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MEDICARE REIMBURSEMENT FOR OPHTHALMIC AMNIOTIC MEMBRANE TISSUE

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1 ***QUESTION:*** What is amniotic membrane tissue and when is it used within eye care?

ANSWER: It is donated human placental tissue configured as a biological bandage used to protect and promote healing of the ocular surface. It contains extracellular matrix components and, depending on the product and processing method, biologically active proteins and growth factors that reduce inflammation and encourage new cell growth. Common ophthalmic indications include: persistent epithelial defects, neurotrophic keratitis, corneal ulceration, chemical injury, severe dry eye disease and ocular surface reconstruction. Payor coverage depends on how and why it is used within regulatory constraints rather than the individual product.

2 ***QUESTION:*** How do ophthalmic amniotic membrane products differ?

ANSWER: Products differ by tissue preservation and processing (e.g., cryopreserved, dehydrated, or decellularized), configuration, physical design, handling, storage, FDA regulatory status, and Instructions for Use. Product substitution is limited by these characteristics. Published science about products is another significant variable.

3 ***QUESTION:*** Does Medicare cover every use of amniotic membrane?

ANSWER: No. Medicare does not provide blanket coverage for all amniotic membrane tissue. Coverage depends upon whether the procedure is reasonable and necessary for the patient's condition, tissue used as instructed, supported by the medical record, and consistent with applicable statutes, regulations, Local Coverage Determinations (LCDs), and Medicare billing instructions. Coverage may differ among Medicare Administrative Contractors and other payors.

4 ***QUESTION:*** Which ICD-10-CM diagnoses support medical necessity?

ANSWER: There is no single diagnosis code that universally applies to claims for procedures that use amniotic membrane. Report the underlying ocular disease or injury that is the reason for the service.[1] Avoid using ICD-10 codes for symptoms or those that are nonspecific or unspecified. In general, only serious conditions support medical necessity for using amniotic membrane. The ICD-10 diagnosis reported on the claim should be consistent with the physician's documented assessment and the medical necessity for the procedure.

5 ***QUESTION:*** What CPT and HCPCS codes apply?

ANSWER: The vast majority of CPT codes describe physician work (*e.g.,* 65778, 65779, 65780).[2] Most HCPCS codes identify supplies.[3] At this time, HCPCS V2790 (amniotic membrane) remains in the code set but generally has no practical value for separate Medicare payment because it is reimbursed as an inherent part of the procedure (*i.e.,* bundled).[4] Most payors agree, but you should verify it because policies differ.

6 ***QUESTION:*** What elements are required in the medical record?

ANSWER: Document date of service, physician assessment, anesthesia, medical necessity, procedure performed, fixation method, laterality, product size, product identification, lot number, and any complications and postoperative instructions. Documentation should support both the CPT code and the clinical decision.

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7

QUESTION: When covered, what does Medicare allow for these procedures?

ANSWER: Physician payment rates vary by the site of service. The 2026 national Medicare Physician Fee Schedule[5] allowable amounts are:

	65778	65779	65780
Physician (in office)	$1,275	$1,141	N/A
Physician (in facility)	$36	$85	$516

The 2026 national Medicare facility allowable amounts are:

	65778	65779	65780
HOPD Facility Fee	$204	$803	$803
ASC Facility Fee	N/A	N/A	$2,199

These amounts are modified by local wage indices so actual payment rates will vary. Other payors set their own rates, which may differ significantly from the Medicare published fee schedule.

8

QUESTION: Are there restrictions regarding other procedures performed on the same day?

ANSWER: Yes. The National Correct Coding Initiative establishes procedure-to-procedure edits for services considered integral, incidental, or mutually exclusive.[6] These may occur in the context of surgical repair, biopsy, excisions, scrapings, grafting, gluing, injections, or application of a bandage contact lens. Because NCCI edits are revised quarterly, physicians should verify current edits before submitting claims.

Additionally, Medicare rules regarding care within the global surgery period apply. The global period for 65778 and 65779 is zero days; it is 90 days for 65780.

9

QUESTION: Regarding reimbursement, what common errors occur?

ANSWER: Common mistakes include:

- Inadequate documentation of medical necessity
- Interventionism instead of choosing the least aggressive treatment that would work
- Too frequent repeated use without supporting documentation
- Reporting diagnoses that do not support medical necessity
- Incorrect CPT selection
- Failure to follow CPT parenthetical instructions directing use of CPT 66999 when tissue adhesive is used with amniotic membrane
- Failure to verify Medicare or other payor policy
- Confusing FDA authorization with Medicare coverage

10

QUESTION: How often is amniotic membrane used?

ANSWER: As a proportion of all eye exams performed on traditional Medicare beneficiaries (Part B), amniotic membrane use is 0.1% of them. This includes 65778, 65779, and 65780. Higher utilization often leads to unwanted payor scrutiny.

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1 2026 ICD-10-CM Official Guidelines for Coding and Reporting. Link here.

2 2026 CPT Professional Edition

3 2026 HCPCS

4 Palmetto GBA. A53441 Billing and Coding: Amniotic Membrane Billing Guidelines for V2790. Link here.

5 In 2026, Medicare has a different, and slightly higher, fee schedule for those practices who participate in an advanced payment methodology program (APM). Most eyecare practices do not participate in APMs, so the allowed amounts shown are for non-APM practices who accept assignment.

6 National Correct Coding Initiative Policy Manual. Link here.

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