Optum

Coding Companion

Ophthalmology

A comprehensive illustrated guide to coding and reimbursement

2025

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.

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 29.3, 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 2025 edition password is: **XXXXXX.** 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

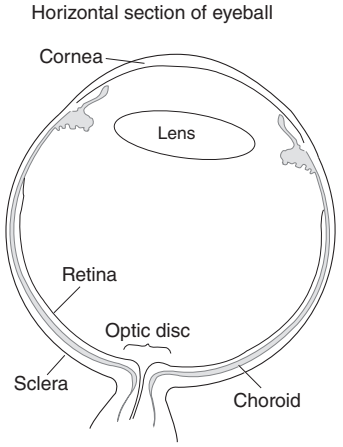
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

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

Injection of the verteporfin is included in 67221 and is not reported separately. Supplies used when providing these procedures may 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	4.34	0.26	8.05
67225	0.47	0.35	0.04	0.86
Facility RVU	**Work**	**PE**	**MP**	**Total**
67221	3.45	2.4	0.26	6.11
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	100-03,80.2
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 2024.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ 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.

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	96040
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 the most 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
- ♂ Male only
- ♀ Female Only
- ☑ 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 2023.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2025 edition password is **XXXXXX**.

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

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. 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.

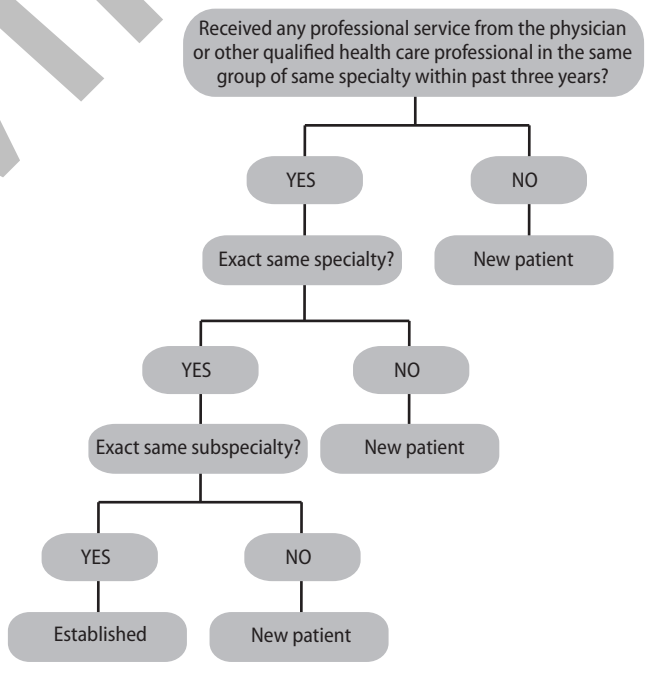
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or

AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶ ◀ = Contains new or revised text

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 and the CPT codebook have identified these codes as telehealth/telemedicine services. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and/or 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. 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** 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; 2017,Aug; 2017,Jun **99203** 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; 2017,Aug; 2017,Jun **99204** 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; 2017,Aug; 2017,Jun **99205** 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; 2017,Aug; 2017,Jun

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.14	0.08	2.15
99203	1.6	1.56	0.17	3.33
99204	2.6	2.11	0.23	4.94
99205	3.5	2.71	0.31	6.52
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.08	1.42
99203	1.6	0.68	0.17	2.45
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

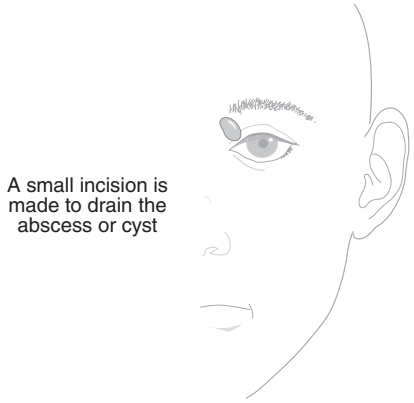
	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,11,40.1.3; 100-04,12,30.6.4; 100-04,12,30.6.10; 100-04,12,190.7; 100-04,12,230; 100-04,12,230.1; 100-04,18,80.2; 100-04,32,12.1
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

10060-10061

10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

10061 complicated or multiple



Explanation

The physician makes a small incision through the skin overlying an abscess for incision and drainage (e.g., carbuncle, cyst, furuncle, paronychia, hidradenitis). The abscess or cyst is opened with a surgical instrument, allowing the contents to drain. The lesion may be curetted and irrigated. The physician leaves the surgical wound open to allow for continued drainage or the physician may place a Penrose latex drain or gauze strip packing to allow continued drainage. Report 10060 for incision and drainage of a simple or single abscess. Report 10061 for complex or multiple cysts. Complex or multiple cysts may require surgical closure at a later date.

Coding Tips

These codes report incision and drainage of integumentary tissue only. For incision and drainage of an abscess or hordeolum of the eyelid, see 67700.

ICD-10-CM Diagnostic Codes

H00.031	Abscess of right upper eyelid ☑
H00.032	Abscess of right lower eyelid ☑
H00.034	Abscess of left upper eyelid ☑
H00.035	Abscess of left lower eyelid ☑
H00.11	Chalazion right upper eyelid ☑
H00.12	Chalazion right lower eyelid ☑
H00.14	Chalazion left upper eyelid ☑
H00.15	Chalazion left lower eyelid ☑
H02.821	Cysts of right upper eyelid ☑
H02.822	Cysts of right lower eyelid ☑
H02.824	Cysts of left upper eyelid ☑
H02.825	Cysts of left lower eyelid ☑
L03.213	Periorbital cellulitis
L08.0	Pyoderma
L08.81	Pyoderma vegetans
L08.89	Other specified local infections of the skin and subcutaneous tissue

AMA: **10060** 2023,Apr; 2022,Feb; 2021,Oct **10061** 2023,Apr; 2022,Feb; 2021,Oct

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
10060	1.22	2.42	0.12	3.76
10061	2.45	3.62	0.3	6.37
Facility RVU	**Work**	**PE**	**MP**	**Total**
10060	1.22	1.8	0.12	3.14
10061	2.45	2.72	0.3	5.47

	FUD	Status	MUE	Modifiers				IOM Reference
10060	10	A	1(2)	51	N/A	N/A	N/A	None
10061	10	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

carbuncle. Infection of the skin that arises from a collection of interconnected infected boils or furuncles, usually from hair follicles infected by *Staphylococcus*. This condition can produce pus and form drainage cavities.

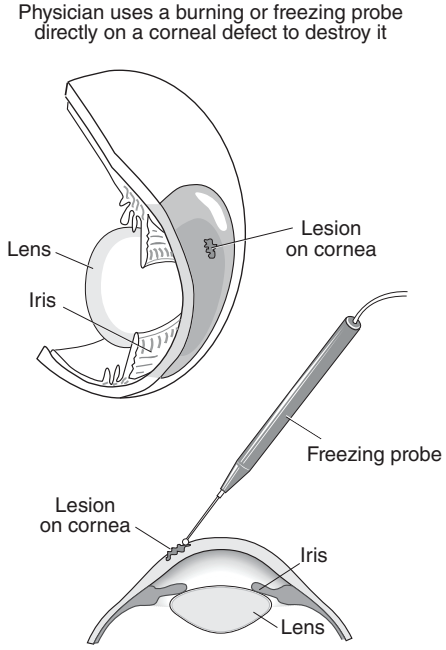
chalazion. Noninfectious, obstructive mass in the oil gland of the eyelid that results in a small chronic lump or inflammation.

furuncle. Inflamed, painful abscess, cyst, or nodule on the skin caused by bacteria, often *Staphylococcus*, entering along the hair follicle.

sebaceous cyst. Benign cyst of the skin or hair follicle filled with keratin and debris rich in lipids. Cysts of the integumentary system may be treated by incision and drainage or puncture aspiration.

65450

65450 Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization



Explanation

The physician applies a freezing probe, a laser beam, or a heat probe directly to a corneal defect to destroy it. Freezing is the most common method used for this procedure. The physician applies antibiotic ointment and sometimes, a pressure patch.

Coding Tips

For excision of a corneal lesion, see 65400. This procedure is generally performed with a topical anesthetic or a subconjunctival injection rather than general anesthesia. 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

C69.11	Malignant neoplasm of right cornea ☑
C69.12	Malignant neoplasm of left cornea ☑
D09.21	Carcinoma in situ of right eye ☑
D09.22	Carcinoma in situ of left eye ☑
D31.11	Benign neoplasm of right cornea ☑
D31.12	Benign neoplasm of left cornea ☑
D48.7	Neoplasm of uncertain behavior of other specified sites
D49.89	Neoplasm of unspecified behavior of other specified sites

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
65450	3.47	5.99	0.26	9.72
Facility RVU	**Work**	**PE**	**MP**	**Total**
65450	3.47	5.78	0.26	9.51

	FUD	Status	MUE	Modifiers				IOM Reference
65450	90	A	1(3)	51	50	N/A	N/A	None

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

anterior. Situated in the front area or toward the belly surface of the body.

benign. Mild or nonmalignant in nature.

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

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

cryotherapy. Any surgical procedure that uses intense cold for treatment.

destruction. Ablation or eradication of a structure or tissue.

edema. Swelling due to fluid accumulation in the intercellular spaces.

herpes simplex disciform keratitis. Deep, localized area of corneal edema and haziness named for its disk shape.

inflammation. Cytologic and chemical reactions that occur in affected blood vessels and adjacent tissues in response to injury or abnormal stimulation from a physical, chemical, or biologic agent.

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

lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma.

malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other body areas.

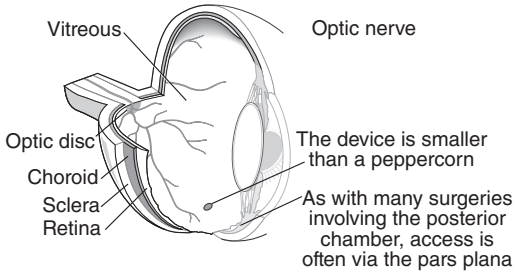
photocoagulation. Application of an intense laser beam of light to disrupt tissue and condense protein material to a residual mass, used especially for treating ocular conditions.

thermocauterization. Tissue destruction by means of a heated instrument point.

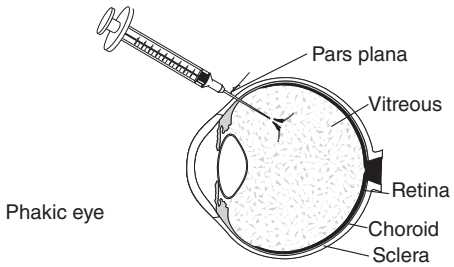
67027-67028

67027 Implantation of intravitreal drug delivery system (eg, ganciclovir implant), includes concomitant removal of vitreous

67028 Intravitreal injection of a pharmacologic agent (separate procedure)



The implantation of an intravitreous drug delivery device. A tiny capsule is implanted and attached to the sclera



Medication may also be injected into the posterior segment

Explanation

The physician implants an intravitreal drug delivery system to provide consistent delivery of a drug to an area of the eye affected by disease. Implants are capable of releasing a controlled amount of a specific drug for months, avoiding drug toxicity and other problems associated with prolonged intravenous therapies. Using a scalpel, the physician makes an inferotemporal pars plana incision. Approximately 0.5 milliliter of vitreous is removed. The implant (e.g., ganciclovir or fluocinolone acetonide) in the form of a small pellet is placed through the wound, implanted into the vitreous, and sutured to the sclera. The wound is closed and intraocular pressure is restored. In 67028, the physician introduces medication into the posterior segment via a small syringe. Drops to numb the eye are used prior to needle insertion as well as antibiotic drops after the procedure is complete. This medication administration does not require any sutures.

Coding Tips

Code 67028 is a separate procedure by definition and is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. If vitreous is removed and sent to an outside laboratory for analysis, report 99000 for handling of the specimen. For removal of a previously placed implant, see 67121. Since the drug delivery system works only for a defined period of time, the drug implant may need to be replaced. When a new replacement implant is inserted into another location without removing the previous implant, report 67027. Do not report 67028 with 65800-65815. Supplies used when providing these procedures may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

E10.3311 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye ☑

E10.3511 Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye ☑

E11.3311 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye ☑

E11.3411 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye ☑

E11.3511 Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye ☑

H30.011 Focal chorioretinal inflammation, juxtapapillary, right eye ☑

H30.021 Focal chorioretinal inflammation of posterior pole, right eye ☑

H30.031 Focal chorioretinal inflammation, peripheral, right eye ☑

H30.041 Focal chorioretinal inflammation, macular or paramacular, right eye ☑

H30.111 Disseminated chorioretinal inflammation of posterior pole, right eye ☑

H30.121 Disseminated chorioretinal inflammation, peripheral right eye ☑

H30.131 Disseminated chorioretinal inflammation, generalized, right eye ☑

H30.891 Other chorioretinal inflammations, right eye ☑

H34.8310 Tributary (branch) retinal vein occlusion, right eye, with macular edema ☑

H34.8311 Tributary (branch) retinal vein occlusion, right eye, with retinal neovascularization ☑

H34.8312 Tributary (branch) retinal vein occlusion, right eye, stable ☑

H35.3211 Exudative age-related macular degeneration, right eye, with active choroidal neovascularization 🅐 ☑

H35.3212 Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization 🅐 ☑

H35.3213 Exudative age-related macular degeneration, right eye, with inactive scar 🅐 ☑

H35.81 Retinal edema

H36.811 Nonproliferative sickle-cell retinopathy, right eye ☑

H36.821 Proliferative sickle-cell retinopathy, right eye ☑

H44.011 Panophthalmitis (acute), right eye ☑

H44.021 Vitreous abscess (chronic), right eye ☑

H44.111 Panuveitis, right eye ☑

AMA: **67027** 2018,Feb **67028** 2018,Feb

Relative Value Units/Medicare Edits

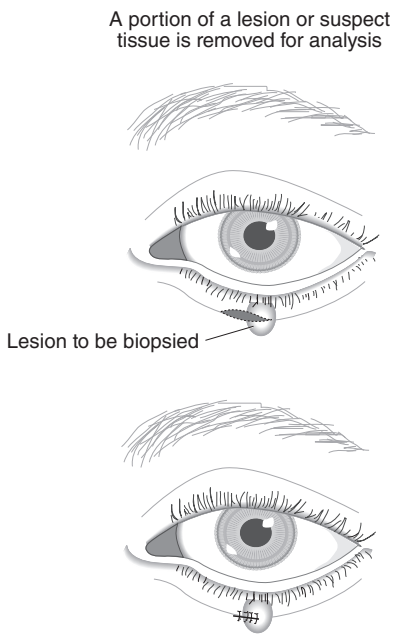
Non-Facility RVU	Work	PE	MP	Total
67027	11.62	12.37	0.9	24.89
67028	1.44	1.8	0.11	3.35
Facility RVU	**Work**	**PE**	**MP**	**Total**
67027	11.62	12.37	0.9	24.89
67028	1.44	1.14	0.11	2.69

	FUD	Status	MUE	Modifiers				IOM Reference
67027	90	A	1(2)	51	50	62*	80	None
67028	0	A	1(3)	51	50	N/A	N/A	

* with documentation

[67810]

67810 Incisional biopsy of eyelid skin including lid margin



Explanation

A local anesthetic is applied and the face and eyelid are prepped and draped. A small amount of tissue is excised from the suspect portion of the eyelid, which may include the lid margin. Sutures may be required to repair the incision.

Coding Tips

This is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). When 67810 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. If multiple areas are biopsied, report 67810 for each site taken and append 59 or an X{EPSU} modifier to additional codes. 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. For biopsy of eyelid skin, see 11102–11107.

ICD-10-CM Diagnostic Codes

C43.111 Malignant melanoma of right upper eyelid, including canthus ☑

C43.112 Malignant melanoma of right lower eyelid, including canthus ☑

C43.121 Malignant melanoma of left upper eyelid, including canthus ☑

C43.122 Malignant melanoma of left lower eyelid, including canthus ☑

C44.1121 Basal cell carcinoma of skin of right upper eyelid, including canthus ☑

C44.1122 Basal cell carcinoma of skin of right lower eyelid, including canthus ☑

C44.1191 Basal cell carcinoma of skin of left upper eyelid, including canthus ☑

C44.1192 Basal cell carcinoma of skin of left lower eyelid, including canthus ☑

C44.1221 Squamous cell carcinoma of skin of right upper eyelid, including canthus ☑

C44.1222 Squamous cell carcinoma of skin of right lower eyelid, including canthus ☑

C44.1291 Squamous cell carcinoma of skin of left upper eyelid, including canthus ☑

C44.1292 Squamous cell carcinoma of skin of left lower eyelid, including canthus ☑

C44.1921 Other specified malignant neoplasm of skin of right upper eyelid, including canthus ☑

C44.1922 Other specified malignant neoplasm of skin of right lower eyelid, including canthus ☑

C44.1991 Other specified malignant neoplasm of skin of left upper eyelid, including canthus ☑

C44.1992 Other specified malignant neoplasm of skin of left lower eyelid, including canthus ☑

C49.0 Malignant neoplasm of connective and soft tissue of head, face and neck

C4A.111 Merkel cell carcinoma of right upper eyelid, including canthus ☑

C4A.112 Merkel cell carcinoma of right lower eyelid, including canthus ☑

C4A.121 Merkel cell carcinoma of left upper eyelid, including canthus ☑

C4A.122 Merkel cell carcinoma of left lower eyelid, including canthus ☑

D21.0 Benign neoplasm of connective and other soft tissue of head, face and neck

D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin

AMA: **67810** 2019,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
67810	1.18	4.26	0.11	5.55
Facility RVU	**Work**	**PE**	**MP**	**Total**
67810	1.18	0.72	0.11	2.01

	FUD	Status	MUE	Modifiers				IOM Reference
67810	0	A	2(3)	51	50	N/A	N/A	None

* with documentation

Terms To Know

chalazion. Noninfectious, obstructive mass in the oil gland of the eyelid that results in a small chronic lump or inflammation.

cyst. Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.

palpebral. Referring or pertaining to the eyelids.

subcutaneous tissue. Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

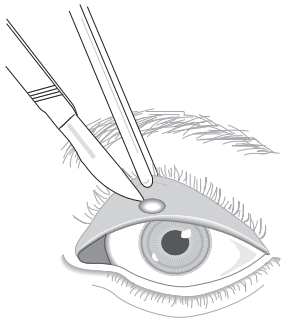
xanthelasma. Small, yellow tumors of the eyelid, usually appearing near the nose. Seen in patients with high blood-fat levels and in the elderly.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

68020

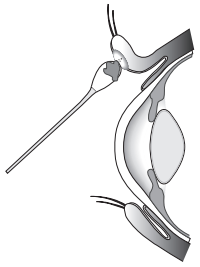
68020 Incision of conjunctiva, drainage of cyst

A cyst is drained through an incision in the conjunctiva



The incision does not extend to the eyelid margin itself

A swab or curette may be used to drain the cyst



Explanation

The patient's face and eyelid are draped and prepped for surgery. Local anesthesia is administered. A vertical or horizontal incision is made in the posterior surface of the eyelid margin. The incision does not extend to the eyelid margin itself. The contents of the cyst are drained either with a cotton-tipped probe or a curette.

Coding Tips

Digital expression of an infected Zeis gland is reported with the appropriate level E/M code. For removal of a foreign body, see 65205–65210. Use of an operating microscope is included in this procedure. Do not report 69990 separately. 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

H11.121 Conjunctival concretions, right eye ☑
H11.122 Conjunctival concretions, left eye ☑
H11.123 Conjunctival concretions, bilateral ☑
H11.441 Conjunctival cysts, right eye ☑
H11.442 Conjunctival cysts, left eye ☑
H11.443 Conjunctival cysts, bilateral ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
68020	1.42	2.08	0.1	3.6
Facility RVU	**Work**	**PE**	**MP**	**Total**
68020	1.42	1.73	0.1	3.25

	FUD	Status	MUE	Modifiers				IOM Reference
68020	10	A	1(3)	51	50	N/A	N/A	None

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

anesthesia. Loss of feeling or sensation, usually induced to permit the performance of surgery or other painful procedures.

chalazion. Noninfectious, obstructive mass in the oil gland of the eyelid that results in a small chronic lump or inflammation.

concretion. Calculus or inorganic mass within an organ, tissue, or body cavity.

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

curette. Spoon-shaped instrument used to scrape out abnormal tissue from a cavity or bone.

cyst. Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.

hordeolum. Acute localized infection of the gland of Zeis (external hordeolum) or Molt or of the meibomian glands (internal hordeolum) of the orbit.

incision and drainage. Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity.

laceration. Tearing injury; a torn, ragged-edged wound.

Meibomian gland. Sebaceous gland located in the tarsal plates along the eyelid margins that produces the lipid components found in tears.

operating microscope. Compound microscope with two or more lens systems or several grouped lenses in one unit that provides magnifying power to the surgeon up to 40X.

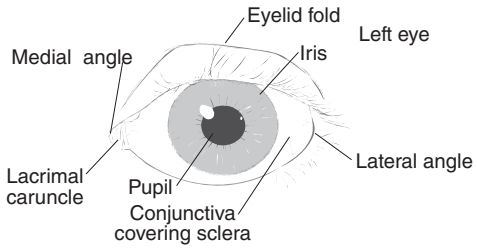
sclera. White, fibrous, outer coating of the eye continuous with the cornea anteriorly and the optic nerve sheath posteriorly that is covered with conjunctival tissue.

sebaceous cyst. Benign cyst of the skin or hair follicle filled with keratin and debris rich in lipids. Cysts of the integumentary system may be treated by incision and drainage or puncture aspiration.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

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; 2017,Sep

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	0.45	0.02	1.35

	FUD	Status	MUE	Modifiers				IOM Reference
92002	N/A	A	1(2)	N/A	N/A	N/A	80*	100-02,15,30.4; 100-04,4,160

* 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.

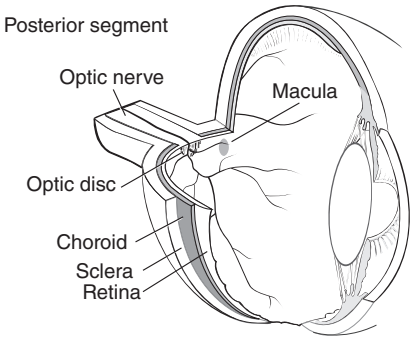
retina. Layer of tissue located at the back of the eye that is sensitive to light similar to that of film in a camera.

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

 ● New ▲ Revised + Add On ★ Telemedicine AMA: CPT Assist [Resequenced] ☑ Laterality

92284

92284 Diagnostic dark adaptation examination with interpretation and report



Explanation

This diagnostic exam tests the function of the two photoreceptors: the rods and the cones. Rods are most sensitive in dim illumination and are responsible for night vision. The cones are more sensitive in bright illuminations and are responsible for day vision. The eye to be tested is exposed to a bright light and the room is darkened. At 30-second intervals, the light is increased and the effect of the stimulus on the retina is measured by an adaptometer machine. This code includes interpretation and report.

Coding Tips

This code requires physician interpretation and report.

ICD-10-CM Diagnostic Codes

E50.5	Vitamin A deficiency with night blindness
H31.111	Age-related choroidal atrophy, right eye A ☑
H31.121	Diffuse secondary atrophy of choroid, right eye ☑
H35.51	Vitreoretinal dystrophy
H35.52	Pigmentary retinal dystrophy
H35.53	Other dystrophies primarily involving the sensory retina
H35.54	Dystrophies primarily involving the retinal pigment epithelium
H36.811	Nonproliferative sickle-cell retinopathy, right eye ☑
H36.821	Proliferative sickle-cell retinopathy, right eye ☑
H46.01	Optic papillitis, right eye ☑
H46.11	Retrobulbar neuritis, right eye ☑
H46.2	Nutritional optic neuropathy
H46.3	Toxic optic neuropathy
H47.011	Ischemic optic neuropathy, right eye ☑
H47.031	Optic nerve hypoplasia, right eye ☑
H47.091	Other disorders of optic nerve, not elsewhere classified, right eye ☑
H53.61	Abnormal dark adaptation curve
H53.62	Acquired night blindness
H53.63	Congenital night blindness
H53.69	Other night blindness
H53.71	Glare sensitivity
H53.72	Impaired contrast sensitivity
H53.8	Other visual disturbances

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92284	0.0	1.37	0.01	1.38
Facility RVU	**Work**	**PE**	**MP**	**Total**
92284	0.0	1.37	0.01	1.38

	FUD	Status	MUE	Modifiers				IOM Reference
92284	N/A	A	1(2)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

ischemia. Deficiency in blood supply causing tissues to be deprived of oxygen, resulting from trauma, mechanical or functional constriction of blood vessels, or a physical obstruction.

neuritis. Inflammation of a nerve or group of nerves, often manifested by loss of function and reflexes, pain, and numbness or tingling.

night blindness. Impairment in the ability to see at night or in dim light. Night blindness is often a symptom of a variety of other medical conditions, such as vitamin A deficiency, retinitis pigmentosa, cystic fibrosis, diabetes, cataracts, or congenital disorders.

optic nerve. Transmits visual information from the retina to the brain.

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

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

Correct Coding Initiative Update 29.3

❖Indicates Mutually Exclusive Edit

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