Optum

Coding Companion

Ophthalmology

A comprehensive illustrated guide to coding and reimbursement

2026

optumcoding.com

Contents

Getting Started with Coding Companion

Coding Companion for Ophthalmology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to ophthalmology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT/HCPCS code description, followed by an easy-to-understand explanation, relative value units, and Medicare edits. The Relative Value Unit/Medicare Edits table will not be included with any CPT/HCPCS code with a "0" (zero) value.

The codes in the appendix are presented in the following order:

- HCPCS
- E/M
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 30.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2026 edition password is: **XXXXX.** Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

67415 Fine needle aspiration of orbital contents

could be found in the index under the following main terms:

Aspiration
Orbital Contents, 67415

or **Fine Needle Aspiration**
Orbital Contents, 67415

or **Orbital Contents**
Aspiration, 67415

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

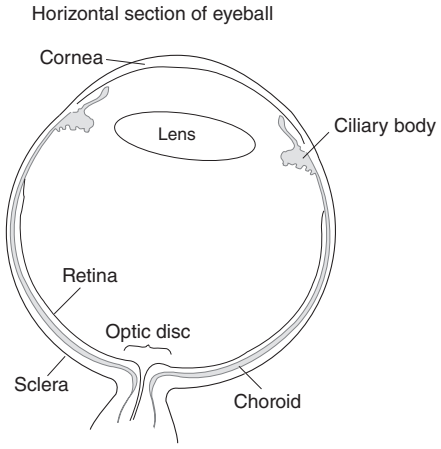
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

67221-67225

67221 Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)

\+ **67225** photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)

The choroid is the middle layer of the posterior eyeball shell. The choroid contains much of the vascular supply to the retina



Explanation

The physician performs photodynamic therapy. This is a two-step procedure used for wet type macular degeneration to treat the abnormal blood vessels that grow under the retina. The fluid and blood present from the new blood vessel growth causes scar formation that destroys vision. Photodynamic therapy closes the abnormal blood vessels to stop or stabilize leakage and improve vision. First, the physician injects the drug Visudyne (verteporfin) intravenously into the patient's arm. This is a dye that marks the abnormal blood vessels under the retina by binding to them. A few minutes after the injection, the ophthalmologist shines a non-thermal 689-nanometer laser light into the patient's eye to activate the drug. The light reacts with the photosensitive chemical in verteporfin, and releases active oxygen molecules that cause cell death in the leaking blood vessels but not healthy ones. When the dye interacts with the light, the abnormal vessels are destroyed and closed off but the normal ones are spared. Report 67221 when photodynamic therapy is performed on one eye and 67225 when photodynamic therapy is performed on the second eye during the same session.

Coding Tips

Infusion of the medication or photodynamic agent is included in the procedure. Supplies used when providing these procedures may be reported separately; the medication can be reported with HCPCS Level II code J3396. Medicare and some other payers may require G0186 be reported for these services. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

C69.31 Malignant neoplasm of right choroid ☑

C69.32 Malignant neoplasm of left choroid ☑

D09.21 Carcinoma in situ of right eye ☑

D09.22 Carcinoma in situ of left eye ☑

D31.31 Benign neoplasm of right choroid ☑

D31.32 Benign neoplasm of left choroid ☑

D49.81 Neoplasm of unspecified behavior of retina and choroid

Associated HCPCS Codes

G0186 Destruction of localized lesion of choroid (for example, choroidal neovascularization); photocoagulation, feeder vessel technique (one or more sessions)

AMA: **67221** 2018,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
67221	3.45	4.37	0.26	8.08
67225	0.47	0.35	0.04	0.86
Facility RVU	**Work**	**PE**	**MP**	**Total**
67221	3.45	2.43	0.26	6.14
67225	0.47	0.3	0.04	0.81

	FUD	Status	MUE	Modifiers				IOM Reference
67221	0	R	1(2)	51	N/A	N/A	N/A	None
67225	N/A	A	1(2)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

choroid. Thin, nourishing vascular layer of the eye that supplies blood to the retina, arteries, and nerves to structures in the anterior part of the eye.

neovascularization. Formation of abnormal blood vessels in the eye, often found in diabetic retinopathy, central retinal vein obstruction, or macular degeneration. These blood vessels are fragile and tend to hemorrhage.

verteporfin. Intravenous drug that is light activated and approved for treatment of age-related macular degeneration.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2026.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2026.
- ▲ This CPT code description is revised for 2026.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services. Note: This icon is not appended to the synchronous audio-video visit codes 98000-98007.

The Centers for Medicare and Medicaid Services (CMS) have identified services that may be performed via telehealth. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96041
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes a common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2025.

The 2026 Medicare edits were not available at the time this book went to press. Updated 2026 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2026 edition password is **XXXXX**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier 26) component of a procedure is provided.

99202-99205

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare has identified these codes as telehealth/telemedicine services. CMS requires the use of a place of service (POS) indicator: POS 02 for telehealth services when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99203** 2024,Oct; 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99204** 2024,Oct; 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99205** 2024,Oct; 2024,Sep; 2024,Mar; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.16	0.08	2.17
99203	1.6	1.59	0.16	3.35
99204	2.6	2.18	0.24	5.02
99205	3.5	2.79	0.33	6.62
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.4	0.08	1.41
99203	1.6	0.68	0.16	2.44
99204	2.6	1.13	0.24	3.97
99205	3.5	1.57	0.33	5.4

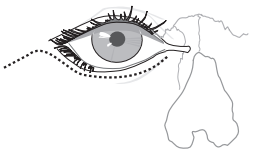
	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

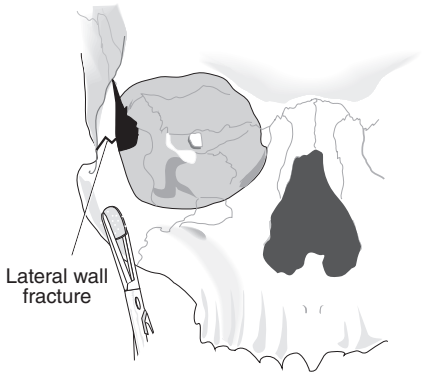
● New ▲ Revised + Add On ★ Telemedicine [Resequenced] ☑ Laterality

21406-21408

21406 Open treatment of fracture of orbit, except blowout; without implant
21407 with implant
21408 with bone grafting (includes obtaining graft)



Lower eyelid incision exposes fracture



Implant may be placed to cover resulting bony hole

Explanation

The physician openly treats a fracture of the orbit, other than a floor blowout fracture. This is a displaced fracture of the orbital rims or walls that can be identified on x-ray. The physician makes periorbital incisions to expose the fracture site. The fractured bones are realigned and may be stabilized with wires, plates, and/or screws. In 21406, no sizable bony holes that would require coverage remain in the orbit. In 21407, after realignment, bony holes remain in the orbit that require coverage to prevent orbital soft tissue from entering into these holes. These holes are usually found in the medial or lateral walls of the orbit. An alloplastic implant is selected, shaped, and placed over the bony hole. In 21408, after realignment, bony holes remain in the orbit, requiring coverage to prevent orbital soft tissue from entering these holes. The holes are usually found in the medial or lateral walls of the orbit. The physician harvests bone from the patient's hip, rib, or skull, and closes the surgically created graft donor site. The bone graft is shaped and placed over the bony hole. In all three procedures, the incisions are closed in both single and multiple layers.

Coding Tips

Any harvest of bone graft is not reported separately. For radiology services, see 70200.

ICD-10-CM Diagnostic Codes

S02.121A Fracture of orbital roof, right side, initial encounter for closed fracture ☑
S02.121B Fracture of orbital roof, right side, initial encounter for open fracture ☑
S02.122A Fracture of orbital roof, left side, initial encounter for closed fracture ☑
S02.122B Fracture of orbital roof, left side, initial encounter for open fracture ☑
S02.81XA Fracture of other specified skull and facial bones, right side, initial encounter for closed fracture ☑
S02.81XB Fracture of other specified skull and facial bones, right side, initial encounter for open fracture ☑
S02.82XA Fracture of other specified skull and facial bones, left side, initial encounter for closed fracture ☑
S02.82XB Fracture of other specified skull and facial bones, left side, initial encounter for open fracture ☑
S02.831A Fracture of medial orbital wall, right side, initial encounter for closed fracture ☑
S02.831B Fracture of medial orbital wall, right side, initial encounter for open fracture ☑
S02.832A Fracture of medial orbital wall, left side, initial encounter for closed fracture ☑
S02.832B Fracture of medial orbital wall, left side, initial encounter for open fracture ☑
S02.841A Fracture of lateral orbital wall, right side, initial encounter for closed fracture ☑
S02.841B Fracture of lateral orbital wall, right side, initial encounter for open fracture ☑
S02.842A Fracture of lateral orbital wall, left side, initial encounter for closed fracture ☑
S02.842B Fracture of lateral orbital wall, left side, initial encounter for open fracture ☑

AMA: **21406** 2022,May; 2020,Dec **21407** 2022,May; 2020,Dec **21408** 2022,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21406	7.42	8.84	1.37	17.63
21407	9.02	9.14	1.16	19.32
21408	12.78	11.99	2.35	27.12
Facility RVU	**Work**	**PE**	**MP**	**Total**
21406	7.42	8.84	1.37	17.63
21407	9.02	9.14	1.16	19.32
21408	12.78	11.99	2.35	27.12

	FUD	Status	MUE	Modifiers				IOM Reference
21406	90	A	1(2)	51	50	62*	80	None
21407	90	A	1(2)	51	50	62*	80	
21408	90	A	1(2)	51	50	62	80	

* with documentation

Terms To Know

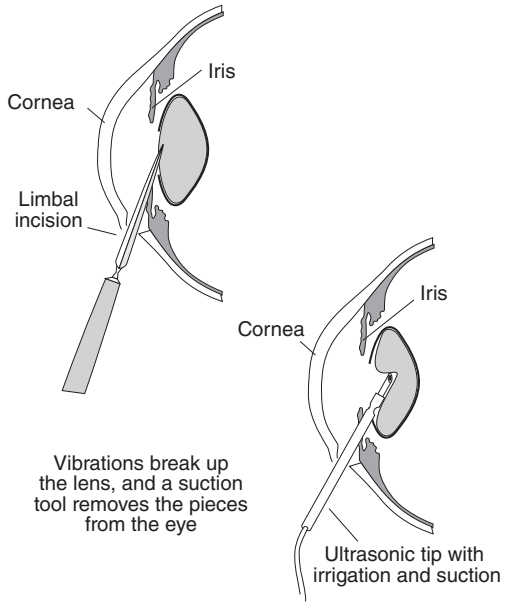
bone graft. Bone that is removed from one part of the body and placed into another bone site without direct re-establishment of blood supply.

orbit. Bony cavity that contains the eyeball, formed by seven bones of the skull: frontal, sphenoid, maxilla, zygomatic, palatine, lacrimal, and ethmoid.

periorbital approach. Surgical approach around the orbital area.

66850

66850 Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration



Explanation

The physician makes an incision in the cornea or the pars plana. The anterior wall of the lens is cut out. The same type of irrigating/aspirating machine used for extracapsular surgery is used for phacofragmentation, but this time the probe is a needle that vibrates 40,000 times per second (phacofragmentation), or sound waves (phacoemulsification, ultrasound) that break up the lens. The physician uses irrigation and suction to remove the once hard nucleus, now liquefied by mechanical or sound vibrations. The physician may close the incision with sutures or may design a sutureless "self-sealing" incision. The physician may restore the intraocular pressure with an injection of water or saline. A topical antibiotic or pressure patch may be applied.

Coding Tips

Lateral canthotomy, iridectomy, iridotomy, anterior capsulotomy, posterior capsulotomy, the use of viscoelastic agents, enzymatic zonulysis, and other pharmacologic agents, as well as subconjunctival or sub-Tenon injections, are included as part of this code for the extraction of the lens. This procedure is generally performed with a local anesthetic or retrobulbar injection rather than general anesthesia. Codes 66840–66940 report a lensectomy by various methods. For removal of lens material by simple aspiration techniques, see 66840; by pars plana approach, see 66852; by intracapsular extraction, see 66920–66930; by extracapsular extraction (other than reported by 66840, 66850, or 66852), see 66940. For removal of an intralenticular foreign body without extraction of the lens, see 65235. For repair of an operative wound, see 66250. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

H25.011 Cortical age-related cataract, right eye A ☑
H25.031 Anterior subcapsular polar age-related cataract, right eye A ☑
H25.041 Posterior subcapsular polar age-related cataract, right eye A ☑
H25.091 Other age-related incipient cataract, right eye A ☑
H25.11 Age-related nuclear cataract, right eye A ☑
H25.21 Age-related cataract, morgagnian type, right eye A ☑
H25.811 Combined forms of age-related cataract, right eye A ☑
H25.89 Other age-related cataract A
H26.011 Infantile and juvenile cortical, lamellar, or zonular cataract, right eye P ☑
H26.031 Infantile and juvenile nuclear cataract, right eye P ☑
H26.041 Anterior subcapsular polar infantile and juvenile cataract, right eye P ☑
H26.051 Posterior subcapsular polar infantile and juvenile cataract, right eye P ☑
H26.061 Combined forms of infantile and juvenile cataract, right eye P ☑
H26.09 Other infantile and juvenile cataract P
H26.111 Localized traumatic opacities, right eye ☑
H26.131 Total traumatic cataract, right eye ☑
H26.211 Cataract with neovascularization, right eye ☑
H26.221 Cataract secondary to ocular disorders (degenerative) (inflammatory), right eye ☑
H26.231 Glaucomatous flecks (subcapsular), right eye ☑
H26.31 Drug-induced cataract, right eye ☑
H26.411 Soemmering's ring, right eye ☑
H26.491 Other secondary cataract, right eye ☑
H26.8 Other specified cataract
H59.021 Cataract (lens) fragments in eye following cataract surgery, right eye ☑
Q12.0 Congenital cataract

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
66850	10.55	12.03	0.82	23.4
Facility RVU	**Work**	**PE**	**MP**	**Total**
66850	10.55	12.03	0.82	23.4

	FUD	Status	MUE	Modifiers				IOM Reference
66850	90	A	1(2)	51	50	N/A	N/A	None

* with documentation

Terms To Know

cataract. Clouding or opacities of the lens that stop clear images from forming on the retina, causing vision impairment or blindness.

foreign body. Any object or substance found in an organ and tissue that does not belong under normal circumstances.

irrigation. To wash out or cleanse a body cavity, wound, or tissue with water or other fluid.

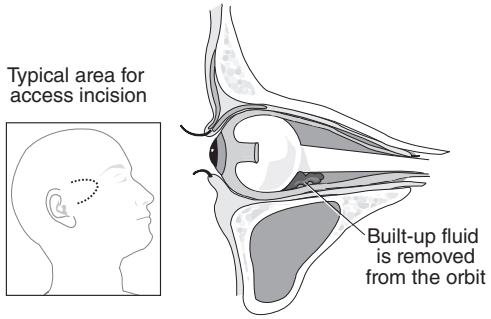
lens. Convex disc of the eye, behind the iris and in front of the vitreous body, that refracts light entering the globe.

phacoemulsification. Cataract extraction in which the lens is fragmented by ultrasonic vibrations and simultaneously irrigated and aspirated.

ultrasound. Imaging using ultra-high sound frequency bounced off body structures.

67440

67440 Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with drainage



The orbitotomy requires a bone flap or window; the bone is replaced during closure

Explanation

The physician makes an incision in the lateral aspect of the orbit. A C-shaped incision is made down to the periosteum overlying the lateral orbital rim. The periosteum is incised posterior to the rim itself. The temporalis muscle is moved aside and the globe is protected with pliable retractors. A vibrating saw is used to remove the bone from the lateral orbital rim. Fluid is excised from the orbit and the bone is replaced and wired into position. The operative wound is closed in layers.

Coding Tips

For orbitotomy with drainage only by frontal or transconjunctival approach without bone flap, see 67405. For fine needle aspiration of orbital contents, see 67415.

ICD-10-CM Diagnostic Codes

H05.011 Cellulitis of right orbit ☑
H05.012 Cellulitis of left orbit ☑
H05.021 Osteomyelitis of right orbit ☑
H05.022 Osteomyelitis of left orbit ☑
H05.031 Periostitis of right orbit ☑
H05.032 Periostitis of left orbit ☑
H05.231 Hemorrhage of right orbit ☑
H05.232 Hemorrhage of left orbit ☑

Relative Value Units/Medicare Edits

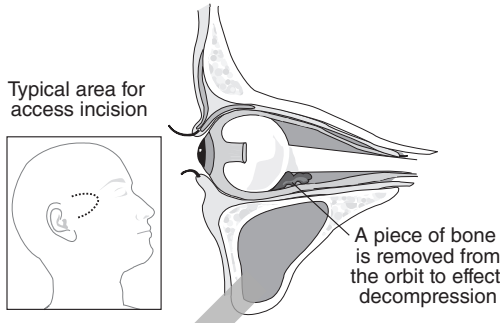
Non-Facility RVU	Work	PE	MP	Total
67440	14.84	24.08	1.18	40.1
Facility RVU	**Work**	**PE**	**MP**	**Total**
67440	14.84	24.08	1.18	40.1

	FUD	Status	MUE	Modifiers				IOM Reference
67440	90	A	1(2)	51	50	62*	80	None

* with documentation

67445

67445 Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of bone for decompression



The orbitotomy requires a bone flap or window; the bone is replaced during closure

Explanation

The physician makes an incision in the lateral aspect of the orbit. A C-shaped incision is made down to the periosteum overlying the lateral orbital rim. The periosteum is incised posterior to the rim itself. The temporalis muscle is moved aside and the globe is protected with pliable retractors. A vibrating saw removes the bone of the lateral orbital rim. A piece of orbital bone is removed for decompression. The bone flap is then replaced and wired into position. The operative wound is closed in layers.

Coding Tips

For orbitotomy with removal of bone for decompression, by frontal or transconjunctival approach without bone flap, see 67414. For optic nerve sheath decompression, see 67570.

ICD-10-CM Diagnostic Codes

C69.61 Malignant neoplasm of right orbit ☑
C79.51 Secondary malignant neoplasm of bone
D16.4 Benign neoplasm of bones of skull and face
D48.0 Neoplasm of uncertain behavior of bone and articular cartilage
D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin
H05.221 Edema of right orbit ☑
H05.241 Constant exophthalmos, right eye ☑
H05.251 Intermittent exophthalmos, right eye ☑
H05.261 Pulsating exophthalmos, right eye ☑
H05.811 Cyst of right orbit ☑

AMA: **67445** 2019,Dec

Relative Value Units/Medicare Edits

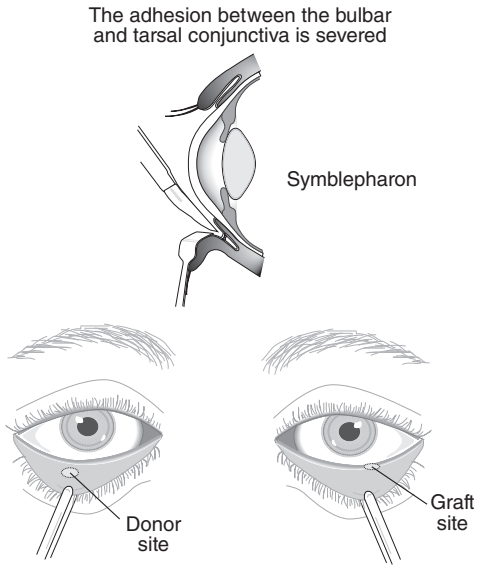
Non-Facility RVU	Work	PE	MP	Total
67445	19.12	24.71	1.67	45.5
Facility RVU	**Work**	**PE**	**MP**	**Total**
67445	19.12	24.71	1.67	45.5

	FUD	Status	MUE	Modifiers				IOM Reference
67445	90	A	1(2)	51	50	62*	80	None

* with documentation

68335

68335 Repair of symblepharon; with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)



A piece of conjunctival tissue or buccal mucosa is grafted over the resulting defect and secured with sutures

Explanation

A symblepharon is an adhesion between the conjunctiva on the eyeball (bulbar conjunctiva) and the conjunctiva on the inner eyelid (tarsal conjunctiva). The patient's face and eyelid are draped and prepped for surgery. Local anesthesia is administered. The physician separates the conjunctival adhesions and grafts replacement tissue over the site of the symblepharon. The tissue for graft can be a free graft of conjunctival tissue from the same or other eye, or buccal mucosa obtained from inside the patient's mouth. The site to which the donor tissue is to be grafted is prepared to accept the tissue. Its margins are freshened and the conjunctival graft is sutured in place. A silicon stent or contact lens may be placed in the eye to prevent the development of further adhesions during the healing process.

Coding Tips

Local anesthesia is included in this service and should not be reported separately. For wound repair, see 65270–65273. For repair of symblepharon, conjunctivoplasty, without graft, see 68330. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

H11.231 Symblepharon, right eye ☑
H11.232 Symblepharon, left eye ☑
H11.233 Symblepharon, bilateral ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
68335	8.46	10.05	0.68	19.19
Facility RVU	**Work**	**PE**	**MP**	**Total**
68335	8.46	10.05	0.68	19.19

	FUD	Status	MUE	Modifiers				IOM Reference
68335	90	A	1(3)	51	50	62*	N/A	None

* with documentation

Terms To Know

adhesion. Abnormal fibrous connection between two structures, soft tissue or bony structures, that may occur as the result of surgery, infection, or trauma.

anterior symblepharon. Adhesions between the eyelid and the eyeball.

buccal. Relating to or toward the cheek.

buccal mucosa. Tissue from the mucous membrane on the inside of the cheek.

conjunctiva. Mucous membrane lining of the eyelids and covering of the exposed, anterior sclera.

graft. Tissue implant from another part of the body or another person.

posterior symblepharon. Adhesions between the eyelid and the eyeball extending into the fornix. May resemble a pterygium.

stent. Tube to provide support in a body cavity or lumen.

symblepharopterygium. Adhesion in which the eyelid is adhered to the eyeball by a band that resembles a pterygium.

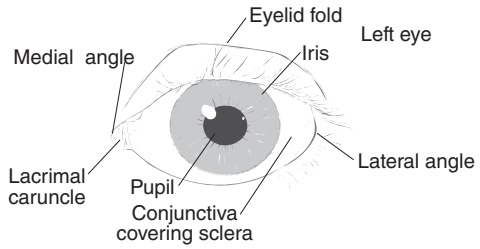
tarsus. Inner connective tissue framework of the eyelids that provides stiffness and shape.

total symblepharon. Adhesion of the entire conjunctival surface between the eyelid and the eyeball.

wound repair. Surgical closure of a wound is divided into three categories: simple, intermediate, and complex. ***simple repair:*** Surgical closure of a superficial wound, requiring single layer suturing of the skin epidermis, dermis, or subcutaneous tissue. ***intermediate repair:*** Surgical closure of a wound requiring closure of one or more of the deeper subcutaneous tissue and non-muscle fascia layers in addition to suturing the skin; contaminated wounds with single layer closure that need extensive cleaning or foreign body removal. ***complex repair:*** Repair of wounds requiring more than layered closure (debridement, scar revision, stents, retention sutures).

92002

92002 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient



Explanation

The physician sees a new patient, one who has not been seen within that group practice for at least three years, for intermediate ophthalmological services. The patient's medical history is reviewed, or interval history if more than three years have passed since the patient was seen within that group practice. General medical observations, an external ocular and adnexal examination, and other diagnostic procedures like ophthalmoscopy, biomicroscopy, or tonometry are done. The visit may include mydriasis (the dilation of the patient's pupils). Generally, the patient has an acute condition that does not require a comprehensive service or the patient is being examined for a chronic, but stable, condition (i.e., known cataract).

Coding Tips

A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the past three years. Services such as slit lamp examination, keratometry, ophthalmoscopy (routine), retinoscopy, tonometry, or motor evaluation are included in 92002 and are not reported separately. For special ophthalmological services that can be reported separately, see 92015–92371. For surgical procedures, see the surgery section under the eye and ocular adnexa subsection. Do not report 92002 with 99173–99174, 99177, or 0469T. Medicare has identified this code as a telehealth/telemedicine service. Telemedicine services may be reported by the performing provider by using the appropriate place of service (POS) indicator: POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home.

ICD-10-CM Diagnostic Codes

H00.011 Hordeolum externum right upper eyelid ☑
H00.012 Hordeolum externum right lower eyelid ☑
H02.421 Myogenic ptosis of right eyelid ☑
H02.831 Dermatochalasis of right upper eyelid ☑
H02.832 Dermatochalasis of right lower eyelid ☑
H04.121 Dry eye syndrome of right lacrimal gland ☑
H10.11 Acute atopic conjunctivitis, right eye ☑
H10.45 Other chronic allergic conjunctivitis
H11.31 Conjunctival hemorrhage, right eye ☑
H16.221 Keratoconjunctivitis sicca, not specified as Sjogren's, right eye ☑
H18.511 Endothelial corneal dystrophy, right eye ☑
H18.521 Epithelial (juvenile) corneal dystrophy, right eye ☑
H18.531 Granular corneal dystrophy, right eye ☑
H18.541 Lattice corneal dystrophy, right eye ☑
H18.551 Macular corneal dystrophy, right eye ☑
H25.011 Cortical age-related cataract, right eye A ☑
H25.11 Age-related nuclear cataract, right eye A ☑
H25.811 Combined forms of age-related cataract, right eye A ☑
H26.491 Other secondary cataract, right eye ☑
H35.031 Hypertensive retinopathy, right eye ☑
H35.371 Puckering of macula, right eye ☑
H35.81 Retinal edema
H36.811 Nonproliferative sickle-cell retinopathy, right eye ☑
H36.821 Proliferative sickle-cell retinopathy, right eye ☑
H40.001 Preglaucoma, unspecified, right eye ☑
H40.011 Open angle with borderline findings, low risk, right eye ☑
H40.031 Anatomical narrow angle, right eye ☑
H43.391 Other vitreous opacities, right eye ☑
H43.811 Vitreous degeneration, right eye ☑
H53.2 Diplopia
H57.8A1 Foreign body sensation, right eye ☑
M35.01 Sjögren syndrome with keratoconjunctivitis
S05.01XA Injury of conjunctiva and corneal abrasion without foreign body, right eye, initial encounter ☑
Z01.020 Encounter for examination of eyes and vision following failed vision screening without abnormal findings
Z01.021 Encounter for examination of eyes and vision following failed vision screening with abnormal findings

AMA: 92002 2021,Jan; 2018,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92002	0.88	1.64	0.02	2.54
Facility RVU	**Work**	**PE**	**MP**	**Total**
92002	0.88	0.44	0.02	1.34

	FUD	Status	MUE	Modifiers				IOM Reference
92002	N/A	A	1(2)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

cataract. Clouding or opacities of the lens that stop clear images from forming on the retina, causing vision impairment or blindness.

choroid. Thin, nourishing vascular layer of the eye that supplies blood to the retina, arteries, and nerves to structures in the anterior part of the eye.

cornea. Five-layered, transparent structure that forms the anterior or front part of the sclera of the eye.

dilation. Artificial increase in the diameter of an opening or lumen made by medication or by instrumentation.

retina. Layer of tissue located at the back of the eye that is sensitive to light similar to that of film in a camera.

tonometry. Measurement of intraocular pressure, usually by means of an instrument placed directly on the eye.

97602

97602 Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

Explanation

A health care provider performs wound care management to promote healing using non-selective debridement techniques to remove devitalized tissue. Non-selective debridement techniques are those in which necrotic and healthy tissue are removed. Non-selective techniques, sometimes referred to as mechanical debridement, include wet-to-moist dressings, enzymatic chemicals, autolytic debridement, abrasion, and larval therapy. Wet-to-moist debridement involves allowing a dressing to proceed from wet to moist and manually removing the dressing, which removes the necrotic and healthy tissue. Chemical enzymes are fast acting products that produce slough of necrotic tissue. Autolytic debridement is accomplished using occlusive or semi-occlusive dressings that keep wound fluid in contact with the necrotic tissue. Types of dressing applications used in autolytic debridement include hydrocolloids, hydrogels, and transparent films. Abrasion involves scraping the wound surface with a tongue blade or similar blunt instrument. Larval treatment may include larvae placement on the wound, which in turn feed off the dead tissue and/or application of the larvae digestive excretions allowing for debridement of dead tissue with no damage to viable tissue.

Coding Tips

Do not report 97602 with 11042–11047 for the same wound. When 97602 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51.

ICD-10-CM Diagnostic Codes

L03.211 Cellulitis of face

L08.89 Other specified local infections of the skin and subcutaneous tissue

L89.816 Pressure-induced deep tissue damage of head

L98.491 Non-pressure chronic ulcer of skin of other sites limited to breakdown of skin

L98.498 Non-pressure chronic ulcer of skin of other sites with other specified severity

AMA: **97602** 2018,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
97602	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
97602	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
97602	N/A	B	0(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

debridement. Removal of dead or contaminated tissue and foreign matter from a wound.

99172

99172 Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination[s] for contrast sensitivity, vision under glare)

Explanation

The patient's visual function is evaluated in this exam with several parts. For visual acuity, the physician asks the patient to stand at a specified distance (20 feet for Snellen eye chart) away from the chart. The patient is instructed to cover the left eye with the left hand or hold a card in front of the lens for those patients wearing eyeglasses. The patient reads the letters on the chart to test the visual acuity of the right eye. The process is repeated for the other eye. Ocular alignment is checked by determining whether the eyes work together in the same direction. The patient is positioned in front of a screen, looking ahead, and the non-tested eye is covered in a field of vision screening. The health care provider flashes objects in various areas in the field of vision and the patient is asked to respond. The patient's response creates a map of the visual field. To test color vision, the patient looks at cards with many different colored dots that make specific shapes. The patient with normal color vision will be able to discern the shapes within the colors. This exam identifies possible vision problems. It does not replace the examination by an ophthalmologist or optometrist and is used as a screening test only.

Coding Tips

This service must employ graduated visual acuity stimuli that allows a quantitative determination of visual acuity (e.g., Snellen chart). This service may not be reported in conjunction with a general ophthalmological service or E/M service. Do not report 99172 with 99173-99174, 99177, or 0469T.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99172	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99172	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
99172	N/A	N	0(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

diagnostic services. Examination or procedure performed on a patient to obtain information to assess the medical condition of the patient or to identify a disease and to determine the nature and severity of an illness or injury.

visual field. Total area in which objects can be seen in the peripheral vision while the eye is focused on a central point.

76529

76529 Ophthalmic ultrasonic foreign body localization

Explanation

B-scan utilizes sound waves in a two-dimensional scanning procedure to display a two-dimensional image of the internal ocular structures and ultrasonically locate a foreign body in the eye. A transducer placed on the eye sends high-frequency sound waves into the eye which reflect back to a receiver, are converted into electrical pulses, and displayed on screen. B-scan can also locate structures or objects in the eye that may be obscured by cataract, hemorrhages, or opacities.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
76529	0.57	1.98	0.02	2.57
Facility RVU	**Work**	**PE**	**MP**	**Total**
76529	0.57	1.98	0.02	2.57

76998

76998 Ultrasonic guidance, intraoperative

Explanation

Ultrasonography is used during a procedure to guide the physician in successfully accomplishing the surgery. Ultrasonic guidance may be used by the physician intraoperatively during many different types of operations on various areas of the body. Examples of intraoperative ultrasonic guidance include evaluating tissue removal in anatomical structures such as the breast, brain, abdominal organs, etc. This procedure may also be used to determine the location and depth of incisions to be made. This code is not to be used for ultrasound guidance for open or laparoscopic radiofrequency tissue ablation.

77002

+ 77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)

Explanation

Fluoroscopic guidance produces x-ray images shown on a screen to assist in visualization of the anatomy, instrument insertion, and/or contrast. This code is specifically reported when utilized for needle biopsy or fine needle aspiration. A cutting biopsy or fine needle is inserted into the target area and the position reaffirmed by fluoroscopy. This is done for an internal mass or lesion that has been positively identified by other diagnostic imaging performed earlier.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
77002	0.54	2.9	0.04	3.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
77002	0.54	2.9	0.04	3.48

78660

78660 Radiopharmaceutical dacryocystography

Explanation

Dacryocystography is the radiographic evaluation of the lacrimal system to localize the site of an obstruction. In diagnostic nuclear medicine, a drop of a radiotracer is instilled in the eye and subsequent imaging by a scintillation or gamma camera is performed to follow the passage of the radioactivity and the rate at which it disappears into the lacrimal system to assess if there is a stone or other blockage that interferes with normal tearing function.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
78660	0.53	3.4	0.05	3.98
Facility RVU	**Work**	**PE**	**MP**	**Total**
78660	0.53	3.4	0.05	3.98

80047

80047 Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)

Explanation

A basic metabolic panel with ionized calcium includes the following tests: calcium (ionized) (82330), carbon dioxide (82374), chloride (82435), creatinine (82565), glucose (82947), potassium (84132), sodium (84295), and urea nitrogen (BUN) (84520). Blood specimen is obtained by venipuncture. See the specific codes for additional information about the listed tests.

80048

80048 Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)

Explanation

A basic metabolic panel with total calcium includes the following tests: total calcium (82310), carbon dioxide (82374), chloride (82435), creatinine (82565), glucose (82947), potassium (84132), sodium (84295), and urea nitrogen (BUN) (84520). The blood specimen is obtained by venipuncture. See the specific codes for additional information about the listed tests.

80050

80050 General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)

Explanation

A general health panel includes the following tests: albumin (82040), total bilirubin (82247), calcium (82310), carbon dioxide (bicarbonate) (82374), chloride (82435), creatinine (82565), glucose (82947), alkaline phosphatase (84075), potassium (84132), total protein (84155), sodium (84295), alanine amino transferase (ALT) (SGPT) (84460), aspartate amino transferase (AST) (SGOT) (84450), urea nitrogen (BUN) (84520), and thyroid stimulating hormone (84443). In addition, this panel includes a hemogram with automated differential (85025 or 85027 and 85004) or hemogram (85027) with manual differential (85007 or 85009). Blood specimen is obtained by venipuncture. See specific codes for additional information about the listed tests.

80051

80051 Electrolyte panel This panel must include the following: Carbon dioxide (bicarbonate) (82374) Chloride (82435) Potassium (84132) Sodium (84295)

Correct Coding Initiative Update 30.3

❖Indicates Mutually Exclusive Edit

0100T 0472T, 0473T, 0708T-0709T, 11000-11006, 11042-11047, 36000, 36410, 36591-36592, 43752, 67005-67025, 67028, 67036, 67039-67041, 67107-67108, 67110, 67250-67255, 67500, 67516, 68200, 69990, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99446-99449, 99451-99452

0198T 36591-36592, 96523

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