

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

Rates: Maximum Reimbursement for Optometry Services

rates max optom

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This section contains a list of procedure codes and maximum allowances within service category. Refer to the *Professional Services* section in this manual for policy information. Reimbursement for optometric services must be in accordance with the maximum reimbursement rates listed in this section, and must not exceed charges made to the general public. Additional routine tests that may be needed should be considered a part of the basic examination. Extensive treatment programs or difficult tests not included in the following list may be billed as unlisted items. Maximum allowances include preparation of necessary forms when an eye appliance is prescribed (*California Code of Regulations* [CCR], Title 22, Section 51518).

To bill for services, providers should use the latest version of the appropriate code book and all its related guidelines and criteria, as adopted by the Department of Health Care Services (DHCS).

Notice: Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009) excluded several optional benefits from coverage under the Medi-Cal program, including dispensing optician and fabricating optical laboratory services. Refer to the *Optional Benefits Exclusion* section in this manual for policy details, including information regarding exemptions to the excluded benefits. All codes listed in this section are affected by the optional benefits exclusion policy. Ocularist services are not impacted by AB X3 5 and remain reimbursable for all Medi-Cal recipients.

Codes and Rates

Optometric services are reimbursed as listed below:

<u>CPT-4 Code</u>	<u>Description</u>	<u>Maximum Allowance</u>
Diagnostic and Ancillary Procedures		
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	\$ 32.80
92004 *	comprehensive, new patient, one or more visits	39.44
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	22.59
92014 *	comprehensive, established patient, one or more visits	39.44
92015	Determination of refractive state	8.01
92020 *	Gonioscopy (separate procedure)	16.40
92025	Computerized corneal topography	<u>26.82</u>

* Coverage of these procedure codes is subject to the special provisions in the *Professional Services* section of this manual.

CPT-4 Code	Description	Maximum Allowance
Diagnostic and Ancillary Procedures (continued)		
92081 *	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	\$ 16.40
92082 *	intermediate examination (eg, at least two isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	22.14
92083 *	extended examination (eg, Goldmann visual fields with at least three isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	22.14
92100 *	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)	28.93
<u>92132</u>	<u>Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral</u>	<u>32.24</u>
<u>92133</u>	<u>Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral; optic nerve</u>	<u>39.33</u>
<u>92134</u>	<u>Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral, retina</u>	<u>39.33</u>
92225 *	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial	46.44
92226 *	subsequent	39.86
92250 *	Fundus photography with interpretation and report	42.13
99201 *	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> • A problem focused history; • a problem focused examination; and • straightforward medical decision making 	11.41

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<u>CPT-4 Code</u>	<u>Description</u>	<u>Maximum Allowance</u>
Diagnostic and Ancillary Procedures (continued)		
99202	Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: <ul style="list-style-type: none"> • An expanded problem focused history; • an expanded problem focused examination; and • straightforward medical decision making 	34.30
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> • A detailed history; • A detailed examination; and • Medical decision making of low complexity 	\$ 57.20
99204 *	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> • A comprehensive history • A comprehensive examination; and • Medical decision making of moderate complexity 	68.90
99205 *	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> • A comprehensive history • A comprehensive examination; and • Medical decision making of high complexity 	82.70
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal.	12.00
99212 *	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: <ul style="list-style-type: none"> • A problem focused history; • A problem focused examination; and • Straightforward medical decision making 	11.41
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: <ul style="list-style-type: none"> • An expanded problem focused history; • An expanded problem focused examination; • Medical decision making of low complexity 	24.00

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<u>CPT-4 Code</u>	<u>Description</u>	<u>Maximum Allowance</u>
Diagnostic and Ancillary Procedures (continued)		
99214 *	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: <ul style="list-style-type: none"> • A detailed history • A detailed examination • Medical decision making of moderate complexity 	\$ 37.50
99215 *	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: <ul style="list-style-type: none"> • A comprehensive history • A comprehensive examination • Medical decision making of high complexity 	57.20
<u>92227</u>	<u>Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral</u>	<u>10.72</u>
<u>92228</u>	<u>Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral</u>	<u>26.66</u>
99241	Office consultation for a new or established patient, which requires these three key components: <ul style="list-style-type: none"> • A problem focused history • A problem focused examination and • Straightforward medical decision making 	30.60
99242	Office consultation for a new or established patient, which requires these three key components: <ul style="list-style-type: none"> • An expanded problem focused history • An expanded problem focused examination and • Straightforward medical decision making 	47.20
99243	Office consultation for a new or established patient, which requires these three key components: <ul style="list-style-type: none"> • A detailed history • A detailed examination and • Medical decision making of low complexity 	59.50

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<u>CPT-4 Code</u>	<u>Description</u>	<u>Allowance</u>
Supplemental Procedures		
65205 *	Removal of foreign body, external eye; conjunctival superficial	\$ 6.74
65210 *	conjunctival embedded (includes concretions), subconjunctival or scleral nonperforating	117.27
65220 *	corneal, without slit lamp	13.48
65222 *	corneal, with slit lamp	20.21
65430	Scraping of cornea, diagnostic, for smear and/or culture	137.75
65435	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)	42.07
65436	with application of chelating agent (eg, EDTA)	163.44
67820 *	Correction of trichiasis; epilation, by forceps only	13.48
67938 *	Removal of embedded foreign body, eyelid	273.27
68761 * **	Closure of the lacrimal punctum; by plug, each	125.47
68801 *	Dilation of lacrimal punctum, with or without irrigation	136.63
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	10.12
92310 *	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	36.40
92311 *	corneal lens for aphakia, one eye	36.40
92312 *	corneal lens for aphakia, both eyes	36.40
92499 * ***	Unlisted ophthalmological service or procedure	By Report
99056 *	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service	7.50
<u>HCPCS Code</u>	<u>Description</u>	<u>Allowance</u>
<u>T1014</u>	<u>Telehealth transmission, per minute, professional services bill separately</u>	<u>\$ 0.24</u>

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** CPT-4 code 68761 billed with Modifier SC is reimbursed \$48.84 for diagnostic closure of the lacrimal punctum, by absorbable plug, one or more closures, includes office visits. Use CPT-4 code 68761 with modifier E1 thru E4 for closure of the lacrimal punctum, by permanent plug.

*** CPT-4 code 92499 billed with ICD-9-CM code 369.00 – 369.40 and “By Report” is reimbursed \$75.11 for low vision examination.