Experience EXPO With Us!

- Main Stage - *Exhibit Hall – Booth F11084*
  Our Main Stage sessions feature free, promotional content for all attendees.
- Vision Series - *Thursday 9/18, Friday 9/19 and Saturday 9/20*
  Grab a bite to eat and continue learning over *Breakfast 8:30-9:30am* or *Lunch 12:00-1:00pm*!* Listen to industry leaders as they address the latest clinical innovations in a relaxed and collaborative environment.

  **Open to Optometrists only. Not for Credit. Meals offered on first-come, first-serve basis to pre-registered attendees.*

- Exhibit Hall Hours
  Thursday, Sept 18 9:30am – 6:00pm
  Friday, Sept 19 9:30am – 6:00pm
  Saturday, Sept 20 9:30am – 3:00pm

Conferee Cafe – Exhibit Hall – Booth P19087

Education Lounge – Level 1 - Conference Area

Conferee Happy Hour Thur, Sept 18 4:30 - 5:30pm

vision expo

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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.

vision expo

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Billing and Coding for Dry Eye

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

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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.*

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first things first...

billing the office visit

92 codes vs 99 codes

VISION EXPO

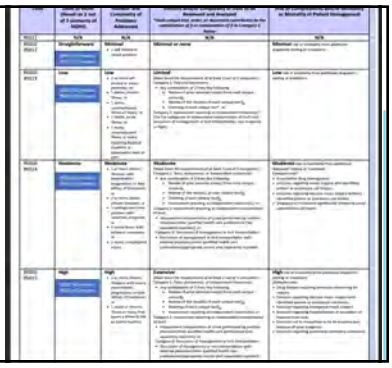
5

VISION EXPO

6

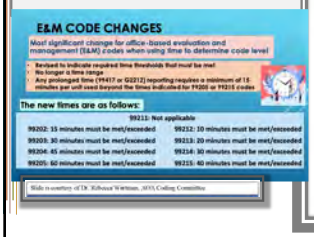
992XX CODING:
You have
TWO options

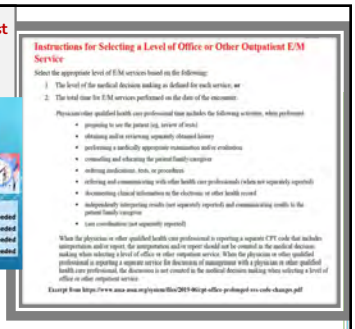
Use traditional medical justification guidelines, BEING CERTAIN to diagnose each OSD issue to show management of multiple conditions



7

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





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If you are included in a downcoding program based on your claims reporting history, please notify the AOA at **stopplanabuses@aoa.org**.

StopPlanAbuses for help if their appeals are unsuccessful.
https://www.aoa.org/advocacy/health-and-vision-plan-advocacy

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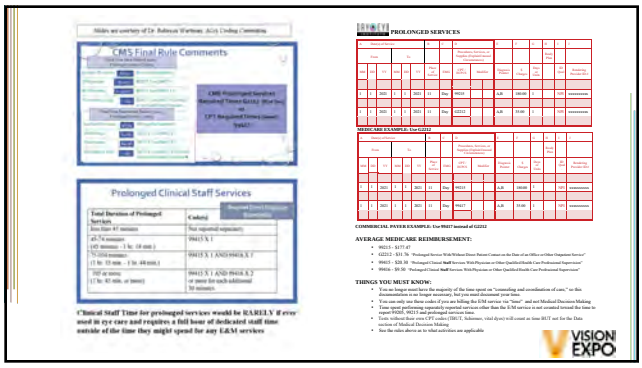

10

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

VISION EXPO

11

G2211

Since early 2024

- Tied t
  - Wh
  - Ac
- Appli
- Canno
- Must
- Docu
- Medicare reimbursement $15-$17, pending region

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."

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G2211 Resources

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

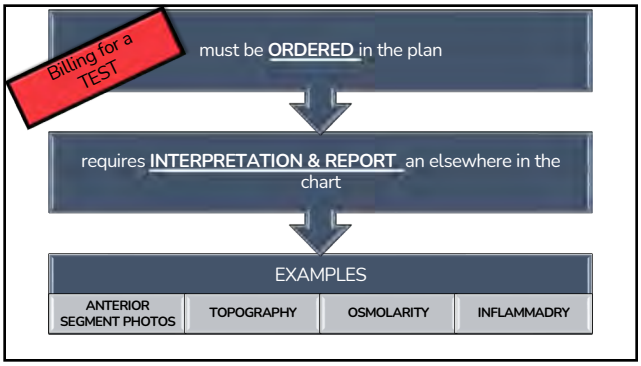
https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf

13

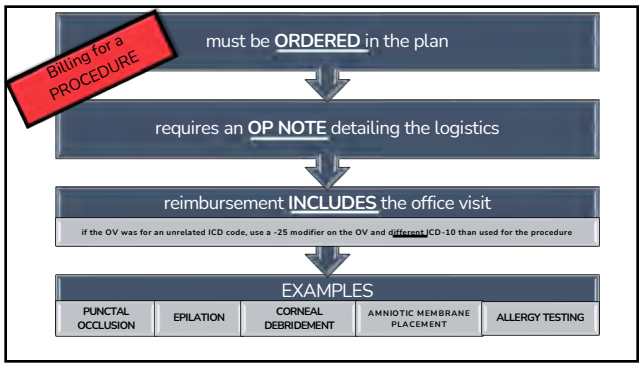
the 3 billing rules you should memorize

seriously

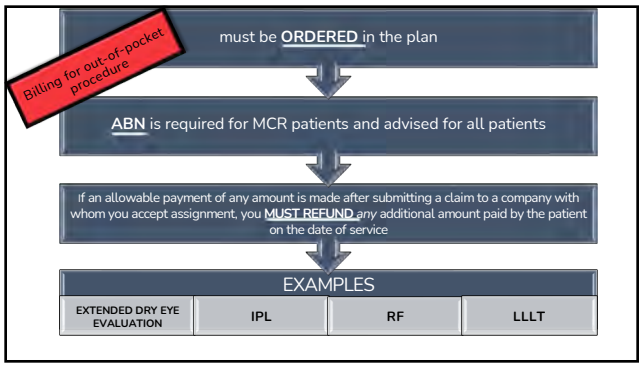
14



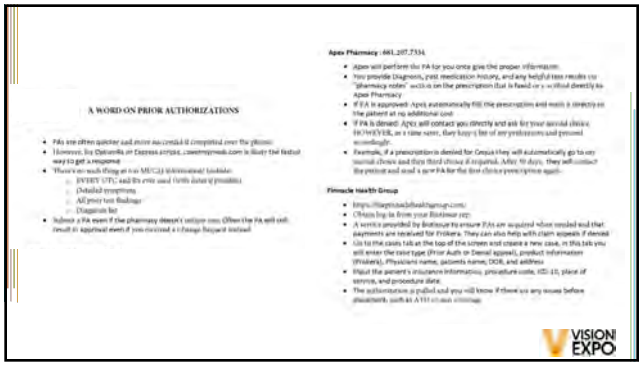
15


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

16


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

17


A WORD ON PRIOR AUTHORIZATIONS
VISION EXPO

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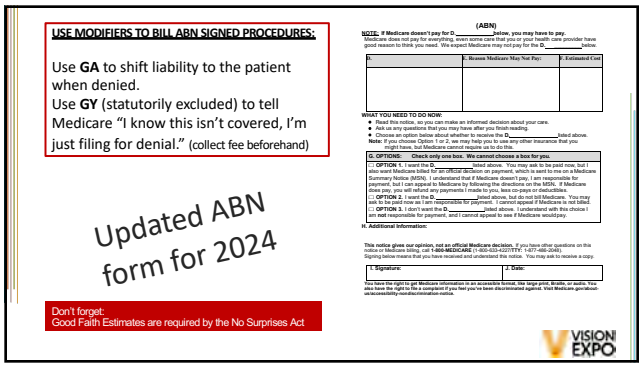
USE MODIFIERS TO BILL ABN SIGNED PROCEDURES:
Use GA to shift liability to the patient when denied.
Use GY (statutorily excluded) to tell Medicare "I know this isn't covered, I'm just filing for denial." (collect fee beforehand)
Updated ABN form for 2024
Don't forget:
Good Faith Estimates are required by the No Surprises Act
(ABN)
VISION EXPO

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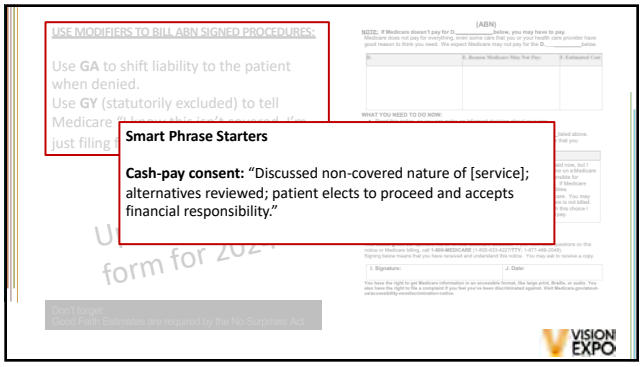
USE MODIFIERS TO BILL ABN SIGNED PROCEDURES:
Use GA to shift liability to the patient when denied.
Use GY (statutorily excluded) to tell Medicare
Smart Phrase Starters
Cash-pay consent: "Discussed non-covered nature of [service]; alternatives reviewed; patient elects to proceed and accepts financial responsibility."
Don't forget:
Good Faith Estimates are required by the No Surprises Act
VISION EXPO

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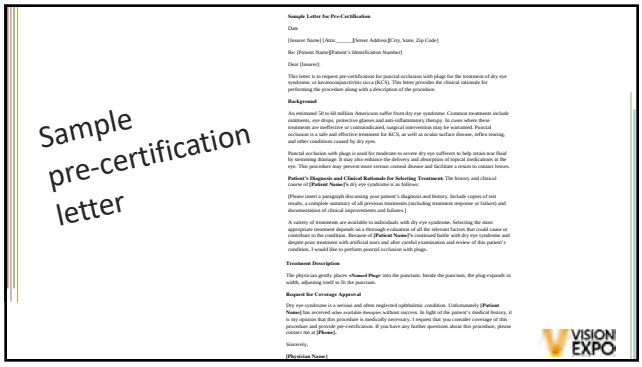
Sample pre-certification letter
Sample Letter for Pre-Certification
Background
Treatment Description
Request for Coverage Approval
VISION EXPO

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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 _____

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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 improvement 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]

23

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 (prior. Tx, warm compress, etc…) and (outcome/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 scan 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)

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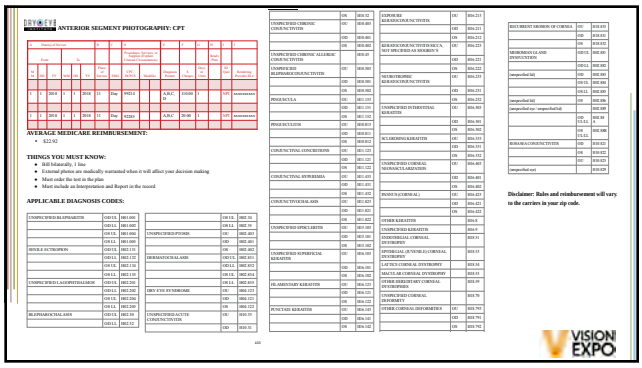
ANTERIOR SEGMENT PHOTOGRAPHY: CPT
AVERAGE MEDICARE REIMBURSEMENT:
$22.92
THINGS YOU MUST KNOW:
Bill bilaterally, 1 line
External photos are medically warranted when it will affect your decision making
Must order the test in the plan
Must include an Interpretation and Report in the record
APPLICABLE DIAGNOSIS CODES:
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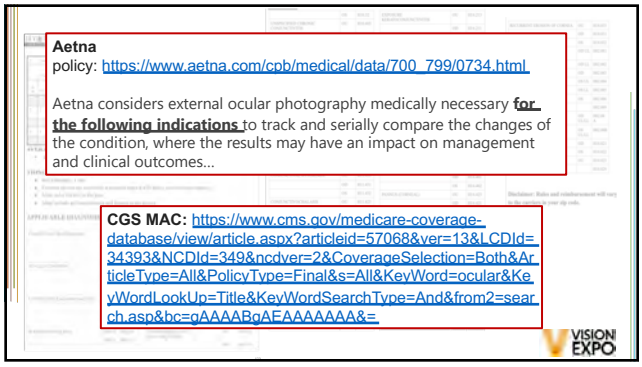
Aetna
policy: https://www.aetna.com/cpb/medical/data/700_799/0734.html
Aetna considers external ocular photography medically necessary for the following indications to track and serially compare the changes of the condition, where the results may have an impact on management and clinical outcomes…
CGS 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=gAAAABgAEAAAAAAA&=
VISION EXPO

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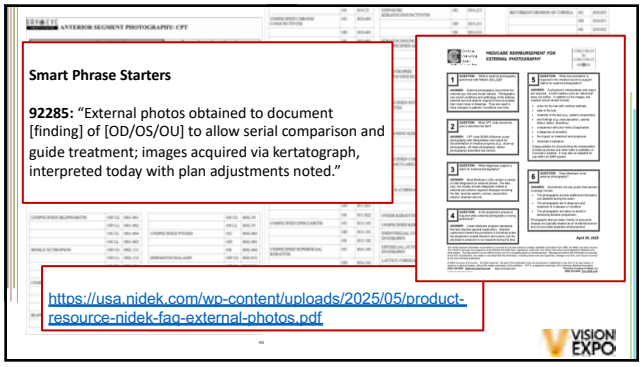
Smart Phrase Starters
92285: "External photos obtained to document [finding] of [OD/OS/OU] to allow serial comparison and guide treatment; images acquired via kertatograph, interpreted today with plan adjustments noted."
https://usa.nidek.com/wp-content/uploads/2025/05/product-resource-nidek-faq-external-photos.pdf
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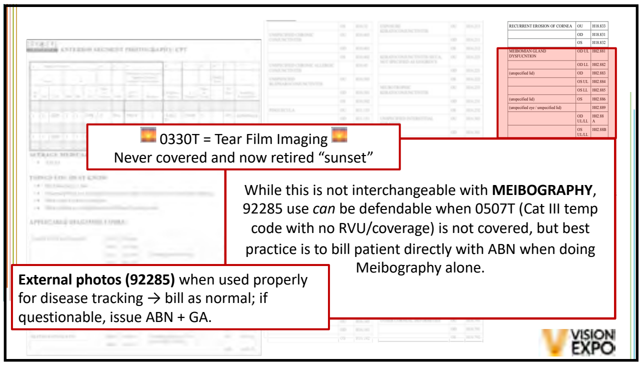
0330T = Tear Film Imaging
Never covered and now retired "sunset"
While this is not interchangeable with MEIBOGRAPHY, 92285 use can be defendable when 0507T (Cat III temp code with no RVU/coverage) is not covered, but best practice is to bill patient directly with ABN when doing Meibography alone.
External photos (92285) when used properly for disease tracking → bill as normal; if questionable, issue ABN + GA.
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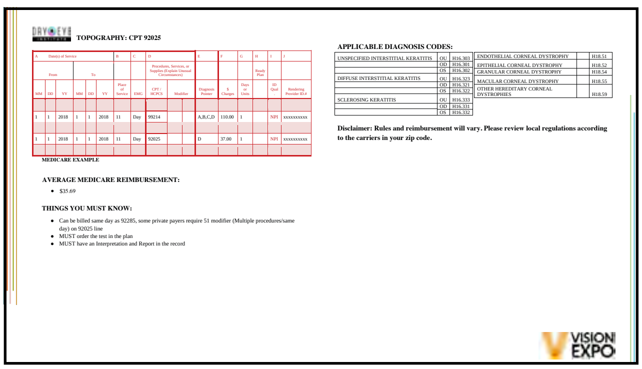
TOPOGRAPHY: CPT 92025
MEDICARE EXAMPLE
AVERAGE MEDICARE REIMBURSEMENT:
$35.69
THINGS YOU MUST KNOW:
Can be billed same day as 92285, some private payers require 51 modifier (Multiple procedures/same day) on 92025 line
MUST order the test in the plan
MUST have an Interpretation and Report in the record
APPLICABLE DIAGNOSIS CODES:
UNSPECIFIED INTERSTITIAL KERATITIS OU H16.303 OD H16.301 OS H16.302
DIFFUSE INTERSTITIAL KERATITIS OU H16.323 OD H16.321 OS H16.322
SCLEROSING KERATITIS OU H16.333 OD H16.331 OS H16.332
ENDOTHELIAL CORNEAL DYSTROPHY H18.51
EPITHELIAL CORNEAL DYSTROPHY H18.52
GRANULAR CORNEAL DYSTROPHY H18.54
MACULAR CORNEAL DYSTROPHY H18.55
OTHER HEREDITARY CORNEAL DYSTROPHIES H18.59
Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.
VISION EXPO

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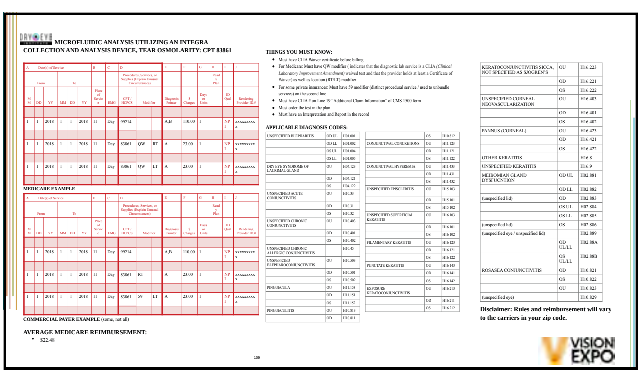
MICROFLUIDIC ANALYSIS UTILIZING AN INTEGRA COLLECTION AND ANALYSIS DEVICE, TEAR OSMOLARITY: CPT 83861
MEDICARE EXAMPLE
COMMERCIAL PAYER EXAMPLE (some, not all)
AVERAGE MEDICARE REIMBURSEMENT:
$22.48
THINGS YOU MUST KNOW:
Must have CLIA Waiver certificate before billing
For Medicare: Must have QW modifier (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:
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 DYSFUCNTION OD UL H02.881
ROSASEA CONJUNCTIVITIS OD H10.821 OS H10.822 OU H10.823
Disclaimer: Rules and reimbursement will vary to the carriers in your zip code.
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VISION EXPO

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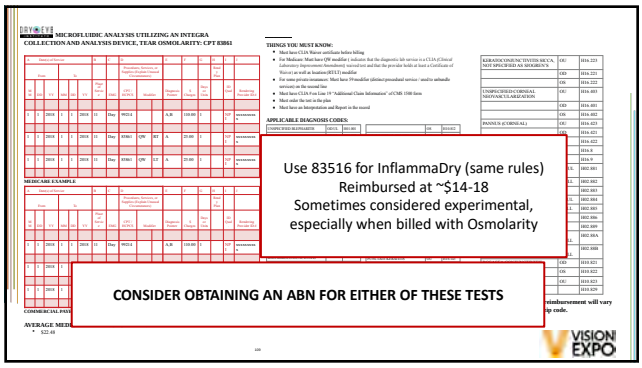
MICROFLUIDIC ANALYSIS UTILIZING AN INTEGRA
COLLECTION AND ANALYSIS DEVICE, TEAR OSMOLARITY: CPT 83861
THINGS YOU MUST KNOW:
Use 83516 for InflammaDry (same rules)
Reimbursed at ~$14-18
Sometimes considered experimental,
especially when billed with Osmolarity
CONSIDER OBTAINING AN ABN FOR EITHER OF THESE TESTS
MEDICARE EXAMPLE
AVERAGE MED
$22.48
VISION EXPO

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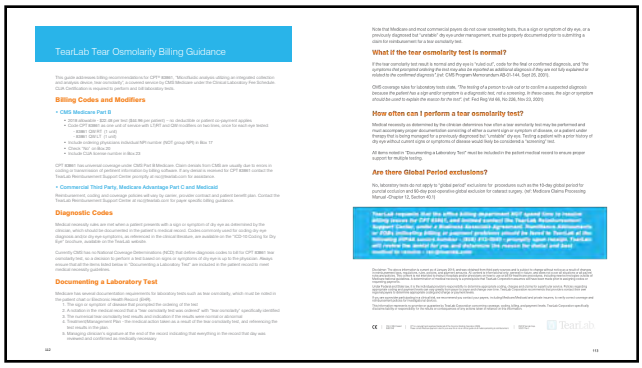
TearLab Tear Osmolarity Billing Guidance
Billing Codes and Modifiers
Diagnostic Codes
Documenting a Laboratory Test
What if the tear osmolarity test is normal?
How often can I perform a tear osmolarity test?
Are there Global Period exclusions?

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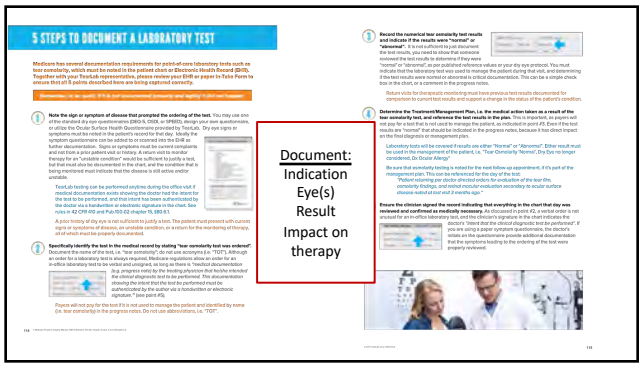
5 STEPS TO DOCUMENT A LABORATORY TEST
Document:
Indication
Eye(s)
Result
Impact on therapy

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PERCUTANEOUS TEST WITH ALLERGENIC EXTRACTS: CPT

A Date(s) of Service From MM	DD	YY	To MM	DD	YY	B Place of Service	C EMG	D Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT / HCPCS	Modifier		E Diagnosis Pointer	F $ Charges	G Days or Units	H Ready Plan	I ID Qual.	J Rendering Provider ID.#
1	1	2018	1	1	2018	11	Day	99214	25		A	110.00	1		NPI	xxxxxxxxxx
1	1	2018	1	1	2018	11	Day	95004			B	8.00	80		NPI	xxxxxxxxxx

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

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

VISION EXPO

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

A Date(s) of Service From MM	DD	YY	To MM	DD	YY	B Place of Service	C EMG	D Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT / HCPCS	Modifier		E Diagnosis Pointer	F $ Charges	G Days or Units	H Ready Plan	I ID Qual.	J Rendering Provider ID.#
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	68720	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.

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VISION EXPO

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PUNCTAL OCCLUSION: CPT 68761

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

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	H04.121
	OS	H04.122
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
NEUROTROPHIC KERATOCONJUNCTIVITIS	OU	H16.233
	OD	H16.231
	OS	H16.232
SICCA SYNDROME, UNSPECIFIED		M35.00
SICCA SYNDROME WITH KERATOCONJUNCTIVITIS		M35.01

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

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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 Sjögren'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.

VISION EXPO

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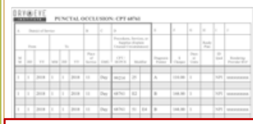
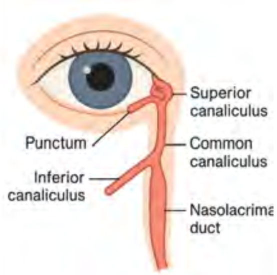
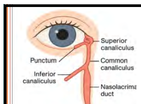


USE 68801 for PUNCTAL DILATION +/- IRRIGATION
(same rules: 10 day global period)
$90—130 reimbursement
Indicated for EPIPHORA / poor tear clearance

USE 68840 for CANALICULAR PROBING +/- IRRIGATION
(same rules: 10 day global period)
$150-165 reimbursement



37



Differentiating Probing Procedures:

Code	Descriptor	When to Use	Bundling/Rules	Global	Average Medicare (2025, NF)
68801	*Dilation of lacrimal punctum, with or without irrigation; unilateral*	Simple punctal dilation ± saline flush to assess patency or relieve obstruction. For cases like poor tear clearance, mucous/debris removal, or suspected stenosis.	• **Unilateral** — use -RT/-LT; some MACs allow -50 if both eyes.• **NCCI edit**: if performed **same eye, same day** as punctal plug insertion (**68761**), 68801 is bundled — cannot bill separately unless clear, distinct indication (modifier -59/XS + documentation).• Cannot bill with 68810–68815 (nasolacrimal duct probing) for same eye/session.	10 days	~$90-130 (non-facility)
68810	*Probing of nasolacrimal duct, with or without irrigation; unilateral*	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 **probing** (not just punctal dilation).	10 days	~$125-135
68815	*Probing of nasolacrimal duct with intubation and stent placement, unilateral*	When probing is performed **with placement of stent/Tube** (e.g., Crawford, silicone).	Higher complexity. Supplies may be separately billable (check payer).	90 days	~$420-460
68840	*Probing of lacrimal canaliculi, unilateral*	For probing confined to **canaliculi** (not full duct).	Mutually exclusive with 68801 (punctal only) same eye/day.	10 days	~$150-165

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

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

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

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.

VISION EXPO

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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 **superficial FB** on the conjunctiva **without incision** (cotton tip, spud, forceps). Does **not** cover embedded concretions.	• Unilateral — append **-RT/-LT**. • Includes removal at slit lamp without incision. • Do **not** bill for multiple superficial FBs in same eye — still **1 unit**. • Not to be used if concretion required incision.	10 days	~$100–110
65210	Removal of foreign body or concretion, conjunctiva, embedded (includes upper lid tarsal plate)	For **concretion removal** or foreign body that is **embedded** and requires incision (needle/spud under lid eversion).	• Unilateral — append **-RT/-LT**. • Must document that lesion was embedded and required instrumentation/incision. • Still **1 unit per eye** even with multiple concretions. • Pair same-day E/M only if significant and separately identifiable (**-25**).	10 days	~$140–150
65220	Removal of foreign body, external eye; corneal, without slit lamp	For corneal FB removal in-office **without slit lamp**.	• Often bundled/denied if slit lamp used (65222).	10 days	~$110
65222	Removal of foreign body, external eye; corneal, with slit lamp	For corneal FB removal at slit lamp.	• Requires slit lamp instrumentation. • Document method and corneal location.	10 days	~$150–160

VISION EXPO

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Differentiating CCH Repair Options:

Code	Descriptor	Use Case (CCh/lesion context)	Rules & Documentation	Global	Medicare 2025 NF (avg)
68110	*Excision of conjunctival lesion; simple*	For **small lesion or redundant conjunctiva ≤1 cm**. Sometimes applied to mild CCh if documented as a "lesion."	• **Unilateral** (RT/LT). • Document **size (≤1 cm)**, location (palpebral/bulbar), and indication (FB sensation, tear film toxicity, etc.). • Pathology report optional but strengthens claim. • Not to be billed with 68320 (conjunctivoplasty).	10 days	$211.86
68115	*Excision of conjunctival lesion >1 cm*	For **larger redundant conjunctiva (>1 cm)** — broader CCh excision in office.	• **Unilateral** (RT/LT). • Document **size >1 cm**, extent of tissue, and reason for removal. • Pathology recommended if specimen significant. • Cannot be billed with 68320 same day (superseded).	10 days	$259.09
68135	*Destruction of conjunctival lesion (any method, e.g., cautery, RF, laser)*	For **ablation/shrinkage** of redundant conjunctiva instead of excision. Sometimes used for CCh treated with thermal cautery.	• **Unilateral** (RT/LT). • Must document **destructive method** (e.g., cautery, RF probe, laser) and lesion treated. • If AMT placed same day (65778), check MAC edits — some bundle.	10 days	$144.85

VISION EXPO

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Differentiating CCH Repair Options:

Code	Descriptor				2025 NF (avg)
68110	*Excision of conjunctival l... simple*				
68115	*Excision of conjunctival l... >1 cm*				
68135	*Destruction o... conjunctival l... (any method, e... cautery, RF, las...*				

Documentation:
- Symptoms: irritation, epiphora, poor tear meniscus, surface toxicity.
- Failed conservative therapy documented.
- Surgical note: eye, quadrant(s), technique (snip, excision, NuVissa plasma pen, etc.), whether AMT placed (self-retained).

VISION EXPO

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Differen...ons:

Code	Descript...		Medicare 2025 NF (avg)
68110	*Excision of conjunctival les... simple*		$211.86
68115	*Excision of conjunctival les... >1 cm*		$259.09
68135	*Destruction of conjunctival les... (any method, e... cautery, RF, las...*		$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+

VISION EXPO

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DRY EYE INSTITUTE

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

A Date(s) of Service From MM	DD	YY	To MM	DD	YY	B Place of Service	C EMG	D Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT / HCPCS	Modifier	E Diagnosis Pointer	F $ Charges	G Days or Units	H Ready Plan	I ID Qual.	J Rendering Provider ID.#
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 From MM	DD	YY	To MM	DD	YY	B Place of Service	C EMG	D Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT / HCPCS	Modifier	E Diagnosis Pointer	F $ Charges	G Days or Units	H Ready Plan	I ID Qual.	J Rendering Provider ID.#
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 commercialinsurances 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
	OD	H16.221
	OS	H16.222
EXPOSURE KERATOCONJUNCTIVITIS	OU	H16.213
	OD	H16.211
	OS	H16.212
PUNCTATE KERATITIS	OU	H16.143
	OD	H16.141
	OS	H16.142
FILAMENTARY KERATITIS	OU	H16.123
	OD	H16.121
	OS	H16.122
NEUROTROPHIC KERATOCONJUNCTIVITIS	OU	H16.233
	OD	H16.231
	OS	H16.232
RECURRENT EROSION OF CORNEA	OU	H18.833
	OD	H18.831
	OS	H18.832
UNSPECIFIED CORNEAL ULCER	OU	H16.003
	OD	H16.001
	OS	H16.002
CENTRAL CORNEAL ULCER	OU	H16.013
	OD	H16.011

	OS	H16.012
OTHER SPECIFIED DISORDERS OF CORNEA	OU	H18.893
	OD	H18.891
	OS	H18.892
CORNEAL ULCER WITH HYPOPYON	OU	H16.033
	OD	H16.031
	OS	H16.032
SCLEROSING KERATITIS	OU	H16.333
	OD	H16.331
	OS	H16.332
PANNUS (CORNEAL)	OU	H16.423
	OD	H16.421
	OS	H16.422
BAND KERATOPATHY	OU	H18.423
	OD	H18.421
	OS	H18.422
NODULAR CORNEAL DEGENERATION	OU	H18.453
	OD	H18.451
	OS	H18.452
OTHER HEREDITARY CORNEAL DYSTROPHIES		H18.59
HERPESVIRAL KERATITIS		B00.52
OTHER DISORDERS OF SCLERA		H15.89

*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.

VISION EXPO

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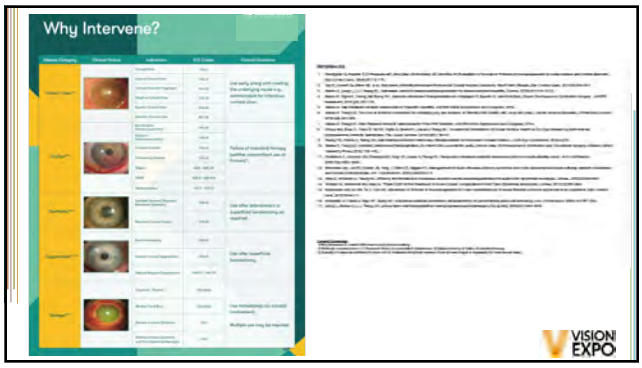
Why Intervene?
VISION EXPO

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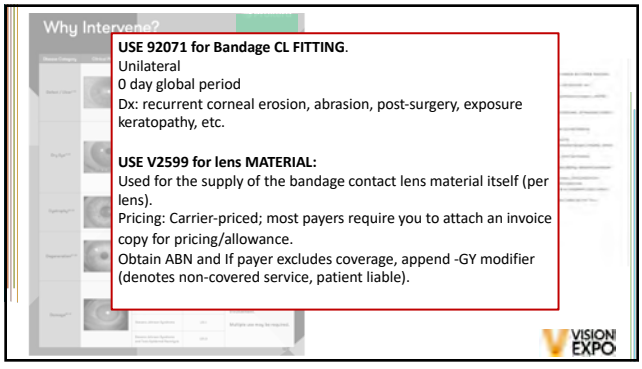
Why Intervene?
USE 92071 for Bandage CL FITTING.
Unilateral
0 day global period
Dx: recurrent corneal erosion, abrasion, post-surgery, exposure keratopathy, etc.
USE V2599 for lens MATERIAL:
Used for the supply of the bandage contact lens material itself (per lens).
Pricing: Carrier-priced; most payers 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).
VISION EXPO

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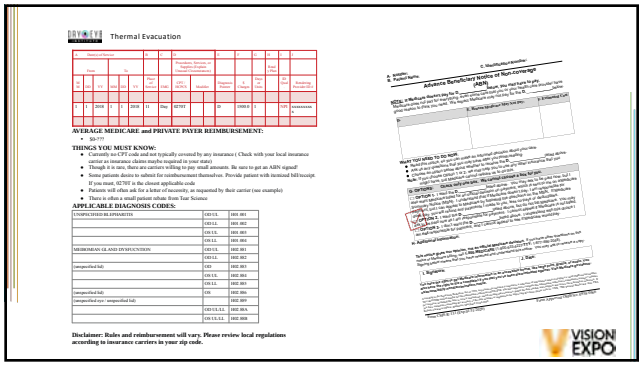
Thermal Evacuation
AVERAGE MEDICARE and PRIVATE PAYER REIMBURSEMENT:
THINGS YOU MUST KNOW:
APPLICABLE DIAGNOSIS CODES:
Disclaimer: Rules and reimbursement will vary. Please review local regulations according to insurance carriers in your zip code.
Advance Beneficiary Notice of Non-coverage (ABN)
VISION EXPO

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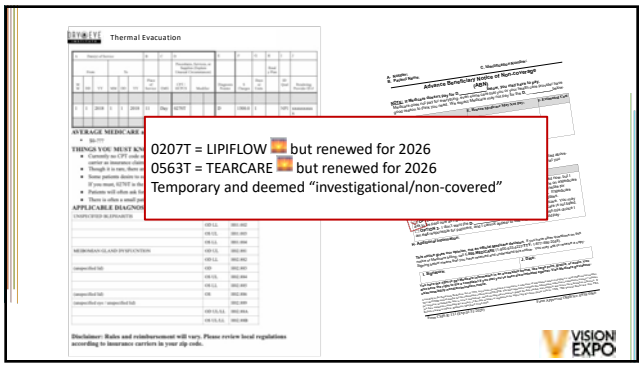
Thermal Evacuation
0207T = LIPIFLOW but renewed for 2026
0563T = TEARCARE but renewed for 2026
Temporary and deemed "investigational/non-covered"
VISION EXPO

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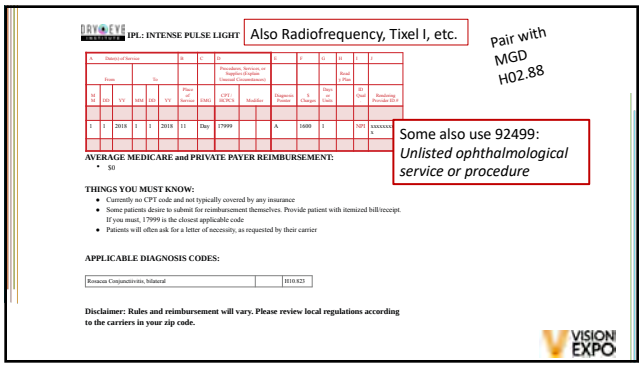
IPL: INTENSE PULSE LIGHT
Also Radiofrequency, Tixel I, etc.
Pair with MGD H02.88
Some also use 92499: Unlisted ophthalmological service or procedure
AVERAGE MEDICARE and PRIVATE PAYER REIMBURSEMENT:
$0
THINGS YOU MUST KNOW:
Currently no CPT code and not typically covered by any insurance
Some patients 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 Conjunctivitis, bilateral
H10.823
Disclaimer: Rules and reimbursement will vary. Please review local regulations according to the carriers in your zip code.
VISION EXPO

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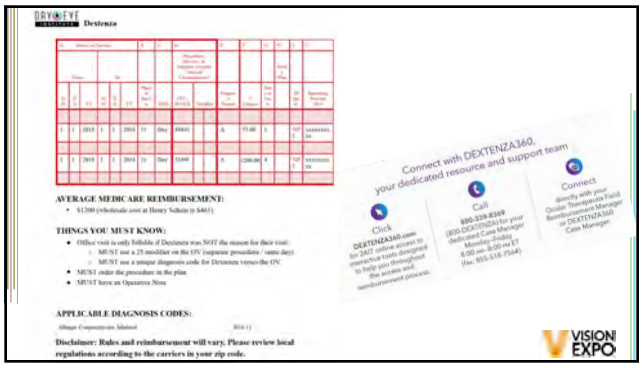
Dextenza
AVERAGE MEDICARE REIMBURSEMENT:
$1200 (wholesale cost at Henry Schein is $461)
THINGS YOU MUST KNOW:
Office visit is only billable if Dextenza was NOT the reason for their visit:
MUST use a 25 modifier on the OV (separate procedure / same day)
MUST use a unique diagnosis code for Dextenza versus the OV.
MUST order the procedure in the plan
MUST have an Operative Note
APPLICABLE DIAGNOSIS CODES:
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
Call
Connect
VISION EXPO

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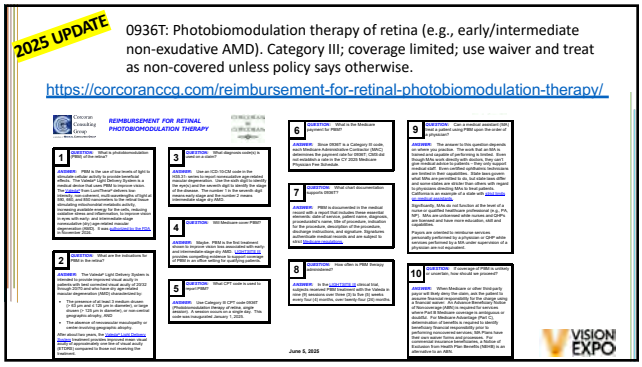
2025 UPDATE

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/



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When in doubt…

Go to

Askthecodingexperts

on the

AOA coding page

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out-of-pocket considerations

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"I'm on a budget ...where do I begin?"

Pay per box diagnostics	Product sales	In office treatments
Inflammadry Fluorescein Lissamine green Red thread test	Sell what they can't get elsewhere Take advantage of drop ship programs with profit share	Start with lower cost or pay per box treatments Manual heat and expression Blepharoexfoliation in office Refer out for advanced treatments

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

Assuming ~$25K

At $99/dry eye eval and 1/week	At $99/dry eye eval and 2/week
+	+
$20/ext photos on 6 patients/day	$20/ext photos on 10 patients/day
⏭ Paid in full in ~8 months	⏭ Paid in full in < 4 months

VISION EXPO

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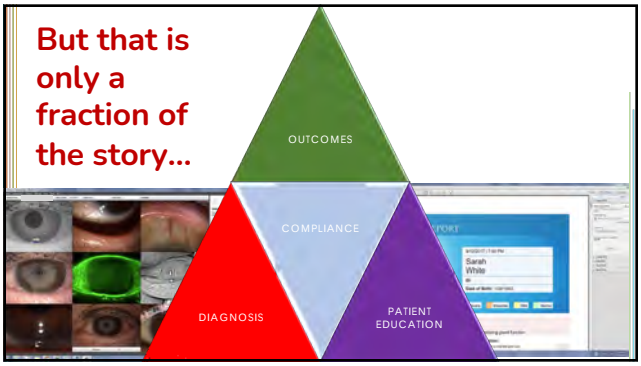
But that is only a fraction of the story…



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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

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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

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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

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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

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Very Severe:
Potential Annual revenue per patient

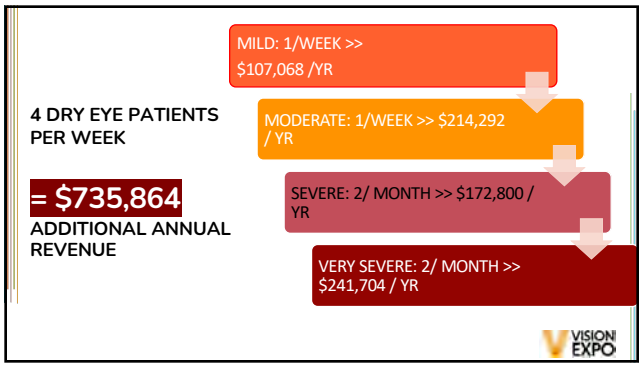
- 10 visits / year : $ 1,150 (DEE + 99205, 99214 x 6, 99213 X 2)
- 6 month Plugs: $217 x 2 = $434 (-60)
- Osmolarity at each visit: $450 (-200)
- Inflammadry at each visit: $300 (-160)
- External photos at each visit: $220
- Topography: $35

- 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)

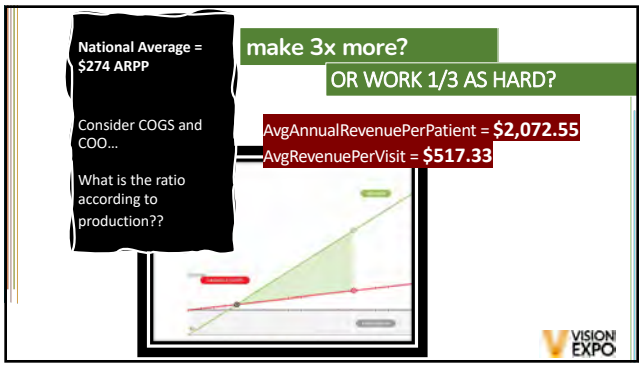
- IPL: $1800
- Amniotic membrane x 2 = $2700 (-1300)
- Thermal evacuation : $1000 (-260)
- Scleral lens fit: $3000 (-340)

TOTAL COLLECTED = $13,851
MINUS COGS –$3,780
NET ~ $10,071
@2 /MONTH = $241,704

63



64



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How do I know what to buy???

Follow these 4 guidelines and …you will know.

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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!

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2. experience

What is the patient's perception…on COMFORT?
on VALUE?

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3. business model

To compare apples to apples, consider…

Cost of device
Cost of applicators

Profit margin per treatment
Conversion rate considering value and MSRP
Repeat interval

…over 3 years

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4. the people

warrantee
training
resources
support
reputation
marketing

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