

**On behalf of Vision Expo, we sincerely thank you for being with us this year.**

## **Vision Expo Has Gone Green!**

We have eliminated all paper session evaluation forms. Please be sure to complete your electronic session evaluations online when you login to request your CE Letter for each course you attended! Your feedback is important to us as our Education Planning Committee considers content and speakers for future meetings to provide you with the best education possible.



# Billing and Coding for Dry Eye

Crystal M. Brimer, OD, FAAO  
Dry Eye Institute  
Wilmington, NC



Dr. Crystal Brimer has received honorarium from Abbvie, B&L, Biotissue, MDelite, NuSight, and Oculus in the past 3 years.

She is on the Speakers Bureau for B&L, Biotissue, Oculus, NuSight, and Sun.

She is on medical advisory board for NuSight and B&L.

She receives royalties from Oculus.

She no longer has a relationship with Mdelite.

#### Financial Conflicts include:

- Dry Eye Institute: Founder
- Vision Source: Dry Eye Protocol I (2017) and II (2022)
- Oculus: Crystal Tear Report/5M platform, consultant and speaker
- MD Elite: PAST Advisor and speaker
- Biotissue: Speaker
- Abbvie: Consultant
- NuSight: Medical advisory board
- Bausch & Lomb: Speaker and Consultant
- Dompe: Clinical trial
- Sun: Consultant and speaker

*\*All relevant financial relationships have been mitigated. The content of this COPE Accredited CE activity was planned and prepared independently by Dr. Crystal Brimer without input from members of an ineligible company.*

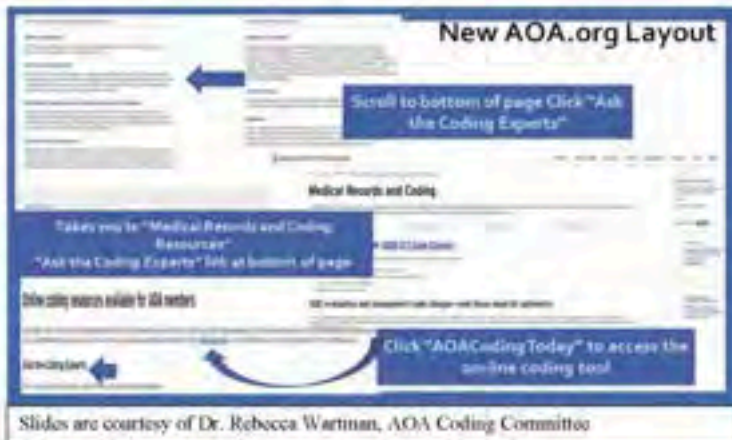
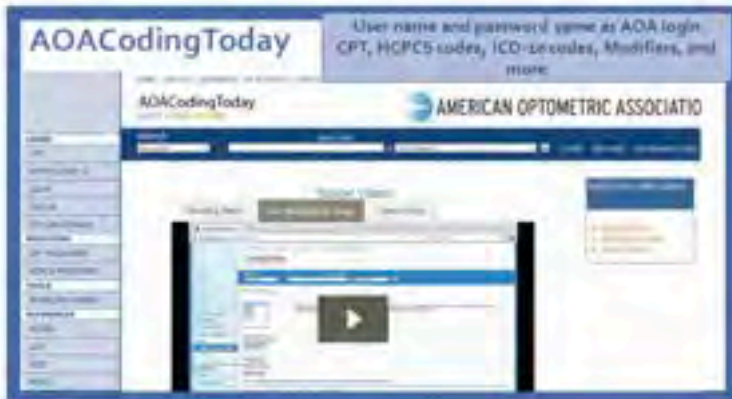


**first things first...**

billing the office visit

92 codes vs 99 codes





92004 & 92014	1 Exam elements in ≥ 1 session w/ Hx, med observation, external/ophthalmoscopic exam, VF, tonometry, initiation of Rx & Tx plan
92002 & 92012	7 Exam elements w/ use of assisting staff & complication. To include Hx, med observation, external & internal. May include SLE, dilation, IOP

Charge for Rxable glaucoma only - ex. final MR in cat post op

S codes (S0020, S021) for healthy, private pay exams that include refraction (S0400 LASIK, S0502 CL) If medical Dx, use 99- codes instead

Modifiers: M - Integral M - Integral w/ PO 23 - separate proc Same d/s M - PO can only S2 - reduced service for same for M - mult proc RT / LT E1 - LUL E2 - LLL E3 - RUL E4 - RLL

**Disclaimer: Rates and reimbursement will vary. Please review local regulations according to the carriers in your zip code. I.e. BCBS of NC considers all 92- codes as routine codes.**

### EYE EXAM ELEMENTS

#### Visual acuity

Give visual field:

EOM's

- Motility
- Alignment

Conjunctiva

- Biline
- Palpebral

Orbital adnexa

- Lids
- Lacrimal gland
- Lacrimal drainage
- Orbita
- Preauricular nodes

Pupil and iris

- Size
- Shape
- Direct and consensual reflexes
- Morphology

Cornea (ill lamp)

- Tear film
- Epithelium
- Striae
- Endothelium

Anterior chamber (ill lamp)

- Depth
- Cells
- Flare

Lens:

- Clarity
- Anterior capsule
- Posterior capsule
- Cortex
- Nucleus

Intraocular pressure:

\*Be sure to note if it has been deferred due to trauma, infection or poor cooperation

Optic nerve disc:

- C/D ratio
- Appearance
- Neuro fiber layer

Retina and vitreous:

Orientation: Time, Place, Person and/or Mood and Affect  
\*Always the 10th element for comprehensive EAM exam

# 992XX CODING: You have TWO options

Use traditional medical justification guidelines, BEING CERTAIN to diagnose each OSD issue to show management of multiple conditions

Code	Level of MDM (Based on 2 out of 3 elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i>	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	<b>Straightforward</b> <i>99202-25 minutes 99212-40 minutes</i>	<b>Minimal</b> • 1 self-limited or minor problem	<b>Minimal or none</b>	<b>Minimal</b> risk of morbidity from additional diagnosis, testing or treatment
99203 99213	<b>Low</b> <i>99203-30 minutes 99213-45 minutes</i>	<b>Low</b> • 1 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury; or • 1 stable acute illness; or • 1 acute, uncomplicated illness or injury, requiring hospitalization or observation level of care	<b>Limited</b> (Must meet the requirements of at least 2 out of 3 categories) Category 1: Test and document • Any combination of 2 from the following: • Review of prior external testing from each unique source; • Review of the results of each unique test; • Ordering of each unique test; or Category 2: Assessment requiring an independent interpretation of tests (The judgment of independent interpretation of tests and discussion of management is test interpretation, per se, moderate or high)	<b>Low</b> risk of morbidity from additional diagnosis, testing or treatment
99204 99214	<b>Moderate</b> <i>99204-45 minutes 99214-60 minutes</i>	<b>Moderate</b> • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable, chronic illnesses; or • 1 uncomplicated acute problem with uncertain prognosis; or • 1 exacerbation, with systemic symptoms; or • 1 acute, complicated injury	<b>Moderate</b> (Must meet the requirements of at least 2 out of 3 categories) Category 1: Test, document, or independent interpretation • Any combination of 2 from the following: • Review of prior external testing from each unique source; • Review of the results of each unique test; • Ordering of each unique test; • Assessment requiring an independent interpretation of tests; Category 2: Assessment requiring an independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional (appropriate source (not separately reported))	<b>Moderate</b> risk of morbidity from additional diagnosis, testing or treatment (Complex only) • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social circumstances of patient
99205 99215	<b>High</b> <i>99205-60 minutes 99215-90 minutes</i>	<b>High</b> • 1 or more chronic illnesses with acute exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat of life or body function	<b>Extensive</b> (Must meet the requirements of at least 2 out of 3 categories) Category 1: Test, document, or independent interpretation • Any combination of 3 from the following: • Review of prior external testing from each unique source; • Review of the results of each unique test; • Ordering of each unique test; • Assessment requiring an independent interpretation of tests; Category 2: Assessment requiring an independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation with external physician/other qualified health care professional (appropriate source (not separately reported))	<b>High</b> risk of morbidity from additional diagnosis, testing or treatment (Complex only) • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergent or critical surgery • Decision regarding hospitalization or escalation of hospital level care • Decision call to transfer care or to de-escalate care because of poor prognosis • Decision regarding potential, complex outcomes

## 2. Track doctor time, unrelated to a test or procedure, not including staff time, and apply time guidelines

### E&M CODE CHANGES

Most significant change for office-based evaluation and management (E&M) codes when using time to determine code level

- Revised to indicate required time thresholds that must be met
- No longer a time range
- Any prolonged time (99417 or G2212) reporting requires a minimum of 15 minutes per unit used beyond the times indicated for 99205 or 99215 codes



#### The new times are as follows:

99211: Not applicable	
99202: 15 minutes must be met/exceeded	99212: 10 minutes must be met/exceeded
99203: 30 minutes must be met/exceeded	99213: 20 minutes must be met/exceeded
99204: 45 minutes must be met/exceeded	99214: 30 minutes must be met/exceeded
99205: 60 minutes must be met/exceeded	99215: 40 minutes must be met/exceeded

Slide is courtesy of Dr. Rebecca Wartman, AOA Coding Committee.

### Instructions for Selecting a Level of Office or Other Outpatient E/M Service

Select the appropriate level of E/M services based on the following:

1. The level of the medical decision making as defined for each service, or
2. The total time for E/M services performed on the date of the encounter.

Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not be counted in the medical decision making when selecting a level of office or other outpatient service. When the physician or other qualified professional is reporting a separate service for discussion of management with a physician or other qualified health care professional, the discussion is not counted in the medical decision making when selecting a level of office or other outpatient service.

Excerpt from <https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf>

If you are included in a downcoding program based on your claims reporting history, please notify the AOA at [stopplanabuses@aoa.org](mailto:stopplanabuses@aoa.org).

StopPlanAbuses for help if their appeals are unsuccessful.

<https://www.aoa.org/advocacy/health-and-vision-plan-advocacy>



Slides are courtesy of Dr. Rebecca Wartman, AOA Coding Committee

### CMS Final Rule Comments

**Total Time Spent Patient (green)**  
Prolonged Service Coding

1 Stop Not reported separately

2 Stop 99415 (1 hr. 14 min.)

3 Stop 99415 (1 hr. 14 min.) AND 99416 (1 hr. 44 min.)

4 Stop 99415 (1 hr. 14 min.) AND 99416 (1 hr. 44 min.) AND 99417 (1 hr. 44 min. or more)

**CMS Prolonged Services  
Required Times (blue box)**  
vs  
**CPT Required Times (Green)**  
**99417**

### Prolonged Clinical Staff Services

Total Duration of Prolonged Services	Code(s)	Requires Direct Physician Supervision
less than 45 minutes	Not reported separately	
45-74 minutes (45 minutes - 1 hr. 14 min.)	99415 X 1	
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99415 X 1 AND 99416 X 1	
105 or more (1 hr. 45 min. or more)	99415 X 1 AND 99416 X 2 or more for each additional 30 minutes.	

**Clinical Staff Time for prolonged services would be RARELY if ever used in eye care and requires a full hour of dedicated staff time outside of the time they might spend for any E&M services**

## DRY EYE INSTITUTE PROLONGED SERVICES

A		Date(s) of Service					B	C	D			E	F	G	H	I	J
From			To			Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)			Diagnosis Pointer	\$ Charges	Days or Units	Ready Plan	ID Qual	Rendering Provider ID.#	
MM	DD	YY	MM	DD	YY			CPT / HCPCS	Modifier								
1	1	2021	1	1	2021	11	Day	99215			A,B	180.00	1		NPI	XXXXXXXXXX	
1	1	2021	1	1	2021	11	Day	G2212			A,B	35.00	1		NPI	XXXXXXXXXX	

**MEDICARE EXAMPLE: Use G2212**

A		Date(s) of Service					B	C	D			E	F	G	H	I	J
From			To			Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)			Diagnosis Pointer	\$ Charges	Days or Units	Ready Plan	ID Qual	Rendering Provider ID.#	
MM	DD	YY	MM	DD	YY			CPT / HCPCS	Modifier								
1	1	2021	1	1	2021	11	Day	99215			A,B	180.00	1		NPI	XXXXXXXXXX	
1	1	2021	1	1	2021	11	Day	99417			A,B	35.00	1		NPI	XXXXXXXXXX	

**COMMERCIAL PAYER EXAMPLE: Use 99417 instead of G2212**

**AVERAGE MEDICARE REIMBURSEMENT:**

- 99215 - \$177.47
- G2212 - \$31.76 "Prolonged Service With/Without Direct Patient Contact on the Date of an Office or Other Outpatient Service"
- 99415 - \$20.30 "Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision"
- 99416 - \$9.50 "Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision"

**THINGS YOU MUST KNOW:**

- You no longer must have the majority of the time spent on "counseling and coordination of care," so this documentation is no longer necessary, but you must document your time.
- You can only use these codes if you are billing the E/M service via "time" and not Medical Decision Making
- Time spent performing separately reported services other than the E/M service is not counted toward the time to report 99205, 99215 and prolonged services time.
- Tests without their own CPT codes (TBUT, Schirmer, vital dyes) will count as time BUT NOT for the Data section of Medical Decision Making
- See the rules above as to what activities are applicable



# G2211

Since early 2024

- Tied to the relationship with the patient
  - Who has a single, serious, or complex condition (glc/amd/ded)
  - Acknowledges the value of continuity of care
- Applicable to 99 codes only
- Cannot be billed on same day as -25 modified E/M + procedure
- Must be a chronic condition
- Document the status of each condition
- Medicare reimbursement \$15-\$17, pending region

# G2211

Since early 2024

- Tied to
- Wh
- Ack
- Applic
- Cann
- Must
- Docu

## Smart Phrase Starters

**G2211:** “Pt with chronic OSD/MGD under longitudinal management. Today’s E/M addresses persistent symptoms, treatment titration, and coordination of ongoing home/device/medication plan; follow-up arranged to monitor response and adjust therapy.”

- Medicare reimbursement \$15-\$17, pending region

# G2211

## Resources

Since early 2011

- Tied to the  
• Who has  
• Acknowledge

<https://www.aoa.org/news/practice-management/billing-and-coding/introducing-the-new-cms-g2211-code>

- Applicable to 99 codes only

- 
- <https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf>
- 
-

the 3 billing rules you  
should memorize

seriously

Billing for a  
TEST

must be ORDERED in the plan

requires INTERPRETATION & REPORT an elsewhere in the  
chart

## EXAMPLES

ANTERIOR  
SEGMENT PHOTOS

TOPOGRAPHY

OSMOLARITY

INFLAMMADRY

Billing for a PROCEDURE

must be ORDERED in the plan



requires an OP NOTE detailing the logistics



reimbursement INCLUDES the office visit

if the OV was for an unrelated ICD code, use a -25 modifier on the OV and different ICD-10 than used for the procedure



### EXAMPLES

PUNCTAL  
OCCLUSION

EPILATION

CORNEAL  
DEBRIDEMENT

AMNIOTIC MEMBRANE  
PLACEMENT

ALLERGY TESTING

Billing for out-of-pocket procedure

must be ORDERED in the plan

ABN is required for MCR patients and advised for all patients

If an allowable payment of any amount is made after submitting a claim to a company with whom you accept assignment, you MUST REFUND any additional amount paid by the patient on the date of service

EXAMPLES

EXTENDED DRY EYE EVALUATION	IPL	RF	LLLT
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## A WORD ON PRIOR AUTHORIZATIONS

- PAs are often quicker and more successful if completed over the phone!
- However, for OptumRx or Express scripts, covermyrx.com is likely the fastest way to get a response
- There's no such thing as too MUCH information! Include:
  - EVERY OTC and Rx ever used (with dates if possible)
  - Detailed symptoms
  - All poor test findings
  - Diagnosis list
- Submit a PA even if the pharmacy doesn't initiate one. Often the PA will still result in approval even if you received a Change Request instead

### Apex Pharmacy : 681.207.7334

- Apex will perform the PA for you once give the proper information
- You provide Diagnosis, past medication history, and any helpful test results via "pharmacy notes" section on the prescription that is faxed or e-scribed directly to Apex Pharmacy
- If PA is approved: Apex automatically fills the prescription and mails it directly to the patient at no additional cost
- If PA is denied: Apex will contact you directly and ask for your second choice. HOWEVER, as a time saver, they keep a list of my preferences and proceed accordingly.
- Example, if a prescription is denied for Cequa they will automatically go to my second choice and then third choice if required. After 30 days, they will contact the patient and send a new PA for the first choice prescription again.

### Pinnacle Health Group

- <https://thepinnaclehealthgroup.com/>
- Obtain log-in from your Blotissue rep
- A service provided by Blotissue to ensure PAs are acquired when needed and that payments are received for Prokera. They can also help with claim appeals if denied
- Go to the cases tab at the top of the screen and create a new case, in this tab you will enter the case type (Prior Auth or Denial appeal), product information (Prokera), Physicians name, patients name, DOB, and address
- Input the patient's insurance information, procedure code, ICD-10, place of service, and procedure date
- The authorization is pulled and you will know if there are any issues before placement, such as ATD or non-coverage

**USE MODIFIERS TO BILL ABN SIGNED PROCEDURES:**

Use **GA** to shift liability to the patient when denied.

Use **GY** (statutorily excluded) to tell Medicare “I know this isn’t covered, I’m just filing for denial.” (collect fee beforehand)

Updated ABN form for 2024

Don't forget: Good Faith Estimates are required by the No Surprises Act

(ABN)

**NOTE:** If Medicare doesn't pay for D. \_\_\_\_\_ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
  - Ask us any questions that you may have after you finish reading.
  - Choose an option below about whether to receive the D. \_\_\_\_\_ listed above.
- Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

**OPTION 1.** I want the D. \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the D. \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

**OPTION 3.** I don't want the D. \_\_\_\_\_ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:
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You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice).



**USE MODIFIERS TO BILL ABN SIGNED PROCEDURES:**

Use **GA** to shift liability to the patient when denied.

Use **GY** (statutorily excluded) to tell Medicare “this is not covered”

just filing for a refund

**Smart Phrase Starters**

**Cash-pay consent:** “Discussed non-covered nature of [service]; alternatives reviewed; patient elects to proceed and accepts financial responsibility.”

Use form for 2024

Don't forget:  
Good Faith Estimates are required by the No Surprises Act

(ABN)  
**NOTE:** If Medicare doesn't pay for D. \_\_\_\_\_ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

**WHAT YOU NEED TO DO NOW:**  
Read this notice, as you can make an informed decision about your care.

listed above.  
that you  
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If Medicare  
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n this choice I  
pay.  
Questions on this  
notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).  
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature: \_\_\_\_\_ J. Date: \_\_\_\_\_

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.



# Sample pre-certification letter

## Sample Letter for Pre-Certification

Date

[Insurer Name] [Attn: \_\_\_\_\_] [Street Address] [City, State, Zip Code]

Re: [Patient Name] [Patient's Identification Number]

Dear [Insurer]:

This letter is to request pre-certification for punctal occlusion with plugs for the treatment of dry eye syndrome, or keratoconjunctivitis sicca (KCS). This letter provides the clinical rationale for performing the procedure along with a description of the procedure.

### Background

An estimated 50 to 60 million Americans suffer from dry eye syndrome. Common treatments include ointments, eye drops, protective glasses and anti-inflammatory therapy. In cases where these treatments are ineffective or contraindicated, surgical intervention may be warranted. Punctal occlusion is a safe and effective treatment for KCS, as well as ocular surface disease, reflex tearing, and other conditions caused by dry eyes.

Punctal occlusion with plugs is used for moderate to severe dry eye sufferers to help retain tear fluid by stemming drainage. It may also enhance the delivery and absorption of topical medications in the eye. This procedure may prevent more serious corneal disease and facilitate a return to contact lenses.

**Patient's Diagnosis and Clinical Rationale for Selecting Treatment:** The history and clinical course of [Patient Name]'s dry eye syndrome is as follows:

[Please insert a paragraph discussing your patient's diagnosis and history. Include copies of test results, a complete summary of all previous treatments (including treatment response or failure) and documentation of clinical improvements and failures.]

A variety of treatments are available to individuals with dry eye syndrome. Selecting the most appropriate treatment depends on a thorough evaluation of all the relevant factors that could cause or contribute to the condition. Because of [Patient Name]'s continued battle with dry eye syndrome and despite prior treatment with artificial tears and after careful examination and review of this patient's condition, I would like to perform punctal occlusion with plugs.

### Treatment Description

The physician gently places <Named Plug> into the punctum. Inside the punctum, the plug expands in width, adjusting itself to fit the punctum.

### Request for Coverage Approval

Dry eye syndrome is a serious and often neglected ophthalmic condition. Unfortunately [Patient Name] has received other available therapies without success. In light of the patient's medical history, it is my opinion that this procedure is medically necessary. I request that you consider coverage of this procedure and provide pre-certification. If you have any further questions about this procedure, please contact me at [Phone].

Sincerely,

[Physician Name]



# Sample Op Note

## Sample Operative Report: Punctal Occlusion with Plugs

Date: \_\_\_\_\_  Patient's name: \_\_\_\_\_

Preoperative diagnosis: Dry eye syndrome  Postoperative diagnosis: Dry eye syndrome  Procedure:  
Punctal occlusion with <Named Plug> [Indicate lid]

The patient has been previously diagnosed with dry eye syndrome and treated with a number of different artificial tears with little or no improvement. The procedure, alternatives, risks and possible complications have been explained to the patient and the patient has given consent for punctal occlusion with <Named Plug>. No guarantee or assurance has been given to the patient as to the results that may be obtained.

<Named Plug> was removed from its package with forceps and the distal end was gently inserted into the punctum at slit lamp. A drop of topical antibiotics was instilled afterwards.

The procedure was repeated for the other punctum.

The patient tolerated the procedure well and left in good condition. The postoperative instructions were given including the medications as well as a follow-up appointment. Signs of infection explained and patient was instructed to return to office at first onset.

Physician's signature \_\_\_\_\_

# Sample letter of appeal

## Sample Letter of Appeal for Claims Denied Coverage

Date

[Insurer Name] [Attn: \_\_\_\_\_] [Street Address] [City, State, Zip Code]

Re: [Patient Name] [Patient's Identification Number]

Dear [Insurer]:

This letter is in response to your denial of the enclosed claim for punctal occlusion with plugs for the treatment of dry eye syndrome or keratoconjunctivitis sicca (KCS). I am submitting this claim for reconsideration. This letter provides the clinical rationale for performing the procedure along with a description of the procedure.

### Background

An estimated 50 to 60 million Americans suffer from dry eye syndrome. Common treatments include ointments, eye drops, protective glasses and anti-inflammatory therapy. In cases where these treatments are ineffective or contraindicated, surgical intervention may be warranted. Punctal occlusion is a safe and effective treatment for KCS, as well as ocular surface disease, reflex tearing, and other conditions caused by dry eyes.

Punctal occlusion with plugs is used for moderate to severe dry eye sufferers to help retain tear fluid by stemming drainage. It may also enhance the delivery and absorption of topical medications in the eye. This procedure may prevent more serious corneal disease and facilitate a return to contact lenses.

**Patient's Diagnosis and Clinical Rationale for Selecting Treatment** The history and clinical course of [Patient Name]'s dry eye syndrome is as follows:

[Please insert a paragraph discussing your patient's diagnosis and history. Include copies of test results, a complete summary of all previous treatments (including treatment response or failure) and documentation of clinical improvements and failures.]

A variety of treatments are available to individuals with dry eye syndrome. Selecting the most appropriate treatment depends on a thorough evaluation of all the relevant factors that could cause or contribute to the condition. Because of [Patient Name]'s continued battle with dry eye syndrome and despite prior treatment with artificial tears and after careful examination and review of this patient's condition, I would like to perform punctal occlusion with plugs.

### Treatment Description

The ophthalmologist or optometrist gently places <Named Plug> into the punctum. Inside the punctum, the plug expands in width, adjusting itself to fit the punctum.

### Request for Coverage Approval

Dry eye syndrome is a serious and often neglected ophthalmic condition. Unfortunately [Patient Name] has received other available therapies without success. In light of the patient's medical history, it is my opinion that this procedure is medically necessary. I request that you reconsider coverage of this procedure and pay my claim for reimbursement. If you have any further questions about this procedure, please contact me at [Phone].

Sincerely,

[Physician Name]



# Sample letter of medical necessity

Date: \_\_\_\_\_

Insurance Company/Payer Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

## **RE: Letter of Medical Necessity for LipiFlow® Thermal Pulsation System**

Patient/Member Name: \_\_\_\_\_

Patient/Member Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

To Whom It May Concern:

Writing on behalf of patient, (patient name) to document the medical necessity of LipiFlow® System for treatment of Meibomian Gland Disease/Disorder. This letter provides information about the patient's medical history and diagnosis and a statement summarizing the treatment rationale.

### **Patient's Medical History and Diagnosis:**

(information regarding patient's condition and specific diagnosis)

(Patient's diagnosis, date of diagnosis, lab results and date, current condition, and history)

(Previous therapies and procedures the patient has undergone for management of their condition)

(Patient's response to these therapies)

(Brief description of the patient's recent symptoms and conditions)

(Patient Name) is a (age)-year-old (male/female) diagnosed with MGD/DED. (Patient Name) has been receiving care since (first exam date). As a result of MGD/DED, my patient (brief description of patient history). Additionally, (patient) has tried (prev. Tx, warm compress, etc...) and (outcomes/NI).

### **Treatment Rationale:**

(information on treatment up to this point, course of care, and why LipiFlow® System is necessary and how it is expected to help the patient)

Based on the above facts, I am confident that you will agree that LipiFlow® System is indicated and medically necessary for this patient.

Considering the patient's history, condition, and the full supported uses of LipiFlow®, I believe treatment with LipiFlow® at this time is warranted, appropriate, and medically necessary, and should be a covered and reimbursed service.

### **Duration:**

The LipiFlow® System treatment takes 12 minutes for each eye. The results are known to last 9-15 months. It may be necessary to repeat the LipiFlow® System treatment annually.

### **Summary:**

In summary, LipiFlow® System is medically necessary for this patient's dry eye condition. Please consider coverage, approve use, and subsequent payment for LipiFlow® System as planned. If any additional information is required to ensure the approval of LipiFlow® System, please do not hesitate to call at (telephone number). Thank you for your prompt attention to this matter.

Sincerely,

(Physician's Name and provider identification number)

(Physician's Signature)



A Date(s) of Service						B	C	D Procedures, Services, or Supplies (Explain Unusual Circumstances)			E	F	G	H	I	J
From			To			Place of Service	EMG	CPT / HCPCS	Modifier	Diagnosis Pointer	\$ Charges	Days or Units	Ready Plan	ID Qual	Rendering Provider ID#	
M M	DD	YY	MM	DD	YY											
1	1	2018	1	1	2018	11	Day	99214		A,B,C,D	110.00	1		NPI	xxxxxxxxxx	
1	1	2018	1	1	2018	11	Day	92285		A,B,C	20.00	1		NPI	xxxxxxxxxx	

**AVERAGE MEDICARE REIMBURSEMENT:**

- \$22.92

**THINGS YOU MUST KNOW:**

- Bill bilaterally, 1 line
- External photos are medically warranted when it will affect your decision making
- Must order the test in the plan
- Must include an Interpretation and Report in the record

**APPLICABLE DIAGNOSIS CODES:**

UNSPECIFIED BLEPHARITIS	OD UL	H01.001			OS UL	H02.34	
	OD LL	H01.002			OS LL	H02.35	
	OS UL	H01.004			UNSPECIFIED PTOSIS	OU	H02.403
	OS LL	H01.005				OD	H02.401
SENILE ECTROPION	OD UL	H02.131				OS	H02.402
	OD LL	H02.132			DERMATOCHALASIS	OD UL	H02.831
	OS UL	H02.134				OD LL	H02.832
	OS LL	H02.135				OS UL	H02.834
UNSPECIFIED LAGOPHTHALMOS	OD UL	H02.201				OS LL	H02.835
	OD LL	H02.202			DRY EYE SYNDROME	OU	H04.123
	OS UL	H02.204				OD	H04.121
	OS LL	H02.205				OS	H04.122
BLEPHAROCHALASIS	OD UL	H02.30			UNSPECIFIED ACUTE CONJUNCTIVITIS	OU	H10.33
	OD LL	H02.32				OD	H10.31

	OS	H10.32
UNSPECIFIED CHRONIC CONJUNCTIVITIS	OU	H10.403
	OD	H10.401
	OS	H10.402
UNSPECIFIED CHRONIC ALLERGIC CONJUNCTIVITIS		H10.45
UNSPECIFIED BLEPHAROCONJUNCTIVITIS	OU	H10.503
	OD	H10.501
	OS	H10.502
PINGUECULA	OU	H11.153
	OD	H11.151
	OS	H11.152
PINGUECULITIS	OU	H10.813
	OD	H10.811
	OS	H10.812
CONJUNCTIVAL CONCRETIONS	OU	H11.123
	OD	H11.121
	OS	H11.122
CONJUNCTIVAL HYPEREMIA	OU	H11.433
	OD	H11.431
	OS	H11.432
CONJUNCTIVOCHALASIS	OU	H11.823
	OD	H11.821
	OS	H11.822
UNSPECIFIED EPISCLERITIS	OU	H15.103
	OD	H15.101
	OS	H15.102
UNSPECIFIED SUPERFICIAL KERATITIS	OU	H16.103
	OD	H16.101
	OS	H16.102
FILAMENTARY KERATITIS	OU	H16.123
	OD	H16.121
	OS	H16.122
PUNCTATE KERATITIS	OU	H16.143
	OD	H16.141
	OS	H16.142

EXPOSURE KERATOCONJUNCTIVITIS	OU	H16.213
	OD	H16.211
	OS	H16.212
KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S	OU	H16.223
	OD	H16.221
	OS	H16.222
NEUTROTROPHIC KERATOCONJUNCTIVITIS	OU	H16.233
	OD	H16.231
	OS	H16.232
UNSPECIFIED INTERSTITIAL KERATITIS	OU	H16.303
	OD	H16.301
	OS	H16.302
SCLEROSING KERATITIS	OU	H16.333
	OD	H16.331
	OS	H16.332
UNSPECIFIED CORNEAL NEOVASCULARIZATION	OU	H16.403
	OD	H16.401
	OS	H16.402
PANNUS (CORNEAL)	OU	H16.423
	OD	H16.421
	OS	H16.422
OTHER KERATITIS		H16.8
UNSPECIFIED KERATITIS		H16.9
ENDOTHELIAL CORNEAL DYSTROPHY		H18.51
EPITHELIAL (JUVENILE) CORNEAL DYSTROPHY		H18.53
LATTICE CORNEAL DYSTROPHY		H18.54
MACULAR CORNEAL DYSTROPHY		H18.55
OTHER HEREDITARY CORNEAL DYSTROPHIES		H18.59
UNSPECIFIED CORNEAL DEFORMITY		H18.70
OTHER CORNEAL DEFORMITIES	OU	H18.793
	OD	H18.791
	OS	H18.792

RECURRENT EROSION OF CORNEA	OU	H18.833
	OD	H18.831
	OS	H18.832
MEIBOMIAN GLAND DYSFUNCTION	OD UL	H02.881
	OD LL	H02.882
(unspecified lid)	OD	H02.883
	OS UL	H02.884
	OS LL	H02.885
(unspecified lid)	OS	H02.886
(unspecified eye / unspecified lid)		H02.889
	OD UL/LL	H02.88A
	OS UL/LL	H02.88B
ROSASEA CONJUNCTIVITIS	OD	H10.821
	OS	H10.822
	OU	H10.823
(unspecified eye)		H10.829

**Disclaimer: Rules and reimbursement will vary to the carriers in your zip code.**



## Aetna

policy: [https://www.aetna.com/cpb/medical/data/700\\_799/0734.html](https://www.aetna.com/cpb/medical/data/700_799/0734.html)

Aetna considers external ocular photography medically necessary **for the following indications** to track and serially compare the changes of the condition, where the results may have an impact on management and clinical outcomes...

**CGS MAC:** <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=57068&ver=13&LCDId=34393&NCDId=349&ncdver=2&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=ocular&KeywordLookUp=Title&KeywordSearchType=And&from2=search.asp&bc=gAAAABgAEAAAAAAAA&=>

	OS	H10.32
UNSPECIFIED CHRONIC CONJUNCTIVITIS	OU	H10.403
	OD	H10.401
	OS	H10.402

EXPOSURE KERATOCONJUNCTIVITIS	OU	H16.213
	OD	H16.211
	OS	H16.212

RECURRENT EROSION OF CORNEA	OU	H18.833
	OD	H18.831
	OS	H18.832

## Smart Phrase Starters

**92285:** “External photos obtained to document [finding] of [OD/OS/OU] to allow serial comparison and guide treatment; images acquired via kертatograph, interpreted today with plan adjustments noted.”

UNSPECIFIED BLEPHARITIS	OD UL	H01.001		OS UL	H02.34
	OD LL	H01.002		OS LL	H02.35
	OS UL	H01.004	UNSPECIFIED PTOSIS	OU	H02.403
	OS LL	H01.005		OD	H02.401
SENILE ECTROPION	OD UL	H02.131		OS	H02.402
	OD LL	H02.132	DERMATOCHALASIS	OD UL	H02.831
	OS UL	H02.134		OD LL	H02.832

	OD	H11.821
	OS	H11.822
UNSPECIFIED EPISCLERITIS	OU	H15.103
	OD	H15.101
	OS	H15.102
UNSPECIFIED SUPERFICIAL KERATITIS	OU	H16.103
	OD	H16.101

OTHER KERATITIS		
UNSPECIFIED KERATITIS		
ENDOTHELIAL CORNEAL DYSTROPHY		
EPITHELIAL (JUVENILE) CORNEAL DYSTROPHY		
LATTICE CORNEAL DYSTROPHY		

**1 QUESTION:** What is external photography performed with Nidek's AEC535?

**ANSWER:** External photography documents the external eye, lids and ocular adnexa. Photographs can record conditions and pathology of the adnexa, external eye and anterior segment more accurately than chart notes or drawings. They are used to track changes in patients' conditions over time.

**2 QUESTION:** What CPT code should we use to describe this test?

**ANSWER:** CPT code 92285 (External ocular photography with interpretation and report for documentation of medical progress (e.g., slit-lamp photography, slit lamp photography, stroboscopic photography) describes this service.

**3 QUESTION:** What diagnoses support a claim for external photography?

**ANSWER:** Most Medicare LCDs contain a variety of valid diagnoses for external photos. The lists vary, but usually include diagnoses related to external and anterior segment diseases involving the lids, lacrimal system, cornea, conjunctiva, anterior chamber and iris.

**4 QUESTION:** Is the physician's presence required while external photography is being performed?

**ANSWER:** Under Medicare program standards, this test requires general supervision. General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the test.

**5 QUESTION:** What documentation is required in the medical record to support claims for external photography?

**ANSWER:** A physician's interpretation and report are required. A brief notation such as "abnormal" does not suffice. In addition to the images, the medical record should include:

- order for the test with medical rationale
- date of the test
- reliability of the test (e.g., patient cooperation)
- test findings (e.g., vascularization, opacity, defect, distal, dendrites)
- comparison with prior tests (if applicable)
- a diagnosis (if possible)
- the impact on treatment and prognosis
- physician's signature

A form suitable for documenting the interpretation of external photos and other tests is available on Corcoran's website. It may also be selected for use within an EMR system.

**6 QUESTION:** Does Medicare cover external photography?

**ANSWER:** Sometimes, the key points that warrant coverage include:

- The photographs provide additional information not obtained during the exam
- The photographs aid in diagnosis and treatment of a disease or condition
- The photography are taken to assist in assessing disease progression

Photographs that are taken merely to document disease are typically treated as an incidental service and not accorded separate reimbursement.

April 20, 2025

This reimbursement information is provided by Corcoran & Corcoran based on publicly available information from CMS, the ABA, and other sources. The reader is strongly encouraged to review Federal and state laws, regulations, code sets, and official instructions promulgated by Medicare and other payors. This document is not an official source nor is it a complete guide or reimbursement. Although we believe the information is accurate at the time of publication, the reader is reminded that this information, including releases and typelines, change over time, and may be incorrect at any time following publication.

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<https://usa.nidek.com/wp-content/uploads/2025/05/product-resource-nidek-faq-external-photos.pdf>







**TOPOGRAPHY: CPT 92025**

A			B			C	D			E	F	G	H	I	J		
Date(s) of Service						Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)			Diagnosis Pointer	S Charges	Days or Units	Ready Plan	ID Qual.	Rendering Provider ID.#	
From			To														
MM	DD	YY	MM	DD	YY												
1	1	2018	1	1	2018	11	Day	99214				A,B,C,D	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	92025				D	37.00	1		NPI	xxxxxxxxxx

**MEDICARE EXAMPLE**

**AVERAGE MEDICARE REIMBURSEMENT:**

- \$35.69

**THINGS YOU MUST KNOW:**

- Can be billed same day as 92285, some private payers require 51 modifier (Multiple procedures/same day) on 92025 line
- MUST order the test in the plan
- MUST have an Interpretation and Report in the record

**APPLICABLE DIAGNOSIS CODES:**

UNSPECIFIED INTERSTITIAL KERATITIS	OU	H16.303	ENDOTHELIAL CORNEAL DYSTROPHY		H18.51
	OD	H16.301	EPITHELIAL CORNEAL DYSTROPHY		H18.52
	OS	H16.302	GRANULAR CORNEAL DYSTROPHY		H18.54
DIFFUSE INTERSTITIAL KERATITIS	OU	H16.323	MACULAR CORNEAL DYSTROPHY		H18.55
	OD	H16.321	OTHER HEREDITARY CORNEAL DYSTROPHIES		H18.59
	OS	H16.322			
SCLEROSING KERATITIS	OU	H16.333			
	OD	H16.331			
	OS	H16.332			

**Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.**





**MICROFLUIDIC ANALYSIS UTILIZING AN INTEGRA  
COLLECTION AND ANALYSIS DEVICE, TEAR OSMOLARITY: CPT 83861**

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To			Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)			Diagnosis Pointer	\$ Charges	Days or Units	Read y Plan	ID Qual	Rendering Provider ID#
M M	DD	YY	MM	DD	YY			CPT / HCPCS	Modifier							
1	1	2018	1	1	2018	11	Day	99214			A,B	110.00	1		NP I	xxxxxxxxx
1	1	2018	1	1	2018	11	Day	83861	QW	RT	A	23.00	1		NP I	xxxxxxxxx
1	1	2018	1	1	2018	11	Day	83861	QW	LT	A	23.00	1		NP I	xxxxxxxxx

**MEDICARE EXAMPLE**

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To			Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)			Diagnosis Pointer	\$ Charges	Days or Units	Read y Plan	ID Qual	Rendering Provider ID#
M M	DD	YY	MM	DD	YY			CPT / HCPCS	Modifier							
1	1	2018	1	1	2018	11	Day	99214			A,B	110.00	1		NP I	xxxxxxxxx
1	1	2018	1	1	2018	11	Day	83861		RT	A	23.00	1		NP I	xxxxxxxxx
1	1	2018	1	1	2018	11	Day	83861	59	LT	A	23.00	1		NP I	xxxxxxxxx

**COMMERCIAL PAYER EXAMPLE (some, not all)**

**AVERAGE MEDICARE REIMBURSEMENT:**

- \$22.48

**THINGS YOU MUST KNOW:**

- Must have CLIA Waiver certificate before billing
- For Medicare: Must have QW modifier ( indicates that the diagnostic lab service is a CLIA (*Clinical Laboratory Improvement Amendment*) waived test and that the provider holds at least a Certificate of Waiver) as well as location (RT/LT) modifier
- For some private insurances: Must have 59 modifier (distinct procedural service / used to unbundle services) on the second line
- Must have CLIA # on Line 19 “Additional Claim Information” of CMS 1500 form
- Must order the test in the plan
- Must have an Interpretation and Report in the record

**APPLICABLE DIAGNOSIS CODES:**

UNSPECIFIED BLEPHARITIS	OD UL	H01.001			OS	H10.812
	OD LL	H01.002	CONJUNCTIVAL CONCRETIONS	OU	H11.123	
	OS UL	H01.004			OD	H11.121
	OS LL	H01.005			OS	H11.122
DRY EYE SYNDROME OF LACRIMAL GLAND	OU	H04.123	CONJUNCTIVAL HYPEREMIA	OU	H11.433	
	OD	H04.121			OD	H11.431
	OS	H04.122			OS	H11.432
UNSPECIFIED ACUTE CONJUNCTIVITIS	OU	H10.33	UNSPECIFIED EPISCLERITIS	OU	H15.103	
	OD	H10.31			OD	H15.101
	OS	H10.32			OS	H15.102
UNSPECIFIED CHRONIC CONJUNCTIVITIS	OU	H10.403	UNSPECIFIED SUPERFICIAL KERATITIS	OU	H16.103	
	OD	H10.401			OD	H16.101
	OS	H10.402			OS	H16.102
UNSPECIFIED CHRONIC ALLERGIC CONJUNCTIVITIS		H10.45	FILAMENTARY KERATITIS	OU	H16.123	
					OD	H16.121
UNSPECIFIED BLEPHAROCONJUNCTIVITIS	OU	H10.503			OS	H16.122
	OD	H10.501	PUNCTATE KERATITIS	OU	H16.143	
	OS	H10.502			OD	H16.141
PINGUECULA	OU	H11.153			OS	H16.142
	OD	H11.151	EXPOSURE KERATOCONJUNCTIVITIS	OU	H16.213	
	OS	H11.152			OD	H16.211
PINGUECULITIS	OU	H10.813			OS	H16.212
	OD	H10.811				

KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S	OU	H16.223
	OD	H16.221
	OS	H16.222
UNSPECIFIED CORNEAL NEOVASCULARIZATION	OU	H16.403
	OD	H16.401
	OS	H16.402
PANNUS (CORNEAL)	OU	H16.423
	OD	H16.421
	OS	H16.422
OTHER KERATITIS		H16.8
UNSPECIFIED KERATITIS		H16.9
MEIBOMIAN GLAND DYSFUNCTION	OD UL	H02.881
	OD LL	H02.882
(unspecified lid)	OD	H02.883
	OS UL	H02.884
	OS LL	H02.885
(unspecified lid)	OS	H02.886
(unspecified eye / unspecified lid)		H02.889
	OD UL/LL	H02.88A
	OS UL/LL	H02.88B
ROSASEA CONJUNCTIVITIS	OD	H10.821
	OS	H10.822
	OU	H10.823
(unspecified eye)		H10.829

**Disclaimer: Rules and reimbursement will vary to the carriers in your zip code.**





**MICROFLUIDIC ANALYSIS UTILIZING AN INTEGRA  
COLLECTION AND ANALYSIS DEVICE, TEAR OSMOLARITY: CPT 83861**

A Date(s) of Service							B	C	D Procedures, Services, or Supplies (Explain Unusual Circumstances)			E	F	G	H	I	J
From			To				Place of Service	EMG	CPT / HCPCS	Modifier	Diagnosis Pointer	\$ Charges	Days or Units	Read y Plan	ID Qual	Rendering Provider ID.#	
M M	DD	YY	MM	DD	YY												
1	1	2018	1	1	2018	11	Day	99214			A,B	110.00	1		NP I	xxxxxxxxx	
1	1	2018	1	1	2018	11	Day	83861	QW	RT	A	23.00	1		NP I	xxxxxxxxx	
1	1	2018	1	1	2018	11	Day	83861	QW	LT	A	23.00	1		NP I	xxxxxxxxx	

**MEDICARE EXAMPLE**

A Date(s) of Service							B	C	D Procedures, Services, or Supplies (Explain Unusual Circumstances)			E	F	G	H	I	J
From			To				Place of Service	EMG	CPT / HCPCS	Modifier	Diagnosis Pointer	\$ Charges	Days or Units	Read y Plan	ID Qual	Rendering Provider ID.#	
M M	DD	YY	MM	DD	YY												
1	1	2018	1	1	2018	11	Day	99214			A,B	110.00	1		NP I	xxxxxxxxx	
1	1	2018	1	1	2018												
1	1	2018	1	1	2018												

A Date(s) of Service							B	C	D Procedures, Services, or Supplies (Explain Unusual Circumstances)			E	F	G	H	I	J
From			To				Place of Service	EMG	CPT / HCPCS	Modifier	Diagnosis Pointer	\$ Charges	Days or Units	Read y Plan	ID Qual	Rendering Provider ID.#	
M M	DD	YY	MM	DD	YY												
1	1	2018	1	1	2018												
1	1	2018	1	1	2018												

**COMMERCIAL PAYE**

**AVERAGE MED**

- \$22.48

**THINGS YOU MUST KNOW:**

- Must have CLIA Waiver certificate before billing
- For Medicare: Must have QW modifier ( indicates that the diagnostic lab service is a CLIA (*Clinical Laboratory Improvement Amendment*) waived test and that the provider holds at least a Certificate of Waiver) as well as location (RT/LT) modifier
- For some private insurances: Must have 59 modifier (distinct procedural service / used to unbundle services) on the second line
- Must have CLIA # on Line 19 "Additional Claim Information" of CMS 1500 form
- Must order the test in the plan
- Must have an Interpretation and Report in the record

**APPLICABLE DIAGNOSIS CODES:**

UNSPECIFIED BLEPHARITIS	OD UL	H01.001		OS	H10.812
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KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S	OU	H16.223
	OD	H16.221
	OS	H16.222
UNSPECIFIED CORNEAL NEOVASCULARIZATION	OU	H16.403
	OD	H16.401
	OS	H16.402
PANNUS (CORNEAL)	OU	H16.423
	OD	H16.421
		H16.422
		H16.8
	UL	H02.881
	LL	H02.882
		H02.883
	JL	H02.884
	LL	H02.885
		H02.886
		H02.889
		H02.88A
	LL	H02.88B
		H10.821
	OS	H10.822
	OU	H10.823
		H10.829

Use 83516 for InflammDry (same rules)  
Reimbursed at ~\$14-18  
Sometimes considered experimental,  
especially when billed with Osmolarity

**CONSIDER OBTAINING AN ABN FOR EITHER OF THESE TESTS**

reimbursement will vary  
ip code.



## TearLab Tear Osmolarity Billing Guidance

This guide addresses billing recommendations for CPT® 83861, "Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity", a covered service by CMS Medicare under the Clinical Laboratory Fee Schedule. CLIA Certification is required to perform and bill laboratory tests.

### Billing Codes and Modifiers

#### • CMS Medicare Part B

- 2018 allowable - \$22.48 per test (\$44.96 per patient) – no deductible or patient co-payment applies
- Code CPT 83861 as one unit of service with LT/RT and QW modifiers on two lines, once for each eye tested:
  - 83861 QW RT (1 unit)
  - 83861 QW LT (1 unit)
- Include ordering physician's individual NPI number (NOT group NPI) in Box 17
- Check "No" on Box 20
- Include CLIA license number in Box 23

CPT 83861 has universal coverage under CMS Part B Medicare. Claim denials from CMS are usually due to errors in coding or transmission of pertinent information by billing software. If any denial is received for CPT 83861 contact the TearLab Reimbursement Support Center promptly at [rsc@tearlab.com](mailto:rsc@tearlab.com) for assistance.

#### • Commercial Third Party, Medicare Advantage Part C and Medicaid

Reimbursement, coding and coverage policies will vary by carrier, provider contract and patient benefit plan. Contact the TearLab Reimbursement Support Center at [rsc@tearlab.com](mailto:rsc@tearlab.com) for payer specific billing guidance.

### Diagnostic Codes

Medical necessity rules are met when a patient presents with a sign or symptom of dry eye as determined by the clinician, which should be documented in the patient's medical record. Codes commonly used for coding dry eye diagnosis and/or dry eye symptoms, as referenced in the clinical literature, are available on the "ICD-10 Coding for Dry Eye" brochure, available on the TearLab website.

Currently CMS has no National Coverage Determinations (NCD) that define diagnosis codes to bill for CPT 83861 tear osmolarity test, so a decision to perform a test based on signs or symptoms of dry eye is up to the physician. Always ensure that all the items listed below in "Documenting a Laboratory Test" are included in the patient record to meet medical necessity guidelines.

### Documenting a Laboratory Test

Medicare has several documentation requirements for laboratory tests such as tear osmolarity, which must be noted in the patient chart or Electronic Health Record (EHR).

1. The sign or symptom of disease that prompted the ordering of the test
2. A notation in the medical record that a "tear osmolarity test was ordered" with "tear osmolarity" specifically identified
3. The numerical tear osmolarity test results and indication if the results were normal or abnormal
4. Treatment/Management Plan - the medical action taken as a result of the tear osmolarity test, and referencing the test results in the plan.
5. Managing clinician's signature at the end of the record indicating that everything in the record that day was reviewed and confirmed as medically necessary

Note that Medicare and most commercial payers do not cover screening tests, thus a sign or symptom of dry eye, or a previously diagnosed but "unstable" dry eye under management, must be properly documented prior to submitting a claim for reimbursement for a tear osmolarity test.

### What if the tear osmolarity test is normal?

If the tear osmolarity test result is normal and dry eye is "ruled out", code for the final or confirmed diagnosis, and "the symptoms that prompted ordering the test may also be reported as additional diagnosis if they are not fully explained or related to the confirmed diagnosis". (ref: CMS Program Memorandum AB-01-144, Sept 26, 2001).

CMS coverage rules for laboratory tests state, "The testing of a person to rule out or to confirm a suspected diagnosis because the patient has a sign and/or symptom is a diagnostic test, not a screening. In these cases, the sign or symptom should be used to explain the reason for the test". (ref: Fed Reg Vol 66, No 226, Nov 23, 2001)

### How often can I perform a tear osmolarity test?

Medical necessity as determined by the clinician determines how often a tear osmolarity test may be performed and must accompany proper documentation consisting of either a current sign or symptom of disease, or a patient under therapy that is being managed for a previously diagnosed but "unstable" dry eye. Testing a patient with a prior history of dry eye without current signs or symptoms of disease would likely be considered a "screening" test.

All items noted in "Documenting a Laboratory Test" must be included in the patient medical record to ensure proper support for multiple testing.

### Are there Global Period exclusions?

No, laboratory tests do not apply to "global period" exclusions for procedures such as the 10-day global period for punctal occlusion and 90-day post-operative global exclusion for cataract surgery. (ref: Medicare Claims Processing Manual -Chapter 12, Section 40.1)

**TearLab requests that the office billing department NOT spend time to resolve billing issues for CPT 83861, and instead contact the TearLab Reimbursement Support Center, under a Business Associate Agreement, Remittance Agreement or ACA including billing or payment problems should be faxed to TearLab at the following HIPAA secure number - (855) 873-9540 - promptly upon receipt. TearLab will review the denial for you and determine the reason for denial and best method to resolve - [rsc@tearlab.com](mailto:rsc@tearlab.com)**

Disclaimer: The above information is current as of January 2018, and was obtained from third-party sources and is subject to change without notice as a result of changes in reimbursement laws, regulations, rules, policies, and payment amounts. All content is informational only, general in nature, and does not cover all situations or all payer rules and policies. This content is not intended to instruct hospitals and/or physicians on how to use or bill for healthcare procedures, including new technologies outside of Medicare national guidelines. A determination of medical necessity is a prerequisite that TearLab Corporation assumes will have been made prior to assigning codes or requesting payments.

Under Federal and State law, it is the individual provider's responsibility to determine appropriate coding, charges and claims for a particular service. Policies regarding appropriate coding and payment levels can vary greatly from payer to payer and change over time. TearLab Corporation recommends that providers contact their own regional payers to determine appropriate coding and charge or payment levels.

If you are a provider participating in a clinical trial, we recommend you contact your payers, including Medicare/Medicaid and private insurers, to verify correct coverage and reimbursement policies for investigational devices.

This information represents no promise or guarantee by TearLab Corporation concerning coverage, coding, billing, and payment levels. TearLab Corporation specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on this information.

## 5 STEPS TO DOCUMENT A LABORATORY TEST

Medicare has several documentation requirements for point-of-care laboratory tests such as tear osmolarity, which must be noted in the patient chart or Electronic Health Record (EHR). Together with your TearLab representative, please review your EHR or paper In-Take Form to ensure that all 5 points described here are being captured correctly.

*Remember: In an office, if a test is documented properly and rightly is covered by Medicare.*

- Note the sign or symptom of disease that prompted the ordering of the test.** You may use one of the standard dry eye questionnaires (DEQ-5, OSDI, or SPEED), design your own questionnaire, or utilize the Ocular Surface Health Questionnaire provided by TearLab. Dry eye signs or symptoms must be noted in the patient's record for that day. Ideally the symptom questionnaire can be added to or scanned into the EHR as further documentation. Signs or symptoms must be current complaints and not from a prior patient visit or history. A return visit to monitor therapy for an "unstable condition" would be sufficient to justify a test, but that must also be documented in the chart, and the condition that is being monitored must indicate that the disease is still active and/or unstable.

TearLab testing can be performed anytime during the office visit if medical documentation exists showing the doctor had the intent for the test to be performed, and that intent has been authenticated by the doctor via a handwritten or electronic signature in the chart. See rules in 42 CFR 410 and Pub.100-02 chapter 15, §80.6.1.

A prior history of dry eye is not sufficient to justify a test. The patient must present with current signs or symptoms of disease, an unstable condition, or a return for the monitoring of therapy, all of which must be properly documented.

- Specifically identify the test in the medical record by stating "tear osmolarity test was ordered".** Document the name of the test, i.e. "tear osmolarity"; do not use acronyms (i.e. "TOT"). Although an order for a laboratory test is always required, Medicare regulations allow an order for an in-office laboratory test to be verbal and unsigned, as long as there is "medical documentation (e.g. progress note) by the treating physician that he/she intended the clinical diagnostic test to be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature." (see point #5).



Payers will not pay for the test if it is not used to manage the patient and identified by name (i.e. tear osmolarity) in the progress notes. Do not use abbreviations, i.e. "TOT".

**Document:  
Indication  
Eye(s)  
Result  
Impact on  
therapy**

- Record the numerical tear osmolarity test results and indicate if the results were "normal" or "abnormal".** It is not sufficient to just document the test results, you need to show that someone reviewed the test results to determine if they were "normal" or "abnormal", as per published reference values or your dry eye protocol. You must indicate that the laboratory test was used to manage the patient during that visit, and determining if the test results were normal or abnormal is critical documentation. This can be a simple check box in the chart, or a comment in the progress notes.



Return visits for therapeutic monitoring must have previous test results documented for comparison to current test results and support a change in the status of the patient's condition.

- Determine the Treatment/Management Plan, i.e. the medical action taken as a result of the tear osmolarity test, and reference the test results in the plan.** This is important, as payers will not pay for a test that is not used to manage the patient, as indicated in point #3. Even if the test results are "normal" that should be indicated in the progress notes, because it has direct impact on the final diagnosis or management plan.

Laboratory tests will be covered if results are either "Normal" or "Abnormal". Either result must be used in the management of the patient, i.e. "Tear Osmolarity 'Normal', Dry Eye no longer considered, Dx Ocular Allergy"

Be sure that osmolarity testing is noted for the next follow-up appointment, if it's part of the management plan. This can be referenced for the day of the test:

*"Patient returning per doctor directed orders for evaluation of the tear film, osmolarity findings, and retinal macular evaluation secondary to ocular surface disease noted at last visit 3 months ago."*

- Ensure the clinician signed the record indicating that everything in the chart that day was reviewed and confirmed as medically necessary.** As discussed in point #2, a verbal order is not unusual for an in-office laboratory test, and the clinician's signature in the chart indicates the doctor's "intent that the clinical diagnostic test be performed". If you are using a paper symptom questionnaire, the doctor's initials on the questionnaire provide additional documentation that the symptoms leading to the ordering of the test were properly reviewed.





**PERCUTANEOUS TEST WITH ALLERGENIC EXTRACTS: CPT**

A Date(s) of Service							B	C	D			E	F	G	H	I	J
From				To			Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)		Diagnosis Pointer	\$ Charges	Days or Units	Read y Plan	ID Qu al.	Rendering Provider ID:#	
M M	D D	YY	M M	D D	YY	CPT/ HCPCS			Modifier								
1	1	2018	1	1	2018	11	Day	99214	25		A	110.00	1		NP I	xxxxxxx xx	
1	1	2018	1	1	2018	11	Day	95004			B	8.00	80		NP I	xxxxxxx xx	

**AVERAGE MEDICARE REIMBURSEMENT:**

- \$3.60 - \$8.00 per unit

**THINGS YOU MUST KNOW:**

- Office visit is only billable if allergy testing was NOT the reason for their visit:
  - MUST use a 25 modifier on the OV (separate procedure / same day)
  - MUST use a unique diagnosis code for the allergy testing verses the OV
- MUST indicate the number of units / test spots (80 for Allerfocus)
- MUST order the procedure in the plan
- MUST have an Operative Note

**APPLICABLE DIAGNOSIS CODES:**

Allergic Conjunctiivitis, bilateral	H10.13
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**Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.**





**CORRECTION OF TRICHIASIS; EPILATION, BY FORCEPS ONLY:  
CPT 67820**

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To			Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)			Diagnosis Pointer	S Charges	Days or Units	Ready Plan	ID Qual	Rendering Provider ID.#
MM	DD	YY	MM	DD	YY			CPT / HCPCS	Modifier							
1	1	2018	1	1	2018	11	Day	99214	25		A,B	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	67820	RT		C	49.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	67820	51	LT	D	49.00	1		NPI	xxxxxxxxxx

**AVERAGE MEDICARE REIMBURSEMENT:**

- \$48.92

**THINGS YOU MUST KNOW:**

- Office visit is only billable if epilation is NOT the reason for the visit.
  - MUST use a 25 modifier on OV (separate procedure / same day)
  - MUST have separate diagnosis code from office visit
- MUST use location modifiers: E1 (UL),E2 (LL),E3 (UR),E4 (LR). However, Medicare is now paying OU and some others are now paying PER EYE only, so use RT and LT instead
- MUST list each separately as 1 unit
- SOME payers require the use of -51 modifier (multiple procedures /same day) on additional lines
- MUST order the procedure in the plan
- MUST have an Operative Note

**APPLICABLE DIAGNOSIS CODES:**

TRICHIASIS WITHOUT ENTROPION	OD UL	H02.051
	OD LL	H02.052
	OS UL	H02.054
	OS LL	H02.055

**Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.**





**PUNCTAL OCCLUSION: CPT 68761**

A		Date(s) of Service					B	C	D			E	F	G	H	I	J
		From		To			Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)			Diagnosis Pointer	\$ Charges	Days or Units	Ready Plan	ID Qual	Rendering Provider ID.#
M	M	DD	YY	MM	DD	YY			CPT / HCPCS	Modifier							
1	1	1	2018	1	1	2018	11	Day	99214	25		A	110.00	1		NPI	XXXXXXXXXX
1	1	1	2018	1	1	2018	11	Day	68761	E2		B	144.00	1		NPI	XXXXXXXXXX
1	1	1	2018	1	1	2018	11	Day	68761	51	E4	B	144.00	1		NPI	XXXXXXXXXX

**AVERAGE MEDICARE REIMBURSEMENT:**

- \$142.76, however reimbursement will only be 50% for any occlusion after the first

**THINGS YOU MUST KNOW:**

- Office visit is only billable if punctal occlusion was NOT the reason for their visit:
  - MUST use a 25 modifier on the OV(separate procedure / same day)
  - MUST use a unique diagnosis code for the punctal occlusion verses the OV
- SOME payers require a 51 modifier (multiple procedures/same day) on second line
- Must add location modifier: E1 (UL),E2 (LL),E3 (UR),E4 (LR)
- Bill the total amount for each line item, though reimbursement will be different for each line
- Includes a 10 day global period: do not bill an OV within 10 days, unless for a separate identifiable reason
- MUST order the procedure in the plan
- MUST have an Operative Note (see example)

**APPLICABLE DIAGNOSIS CODES:**

DRY EYE SYNDROME OF LACRIMAL GLAND	OU	H04.123		OD	H16.211
	OD	H04.121		OS	H16.212
	OS	H04.122	KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S	OU	H16.223
UNSPECIFIED SUPERFICIAL KERATITIS	OU	H16.103		OD	H16.221
	OD	H16.101		OS	H16.222
	OS	H16.102	NEUROTROPIC KERATOCONJUNCTIVITIS	OU	H16.233
FILAMENTARY KERATITIS	OU	H16.123		OD	H16.231
	OD	H16.121		OS	H16.232
	OS	H16.122	SICCA SYNDROME, UNSPECIFIED		M35.00
PUNCTATE KERATITIS	OU	H16.143	SICCA SYNDROME WITH KERATOCONJUNCTIVITIS		M35.01
	OD	H16.141			
	OS	H16.142			
EXPOSURE KERATOCONJUNCTIVITIS	OU	H16.213			

**Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.**

# Billing Guide for Punctal Occlusion

Lacrivera has created this guide to serve as an introduction to the billing procedures, requirements and codes relative to punctal occlusion.

**General Information**

- All punctal occlusion is billed the same, regardless if permanent silicone plugs or temporary synthetic/collagen inserts are used.
- Allow a 10 day post-op period following the insertion of collagen plugs before inserting permanent plugs.
- When occluding more than one punctum at the same time, the first procedure is allowed at 100% and each additional procedure is allowed at 50%.

**Documentation**

In addition to proper coding, be sure the procedure is properly and sufficiently documented.

- Document the patient's dry eye complaint. Be sure to note the patient's pertinent history, symptoms and affect on daily activities.
- Document unsuccessful alternative treatments. This should include the use of artificial tear supplements with continued dry eye symptoms.
- Document examination and evaluation of tear production to confirm Dry Eye Syndrome. This may include ZoneQuick, Schirmer, Rose Bengal Staining, and/or Tear Break-Up Time tests. Some tests may not be separately billable.
- Document that you have clearly explained to the patient the potential risks and benefits of punctal occlusion.

**THE CODES TO KNOW**

**Primary Diagnosis Codes**

- H04.121 Dry Eye Syndrome of Right Lacrimal Gland
- H04.122 Dry Eye Syndrome of Left Lacrimal Gland
- H04.123 Dry Eye Syndrome of Bilateral Lacrimal Glands
- H04.129 Dry Eye Syndrome of Unspecified Gland

**Secondary Diagnosis Codes**

- H16.109 Unspecified superficial keratitis
- H16.229 Keratoconjunctivitis sicca
- H57.8 Redness or discharge
- M35.01 Keratoconjunctivitis sicca associated with Sjogren's disease

**CPT Procedure Code**

- 68761 Closure of the lacrimal punctum by plug, each

**Supply Code**

A4263 (HCPCS) or 99070

Medicare combines the office visit, procedure and supply of collagen/silicone plugs, thus they are not billed separately. Some private insurance companies may accept a separate supply code.

**Punctum Identification**

- E1 Upper lid, left
- E2 Lower lid, left
- E3 Upper lid, right
- E4 Lower lid, right

**Modifiers**

- 25 Separately identifiable service by the same doctor on the same day
- 51 Additional procedure

*The information in this guide is believed to be accurate but is not intended to serve as an authority or to comprehensively address proper billing procedures. Always refer to official documentation provided by Medicare and/or private insurance carriers.*



**DRY EYE INSTITUTE** PUNCTAL OCCLUSION: CPT 68761

A Date(s) of Service							B	C	D			E	F	G	H	I	J
From			To				Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)			Diagnosis Pointer	\$ Charges	Days or Units	Rendy Plan	ID Qual	Rendering Provider ID.#
M	DD	YY	MM	DD	YY	CPT / HCPCS			Modifier								
1	1	2018	1	1	2018	11	Day	99214	25		A	110.00	1		NPI	XXXXXXXXXX	
1	1	2018	1	1	2018	11	Day	68761	E2		B	144.00	1		NPI	XXXXXXXXXX	
1	1	2018	1	1	2018	11	Day	68761	51 E4		B	144.00	1		NPI	XXXXXXXXXX	

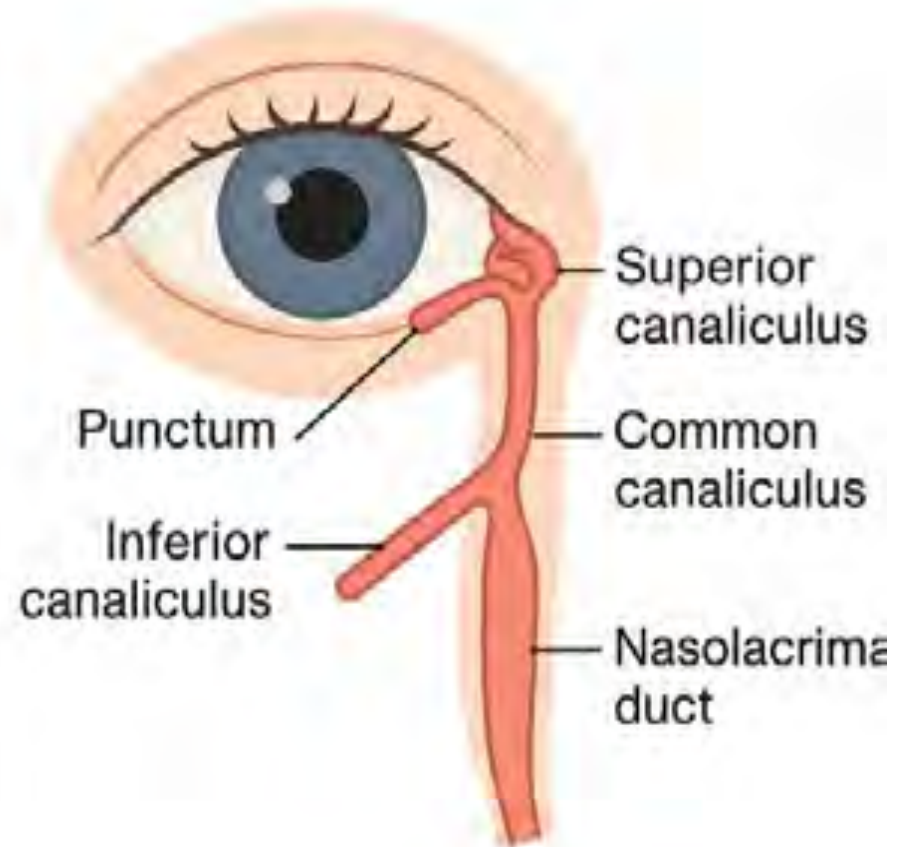
**USE 68801 for PUNCTAL DILATION +/- IRRIGATION**

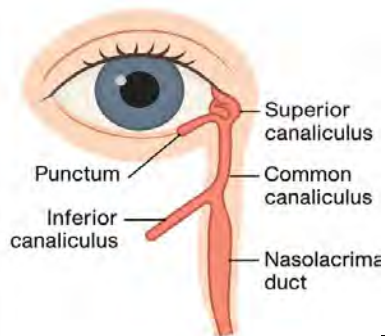
(same rules: 10 day global period)  
\$90—130 reimbursement

Indicated for EIPHORA / poor tear clearance

**USE 68840 for CANALICULAR PROBING +/- IRRIGATION**

(same rules: 10 day global period)  
\$150-165 reimbursement





# Differentiating Probing Procedures:

Code	Descriptor	When to Use	Bundling/Rules	Global	Average Medicare (2025, NF)
68801	<i>Dilation of lacrimal punctum, with or without irrigation; unilateral</i>	Simple punctal dilation ± saline flush to assess patency or relieve obstruction. For cases like poor tear clearance, mucous/debris removal, or suspected stenosis.	<ul style="list-style-type: none"> <li>• <b>Unilateral</b> — use -RT/-LT; some MACs allow -50 if both eyes.</li> <li>• <b>NCCI edit:</b> if performed <b>same eye, same day</b> as punctal plug insertion (<b>68761</b>), 68801 is bundled — cannot bill separately unless clear, distinct indication (modifier -59/XS + documentation).</li> <li>• Cannot bill with 68810–68815 (nasolacrimal duct probing) for same eye/session.</li> </ul>	10 days	~\$90-130 (non-facility)
68810	<i>Probing of nasolacrimal duct, with or without irrigation; unilateral</i>	When a probe is used beyond the punctum into the canaliculus/duct to relieve obstruction. Often in congenital or acquired NLDO.	Not bundled with 68801 — choose one based on depth/extent. Requires clear documentation of <b>probing</b> (not just punctal dilation).	10 days	~\$125-135
68815	<i>Probing of nasolacrimal duct with intubation and stent placement, unilateral</i>	When probing is performed <b>with placement of stent/Tube</b> (e.g., Crawford, silicone).	Higher complexity. Supplies may be separately billable (check payer).	90 days	~\$420-460
68840	<i>Probing of lacrimal canaliculi, unilateral</i>	For probing confined to <b>canaliculi</b> (not full duct).	Mutually exclusive with 68801 (punctal only) same eye/day.	10 days	~\$150-165



**REMOVAL OF CORNEAL EPITHELIUM; WITH OR WITHOUT CHEMOCAUTERIZATION (ABRASION, CURETTAGE):CPT 65435**

A			B			C	D			E	F	G	H	I	J	
Date(s) of Service						Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)			Diagnosis Pointer	\$ Charges	Days or Units	Ready Plan	ID Qual	Rendering Provider ID.#
From			To													
MM	DD	YY	MM	DD	YY			CPT / HCPCS	Modifier							
1	1	2018	1	1	2018	11	Day	99214	25		A,B	110.00	1		NPI	XXXXXXXXXX
1	1	2018	1	1	2018	11	Day	65435	RT		C	79.00	1		NPI	XXXXXXXXXX

**AVERAGE MEDICARE REIMBURSEMENT:**

- \$80.55

**THINGS YOU MUST KNOW:**

- Office visit is only billable if debridement is NOT the reason for the visit.
  - MUST use a 25 modifier on OV (separate procedure / same day)
  - MUST have separate diagnosis code from office visit
- MUST use location modifier: RT or LT
- 0 day global period: ok to bill any subsequent OV as necessary
- MUST order the procedure in the plan
- MUST have an Operative Note

**APPLICABLE DIAGNOSIS CODES:**

FILAMENTARY KERATITIS, BILATERAL	OU	H16.123
	OD	H16.121
	OS	H16.122

**Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.**





REMOVAL OF CORNEAL EPITHELIUM; WITH OR WITHOUT  
CHEMOCAUTERIZATION (ABRASION, CURETTAGE):CPT 65435

A	Date(s) of Service	B	C	D	E	F	G	H	I	J
---	--------------------	---	---	---	---	---	---	---	---	---

65205: Removal of superficial conjunctival FB

65210: Removal of embedded conjunctival FB (includes concretions)

Dx: H11.121/H11.122/H11.123 (OD/OS/OU).

- Average Medicare reimbursement: ~\$160 (unilateral).
- Unilateral; bill RT/LT.
- Global: 0 days (minor procedure).
- Documentation: lid everted, concretion embedded, instrument used, anesthesia, after-care.

Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.



# Differentiating Removal Procedures:

Code	Descriptor	When to Use	Rules / Bundling	Global	Avg Medicare 2025 (NF)
65205	Removal of superficial foreign body, external eye; conjunctiva	For removal of <b>superficial FB</b> on the conjunctiva <b>without incision</b> (cotton tip, spud, forceps). Does <b>not</b> cover embedded concretions.	<ul style="list-style-type: none"> <li>• Unilateral — append <b>-RT/-LT</b>.</li> <li>• Includes removal at slit lamp without incision.</li> <li>• Do <b>not</b> bill for multiple superficial FBs in same eye — still <b>1 unit</b>.</li> <li>• Not to be used if concretion required incision.</li> </ul>	10 days	~\$100–110
65210	Removal of foreign body or concretion, conjunctiva, embedded (includes upper lid tarsal plate)	For <b>concretion removal</b> or foreign body that is <b>embedded</b> and requires incision (needle/spud under lid eversion).	<ul style="list-style-type: none"> <li>• Unilateral — append <b>-RT/-LT</b>.</li> <li>• Must document that lesion was embedded and required instrumentation/incision.</li> <li>• Still <b>1 unit per eye</b> even with multiple concretions.</li> <li>• Pair same-day E/M only if significant and separately identifiable (<b>-25</b>).</li> </ul>	10 days	~\$140–150
65220	Removal of foreign body, external eye; corneal, without slit lamp	For corneal FB removal in-office <b>without slit lamp</b> .	<ul style="list-style-type: none"> <li>• Often bundled/denied if slit lamp used (65222).</li> </ul>	10 days	~\$110
65222	Removal of foreign body, external eye; corneal, with slit lamp	For corneal FB removal at slit lamp.	<ul style="list-style-type: none"> <li>• Requires slit lamp instrumentation.</li> <li>• Document method and corneal location.</li> </ul>	10 days	~\$150–160

# Differentiating CCH Repair Options:

Code	Descriptor	Use Case (CCh/lesion context)	Rules & Documentation	Global	Medicare 2025 NF (avg)
68110	<i>Excision of conjunctival lesion; simple</i>	For <b>small lesion or redundant conjunctiva ≤1 cm</b> . Sometimes applied to mild CCh if documented as a “lesion.”	<ul style="list-style-type: none"> <li>• <b>Unilateral</b> (RT/LT).</li> <li>• Document <b>size (≤1 cm)</b>, location (palpebral/bulbar), and indication (FB sensation, tear film toxicity, etc.).</li> <li>• Pathology report optional but strengthens claim.</li> <li>• Not to be billed with 68320 (conjunctivoplasty).</li> </ul>	10 days	\$211.86
68115	<i>Excision of conjunctival lesion &gt;1 cm</i>	For <b>larger redundant conjunctiva (&gt;1 cm)</b> — broader CCh excision in office.	<ul style="list-style-type: none"> <li>• <b>Unilateral</b> (RT/LT).</li> <li>• Document <b>size &gt;1 cm</b>, extent of tissue, and reason for removal.</li> <li>• Pathology recommended if specimen significant.</li> <li>• Cannot be billed with 68320 same day (superseded).</li> </ul>	10 days	\$259.09
68135	<i>Destruction of conjunctival lesion (any method, e.g., cautery, RF, laser)</i>	For <b>ablation/shrinkage</b> of redundant conjunctiva instead of excision. Sometimes used for CCh treated with thermal cautery.	<ul style="list-style-type: none"> <li>• <b>Unilateral</b> (RT/LT).</li> <li>• Must document <b>destructive method</b> (e.g., cautery, RF probe, laser) and lesion treated.</li> <li>• If AMT placed same day (65778), check MAC edits — some bundle.</li> </ul>	10 days	\$144.85



# Differences in CPT Billing Options:

Code	Descriptor	Medicare 2025 NF (avg)
68110	Excision of conjunctival lesion simple	\$211.86
68115	Excision of conjunctival lesion >1 cm	\$259.09
68135	Destruction of conjunctival lesion (any method, electrocautery, RF, laser)	\$144.85

## \*\*OR/ASC — Ophthalmology Only:\*\*

- 68320 – Conjunctivoplasty w/ graft or rearrangement  
Global: 90 days | ~\$600–800
- 68325 – Conjunctivoplasty w/ buccal graft (includes harvest)  
Global: 90 days | ~\$600–700
- 65779 – Amniotic membrane, sutured (single layer)  
Global: 90 days | ~\$800–1000+
- 65780 – AM multilayer, sutured (surface reconstruction)  
Global: 90 days | ~\$500–700+



**PLACEMENT OF AMNIOTIC MEMBRANE ON THE OCULAR SURFACE; WITHOUT SUTURES (PROKERA): CPT 65778**

A Date(s) of Service						B	C	D Procedures, Services, or Supplies (Explain Unusual Circumstances)			E	F	G	H	I	J
From			To			Place of Service	EMG	CPT / HCPCS	Modifier	Diagnosis Pointer	\$ Charges	Days or Units	Ready Plan	ID Qual	Rendering Provider ID.#	
MM	DD	YY	MM	DD	YY											
1	1	2018	1	1	2018	11	Day	99214	25	A,B	110.00	1		NPI	XXXXXXXXXX	
1	1	2018	1	1	2018	11	Day	65778	RT	C	1500.0	1		NPI	XXXXXXXXXX	

**MEDICARE EXAMPLE**

A Date(s) of Service						B	C	D Procedures, Services, or Supplies (Explain Unusual Circumstances)			E	F	G	H	I	J
From			To			Place of Service	EMG	CPT / HCPCS	Modifier	Diagnosis Pointer	\$ Charges	Days or Units	Ready Plan	ID Qual	Rendering Provider ID.#	
MM	DD	YY	MM	DD	YY											
1	1	2018	1	1	2018	11	Day	99214	25	A,B	110.00	1		NPI	XXXXXXXXXX	
1	1	2018	1	1	2018	11	Day	65778	RT	C	1500.0	1		NPI	XXXXXXXXXX	
1	1	2018	1	1	2018	11	Day	V2790	RT	C	500.00	1		NPI	XXXXXXXXXX	

**COMMERCIAL PAYER EXAMPLE**

**AVERAGE MEDICARE REIMBURSEMENT:**

- \$1,068 - \$1,523

**THINGS YOU MUST KNOW:**

- 0 day global period: Subsequent visits can be billed independently of the procedure

- Prokera fee includes an office visit for insertion. It would be a very RARE occasion to bill an OV on this day, and only if there is a separate identifiable reason. In this case, you MUST add a 25 modifier on the OV
- Some commercial insurances may reimburse supply code, V-2790. This is rare, but worth submitting initially.
- Strongly advised that you call *all* commercial payers beforehand to confirm that no Prior Authorization is needed and to confirm if Prokera will be applied to their deductible. No one wants a surprise.
- Must order the procedure in the plan
- Must have an Operative Note (see example)
- It is wise to have Prokera on hand in order to respond immediately to unexpected epithelial disruption

**APPLICABLE DIAGNOSIS CODES:**

KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S	OU	H16.223	OTHER SPECIFIED DISORDERS OF CORNEA	OS	H16.012
	OD	H16.221		OU	H18.893
	OS	H16.222		OD	H18.891
EXPOSURE KERATOCONJUNCTIVITIS	OU	H16.213		OS	H18.892
	OD	H16.211	CORNEAL ULCER WITH HYPOPYON	OU	H16.033
	OS	H16.212		OD	H16.031
PUNCTATE KERATITIS	OU	H16.143		OS	H16.032
	OD	H16.141	SCLEROSING KERATITIS	OU	H16.333
	OS	H16.142		OD	H16.331
FILAMENTARY KERATITIS	OU	H16.123		OS	H16.332
	OD	H16.121	PANNUS (CORNEAL)	OU	H16.423
	OS	H16.122		OD	H16.421
NEUTROTROPHIC KERATOCONJUNCTIVITIS	OU	H16.233		OS	H16.422
	OD	H16.231	BAND KERATOPATHY	OU	H18.423
	OS	H16.232		OD	H18.421
RECURRENT EROSION OF CORNEA	OU	H18.833		OS	H18.422
	OD	H18.831	NODULAR CORNEAL DEGENERATION	OU	H18.453
	OS	H18.832		OD	H18.451
UNSPECIFIED CORNEAL ULCER	OU	H16.003	OTHER HEREDITARY CORNEAL DYSTROPHIES		H18.59
	OD	H16.001			
	OS	H16.002	HERPESVIRAL KERATITIS		B00.52
CENTRAL CORNEAL ULCER	OU	H16.013	OTHER DISORDERS OF SCLERA		H15.89
	OD	H16.011			

\*These are general guidelines however local carriers will vary (Ex: BCBS in FL and AL will not reimburse if billed with H16.143/H16.141/H16.142/H16.149)

\*Use caution when billing BCBS. In some states BCBS will only reimburse if the membrane is stitched in place. This is new! In this case, collect from the patient on the day of service.

**Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.**



# Why Intervene?

Disease Category	Clinical Picture	Indications	ICD Codes	Clinical Guidance
Defect / Ulcer <sup>1,2</sup>		Corneal Ulcer	H18.02	Use early along with treating the underlying cause e.g., antimicrobials for infectious corneal ulcer.
		Ulcerated Epithelial Defect	H18.01	
		Corneal Ulcer with Hyaloid Membrane	H18.03	
		Marginal Corneal Ulcer	H18.04	
		Spontaneous Corneal Ulcer	H18.05	
Dry Eye <sup>3</sup>		Microcystic Keratoconjunctivitis	H18.20	Failure of standard therapy justifies concomitant use of ProKera <sup>®</sup> .
		Essential Keratoconjunctivitis	H18.21	
		Recurrent Keratitis	H18.24	
		Fluorescing Keratitis	H18.22	
		Sjogren	H18.1 - H18.18	
		Other	H18.0 - H18.09	
Dystrophy <sup>3,4</sup>		Lymphoid (Mucous) Membrane Metastatic Epitheliopathy	H18.32	Use after debridement or superficial keratectomy as required.
		Recurrent Corneal Erosion	H18.30	
Degeneration <sup>3,4</sup>		Band Keratopathy	H18.42	Use after superficial keratectomy.
		Ulcerated Corneal Degeneration	H18.40	
		Refractile Marginal Degeneration	H18.41 - H18.43	
Damage <sup>3,4</sup>		Chemical / Thermal	T94.00-94.99	Use immediately for corneal involvement.
		Welder's / Acid Burns	T80.00-80.99	
		Stevens-Johnson Syndrome	L87.1	
Recurrent/Refractile Epitheliopathy and Toxic Epithelial Necrolysis	L87.2			

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## General Guidelines:

- Why Intervene: To control inflammation and promote healing
- Medically necessary when: 1) Persistent defect 2) uncontrolled inflammation 3) Delayed healing 4) Failure of standard therapy
- Typically 3-5 days are sufficient for most mild to moderate indications however it can be used longer or repeatedly for more severe cases.

## Why Intervene?

Disease Category Clinical P

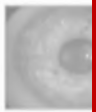
Defect / Ulcer<sup>22-23</sup>



Dry Eye<sup>24-25</sup>



Dystrophy<sup>26-27</sup>



Degeneration<sup>27-28</sup>



Damage<sup>29-31</sup>



Disease Category	Clinical Presentation	ICD-9-CM Code	Notes
Stevens-Johnson Syndrome		L51.1	Multiple use may be required.
Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis		L51.3	

### **USE 92071 for Bandage CL FITTING.**

Unilateral

0 day global period

Dx: recurrent corneal erosion, abrasion, post-surgery, exposure keratopathy, etc.

### **USE V2599 for lens MATERIAL:**

Used for the supply of the bandage contact lens material itself (per lens).

Pricing: Carrier-priced; most payers require you to attach an invoice copy for pricing/allowance.

Obtain ABN and If payer excludes coverage, append -GY modifier (denotes non-covered service, patient liable).

Cornea and ocular disorders,  
20130330-047,  
Ophthalmic Surgery, JAYEE  
Owen, JF Medical London,  
by Sefried  
PTE,  
Ocular Surgery Atlanta, Ocular  
and Contact Lens,  
for billing and/or insurance  
New: 201020000005,  
32 365-065,  
can replace Eye Contact  
at 2009, 145 957-764.



## Thermal Evacuation

A		Date(s) of Service					B	C	D			E	F	G	H	I	J
		From			To		Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)			Diagnosis Pointer	\$ Charges	Days or Units	Read y Plan	ID Qual .	Rendering Provider ID#
M	M	DD	YY	MM	DD	YY			CPT / HCPCS	Modifier							
1	1	2018	1	1	2018	11	Day	0270T				D	1500.0	1		NPI	XXXXXXXXX

### AVERAGE MEDICARE and PRIVATE PAYER REIMBURSEMENT:

- \$0-???

### THINGS YOU MUST KNOW:

- Currently no CPT code and not typically covered by any insurance ( Check with your local insurance carrier as insurance claims may be required in your state)
- Though it is rare, there are carriers willing to pay small amounts. Be sure to get an ABN signed!
- Some patients desire to submit for reimbursement themselves. Provide patient with itemized bill/receipt. If you must, 0270T is the closest applicable code
- Patients will often ask for a letter of necessity, as requested by their carrier (see example)
- There is often a small patient rebate from Tear Science

### APPLICABLE DIAGNOSIS CODES:

UNSPECIFIED BLEPHARITIS	OD UL	H01.001
	OD LL	H01.002
	OS UL	H01.003
	OS LL	H01.004
MEIBOMIAN GLAND DYSFUCNTION	OD UL	H02.881
	OD LL	H02.882
(unspecified lid)	OD	H02.883
	OS UL	H02.884
	OS LL	H02.885
(unspecified lid)	OS	H02.886
(unspecified eye / unspecified lid)		H02.889
	OD UL/LL	H02.88A
	OS UL/LL	H02.88B

**Disclaimer: Rules and reimbursement will vary. Please review local regulations according to insurance carriers in your zip code.**

A. Notifier:  
B. Patient Name:  
C. Identification Number:

### Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. \_\_\_\_\_ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

#### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
  - Ask us any questions that you may have after you finish reading.
  - Choose an option below about whether to receive the D. \_\_\_\_\_ listed above. If Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

#### G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1. I want the D. \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2. I want the D. \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- OPTION 3. I don't want the D. \_\_\_\_\_ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

#### H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:

J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1899.

Form CMS-R-131 (Exp.01/31/2026)

Form Approved OMB No. 0938-0566





Also Radiofrequency, Tixel I, etc.

Pair with  
MGD  
H02.88

A Date(s) of Service						B	C	D			E	F	G	H	I	J
From			To			Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)			Diagnosis Pointer	\$ Charges	Days or Units	Read y Plan	ID Qual .	Rendering Provider ID.#
M M	DD	YY	MM	DD	YY			CPT / HCPCS	Modifier							
1	1	2018	1	1	2018	11	Day	17999			A	1600	1		NPI	xxxxxxx x

Some also use 92499:  
*Unlisted ophthalmological service or procedure*

**AVERAGE MEDICARE and PRIVATE PAYER REIMBURSEMENT:**

- \$0

**THINGS YOU MUST KNOW:**

- Currently no CPT code and not typically covered by any insurance
- Some patients desire to submit for reimbursement themselves. Provide patient with itemized bill/receipt. If you must, 17999 is the closest applicable code
- Patients will often ask for a letter of necessity, as requested by their carrier

**APPLICABLE DIAGNOSIS CODES:**

Rosacea Conjunctiivitis, bilateral	H10.823
------------------------------------	---------

**Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.**

A. Date of Service		B.	C.	D.	E.	F.	G.	H.	I.	J.					
From		To		Place of Service	Procedure Code	Diagnosis Code	Units	Day of the Week	Modifier	Billing Code	Billing Rate				
MM	DD	YY	MM									DD	YY	PT	CH
1	1	2018	1	1	2018	11	Day	68841		A	55.00	1		NP	XXXXXXXXXX
1	1	2018	1	1	2018	11	Day	11096		A	1200.00	4		NP	XXXXXXXXXX

**AVERAGE MEDICARE REIMBURSEMENT:**

- \$1200 (wholesale cost at Henry Schein is \$461)

**THINGS YOU MUST KNOW:**

- Office visit is only billable if Dextenza was NOT the reason for their visit
  - MUST use a 25 modifier on the OV (separate procedure / same day)
  - MUST use a unique diagnosis code for Dextenza verses the OV
- MUST order the procedure in the plan
- MUST have an Operative Note

**APPLICABLE DIAGNOSIS CODES:**

Allergic Conjunctivitis, bilateral H10.13

**Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.**

Connect with DEXTENZA360,  
your dedicated resource and support team



**Click**  
DEXTENZA360.com  
for 24/7 online access to  
interactive tools designed  
to help you throughout  
the access and  
reimbursement process.



**Call**  
800-339-8369  
(800-DEXTENZA) for your  
dedicated Case Manager  
Monday-Friday  
8:00 AM-8:00 PM ET  
(fax: 855-518-7564)



**Connect**  
directly with your  
Ocular Therapeutic Field  
Reimbursement Manager  
or DEXTENZA360  
Case Manager.

## How to complete a CMS-1500 form for DEXTENZA

Follow the guide below on how to fill out a CMS-1500 form for DEXTENZA reimbursement. Ensure that you enter all applicable patient information.

### Sample Physician Claim Form

The image shows a sample CMS-1500 Physician Claim Form for DEXTENZA. The form is titled "HEALTH INSURANCE CLAIMS" and includes a QR code in the top left corner. The form is divided into several sections, with callouts pointing to specific boxes:

- Box 21:** Enter the appropriate ICD-10 code(s).
- Box 21:** Enter "0" for ICD-10 CM.
- Box 24 Service Lines (red-shaded lines):** Using a unique product code for DEXTENZA (U10W), use the following NDC (0447036205401\*UW1).
- Box 24D:** Enter the CPT code for the surgical procedure (e.g., 64994). Enter the HCPCS code to treat DEXTENZA (J-codes) and the CPT code for DEXTENZA insertion.
- Box 24F:** Enter price of DEXTENZA from price schedule.
- Box 24G:** Enter a unit of 1 for the procedure codes (64994 and 03567).

\*11 digit NDC, 1040 0268 01, may be required by certain payers.

NDC is to be preceded with the qualifier 04 and followed immediately by the 11 digit NDC in positions 01 through 11. Quantity of NDC is to be preceded by the appropriate qualifier (04) in units in positions 17 through 24.

CPT Copyright © 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FAR/DFARS Restrictions Apply to Government Use. The schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

HCPCS - Healthcare Common Procedure Coding System.

**Note:** The information presented is based on the paper claim format; please adapt this information to electronic equivalent fields in your software systems. The coding information discussed in this document and sample form is provided for informational purposes only, is subject to change, and should not be construed as legal advice. The codes listed below may not apply to all patients or to all health insurance plans; providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to a specific patient.

**Please see Indication and Important Safety Information on back cover and full Prescribing Information in pocket.**

**VISION  
EXPO**

2025 UPDATE

0936T: Photobiomodulation therapy of retina (e.g., early/intermediate non-exudative AMD). Category III; coverage limited; use waiver and treat as non-covered unless policy says otherwise.

<https://corcoranccg.com/reimbursement-for-retinal-photobiomodulation-therapy/>



REIMBURSEMENT FOR RETINAL PHOTOBIO-MODULATION THERAPY



**1** **QUESTION:** What is photobiomodulation (PBM) of the retina?

**ANSWER:** PBM is the use of low levels of light to stimulate cellular activity to provide beneficial effects. The Valeda® Light Delivery System is a medical device that uses PBM to improve vision. The Valeda® from LumiThera® delivers low-intensity, non-coherent, multi-wavelengths of light at 590, 660, and 850 nanometers to the retinal tissue stimulating mitochondrial metabolic activity, increasing available energy for the cells, reducing oxidative stress and inflammation, to improve vision in eyes with early- and intermediate-stage nonexudative (dry) age-related macular degeneration (AMD). It was [authorized by the FDA](#) in November 2024.

**2** **QUESTION:** What are the indications for PBM in the retina?

**ANSWER:** The Valeda® Light Delivery System is intended to provide improved visual acuity in patients with best corrected visual acuity of 20/32 through 20/70 and who have dry age-related macular degeneration (AMD) characterized by:

- The presence of at least 3 medium drusen (> 63 µm and ≤ 125 µm in diameter), or large drusen (> 125 µm in diameter), or non-central geographic atrophy, AND
- The absence of neovascular maculopathy or center-involving geographic atrophy.

After about two years, the [Valeda® Light Delivery System](#) treatment provides improved mean visual acuity of approximately one line of visual acuity (ETDRS) compared to those not receiving the treatment.

**3** **QUESTION:** What diagnosis code(s) is used on a claim?

**ANSWER:** Use an ICD-10-CM code in the H35.31- series to report nonexudative age-related macular degeneration. Use the sixth digit to identify the eye(s) and the seventh digit to identify the stage of the disease. The number 1 in the seventh digit means early stage and the number 2 means intermediate stage dry AMD.

**4** **QUESTION:** Will Medicare cover PBM?

**ANSWER:** Maybe. PBM is the first treatment shown to improve vision loss associated with early- and intermediate-stage dry AMD. [LIGHTSITE III](#) provides compelling evidence to support coverage of PBM in an office setting for qualifying patients.

**5** **QUESTION:** What CPT code is used to report PBM?

**ANSWER:** Use Category III CPT code 0936T (*Photobiomodulation therapy of retina, single session*). A session occurs on a single day. This code was inaugurated January 1, 2025.

**6** **QUESTION:** What is the Medicare payment for PBM?

**ANSWER:** Since 0936T is a Category III code, each Medicare Administrative Contractor (MAC) determines the payment rate for 0936T; CMS did not establish a rate in the CY 2025 Medicare Physician Fee Schedule.

**7** **QUESTION:** What chart documentation supports 0936T?

**ANSWER:** PBM is documented in the medical record with a report that includes these essential elements: date of service, patient name, diagnosis, proceduralist's name, title of procedure, indication for the procedure, description of the procedure, discharge instructions, and signature. Signatures authenticate medical records and are subject to strict [Medicare regulations](#).

**8** **QUESTION:** How often is PBM therapy administered?

**ANSWER:** In the [LIGHTSITE III](#) clinical trial, subjects received PBM treatment with the Valeda in nine (9) sessions over three (3) to five (5) weeks every four (4) months, over twenty-four (24) months.

**9** **QUESTION:** Can a medical assistant (MA) treat a patient using PBM upon the order of a physician?

**ANSWER:** The answer to this question depends on where you practice. The work that an MA is trained and capable of performing is limited. Even though MAs work directly with doctors, they can't give medical advice to patients – they only support medical staff. Even certified ophthalmic technicians are limited in their capabilities. State laws govern what MAs are permitted to do, but state laws differ and some states are stricter than others with regard to physicians directing MAs to treat patients. California is an example of a state with [strict limits on medical assistants](#).

Significantly, MAs do not function at the level of a nurse or qualified healthcare professional (e.g., PA, NP). MAs are unlicensed while nurses and QHPs are licensed and have more education, skill and capabilities.

Payors are oriented to reimburse services personally performed by a physician or QHP while services performed by a MA under supervision of a physician are not equivalent.

**10** **QUESTION:** If coverage of PBM is unlikely or uncertain, how should we proceed?

**ANSWER:** When Medicare or other third-party payor will likely deny the claim, ask the patient to assume financial responsibility for the charge using a financial waiver: An Advance Beneficiary Notice of Noncoverage (ABN) is required for services where Part B Medicare coverage is ambiguous or doubtful. For Medicare Advantage (Part C), determination of benefits is required to identify beneficiary financial responsibility prior to performing noncovered services; MA Plans have their own waiver forms and processes. For commercial insurance beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN.

June 5, 2025



When in doubt...

Go to

Askthecodingexperts

on the

AOA coding page



out-of-pocket  
considerations

# “I’m on a budget ...where do I begin?”



## How long does it take to pay for the average diagnostic instrument?

Assuming ~\$25K

At \$99/dry eye eval and 1/week



\$20/ext photos on 6 patients/day

▶▶ Paid in full in ~8 months

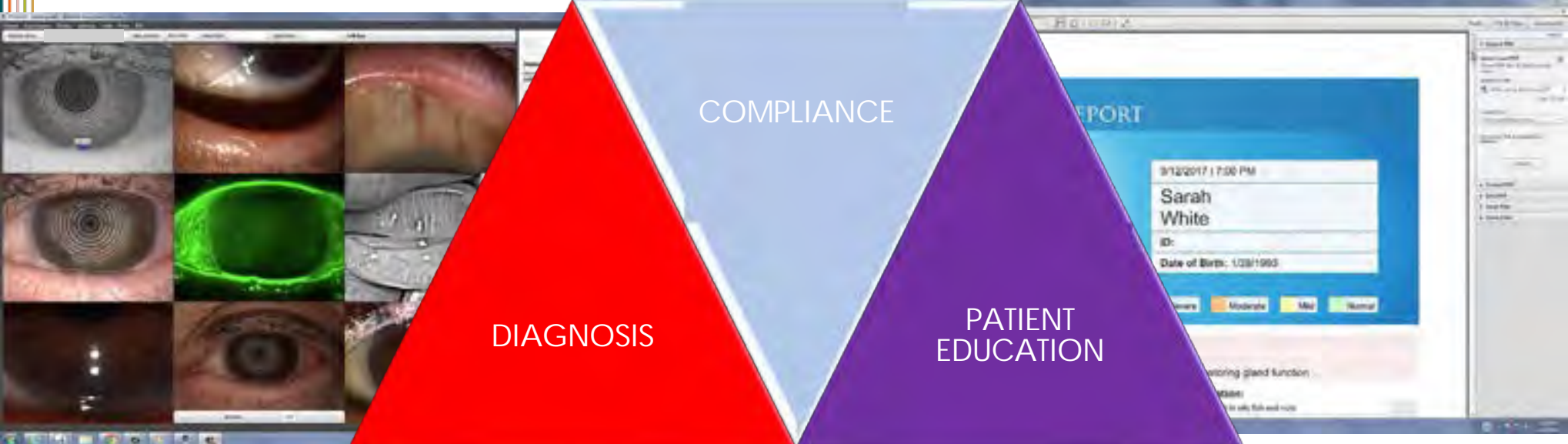
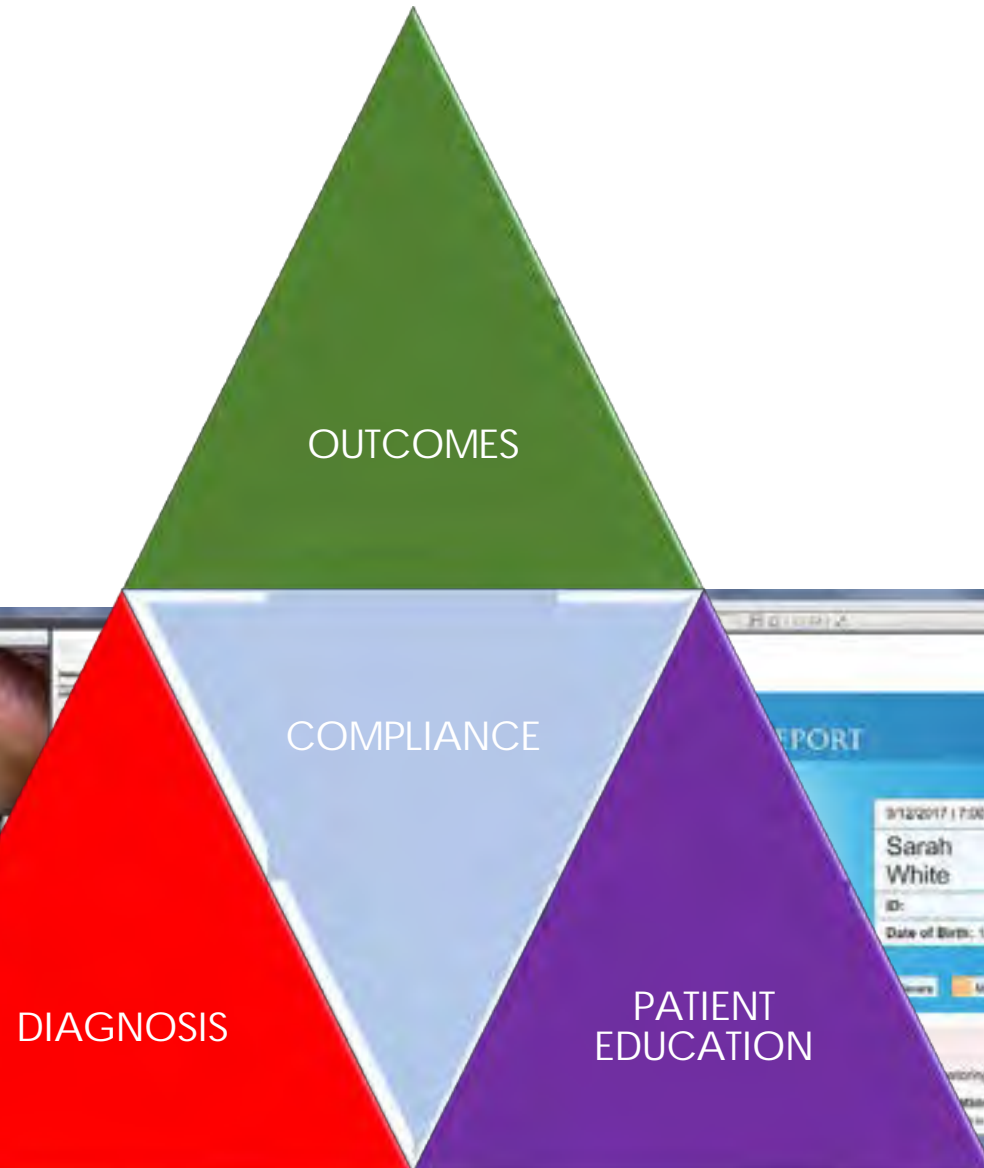
At \$99/dry eye eval and 2/week



\$20/ext photos on 10 patients/day

▶▶ Paid in full in < 4 months

But that is  
only a  
fraction of  
the story...



# POTENTIAL ROI: VISIT #1

- OFFICE VISIT (99205): \$216.77
  - OSMO: \$22.48 X 2
  - INFLAMMADRY: \$14.24 X 2
  - EXTERNAL PHOTOS: \$22.92
  - DRY EYE EVAL (OOP FOR 5M): \$99
  - PLUS TOPO (IF WARRANTED): \$35.69
  - TOTAL FEES COLLECTED: **\$447.82**
  - WARM COMPRESS MASK: \$80 (-40)
  - OMEGA 3: \$108 (-45)
  - LID SCRUB: \$18 (-9)
  - Hypochlorous acid: \$38 (-18)
  - SLEEP MASK: \$60 (-30)
  - TOTAL POTENTIAL PURCHASES: \$304
  - NET = \$162
- TOTAL NET = \$609.82



## Mild:

### Potential Annual revenue per patient

- 3 visits / year : \$431  
(DEE + 99205, 99214, 99213 )
- 6 month Plugs: \$217 x 2 = \$434  
(-60)
- Osmolarity at each visit: \$135  
(-60)
- Inflammadry at each visit: \$90  
(-48)
- External photos at each visit: \$66
- Omega 3: \$648 (-270)
- Tranquileyes W/C Mask: \$80 (-40)
- Lid scrubs X 9: \$108 (-54)
- Pure & Clean x 10: \$380 (-180)
- In office lid exfoliation: \$200
- In office expression with Eye Cloud x 2: \$100

TOTAL COLLECTED = \$2,771  
MINUS COGS ~\$712  
NET ~ \$2,059  
**@1/WEEK = \$107,068**

\*Treatment equipment  
investment: ~\$300



## Moderate:

# Potential Annual revenue per patient

- 5 visits / year : \$646 (DEE + 99205, 99214, 99214, 99213, 99213)
- 6 month Plugs: \$217 x 2 = \$434 (-60)
- Osmolarity at each visit: \$225 (-100)
- Inflammadry at each visit: \$150 (-80)
- External photos at each visit: \$110
- Omega 3: \$648 (-270)
- Tranquileyes W/C Mask: \$80 (-40)
- Pure & Clean
- NuLids: \$309 (-\$189) + \$360 (-\$252)
- Eye Wash x 6: \$36 (-15)
- Sleep mask: \$60 (-30)
- IPL: \$1800

TOTAL COLLECTED = \$5,337

MINUS COGS ~\$1,216

NET ~ \$4,121

@1/WEEK = \$214,292



## Severe:

# Potential Annual revenue per patient

- 8 visits / year : \$1061 (DEE + 99205, 99214 x 6, 99213)
- 6 month Plugs: \$217 x 2 = \$434 (-60)
- Osmolarity at each visit: \$360 (-160)
- Inflammadry at each visit: \$240 (-128)
- External photos at each visit: \$176
- Topography: \$35
- Omega 3: \$648 (-270)
- Omega 6: \$456 (-324)
- Tranquileyes W/C Mask: \$80 (-40)
- Pure and Clean x
- Cliradex Light x 3: \$90(-45)
- NuLids: \$309 (-\$189) + \$360 (-\$252)
- Eye wash x 20: \$120 (-50)
- Sleep mask: \$60 (-30)
- PM Tear gel x 8: \$160(-80)
- IPL: \$1800
- Amniotic membrane x 2 = \$2700 (-1300)
- Thermal evacuation: \$1000 (-260)

TOTAL COLLECTED = \$10,568

MINUS COGS ~\$3,368

NET ~ \$7,200

@2/MONTH = \$172,800



# Very Severe: Potential Annual revenue per patient

- 10 visits / year : \$ 1,150 (DEE + 99205, 99214 x 6, 99213 X 2)
- 6 month Plugs: \$217 x 2 = \$434 (-60)
- Osmolarity at each visit: \$450 (-200)
- Inflammadry at each visit: \$300 (-160)
- External photos at each visit: \$220
- Topography: \$35
- Omega 3: \$648 (-270)
- Omega 6: \$456 (-324)
- Tranquileyes W/C Mask: \$80 (-40)
- Pure and Clean x 10: \$380 (-180)
- NuLids: \$309 (-\$189) + \$360 (-\$252)
- Eye wash x 20: \$120 (-50)
- Sleep mask: \$60 (-30)
- PM Tear gel x 8: \$160(-80)
- Cliradex Light x 3: \$90(-45)
- IPL: \$1800
- Amniotic membrane x 2 = \$2700 (-1300)
- Thermal evacuation : \$1000 (-260)
- Scleral lens fit: \$3000 (-340)

TOTAL COLLECTED = \$13,851

MINUS COGS ~\$3,780

NET ~ \$10,071

@2 /MONTH = \$241,704



4 DRY EYE PATIENTS  
PER WEEK

**= \$735,864**

ADDITIONAL ANNUAL  
REVENUE

MILD: 1/WEEK >>

\$107,068 /YR

MODERATE: 1/WEEK >> \$214,292  
/ YR

SEVERE: 2/ MONTH >> \$172,800 /  
YR

VERY SEVERE: 2/ MONTH >>  
\$241,704 / YR

National Average =  
\$274 ARPP

Consider COGS and  
COO...

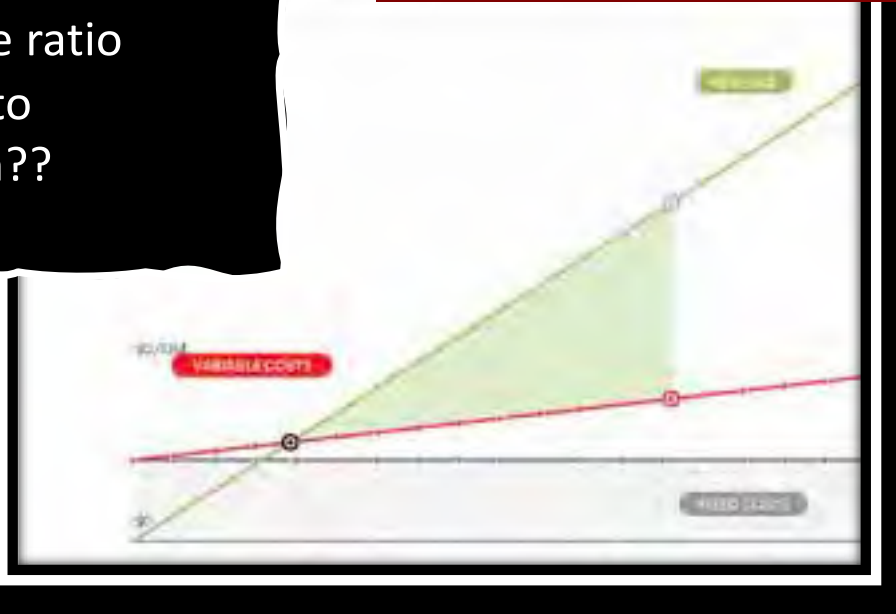
What is the ratio  
according to  
production??

make 3x more?

OR WORK 1/3 AS HARD?

AvgAnnualRevenuePerPatient = **\$2,072.55**

AvgRevenuePerVisit = **\$517.33**



# **How do I know what to buy???**

Follow these 4 guidelines and ...you will know.

caveat:

MUST BE IN THIS ORDER

## 1. efficacy

If it works... IT WILL PAY FOR ITSELF!

If it doesn't... DON'T GET IT, EVEN IF IT'S FREE!

## 2. experience

What is the patient's perception... on COMFORT?

on VALUE?

To compare apples to apples, consider...

### 3. business model

Cost of device

Cost of applicators

Profit margin per treatment

Conversion rate considering value and MSRP

Repeat interval

...over 3 years



## 4. the people

warrantee  
training

resources  
support

reputation  
marketing



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