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Table I-4.(a) 2010 CPT ¹ Fee Schedule for Vision Services

Code	Description	Optometrist	Optician	Vision Group	Maximum Allowable
65205	REMOVE FOREIGN BODY FROM EYE	X		X	\$82.78
65210	REMOVE FOREIGN BODY FROM EYE	X		X	\$101.03
65220	REMOVE FOREIGN BODY FROM EYE	X		X	\$84.28
65222	REMOVE FOREIGN BODY FROM EYE	X		X	\$111.32
65430	CORNEAL SMEAR	X		X	\$168.70
65435	CURETTE/TREAT CORNEA	X		X	\$115.43
65436	CURETTE/TREAT CORNEA	X		X	\$565.28
65600	REVISION OF CORNEA	X		X	\$551.98
67820	REVISE EYELASHES	X		X	\$77.27
67840	REMOVE EYELID LESION	X		X	\$374.65
67938	REMOVE EYELID FOREIGN BODY	X		X	\$317.60
68020	INCISE/DRAIN EYELID LINING	X		X	\$172.46
68040	TREATMENT OF EYELID LESIONS	X		X	\$97.10
68761	CLOSE TEAR DUCT OPENING	X		X	\$205.59
68801	DILATE TEAR DUCT OPENING	X		X	\$168.47
68810	PROBE NASOLACRIMAL DUCT	X		X	\$330.94
68840	EXPLORE/IRRIGATE TEAR DUCTS	X		X	\$178.10
76511	OPHTH US, QUANT A ONLY	X			\$147.86
76512	OPHTH US, B W/NON-QUANT A	X			\$139.95
76513	ECHO EXAM OF EYE, WATER BATH	X			\$126.08
76514	ECHO EXAM OF EYE, THICKNESS	X	X	X	\$21.30
76516	ECHO EXAM OF EYE	X			\$102.31
76519	ECHO EXAM OF EYE	X			\$108.82
76529	ECHO EXAM OF EYE	X			\$103.67
92002	EYE EXAM, NEW PATIENT	X		X	\$113.60
92004	EYE EXAM, NEW PATIENT	X		X	\$216.03
92012	EYE EXAM ESTABLISHED PAT	X		X	\$119.86

CPT code descriptions are shortened to 28 characters or less to comply with copyright restrictions.
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Code	Description	Optometrist	Optician	Vision Group	Maximum Allowable
92014	EYE EXAM & TREATMENT	X		X	\$176.19
92015	REFRACTION	X		X	\$46.77
92018	NEW EYE EXAM & TREATMENT	X		X	\$230.42
92019	EYE EXAM & TREATMENT	X		X	\$115.49
92020	SPECIAL EYE EVALUATION	X		X	\$41.08
92060	SPECIAL EYE EVALUATION	X		X	\$89.92
92065	ORTHOPTIC/PLEOPTIC TRAINING	X		X	\$68.59
92070	FITTING OF CONTACT LENS	X	X	X	\$99.91
92081	VISUAL FIELD EXAMINATION(S)	X		X	\$75.71
92082	VISUAL FIELD EXAMINATION(S)	X		X	\$100.52
92083	VISUAL FIELD EXAMINATION(S)	X		X	\$114.36
92100	SERIAL TONOMETRY EXAM(S)	X		X	\$133.07
92120	TONOGRAPHY & EYE EVALUATION	X		X	\$110.49
92130	WATER PROVOCATION TONOGRAPH	X		X	\$120.99
92135	OPHTH DX IMAGING POST SEG	X	X	X	\$67.22
92140	GLAUCOMA PROVOCATIVE TESTS	X		X	\$84.05
92225	SPECIAL EYE EXAM, INITIAL	X		X	\$40.26
92226	SPECIAL EYE EXAM, SUBSEQUENT	X		X	\$36.03
92250	EYE EXAM WITH PHOTOS	X		X	\$101.43
92260	OPHTHALMOSCOPY/DYNAMOMETRY	X		X	\$27.07
92270	ELECTRO-OCULOGRAPHY	X		X	\$128.41
92275	ELECTRORETINOGRAPHY	X		X	\$195.60
92283	COLOR VISION EXAMINATION	X		X	\$63.83
92284	DARK ADAPTATION EYE EXAM	X		X	\$81.66
92285	EYE PHOTOGRAPHY	X		X	\$58.19
92286	INTERNAL EYE PHOTOGRAPHY	X		X	\$165.11
92310 **	CONTACT LENS FITTING	X	X	X	\$80.00

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Table I-4.(a) 2010 CPT¹ Fee Schedule for Vision Services

Code	Description	Optometrist	Optician	Vision Group	Maximum Allowable
92311 **	CONTACT LENS FITTING	X	X	X	\$80.00
92312 **	CONTACT LENS FITTING	X	X	X	\$80.00
92313 **	CONTACT LENS FITTING	X	X	X	\$80.00
92315 **	PRESCRIPTION OF CONTACT LENS	X	X	X	\$80.00
92316 **	PRESCRIPTION OF CONTACT LENS	X	X	X	\$80.00
92340	FITTING OF SPECTACLES	X	X	X	\$30.00
92341	FITTING OF SPECTACLES	X	X	X	\$30.00
92342	FITTING OF SPECTACLES	X	X	X	\$30.00
92352	SPECIAL SPECTACLES FITTING	X	X	X	\$59.59
92353	SPECIAL SPECTACLES FITTING	X	X	X	\$70.84
92358	EYE PROSTHESIS SERVICE	X		X	\$20.31
99002	DEVICE HANDLING	X	X	X	\$6.00
99201	OFFICE/OUTPATIENT VISIT, NEW	X		X	\$62.46
99202	OFFICE/OUTPATIENT VISIT, NEW	X		X	\$109.84
99203	OFFICE/OUTPATIENT VISIT, NEW	X		X	\$160.27
99204	OFFICE/OUTPATIENT VISIT, NEW	X		X	\$252.60
99205	OFFICE/OUTPATIENT VISIT, NEW	X		X	\$319.74
99211	OFFICE/OUTPATIENT VISIT, EST	X		X	\$29.70
99212	OFFICE/OUTPATIENT VISIT, EST	X		X	\$62.46
99213	OFFICE/OUTPATIENT VISIT, EST	X		X	\$108.29
99214	OFFICE/OUTPATIENT VISIT, EST	X		X	\$163.18
99215	OFFICE/OUTPATIENT VISIT, EST	X		X	\$221.58
99221	INITIAL HOSPITAL CARE	X		X	\$136.05
99222	INITIAL HOSPITAL CARE	X		X	\$184.15
99223	INITIAL HOSPITAL CARE	X		X	\$271.69
99231	SUBSEQUENT HOSPITAL CARE	X		X	\$66.52
99232	SUBSEQUENT HOSPITAL CARE	X		X	\$120.29

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Code	Description	Optometrist	Optician	Vision Group	Maximum Allowable
99233	SUBSEQUENT HOSPITAL CARE	X		X	\$172.68
99241	OFFICE CONSULTATION	X		X	\$78.57
99242	OFFICE CONSULTATION	X		X	\$150.26
99243	OFFICE CONSULTATION	X		X	\$206.34
99244	OFFICE CONSULTATION	X		X	\$310.73
99245	OFFICE CONSULTATION	X		X	\$380.86
99251	INPATIENT CONSULTATION	X		X	\$86.34
99252	INPATIENT CONSULTATION	X		X	\$131.96
99253	INPATIENT CONSULTATION	X		X	\$201.58
99254	INPATIENT CONSULTATION	X		X	\$291.91
99255	INPATIENT CONSULTATION	X		X	\$352.78
99281	EMERGENCY DEPT VISIT	X		X	\$36.88
99282	EMERGENCY DEPT VISIT	X		X	\$71.58
99283	EMERGENCY DEPT VISIT	X		X	\$109.14
99284	EMERGENCY DEPT VISIT	X		X	\$205.72
99285	EMERGENCY DEPT VISIT	X		X	\$304.18
99288 **	DIRECT ADVANCED LIFE SUPPORT	X		X	\$125.00

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AFFILIATED COMPUTER SERVICES, INC.
Provider Inquiry Recipient Eligibility for Vision Services

ACS is now a Xerox company

FAX: (907) 644-8126

Provider: NPI[†] or Medicaid Contract ID[†] _____ Provider Name _____ Date _____
 Contact Person _____ Provider FAX _____ Provider Phone _____

Please submit: 1) the recipient name, 2) month and year of service, and 3) at least one other patient identifier such as the recipient Medicaid ID, the SSN, or the Date of Birth (DOB). Provider Inquiry will verify recipient eligibility for the month and year indicated in the Month/Year of Service field, and will indicate if they have received a vision exam or glasses within the last year.

1. _____ Eligible (Yes) (No) Medicaid _____ CAMA _____
 (Medicaid or SSN) (Recipient Name) (DOB) (Month/Year of Service) (Code) (Code)
 Exam Glasses Neither TPL _____
 Within the last year (Code) (Policy Name) (Effective Dates) (Policy No. or Subscriber Group No.)

2. _____ Eligible (Yes) (No) Medicaid _____ CAMA _____
 (Medicaid or SSN) (Recipient Name) (DOB) (Month/Year of Service) (Code) (Code)
 Exam Glasses Neither TPL _____
 Within the last year (Code) (Policy Name) (Effective Dates) (Policy No. or Subscriber Group No.)

3. _____ Eligible (Yes) (No) Medicaid _____ CAMA _____
 (Medicaid or SSN) (Recipient Name) (DOB) (Month/Year of Service) (Code) (Code)
 Exam Glasses Neither TPL _____
 Within the last year (Code) (Policy Name) (Effective Dates) (Policy No. or Subscriber Group No.)

4. _____ Eligible (Yes) (No) Medicaid _____ CAMA _____
 (Medicaid or SSN) (Recipient Name) (DOB) (Month/Year of Service) (Code) (Code)
 Exam Glasses Neither TPL _____
 Within the last year (Code) (Policy Name) (Effective Dates) (Policy No. or Subscriber Group No.)

5. _____ Eligible (Yes) (No) Medicaid _____ CAMA _____
 (Medicaid or SSN) (Recipient Name) (DOB) (Month/Year of Service) (Code) (Code)
 Exam Glasses Neither TPL _____
 Within the last year (Code) (Policy Name) (Effective Dates) (Policy No. or Subscriber Group No.)

Completed by _____ (ACS Provider Inquiry Specialist) _____ (Date Completed)

^{*} National Provider Identifier
[†] Formerly known as Alaska Medical Assistance Provider Number