Optum

Coding Companion

Ophthalmology

A comprehensive illustrated guide to coding and reimbursement

2024

optumcoding.com

Contents

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/HCPCS 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/HCPCS 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 Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. 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.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT code description, followed by an easy-to-understand explanation.

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, RVUs, HCPCS, 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 28.3, 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 website address is http://www.optumcoding.com/ProductUpdates/. The 2024 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.

Sample Page and Key

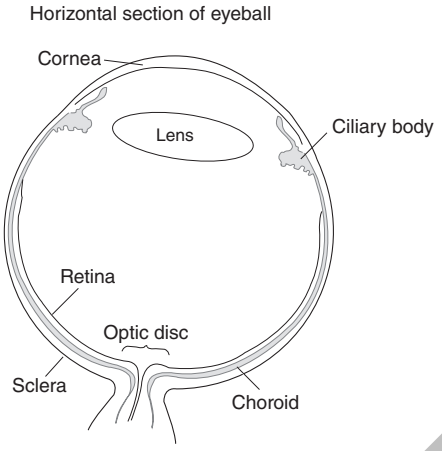
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

67221-67225

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



Explanation

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

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

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

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

AMA: **67221** 2018,Feb; 2016,Feb **67225** 2016,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
67221	3.45	4.24	0.25	7.94
67225	0.47	0.34	0.04	0.85
Facility RVU	**Work**	**PE**	**MP**	**Total**
67221	3.45	2.32	0.25	6.02
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

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/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2024.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ 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 audio-visual 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 93 or 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.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

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 Optum 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.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2023 edition password is **23SPECIALTY**.

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

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care 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 inpatient and observation care 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 codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

New and Established Patients

▶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 evaluation and management services. 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 **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

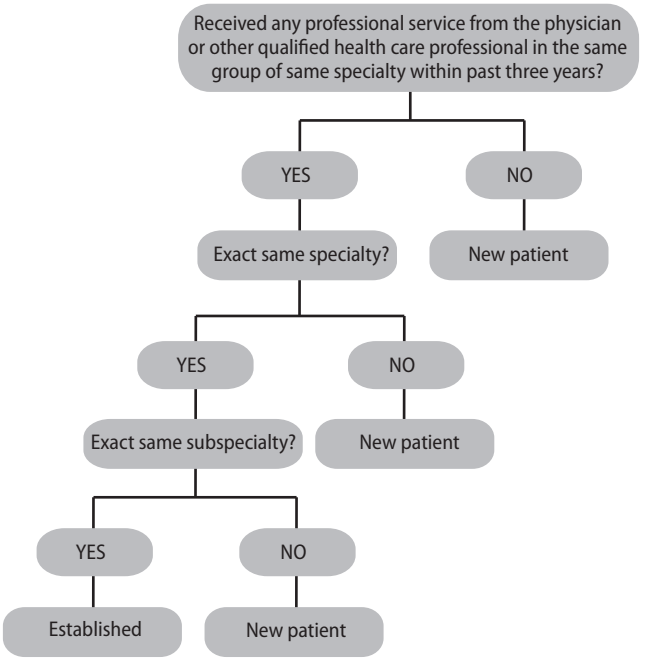
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other 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 subspecialty** 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 for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶◀ = Contains new or revised text

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 and 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 not considered 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 patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. 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** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.6	1.52	0.17	3.29
99204	2.6	2.06	0.24	4.9
99205	3.5	2.66	0.32	6.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.17	2.44
99204	2.6	1.11	0.24	3.95
99205	3.5	1.54	0.32	5.36

	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

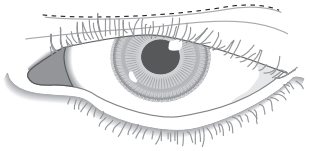
Terms To Know

new patient. Patient who is receiving face-to-face care from a physician or other 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.

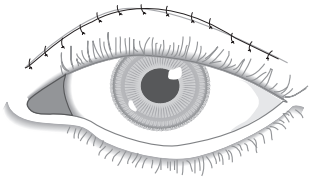
15822-15823

15822 Blepharoplasty, upper eyelid;
15823 with excessive skin weighting down lid

An incision is made in the crease of the upper eyelid. Excess tissue is excised from the upper eyelid



The incision is closed with sutures



Explanation

The physician performs a blepharoplasty of the upper eyelid. Through an incision usually in the crease of the upper eyelid, the physician dissects the skin of the upper eyelid to the subcutaneous/muscle fascial layers. The skin is pulled tight and redundant skin is excised. Muscle fascia may be sutured to support sagging muscles. In 15823, orbital fat may be removed from the tissues as well as excessive redundant skin that mechanically weighs down the eyelid, obstructing the visual field. The incision is closed with layers.

Coding Tips

These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). These codes may report elective blepharoplasty performed for cosmetic reasons. Since these procedures may not be medically necessary, the patient may be responsible for charges. Since visual field examination codes 92081-92083 are performed before scheduling a patient for a blepharoplasty, these codes should not be reported separately for the same date of service. Verify with the insurance carrier for coverage. Codes 15822-15823 require Medicare prior approval for hospital outpatient departments (OPD). Check with other payers regarding prior approval policies. For blepharoplasty of the lower eyelid, see 15820 and 15821. For ectropion and entropion repair, see 67914–67924. 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

H02.31 Blepharochalasis right upper eyelid ☑
H02.34 Blepharochalasis left upper eyelid ☑
H02.411 Mechanical ptosis of right eyelid ☑
H02.412 Mechanical ptosis of left eyelid ☑
H02.421 Myogenic ptosis of right eyelid ☑
H02.422 Myogenic ptosis of left eyelid ☑
H02.431 Paralytic ptosis of right eyelid ☑
H02.432 Paralytic ptosis of left eyelid ☑
H02.831 Dermatochalasis of right upper eyelid ☑
H02.834 Dermatochalasis of left upper eyelid ☑
H02.89 Other specified disorders of eyelid
L90.5 Scar conditions and fibrosis of skin
L91.8 Other hypertrophic disorders of the skin
Q10.3 Other congenital malformations of eyelid
Z41.1 Encounter for cosmetic surgery

AMA: **15822** 2022,Feb; 2021,Aug; 2021,Mar **15823** 2022,Feb; 2021,Aug; 2021,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
15822	4.62	8.51	0.54	13.67
15823	6.81	10.86	0.6	18.27
Facility RVU	**Work**	**PE**	**MP**	**Total**
15822	4.62	6.6	0.54	11.76
15823	6.81	8.71	0.6	16.12

	FUD	Status	MUE	Modifiers				IOM Reference
15822	90	A	1(2)	51	50	N/A	N/A	None
15823	90	A	1(2)	51	50	N/A	N/A	

* with documentation

Terms To Know

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.

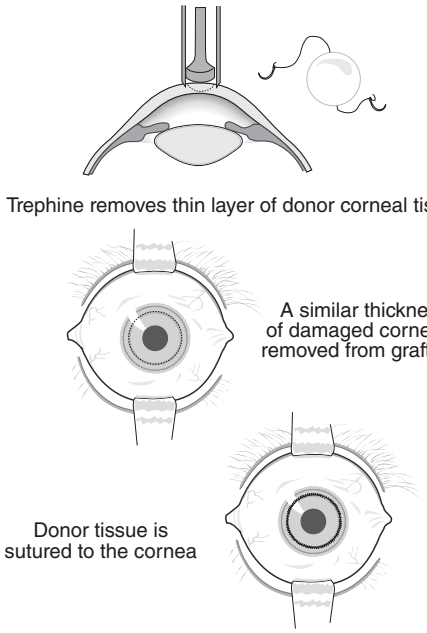
blepharoplasty. Plastic surgery of the eyelids to remove excess fat and redundant skin weighting down the lid. The eyelid is pulled tight and sutured to support sagging muscles.

dermatochalasis. Acquired form of connective tissue disease in which decreased elastic tissue formation and abnormal elastin production result in loss of elasticity. Usually a cosmetic problem, it can be associated with aging and may affect the visual field.

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

65710

65710 Keratoplasty (corneal transplant); anterior lamellar



Explanation

The physician performs an anterior lamellar corneal transplant (keratoplasty). "Lamellar" means thin layer and refers to the outermost layers of the cornea. The physician measures the patient's cornea to select the size of trephine that will be used to excise corneal tissue. The physician punches a circular hole in the outermost layers of the cornea of a donor eye, using the trephine. The physician removes the round layer of corneal tissue, threads it with sutures, and sets it aside. The trephine is used to repeat this process in the cornea of the patient, removing the defective corneal tissue. The donor cornea is of similar diameter and thickness as the removed tissue. The donor cornea is positioned with the preplaced sutures; additional sutures secure it to the cornea. The physician may use a saline or air injection into the anterior chamber during the procedure. When the procedure is completed, the speculum is removed. Antibiotic ointment and a pressure patch may be applied. This code includes preparation of the donor material.

Coding Tips

All corneal transplant codes include the use of fresh or preserved grafts and the preparation by the physician of these materials. Do not use this code to report refractive keratoplasty procedures. Do not report 65710 with 92025 for computerized corneal topography. For fitting of a contact lens for treatment of disease, see 92071 or 92072. For laser incisions in the donor and recipient corneas prior to a corneal transplant, see 69999. This procedure is generally performed with a subconjunctival injection rather than general anesthesia. This code is also used to report the rotation of a patient's own lamellar corneal tissue in an uncommon procedure in which the patient's corneal tissue is excised, rotated, and reattached to move a corneal defect out of the visual field. 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

H16.071 Perforated corneal ulcer, right eye ☑
H16.331 Sclerosing keratitis, right eye ☑
H17.11 Central corneal opacity, right eye ☑
H17.811 Minor opacity of cornea, right eye ☑
H17.821 Peripheral opacity of cornea, right eye ☑
H18.11 Bullous keratopathy, right eye ☑
H18.211 Corneal edema secondary to contact lens, right eye ☑
H18.221 Idiopathic corneal edema, right eye ☑
H18.421 Band keratopathy, right eye ☑
H18.43 Other calcerous corneal degeneration
H18.441 Keratomalacia, right eye ☑
H18.451 Nodular corneal degeneration, 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 ☑
H18.611 Keratoconus, stable, right eye ☑
H18.621 Keratoconus, unstable, right eye ☑
H18.731 Descemetocele, right eye ☑
H18.831 Recurrent erosion of cornea, right eye ☑
H18.891 Other specified disorders of cornea, right eye ☑
Q13.3 Congenital corneal opacity
Q13.4 Other congenital corneal malformations
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 ☑
S05.51XA 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 ☑
T85.318A Breakdown (mechanical) of other ocular prosthetic devices, implants and grafts, initial encounter
T86.8411 Corneal transplant failure, right eye ☑
T86.8421 Corneal transplant infection, right eye ☑
T86.8481 Other complications of corneal transplant, right eye ☑

AMA: **65710** 2016,Feb

Relative Value Units/Medicare Edits

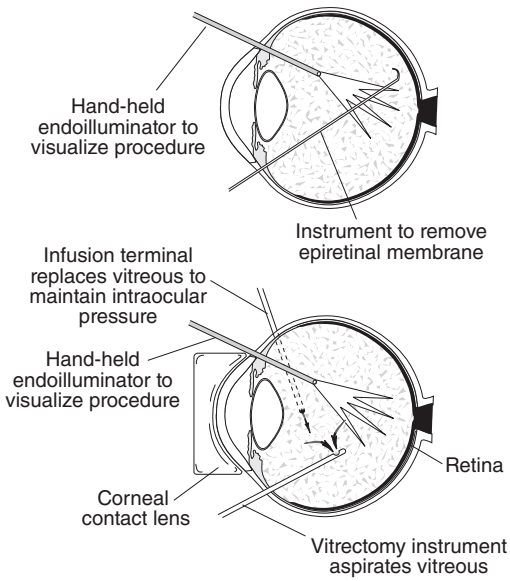
Non-Facility RVU	Work	PE	MP	Total
65710	14.45	17.67	1.1	33.22
Facility RVU	**Work**	**PE**	**MP**	**Total**
65710	14.45	17.67	1.1	33.22

	FUD	Status	MUE	Modifiers				IOM Reference
65710	90	A	1(2)	51	50	62*	80	100-03,80.7

* with documentation

67036

67036 Vitrectomy, mechanical, pars plana approach;



Explanation

The physician performs a mechanical vitrectomy, utilizing a pars plana approach. The physician applies a special contact lens to the cornea to better visualize the back of the eye. Three small incisions are made in the eyeball, each about 4 mm from the juncture of the cornea and sclera. One incision is for a light cannula, one for an infusion cannula, and one for the cutting or suction instruments. The physician extracts the vitreous, using a mechanical cutting and suctioning process that may involve a rotoextractor or vitreous infusion suction cutter (VISC). This is often called a posterior sclerotomy in operative reports. The cannulas are extracted and the incisions repaired with layered closures. Injections may be required to reestablish intraocular pressure. A topical antibiotic or pressure patch may be applied.

Coding Tips

This procedure is generally performed with a retrobulbar injection rather than general anesthesia. For use of vitrectomy in retinal detachment surgery, see 67108 and 67113. For use of the ophthalmic endoscope with this procedure, see 66990. For associated lensectomy, see 66840–66940. For associated removal of a foreign body, see 65260 and 65265. For radiation application to the intraocular epiretinal area, report 67299 in addition to 67036. 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

H33.011 Retinal detachment with single break, right eye ☑
H33.021 Retinal detachment with multiple breaks, right eye ☑
H33.031 Retinal detachment with giant retinal tear, right eye ☑
H33.041 Retinal detachment with retinal dialysis, right eye ☑
H33.051 Total retinal detachment, right eye ☑
H33.21 Serous retinal detachment, right eye ☑
H33.41 Traction detachment of retina, right eye ☑
H34.821 Venous engorgement, right eye ☑
H35.021 Exudative retinopathy, right eye ☑
H35.121 Retinopathy of prematurity, stage 1, right eye ☑
H35.131 Retinopathy of prematurity, stage 2, right eye ☑
H35.141 Retinopathy of prematurity, stage 3, right eye ☑
H35.151 Retinopathy of prematurity, stage 4, right eye ☑
H35.161 Retinopathy of prematurity, stage 5, right eye ☑
H35.341 Macular cyst, hole, or pseudohole, right eye ☑
H43.01 Vitreous prolapse, right eye ☑
H43.11 Vitreous hemorrhage, right eye ☑
H43.21 Crystalline deposits in vitreous body, right eye ☑
H43.311 Vitreous membranes and strands, right eye ☑
H43.811 Vitreous degeneration, right eye ☑
H43.821 Vitreomacular adhesion, right eye 🅰 ☑
H44.011 Panophthalmitis (acute), right eye ☑
H44.021 Vitreous abscess (chronic), right eye ☑
H44.111 Panuveitis, right eye ☑
H44.641 Retained (old) magnetic foreign body in posterior wall of globe, right eye ☑
H44.651 Retained (old) magnetic foreign body in vitreous body, right eye ☑
H44.691 Retained (old) intraocular foreign body, magnetic, in other or multiple sites, right eye ☑
H44.741 Retained (nonmagnetic) (old) foreign body in posterior wall of globe, right eye ☑
H44.751 Retained (nonmagnetic) (old) foreign body in vitreous body, right eye ☑
H44.791 Retained (old) intraocular foreign body, nonmagnetic, in other or multiple sites, right eye ☑
H59.031 Cystoid macular edema following cataract surgery, right eye ☑
H59.89 Other postprocedural complications and disorders of eye and adnexa, not elsewhere classified
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 ☑
S05.51XA Penetrating wound with foreign body of right eyeball, initial encounter ☑
S05.52XA Penetrating wound with foreign body of left eyeball, initial encounter ☑

AMA: **67036** 2016,Sep; 2016,Feb

Relative Value Units/Medicare Edits

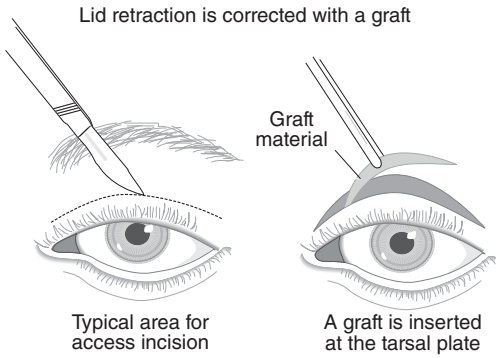
Non-Facility RVU	Work	PE	MP	Total
67036	12.13	12.85	0.95	25.93
Facility RVU	**Work**	**PE**	**MP**	**Total**
67036	12.13	12.85	0.95	25.93

	FUD	Status	MUE	Modifiers				IOM Reference
67036	90	A	1(2)	51	50	62*	80	None

* with documentation

67911

67911 Correction of lid retraction



Explanation

The physician administers local anesthetic and the patient's face and eyelid are draped and prepped for surgery. The physician outlines the incision line, usually in the crease of the upper lid. The distal portion of the tendon responsible for elevating the lid (levator aponeurosis) is isolated from its attachment to the tarsal plate. The levator aponeurosis is allowed to retract itself posteriorly or autogenous graft materials are inserted between the levator aponeurosis and the tarsal plate. The patient is generally placed in a sitting position and the amount of the retraction of the levator aponeurosis is judged by the position of the eyelid while the patient is sitting on the table. Alternatively, the eyelid margin may be placed approximately 2 mm below the limbus. When the lid is positioned satisfactorily, it is affixed. The incision is closed with sutures.

Coding Tips

This procedure includes a full-thickness graft and should not be reported separately. Harvesting of fascia lata or other tissue grafts is reported separately, see 15769, 20920, or 20922. For liposuction of fat for grafting, see 15773 and 15774. Code 67911 requires Medicare prior approval for hospital outpatient departments (OPD). Check with other payers regarding prior approval policies. For correction of trichiasis by mucous membrane graft, see 67835. For correction of lagophthalmos, see 67912. 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

H02.221	Mechanical lagophthalmos right upper eyelid ☑
H02.222	Mechanical lagophthalmos right lower eyelid ☑
H02.224	Mechanical lagophthalmos left upper eyelid ☑
H02.225	Mechanical lagophthalmos left lower eyelid ☑
H02.231	Paralytic lagophthalmos right upper eyelid ☑
H02.232	Paralytic lagophthalmos right lower eyelid ☑
H02.234	Paralytic lagophthalmos left upper eyelid ☑
H02.235	Paralytic lagophthalmos left lower eyelid ☑
H02.531	Eyelid retraction right upper eyelid ☑
H02.532	Eyelid retraction right lower eyelid ☑
H02.534	Eyelid retraction left upper eyelid ☑
H02.535	Eyelid retraction left lower eyelid ☑
H05.89	Other disorders of orbit
H16.211	Exposure keratoconjunctivitis, right eye ☑
H16.212	Exposure keratoconjunctivitis, left eye ☑
Q10.3	Other congenital malformations of eyelid

AMA: **67911** 2021,Nov; 2016,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
67911	7.5	8.07	0.6	16.17
Facility RVU	**Work**	**PE**	**MP**	**Total**
67911	7.5	8.07	0.6	16.17

	FUD	Status	MUE	Modifiers				IOM Reference
67911	90	A	2(3)	51	50	N/A	N/A	None

* with documentation

Terms To Know

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

blepharospasm. Involuntary contraction of the orbicularis oculi muscle, resulting in the eyelids being completely closed.

cranial nerve. Twelve paired bundles of nerves connected to the brain that control ocular, auditory, and nasal senses; facial muscles; and oral and throat muscles.

distal. Located farther away from a specified reference point or the trunk.

graft. Tissue implant from another part of the body or another person.

late effect. Abnormality, dysfunction, or other residual condition produced after the acute phase of an illness, injury, or disease is over. There is no time limit on when late effects can appear.

limbus. Border of the cornea where it meets the sclera.

paralytic lagophthalmos. Palsy of the seventh cranial nerve, which prevents full closure of the eyelids.

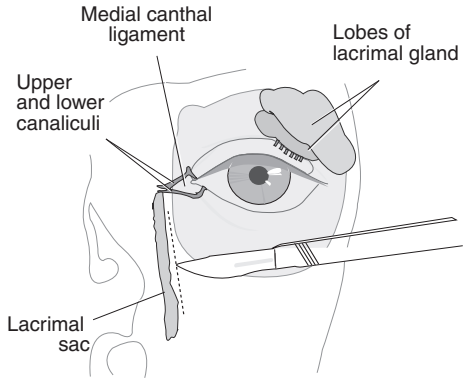
retraction. Act of holding tissue or a structure back away from its normal position or the field of interest.

spastic entropion. Intermittent and involuntary turning inward of the eyelid margin.

tendon. Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

68520

68520 Excision of lacrimal sac (dacryocystectomy)



The lacrimal sac is excised

Explanation

The lacrimal system serves to keep the conjunctiva and cornea moist through the production, distribution, and elimination of tears. The lacrimal sac is an enlarged portion of the lacrimal duct that eliminates these tears. The physician administers a local anesthetic along the medial canthal tendon. An incision is made midway between the bridge of the nose and the medial canthal tendon. The dissection is carried down to the periosteum overlying the bone of the superior lacrimal crest. A periosteal elevator is used to separate the lacrimal sac from its normal location. The sac is removed. The wound is repaired with layered sutures.

Coding Tips

For a biopsy of the lacrimal sac, see 68525. For excision of the lacrimal gland, see 68500–68505. 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

B55.1	Cutaneous leishmaniasis
C69.51	Malignant neoplasm of right lacrimal gland and duct ☑
C69.52	Malignant neoplasm of left lacrimal gland and duct ☑
D31.51	Benign neoplasm of right lacrimal gland and duct ☑
D31.52	Benign neoplasm of left lacrimal gland and duct ☑
D48.7	Neoplasm of uncertain behavior of other specified sites
D49.89	Neoplasm of unspecified behavior of other specified sites
H04.411	Chronic dacryocystitis of right lacrimal passage ☑

AMA: 68520 2016,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
68520	8.78	12.13	0.72	21.63
Facility RVU	**Work**	**PE**	**MP**	**Total**
68520	8.78	12.13	0.72	21.63

	FUD	Status	MUE	Modifiers				IOM Reference
68520	90	A	1(2)	51	50	N/A	80*	None

* with documentation

Terms To Know

anesthesia. Loss of feeling or sensation, usually induced to permit the performance of surgery or other painful procedures.

benign. Mild or nonmalignant in nature.

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.

dacryocystalgia. Pain within the lacrimal sac.

dacryocystitis. Lacrimal sac inflammation.

dacryocystocele. Hernia of the lacrimal sac.

dacryocystography. Radiographic examination of the lacrimal system, or tear ducts. A catheter is introduced into the canaliculus and radiopaque dye is injected.

dacryocystostenosis. Narrowing of the lacrimal sac.

dacryocystotome. Instrument used for incising the lacrimal duct strictures.

incision. Act of cutting into tissue or an organ.

lacrimal. Tear-producing gland or ducts that provides lubrication and flushing of the eyes and nasal cavities.

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.

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

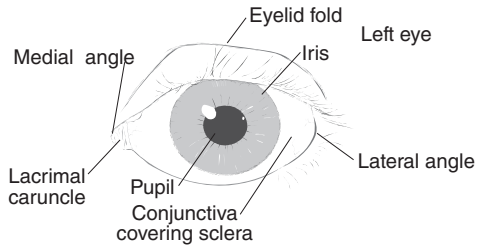
periosteum. Double-layered connective membrane on the outer surface of bone.

stenosis. Narrowing or constriction of a passage.

tendon. Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

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** 2021,Jan; 2018,Feb; 2017,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92002	0.88	1.61	0.04	2.53
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.

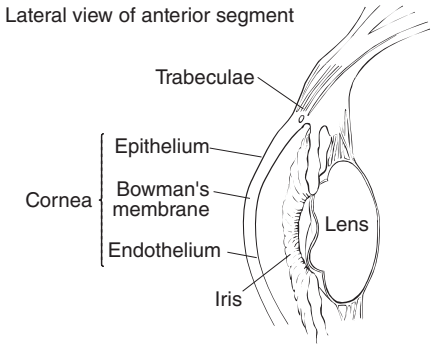
retina. Layer of tissue located at the back of the eye that is sensitive to light similar to that of film in a camera.

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

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

92287

92287 Anterior segment imaging with interpretation and report; with fluorescein angiography



Anterior components of the eye are photographed with equipment capable of providing microscopic images

Explanation

The physician performs microscopy to examine the iris. This procedure includes fluorescein angiography, which is for the detection of abnormalities of retinal blood vessels. The angioscopy begins when a small amount of fluorescein dye is injected into the arm. The dye is transported to the eye through the blood vessels. As the dye traverses the vessels in the iris, the iris is viewed through the scope using filters that enhance the fluorescence of the eye. This test is most often used to delineate fine neovascularization of tumors in the anterior segment.

Coding Tips

Venous access and the administration of dye are integral to this procedure and are not reported separately. This is a unilateral or bilateral procedure. Modifier 50 is not required for bilateral services and modifier 52 is not required when only one eye is examined. Routine ophthalmoscopy is included in general and special ophthalmological services and is not reported separately. For ophthalmic examination, see 92002–92014. For evaluation and management services, see 99202–99215 and 99242–99245. For anterior segment computerized ophthalmic diagnostic evaluation, see 92132.

ICD-10-CM Diagnostic Codes

E10.36	Type 1 diabetes mellitus with diabetic cataract
E11.3311	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye ☑
E11.3391	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye ☑
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye ☑
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye ☑
E11.36	Type 2 diabetes mellitus with diabetic cataract
H21.261	Iris atrophy (essential) (progressive), right eye ☑
Q12.0	Congenital cataract
Q12.1	Congenital displaced lens
Q12.2	Coloboma of lens
Q12.3	Congenital aphakia
Q12.4	Spherophakia

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92287	0.81	4.48	0.03	5.32
Facility RVU	**Work**	**PE**	**MP**	**Total**
92287	0.81	4.48	0.03	5.32

	FUD	Status	MUE	Modifiers				IOM Reference
92287	N/A	A	1(2)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

angiography. Radiographic imaging of the arteries. Imaging may be performed to study the vasculature of any given organ, body system, or area of circulation such as the brain, heart, chest, kidneys, limbs, gastrointestinal tract, aorta, and pulmonary circulation to visualize the formation and the function of the blood vessels to detect problems such as a blockage or stricture. A catheter is inserted through an accessible blood vessel and the artery is injected with a radiopaque contrast material after which x-rays are taken.

angioscopy. Visualization of capillary blood vessels with a microscope, or the inside of a blood vessel with a fiberoptic-equipped catheter.

bilateral. Consisting of or affecting two sides.

capillary. Tiny, minute blood vessel that connects the arterioles (smallest arteries) and the venules (smallest veins) and acts as a semipermeable membrane between the blood and the tissue fluid.

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.

iris. Pigmented membrane behind the cornea and in front of the lens that contracts and expands to enlarge or shrink the size of the pupil to regulate the light entering 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.

photography. Still image pictures that may be digital or film generated.

slit lamp biomicroscope. Microscope with fine, intense light used to visualize structures at the front of the eye.

unilateral. Located on or affecting one side.

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