Rates: Maximum Reimbursement for Optometry Services

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

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

Codes and Rates

Optometric services are reimbursed as listed below:

Diagnostic and Ancillary Procedures

Table of Diagnostic and Ancillary Procedures

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

Table of Diagnostic and Ancillary Procedures (continued)

CPT Code	Description	Maximum Allowance
92081*	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	$16.40
92082*	‹‹Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least two isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)››	$22.14
92083*	‹‹Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least three isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)››	$22.14
92100*	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)	$28.93
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	$32.24
92133	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral; optic nerve	$39.33
92134	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral, retina	$39.33
92250*	Fundus photography with interpretation and report	$42.13

Table of Diagnostic and Ancillary Procedures (continued)

CPT Code	Description	Maximum Allowance
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 time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	$34.30
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 time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	$57.20
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 time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	$68.90
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 time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	$82.70
99211	‹‹Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional.››	$12.00
99212*	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	$11.41
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	$24.00

Table of Diagnostic and Ancillary Procedures (continued)

CPT Code	Description	Maximum Allowance
99214*	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	$37.50
99215*	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter	$57.20
92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral	$10.72
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	$26.66
99242	Office consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination and • Straightforward medical decision making	$47.20
99243	Office consultation for a new or established patient, which requires these three key components: • A detailed history • A detailed examination and • Medical decision making of low complexity	$59.50
99417*	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	N/A

Supplemental Procedures

‹‹Table of Supplemental Procedures: CPT Codes››

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

‹‹Table of Supplemental Procedures: HCPCS Codes››

HCPCS Code	Description	Maximum Allowance
T1014	Telehealth transmission, per minute, professional services bill separately	$0.24

Legend

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

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Coverage of these procedure codes is subject to the special provisions in the Professional Services section of this manual.
¥	CPT code 68761 billed with Modifier SC is reimbursed $48.84 for diagnostic closure of the lacrimal punctum, by absorbable plug, one or more closures, includes office visits. Use CPT code 68761 with modifier E1 thru E4 for closure of the lacrimal punctum, by permanent plug
+	CPT code 92499 billed with ICD-10-CM code H54.0X33 thru H54.3, H54.8 and “By Report” is reimbursed $75.11 for low vision examination.