**QUESTION:** What is conjunctivochalasis?

**ANSWER:** The term describes excess folds in the conjunctiva. Symptoms include: foreign body sensation, redness, irritation, pain, and epiphora. Conjunctivochalasis may be associated with aqueous tear deficiency, meibomian gland dysfunction, blepharitis, and other less common conditions. It is more common in the elderly due to gradual thinning of the conjunctiva and loss of adhesion to the underlying sclera related to the dissolution of Tenon’s capsule.

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**QUESTION:** What treatments are available for this condition?

**ANSWER:** Treatment with topical anti-inflammatory agents and artificial tears is the first line. Surgery to remove the symptomatic conjunctival folds may be considered when pharmaceuticals provide little or no help.

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**QUESTION:** What documentation supports treatment of conjunctivochalasis?

**ANSWER:** A treatment plan is justified by medical necessity and the patient’s pertinent complaint(s). In this case, it would be based on the provider’s examination of the anterior segment of the eye, and a discussion about the treatment options.

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**QUESTION:** What role does amniotic membrane play in the surgical treatment of conjunctivochalasis?

**ANSWER:** The removal of conjunctival folds results in a large elliptical defect in the conjunctiva, which is repaired with one or two layers of amniotic membrane covered with conjunctiva, and sutured in place. Sometimes tissue glue is used. Amniotic membrane provides a scaffold for cell regrowth into the defect and promotes patient recovery.

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**QUESTION:** What CPT code is used to describe this procedure?

**ANSWER:** Because there are several surgical techniques involving surgical removal of conjunctival folds and placement of amniotic membrane in the defect, there are multiple CPT codes that may apply. Three key factors determine the selection:

1. the size of the excision for the lesion,
2. the number of amniotic membrane layers,
3. use of tissue glue.

- 65779 – Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured
- 65780 – Ocular surface reconstruction; amniotic membrane transplantation, multiple layers
- 68110 – Excision of lesion, conjunctiva; up to 1 cm
- 68115 – Excision of lesion, conjunctiva; over 1 cm

For placement of amniotic membrane using tissue glue, use 66999.

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6. **QUESTION:** What is Medicare allow for surgeons?

**ANSWER:** Payment rates vary by type of provider and site of service. In the second half of 2015, the Medicare allowed amounts for a surgeon performing the procedure are:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>In Office</th>
<th>In Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>65779</td>
<td>$1,243</td>
<td>$288</td>
</tr>
<tr>
<td>65780</td>
<td>$903</td>
<td>$903</td>
</tr>
<tr>
<td>68110</td>
<td>$228</td>
<td>$152</td>
</tr>
<tr>
<td>68115</td>
<td>$315</td>
<td>$187</td>
</tr>
</tbody>
</table>

These amounts are adjusted in each locality by local indices. Other payers set their own fee schedules, which may differ considerably from Medicare rates.

The value of CPT 66999 is determined by the Medicare Administrative Contractor for the surgeon. Again, other payers may have different policies.

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8. **QUESTION:** Does the facility or surgeon receive separate payment for the supply of amniotic membrane?

**ANSWER:** Not for Medicare. HCPCS code V2790, Amniotic membrane for surgical reconstruction per procedure, is no longer eligible for discrete Medicare payment in any setting. Reimbursement for the supply is included with payment for the procedure. Other payers do not necessarily follow Medicare’s approach.

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7. **QUESTION:** What is the Medicare facility reimbursement?

**ANSWER:** Payment rates vary by type of provider and site of service. In the second half of 2015, the Medicare allowed amounts are:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>HOPD</th>
<th>ASC</th>
</tr>
</thead>
<tbody>
<tr>
<td>65779</td>
<td>$2,668</td>
<td>$0</td>
</tr>
<tr>
<td>65780</td>
<td>$2,668</td>
<td>$1,462</td>
</tr>
<tr>
<td>68110</td>
<td>$1,535</td>
<td>$158</td>
</tr>
<tr>
<td>68115</td>
<td>$1,535</td>
<td>$841</td>
</tr>
</tbody>
</table>

These amounts are adjusted in each locality by local indices. Other payers set their own fee schedules, which may differ considerably from Medicare rates.

The value of CPT 66999 is $752 for the HOPD; there is no facility fee at all for an ASC. Again, other payers may have different policies.

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9. **QUESTION:** How often is the procedure performed?

**ANSWER:** Within the Medicare program, 65779, 65780, 68110, and 68115 are infrequently performed.

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September 15, 2015

The reader is strongly encouraged to review federal and state laws, regulations, code sets (including ICD-9 and ICD-10), and official instructions promulgated by Medicare and other payers. This document is not an official source nor is it a complete guide on reimbursement. The reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

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