BioTissue Ocular

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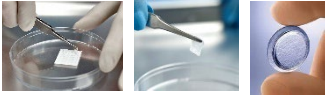
2024 Ocular Coding with Amniotic Membranes

Physician Fee Schedule – Facility and Non-Facility Settings (CY 2024)						
CPT	Descriptor	Medicare Physician Fee Schedule				
		NON-FACILITY		FACILITY		
		Non-Facility RVUs	National Average Payment	Facility RVUs	National Average Payment	
Placement of Amniotic Membrane Coding						
65778	Placement of amniotic membrane on the ocular surface; without sutures	32.64	$1,086.50	1.30	$43.27	
65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	34.67	$1,154.08	3.49	$116.17	
Pterygium Procedural Coding						
65426	Excision or transposition of pterygium; with graft	20.00	$665.75	14.24	474.01	
Conjunctival Procedures						
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	N/A	N/A	17.61	$586.19	
68110	Excision of lesion, conjunctiva; up to 1 cm	7.07	$235.34	4.42	$147.13	
68115	Excision of lesion, conjunctiva; over 1 cm	9.93	$330.54	5.44	$181.08	
68320	Conjunctivoplasty; with conjunctival graft or extensive rearrangement	22.21	$739.32	16.07	$534.93	
68326	Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement	NA	N/A	19.14	$637.12	
68330	Repair of symblepharon; conjunctivoplasty, without graft	18.62	$619.81	13.69	$455.71	
Glaucoma Procedures						
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	N/A	N/A	32.54	$1,083.18	
66172	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	N/A	N/A	35.54	$1,183.04	
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	N/A	N/A	33.84	$1,126.45	
66185	Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft	N/A	N/A	25.31	$842.51	
Supply Code						
V2790	Amniotic membrane for surgical reconstruction, per procedure	N/A	N/A	N/A	Contractor Priced	



CPT 65426 / HCPCS V2790 Code Information:

CPT 65426: (Excision or transposition of pterygium; with graft) If the provider secures the amniotic membrane transplant with glue instead of using a conjunctival graft, CPT 65426 may still be reported. When reporting the placement of the amniotic membrane separately, CPT 66999 should be reported if glue is used.

HCPCS V2790: V2790 – Amniotic membrane for surgical reconstruction, per procedure, is a supply code. Medicare and many Commercial payors consider payment for the supply included in the payment for the procedure code. Payors may have different policies regarding the supply of the amniotic tissue. Check your commercial payor policies and contracts to determine coverage and payment associated with CPT code 65778 and HCPCS code V2790, as this will vary from payor to payor.

HCPCS code V2790 should not be billed to Part B separately except as noted below:

- HCPCS code V2790 can be reimbursed separately in an office setting when billed with CPT Code 65780. A copy of the invoice must be submitted when billing V2790 and 65780 on the same claim.
- HCPCS code V2790 should not be billed with CPT Code 65775. However, if amniotic membrane application is required during that procedure, then either CPT Codes 65778 or 65779, depending on the method of application of the membrane must be billed with 65775 when a membrane is applied. As indicated above, Medicare includes payment for the amniotic membrane supply (V2790) in payment for CPT Codes 65778 and 65779. Therefore V2790 should not be billed separately when those codes are billed to Medicare. Commercial payors may have different policies regarding the payment for the amniotic membrane graft supply.

CMS.gov

References/Notes:

- The payment rates specified in this document are Centers for Medicare & Medicaid Services (CMS) national unadjusted averages. Actual payment rates will vary based on geographic adjustments and are updated quarterly. Commercial payment rates will vary per contract.
- By Report – For CPT codes that have not been assigned RVUs (e.g., miscellaneous codes), there is no national payment rate. Providers must provide detailed operative notes describing the service provided. If there is an existing service with an established CPT code that involves similar work, that CPT code may be provided as a suggested crosswalk for payment purposes.
- CY 2024 Changes to Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule with Comment and Final CY 2024 Payment Rates (CMS 1786-FC); Addendum B and ASC Addenda.
- CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1786-FC); Addendum B. All MPFS Fee Schedules calculated using CF of $33.2875 effective March 9, 2024.
- Current Procedural Terminology (CPT®) is a registered trademark of the American Medical Association.
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Key to Hospital Outpatient and ASC Settings Abbreviations:

SI – Status Indicator

APC – Ambulatory Payment Classifications

ASC – Ambulatory Surgical Center

OPPS – Hospital Outpatient Prospective Payment System

Q2 - Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "T." Otherwise, payment is made through a separate APC.
J1 - All covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI=F, G, H, L, and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.

If two or more "J1" services appear on the same claim, the procedure with the higher rank based on cost is considered the "primary" service, and payment is based upon the C-APC to which that service is assigned.

Procedure coding should be based upon medical necessity, procedures, and supplies provided to the patient. Coding and reimbursement information is provided for educational purposes only and does not assure coverage of the specific item or service in each case. BioTissue and The Pinnacle Health Group make no guarantee of coverage or reimbursement of fees. These payment rates are nationally unadjusted average amounts and do not account for differences in payment due to geographic variation. Contact your local Medicare Administrative Contractor (MAC) or CMS for specific information as payment rates listed are subject to change. To the extent that you submit cost information to Medicare, Medicaid, or any other reimbursement program to support claims for services or items, you are obligated to accurately report the actual price paid for such items, including any subsequent adjustments. CPT® five-digit numeric codes, descriptions, and numeric modifiers only are Copyright AMA.

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In the Hospital Outpatient Prospective Payment System (OPPS), CMS assigns all CPT and HCPCS codes a Status Indicator (SI), which indicates when and how a service is considered for payment. Status indicators that apply to the procedures listed in this guide are provided below:

Facility Reimbursement – Hospital Outpatient and ASC Settings (CY 2024)					
CPT	Descriptor	OPPS			ASC
		SI	APC	Payment	Payment
Placement of Amniotic Membrane Coding					
65778	Placement of amniotic membrane on the ocular surface; without sutures	Q2	5502	$964.64	Packaged
65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	Q2	5504	$3,683.86	Packaged
Pterygium Procedural Coding					
65426	Excision or transposition of pterygium; with graft	J1	5503	$2,226.48	$978.51
Conjunctival Procedures					
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	J1	5504	$3,683.86	$1,487.29
68110	Excision of lesion, conjunctiva; up to 1 cm	J1	5503	$2,226.48	$128.03
68115	Excision of lesion, conjunctiva; over 1 cm	J1	5503	$2,226.48	$978.51
68320	Conjunctivoplasty; with conjunctival graft or extensive rearrangement	J1	5503	$2,226.48	$978.51
68326	Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement	J1	5504	$3,683.86	$1,487.29
68330	Repair of symblepharon; conjunctivoplasty, without graft	J1	5491	$2,220.35	$1,183.70
Glaucoma Procedures					
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	J1	5491	$2,220.35	$1,183.70
66172	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	J1	5491	$2,220.35	$1,183.70
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	J1	5492	$3,873.90	$2,625.81
66185	Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft	J1	5491	$2,220.35	$1,183.70
Supply Code					
V2790	Amniotic membrane for surgical reconstruction, per procedure	N	N/A	Packaged	Packaged

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The ICD-10 diagnostic codes listed below include only those that map to a CPT code relative to pterygium, conjunctival, or glaucoma procedure provided in the previous table. Codes ending with a “dash” mean additional digits may be required to obtain greater specificity.

Relevant Ocular Diagnosis Codes	
ICD-10-CM	Description
B94.0	Sequelae of trachoma
C69.0-	Malignant neoplasm
C79.49	Secondary malignant neoplasm of other parts of nervous system
D09.2-	Carcinoma in situ
D31.0-	Benign neoplasm of conjunctive
D48.7	Neoplasm of uncertain behavior of other specified sites
D49.89	Neoplasm of unspecified behavior of other specified sites
H04.12-	Dry eye syndrome of lacrimal glands
H10.81-	Pingueculitis
H11.00-	Unspecified pterygium
H11.01-	Amyloid pterygium
H11.02-	Central pterygium
H11.03-	Double pterygium
H11.04-	Peripheral pterygium
H11.05-	Peripheral pterygium, progressive
H11.44-	Conjunctival cysts
H11.06-	Recurrent pterygium
H11.21-	Conjunctival adhesions and strands (localized)
H11.22-	Conjunctival granuloma
H11.24-	Scarring of conjunctiva
H11.44-	Conjunctival cysts
H11.81-	Pseudopterygium of conjunctiva
H11.82-	Conjunctivochalasis
H16.00-	Unspecified corneal ulcer
H16.01-	Central corneal ulcer
H16.02-	Ring corneal ulcer
H16.03-	Corneal ulcer with hypopyon
H16.04-	Marginal corneal ulcer
H16.05-	Mooren's corneal ulcer
H16.06-	Mycotic corneal ulcer
H16.07-	Perforated corneal ulcer
H16.12-	Filamentary keratitis
H16.14-	Punctate keratitis
H16.223	Keratoconjunctivitis sicca, not specified as Sjogren's, bilateral
H16.23-	Neurotrophic keratoconjunctivitis
H18.1-	Bullous keratopathy
H18.40	Unspecified corneal degeneration
H18.41-	Arcus senilis
H18.42-	Band keratopathy
H18.43	Other calcerous corneal degeneration
H18.44-	Keratomalacia

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Relevant Ocular Diagnosis Codes

ICD-10-CM	Description
H18.45-	Nodular corneal degeneration
H18.46-	Peripheral corneal degeneration
H18.49	Other corneal degeneration
H18.50	Unspecified hereditary corneal dystrophies
H18.51	Endothelial corneal dystrophy
H18.52	Epithelial (juvenile) corneal dystrophy
H18.53	Granular corneal dystrophy
H18.54	Lattice corneal dystrophy
H18.55	Macular corneal dystrophy
H18.59	Other hereditary corneal dystrophies
H18.73-	Descemetocele
H18.82-	Corneal disorder due to contact lens
H40.05-	Ocular hypertension
H40.06-	Primary angle closure without glaucoma damage
H40.10X-	Unspecified open-angle glaucoma
H40.11-	Primary open-angle glaucoma
H40.12-	Low-tension glaucoma
H40.13-	Pigmentary glaucoma
H4014-	Capsular glaucoma with pseudoexfoliation of lens
H40.15-	Residual stage of open-angle glaucoma
H40.20X-	Unspecified primary angle-closure glaucoma
H40.22-	Chronic angle-closure glaucoma
H40.23-	Intermittent angle-closure glaucoma
H40.24-	Residual stage of angle-closure glaucoma
H40.30-	Glaucoma secondary to eye trauma
H40.40-	Glaucoma secondary to eye inflammation
H40.50-	Glaucoma secondary to other eye disorders
H40.60-	Glaucoma secondary to drugs
H40.81-	Glaucoma with increased episcleral venous pressure
H40.82-	Hypersecretion glaucoma
H40.83-	Aqueous misdirection
H40.89	Other specified glaucoma
H40.9	Unspecified glaucoma
H42	Glaucoma in diseases classified elsewhere
H59.09-	Other disorders of the eye following cataract surgery
L51.1	Stevens-Johnson syndrome
Q13.1	Absence of iris
Q15.0	Congenital glaucoma
S05.0-	Injury of conjunctiva and corneal abrasion without foreign body
T26.1-	Burn of cornea
T26.6-	Corrosion of cornea and conjunctival sac
T26.7	Corrosion with resulting rupture and destruction of eyeball
T26.8	Corrosions of other specified parts of eye and adnexa
T26.9	Corrosion of eye and adnexa, part unspecified
T86.84-	Corneal transplant

If you have any additional questions regarding coding, coverage and payment; or require assistance with pre-determination, prior authorization, or coverage appeals for a particular patient, please contact the BioTissue Reimbursement Hotline at 866-369-9290 or email biotissueocular@thepinnaclehealthgroup.com.

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Common Modifiers Used in Ocular Coding

RT* – Right eye

LT* – Left eye

E1 – Upper left eyelid

E2 – Lower left eyelid

E3 – Upper right eyelid

E4 – Lower right eyelid

24 – Use for unrelated E/M by the same doctor during the postoperative period.

25 – Used when a distinct service is provided by the same doctor on the same day as another procedure. Appended to E/M code, not surgical code.

50* – Bilateral procedure

51 – Use when multiple procedures are performed on the same day during the same encounter.

57 – Appended to an exam when the decision to perform a major surgery was made at this encounter.

58 – Staged procedure

59 – Used when two different procedures that are not normally reported together are appropriately billed together under the set circumstances.

78 - Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period.

79 – Use for unrelated procedure during the postoperative period performed by the same doctor.

*Not all ICD-10 diagnosis codes include laterality, but when a code does, ensure that the diagnosis code and appended modifier are telling the same story.

SOURCE: https://questns.com/ophthalmology-cpt-codes-modifiers-for-2022/