Ophthalmology is many things: a science, an art, and a business. The purpose of Coding Coach: The Complete Ophthalmic Reference is to assist you—the physician, the technician, the billing staff, the administrator—with the intricacies of ophthalmic coding and documentation, and in doing so, help you in your efforts to appropriately maximize reimbursement.

Codes from the following sections of CPT are included in this book:
- Integumentary System
- Musculoskeletal System
- Respiratory System
- Cardiovascular System
- Digestive System
- Nervous System
- Eye and Ocular Adnexa
- Radiology
- Special Ophthalmological Services
- Other Services and Procedures
- Category III

Coding Coach is not intended to replace the entire CPT 2020 book; it is intended only as an enhancement for ophthalmic coding.

The enclosed information is derived from numerous up-to-date resources. However, because coding changes may vary by payer and also are updated frequently, you should still consult your local payer website, and pay particular attention to their local coverage determination (LCD) policies. The Academy also has a dedicated page for practices to view their current policies. Visit aao.org/LCDS for additional information.

This complete guide offers a comprehensive list of modifiers and place of service codes.

The Index is a quick reference to a particular code by key word.

Please send any questions or comments you may have regarding this publication to coding@aao.org.

Each page includes the CPT codes:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>RVU Office</th>
<th>Medicare</th>
<th>Private Payer</th>
<th>Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>15822</td>
<td>12.91 / 11.22</td>
<td>90</td>
<td>90</td>
<td>NO</td>
</tr>
<tr>
<td>15823</td>
<td>17.44 / 15.54</td>
<td>90</td>
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</tr>
</tbody>
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The relative value units (RVU) for the office and facility:

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</table>

This will enable you to verify site-of-service differential where you may be paid a higher amount in your office than when the procedure is performed in the hospital.

RVUs also alert you to which procedure has a higher value. When multiple procedures are performed in the same operative setting, the code with the higher RVU should be listed first.

When RVU values are the same for the office and facility, it is an indication that the procedure is rarely or never performed in the non-facility (office) setting.

Example:

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The global surgical period for Medicare and private payers:

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</table>
Note that while Medicare recognizes a minor surgical period of 0 or 10 days, private payers recognize a 0- or 10-day global period.

For major surgeries, Medicare recognizes a 90-day global period, while private payers recognize a 60- or 90-day global period.

The global concept does not apply to the code.

The carrier determines whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.

The code is related to another service and is always included in the global period of the other service.

The last item in this shaded bar shows whether or not an assistant at surgery may be a covered benefit.

<table>
<thead>
<tr>
<th>RVU OF / FAC</th>
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<th>PRIVATE PAYER</th>
<th>ASST</th>
</tr>
</thead>
<tbody>
<tr>
<td>15822</td>
<td></td>
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</tbody>
</table>

Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.

Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.

Concept does not apply.

The last item in this shaded box shows whether or not the special testing services are submitted as unilateral or bilateral.

<table>
<thead>
<tr>
<th>RVU OF / FAC</th>
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<th>PRIVATE PAYER</th>
<th>UNI/BI</th>
</tr>
</thead>
<tbody>
<tr>
<td>92153</td>
<td></td>
<td>1.05 / 1.05</td>
<td>BI</td>
</tr>
</tbody>
</table>

Payment is made at 100 percent per eye when medical necessity exists.

Service is inherently bilateral, meaning that payment will be the same if one or both eyes are tested.

These are codes which the National Correct Coding Initiative deems not separately payable when performed in the same operative session.

Also provided:
- Layperson’s definition of the CPT code
- Coding Clues
- CPT and HCPCS modifiers
- Diagnosis codes deemed payable
- Ambulatory surgery center (ASC) coverage of group
- Determination if procedure is payable per eye, per session, or per lid

Special Testing Services Section also includes bilateral or unilateral payment indicators.

Key
- Prior to a CPT code indicates a new CPT code
- Prior to a CPT code indicates a change in CPT description
- Prior to a CPT code indicates an add-on code (Modifier -51 exempt)
- Prior to a CPT code indicates may be used to report telemedicine services
- Prior to a CPT code indicates out of sequence
H04.532 Neonatal obstruction of left nasolacrimal duct
H04.533 Neonatal obstruction of bilateral nasolacrimal duct
H04.541 Stenosis of right lacrimal canaliculi
H04.542 Stenosis of left lacrimal canaliculi
H04.543 Stenosis of bilateral lacrimal canaliculi
H04.551 Acquired stenosis of right nasolacrimal duct
H04.552 Acquired stenosis of left nasolacrimal duct
H04.553 Acquired stenosis of bilateral nasolacrimal duct
H04.571 Stenosis of right lacrimal sac
H04.572 Stenosis of left lacrimal sac
H04.573 Stenosis of bilateral lacrimal sac
Q10.4 Absence and agenesis of lacrimal apparatus (Congenital absence of punctum lacrimale)
Q10.6 Other congenital malformations of lacrimal apparatus (Congenital malformation of lacrimal apparatus NOS)

68760-68761

<table>
<thead>
<tr>
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<th>ASST</th>
</tr>
</thead>
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<tr>
<td>68760</td>
<td>6.07 / 4.11</td>
<td>10</td>
<td>10</td>
<td>N/A</td>
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<tr>
<td>68761</td>
<td>4.20 / 3.32</td>
<td>10</td>
<td>10</td>
<td>DOC</td>
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</tbody>
</table>

CCI 68760: G0463, 0124T, 0186T, 12011, 12013, 12014, 12015, 12016, 12017, 12018, 12051, 12052, 12053, 12054, 12055, 12056, 12057, 13150, 13151, 13152, 13153, 67500, 68440, 68705, 68770, 68801, 92012, 92014, 92018, 92019, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239, 99240, 99242, 99243, 99244, 99245, 99246, 12015, 12016, 12017, 12018, 12051, 12052, 12053, 12054, 12055, 12056, 12057, 13150, 13151, 13152, 13153, 67500, 68440, 68705, 68770, 68801, 92012, 92014, 92018, 92019, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99237, 99238, 99239, 99240, 99242, 99243, 99244, 99245, 99246, 99247, 99248, 99249, 99349, 99350, 99374, 99375, 99377, 99378

Mutually Exclusive: 99149, 99150, 99155, 99156, 99157, 99446, 99447, 99448, 99449, 99493, 99496

68760
Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery

68761
Closure of the lacrimal punctum; by plug, each

Definition
Punctal plugs are devices placed in the punctum to prevent normal tear drainage and to preserve tears in order to keep the cornea and conjunctiva moist.

Coding Clues
- When billing an established patient office visit the same day, make sure the criteria for modifier -25 is met.
- 68760 has a MUE edit of 4.
- 68761 has a MUE edit of 4.
- The same CPT code 68761 is used when coding temporary (collagen) and permanent (silicone) plugs. It is not necessary to distinguish the difference to the payer.
- In 2002, Medicare bundled the supply of the plug with the insertion. It is not appropriate to obtain an ABN and bill the patient.
- Non-Medicare payers may pay separately for the supply of the plug with HCPCS codes:
  - A4262 for collagen.
  - A4263 for silicone.
- 99070. List punctal plugs as the supply in the free-form text area of the CMS 1500 form.
- The following symptoms may be described in the chief complaint: redness, excessive tearing, stinging, burning, etc.
- There should be evidence of tear or gland deficiency.
- Because of the increase in utilization for punctual plugs, payers are auditing chart documentation with increasing regularity. Chart
documentation should describe the patient complaint as dry, burning, itching, and/or excessive tearing. Payers also require that the physician only insert punctal plugs when other methods of treatment such as artificial tears, ointments, humidifier, etc., have been tried and proved unsuccessful.

- In most cases of dry eye syndrome requiring punctum plugs or punctum closure, placement of one plug in (or closure of) each lower punctum will suffice to alleviate the problem. Medicare will reimburse for two plugs per beneficiary or two permanent closures per beneficiary on any given day.

- Up to two additional plugs or two additional closures may be performed for a total of four, but documentation must clearly show that the two additional plugs or closures were medically necessary as additional treatment to alleviate the condition.

- It is not appropriate to use CPT code 68530 when removing a punctal plug. Removal is not separately billable. It is incidental to the office exam.

- For insertion and removal of drug-eluting implant into lacrimal canaliculus for intra-ocular pressure, use 0356T.

**CPT Modifiers**
- -25 Significant, separate E/M service same day as minor procedure
- -50 Bilateral procedure

**HCPCS Modifiers**
- -RT Right eye
- -LT Left eye
- -E1 Left upper lid
- -E2 Left lower lid
- -E3 Right upper lid
- -E4 Right lower lid

**Diagnosis Codes**
- H04.121 Dry eye syndrome of right lacrimal gland (Tear film insufficiency, NOS)
- H04.122 Dry eye syndrome of left lacrimal gland (Tear film insufficiency, NOS)
- H04.123 Dry eye syndrome of bilateral lacrimal glands (Tear film insufficiency, NOS)
- H16.011 Central corneal ulcer, right eye
- H16.012 Central corneal ulcer, left eye
- H16.013 Central corneal ulcer, bilateral
- H16.021 Ring corneal ulcer, right eye
- H16.022 Ring corneal ulcer, left eye
- H16.023 Ring corneal ulcer, bilateral
- H16.041 Marginal corneal ulcer, right eye
- H16.042 Marginal corneal ulcer, left eye
- H16.043 Marginal corneal ulcer, bilateral
- H16.051 Mooren’s corneal ulcer, right eye
- H16.052 Mooren’s corneal ulcer, left eye
- H16.053 Mooren’s corneal ulcer, bilateral
- H16.061 Mycotic corneal ulcer, right eye
- H16.062 Mycotic corneal ulcer, left eye
- H16.063 Mycotic corneal ulcer, bilateral
- H16.071 Perforated corneal ulcer, right eye
- H16.072 Perforated corneal ulcer, left eye
- H16.073 Perforated corneal ulcer, bilateral
- H16.121 Filamentary keratitis, right eye
- H16.122 Filamentary keratitis, left eye
- H16.123 Filamentary keratitis, bilateral
- H16.141 Punctate keratitis, right eye
- H16.142 Punctate keratitis, left eye
- H16.143 Punctate keratitis, bilateral
- H16.211 Exposure keratoconjunctivitis, right eye
- H16.212 Exposure keratoconjunctivitis, left eye
- H16.213 Exposure keratoconjunctivitis, bilateral
- H16.221 Keratoconjunctivitis sicca, not specified as Sjögren’s, right eye
- H16.222 Keratoconjunctivitis sicca, not specified as Sjögren’s, left eye
- H16.223 Keratoconjunctivitis sicca, not specified as Sjögren’s, bilateral
- H16.231 Neurotrophic keratoconjunctivitis, right eye
- H16.232 Neurotrophic keratoconjunctivitis, left eye
- H16.233 Neurotrophic keratoconjunctivitis, bilateral
- H18.831 Recurrent erosion of cornea, right eye
- H18.832 Recurrent erosion of cornea, left eye
- H18.833 Recurrent erosion of cornea, bilateral
- M35.01 Sicca syndrome [Sjögren] with keratoconjunctivitis