AAPC

Your essential illustrated coding guide for ophthalmology & optometry, including CPT®, HCPCS Level II, tips, CPT® to ICD-10-CM Cross References, NCCI edits, and RVU information

CODERS' SPECIALTY GUIDE

Ophthalmology & Optometry

2026

Contents

Integumentary System

11640

Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less

Clinical Responsibility

After appropriate preparation and local anesthesia, a margin of healthy tissue is identified and outlined with a marking pen. The provider makes a full-thickness incision through the skin. He excises (cuts out) the entire lesion including the margins previously outlined. All margins are cleaned, bleeding is controlled, and the wound is closed with sutures. The lesion may be sent to a laboratory for further evaluation or a frozen section performed and additional excision of margins performed if needed.

The provider performs this excision on a malignant lesion, such as melanoma, squamous cell carcinoma, or basal cell carcinoma, with excision diameter of 0.5 cm or less, including the margins, from the face, ears, eyelids, nose, lips.

Malignant lesions are locally invasive, can destroy healthy tissue as they grow, and can possibly metastasize (spread from one body part to another).

Coding Tips

For the same procedure on a lesion with a diameter of 0.6 to 1.0 cm, see 11641.

For the same procedure on a lesion with a diameter of 1.1 to 2.0 cm, see 11642.

For the same procedure on a lesion with a diameter of 2.1 to 3.0 cm, see 11643.

For the same procedure on a lesion with a diameter of 3.1 to 4.0 cm, see 11644.

For the same procedure on a lesion with a diameter of over 4.0 cm, see 11646.

If a provider excises multiple lesions of different diameters, apply modifier 59, Distinct procedural service, to the code for the second lesion.

If the provider performs a second excision on the same lesion area because the pathology report came back with positive margins during the global period of the first excision, you will need to append modifier 58 to the second procedure. You should append modifier 58 when a procedure or service is planned or anticipated at the time of the original procedure (staged), and is more extensive than the original procedure.

Also, be sure to use the same malignant diagnosis again, even if the most recent excision shows no cancer cells in the specimen.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $123.89, Non Facility Fee: $196.99
RVU (Facility): Work RVU 1.67, Practice Exp. RVU 1.95, Malpractice RVU 0.21, Total RVU 3.83
RVU (Non-Facility): Work RVU 1.67, Practice Exp. RVU 4.21, Malpractice RVU 0.21, Total RVU 6.09
MPFS Payment Policy Indicators: Global Period 010, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

22, 51, 52, 53, 54, 55, 56, 58, 59, 73, 74, 76, 77, 78, 79, 99, AQ, AR, E1, E2, E3, E4, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 31.0)

00170[0], 0213T[0], 0216T[0], 0596T[1], 0597T[1], 10061[1], 11000[1], 11001[1], 11004[1], 11005[1], 11006[1], 11042[1], 11043[1], 11044[1], 11045[1], 11046[1], 11047[1], 11102[1], 11104[1], 11106[1], 11900[1], 11901[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 17000[1], 17004[1], 17250[1], 17262[1], 17263[1], 17264[1], 17266[1], 17272[1], 17273[1], 17274[1], 17276[1], 17281[1], 17282[1], 17283[1], 17284[1], 17286[1], 36000[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0], 36600[1], 36640[1], 41826[1], 41827[1], 42107[1], 43752[1], 51701[1], 51702[1], 51703[1], 62320[0], 62321[0], 62322[0], 62323[0], 62324[0], 62325[0], 62326[0], 62327[0], 64400[0], 64405[0], 64408[0], 64415[0], 64416[0], 64417[0], 64418[0], 64420[0], 64421[0], 64425[0], 64430[0], 64435[0], 64445[0], 64446[0], 64447[0], 64448[0], 64449[0], 64450[1], 64451[0], 64454[1], 64461[0], 64462[0], 64463[0], 64479[0], 64480[0], 64483[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 67810[1], 69990[0], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 97597[1], 97598[1], 97602[1], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[0], 99496[0], G0168[1], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

C00.0-C00.9, C14.8, C43.0, C43.10, C43.111, C43.112, C43.121, C43.122, C43.20-C43.22, C43.30-C43.39, C44.00-C44.09, C44.101, C44.1021, C44.1022, C44.1091, C44.1092, C44.111, C44.1121, C44.1122, C44.1191, C44.1192, C44.121, C44.1221, C44.1222, C44.1291, C44.1292, C44.131, C44.1321, C44.1322, C44.1391, C44.1392, C44.191, C44.1921, C44.1922, C44.1991, C44.1992, C44.201-C44.209, C44.211-C44.219, C44.221-C44.229, C44.291-C44.299, C44.300-C44.309, C44.310-C44.319, C44.320-C44.329, C44.390-C44.399, C47.0, C49.0, C4A.0, C4A.10, C4A.111, C4A.112, C4A.121, C4A.122, C4A.20-C4A.22, C4A.30-C4A.39, C76.0, D00.00-D00.08, D03.0, D03.10, D03.111, D03.112, D03.121, D03.122, D03.20-D03.22, D03.30, D03.39, D04.0, D04.10, D04.111, D04.112, D04.121, D04.122, D04.20-D04.22, D04.30, D04.39, H01.00A, T81.40XA-T81.40XS, Z86.007

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Eye and Ocular Adnexa

65091

Evisceration of ocular contents; without implant

Clinical Responsibility

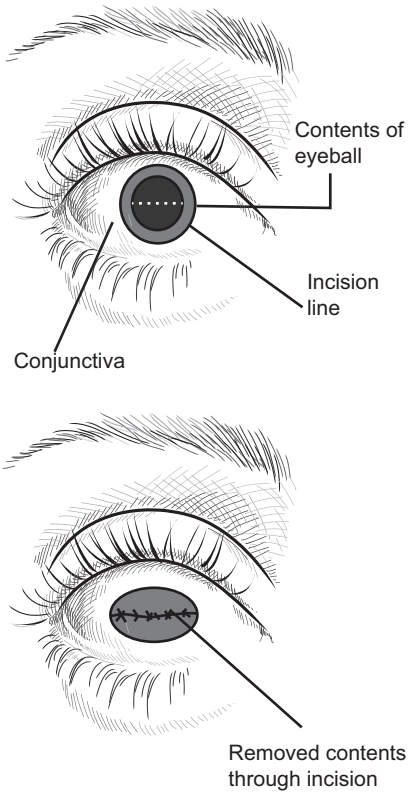
When the patient is appropriately prepped and anesthetized, the provider makes an incision at the limbus using a surgical blade and excises the cornea with curved scissors. He then removes the intraocular contents using an evisceration spoon and closes the scleral wound with sutures. He applies antibiotic drops. He closes Tenon's capsule and the conjunctiva in separate overlying layers.

Coding Tips

A provider may fit and place an orbital conformer, a placeholder for the missing eye, under general anesthesia. How to code this depends on the situation in which you are placing the orbital conformer. If you are placing the conformer as part of an enucleation or evisceration procedure, you would not bill separately for the procedure as it would be included in the surgical code. Because an orbital conformer is a temporary implant, when billing the surgical procedure, you would select the code that states in its description without an implant. The two code choices would be 65091 and 65101, Enucleation of eye, without implant. When placing a permanent implant, use the code that includes an implant to report the service. If you are placing the conformer for the repair of symblepharon, which is an adhesion between conjunctival surfaces that may be caused by inflammation, trauma, or previous surgery, you should use 68340, Repair of symblepharon; division of symblepharon, with or without insertion of conformer or contact lens.

For the same service with placement of an implant, see 65093.

Illustration



65091

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $708.39, Non Facility Fee: $708.39
RVU (Facility): Work RVU 7.26, Practice Exp. RVU 14.08, Malpractice RVU 0.56, Total RVU 21.90
RVU (Non-Facility): Work RVU 7.26, Practice Exp. RVU 14.08, Malpractice RVU 0.56, Total RVU 21.90
MPFS Payment Policy Indicators: Global Period 090, Preop 10.00%, Intraop 70.00%, Postop 20.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 47, 50, 51, 52, 53, 54, 55, 56, 58, 59, 62, 63, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0213T[0], 0216T[0], 0596T[1], 0597T[1], 0708T[1], 0709T[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 12020[1], 12021[1], 12031[1], 12032[1], 12034[1], 12035[1], 12036[1], 12037[1], 12041[1], 12042[1], 12044[1], 12045[1], 12046[1], 12047[1], 12051[1], 12052[1], 12053[1], 12054[1], 12055[1], 12056[1], 12057[1], 13100[1], 13101[1], 13102[1], 13120[1], 13121[1], 13122[1], 13131[1], 13132[1],

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65150

Reinsertion of ocular implant; with or without conjunctival graft

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider opens the scleral shell, which had been closed in a previous evisceration or enucleation procedure. He reinserts the implant. He closes the conjunctival membrane over the implant, applying a graft, if necessary, to close the defect.

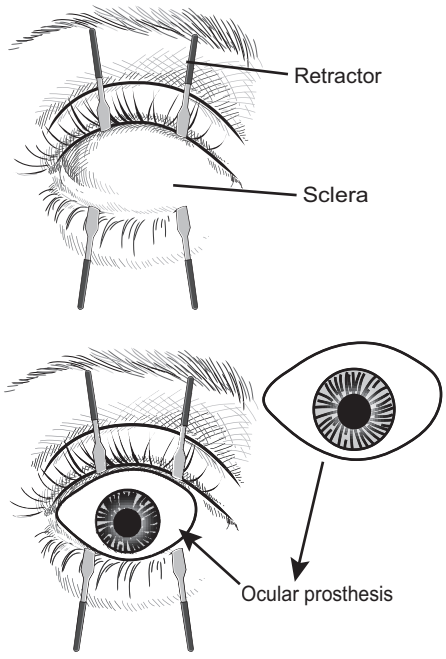
Coding Tips

If the provider uses foreign material for reinforcement and/or attachment of muscles to the implant during the reinsertion, see 65155.

Your provider may use a surgical assistant during this procedure, and you should check whether your insurers will pay for that. For instance, if you review the Medicare Provider Fee Schedule, you'll see that Medicare assigns the 2 indicator to this code in the ASST SURG column, which means that payment restrictions for assistants at surgery do not apply to this particular procedure and that an assistant at surgery may be paid, according to Medicare, although without a guarantee. Therefore, you should bill for a surgical assistant during these procedures if the documentation demonstrates medical necessity for the assist. If the payer accepts the assistant surgeon's charge, you'll append modifier 80, Assistant surgeon, for the services of the assisting provider.

Do note that if the surgical assistant is not a provider, you may be required to use modifier AS, Physician assistant, nurse practitioner, or clinical nurse specialist services for a surgical assistant, to represent the assistant's work. Check with your payer for their preference.

Illustration



65150

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $667.96, Non Facility Fee: $667.96
RVU (Facility): Work RVU 6.43, Practice Exp. RVU 13.72, Malpractice RVU 0.50, Total RVU 20.65
RVU (Non-Facility): Work RVU 6.43, Practice Exp. RVU 13.72, Malpractice RVU 0.50, Total RVU 20.65
MPFS Payment Policy Indicators: Global Period 090, Preop 10.00%, Intraop 70.00%, Postop 20.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 47, 50, 51, 52, 53, 54, 55, 56, 58, 63, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT

NCCI Alerts (version 31.0)

0213T^{0}, 0216T^{0}, 0596T^{1}, 0597T^{1}, 0708T^{1}, 0709T^{1}, 11000^{1}, 11001^{1}, 11004^{1}, 11005^{1}, 11006^{1}, 11042^{1}, 11043^{1}, 11044^{1}, 11045^{1}, 11046^{1}, 11047^{1}, 12001^{1}, 12002^{1}, 12004^{1}, 12005^{1}, 12006^{1}, 12007^{1}, 12011^{1}, 12013^{1}, 12014^{1}, 12015^{1}, 12016^{1}, 12017^{1}, 12018^{1}, 12020^{1}, 12021^{1}, 12031^{1}, 12032^{1}, 12034^{1}, 12035^{1}, 12036^{1}, 12037^{1}, 12041^{1}, 12042^{1}, 12044^{1}, 12045^{1}, 12046^{1}, 12047^{1}, 12051^{1}, 12052^{1}, 12053^{1}, 12054^{1}, 12055^{1}, 12056^{1}, 12057^{1}, 13100^{1}, 13101^{1}, 13102^{1}, 13120^{1}, 13121^{1}, 13122^{1}, 13131^{1}, 13132^{1}, 13133^{1}, 13151^{1}, 13152^{1}, 13153^{1}, 36000^{1}, 36400^{1}, 36405^{1}, 36406^{1}, 36410^{1}, 36420^{1}, 36425^{1}, 36430^{1}, 36440^{1}, 36591^{0}, 36592^{0}, 36600^{1}, 36640^{1}, 43752^{1}, 51701^{1}, 51702^{1}, 51703^{1}, 62320^{0}, 62321^{0}, 62322^{0}, 62323^{0}, 62324^{0}, 62325^{0}, 62326^{0}, 62327^{0}, 64400^{0}, 64405^{0}, 64408^{0}, 64415^{0}, 64416^{0}, 64417^{0}, 64418^{0}, 64420^{0}, 64421^{0}, 64425^{0}, 64430^{0}, 64435^{0}, 64445^{0}, 64446^{0}, 64447^{0}, 64448^{0}, 64449^{0}, 64450^{0}, 64451^{0}, 64454^{0}, 64461^{0}, 64462^{0}, 64463^{0}, 64479^{0}, 64480^{0}, 64483^{0}, 64484^{0}, 64486^{0}, 64487^{0}, 64488^{0}, 64489^{0}, 64490^{0}, 64491^{0}, 64492^{0}, 64493^{0}, 64494^{0}, 64495^{0}, 64505^{0}, 64510^{0}, 64517^{0}, 64520^{0}, 64530^{0}, 65125^{1}, 65155^{1}, 65175^{1}, 67250^{1}, 67500^{1}, 69990^{0}, 92012^{1}, 92014^{1}, 92018^{1}, 92019^{1}, 93000^{1}, 93005^{1}, 93010^{1}, 93040^{1}, 93041^{1}, 93042^{1}, 93318^{1}, 93355^{1}, 94002^{1}, 94200^{1}, 94680^{1}, 94681^{1}, 94690^{1}, 95812^{1}, 95813^{1}, 95816^{1}, 95819^{1}, 95822^{1}, 95829^{1}, 95955^{1}, 96360^{1}, 96361^{1}, 96365^{1}, 96366^{1}, 96367^{1}, 96368^{1}, 96372^{1}, 96374^{1}, 96375^{1}, 96376^{1}, 96377^{1}, 96523^{0}, 97597^{1}, 97598^{1}, 97602^{1}, 99155^{0}, 99156^{0}, 99157^{0}, 99211^{1}, 99212^{1}, 99213^{1}, 99214^{1}, 99215^{1}, 99221^{1}, 99222^{1}, 99223^{1}, 99231^{1}, 99232^{1}, 99233^{1}, 99234^{1}, 99235^{1}, 99236^{1}, 99238^{1}, 99239^{1}, 99242^{1}, 99243^{1}, 99244^{1}, 99245^{1}, 99252^{1}, 99253^{1}, 99254^{1}, 99255^{1}, 99291^{1}, 99292^{1}, 99304^{1}, 99305^{1}, 99306^{1}, 99307^{1}, 99308^{1}, 99309^{1}, 99310^{1}, 99315^{1}, 99316^{1}, 99347^{1}, 99348^{1}, 99349^{1}, 99350^{1}, 99374^{1}, 99375^{1}, 99377^{1}, 99378^{1}, 99446^{0}, 99447^{0}, 99448^{0}, 99449^{0}, 99451^{0}, 99452^{0}, 99495^{0}, 99496^{0}, G0463^{1}, G0471^{1}, J0670^{1}

ICD-10-CM Cross References

H10.821-H10.829, H44.89, T81.30XA, T81.33XA, T85.29XA, T85.398A, T85.692A, T85.698A, T85.79XA, Z44.20-Z44.22, Z85.840

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65155

Reinsertion of ocular implant; with use of foreign material for reinforcement and/or attachment of muscles to implant

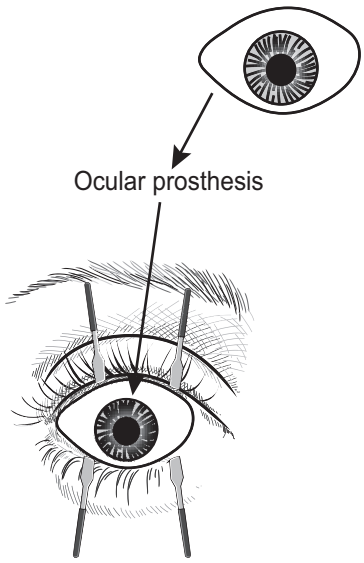
Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider opens the scleral shell, which had been closed in a previous evisceration or enucleation procedure. He reinserts the implant. He uses suture or graft tissue to attach the muscles or reinforce them. He closes the conjunctival membrane over the implant.

Coding Tips

For the same service with or without conjunctival graft or the use of foreign material for reinforcement and/or attachment of muscles to the implant, see 65150.

Illustration



65155

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $923.49, Non Facility Fee: $923.49
RVU (Facility): Work RVU 10.10, Practice Exp. RVU 17.65, Malpractice RVU 0.80, Total RVU 28.55
RVU (Non-Facility): Work RVU 10.10, Practice Exp. RVU 17.65, Malpractice RVU 0.80, Total RVU 28.55
MPFS Payment Policy Indicators: Global Period 090, Preop 10.00%, Intraop 70.00%, Postop 20.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 47, 50, 51, 52, 53, 54, 55, 56, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AQ, AR, CR, ET, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0213T^{0}, 0216T^{0}, 0596T^{1}, 0597T^{1}, 0708T^{1}, 0709T^{1}, 11000^{1}, 11001^{1}, 11004^{1}, 11005^{1}, 11006^{1}, 11042^{1}, 11043^{1}, 11044^{1}, 11045^{1}, 11046^{1}, 11047^{1}, 12001^{1}, 12002^{1}, 12004^{1}, 12005^{1}, 12006^{1}, 12007^{1}, 12011^{1}, 12013^{1}, 12014^{1}, 12015^{1}, 12016^{1}, 12017^{1}, 12018^{1}, 12020^{1}, 12021^{1}, 12031^{1}, 12032^{1}, 12034^{1}, 12035^{1}, 12036^{1}, 12037^{1}, 12041^{1}, 12042^{1}, 12044^{1}, 12045^{1}, 12046^{1}, 12047^{1}, 12051^{1}, 12052^{1}, 12053^{1}, 12054^{1}, 12055^{1}, 12056^{1}, 12057^{1}, 13100^{1}, 13101^{1}, 13102^{1}, 13120^{1}, 13121^{1}, 13122^{1}, 13131^{1}, 13132^{1}, 13133^{1}, 13151^{1}, 13152^{1}, 13153^{1}, 36000^{1}, 36400^{1}, 36405^{1}, 36406^{1}, 36410^{1}, 36420^{1}, 36425^{1}, 36430^{1}, 36440^{1}, 36591^{0}, 36592^{0}, 36600^{1}, 36640^{1}, 43752^{1}, 51701^{1}, 51702^{1}, 51703^{1}, 62320^{0}, 62321^{0}, 62322^{0}, 62323^{0}, 62324^{0}, 62325^{0}, 62326^{0}, 62327^{0}, 64400^{0}, 64405^{0}, 64408^{0}, 64415^{0}, 64416^{0}, 64417^{0}, 64418^{0}, 64420^{0}, 64421^{0}, 64425^{0}, 64430^{0}, 64435^{0}, 64445^{0}, 64446^{0}, 64447^{0}, 64448^{0}, 64449^{0}, 64450^{0}, 64451^{0}, 64454^{0}, 64461^{0}, 64462^{0}, 64463^{0}, 64479^{0}, 64480^{0}, 64483^{0}, 64484^{0}, 64486^{0}, 64487^{0}, 64488^{0}, 64489^{0}, 64490^{0}, 64491^{0}, 64492^{0}, 64493^{0}, 64494^{0}, 64495^{0}, 64505^{0}, 64510^{0}, 64517^{0}, 64520^{0}, 64530^{0}, 65125^{1}, 65175^{1}, 67250^{1}, 67500^{1}, 69990^{0}, 92012^{1}, 92014^{1}, 92018^{1}, 92019^{1}, 93000^{1}, 93005^{1}, 93010^{1}, 93040^{1}, 93041^{1}, 93042^{1}, 93318^{1}, 93355^{1}, 94002^{1}, 94200^{1}, 94680^{1}, 94681^{1}, 94690^{1}, 95812^{1}, 95813^{1}, 95816^{1}, 95819^{1}, 95822^{1}, 95829^{1}, 95955^{1}, 96360^{1}, 96361^{1}, 96365^{1}, 96366^{1}, 96367^{1}, 96368^{1}, 96372^{1}, 96374^{1}, 96375^{1}, 96376^{1}, 96377^{1}, 96523^{0}, 97597^{1}, 97598^{1}, 97602^{1}, 99155^{0}, 99156^{0}, 99157^{0}, 99211^{1}, 99212^{1}, 99213^{1}, 99214^{1}, 99215^{1}, 99221^{1}, 99222^{1}, 99223^{1}, 99231^{1}, 99232^{1}, 99233^{1}, 99234^{1}, 99235^{1}, 99236^{1}, 99238^{1}, 99239^{1}, 99242^{1}, 99243^{1}, 99244^{1}, 99245^{1}, 99252^{1}, 99253^{1}, 99254^{1}, 99255^{1}, 99291^{1}, 99292^{1}, 99304^{1}, 99305^{1}, 99306^{1}, 99307^{1}, 99308^{1}, 99309^{1}, 99310^{1}, 99315^{1}, 99316^{1}, 99347^{1}, 99348^{1}, 99349^{1}, 99350^{1}, 99374^{1}, 99375^{1}, 99377^{1}, 99378^{1}, 99446^{0}, 99447^{0}, 99448^{0}, 99449^{0}, 99451^{0}, 99452^{0}, 99495^{0}, 99496^{0}, G0463^{1}, G0471^{1}, J0670^{1}

ICD-10-CM Cross References

H44.89, T81.30XA, T81.33XA, T85.29XA, T85.398A, T85.692A, T85.698A, T85.79XA, Z44.20-Z44.22, Z85.840

65175

Removal of ocular implant

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider places an ocular speculum into the eye socket. She then carefully lifts the implant, and excises and retracts any conjunctival tissue and Tenon's capsule that may be covering the prosthesis. The provider then carefully removes the implant excising any extraocular muscle attachment and avoiding damage to the surrounding tissue. This procedure may be done due to recurring, long standing or extensive implant exposure with an infection that is resistant to treatment. The implant is seldom replaced at the same sitting.

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67218

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

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider dilates both of the patient's eyes and examines the fundus using a binocular indirect ophthalmoscope to identify the tumor in the eye. He then removes a portion of the conjunctiva extending up to the limbus in a procedure known as a partial limbal peritomy. He also examines the eye for extension of the tumor outside the sclera. He then transilluminates the tumor to identify the silhouette of the tumor. He marks the silhouette with diathermy and or he may use a marking pen. The provider may also remove extracapsular muscles depending on the location of the tumor, to put the plaque in place. He takes a cold, no seeds, plaque and sews the plaque against the muscles using sutures. The patient is then taken to the recovery area after a lead shield has been placed over the eye.

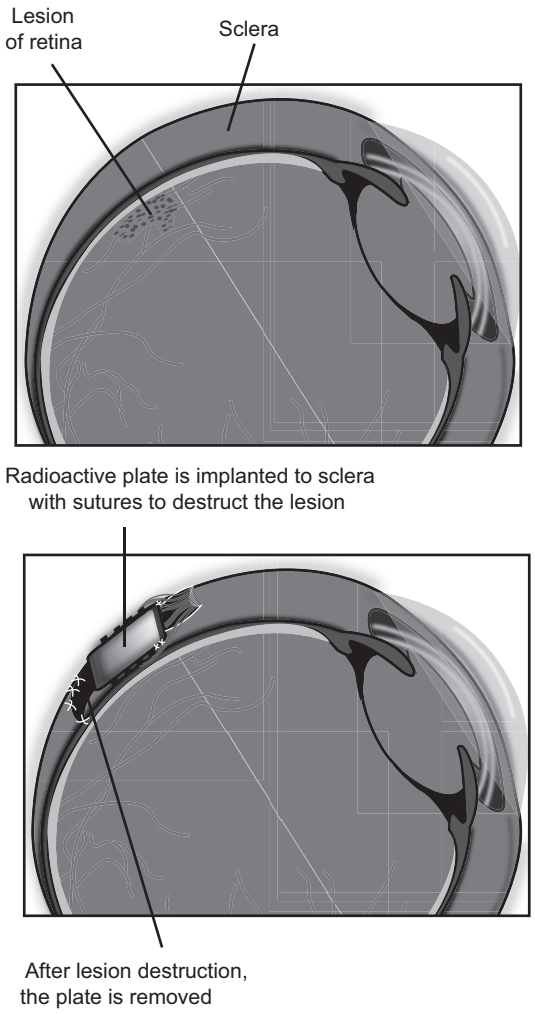
The plaque remains in place for four to five days. On the fifth day, the provider reopens the patient's conjunctiva, reflects back the muscles, cuts the sutures, and removes the plaque. He places the plaque back into a lead container. He subsequently performs a radioactive survey of the patient's face, orbit, and the surrounding surgical drape and shield. The provider uses sutures to replace the muscles back in position. He also closes the conjunctiva using sutures and injects subconjunctival antibiotics and steroids.

Coding Tips

Report this code only once for a defined treatment period since treatment may include one or more sessions at different encounter times.

If the provider performs a bilateral procedure, use modifier 50.

Illustration



67218

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $1,328.47, Non Facility Fee: $1,328.47
RVU (Facility): Work RVU 20.36, Practice Exp. RVU 19.13, Malpractice RVU 1.58, Total RVU 41.07
RVU (Non-Facility): Work RVU 20.36, Practice Exp. RVU 19.13, Malpractice RVU 1.58, Total RVU 41.07
MPFS Payment Policy Indicators: Global Period 090, Preop 10.00%, Intraop 70.00%, Postop 20.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 50, 51, 52, 54, 55, 56, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AQ, AR, CR, ET, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0213T[0], 0216T[0], 0596T[1], 0597T[1], 0708T[1], 0709T[1], 11000[1], 11001[1], 11004[1], 11005[1], 11006[1], 11042[1], 11043[1], 11044[1], 11045[1], 11046[1], 11047[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 12020[1], 12021[1],

Modifier: 0 = not allowed, 1 = allowed

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12031[1], 12032[1], 12034[1], 12035[1], 12036[1], 12037[1], 12041[1], 12042[1], 12044[1], 12045[1], 12046[1], 12047[1], 12051[1], 12052[1], 12053[1], 12054[1], 12055[1], 12056[1], 12057[1], 13100[1], 13101[1], 13102[1], 13120[1], 13121[1], 13122[1], 13131[1], 13132[1], 13133[1], 13151[1], 13152[1], 13153[1], 36000[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0], 36600[1], 36640[1], 43752[1], 51701[1], 51702[1], 51703[1], 62320[0], 62321[0], 62322[0], 62323[0], 62324[0], 62325[0], 62326[0], 62327[0], 64400[0], 64405[0], 64408[0], 64415[0], 64416[0], 64417[0], 64418[0], 64420[0], 64421[0], 64425[0], 64430[0], 64435[0], 64445[0], 64446[0], 64447[0], 64448[0], 64449[0], 64450[0], 64451[0], 64454[0], 64461[0], 64462[0], 64463[0], 64479[0], 64480[0], 64483[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 67005[1], 67010[1], 67015[1], 67025[1], 67028[1], 67030[1], 67031[1], 67036[1], 67039[1], 67040[1], 67041[1], 67500[1], 67516[1], 69990[0], 92012[1], 92014[1], 92018[1], 92019[1], 92201[1], 92202[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 97597[1], 97598[1], 97602[1], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[0], 99496[0], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

C69.20-C69.22, C69.30-C69.32, C69.90-C69.92, C79.32, C79.40, C79.49, D09.20-D09.22, D18.09, D31.20-D31.22, D31.30-D31.32, D48.7, D49.81, E08.311, E08.319, E08.3211-E08.3219, E08.3291-E08.3299, E08.3311-E08.3319, E08.3391-E08.3399, E08.3411-E08.3419, E08.3521-E08.3529, E08.3531-E08.3539, E08.3541-E08.3549, E08.3551-E08.3553, E08.37X1-E08.37X9, E09.311, E09.319, E09.3211-E09.3219, E09.3291-E09.3299, E09.3311-E09.3319, E09.3391-E09.3399, E09.3411-E09.3419, E09.3491-E09.3499, E09.3511-E09.3519, E09.3521-E09.3529, E09.3531-E09.3539, E09.3541-E09.3549, E09.3551-E09.3559, E09.37X1-E09.37X9, E10.311, E10.319, E10.3211-E10.3219, E10.3291-E10.3299, E10.3311-E10.3319, E10.3391-E10.3399, E10.3411-E10.3419, E10.3491-E10.3499, E10.3511-E10.3519, E10.3521-E10.3529, E10.3531-E10.3539, E10.3541-E10.3549, E10.3551-E10.3559, E10.3591-E10.3599, E10.36, E10.37X1-E10.37X9, E10.39, E11.311, E11.319, E11.3211-E11.3219, E11.3291-E11.3299, E11.3311-E11.3319, E11.3391-E11.3399, E11.3411-E11.3419, E11.3491-E11.3499, E11.3511-E11.3519, E11.3521-E11.3529, E11.3531-E11.3539, E11.3541-E11.3549, E11.3551-E11.3559, E11.3591-E11.3599, E11.36, E11.37X1-E11.37X9, E11.39, E13.311, E13.319, E13.3211-E13.3219, E13.3291-E13.3299, E13.3311-E13.3319, E13.3391-E13.3399, E13.3411-E13.3419, E13.3491-E13.3499, E13.3511-E13.3519, E13.3521-E13.3529, E13.3531-E13.3539, E13.3541-E13.3549, E13.3551-E13.3559, E13.3591-E13.3599, E13.36, E13.37X1-E13.37X9, E13.39, H34.10-H34.13, H34.8110-H34.8112, H34.8120-H34.8122, H34.8130-H34.8132, H34.8190-H34.8192, H34.8310-H34.8312, H34.8320-H34.8322, H34.8330-H34.8332, H34.8390-H34.8392, H35.021-H35.029, H35.051-H35.059, H35.09, H35.30, H35.3110-H35.3114, H35.3120-H35.3124, H35.3130-H35.3134, H35.3190-H35.3194, H35.3210-H35.3213, H35.3220-H35.3223, H35.3230-H35.3233, H35.3290, H35.3291, H35.3293, H35.341-H35.349, H35.351-H35.359, H35.711-H35.719, H35.721-H35.729, H35.731-H35.739, H35.81, H36.89, H44.2A3, H44.2B1-H44.2B9, H44.2C1-H44.2C9, H44.2D1-H44.2D9, H44.2E1-H44.2E9, H57.89

67220

Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

Clinical Responsibility

Choroidal neovascularization is a disease in which there is abnormal blood vessel growth in the choroidal layer of the eye. It may result in loss of vision. When the patient is appropriately prepped and anesthetized, the provider, in one or more sessions, uses a laser beam to coagulate or seal the abnormal blood vessels that have grown in the choroid. This in turn prevents any leakage of blood that can cause loss of vision in the eye.

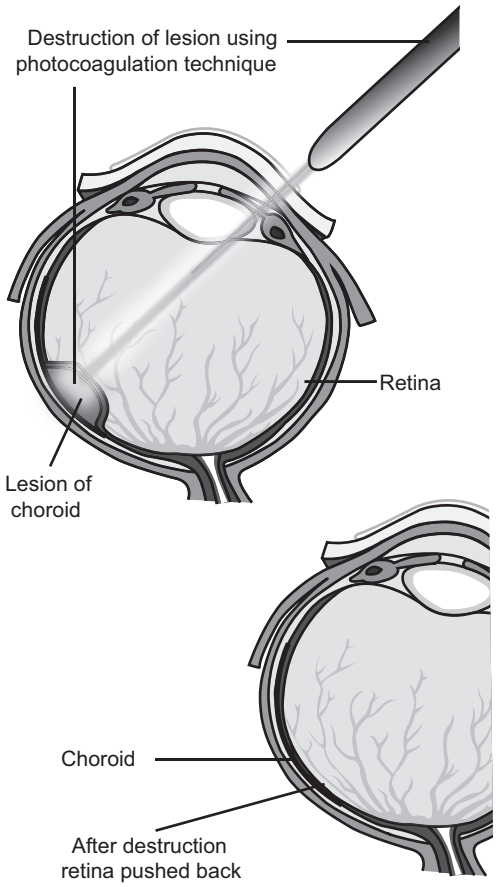
Coding Tips

When the provider treats a localized lesion of the choroid using photodynamic therapy, use 67221, Destruction of localized lesion of choroid e.g., choroidal neovascularization; photodynamic therapy, includes intravenous infusion.

Report this code only once for a defined treatment period since treatment may include one or more sessions at different encounter times.

If the provider performs a bilateral procedure, use modifier 50.

Illustration



67220

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Radiology

70030

Radiologic examination, eye, for detection of foreign body

Clinical Responsibility

The provider takes a plain X-ray of the eye to determine whether the patient has a foreign body in the eye.

Coding Tips

Be sure that the provider's documentation clearly describes each view taken in a radiology service. Check the documentation for the patient's body position and projection of the X-ray to assign the correct number of views.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $32.02, Non Facility Fee: $32.02
RVU (Facility): Work RVU 0.18, Practice Exp. RVU 0.79, Malpractice RVU 0.02, Total RVU 0.99
RVU (Non-Facility): Work RVU 0.18, Practice Exp. RVU 0.79, Malpractice RVU 0.02, Total RVU 0.99
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 1, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

26, 50, 52, 76, 77, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, FX, FY, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, TC

NCCI Alerts (version 31.0)

36591^0, 36592^0, 96523^0

ICD-10-CM Cross References

H05.50-H05.53, H44.601-H44.609, H44.611-H44.619, H44.631-H44.639, H44.641-H44.649, H44.651-H44.659, H44.711-H44.719, H44.721-H44.729, H44.731-H44.739, H44.741-H44.749, H44.751-H44.759, H57.8A1-H57.8A9, H59.351-H59.359, R09.A9, S02.121D-S02.121G, S02.121K, S02.121S, S02.122D-S02.122G, S02.122K, S02.122S, S02.129D-S02.129G, S02.129K, S02.129S, S02.831D-S02.831G, S02.831K, S02.831S, S02.832D-S02.832G, S02.832K, S02.832S, S02.839D-S02.839G, S02.839K, S02.839S, S02.841D-S02.841G, S02.841K, S02.841S, S02.842D-S02.842G, S02.842K, S02.842S, S02.849D-S02.849G, S02.849K, S02.849S, S02.85XD-S02.85XG, S02.85XK, S02.85XS, T75.89XD, T75.89XS, T81.513D, T81.513S, T81.533D, T81.533S, T81.69XD, T81.69XS, Z03.823, Z18.09, Z18.10, Z18.11, Z18.2

70170

Dacryocystography, nasolacrimal duct, radiological supervision and interpretation

Clinical Responsibility

This code represents the technical and professional components of a service in which the provider performs or supervision and interpretation of radiographic examination of the lacrimal sacs and ducts. The patient undergoes separately reportable injection of contrast medium through the inferior canaliculus after administration of local anesthesia. The provider supervises the performance of the entire radiological procedure and interprets the findings. The provider who performs imaging supervision and interpretation for this procedure reports this code.

Coding Tips

To assign a code whose descriptor includes contrast, the contrast must be intravascular, intraarticular, or intrathecal.

Depending on the payer's guidelines, providers who supply contrast may also separately report the contrast using a 99070 supply code or a HCPCS Level II code. Check individual payers' policies for contrast coverage and reportable supply codes.

There may be rare instances where one provider supervises the radiology service and another provider interprets it. According to Medicare guidelines, each provider should report the radiology code and append reduced service modifier 52. Each should also append modifier 26 to the code to report only the professional component.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $0.00, Non Facility Fee: $0.00
RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00
RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: C, PC/TC Indicator: 1, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

26, 52, 76, 77, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, FX, FY, GA, GC, GJ, GR, GY, GZ, KX, PD, Q5, Q6, QJ, TC

NCCI Alerts (version 31.0)

36591^0, 36592^0, 76000^1, 77001^1, 77002^1, 78660^0, 96523^0, 99446^1, 99447^1, 99448^1, 99449^1, 99451^1, 99452^1

ICD-10-CM Cross References

H04.001-H04.009, H04.011-H04.019, H04.021-H04.029, H04.031-H04.039, H04.111-H04.119, H04.121-H04.129, H04.141-H04.149, H04.301-H04.309, H04.311-H04.319, H04.321-H04.329, H04.331-H04.339, H04.411-H04.419, H04.421-H04.429, H04.431-H04.439, H04.511-H04.519, H04.551-H04.559, H04.571-H04.579, Q10.4-Q10.6, T75.89XD, T75.89XS

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76377

3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation

Clinical Responsibility

The provider performs interpretation and reporting for computed tomography (CT) magnetic resonance imaging (MRI), ultrasound, or other tomographic modality under concurrent supervision with the added complexity of image postprocessing by 3D image rendering. The technician does the reformatting work on an independent workstation. The technician takes multiple thin section images and rebuilds a three-dimensional image from them. Both need a concurrent supervision of image postprocessing three-dimensional manipulations of the data set and image rendering. The major characteristic feature of this procedure is that the provider performs image postprocessing within a separate workstation. The benefits of 3D interpretation are that it provides different 3D complex renderings, 3D image recovery, 3D image segmentation, and quantitative analysis.

Coding Tips

If the provider does not require an independent work station for image processing, use code 76376.

There may be rare instances where one provider supervises the radiology service and another provider interprets it. According to Medicare guidelines, each provider should report the radiology code and append reduced service modifier 52. Each should also append modifier 26 to the code to report only the professional component.

If you are reporting only the professional component for the service, you should append professional component modifier 26 to the code.

If you are reporting only the technical component for the radiology service, you would append modifier TC to the radiology code. Note, however, that payer policy may exempt hospitals from appending modifier TC because the hospital's portion is inherently technical.

Do not append a professional or technical modifier to the code when reporting a global service in which one provider renders both the professional and technical components.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $76.98, Non Facility Fee: $76.98
RVU (Facility): Work RVU 0.79, Practice Exp. RVU 1.53, Malpractice RVU 0.06, Total RVU 2.38
RVU (Non-Facility): Work RVU 0.79, Practice Exp. RVU 1.53, Malpractice RVU 0.06, Total RVU 2.38
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 1, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

26, 52, 59, 76, 77, 79, 80, 81, 82, 99, AQ, AR, AS, CR, CT, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, TC, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0582T[1], 36591[0], 36592[0], 76376[0], 76942[1], 76998[1], 93319[0], 96523[0], C8937[1]

ICD-10-CM Cross References

C31.9, C47.0, C49.0, C4A.10, C4A.20-C4A.22, C69.40-C69.42, C69.60-C69.62, C69.80-C69.82, C69.90-C69.92, C75.0, C76.0, C77.0, C81.01, C81.11, C81.21, C81.31, C81.41, C81.71, C81.91, D35.1, D44.2, E21.0-E21.5, G21.4, G24.1-G24.3, G24.9, G25.0-G25.2, I05.0-I05.9, I08.0, I08.1, I08.3, I08.8, I08.9, I23.1, I23.2, I23.4, I23.5, I33.0, I34.0, I34.1, I34.81, I34.89, I34.9, I36.1, I36.2, I36.8, I36.9, I39, I48.0-I48.4, I48.11, I48.19, I48.20, I48.21, I48.91, I48.92, I51.0-I51.2, I97.0, I97.110, I97.111, I97.120, I97.121, I97.130, I97.131, I97.190, I97.191, J39.3-J39.9, L04.0, M79.5, P22.0, P28.30-P28.39, P28.40-P28.49, P28.5, Q21.10-Q21.19, Q21.20-Q21.23, Q23.2-Q23.4, Q34.9, R04.1, R22.0, R22.1, R40.2A, R90.82, R91.1, R91.8, R93.0, R93.1, R93.3, R93.41, R93.421, R93.422, R93.49, R93.5, R93.6, R93.7, R93.89, S11.021A, S11.022A, S11.023A, S11.024A, S11.025A, S11.029A, S11.031A, S11.032A, S11.033A, S11.034A, S11.035A, S11.039A, S11.80XA, S11.81XA, S11.82XA, S11.83XA, S11.84XA, S11.85XA, S11.89XA, S11.90XA, S11.91XA, S11.92XA, S11.93XA, S11.94XA, S11.95XA, S13.4XXA, S13.5XXA, T82.01XA-T82.01XS, T82.02XA-T82.02XS, T82.03XA-T82.03XS, T82.09XA-T82.09XS, T82.519A-T82.519S, T82.529A-T82.529S, T82.539A-T82.539S, T82.599A-T82.599S, T82.6XXA-T82.6XXS, T82.7XXA-T82.7XXS, T82.817A-T82.817S, T82.827A-T82.827S, T82.837A-T82.837S, T82.847A-T82.847S, T82.857A-T82.857S, T82.867A-T82.867S, T82.897A-T82.897S, T82.9XXA-T82.9XXS, Z01.30, Z01.31, Z01.82, Z01.89

76499

Unlisted diagnostic radiographic procedure

Clinical Responsibility

The provider performs a diagnostic radiographic, or X-ray, procedure that is not represented by any of the standard and active CPT® codes available.

Coding Tips

CPT® guidelines instruct that you should not choose a code that merely approximates the service provided. You should report the service using only the appropriate unlisted procedure code if no such specific procedure or service code exists.

You must report a Category III code when available in place of an unlisted procedure code.

When reporting a procedure with an unlisted code, submit a cover letter explaining the reason for choosing the unlisted code instead of a defined, active code. Include one or more similar codes, and compare your service to those codes to justify the claim amount you are billing. Also include the operative notes or other relevant documentation to strengthen the claim and to avoid a possible denial. Your payers will consider claims with unlisted procedure

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Medicine

92002

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

Clinical Responsibility

The provider evaluates a new patient for routine care as well as existing eye problems. He takes a history, examines the eye and adjacent structures and performs other services that can include keratometry, routine ophthalmoscopy, retinoscopy, tonometry, or motor evaluation. The provider also starts diagnostic or treatment programs.

Coding Tips

A new patient has not received any professional services from the provider or another provider of the same specialty in the same group practice within the past three years. Either comprehensive or intermediate can apply for both new and established patients.

To report the evaluation of new or existing conditions complicated by a new diagnostic or management problem for a new patient, use 92002; for an established patient, use 92012, Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient.

To report the evaluation of the complete visual system and treatment over the course of one or more visits, use 92004, Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits, or for an established patient, 92014, Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits.

Both the E/M codes, 99202 to 99215, Office or other outpatient visit, etc., and the general ophthalmological services codes, 92002 to 92014, Ophthalmological services: medical examination and evaluation, etc., describe office visits. Don't choose based on the amount of reimbursement. Pick the code that most clearly describes the service the provider renders. If the provider strictly evaluates the function of the eye, report an eye code. If, however, the provider evaluates the eye as it relates to a systemic disease process, report the appropriate E/M code.

For example, a new patient presents complaining of blurred vision. The provider performs a comprehensive examination including checking her visual acuity, gross visual fields, ocular mobility, retinas and intraocular pressure. Because this is strictly an examination of eye function, use 92004. In this case, the proper treatment may be to continue monitoring the condition without treating.

Suppose, however, a patient with chronic blepharitis comes in due to a recent foreign body sensation, and the patient complains of a recurring headache. The patient had an unremarkable comprehensive exam four months ago, and the provider does not think the patient needs another dilated exam. A slit lamp exam reveals a lash rubbing the cornea on the painful eye. Refraction indicates a significant increase in hyperopia, which may explain the patient's headache. You can report an E/M code as long as you meet the higher standard of documentation for the E/M codes.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $43.34, Non Facility Fee: $81.19
RVU (Facility): Work RVU 0.88, Practice Exp. RVU 0.44, Malpractice RVU 0.02, Total RVU 1.34
RVU (Non-Facility): Work RVU 0.88, Practice Exp. RVU 1.61, Malpractice RVU 0.02, Total RVU 2.51
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

24, 25, 27, 32, 57, 76, 77, 79, 80, 81, 82, 99, AG, AP, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, GW, KX, PD, Q5, Q6, QJ

NCCI Alerts (version 31.0)

0469T^{0}, 36591^{0}, 36592^{0}, 92004^{0}, 92014^{0}, 92227^{0}, 92228^{0}, 96156^{0}, 96158^{0}, 96159^{0}, 96164^{0}, 96165^{0}, 96167^{0}, 96168^{0}, 96523^{0}, 97802^{0}, 97803^{0}, 97804^{0}, 99172^{0}, 99173^{0}, 99174^{0}, 99177^{0}, 99605^{1}, 99606^{1}, G0117^{0}, G0118^{0}, G0270^{0}, G0271^{0}

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code. Please check individual payer guidelines for specific coverage determinations.

92004

Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

Clinical Responsibility

The provider evaluates a new patient for routine care as well as existing eye problems. He takes a history, examines the eye and adjacent structures, and performs other services that can include keratometry, routine ophthalmoscopy, retinoscopy, tonometry, or motor evaluation. The provider also starts diagnostic or treatment programs. The evaluation may take place over one or more visits and typically entails more diagnostic procedures than an intermediate level evaluation.

Coding Tips

When the provider performs intermediate ophthalmological evaluation in a new patient, use 92002, Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient.

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If a patient returns for a dilated follow up also known as a dilated fundus examination or DFE, report the provider services including both days' work as one unit of a comprehensive ophthalmological examination 92004 or 92014, Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits. Medicare has stated that a comprehensive ophthalmological examination may take place on more than one day.

Keep in mind that some private payers may only pay for the 92004 or 92014 codes once per year because they consider these codes to be annual eye exams. Reporting these codes including 92002, Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient, and 92012, Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient twice within a short period of time may preclude payment and require payment reviews for medical necessity.

Append modifier 25, Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service, with 92004 when the provider inserts punctual plug on the same day. Some payers may pay for the eye codes without modifier 25 when reported with a procedure or diagnostic service. You should first check that your chart note supports billing the eye code with modifier 25. You must prove that the eye code was a significant, separate service from the punctal plug insertion 68761, Closure of the lacrimal punctum; by plug, each because every procedure has a small amount of evaluation and management services already built into it.

You may determine that another coding option, such as an E/M code from 99202 to 99215, Office or other outpatient visit, suits a particular service better than an eye code. Always report the code that is appropriate for your service.

There is a 10-day global period for punctal plug insertions. If the patient reports improvement later, and returns within 10 days to have permanent plugs placed, you may only bill for the insertion not a separate office visit because the plug insertion is the only reason for that visit.

However, if the patient returns after 10 days, you can bill an E/M or eye code if medical necessity supports the new evaluation and management services.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $89.28, Non Facility Fee: $142.97
RVU (Facility): Work RVU 1.82, Practice Exp. RVU 0.90, Malpractice RVU 0.04, Total RVU 2.76
RVU (Non-Facility): Work RVU 1.82, Practice Exp. RVU 2.56, Malpractice RVU 0.04, Total RVU 4.42
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

24, 25, 27, 32, 57, 76, 77, 79, 80, 81, 82, 99, AG, AP, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, GW, KX, PD, Q5, Q6, QJ

NCCI Alerts (version 31.0)

0469T^0, 36591^0, 36592^0, 92227^0, 92228^0, 96156^0, 96158^0, 96159^0, 96164^0, 96165^0, 96167^0, 96168^0, 96523^0, 97802^0, 97803^0, 97804^0, 99172^0, 99173^0, 99174^0, 99177^0, 99605^1, 99606^1, G0117^0, G0118^0, G0270^0, G0271^0

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code. Please check individual payer guidelines for specific coverage determinations.

92012

Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

Clinical Responsibility

For this CPT® code, an Ophthalmologist sees an established patient for an intermediate level eye examination. Generally, a patient is considered to be "established" if the same physician, or any physician in the group practice (or any physician of the same specialty who is billing under the same group number), has seen the patient for a face-to-face service within the past 36 months.

Coding Tips

Intermediate ophthalmological service describes an evaluation of a new or existing condition complicated with an acute problem that may not be related to the primary diagnosis including the review of previous history, a general examination, a few diagnostic procedures. It may include mydriasis for conducting ophthalmoscopy.

The main difference between 92012 and 92014 is that 92014 requires dilation unless medically contraindicated.

A comprehensive exam (92014 for an established patient or 92004 for a new patient) also includes more exam components than an intermediate exam (92012 for an established patient or 92002 for a new patient). For example, an insurer may require that you include nine or more of these elements in a comprehensive exam:

Visual acuity (not including refractive error), gross visual fields, eyelids and adnexa, ocular mobility, pupils, iris, conjunctiva, cornea, anterior chamber, lens, intraocular pressure, retina (vitreous, macula, periphery, and vessels), and optic disc.

Some insurers may require that certain elements, such as gross visual field tests and ocular mobility tests, be covered in all comprehensive tests. Examination of the eyelids and adnexa may be mandatory for an intermediate exam. Most dilated exams will include nine or more of the above items.

Even though CPT® does not support this restriction, some insurers consider 92002-92014 to be used only for routine vision exams. Be sure to check your carrier for its rules.

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HCPCS Level II Codes

Outpatient PPS

C1839

Iris prosthesis

Clinical Responsibility

Report this code for an artificial, synthetic iris used to replace a damaged or missing iris. An artificial iris is a flexible, biocompatible silicone device for use in adults or children with an absent or damaged iris. It helps control the amount of light entering the eye, improves contrast, and reduces glare and light sensitivity. It may also improve cosmetic appearance as the prosthesis is custom made to match the patient's iris in the other eye.

Coding Tips

An iris prosthesis may be considered investigational or not medically necessary by some payers, so check with the payer to determine coverage.

To report the supply of an ocular implant to replace a missing eye, see L8610.

BETOS

D1A: Medical/surgical supplies

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Prosthetic Procedures

L8608

Miscellaneous external component, supply or accessory for use with the argus ii retinal prosthesis system

Clinical Responsibility

Report this code for the supply of miscellaneous components, such as batteries or cables, or accessories such as specialized glasses that are required by the Argus® II retinal prosthesis system. The external components include a pair of glasses with a camera, processor, and a transmitter. The internal components consist of a receiver, transmitter, and an electrode array that stimulates the membrane over the retina. The camera captures the image, processes it, and transmits the information to the receiver. The receiver then transmits the image to the electrode array which stimulates the receptors to produce partial vision. This system stimulates the retina to induce visual perception in blind patients with severe to profound retinitis pigmentosa and bare light or no light perception in both eyes.

Retinitis pigmentosa refers to a group of inherited, degenerative eye diseases where the light sensitive retina of the eye slowly and progressively degenerates.

BETOS

D1F: Prosthetic/Orthotic devices

L8609

Artificial cornea

Clinical Responsibility

An artificial cornea acts as a substitute for patients who have corneal blindness or any eye disease, reject a human cornea tissue transplant, and have no other option to restore or improve vision. An artificial cornea helps to restore vision in such patients. An artificial cornea is also known as a keratoprosthesis. A keratoprosthesis is generally made of a clear, strong, and flexible biocompatible acrylic material that is similar to lenses.

Coding Tips

L codes represent orthotics, devices that help a patient to regain normal functioning, and prosthetics, artificial or manmade replacements for body parts.

The code represents the basic prosthesis required during a surgical procedure.

For insertion of an artificial cornea via surgery, report CPT® code 65770, Keratoprosthesis.

BETOS

D1F: Prosthetic/Orthotic devices

L8610

Ocular implant

Clinical Responsibility

An ocular implant, or ocular prosthesis, replaces a damaged or missing eye following an enucleation procedure. An ocular implant fits under the eyelids and over an orbital implant that fills the empty eye socket. The eye muscles support the implant, allowing it to move in conjunction with the other eye.

Coding Tips

L codes represent orthotics, devices that help a patient to regain normal functioning, and prosthetics, artificial or manmade replacements for body parts.

The code represents the basic prosthesis required during a surgical procedure.

For the insertion, reinsertion, and or removal of ocular implants, sees CPT® codes 65130 to 65175.

BETOS

D1F: Prosthetic/Orthotic devices

L8612

Aqueous shunt

Clinical Responsibility

An aqueous shunt, or glaucoma drainage device, is a small tube that treats glaucoma by allowing excess fluid to drain, especially in patients with unusual scarring, a complex form of glaucoma, or any prior unsuccessful surgery. The implant fixes into the eye at the meeting point of the cornea and sclera and drains fluid from the eye. A patch made from human pericardial tissue covers the shunt to prevent erosion through the conjunctiva.

Coding Tips

L codes represent orthotics, devices that help a patient to regain normal functioning, and prosthetics, artificial or manmade replacements for body parts.

The code represents the basic prosthesis required during a surgical procedure.

For the insertion and revision of an aqueous shunt, see CPT® codes 66179 to 66180.

BETOS

D1F: Prosthetic/Orthotic devices

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ICD-10-CM Cross Reference Details

A00.0 Cholera due to Vibrio cholerae 01, biovar cholerae
A00.1 Cholera due to Vibrio cholerae 01, biovar eltor
A00.9 Cholera, unspecified
A01.01 Typhoid meningitis
A02.0 Salmonella enteritis
A02.1 Salmonella sepsis
A02.21 Salmonella meningitis
A03.0 Shigellosis due to Shigella dysenteriae
A03.8 Other shigellosis
A04.5 Campylobacter enteritis
A04.6 Enteritis due to Yersinia enterocolitica
A04.8 Other specified bacterial intestinal infections
A04.9 Bacterial intestinal infection, unspecified
A05.0 Foodborne staphylococcal intoxication
A05.1 Botulism food poisoning
A05.4 Foodborne Bacillus cereus intoxication
A05.8 Other specified bacterial foodborne intoxications
A05.9 Bacterial foodborne intoxication, unspecified
A06.0 Acute amebic dysentery
A06.2 Amebic nondysenteric colitis
A06.3 Ameboma of intestine
A06.4 Amebic liver abscess
A06.81 Amebic cystitis
A06.82 Other amebic genitourinary infections
A06.89 Other amebic infections
A08.0 Rotaviral enteritis
A08.2 Adenoviral enteritis
A08.31 Calicivirus enteritis
A08.32 Astrovirus enteritis
A08.39 Other viral enteritis
A09 Infectious gastroenteritis and colitis, unspecified
A15.0 Tuberculosis of lung
A15.4 Tuberculosis of intrathoracic lymph nodes
A15.5 Tuberculosis of larynx, trachea and bronchus
A15.6 Tuberculous pleurisy
A15.7 Primary respiratory tuberculosis
A15.8 Other respiratory tuberculosis
A15.9 Respiratory tuberculosis unspecified
A17.0 Tuberculous meningitis
A17.1 Meningeal tuberculoma
A17.81 Tuberculoma of brain and spinal cord
A17.82 Tuberculous meningoencephalitis
A17.83 Tuberculous neuritis
A17.89 Other tuberculosis of nervous system
A17.9 Tuberculosis of nervous system, unspecified
A18.01 Tuberculosis of spine
A18.02 Tuberculous arthritis of other joints
A18.03 Tuberculosis of other bones
A18.09 Other musculoskeletal tuberculosis
A18.10 Tuberculosis of genitourinary system, unspecified
A18.11 Tuberculosis of kidney and ureter
A18.12 Tuberculosis of bladder
A18.13 Tuberculosis of other urinary organs
A18.14 Tuberculosis of prostate
A18.15 Tuberculosis of other male genital organs
A18.16 Tuberculosis of cervix
A18.17 Tuberculous female pelvic inflammatory disease
A18.18 Tuberculosis of other female genital organs
A18.2 Tuberculous peripheral lymphadenopathy
A18.31 Tuberculous peritonitis
A18.32 Tuberculous enteritis
A18.39 Retroperitoneal tuberculosis
A18.4 Tuberculosis of skin and subcutaneous tissue
A18.50 Tuberculosis of eye, unspecified
A18.51 Tuberculous episcleritis
A18.52 Tuberculous keratitis
A18.53 Tuberculous chorioretinitis
A18.54 Tuberculous iridocyclitis
A18.59 Other tuberculosis of eye
A18.6 Tuberculosis of (inner) (middle) ear
A18.7 Tuberculosis of adrenal glands
A18.81 Tuberculosis of thyroid gland
A18.82 Tuberculosis of other endocrine glands
A18.83 Tuberculosis of digestive tract organs, not elsewhere classified
A18.84 Tuberculosis of heart
A18.85 Tuberculosis of spleen
A18.89 Tuberculosis of other sites
A19.0 Acute miliary tuberculosis of a single specified site
A19.1 Acute miliary tuberculosis of multiple sites
A19.2 Acute miliary tuberculosis, unspecified
A19.8 Other miliary tuberculosis
A20.3 Plague meningitis
A22.7 Anthrax sepsis
A26.7 Erysipelothrix sepsis
A27.81 Aseptic meningitis in leptospirosis
A28.8 Other specified zoonotic bacterial diseases, not elsewhere classified
A28.9 Zoonotic bacterial disease, unspecified
A31.0 Pulmonary mycobacterial infection
A31.1 Cutaneous mycobacterial infection
A31.8 Other mycobacterial infections
A31.9 Mycobacterial infection, unspecified
A32.11 Listerial meningitis
A32.12 Listerial meningoencephalitis
A32.7 Listerial sepsis
A33 Tetanus neonatorum
A34 Obstetrical tetanus
A35 Other tetanus
A36.0 Pharyngeal diphtheria
A36.1 Nasopharyngeal diphtheria
A36.2 Laryngeal diphtheria
A36.3 Cutaneous diphtheria
A36.81 Diphtheritic cardiomyopathy
A36.82 Diphtheritic radiculomyelitis
A36.83 Diphtheritic polyneuritis
A36.84 Diphtheritic tubulo-interstitial nephropathy
A36.85 Diphtheritic cystitis
A36.86 Diphtheritic conjunctivitis
A36.89 Other diphtheritic complications
A36.9 Diphtheria, unspecified
A37.00 Whooping cough due to Bordetella pertussis without pneumonia
A37.01 Whooping cough due to Bordetella pertussis with pneumonia
A37.10 Whooping cough due to Bordetella parapertussis without pneumonia
A37.11 Whooping cough due to Bordetella parapertussis with pneumonia
A37.80 Whooping cough due to other Bordetella species without pneumonia
A37.81 Whooping cough due to other Bordetella species with pneumonia
A37.90 Whooping cough, unspecified species without pneumonia
A37.91 Whooping cough, unspecified species with pneumonia
A38.0 Scarlet fever with otitis media
A38.1 Scarlet fever with myocarditis
A38.8 Scarlet fever with other complications
A38.9 Scarlet fever, uncomplicated
A39.0 Meningococcal meningitis
A39.89 Other meningococcal infections
A39.9 Meningococcal infection, unspecified
A40.0 Sepsis due to streptococcus, group A
A40.1 Sepsis due to streptococcus, group B
A40.3 Sepsis due to Streptococcus pneumoniae
A40.8 Other streptococcal sepsis
A40.9 Streptococcal sepsis, unspecified
A41.01 Sepsis due to Methicillin susceptible Staphylococcus aureus

A41.02 Sepsis due to Methicillin resistant Staphylococcus aureus
A41.1 Sepsis due to other specified staphylococcus
A41.2 Sepsis due to unspecified staphylococcus
A41.3 Sepsis due to Hemophilus influenzae
A41.4 Sepsis due to anaerobes
A41.50 Gram-negative sepsis, unspecified
A41.51 Sepsis due to Escherichia coli [E. coli]
A41.52 Sepsis due to Pseudomonas
A41.53 Sepsis due to Serratia
A41.54 Sepsis due to Acinetobacter baumannii
A41.59 Other Gram-negative sepsis
A41.81 Sepsis due to Enterococcus
A41.89 Other specified sepsis
A41.9 Sepsis, unspecified organism
A42.0 Pulmonary actinomycosis
A42.7 Actinomycotic sepsis
A42.81 Actinomycotic meningitis
A43.0 Pulmonary nocardiosis
A43.1 Cutaneous nocardiosis
A43.8 Other forms of nocardiosis
A43.9 Nocardiosis, unspecified
A48.1 Legionnaires' disease
A48.8 Other specified bacterial diseases
A49.01 Methicillin susceptible Staphylococcus aureus infection, unspecified site
A49.02 Methicillin resistant Staphylococcus aureus infection, unspecified site
A49.2 Hemophilus influenzae infection, unspecified site
A49.8 Other bacterial infections of unspecified site
A49.9 Bacterial infection, unspecified
A50.41 Late congenital syphilitic meningitis
A50.54 Late congenital cardiovascular syphilis
A51.31 Condyloma latum
A51.41 Secondary syphilitic meningitis
A51.42 Secondary syphilitic female pelvic disease
A52.00 Cardiovascular syphilis, unspecified
A52.05 Other cerebrovascular syphilis
A52.09 Other cardiovascular syphilis
A52.11 Tabes dorsalis
A52.12 Other cerebrospinal syphilis
A52.13 Late syphilitic meningitis
A52.14 Late syphilitic encephalitis
A52.15 Late syphilitic neuropathy
A52.17 General paresis
A52.19 Other symptomatic neurosyphilis
A52.2 Asymptomatic neurosyphilis
A52.73 Symptomatic late syphilis of other respiratory organs
A52.74 Syphilis of liver and other viscera
A52.76 Other genitourinary symptomatic late syphilis
A54.00 Gonococcal infection of lower genitourinary tract, unspecified
A54.01 Gonococcal cystitis and urethritis, unspecified
A54.02 Gonococcal vulvovaginitis, unspecified
A54.03 Gonococcal cervicitis, unspecified
A54.09 Other gonococcal infection of lower genitourinary tract
A54.1 Gonococcal infection of lower genitourinary tract with periurethral and accessory gland abscess
A54.21 Gonococcal infection of kidney and ureter
A54.22 Gonococcal prostatitis
A54.23 Gonococcal infection of other male genital organs
A54.24 Gonococcal female pelvic inflammatory disease
A54.29 Other gonococcal genitourinary infections
A54.30 Gonococcal infection of eye, unspecified
A54.31 Gonococcal conjunctivitis
A54.32 Gonococcal iridocyclitis
A54.33 Gonococcal keratitis
A54.39 Other gonococcal eye infection
A54.40 Gonococcal infection of musculoskeletal system, unspecified
A54.41 Gonococcal spondylopathy
A54.42 Gonococcal arthritis
A54.43 Gonococcal osteomyelitis
A54.49 Gonococcal infection of other musculoskeletal tissue
A54.5 Gonococcal pharyngitis
A54.6 Gonococcal infection of anus and rectum
A54.81 Gonococcal meningitis
A54.82 Gonococcal brain abscess
A54.83 Gonococcal heart infection
A54.84 Gonococcal pneumonia
A54.85 Gonococcal peritonitis
A54.86 Gonococcal sepsis
A54.89 Other gonococcal infections
A54.9 Gonococcal infection, unspecified
A55 Chlamydial lymphogranuloma (venereum)
A56.00 Chlamydial infection of lower genitourinary tract, unspecified
A56.01 Chlamydial cystitis and urethritis
A56.02 Chlamydial vulvovaginitis
A56.09 Other chlamydial infection of lower genitourinary tract
A56.11 Chlamydial female pelvic inflammatory disease
A56.19 Other chlamydial genitourinary infection
A56.2 Chlamydial infection of genitourinary tract, unspecified
A56.3 Chlamydial infection of anus and rectum
A56.4 Chlamydial infection of pharynx
A56.8 Sexually transmitted chlamydial infection of other sites
A59.00 Urogenital trichomoniasis, unspecified
A59.01 Trichomonal vulvovaginitis
A59.03 Trichomonal cystitis and urethritis
A59.09 Other urogenital trichomoniasis
A59.8 Trichomoniasis of other sites
A59.9 Trichomoniasis, unspecified
A60.00 Herpesviral infection of urogenital system, unspecified
A60.01 Herpesviral infection of penis
A60.04 Herpesviral vulvovaginitis
A60.9 Anogenital herpesviral infection, unspecified
A63.0 Anogenital (venereal) warts
A63.8 Other specified predominantly sexually transmitted diseases
A64 Unspecified sexually transmitted disease
A66.0 Initial lesions of yaws
A66.2 Other early skin lesions of yaws
A66.3 Hyperkeratosis of yaws
A67.0 Primary lesions of pinta
A67.1 Intermediate lesions of pinta
A67.2 Late lesions of pinta
A67.3 Mixed lesions of pinta
A68.1 Tick-borne relapsing fever
A69.21 Meningitis due to Lyme disease
A71.0 Initial stage of trachoma
A71.1 Active stage of trachoma
A71.9 Trachoma, unspecified
A74.0 Chlamydial conjunctivitis
A74.81 Chlamydial peritonitis
A74.89 Other chlamydial diseases
A74.9 Chlamydial infection, unspecified
A79.82 Anaplasmosis [A. phagocytophilum]
A80.0 Acute paralytic poliomyelitis, vaccine-associated
A80.1 Acute paralytic poliomyelitis, wild virus, imported
A80.2 Acute paralytic poliomyelitis, wild virus, indigenous
A80.30 Acute paralytic poliomyelitis, unspecified
A80.39 Other acute paralytic poliomyelitis
A80.4 Acute nonparalytic poliomyelitis
A80.9 Acute poliomyelitis, unspecified
A81.00 Creutzfeldt-Jakob disease, unspecified
A81.01 Variant Creutzfeldt-Jakob disease
A81.09 Other Creutzfeldt-Jakob disease
A81.1 Subacute sclerosing panencephalitis
A81.2 Progressive multifocal leukoencephalopathy
A81.81 Kuru
A81.82 Gerstmann-Straussler-Scheinker syndrome
A81.83 Fatal familial insomnia
A81.89 Other atypical virus infections of central nervous system
A81.9 Atypical virus infection of central nervous system, unspecified
A82.9 Rabies, unspecified
A84.0 Far Eastern tick-borne encephalitis [Russian spring-summer encephalitis]
A84.1 Central European tick-borne encephalitis
A84.89 Other tick-borne viral encephalitis

Modifier Descriptors

Modifier	Description
CPT® Modifiers	
22	Increased Procedural Services
23	Unusual Anesthesia
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
26	Professional Component
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
32	Mandated Services
33	Preventive Services
47	Anesthesia by Surgeon
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons
63	Procedure Performed on Infants less than 4 kg
66	Surgical Team
73	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
74	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional

Modifier	Description
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
90	Reference (Outside) Laboratory
91	Repeat Clinical Diagnostic Laboratory Test
92	Alternative Laboratory Platform Testing
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
96	Habilitative Services
97	Rehabilitative Services
99	Multiple Modifiers
CPT® Category II Modifiers	
1P	Performance Measure Exclusion Modifier due to Medical Reasons
2P	Performance Measure Exclusion Modifier due to Patient Reasons
3P	Performance Measure Exclusion Modifier due to System Reasons
8P	Performance Measure Reporting Modifier - Action Not Performed, Reason Not Otherwise Specified
HCPCS Level II Modifiers	
A1	Dressing for one wound
A2	Dressing for two wounds
A3	Dressing for three wounds
A4	Dressing for four wounds
A5	Dressing for five wounds
A6	Dressing for six wounds
A7	Dressing for seven wounds
A8	Dressing for eight wounds
A9	Dressing for nine or more wounds
AA	Anesthesia services performed personally by anesthesiologist

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Modifier	Description
AB	Audiology service furnished personally by an audiologist without a physician/npp order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
AE	Registered dietician
AF	Specialty physician
AG	Primary physician
AH	Clinical psychologist
AI	Principal physician of record
AJ	Clinical social worker
AK	Non participating physician
AM	Physician, team member service
AO	Alternate payment method declined by provider of service
AP	Determination of refractive state was not performed in the course of diagnostic ophthalmological examination
AQ	Physician providing a service in an unlisted health professional shortage area (HPSA)
AR	Physician provider services in a physician scarcity area
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
AT	Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942)
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
AW	Item furnished in conjunction with a surgical dressing
AX	Item furnished in conjunction with dialysis services
AY	Item or service furnished to an ESRD patient that is not for the treatment of ESRD
AZ	Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment
BA	Item furnished in conjunction with parenteral enteral nutrition (PEN) services
BL	Special acquisition of blood and blood products
BO	Orally administered nutrition, not by feeding tube
BP	The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
BR	The beneficiary has been informed of the purchase and rental options and has elected to rent the item
BU	The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision
CA	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission
CB	Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable
CC	Procedure code change (use 'CC' when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)
CD	AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable
CE	AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity
CF	AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable
CG	Policy criteria applied
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
CR	Catastrophe/disaster related
CS	Cost-sharing waived for specified COVID-19 testing-related services that result in and order for or administration of a COVID-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in rural health clinics and federally qualified health centers during the COVID-19 public health emergency

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Terminology

Terms	Definition
Ab externo	The term means outside the eye; indicates the procedure of surgery starting from the eye's exterior and proceeding to the anterior chamber.
Ablation	Removal of a body part or organ or destruction of its function.
Abscess	A collection of pus in a walled off sac or pocket, the result of infection.
Actinic keratoses	Rough, scaly patches of skin that develop from prolonged exposure to sun.
Acute	A medical condition or injury of sudden onset, sometimes severe in nature, and typically last a short period of time; opposite of chronic.
Adhesions	Fibrous bands, which typically result from inflammation or injury during surgery, that form between tissues and organs; they may be thought of as internal scar tissue.
Age-related macular degeneration, or AMD	Weakening of the central area of the retina called the macula; AMD leads to vision loss in people age 50 or older.
Allergenic extract	A protein containing an extract purified from a substance to which a patient may be allergic.
Allograft	A tissue graft harvested from one person for another; donors include cadavers and living individuals related or unrelated to the recipient; also called allogeneic graft and homograft.
Amblyogenic developmental stage	Phase during early visual development in which the visual system is at risk to develop abnormal vision.
Amblyopia	Decreased vision due to a disconnect between the eye and the brain.
Amniograft	Using the amniotic membrane from a caesarean section to replace or repair defective tissue.
Amniotic membrane	Inside of placenta in which the fetus develops.
Anastomosis	Connection between two structures, anatomical or surgically created, such as between two blood vessels or the colon after resection of a part; types of anastomoses include end to side and side to side.
Anatomic topography	Study of regions or divisions of the body and determining the relationship between various structures in that region.
Anesthesia	A medication that reduces or eliminates sensitivity to pain; local or regional anesthesia reduce sensation to pain in specific areas of the body.
Angiography	An X-ray study of the blood vessels that help providers diagnoses and treat medical conditions; angiography uses a radiopaque substance, called dye, to make the blood vessels visible under X-ray.
Angle closure glaucoma	Type of glaucoma where the pressure inside the eye rises quickly because the drainage canals get blocked or covered over; also known as acute glaucoma or narrow angle glaucoma.
Angle width	Area of vision at a particular point of view.
Anomaloscope	Instrument used to test for color blindness.
Anterior	Closer to the front part of the body or a structure.
Anterior chamber	The space in the anterior or front segment of the eye, between the cornea, that focuses incoming light, and the iris, the colored ring membrane around the pupil; contains a clear liquid called aqueous humor.
Anterior chamber of eye	The space between the cornea and the iris, filled with the aqueous humor and communicating through the pupil with the posterior chamber.
Anterior hyaloid membrane	Tissue that separates the front portion of the vitreous, a gelatinous material, from the lens.
Anterior lamellar	Disc present in the front of the eye.
Anterior lamellar keratoplasty	Technique for partial thickness corneal transplantation that preserves endothelial cells after removing all or part of the stroma, resulting in a less thick but uniform residual bed.
Anterior limiting lamina	Tissue layer in the cornea between the outer layer and the stroma, also known as Bowman's layer.
Anterior segment of the eye	The forward one third of the eye that resides in front of the lens, filled with a clear liquid called aqueous humor; divided into anterior and posterior chambers connected by the pupil.
Anterior synechiae	Adhesion between the iris and the cornea.

Terms	Definition
Antibiotic	Substance that inhibits infection.
Anticoagulant	A drug that prevents clot formation within the blood vessels and dissolves any blood clot formed previously.
Antifibrotic agents	Drugs preventing fibrosis.
Aphakia	The lens of the eye is not present, preventing the ability to adjust focus between objects at different distances.
Aqueous fluid, or humor	Clear fluid in the anterior chamber of the eye that fills up the space between the lens and the cornea; provides cushion effect.
Aqueous outflow canal	Network through which aqueous humor flows.
Aqueous shunt	An apparatus that the provider implants to control intraocular pressure in the anterior chamber of the eye by allowing aqueous fluid to drain from the anterior chamber.
Artificial lens	Also called an intraocular lens, which is implanted in the eye of a patient who has had a cataract removed or to replace a damaged natural lens.
Aspirate	Small amount of cells or fluid from a cyst or mass.
Aspiration	Removal of fluid, gas, or other material through a tube attached to a suction device, often combined with irrigation; the instillation of fluid to wash out a cavity, such as the abdomen or stomach, or to clean a wound; also withdrawal of material, often with a needle; can also refer to breathing in fluid or food material.
Astigmatism	Condition in which the cornea improperly focuses an image onto the innermost tunic of eyeball.
Autogenous graft	Tissue harvested from the patient's own body used to replace diseased, damaged, or missing tissue.
Autograft	A tissue graft harvested from another location in the patient's own body.
Autologous fascial sling	Fascial tissue harvested from the patient's own body, shaped into a sling, or strap and used to connect one structure closely to another.
Automated refraction	Use of an instrument that calculates the amount of correction necessary in an eyeglass prescription.
Avascular	Lacking blood supply.
Axial length	Distance between the front third of the eye and the back two thirds of the eyeball.
Balanced salt solution	A solution containing various salts that matches the pH and salt concentration in the body.
Bandage contact lens	Lens which protects the cornea after surgery, allowing it to heal.
Banked fascia	Fascia, fatty or fibrous connective tissue, from a donor source, typically from a cadaver, or deceased person.
Basal cell carcinoma (BCC) of the skin	The most common type of skin cancer; it arises from uncontrolled multiplication of basal cells in the deepest layer of the dermis; light-skinned and older individuals are at greater risk for developing BCC; BCC rarely metastasizes, but it can be invasive and aggressive.
Benign	Not malignant, generally treatable or not needing treatment.
Bilateral	On both the sides of the body.
Binocular indirect ophthalmoscopy	An investigation to view through a dilated pupil the internal surface of the hollow eye cavity, in indirect ophthalmoscopy the machine produces an inverted image of the fundus of the eye.
Biometry	Biological measurements.
Biomicroscope	Scope used to examine the structures of the eye.
Biopsy	This is a medical technique to collect small amount of sample of abnormal cells or tissues from the affected site in order to diagnose the disease or to confirm the normality.
Blepharoplasty	The surgical removal of excess of fat, muscle, and loose skin around the eyelids.
Blepharoptosis	Drooping of the upper eyelid.
Blepharospasm	Spontaneous automatic firm closing of the eyelids, or twitching, which is not under ones voluntary control.
Blepharotomy	Surgical incision of the eyelid.
Blood clot	End product of coagulation, the process that changes liquid blood to a gel.
Blunt dissection	Separation of tissue layers using the fingers; sharp dissection separates tissue layers using a blade.

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