

Ophthalmology - Retinopathy Coding Tip Sheet

92002 and 92004: New patient eye exam and evaluation
 92012 and 92014*: Established patient eye exam and evaluation
 *92014 requires dilation unless medically contraindicated

These CPT II codes can be billed alone or with other services.

2022F: Dilated retinal eye exam with interpretation by an ophthalmologist/optometrist
 2024F: 7 standard field stereoscopic photos with interpretation by an ophthalmologist/optometrist
 2026F: Eye imaging validated to match diagnosis from 7 standard field stereoscopic photo results
 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year)

When your diabetic patient has a negative eye exam,
 submit your eye exam claim with either of the following ICD-10 codes:

ICD-10 Diagnosis Code E10.9 – Type 1 diabetes mellitus without complications

ICD-10 Diagnosis Code E11.9 – Type 2 diabetes mellitus without complications

CPT II Code 3072F – Low risk for retinopathy (no evidence of retinopathy in the prior year)

If your diabetic patient has a positive exam,
 submit your eye exam claim with the appropriate ICD-10 diagnosis codes:

Diagnosis	DM Type 1	DM Type 2
No Retinopathy	E10.9	E11.9
PDR and ME	E10.351__	E11.351__
PDR and no ME	E10.359__	E11.359__
Mild NPDR and ME	E10.321__	E11.321__
Mild NPDR and no ME	E10.329__	E11.329__
Moderate NPDR and ME	E10.331__	E11.331__
Moderate NPDR and no ME	E10.339__	E11.339__
Severe NPDR and ME	E10.341__	E11.341__
Severe NPDR and no ME	E10.349__	E11.349__

ME – Macular Edema

PDR – Proliferative Diabetic Retinopathy

NPDR – Nonproliferative Diabetic Retinopathy

__ = Additional required digit for diagnosis code:

1 = Right eye

2 = Left eye

3 = Bilateral

For example, E10.3513 = PDR and ME, DM Type 1, Bilateral eyes