questions, please contact the Business Support Desk at 1-800-605-2965; or
2) This code may have been rejected as a procedure that is "normally only performed once" (i.e.: total bilateral thyroidectomy) or only repeated after a reasonable interval (i.e.: delivery), please verify service code submitted for accuracy. If appropriate, correct your claim details and resubmit through your vendor system OR submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information to support this unique billing scenario.

BA Duplicate - same physician/dentist/optometrist - payment has been made for the same service provided on the same day. Use Query Claims in Customer Portal to review this patient's claim history. To search, use the patients HSN, Province, your Billing and Group Number to display all claims processed and their status. This will display your claim history (paid, pended or rejected) and locate any/all duplicate submissions.

BB Possible duplication of a payment for a similar service. If no duplication, submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

BC Duplicate - same clinic - payment has been made to another physician/dentist/optometrist in your clinic for a similar service on the same day. Please check your records. If appropriate, submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

BD The beneficiary has been paid, based on the claim previously submitted.

BE This payment schedule service code and/or diagnostic code applies to a specific age and/or sex.

BG Billed less than Listed Payment -- appropriate payment for the date of service has been approved

BH Payment Approved at: 1) Payment Schedule listed rate in effect for the date of service based on your specialty. 2) The referred rate because a valid referring physician was provided. 3) The unreferred rate because of one of the following: The 4-digit referring doctor is not valid; We could find no record of the "referring physician" being licensed to practice; or No referring doctor number was submitted.

BJ **PHYSICIAN/OPTOMETRIST:** Payment for this item can only be made if the patient was referred and the 4-digit referring doctor number is indicated in the appropriate field. Please re-submit: 1) if referred, with the 4-digit referring doctor in the appropriate field; 2) if unreferred, using appropriate code and fee.

BK Your claim for service(s) has been assessed based on the service code requirements for billing and any related assessment rules as indicated in the Payment Schedule. Please refer to your Payment Schedule.

BN You were asked for additional information to assess this claim, no reply received without this information, the claim cannot be processed.

BO The approved service code and payment is based on your description of the service.

BP Payment adjustment based on: 1) Your resubmission; 2) Our review of assessment; 3) Information received through Query Claims - Supplementary Claim Information; OR 4) Your Request for Recovery of this Claim through Query Claims - Physician Requested Recovery.

BQ The service code and/or amount submitted are incorrect. Please review and resubmit.

BR Blank or invalid service code -- please review.

BT Approved at the maximum amount consistent with your description of the service provided.

BW Billed more than listed Payment -- appropriate payment for the date of service has been approved.

BZ Payment is based on the amount payable to a Saskatchewan optometrist providing the same service.

CA **OPTOMETRIST:** Non-Insured Services: Examinations or services to provide certificates or reports requested by a third party are not insured, e.g., for: - Attendance at camps, - Employment, - Employment insurance programs, - Participation in Sports, - Insurance, - Judicial purposes, - Motor vehicle or other licenses (see 23U).

CB **OPTOMETRIST:** The following are not insured: - Advice by telephone - Appliances (Prostheses) - Committee or advisory service - Contractual service for a government department or agency - Eye glasses (fitting, frames or lens) - Medication - Secretarial or a reporting fee - Travel by an optometrist.

CE Non-Registered Provider of Service -- a service is not insured by MSB if it was provided by an optometrist or a graduate student who is not registered with or licensed by the appropriate agency of the province, state or country in which he practices.

CF This service code is not valid for this date, because it is either: 1) Prior to implementation; or 2) After deletion from the Payment Schedule.

CG **OPTOMETRIST:** Optometrist billing for their immediate Family -- a service is not insured when provided by an optometrist to themself or any member of their immediate family. Reference: Regulations under the Medical Care Insurance Act.

CH These services appear to be the responsibility of the Department of Veteran's Affairs (DVA). Please send the appropriate form to DVA, Treatment Benefit Unit, Box 6050, Winnipeg, Manitoba, R3C 4G5. If they do not accept responsibility, please resubmit the claim electronically indicating "D" in the claim type field to indicate not DVA responsibility.

CI The service provided cannot be paid for an out-of-province beneficiary; there is no reciprocal billing process for optometric claims

CM Claims received more than six months after the date of service. A resubmitted claim must be returned within one month. Resubmitted claims must include original claim number and the date of the original submission. If factors beyond your control prevented submission within six months, the following details must be received in writing addressed to the Manager, Claims Unit. Submit the required information through Customer Portal using Query Claims - Supplementary Claim Information - Request for extension of time limit (Explan code CM-CN). Please include - 1) List of claims for which you are requesting the time limit approval; 2) Service codes and dollar amounts; 3) Number of Patients; 4) Dates of service; 5) Circumstances for the delay in submitting your accounts; and 6) Date of submission.

CN Claims received more than 12 months after the date of service cannot be accepted for any reason. Reference: Medical Care Insurance Act, Section 14A and Related Regulations.

CT Workers' Compensation Board (WCB) has advised MSB that they have paid you for this service.

CW These services appear to be the responsibility of WCB. Please submit a claim to the WCB at Suite 200 – 1881 Scarth Street, Regina, S4P 4L1. If they do not accept responsibility, WCB will forward the claim back to you. If the claim has not yet been paid, please submit an automated claim to MSB indicating "W" in claim type field to indicate not WCB responsibility and a comment indicating the date submitted to and rejected by WCB.

CZ Services in relation to the wearing or provision of contact lenses other than a routine eye refraction (2U, 4U) are not insured.

DA Only one visit type service is approved during a single patient contact. If there were 2 separate patient contacts, please provide reason and time of the second visit. Submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

DD Please verify date(s) of service and resubmit.

FD This service code is listed as a bilateral procedure. Therefore, only one (1) is payable per patient contact.

FM Approved only with specified services as listed in the Payment Schedule.

GB This claim has been reviewed by a Medical Consultant. The documentation provided does not support the code(s) submitted. No further action will be undertaken by MSB unless new information is submitted which supports the claim(s). Submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

JP Claim is being rejected because this code has been billed and paid to another physician/optometrist/dentist or provider.

KQ Post-Operative Visit following major eye surgery is an inclusion within the payment to the surgeon in the same clinic.

SA 2U or 4U -- a previous examination was provided to this beneficiary by yourself or another optometrist or physician within the designated time span:

- 18-64 years - Minimum Time - 24 months
- All other ages - Minimum Time - 12 months

If resubmitting, please indicate:

1. Previous and current refractive errors.
2. Any medical factors necessitating current examination.
3. Name of referring physician if patient referred.

SB A 2U or 4U has been paid to you or another optometrist during the interval between the dates given on your claim for your previous and current eye examination.

SD 12U is not approved when a 2U, 4U, 15U, 16U, or 22U has been paid within the preceding 90 days unless indicated for an unrelated condition.

SE 21U is payable only for:

1. Beneficiaries 18 years of age or older, with an insured 2U or 4U service and
2. A Supplementary Health, Family Health Benefits & Seniors' Income Plan Programs beneficiary 17 years of age or older.

SF The maximum number of services has been exceeded for a 15U or 16U; a 15U or 16U cannot be provided within 30 days of a 2U, 4U, 12U or 22U.

SG The factors indicated have been reviewed and are not considered sufficient to warrant payment of a second refraction within the designated time span.

SH 31U is payable period only:

1. One service per 12-month period; and
2. All Saskatchewan beneficiaries, subject to assessment rules.

SI 34U is only payable with an insured 15U or 16U service.

SJ 22U - a previous examination was provided to this beneficiary by yourself/another optometrist/physician within the designated time span: All ages - Minimum Time - 12 months

SK 35U, 36U, 37U, 38U are payable only with an insured 22U service.

SL 35U, 36U, 37U, 38U -- approved only once within a period of 12 consecutive months for the same optometrist or clinic.

SS Coverage for examination of the eyes is limited to those under the age of 18, Social Assistance recipients nominated to receive Supplementary Health benefits, recipients of Family Health Plan benefits and Seniors receiving the Saskatchewan Income Plan supplement. According to our information, the patient is not eligible for coverage.

SX Insufficient information given to process your claim. Please resubmit with a more complete explanation of service(s) provided. If this was a post-surgical visit, indicate nature of surgery, date and name of surgeon.

ZA The patient identity information on the claim (month or year of birth, sex or surname) does not correspond to information on the Health Services Card. Please check the Health Services Card, make the claim corrections and resubmit

ZC The submitted claim contains invalid data other than patient identification data, e.g. September 31, the submitted fee at zero dollars, the 13 month, a lower case alpha character, a partially blank field as HSN, wrong location of service, a service not allowed for premiums etc. If appropriate, correct your claim details and resubmit through your vendor system.

ZD Please verify the following: 1. Date(s) of service 2. Date of birth AND/OR 3. A claim that spans over multiple months for non-hospital care services must be separated per calendar month. If appropriate, correct your claim details and resubmit through your vendor system.

ZF The optometrist is not eligible to submit for services on the indicated date of service.

ZL **OPTOMETRIST**: The submitted referring doctor number is invalid. Please check the referring doctor name and number. Please correct and resubmit your claim, if appropriate. Please do not query this claim in Customer Portal.

ZM The claim contains an invalid diagnostic code according to the International Classification of Diseases - 9th Revision. Please check the diagnosis, diagnostic code and table of invalid codes. If appropriate, correct your claim details and resubmit through your vendor system.

ZN The Ministry of Health has received multiple claims from the same optometrist/same clinic for the same service code with the same date of service under the same HSN. One of the claim(s) is either pending (no further action on your part) or rejected (refer to the explanatory code provided). Please do not resubmit. Use Query Claims in Customer Portal to review this patient's claim history. To search, use the patients HSN, Province, your Billing and Group Number to display all claims processed and their status. This will display your claim history (paid, pended or rejected) and locate any/all duplicate submissions.

ZP An invalid mode of payment has been used on this claim.

ZS The claim was submitted as a Professional Corporation (PC) claim; however, no PC information has been received, or the PC claim is not valid on this date.

ZT Please refer to the comment record(s) being returned by MSB for a more detailed explanation.

Appendix A – High Risk Glaucoma Suspect

For the duration of the pilot, eligible fees for Glaucoma Suspect with High Risk (or already on topical treatment) must meet any of the following criteria:

1. Presence of IOP > 27mm Hg.
2. Presence of IOP > 24mm Hg if associated with relative thin central corneal thickness (CCT) i.e., less than 550 microns.
3. Presence of very suspicious optic disc findings, such as rim notches, disc hemorrhages, localized retinal nerve fiber layer (RNFL) defects, but with normal visual fields.
4. Elevated IOP associated with other causes of secondary glaucoma such as pseudoexfoliation syndrome, pigment dispersion, uveitis, iris or angle neovascularization.
5. Glaucoma suspects who are already being treated with IOP-lowering medications for ocular hypertension.
6. Drainage angle deemed at high risk for closure (typically 180 degrees or more of iridotrabecular contact [ITC].
7. Glaucomatous visual field defects, including any of the following: an isolated scotoma, an arcuate scotoma, a nasal step, and generalized depression.