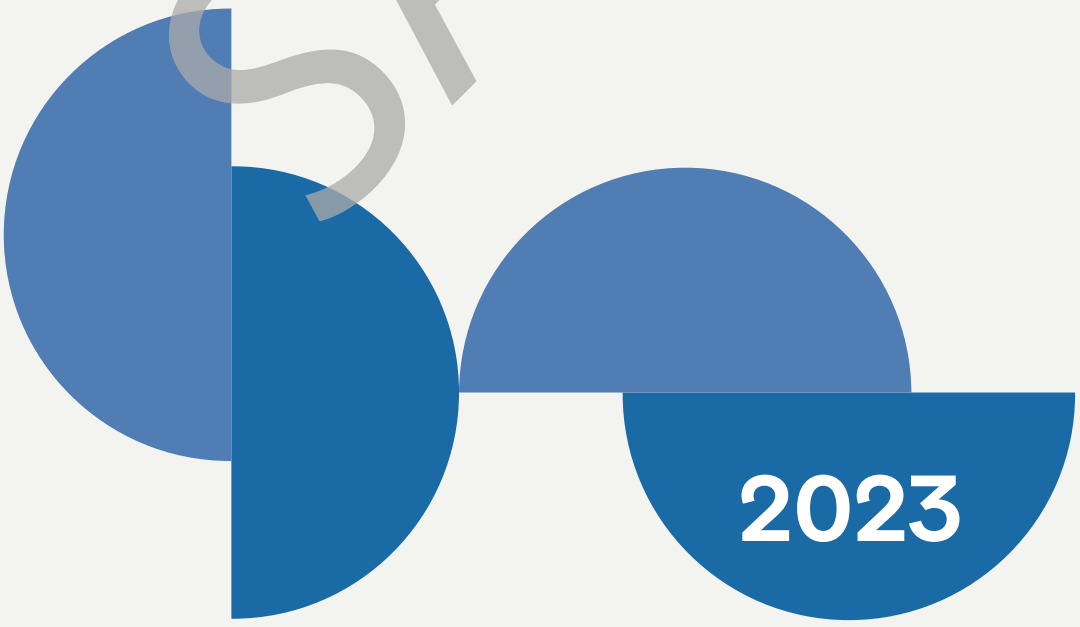
Optum

Coding Companion

Ophthalmology

A comprehensive illustrated guide to coding and reimbursement



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Getting Started with Coding Companion

Coding Companion for Ophthalmology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT Codes

For ease of use, evaluation and management codes related to Ophthalmology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum360 *Coding Companion* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions

Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

The codes in the appendix are presented in the following order:

- HCPCS
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edits and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version XX.X, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes) and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is http://www.optum360coding.com/ProductUpdates/. The 2023 edition password is: **XXXXX.** Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

67415 Fine needle aspiration of orbital contents

could be found in the index under the following main terms:

Aspiration
Orbital Contents, 67415
OR
Fine Needle Aspiration
Orbital Contents, 67415
OR
Orbital Contents
Aspiration, 67415

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

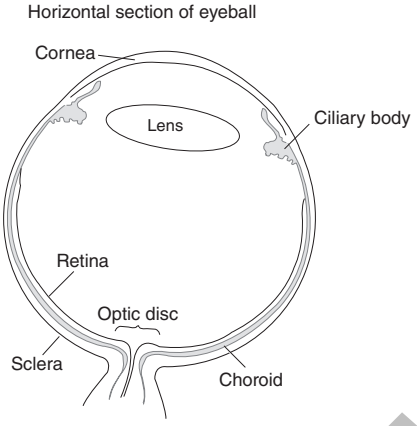
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

67221-67225 1

67221 Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)

\+ **67225** photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)

The choroid is the middle layer of the posterior eyeball shell. The choroid contains much of the vascular supply to the retina 2



Explanation 3

The physician performs photodynamic therapy. This is a two-step procedure used for wet type macular degeneration to treat the abnormal blood vessels that grow under the retina. The fluid and blood present from the new blood vessel growth causes scar formation that destroys vision. Photodynamic therapy closes the abnormal blood vessels to stop or stabilize leakage and improve vision. First, the physician injects the drug Visudyne (verteporfin) intravenously into the patient's arm. This is a dye that marks the abnormal blood vessels under the retina by binding to them. A few minutes after the injection, the ophthalmologist shines a non-thermal 689-nanometer laser light into the patient's eye to activate the drug. The light reacts with the photosensitive chemical in verteporfin, and releases active oxygen molecules that cause cell death in the leaking blood vessels but not healthy ones. When the dye interacts with the light, the abnormal vessels are destroyed and closed off but the normal ones are spared. Report 67221 when photodynamic therapy is performed on one eye and 67225 when photodynamic therapy is performed on the second eye during the same session.

Coding Tips 4

Injection of the verteporfin is included in 67221 and is not reported separately. Supplies used when providing these procedures may be reported with HCPCS Level II code J3396. Medicare and some other payers may require G0186 be reported for these services. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes 5

C69.31 Malignant neoplasm of right choroid ☑

C69.32 Malignant neoplasm of left choroid ☑

D09.21 Carcinoma in situ of right eye ☑

D09.22 Carcinoma in situ of left eye ☑

D31.31 Benign neoplasm of right choroid ☑

D31.32 Benign neoplasm of left choroid ☑

D49.81 Neoplasm of unspecified behavior of retina and choroid

Associated HCPCS Codes 6

G0186 Destruction of localized lesion of choroid (for example, choroidal neovascularization); photocoagulation, feeder vessel technique (one or more sessions)

AMA: **67221** 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016, 2015,Jan,16 **67225** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2016,Feb,12; 2015,Jan,16 7

Relative Value Units/Medicare Edits 8

Non-Facility RVU	Work	PE	MP	Total
67221	3.45	4.35	0.26	8.06
67225	0.47	0.34	0.04	0.85
Facility RVU	**Work**	**PE**	**MP**	**Total**
67221	3.45	2.32	0.26	6.03
67225	0.47	0.29	0.04	0.8

	FUD	Status	MUE	Modifiers				IOM Reference
67221	0	R	1(2)	51	N/A	N/A	N/A	100-03,80.2
67225	N/A	A	1(2)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know 9

choroid. Thin, nourishing vascular layer of the eye that supplies blood to the retina, arteries, and nerves to structures in the anterior part of the eye.

neovascularization. Formation of abnormal blood vessels in the eye, often found in diabetic retinopathy, central retinal vein obstruction, or macular degeneration. These blood vessels are fragile and tend to hemorrhage.

verteporfin. Intravenous drug that is light activated and approved for treatment of age-related macular degeneration.

1. CPT Codes and Descriptions

This edition of *Coding Companion* is updated with CPT codes for year 2023.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum360 and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2023.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier26) component of a procedure is provided.

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient's encounter is classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The decision tree on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number/complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are no longer used when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2020,Dec,11; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99204** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3 **99205** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.1	0.09	2.12
99203	1.6	1.51	0.15	3.26
99204	2.6	2.04	0.23	4.87
99205	3.5	2.62	0.31	6.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.15	2.42
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

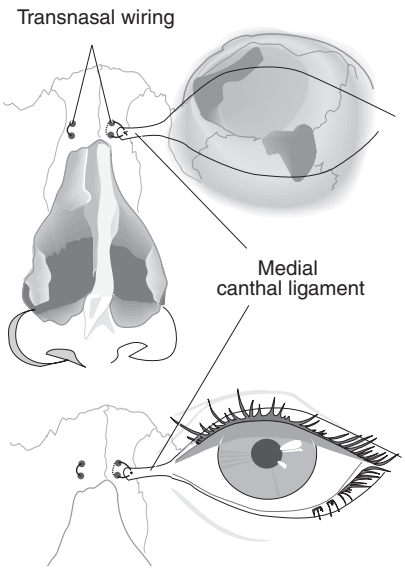
* with documentation

Terms To Know

new patient. Patient who is receiving face-to-face care from a provider/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider based clinic or emergency department, within the past three years.

21280

21280 Medial canthopexy (separate procedure)



Ligament and wire are passed through drilled hole and ligated to bone

Explanation

The physician reattaches the medial canthal ligament. The medial canthal ligament is attached medially to nasal-orbital bones and laterally to the orbital fascia, the upper eyelid, and the lower eyelid. The ligament is isolated through a bicoronal incision or through skin incisions placed beside the ligament. After locating the ligament, stainless steel suture or wire is placed through the ligament. A hole is made in the nasal bones on the opposite side with a drill or awl. The suture or wire is passed under the nasal complex to the opposite side through the bony hole. The suture or wire is ligated to the bone. Any incisions are repaired with a layered closure.

Coding Tips

Detachment of the medial canthal ligament usually results from fractures of the nasal-orbital-ethmoidal region or from laceration of the ligament. This separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append 59 or an X{EPSU} modifier. For lateral canthopexy, see 21282. For medial or lateral canthoplasty, see 67950. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

Q10.3 Other congenital malformations of eyelid

Q15.8 Other specified congenital malformations of eye

S00.272A Other superficial bite of left eyelid and periocular area, initial encounter ☑

S01.111A Laceration without foreign body of right eyelid and periocular area, initial encounter ☑

S01.112A Laceration without foreign body of left eyelid and periocular area, initial encounter ☑

S01.121A Laceration with foreign body of right eyelid and periocular area, initial encounter ☑

S01.122A Laceration with foreign body of left eyelid and periocular area, initial encounter ☑

S01.131A Puncture wound without foreign body of right eyelid and periocular area, initial encounter ☑

S01.132A Puncture wound without foreign body of left eyelid and periocular area, initial encounter ☑

S01.141A Puncture wound with foreign body of right eyelid and periocular area, initial encounter ☑

S01.142A Puncture wound with foreign body of left eyelid and periocular area, initial encounter ☑

S01.151A Open bite of right eyelid and periocular area, initial encounter ☑

S01.152A Open bite of left eyelid and periocular area, initial encounter ☑

S05.21XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, right eye, initial encounter ☑

S05.31XA Ocular laceration without prolapse or loss of intraocular tissue, right eye, initial encounter ☑

S05.32XA Ocular laceration without prolapse or loss of intraocular tissue, left eye, initial encounter ☑

S05.41XA Penetrating wound of orbit with or without foreign body, right eye, initial encounter ☑

S05.42XA Penetrating wound of orbit with or without foreign body, left eye, initial encounter ☑

S05.51XA Penetrating wound with foreign body of right eyeball, initial encounter ☑

S05.52XA Penetrating wound with foreign body of left eyeball, initial encounter ☑

S05.61XA Penetrating wound without foreign body of right eyeball, initial encounter ☑

S05.62XA Penetrating wound without foreign body of left eyeball, initial encounter ☑

AMA: **21280** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21280	7.13	9.06	0.71	16.9
Facility RVU	**Work**	**PE**	**MP**	**Total**
21280	7.13	9.06	0.71	16.9

	FUD	Status	MUE	Modifiers				IOM Reference
21280	90	A	1(2)	51	50	N/A	80*	None

* with documentation

Terms To Know

medial canthopexy. Fixation or reattachment of the medial canthal ligament of the eye.

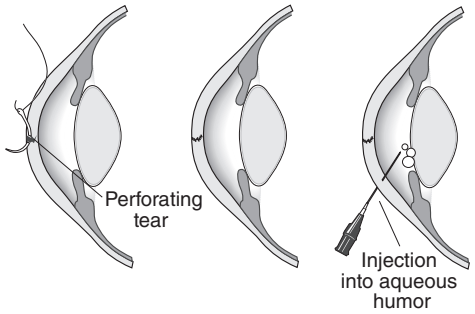
medial canthus. Junction of the upper and lower eyelids near the nose.

65275-65285

65275 Repair of laceration; cornea, nonperforating, with or without removal foreign body

65280 cornea and/or sclera, perforating, not involving uveal tissue

65285 cornea and/or sclera, perforating, with reposition or resection of uveal tissue



Explanation

The physician removes any foreign body from the cornea with a hollow needle or forceps and the wound is irrigated. The nonperforating tear in the cornea (e.g., 65275) is repaired with sutures. In 65280 and 65285, the perforating tear in the cornea and any tear in the sclera may be sutured. The cornea may be splinted using a soft contact lens bandage. An air or saline injection may be required to reestablish proper ocular pressure in the anterior chamber. If the laceration involves the uveal tissue (the vascular layer beneath the sclera), injured tissue may be cut out or repositioned before the uvea is sutured (e.g., 65285), and the sclera and conjunctiva may each require separate closure. In any of the three procedures, topical antibiotic or a pressure patch may be applied.

Coding Tips

Repair of the laceration includes any use of a conjunctival flap or restoration of the anterior chamber by air or saline injection. These procedures are generally performed with a topical anesthetic, a subconjunctival injection, or retrobulbar injection rather than general anesthesia. If a therapeutic contact lens is applied, it can be reported separately with 92071. For repair of the iris or ciliary body, see 66680. For repair of a wound of the lacrimal system, see 68700. For repair of an operative wound, see 66250; codes 65280 and 65285 are not used for this repair. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

S05.00XA Injury of conjunctiva and corneal abrasion without foreign body, unspecified eye, initial encounter

S05.01XA Injury of conjunctiva and corneal abrasion without foreign body, right eye, initial encounter ☑

S05.02XA Injury of conjunctiva and corneal abrasion without foreign body, left eye, initial encounter ☑

S05.21XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, right eye, initial encounter ☑

S05.22XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, left eye, initial encounter ☑

S05.30XA Ocular laceration without prolapse or loss of intraocular tissue, unspecified eye, initial encounter

S05.31XA Ocular laceration without prolapse or loss of intraocular tissue, right eye, initial encounter ☑

S05.32XA Ocular laceration without prolapse or loss of intraocular tissue, left eye, initial encounter ☑

AMA: **65275** 2016,Feb,12 **65280** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2016,Feb,12; 2015,Jan,16 **65285** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2016,Feb,12; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
65275	6.29	10.51	0.47	17.27
65280	9.1	9.6	0.68	19.38
65285	15.36	15.46	1.15	31.97
Facility RVU	**Work**	**PE**	**MP**	**Total**
65275	6.29	6.58	0.47	13.34
65280	9.1	9.6	0.68	19.38
65285	15.36	15.46	1.15	31.97

	FUD	Status	MUE	Modifiers				IOM Reference
65275	90	A	1(3)	51	50	N/A	80*	None
65280	90	A	1(3)	51	50	N/A	80*	
65285	90	A	1(3)	51	50	N/A	N/A	

* with documentation

Terms To Know

conjunctiva. Mucous membrane lining of the eyelids and covering of the exposed, anterior sclera.

cornea. Five-layered, transparent structure that forms the anterior or front part of the sclera of the eye.

fluorescein stain. Fluorescein dye is instilled into the eye to stain local defects that are visible with cobalt blue illumination.

foreign body. Any object or substance found in an organ and tissue that does not belong under normal circumstances.

laceration. Tearing injury; a torn, ragged-edged wound.

resection. Surgical removal of a part or all of an organ or body part.

sclera. White, fibrous, outer coating of the eye continuous with the cornea anteriorly and the optic nerve sheath posteriorly that is covered with conjunctival tissue.

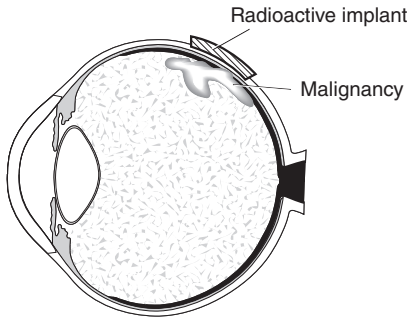
uvea. Vascular coat of the eye located in the middle, pigmentary region composed of the iris, choroid, and ciliary body.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

67218

67218 Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; radiation by implantation of source (includes removal of source)

A radioactive implant is secured in the posterior segment at the site of the lesion. The implant is later retrieved



Explanation

The physician treats a malignancy, tumor, growth, or edema by exposing it to a radioactive implant. The plaque-like implant is secured with sutures to the sclera overlying the site of a malignancy. At a future time, the physician recovers the implant. The incision is repaired. An antibiotic ointment and pressure patch may be applied.

Coding Tips

Multiple sessions are reported only once during the global period. The retrieval of the implant is included as part of this procedure and should not be reported separately. This procedure is generally performed with a retrobulbar injection rather than general anesthesia. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

C69.21 Malignant neoplasm of right retina ☑
C69.22 Malignant neoplasm of left retina ☑
C69.31 Malignant neoplasm of right choroid ☑
C69.32 Malignant neoplasm of left choroid ☑
D09.21 Carcinoma in situ of right eye ☑
D09.22 Carcinoma in situ of left eye ☑
D18.09 Hemangioma of other sites
D31.21 Benign neoplasm of right retina ☑
D31.22 Benign neoplasm of left retina ☑
D31.31 Benign neoplasm of right choroid ☑
D31.32 Benign neoplasm of left choroid ☑
D49.81 Neoplasm of unspecified behavior of retina and choroid

AMA: **67218** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2016,Feb,12; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
67218	20.36	18.32	1.51	40.19
Facility RVU	**Work**	**PE**	**MP**	**Total**
67218	20.36	18.32	1.51	40.19

	FUD	Status	MUE	Modifiers				IOM Reference
67218	90	A	1(2)	51	50	N/A	N/A	None

* with documentation

Terms To Know

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

destruction. Ablation or eradication of a structure or tissue.

hemangioma. Benign neoplasm arising from vascular tissue or malformations of vascular structures. It is most commonly seen in children and infants as a tumor of newly formed blood vessels due to malformed fetal angioblastic tissues.

interstitial radiation. Radioactive source placed into the tissue being treated.

localization. Limitation to one area.

macula. Central region of the retina responsible for the sharpest vision, allowing for reading and color visualization.

malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other body areas.

ocular implant. Implant inside muscular cone.

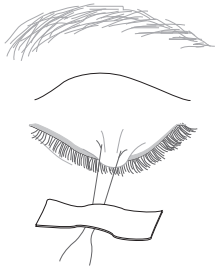
orbital implant. Implant outside the muscular cone of the eye.

radioactive substances. Materials used in the diagnosis and treatment of disease that emit high-speed particles and energy-containing rays.

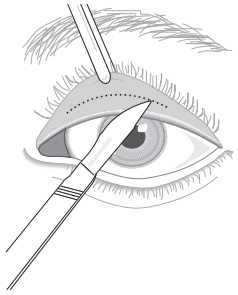
67909

67909 Reduction of overcorrection of ptosis

A previous surgery created a new defect that is repaired here



The physician incises the levator aponeurosis and repositions it; the incision is repaired with sutures



Explanation

The physician reduces overcorrection of ptosis. The physician administers a local anesthetic and the patient's face and eyelid are draped and prepped for surgery. With an incision usually at the site of the previous incision, the physician attempts to reduce a previous overcorrection of ptosis. The levator aponeurosis is cut free of or disinserted from its attachment to the levator aponeurosis, and the incision is repaired with sutures.

Coding Tips

Local anesthesia is included in this service and should not be reported separately. This procedure includes the use of the operating microscope (69990). If the reduction of overcorrection of ptosis is performed by the same surgeon and within the global period of the original surgery, it is not reported separately. Some payers require that the eyelid treated be reported by appending modifier E1 for the left upper eyelid or E3 for the right upper eyelid. For correction of lid retraction, see 67911. Use of an operating microscope is included in this procedure. Do not report 69990 separately. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

H59.89 Other postprocedural complications and disorders of eye and adnexa, not elsewhere classified

AMA: **67909** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2016,Feb,12; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
67909	5.57	10.15	0.48	16.2
Facility RVU	**Work**	**PE**	**MP**	**Total**
67909	5.57	6.6	0.48	12.65

	FUD	Status	MUE	Modifiers				IOM Reference
67909	90	A	1(2)	51	50	N/A	N/A	None

* with documentation

Terms To Know

adnexa. Appendages, adjunct parts, or connecting structures, related by functionality.

aponeurosis. Flat expansion of white, ribbon-like tendinous tissue that functions as the connection of a muscle to its moving part.

atrophy. Reduction in size or activity in an anatomic structure, due to wasting away from disease or other factors.

blepharochalasis. Loss of elasticity and relaxation of skin of the eyelid, thickened or indurated skin on the eyelid associated with recurrent episodes of edema, and intracellular atrophy.

cicatricial entropion. Scarring that results in inversion of the eyelid, causing the lid margin to rest against and irritate the eyeball.

congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.

edema. Swelling due to fluid accumulation in the intercellular spaces.

incision. Act of cutting into tissue or an organ.

local anesthesia. Induced loss of feeling or sensation restricted to a certain area of the body, including topical, local tissue infiltration, field block, or nerve block methods.

myogenic ptosis. Drooping of a muscle due to a defect.

operating microscope. Compound microscope with two or more lens systems or several grouped lenses in one unit that provides magnifying power to the surgeon up to 40X.

ptosis. Drooping or displacement of the upper eyelid, caused by paralysis, muscle problems, or outside mechanical forces.

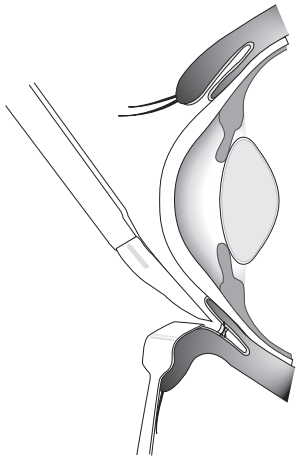
retraction. Act of holding tissue or a structure back away from its normal position or the field of interest.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

68340

68340 Repair of symblepharon; division of symblepharon, with or without insertion of conformer or contact lens

The adhesion (symblepharon) between the bulbar and tarsal conjunctiva is severed



A temporary contact lens or conformer may be applied

Explanation

A symblepharon is an adhesion between the conjunctiva on the eyeball (bulbar conjunctiva) and the conjunctiva on the inner eyelid (tarsal conjunctiva). The patient's face and eyelid are draped and prepped for surgery. Local anesthesia is administered. The physician divides the adhesions between the globe and palpebral conjunctiva. No other repair is usually needed, although a conformer or contact lens may be placed in the eye to prevent the development of further adhesions during the healing process.

Coding Tips

For wound repair, see 65270–65273. For symblepharon repair without graft, see 68330; with graft, see 68335. Supplies used when providing this procedure may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

H11.231 Symblepharon, right eye ☑
H11.232 Symblepharon, left eye ☑
H11.233 Symblepharon, bilateral ☑
H11.239 Symblepharon, unspecified eye

AMA: **68340** 2016,Feb,12

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
68340	4.97	12.38	0.37	17.72
Facility RVU	**Work**	**PE**	**MP**	**Total**
68340	4.97	6.13	0.37	11.47

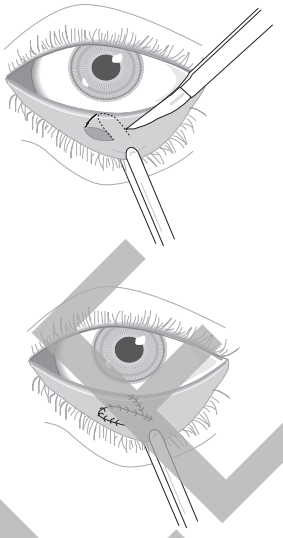
	FUD	Status	MUE	Modifiers				IOM Reference
68340	90	A	1(3)	51	50	N/A	80*	None

* with documentation

68360

68360 Conjunctival flap; bridge or partial (separate procedure)

A tongue of conjunctiva is freed and advanced via a flap to another site where it is secured with sutures



This can be performed on conjunctival tissue of the eyeball or of the eyelid

Explanation

The patient's face and eyelid are draped and prepped for surgery. Local anesthesia is administered. The physician elevates the conjunctiva from the Tenon's capsule and a small tongue of free conjunctiva is advanced via a flap to another site where it is secured with sutures.

Coding Tips

This separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append 59 or an X{EPSU} modifier. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

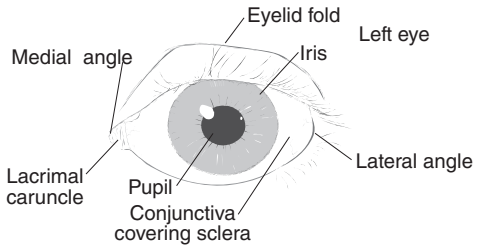
ICD-10-CM Diagnostic Codes

B00.52 Herpesviral keratitis
B94.0 Sequelae of trachoma
C69.01 Malignant neoplasm of right conjunctiva ☑
C69.02 Malignant neoplasm of left conjunctiva ☑
D09.21 Carcinoma in situ of right eye ☑
D09.22 Carcinoma in situ of left eye ☑
D31.01 Benign neoplasm of right conjunctiva ☑
D31.02 Benign neoplasm of left conjunctiva ☑
D48.7 Neoplasm of uncertain behavior of other specified sites
D49.89 Neoplasm of unspecified behavior of other specified sites
H11.011 Amyloid pterygium of right eye ☑
H11.041 Peripheral pterygium, stationary, right eye ☑
H11.061 Recurrent pterygium of right eye ☑
H11.211 Conjunctival adhesions and strands (localized), right eye ☑
H11.221 Conjunctival granuloma, right eye ☑

 N Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only

92002

92002 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient



Explanation

The physician sees a new patient, one who has not been seen within that group practice for at least three years, for intermediate ophthalmological services. The patient's medical history is reviewed, or interval history if more than three years have passed since the patient was seen within that group practice. General medical observations, an external ocular and adnexal examination, and other diagnostic procedures like ophthalmoscopy, biomicroscopy, or tonometry are done. The visit may include mydriasis (the dilation of the patient's pupils). Generally, the patient has an acute condition that does not require a comprehensive service or the patient is being examined for a chronic, but stable, condition (i.e., known cataract).

Coding Tips

A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty who belongs to the same group practice within the past three years. Report general ophthalmological service codes 92002–92014 or an appropriate evaluation and management service when the physician provides the prescription, fitting, and/or medical supervision services for adaptation of an artificial eye. Do not report 92002 with 99173-99174 or 99177. Medicare has provisionally identified this code as a telehealth/telemedicine service. Current Medicare coverage guidelines should be reviewed. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to this procedure code. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

H00.011 Hordeolum externum right upper eyelid ☑
H00.012 Hordeolum externum right lower eyelid ☑
H02.421 Myogenic ptosis of right eyelid ☑
H02.831 Dermatochalasis of right upper eyelid ☑
H02.832 Dermatochalasis of right lower eyelid ☑
H04.121 Dry eye syndrome of right lacrimal gland ☑
H10.11 Acute atopic conjunctivitis, right eye ☑
H10.45 Other chronic allergic conjunctivitis
H11.31 Conjunctival hemorrhage, right eye ☑
H16.221 Keratoconjunctivitis sicca, not specified as Sjogren's, right eye ☑
H18.511 Endothelial corneal dystrophy, right eye ☑
H18.521 Epithelial (juvenile) corneal dystrophy, right eye ☑
H18.531 Granular corneal dystrophy, right eye ☑
H18.541 Lattice corneal dystrophy, right eye ☑
H18.551 Macular corneal dystrophy, right eye ☑
H25.011 Cortical age-related cataract, right eye A ☑
H25.11 Age-related nuclear cataract, right eye A ☑
H25.811 Combined forms of age-related cataract, right eye A ☑
H26.491 Other secondary cataract, right eye ☑
H35.031 Hypertensive retinopathy, right eye ☑
H35.371 Puckering of macula, right eye ☑
H35.81 Retinal edema
H40.001 Preglaucoma, unspecified, right eye ☑
H40.011 Open angle with borderline findings, low risk, right eye ☑
H40.031 Anatomical narrow angle, right eye ☑
H43.391 Other vitreous opacities, right eye ☑
H43.811 Vitreous degeneration, right eye ☑
H53.2 Diplopia
M35.01 Sjögren syndrome with keratoconjunctivitis
S05.01XA Injury of conjunctiva and corneal abrasion without foreign body, right eye, initial encounter ☑
S05.02XA Injury of conjunctiva and corneal abrasion without foreign body, left eye, initial encounter ☑
Z01.020 Encounter for examination of eyes and vision following failed vision screening without abnormal findings
Z01.021 Encounter for examination of eyes and vision following failed vision screening with abnormal findings

AMA: 92002 2018,Jan,8; 2018,Feb,11; 2018,Feb,3; 2017,Sep,14; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92002	0.88	1.59	0.04	2.51
Facility RVU	**Work**	**PE**	**MP**	**Total**
92002	0.88	0.44	0.04	1.36

	FUD	Status	MUE	Modifiers				IOM Reference
92002	N/A	A	1(2)	N/A	N/A	N/A	80*	100-02,15,30.4; 100-04,4,160

* with documentation

Terms To Know

cataract. Clouding or opacities of the lens that stop clear images from forming on the retina, causing vision impairment or blindness.

choroid. Thin, nourishing vascular layer of the eye that supplies blood to the retina, arteries, and nerves to structures in the anterior part of the eye.

cornea. Five-layered, transparent structure that forms the anterior or front part of the sclera of the eye.

dilation. Artificial increase in the diameter of an opening or lumen made by medication or by instrumentation.

retina. Layer of tissue located at the back of the eye that is sensitive to light similar to that of film in a camera.

tonometry. Measurement of intraocular pressure, usually by means of an instrument placed directly on the eye.

Correct Coding Initiative Update

❖Indicates Mutually Exclusive Edit

0071T 0213T, 0216T, 36000, 36410, 36591-36592, 51701-51702, 57180, 57400-57410, 57452, 57500, 57530, 57800, 58100, 61650, 62324-62327, 64415-64417, 64435, 64450, 64454, 64486-64490, 64493, 69990, 72195-72197, 74712, 76376-76380, 76940, 76998, 77013, 77021-77022, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452, G0471

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