This section describes program information and billing policies for ophthalmology services.

**Correct Claim Form**

Ophthalmological services can be billed on either a CMS-1500 or UB-04 (outpatient providers) claim form. The following ophthalmological and eye appliance procedure codes, however, must be billed only on the CMS-1500:

**CPT® codes**: 68761, 92002 thru 92060, 92071 thru 92284, 92310 thru 92353, 92370, 92371 and 92499


**Modifiers**

Ophthalmological services and eye appliances (frames, lenses, contact lens, etc.) must be billed with the appropriate modifier(s). Vision care modifiers are listed in the *Modifiers for Vision Care Services* section of the Part 2 *Vision Care* manual.

**Unilateral**

The following CPT 90000 series of codes for eye procedures are considered unilateral services.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92230</td>
<td>Fluorescein angioscopy with interpretation and report</td>
</tr>
</tbody>
</table>

When performed on one eye, these procedures must be billed with a quantity of “1” and either modifier LT (left side) or RT (right side) to indicate which eye.

When performed on both eyes, these procedures must be billed on a single line using the modifier 50 (bilateral procedure) with a quantity of “2.”
Bilateral

The following CPT 90000 series of codes for eye procedures are considered bilateral services. Therefore, a code should be billed only once, regardless of whether the procedure was performed on one or both eyes. However, in the case of eye surgeries, this does not apply, and the appropriate code should be used to specify whether the procedure was unilateral or bilateral.

When performed as a bilateral procedure, claims must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of “1”, for CPT codes 92132 thru 92134, 92202 and 92227 thru 92229. The allowed service is one per day, whether it is unilateral or bilateral. No documentation is required for CPT codes listed above.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>* 92132</td>
<td>Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral</td>
</tr>
<tr>
<td>* 92133</td>
<td>Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve</td>
</tr>
<tr>
<td>* 92134</td>
<td>Retina</td>
</tr>
<tr>
<td>92201</td>
<td>Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease, with interpretation and report, unilateral or bilateral</td>
</tr>
<tr>
<td>92202</td>
<td>Ophthalmoscopy, extended; with drawing of optic nerve or macula, with interpretation and report, unilateral or bilateral</td>
</tr>
<tr>
<td>92227</td>
<td>Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral</td>
</tr>
<tr>
<td>* 92228</td>
<td>Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral</td>
</tr>
<tr>
<td>92229</td>
<td>Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral</td>
</tr>
</tbody>
</table>
CPT Codes for Bilateral Service Eye Procedures (continued)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>* 92235</td>
<td>Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral</td>
</tr>
<tr>
<td>* 92240</td>
<td>Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral</td>
</tr>
<tr>
<td>* 92242</td>
<td>Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral</td>
</tr>
</tbody>
</table>

When performed on one eye, these procedures must be billed with a quantity of “1” and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, these procedures must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of “1.”

Note: CPT codes 92235, 92240 and 92242 are not reimbursable with modifiers LT, RT or 50.

CPT codes 92227, 92228, and 92229 are not reimbursable for the same recipient on the same date of service by any provider in conjunction with codes 92002 thru 92014, 92133, 92134, 92227, 92228, 92250 or Evaluation and Management (E&M) codes 99202 thru 99350 and 99417.

Ophthalmic Diagnostic Imaging: Billing Restrictions

CPT codes 92132 thru 92134 (scanning computerized ophthalmic diagnostic imaging with interpretation and report, unilateral or bilateral) are not reimbursable when billed for the same recipient, by the same rendering provider, for the same date of service as the following codes:

CPT Codes for Billing Ophthalmic Diagnostic Imaging

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76512</td>
<td>Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)</td>
</tr>
<tr>
<td>92250</td>
<td>Fundus photography with interpretation and report</td>
</tr>
</tbody>
</table>

ICD-10-CM Diagnosis Code Requirements

Refer to the Ophthalmology: Diagnosis Codes section in this manual for ICD-10-CM diagnosis codes that must be billed in conjunction with codes 92132 thru 92134.
Corneal Pachymetry

CPT code 76514 is payable only once-in-a-lifetime when billed with the glaucoma-related diagnosis codes indicated in the Professional Services: Diagnosis Code section in this manual. Refer to the Radiology: Diagnosis Ultrasound section for the ICD-10-CM diagnosis codes to bill in conjunction with code 76514 for payment, in the appropriate Part 2 manual.

Computerized Corneal Topography

Computerized corneal topography (CPT code 92025) is reimbursable to optometrists within their scope of practice. It requires medical review.

When billing for code 92025, providers must document in the Remarks field (Box 80)/Additional Claim Information field (Box 19) of the claim or on an attachment that the service was performed according to one of the following criteria:

- Pre- or post-operatively for corneal transplant (codes 65710, 65730, 65750, 65755 and 65756)
- Pre- or post-operatively prior to cataract surgery due to irregular corneal curvature or irregular astigmatism
- In the treatment of irregular astigmatism as a result of corneal disease or trauma
- To assist in the fitting of contact lenses for patients with corneal disease or trauma (ICD-10-CM diagnosis codes H17.0 thru H18.9)
- To assist in defining further treatment

This procedure is not covered under the following conditions:

- When performed pre- or post-operatively for non-Medi-Cal covered refractive surgery procedures such as codes 65760 (kerato mileusis), 65765 (keratophakia), 65767 (epikeratoplasty), 65771 (radial keratotomy), 65772 (corneal relaxing incision) and 65775 (corneal wedge resection)
- When performed for routine screening purposes in the absence of associated signs, symptoms, illness or injury
Billing Requirements

CPT code 92025 must be billed with the appropriate modifiers. When billing for both the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC.

Note: Do not bill modifier 99 with CPT code 92025. The claim will be denied.

Bevacizumab

Bevacizumab is a recombinant humanized monoclonal IgG1 antibody that binds to and inhibits the biologic activity of human vascular endothelial growth factor (VEGF) in vitro and in vivo assay systems.

Required Codes

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Code Range</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>C18.0 thru C20</td>
<td>E08.311</td>
<td>E09.3211 thru E09.3213</td>
</tr>
<tr>
<td>C21.2</td>
<td>E08.3211 thru E08.3213</td>
<td>E09.3219</td>
</tr>
<tr>
<td>C21.8</td>
<td>E08.3219</td>
<td>E09.3311 thru E09.3313</td>
</tr>
<tr>
<td>C34.00 thru C34.92</td>
<td>E08.3311 thru E08.3313</td>
<td>E09.3319</td>
</tr>
<tr>
<td>C48.1 thru C48.2</td>
<td>E08.3319</td>
<td>E09.3411 thru E09.3413</td>
</tr>
<tr>
<td>C50.011 thru C50.929</td>
<td>E08.3411 thru E08.3413</td>
<td>E09.3419</td>
</tr>
<tr>
<td>C53.0 thru C53.9</td>
<td>E08.3419</td>
<td>E09.3511 thru E09.3513</td>
</tr>
<tr>
<td>C56.1 thru C57.4</td>
<td>E08.3511 thru E08.3513</td>
<td>E09.3519</td>
</tr>
<tr>
<td>C64.1 thru C64.9</td>
<td>E08.3519</td>
<td>E10.311</td>
</tr>
<tr>
<td>C71.0 thru C71.9</td>
<td>E09.311</td>
<td></td>
</tr>
</tbody>
</table>
«Required Codes (continued)»

<table>
<thead>
<tr>
<th>E10.3211 thru E10.3213</th>
<th>E11.3419</th>
<th>H34.8130 thru H34.8132</th>
</tr>
</thead>
<tbody>
<tr>
<td>E10.3219</td>
<td>E11.3511 thru E11.3513</td>
<td>H34.8190 thru H34.8192</td>
</tr>
<tr>
<td>E10.3311 thru E10.3313</td>
<td>E11.3519</td>
<td>H34.8310 thru H34.8312</td>
</tr>
<tr>
<td>E10.3319</td>
<td>E13.311</td>
<td>H34.8320 thru H34.8322</td>
</tr>
<tr>
<td>E10.3411 thru E10.3413</td>
<td>E13.3211 thru E13.3213</td>
<td>H34.8330 thru H34.8332</td>
</tr>
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<td>E10.3419</td>
<td>E13.3219</td>
<td>H34.8390 thru H34.8392</td>
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<td>E10.3519</td>
<td>E13.3319</td>
<td>H35.3220 thru H35.3223</td>
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<tr>
<td>E11.311</td>
<td>E13.3411 thru E13.3413</td>
<td>H35.3230 thru H35.3233</td>
</tr>
<tr>
<td>E11.3211 thru E11.3213</td>
<td>E13.3419</td>
<td>H35.3290 thru H35.3293</td>
</tr>
<tr>
<td>E11.3311 thru E3313</td>
<td>E13.3519</td>
<td>H35.359</td>
</tr>
<tr>
<td>E11.3319</td>
<td>H34.8110 thru H34.8112</td>
<td>H35.81</td>
</tr>
<tr>
<td>E11.3411 thru E11.3413</td>
<td>H34.8120 thru H34.8122</td>
<td></td>
</tr>
</tbody>
</table>

**Dosage**

Dosage is variable depending upon which disease is being treated.

**Billing**

HCPCS code: J9035 (injection, bevacizumab, 10 mg)

Providers may bill for the quantity that is equal to the amount given to the patient plus the amount wasted up to a total dose of 10 mg (one unit). Maximum reimbursement will not exceed 10 mg (one unit), per patient, per date of service when bevacizumab is used as an intravitreal injection. This limitation applies only to the intravitreal use of bevacizumab.

Appropriate site modifiers are LT, RT or 50 (bilateral). CPT code 67028 (intravitreal injection of a pharmacologic agent [separate procedure]) must be billed on the same claim form.
Ranibizumab
Ranibizumab is a recombinant humanized IgG1 kappa isotype monoclonal antibody fragment designed for intraocular use. Ranibizumab binds to and inhibits the biologic activity of human vascular endothelial growth factor A (VEGF-A).

Indications
Ranibizumab is indicated for the treatment of:

- Diabetic macular edema
- Central retinal vein occlusion
- Branch retinal vein occlusion
- Neovascular age-related macular degeneration
- Cystoid macular degeneration
- Retinal/macular edema following retinal vein occlusion

Authorization
An approved Treatment Authorization Request (TAR) is required for reimbursement. The TAR must include medical justification for the use of ranibizumab over bevacizumab.

Dosage
Dosage is variable depending upon which disease is being treated.

Billing
HCPCS code: J2778 (injection, ranibizumab, 0.1 mg)
Appropriate site modifiers are LT, RT or 50 (bilateral). CPT code 67028 (intravitreal injection of a pharmacologic agent [separate procedure]) must be billed on the same claim form.
**Ranibizumab-nuna for Intravitreal Use (Byooviz)**

Ranibizumab products bind to the receptor binding site of active forms of VEGF-A, including the biologically active, cleaved form of this molecule, VEGF110. VEGF-A has been shown to cause neovascularization and leakage in models of ocular angiogenesis and vascular occlusion and is thought to contribute to pathophysiology of neovascular AMD, mCNV, and macular edema following RVO. The binding of ranibizumab products to VEGF-A prevents the interaction of VEGF-A with its receptors (VEGFR1 and VEGFR2) on the surface of endothelial cells, reducing endothelial cell proliferation, vascular leakage, and new blood vessel formation.

**Indications**

All FDA-approved indications

**Dosage**

FDA-approved dosages

**TAR Requirement**

An approved *Treatment Authorization Request* (TAR) is required for reimbursement

**TAR Criteria**

Byooviz is considered medically necessary when all of the following conditions are met:

- Must be used for FDA approved indications and dosages
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with an ophthalmologist
- Patient has a diagnosis of:
  - Neovascular (Wet) Age-Related Macular Degeneration (AMD)
  - Macular Edema Following Retinal Vein Occlusion (RVO)
  - Myopic Choroidal Neovascularization (mCNV)
- Patient has tried and failed an intravitreal vascular endothelial growth factor (VEGF) inhibitor (for example, bevacizumab, ranibizumab, aflibercept) unless contraindicated or clinically inappropriate
- Documentation of patient’s best corrected visual acuity (BCVA) score at baseline and periodically during treatment

Initial authorization is for six months (three months for mCNV)
Continued therapy

- Patient continues to meet initial approval criteria
- Patient has experienced a clinically significant positive benefit as evidenced by at least one of the following:
  - Improvement in best corrected visual acuity (BCVA) score from baseline
  - Minimal observable CNV lesion growth
  - Detained neovascularization.
- Patient has an absence of unacceptable toxicity such as endophthalmitis, retinal detachment, increases in intraocular pressure (IOP) and arterial thromboembolic events.

Reauthorization is for six months (three months for mCNV)

Age Limit
Must be 18 years of age or older

Billing
HCPCS code: Q5124, (injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg)

Prescribing Restriction(s)
Frequency of billing equals 0.5 mg/5 units in each eye every 28 days
Maximum billing unit(s) equals 0.5 mg/5 units in each eye

Aflibercept
Aflibercept is a recombinant fusion protein consisting of portions of human vascular endothelial growth factor (VEGF) receptors 1 and 2 extracellular domains fused to the Fc portion of human IgG1. Aflibercept acts as a soluble decoy receptor that binds VEGF-A and placental growth factor and thereby can inhibit the binding and activation of these cognate VEGF receptors.

Indications
All FDA-approved indications
Dosage

FDA-approved dosages

TAR Requirement

An approved Treatment Authorization Request (TAR) is required for reimbursement. The TAR must include documentation that demonstrates the following:

- The patient is 18 years of age or older.
- The patient has tried and failed or is intolerant to less expensive, clinically appropriate alternatives.
- The patient does not have an active ocular or periocular infection.
- The patient does not have an active intraocular inflammation.
- Aflibercept is used for FDA-approved indications, dosages and usages.
- The initial approval is for 12 months.

**Note:** The TAR is renewable if the patient continues to meet the criteria for medical necessity.

Billing

HCPCS code J0178 (injection, aflibercept, 1 mg)

Appropriate site modifiers are LT, RT or 50 (bilateral). CPT code 67028 (intravitreal injection of a pharmacologic agent [separate procedure]) must be billed on the same claim form.

Verteporfin

Verteporfin therapy is a two-stage process requiring administration of both verteporfin for injection and nonthermal red light. Following intravenous administration, verteporfin is transported by lipoproteins to the neovascular endothelium in the affected eye(s), including choroidal neovascularature and the retina. Verteporfin then needs to be activated by nonthermal red light, which results in local damage to the endothelium, leading to temporary choroidal vessel occlusion.
Indications
Intravenous verteporfin is indicated for the treatment of:

- Age-related macular degeneration in patients with predominantly classic subfoveal choroidal neovascularization
- Pathologic myopia
- Presumed ocular histoplasmosis

Authorization
An approved Treatment Authorization Request (TAR) is required for reimbursement only when the dosage exceeds 16 mg.

Required Codes
One of the following ICD-10-CM codes is required for reimbursement:
† B39.4, † B39.5, † B39.9, H35.3210 thru H35.3293, H44.20 thru H44.2A9.

Dosage
The recommended dosage is 6 mg per m\(^2\) body surface area.

Billing
HCPCS code J3396 (injection, verteporfin, 0.1 mg)
“By Report” Procedures

In some situations, it may be necessary to bill “By Report” – include a brief report that justifies the procedure.

The following CPT codes require medical justification. Claims for these procedures will suspend for medical review and/or manual pricing. Justification includes but is not limited to the patient’s diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome and a statement of the treatment plan that indicates whether a referral was made.

CPT Codes Requiring Medical Justification

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>65210</td>
<td>Removal of foreign body, external eye; conjunctival embedded</td>
</tr>
<tr>
<td>67938</td>
<td>Removal of embedded foreign body, eyelid</td>
</tr>
<tr>
<td>68761</td>
<td>Closure of the lacrimal punctum</td>
</tr>
<tr>
<td>68801</td>
<td>Dilation of the lacrimal punctum</td>
</tr>
<tr>
<td>92018</td>
<td>Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete</td>
</tr>
<tr>
<td>92019</td>
<td>limited</td>
</tr>
<tr>
<td>92025</td>
<td>Computerized corneal topography, unilateral or bilateral, with interpretation and report</td>
</tr>
<tr>
<td>92100</td>
<td>Serial tonometry</td>
</tr>
<tr>
<td>92250</td>
<td>Fundus photography with interpretation and report</td>
</tr>
<tr>
<td>92310 thru 92312</td>
<td>Contact lens evaluations</td>
</tr>
<tr>
<td>92499</td>
<td>Unlisted ophthalmological service or procedure</td>
</tr>
</tbody>
</table>
**Routine Examinations**
Claims by either an ophthalmologist or optometrist for routine comprehensive eye examinations (CPT codes 92004 [new patient] and 92014 [established patient]) are covered once every two years for recipients of any age.

**Determination of Refractive State**
When performed, determination of refractive state (CPT code 92015) must be separately reported when billed in conjunction with CPT code 92004 or 92014.

Code 92015 is considered typical postoperative follow-up care included in the surgical package for cataract extraction surgeries. Therefore, this service is not reimbursable when billed in conjunction with or within the 90-day post follow-up period of CPT codes 66840, 66850, 66852, 66920, 66930, 66940 and 66982 thru 66985.

**Tonometry**
Tonometry services are included in an eye examination and should not be billed as a separate procedure.

*Note:* This is a one-time measurement and not serial tonometry.

**Diagnostic Drugs**
The use of topically applied diagnostic drugs (cycloplegic, mydriatic or anesthetic topical pharmaceutical agents) is included in the reimbursement of ophthalmological procedures.

**Interim Examinations**
A second eye examination with refraction within 24 months is covered only when a sign or symptom indicates a need for this service. Claims billed with CPT codes 92004 and 92014 must include the appropriate ICD-10-CM code that justifies the examination in (Box 67) of the UB-04 claim form or Nature of Illness or Injury field (Box 21) of the CMS-1500 claim. This policy applies whether the claim is submitted by the provider of the prior examination or by a different provider. Refer to the Professional Services: Diagnosis Codes section in the Part 2 Vision Care manual for a list of required ICD-10-CM diagnosis codes when billing for interim comprehensive eye examinations within the 24-month benefit period.
**E&M Codes Not Reimbursable With Eye Examination Services**

Evaluation and Management (E&M) visit codes (CPT codes 99202 thru 99215 and 99417) should not be billed with eye examination codes (CPT codes 92002, 92004, 92012 and 92014) by the same provider, for the same recipient and date of service. Reimbursement for duplicate services will be reduced or denied.

**Medicare-Covered Services**

Eye examinations for Medicare/Medi-Cal-eligible recipients must be billed to Medicare prior to billing Medi-Cal for the following claims:

- Examinations performed in conjunction with eye disease (such as glaucoma or cataract) or eye injury
- Interim examinations for recipients with a sign or symptom that justifies the need for an examination (providers must include the principal ICD-10-CM diagnosis code on the claim)

**Medicare Non-Covered**

Routine examinations for the purpose of prescribing, fitting or changing eyeglasses, as well as eye refractions, are not covered by Medicare. Eye examination claims (CPT codes 92002, 92004, 92012 and 92014) for Medicare/Medi-Cal-eligible recipients with only diagnoses for disorders, refraction, accommodation and color vision deficiencies may be billed directly to Medi-Cal. The recipient’s primary ICD-10-CM diagnosis code must be entered in the Principal Diagnosis Code field (Box 67) of the UB-04 claim form or Diagnosis or Nature of Illness or Injury field (Box 21) of the CMS-1500 claim form. Determination of refractive state (CPT code 92015) is not covered by Medicare and may be billed directly to Medi-Cal.

Refer to the Medicare Non-Covered Services: CPT® Codes section in this manual for a list of ICD-10-CM diagnosis codes that may be submitted directly to Medi-Cal in conjunction with CPT codes 92002, 92004, 92012 and 92014.
Hard Copy Billing Crossover Claims

Claims that do not automatically cross over electronically from Medicare carriers must be hard copy billed to the California MMIS Fiscal Intermediary Crossover Unit on a CMS-1500 claim form. Refer to the Medicare/Medi-Cal Crossover Claims: Vision Care section in the appropriate Part 2 manual for detailed crossover billing information.

Providers must attach a copy of the Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN) to all crossover claims.

Refractive services (CPT code 92015) may be billed directly to Medi-Cal.

Contact Lenses

Claims billed with CPT codes 92071 (fitting of contact lens for treatment of ocular surface disease), 92072 (fitting of contact lens for management of keratoconus, initial fitting), 92310 (prescription of optical and physical characteristics of and fitting of contact lenses, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia), 92311 (prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye) and 92312 (prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes) require authorization (a Treatment Authorization Request) from the Department of Health Care Services (DHCS) Vision Services Branch (VSB). Refer to the Contact Lenses and TAR Completion for Vision Care sections in the Part 2 Vision Care manual for policy and billing instructions.

Modifiers 22 and SC

Providers can only use modifiers 22 and SC when billing for CPT codes 92071, 92072 and 92310 thru 92312.

Required Information

The following information is required in the Medical Justification field of the 50-3 Treatment Authorization Request (TAR) form or on a separate attachment. For additional information about the authorization process, refer to the TAR Completion for Vision Care section in the Part 2 Vision Care manual.

- Valid diagnosis or condition that precludes the satisfactory wearing of conventional eyeglasses, including documentation of clinical data when possible
- Best corrected visual acuities through eyeglasses and contact lenses
• Identification of the contact lens to be used by trade or manufacturer’s name, base curve, diameter and power

• For a diagnosis of aniseikonia (ICD-10-CM code H52.32), a statement that indicates why eyeglasses cannot be used and supporting clinical data. (Anisometropia greater than three diopters, coupled with the presence of symptoms commonly associated with aniseikonia can qualify contact lenses for authorization. Where a smaller degree of anisometropia is present, detailed justification is required.)

• For conditions where contact lenses are the only option, a statement of the chronic pathology or deformity of the nose, skin or ears that precludes the wearing of conventional eyeglasses

• If extended wear contact lenses are prescribed, justification of why conventional, disposable or plan replacement extended wear lenses rather than daily wear lenses are necessary. (When infirmity is a pertinent factor in the decision, a statement that demonstrates the immediate availability of someone to assist the recipient in lens insertion, centering and removal is required.)

• A statement that indicates whether a recipient has worn contact lenses in the past

**Cataract Surgery Supplies**

The following HCPCS codes are used to bill cataract surgery supplies and drugs:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2630</td>
<td>Anterior chamber intraocular lens</td>
</tr>
<tr>
<td>V2631</td>
<td>Iris supported intraocular lens</td>
</tr>
<tr>
<td>V2632</td>
<td>Posterior chamber intraocular lens</td>
</tr>
</tbody>
</table>

Refer to the *Ophthalmology: Diagnosis Codes* section in this manual for ICD-10-CM diagnosis codes that must be billed in conjunction with HCPCS codes V2630 thru V2632. Claims for codes V2630 thru V2632 are manually priced and must include an invoice.
Ocular Prosthesis

Supply of ocular prosthesis is billed with HCPCS codes V2623 thru V2629. Services for prosthetic eyes and modification of prosthetic eyes must be billed on a CMS-1500 claim form. Codes V2623 and V2627 thru V2629 must be billed with modifier NU or RP.

Note: Modifiers NU and RP cannot be billed on the same claim line; separate claims must be used.

Refer to the Prosthetic Eyes section in the Part 2 Vision Care manual for additional policy and billing information.

Fluocinolone Acetonide, Intravitreal Implant (Retisert)

Fluocinolone acetonide intravitreal implant, 0.59 mg, is a sterile implant designed to release fluocinolone acetonide locally to the posterior segment of the eye at a nominal initial rate of 0.6 µg/day, decreasing over the first month to a steady state between 0.3 thru 0.4 µg/day over approximately 30 months. Corticosteroids inhibit the inflammatory response to a variety of inciting agents and probably delay or slow healing. They inhibit the edema, fibrin deposition, capillary dilation, leukocyte migration, capillary proliferation, fibroblast proliferation, deposition of collagen, and scar formation associated with inflammation. Corticosteroids are capable of producing a rise in intraocular pressure.

Indications
All FDA-approved indications

Dosage
FDA-approved dosages

TAR Requirement
An approved Treatment Authorization Request (TAR) is required for reimbursement. The TAR must meet the following criteria for approval:

- Prescribed for FDA-approved indications and dosing regimens
- Must have a diagnosis of chronic (equal to or greater than 1 year) of non-infectious uveitis affecting the posterior segment of the eye
• Must be 12 years of age or older
• Must have failed (i.e., recurrent uveitis despite use of traditional therapy) or was intolerant to traditional treatment including intravitreal steroid injections, systemic corticosteroids and/or immunosuppressive agents (i.e., cyclosporine, azathioprine, methotrexate), or
• Must be experiencing adverse events associated with high dose systemic steroid or immunosuppressive therapy.

**Age Limits**
Must be 12 years of age or older

**Billing**
HCPCS code J7311 (injection, fluocinolone acetonide, intravitreal implant [Retisert], 0.01 mg)

**Prescribing Restrictions**
Frequency of billing equals every 30 months
Maximum billing units equals 1 implant equals 0.59 mg equals 59 units per eye

**Fluocinolone Acetonide Intravitreal Implant (Iluvien)**
Cortocosteroids inhibit phospholipase A2 lipocortin induction Lipocortins may control biosynthesis of prostaglandins and leukotrienes by inhibiting arachidonic acid. Arachidonic acid is released by membrane phospholipids by phospholipase A2.

**Indications**
All FDA-approved indications

**Dosage**
FDA-approved dosages
TAR Requirement
An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must meet the following criteria for approval:

- FDA-approved indications
- Must be 18 years or older
- Must not have active an ocular or periocular infection
- Must not have glaucoma
- Must have a diagnosis of macular edema
- Must have previously received a treatment course with corticosteroids and did not have a clinically significant rise in intraocular pressure

Age Limits
Must be 18 years of age or older

Billing
HCPCS code J7313 (injection, fluocinolone acetonide, intravitreal implant [Iluvien], 0.01 mg)

Prescribing Restrictions
Frequency of billing equals Every 36 months
Maximum billing units equals 1 implant equals 0.19 mg equals 19 units per eye

Fluocinolone Acetonide Intravitreal Implant (Yutiq)
Fluocinolone acetonide intravitreal implant is a corticosteroid and inhibits phospholipase A2 via lipocortin induction. Lipocortins may control biosynthesis of prostaglandins and leukotrienes by inhibiting arachidonic acid. Arachidonic acid is released by membrane phospholipids by phospholipase A2.
**Indications**
All FDA-approved indications

**Dosage**
FDA-approved dosages

**TAR Requirement**
An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must meet the following criteria for approval:

- Prescribed for FDA-approved indication and dosage
- Patient has a diagnosis of chronic (duration of one year or more) non-infectious uveitis affecting the posterior segment of the eye
- Patient is 18 years of age or older
- At least one of the following two options has been met for the affected eye(s):
  - Individual has experienced a treatment failure or intolerance of at least two administrations of intra- or peri-ocular injections of corticosteroids, or one conventional therapy, for example:
    - Systemic or topical corticosteroids such as prednisone or prednisolone acetate respectively
    - Immunosuppressive agents (for example, azathioprine, cyclosporine, methotrexate or mycophenolate)
    - Tumor Necrosis Factor (TNF) inhibitors (for example Humira®)
    - Individual has experienced at least two separate recurrences of uveitis requiring treatment with systemic corticosteroids or ocular injections of corticosteroids.

**Age Limits**
Must be 18 years of age or older
Billing
HCPCS code J7314 (injection, fluocinolone acetonide, intravitreal implant [Yutiq], 0.01 mg)

Prescribing Restrictions
Frequency of billing equals Every 36 months
Maximum billing units equals 1 implant equals 0.18 mg equals 18 units per eye

Date Appliance Delivered
Welfare and Institutions Code, Section 14043.341 requires providers to obtain and keep a record of Medi-Cal recipients' signatures when dispensing a product or prescription or when obtaining a laboratory specimen. Therefore, dispensing optical providers (ophthalmologists, optometrists and dispensing opticians) who dispense a device (eye appliances) requiring a written order or prescription must maintain the following items in their files to qualify for Medi-Cal reimbursement:

- Signature of the person receiving the eye appliance
- Medi-Cal recipient’s printed name and signature
- Date signed
- Prescription number or item description of the eye appliance dispensed
- Relationship of the recipient to the person receiving the prescription if the recipient is not picking up the eye appliance

Dexamethasone 9% Intraocular
Dexamethasone 9% Intraocular is a corticosteroid suspension for intraocular administration.

Indications
Dexamethasone 9% Intraocular is used to manage post-operative inflammation of the eye.

Age
18 years of age and older
Dosage
A single dose of 0.005 mL dexamethasone 9% suspension (equivalent to 517 micrograms) is injected into the posterior chamber inferiorly behind the iris at the end of eye surgery.

Authorization
No Treatment Authorization Request (TAR) is generally required for reimbursement.

Required Codes
One of the following modifiers is required for reimbursement:
LT (Left side)
RT (Right side)

Billing
HCPCS code J1095 (injection, dexamethasone 9% intraocular, 1 mcg) One (1) unit of J1095 equals 1 mcg of dexamethasone 9% intraocular suspension

Dexamethasone Intravitreal Implant
Dexamethasone, a potent corticosteroid, has been shown to suppress inflammation by inhibiting multiple inflammatory cytokines resulting in decreased edema, fibrin deposition, capillary leakage and migration of inflammatory cells. The intravitreal implant contains dexamethasone in a solid polymer drug delivery system. The drug is preloaded into a single-use, specially designed applicator to facilitate injection of the rod-shaped implant directly into the vitreous.

Indications
Intravitreal dexamethasone is indicated for the treatment of:
- Macular edema following branch retinal vein occlusion or central retinal vein occlusion
- Non-infectious uveitis affecting the posterior segment of the eye
- Diabetic macular edema
- Recipients must be 18 years of age or older.
Authorization
An approved TAR is required for reimbursement.

Dosing
The recommended dose is 0.7 mg utilizing the pre-loaded single use applicator.

Billing
HCPCS code J7312 (injection, dexamethasone intravitreal implant, 0.1 mg)
Use modifiers LT (left side) and RT (right side) for bilateral procedures. Providers must document use of modifiers LT and RT on separate claim lines.

Triamcinolone Acetonide, for Suprachoroidal Use (Xipere™)
Triamcinolone acetonide is a synthetic glucocorticoid (glucocorticoids are often referred to as corticosteroids) with immunosuppressive and anti-inflammatory activity. The primary mechanism of action for triamcinolone acetonide is as a corticosteroid hormone receptor agonist.

Indications
All FDA-approved indications

Dosage
FDA-approved dosages

TAR Requirement
An approved Treatment Authorization Request (TAR) is required for reimbursement
TAR Criteria

Must submit clinical documentation to substantiate the following:

- Must be used for FDA approved indications and dosages
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with an ophthalmologist
- Patient has a diagnosis of macular edema associated with non-infectious uveitis
- Patient does not have uveitis due to infections such as herpes simplex or herpes zoster
- Documentation of patients’ best corrected visual acuity (BCVA) at baseline and periodically during treatment
- Patient will not concomitantly use intravitreal corticosteroid injections or intravitreal corticosteroid implant
- Patient does not have untreated intraocular pressure or uncontrolled glaucoma
- Patient has tried and failed topical and oral corticosteroids unless contraindicated or clinically inappropriate
- Dose does not exceed 4 mg (1 vial) per eye every 12 weeks

Initial authorization is for six months (two injections per eye)

Continued therapy

- Patient continues to meet initial approval criteria
- Patient has absence of unacceptable toxicity from the drug such as glaucoma, increase in intraocular pressure, cataracts, etc.
- Patient has experienced clinical response as evidenced improvement or stabilization in best corrected visual acuity from baseline.

Six months (two injections per eye)

Age Limit

Must be 18 years of age or older

Billing

HCPCS code: C9092 (injection, triamcinolone acetonide, suprachoroidal (xipere), 1 mg)
Prescribing Restriction(s)
Frequency of billing equals 4 mg/4 units each eye as a single dose every three months. Maximum billing unit(s) equals 4 mg/4 units each eye as a single dose.

Dexamethasone Ophthalmic Insert (Dextenza)
Dexamethasone ophthalmic insert, a corticosteroid, is a resorbable, intracanalicular insert. It is intended to be inserted in the lower lacrimal punctum into the canaliculus and does not require removal. It decreases inflammation by suppression of neutrophil migration, decreased production of inflammatory mediators, and reversal of increased capillary permeability; suppresses normal immune response.

Indications
All FDA-approved indications

Dosage
FDA-approved dosages

TAR Requirement
An approved Treatment Authorization Request (TAR) is required for reimbursement. The TAR must meet the following criteria for approval:

- Prescribed for FDA-approved indications and dosing regimens
- Must be 18 years of age or older
- Must verify that Dextenza will be placed by a provider immediately following ophthalmic surgery
• Must provide date of ophthalmic surgery
• Must provide clinical reasons why a corticosteroid ophthalmic solution or suspension is inadequate
• Must limit quantity to two inserts in a 30-day period

Age Limits
Must be 18 years of age or older

Billing
HCPCS code J1096 (dexamethasone, lacrimal ophthalmic insert, 0.1 mg)

Prescribing Restrictions
Frequency of billing equals Every 30 days
Maximum billing units equals 1 insert equals 0.4 mg equals 4 units per eye

Pegaptanib Sodium
Pegaptanib is a selective vascular endothelial growth factor (VEGF) antagonist. VEGF induces angiogenesis and increases vascular permeability and inflammation, all of which are thought to contribute to the progression of the neovascular (wet) form of age-related macular degeneration (AMD), a leading cause of blindness. VEGF has been implicated in blood retinal barrier breakdown and pathological ocular neovascularization.

Indications
Pegaptanib sodium is indicated for the treatment of Neovascular (wet) age-related macular degeneration.

Authorization
An approved Treatment Authorization Request (TAR) is required for reimbursement.
Dosage
The recommended and maximum dose is 0.3 mg every six weeks by intravitreous injection to the eye being treated.

Billing
HCPCS code J2503 (injection, pegaptanib sodium, 0.3 mg)

Phenylephrine and Ketorolac Ophthalmic Solution (Omidria)
Phenylephrine and ketorolac ophthalmic solution is an alpha1-adrenergic receptor agonist and nonselective cyclooxygenase inhibitor.

Ketorolac: Anti-inflammatory; nonsteroidal anti-inflammatory agent (NSAID); inhibits COX-1 and COX-2 which results in decreased tissue concentrations of prostaglandins to reduce pain caused by surgical trauma.

Phenylephrine: α1-adrenergic receptor agonist; acts as a mydriatic agent by contracting the radial muscle of the iris.

Indications
All FDA-approved indications

Dosage
FDA-approved dosages

TAR Requirement
No Treatment Authorization Request (TAR) is required for reimbursement.

Billing
HCPCS code J1097 (phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml)
Prescribing Restrictions
Maximum billing units = 4 ml = 4 units

Ocriplasmin
Ocriplasmin is a truncated form of human plasmin produced by recombinant DNA technology in a Pichia pastoris expression system. Ocriplasmin has proteolytic activity against protein components of the vitreous body and the vitreoretinal interface, thereby dissolving the protein matrix responsible for the vitreomacular adhesion.

Indications
Ocriplasmin is indicated for the treatment of symptomatic vitreomacular adhesion.

Required Code
One or more of the following ICD-10-CM diagnosis codes are required for reimbursement: H43.821 thru H43.829.

Dosage
The recommended dose is 0.125 mg administered by intravitreal injection to the affected eye once as a single dose. If both eyes require treatment, a second vial is to be used for the second eye.

Billing
HCPCS code J7316 (injection, ocriplasmin, 0.125 mg)
Four (4) units of ocriplasmin for each eye with one administration fee is allowed.

Bimatoprost (Durysta™)
See Injections: Drugs A-D Policy in the appropriate Part 2 manual for policy pertaining to bimatoprost and its corresponding procedure code.
**Brolucizumab-dbll (Beovu)**

Brolucizumab is a recombinant humanized monoclonal antibody vascular endothelial growth factor (VEGF) inhibitor that binds to the three major isoforms of VEGF-A, thereby suppressing endothelial cell proliferation, neovascularization, and vascular permeability to slow vision loss.

**Indications**

All FDA-approved indications

**Dosage**

FDA-approved dosages

**Authorization**

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

**TAR Criteria**

For TAR approval, must submit clinical documentation that demonstrates the following:

- Must be for FDA-approved indications and dosing regimens
- Must be 18 years of age or older
- Must have a diagnosis of Neovascular (wet) Age-Related Macular Degeneration (AMD)
- Patient has tried and failed or is intolerant to treatment with an intravitreal VEGF inhibitor (eg. Bevacizumab or ranibizumab)
- Patient must not have ocular or periocular infections
- Patient must not have an active intraocular inflammation

**Initial approval is for 12 months**

**Continued therapy**

- Patient continues to meet initial approval criteria
- Patient has shown positive clinical response as evidenced by improvement/stabilization in visual acuity or therapy is for maintenance of corrected visual acuity from previous therapy.
- Absence of unacceptable toxicity such as endophthalmitis, retinal detachments, increase in intraocular pressure, retinal vasculitis/retinal vascular occlusion, or arterial thromboembolic events

**Reauthorization is for 12 months**

Part 2 – Ophthalmology
Age Limits
Must be 18 years of age or older

Billing
HCPCS code J0179 (injection, brolucizumab-dbll, 1 mg)

Prescribing Restrictions
Frequency of billing equals every 25 thru 31 days for the first three doses, then every 8 thru 12 weeks. Maximum billing unit(s) equals 6 mg equals 6 units.

«Ranibizumab for Intravitreal Use via SUSVIMO Ocular Implant (Susvimo™)
Ranibizumab binds to the receptor binding site of multiple biologically active forms of VEGF-A, including VEGF. VEGF-A has been shown to cause neovascularization and leakage in models of ocular angiogenesis and vascular occlusion and is thought to contribute to pathophysiology of neovascular AMD. The binding of ranibizumab to VEGF-A prevents the interaction of VEGF-A with its receptors (VEGFR1 and VEGFR2) on the surface of endothelial cells, reducing endothelial cell proliferation, vascular leakage, and new blood vessel formation.

Indications
All FDA-approved indications

Dosage
FDA-approved dosages

TAR Requirements
An approved Treatment Authorization Request (TAR) is required for reimbursement»
Tar Criteria

Susvimo is considered medically necessary when all of the following conditions are met:

- Must be used for FDA approved indications and dosages
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with an ophthalmologist
- Patient has a diagnosis of Neovascular (wet) Age-related Macular Degeneration (AMD) within the prior 9 months
- Patient has received 3 or more doses of anti-VEGF intravitreal agents in the affected eye within the prior 6 months and demonstrated a response to an anti-VEGF intravitreal agent (for example, aflibercept, bevacizumab, brolucizumab, etc.)
- Documentation of distance Best Corrected Visual Acuity (BCVA) score at baseline and periodically during treatment
- Supplemental treatment with 0.5 mg intravitreal ranibizumab injection may be administered in the affected eye if clinically necessary
- Patient does not have active ocular or periocular infections
- Patient does not have active intraocular inflammation

Initial authorization is for six months

Continued therapy

- Patient continues to meet initial approval criteria
- Patient has shown clinical response as evidenced by an improvement from baseline in distance Best Corrected Visual Acuity (BCVA) score
- Patient does not have unacceptable toxicity such as endophthalmitis, rhegmatogenous retinal detachment, implant dislocation, vitreous hemorrhage, conjunctival retraction, conjunctival erosion, and conjunctival bleb

Reauthorization is for six months
Age Limit
Must be 18 years of age or older

Billing
HCPCS code: C9093, injection, ranibizumab, via sustained release intravitreal implant (susvimo), 0.1 mg

Prescribing Restriction(s)
Frequency of billing equals 2 mg/20 units each eye every 24 weeks. Maximum billing unit(s) equals 2 mg/20 units each eye.
**Legend**

Symbols used in the document above are explained in the following table.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>‹‹</td>
<td>This is a change mark symbol. It is used to indicate where on the page the most recent change begins.</td>
</tr>
<tr>
<td>››</td>
<td>This is a change mark symbol. It is used to indicate where on the page the most recent change ends.</td>
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<tr>
<td>*</td>
<td>This code is split-billable. When billing for both the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC.</td>
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<tr>
<td>†</td>
<td>Please refer to ICD-10-CM coding guidelines for use of additional code for retinitis (H32) and proper sequencing.</td>
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