

Professional Services

This section contains information about rendering professional ophthalmological services and program coverage (*California Code of Regulations* [CCR], Title 22, Sections 51306 and 51518). Refer to the *Professional Services Billing Examples: CMS-1500* section of this manual for billing information on the *CMS-1500* claim form. Refer also to the *Professional Services: Diagnosis Codes* section for a list of procedures and conditions that require a valid ICD-9-CM diagnosis code on the claim for payment.

Notice: Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009) excluded several optional benefits from coverage under the Medi-Cal program, including dispensing optician and fabricating optical laboratory services. Refer to the *Optional Benefits Exclusion* section in this manual for policy details, including information regarding exemptions to the excluded benefits. Certain codes listed in this section are affected by the optional benefits exclusion policy. Ocularist services are not impacted by AB X3 5 and remain reimbursable for all Medi-Cal recipients.

GENERAL INFORMATION

Claim Submission

Optometrist and ophthalmologist providers are required to submit claims for vision care services and eye appliances on the *CMS-1500* claim form.

Hospital outpatient departments and organized outpatient clinics can bill for ophthalmological services on the *CMS-1500* or *UB-04* claim form. However, the following ophthalmological and eye appliance procedure codes must be billed only on the *CMS-1500* claim form:

CPT-4 codes: 68761, 92002 – 92060, 92071 – 92284, 92310 – 92353, 92370, 92371 and 92499

HCPCS codes: S0500, S0512, S0514, S0516, V2020 – V2499, V2500, V2501, V2510, V2511, V2513 – V2521, V2523, V2599, V2600 – V2615, V2623 – V2629, V2702 – V2718, V2744 – V2755, V2760 – V2770, V2781 – V2784 and V2799

Usual and Customary Fee

Providers are prohibited from submitting claims for reimbursement for services rendered to any Medi-Cal recipient in amounts greater than the usual and customary fees charged to the general public. (There are some exceptions for free organized outpatient clinics, per CCR, Title 22, Sections 51480 and 51501.)

Billing Recipients

Providers are prohibited from billing recipients for Medi-Cal-covered services. Charges exceeding Medi-Cal allowances may not be billed to recipients. Refer to the *Provider Guidelines* section in the Part 1 manual for information.

Non-Covered Services The following are not Medi-Cal benefits:

- Orthoptics and pleoptics
- Control of myopia
- Orthokeratology
- Syntonics
- Holistic vision care
- Iridology
- Supplies and services outside the scope of licensure or registration of a practitioner

COMPREHENSIVE EYE EXAMINATIONS

Routine Examinations

Claims by either an ophthalmologist or optometrist for routine comprehensive eye examinations (CPT-4 codes 92004 [new patient] and 92014 [established patient]) are covered once every two years regardless of age.

Determination of Refractive State

When performed, determination of refractive state (CPT-4 code 92015) must be separately reported when billed in conjunction with CPT-4 code 92004 or 92014.

Code 92015 is considered typical postoperative follow-up care included in the surgical package for cataract extraction surgeries. Therefore, this service is not reimbursable when billed in conjunction with or within the 90-day post follow-up period of CPT-4 codes 66840, 66850, 66852, 66920, 66930, 66940 and 66982 – 66985.

Tonometry

Tonometry services are included in an eye examination and should not be billed as a separate procedure.

Note: This is a one-time measurement and not serial tonometry (CPT-4 code 92100).

Diagnostic Drugs

The use of topically applied diagnostic drugs (cycloplegic, mydriatic or anesthetic topical pharmaceutical agents) is included in the reimbursement of ophthalmological procedures.

Interim Examinations

A second eye examination with refraction within 24 months is covered only when a sign or symptom indicates a need for this service. Claims billed with CPT-4 codes 92004 and 92014 must include the appropriate ICD-9-CM code that justifies the examination in the *Diagnosis or Nature of Illness or Injury* field (Box 21) of the *CMS-1500* claim form. This policy applies, whether the claim is submitted by the provider of the prior examination, or by a different provider. Refer to the *Professional Services: Diagnosis Codes* section in this manual for a list of ICD-9-CM diagnosis codes required with CPT-4 codes 92004 and 92014 when billing for interim comprehensive eye examinations within the 24-month benefit period.

E&M Codes Not Reimbursable With Eye Examination Services

Evaluation and Management (E&M) visit codes (CPT-4 codes 99201 – 99215) should not be billed with eye examination codes (CPT-4 codes 92002, 92004, 92012, 92014) by the same provider, for the same recipient on the same date of service. Reimbursement for duplicate services will be reduced or denied.

SUPPLEMENTAL SERVICES

Definition

Supplemental services are billed in addition to an eye examination or evaluation in order to treat a patient's condition or to obtain additional information to determine the patient's diagnosis or whether referral to another practitioner is necessary. Supplemental services are not covered when the basic eye examination provides sufficient information to enable the practitioner to adequately make a diagnosis or decide whether a referral is necessary. Claims for supplemental services are covered only when adequately justified for medical necessity either with the claim or in the medical record. Supplemental procedures may be provided without a preceding eye examination and evaluation only when specifically requested by a physician or a governmental agency due to a specific ocular anomaly.

Covered Services

Supplemental services include the following:

- Closure of the lacrimal punctum, by plug, each (CPT-4 code 68761)
 - Computerized corneal topography (CPT-4 code 92025)
 - Contact lens evaluation (CPT-4 codes 92071, 92072 and 92310 – 92312), including necessary professional follow-up services for a period of six months
- Note:** CPT-4 codes 92071, 92072 and 92310 – 92312 require authorization from the Department of Health Care Services (DHCS) Vision Services Branch (VSB). Refer to the *Contact Lens* section in this manual for additional billing information.
- Corneal debridement (CPT-4 codes 65435 and 65436)
 - Corneal pachymetry (CPT-4 code 76514)
 - Corneal scraping (CPT-4 code 65430)
 - Dilation and irrigation of lacrimal punctum (CPT-4 code 68801)
 - Epilation (CPT-4 code 67820)
 - Extended ophthalmoscopy (CPT-4 code 92225)
 - Fundus photography (CPT-4 code 92250)
 - Gonioscopy (CPT-4 code 92020)
 - Low vision services (billed with CPT-4 code 92499), including evaluation, fitting of low vision devices and six months follow-up care
 - Out-of-office call (CPT-4 code 99056)
 - Removal of foreign body (CPT-4 codes 65205, 65210, 65220, 65222, 67938)
 - Serial tonometry (CPT-4 code 92100)
 - Unlisted service or procedure (CPT-4 code 92499)
 - Visual field examinations (CPT-4 codes 92081, 92082, 92083)

Teleophthalmology by Optometrists

Teleophthalmology and by store and forward means an asynchronous transmission of medical information to be reviewed at a later time by a physician or optometrist at a distant site, where the physician or optometrist at the distant site reviews the medical information without the patient being present in real-time. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Section 3041 of the *Business and Professions Code*, a referral must be made with an appropriate physician and surgeon or ophthalmologist, as required.

Store and Forward Guidelines

The telehealth equipment and transmission speed must be sufficient to support the services billed to Medi-Cal. Staff involved in the telehealth encounter must be trained in the use of the telehealth equipment and understand its use. The images must be specific to the patient's condition and adequate for meeting the procedural definition of the national code that is billed.

Providers are also required to include the following information in the medical record:

- A record of the written or verbal request for the consultation by the referring provider or other source.
- Documentation of the opinion, advice or recommended service by the consulting provider.
- A copy of the written report of the findings and recommendations to the referring provider or other source.
- Verbal and written informed consent from the patient or the patient's legal representative if the consulting provider has ultimate authority over the care or primary diagnosis of the patient.

Billing and Reimbursement

The originating site facility fee is reimbursable only to the originating site when billed with HCPCS code Q3014 (telehealth originating site facility fee). Transmission costs incurred from providing telehealth services via audio/video communication are reimbursable for the original site and the consulting provider when billed with HCPCS code T1014 (telehealth transmission, per minute, professional services bill separately). Expenses involving telehealth equipment and telecommunications and transmission costs by Internet service providers will not be reimbursed by Medi-Cal.

Optometrist providers may submit claims to Medi-Cal for teleophthalmology services provided via store and forward using the following office consultation CPT-4 codes:

<u>CPT-4 Code</u>	<u>E&M Description</u>
99241 – 99243	Office consultation, new or established patient

When billing these CPT-4 codes, providers must enter the name and National Provider Identifier (NPI) of the referring provider in Box 17 (*Name of Referring Provider or Other Source*) and Box 17b (*NPI*), respectively, on the *CMS-1500* claim form.

Modifier GQ

Teleophthalmology services by store and forward must be billed with modifier GQ (service rendered by store and forward telecommunications system). Only the portion(s) rendered from the distant site (hub) are billed with modifier GQ.

The use of modifier GQ does not alter reimbursement for the CPT-4 or HCPCS code billed.

Teleophthalmology
Record-Keeping/Security
Requirements

Providers must adhere to the same record-keeping requirements as specified in the *Welfare & Institutions Code (W&I Code)* and the *California Code of Regulations (CCR)* for use of audio clips, video clips, still images of the patient, and/or clinical data submitted by the referring provider or other source using store and forward telehealth.

All telehealth activities must comply with the requirements of Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and all other applicable state and federal laws and regulations.

Reasons for Non-Coverage

Asynchronous telecommunications system (store and forward telehealth) in single media format does not include telephone calls, images transmitted via facsimile machine, and text messages without visualization of the patient (electronic mail). Audio clips, video clips, still images and photographs must be specific to the patient's condition and adequate for rendering or confirming a diagnosis and/or treatment plan.

MEDICARE/MEDI-CAL CROSSOVER CLAIMS

Medicare Covered Services

Eye examinations for Medicare/Medi-Cal-eligible recipients must be billed to Medicare prior to billing Medi-Cal for the following claims:

- Examinations performed in conjunction with eye disease (such as, glaucoma or cataract) or eye injury
- Interim examinations for recipients with a sign or symptom that justifies the need for an examination (providers must include the principal ICD-9-CM code on the claim)

Medicare Non-Covered

Routine examinations for the purpose of prescribing, fitting or changing eyeglasses, as well as eye refractions, are not covered by Medicare. Eye examination claims (CPT-4 codes 92002, 92004, 92012 and 92014) for Medicare/Medi-Cal-eligible recipients with only diagnoses for disorders of refraction, accommodation and color vision deficiencies may be billed directly to Medi-Cal. The recipient's primary ICD-9-CM diagnosis code must be entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21) of the *CMS-1500* claim. Determination of refractive state (CPT-4 code 92015) is not covered by Medicare and may be billed directly to Medi-Cal.

Refer to the *Medicare Non-Covered Services: CPT-4 Codes* section in this manual for a list of ICD-9-CM diagnosis codes that may be billed directly to Medi-Cal for CPT-4 codes 92002, 92004, 92012 and 92014.

Hard Copy Billing

Claims that do not automatically cross over electronically from Medicare carriers must be hard copy billed to the Department of Health Care Services (DHCS) Fiscal Intermediary (FI) Crossover Unit on a *CMS-1500* claim. Refer to the *Medicare/Medi-Cal Crossover Claims: Vision Care* section in this manual for detailed crossover billing information.

Providers must attach a copy of the *Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)* to all crossover claims.

BILLING

Eye Appliances

Dispensing optical providers (ophthalmologists, optometrists and dispensing opticians) must use the *CMS-1500* claim to bill for eye appliances. For further instructions about completing the *CMS-1500* claim, see the *CMS-1500 Completion for Vision Care* section in this manual.

General Ophthalmological Services

General ophthalmological services (eye examinations and contact lens evaluations) must be billed on the *CMS-1500* claim with their specific HCPCS modifiers for reimbursement. Refer to the *Modifiers: Approved List* section in this manual for a complete list of modifiers to use with ophthalmological services.

Contact Lenses Services

Claims billed with CPT-4 codes 92071 (fitting of contact lens for treatment of ocular surface disease), 92072 (fitting of contact lens for management of keratoconus, initial fitting), 92310 (prescription of optical and physical characteristics of and fitting of contact lenses, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia), 92311 (...corneal lens for aphakia, one eye) and 92312 (...corneal lens for aphakia, both eyes) require authorization from the DHCS Vision Services Branch (VSB).

Refer to the *Contact Lens* and *TAR Completion for Vision Care* sections in this manual for policy, billing and 50-3 TAR information.

Modifiers 22 and SC

Providers can only use modifiers 22 and SC when billing for CPT-4 codes 92071, 92072 and 92310 – 92312.

Ocular Prosthesis

Supply of ocular prosthesis is billed with HCPCS codes V2623 – V2629. Services for prosthetic eyes and modification of prosthetic eyes must be billed on the *CMS-1500* claim. HCPCS codes V2623 and V2627 – V2629 must be billed with modifier NU or RP. HCPCS codes V2624 – V2626 must be billed with modifier SC.

Note: When both modifiers NU and RP are required for a certain procedure, use a separate claim line for each procedure code/modifier combination.

Refer to the *Prosthetic Eyes* section in this manual for additional policy and billing information. Prosthetic eye services are exempt from the optional benefits exclusion policy.

Consultations	<p>Optometry providers billing office consultations (CPT-4 codes 99241 – 99243) must document the name and identification number of the referring provider in the <i>Name of Referring Provider or Other Source</i> (Box 17) and <i>NPI</i> (Box 17B) fields on the <i>CMS-1500</i> claim.</p>
Out-of-Office Calls	<p>Out-of-office calls (CPT-4 code 99056) require a justification letter – either an original or a copy – attached to the <i>CMS-1500</i>. The letter must include the following:</p> <ul style="list-style-type: none"> • Patient’s name from the claim • Unusual circumstances, specifically detailed, that prevented an office visit (for example, the patient is bedridden or non-ambulatory) • Signature of one of the following: physician, nursing home administrator, patient’s guardian or relative, or the patient <p>CPT-4 code 99056 must be billed as a concurrently supplied professional service or procedure (CPT-4 codes 92002, 92004, 92012, 92014, 92310 – 92312, 99201 – 99215 and 92499) or the claim will be denied. This service cannot be billed for dispensing eye appliances.</p>
Modifiers	<p>Appropriate modifier(s) may be required when billing ophthalmological services and eye appliances. Refer to the <i>Modifiers Used With Vision Care Procedure Codes</i> section in this manual for a list of required or allowable modifiers and their corresponding procedure codes.</p>
Closure of Lacrimal Punctum	<p>For CPT-4 code 68761 (closure of the lacrimal punctum, by plug, each), use modifier SC (medically necessary service/supply) to indicate use of temporary collagen punctal plugs. Modifiers E1 (upper left, eyelid), E2 (lower left, eyelid), E3 (upper right, eyelid) and E4 (lower right, eyelid) are billed to indicate use of permanent silicone punctal plugs. When billing with multiple modifiers (E1 to E4), each procedure code/modifier combination must be billed on a separate claim line with a maximum quantity of “1.”</p> <p>Note: CPT-4 code 68761 billed with modifier SC is not reimbursable when billed with any other surgical modifier (E1 to E4) by the same provider, for the same recipient on the same date of service.</p>

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10

Removal of Foreign Body, External Eye	For CPT-4 codes 65210 (removal of foreign body, external eye, conjunctival embedded), 67820 (correction of trichiasis) and 67938 (removal of foreign body, eyelid), modifiers 22 (unusual procedural services) and 54 (surgical care only) are allowable modifiers but are not required for reimbursement.
Contact Lens Evaluation	For CPT codes 92310 – 92312 (contact lens evaluation) use either modifier 22 or SC.
Corneal Pachymetry	CPT-4 code 76514 is payable only once-in-a-lifetime when billed with the glaucoma-related diagnosis codes indicated in the <i>Professional Services: Diagnosis Code</i> section in this manual.
Corneal Pachymetry	CPT-4 code 76514 is payable only once-in-a-lifetime when billed with the glaucoma-related diagnosis codes indicated in the <i>Professional Services: Diagnosis Code</i> section in this manual.

Diagnosis Codes

The following CPT-4 codes require an ICD-9-CM code in the *Diagnosis or Nature of Illness or Injury* field (Box 21) of the *CMS-1500* claim form for payment. Failure to supply a valid ICD-9-CM code will result in denial of the claim.

<u>CPT-4 Code</u>	<u>Description</u>
65205	Removal of foreign body, external eye, conjunctival superficial
65210	Removal of foreign body, external eye, conjunctival embedded
65220	Removal of foreign body, corneal, without slit lamp
65222	Removal of foreign body, corneal, with slit lamp
67820	Correction of trichiasis
67938	Removal of foreign body, eyelid
68761	Closure of lacrimal punctum
68801	Dilation of lacrimal punctum
92020	Gonioscopy
92025	Computerized corneal topography
92081 – 92083	Visual field examination
92100	Serial tonometry
92132 – 92134	Scanning computerized ophthalmic imaging
92225	Extended ophthalmoscopy
92227	Remote imaging
92228	Remote imaging for monitoring and management
92250	Fundus photography

Note: Medi-Cal only accepts the first two ICD-9-CM diagnosis codes in the *Diagnosis or Nature of Illness or Injury* field (Box 21) of the *CMS-1500* claim. Therefore, a separate claim form may be required when billing multiple procedures that require different diagnosis codes on the same date of service.

Medical Justification

The following CPT-4 codes require medical justification, which must include, but is not limited to, the patient's diagnosis and associated symptoms, a short explanation of why the visit was necessary, a summary of services performed and the outcome, and a statement of the treatment plan that indicates whether a referral was made.

<u>CPT-4 Code</u>	<u>Description</u>
65210	Removal of foreign body, external eye; conjunctival embedded
67938	Removal of embedded foreign body, eyelid
68761	Closure of the lacrimal punctum
68801	Dilation of the lacrimal punctum
76514	Corneal pachymetry
92025	Computerized corneal topography
92100	Serial tonometry
92310 – 92312	Contact lens evaluations
92499	Unlisted ophthalmological service or procedure
99205, 99215	Evaluation and Management *
99506	Out-of-Office call *

* For optometrists only.

Additional Documentation

In addition to documenting thoroughly in the medical record, providers may be required to submit documentation with the claim indicating the reason additional benefits are warranted when frequency limits are exceeded for all ophthalmological services.

When multiple procedure codes in the range of CPT-4 codes 92020 – 92287 are billed on the same date of service, additional documentation may be required to determine appropriateness of service.

Specific Documentation Requirements

Listed below are specific documentation requirements for the procedure:

Removal of Foreign Body
External Eye

The following documentation must be included with claims for CPT-4 code 65210:

- Complaints of foreign body sensation, irritation or pain
- Description of embedded foreign body removed from patient's eye
- Statement of the treatment plan, including but not limited to, medications prescribed, technique used, follow-up schedule, and whether a referral was made.
- If additional benefits are warranted, a statement indicating why additional benefits are medically necessary for the patient.

Removal of Foreign Body
Eyelid

The following documentation must be included with claims for CPT-4 code 67938 (removal of foreign body, eyelid):

- Complaints of foreign body sensation, irritation or pain
- Description of embedded foreign body removed from patient's eye
- Statement of the treatment plan, including but not limited to, medications prescribed, technique used, follow-up schedule, and whether a referral was made
- If additional benefits are warranted, a statement indicating why additional benefits are medically necessary for the patient

Closure of Lacrimal Punctum	<p>The following documentation must be included with claims for CPT-4 code 68761 (closure of lacrimal punctum, by plug, each):</p> <ul style="list-style-type: none">• Complaints from patients of one of the following symptoms: scratchy, sandy, foreign body sensation, itching, excessive mucous secretion, burning sensation, photosensitivity, redness, and pain• Results of Shirmer test or Tear Breakup Time (TBUT) test or equivalent• Whether artificial tears or lubricating eye drops were used and their effectiveness in reducing patient's symptoms prior to billing this code• Whether temporary collagen punctal plugs were used and their effectiveness in reducing patient's symptoms prior to billing this code (68761 with modifiers -E1 through -E4). Refer to <i>Modifiers Used With Vision Care Procedure Codes</i> section in this manual for additional information.
Closure of Lacrimal Punctum More Than Once Per Lifetime	<p>The documentation of additional services (CPT-4 code 68761 billed more than once per lifetime, same recipient, same provider) must include one of the following circumstances:</p> <ul style="list-style-type: none">• Lost punctal plugs due to spontaneous extrusion or• Complaints of local discomfort at the plug site or excessive tearing resulting in removal of the plug and• Documentation that punctal plugs of different size, brand, and/or material were used as replacement.
Dilation of Lacrimal Punctum	<p>The following documentation must be included with claims for CPT-4 code 68801 (dilation of lacrimal punctum):</p> <ul style="list-style-type: none">• Medical record documentation should indicate that before these procedures were performed an adequate lacrimal work-up and non-invasive evaluation was completed. Such an evaluation should include at minimum the following:<ul style="list-style-type: none">– Consideration by history and physical examination (including slit lamp) of likely pre-punctal and/or non-obstructive causes for epiphora, such as disturbances of ocular surface tear flow by lid malposition, allergy, dry eye or blepharitis– Non-invasive testing to diagnose punctal or post-punctal obstruction and to identify the site and degree of obstruction, such as by using dye disappearance testing when appropriate– Initiation of appropriate treatment

- The medical record must contain a clear procedure note, documenting the anesthesia, dilation, probing and irrigation procedures. It must indicate the results, such as the likely site(s) of obstruction and whether and to what degree patency has been confirmed/established, or persistent obstruction remains.
- If additional benefits are warranted, a statement indicating why additional benefits are medically necessary for the patient.

Computerized Corneal Topography

Computerized corneal topography (CPT-4 code 92025) is reimbursable to optometrists within their scope of practice. It requires medical review.

When billing for code 92025, providers must document in the *Additional Claim Information* field (Box 19) of the claim or on an attachment that the service was performed according to one of the following criteria:

- Pre- or post-operatively for corneal transplant (codes 65710, 65730, 65750, 65755 and 65756)
- Pre- or post-operatively prior to cataract surgery due to irregular corneal curvature or irregular astigmatism
- In the treatment of irregular astigmatism as a result of corneal disease or trauma
- To assist in the fitting of contact lenses for patients with corneal disease or trauma (ICD-9-CM diagnosis codes 371 – 371.9)
- To assist in defining further treatment

This procedure is not covered under the following conditions:

- When performed pre- or post-operatively for non-Medi-Cal covered refractive surgery procedures such as codes 65760 (kerato mileusis), 65765 (keratophakia), 65767 (epikeratoplasty), 65771 (radial keratotomy), 65772 (corneal relaxing incision) and 65775 (corneal wedge resection)
- When performed for routine screening purposes in the absence of associated signs, symptoms, illness or injury

Billing Restrictions

When billing CPT-4 code 92025, providers must follow split-billing procedures. When billing for both the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC.

Note: Do not bill modifier 99 with split-billable codes. The claim will be denied.

Serial Tonometry

Serial tonometry (CPT-4 code 92100) is indicated for the following conditions:

- To guide treatment during the course of acute care for symptomatic or potentially dangerous elevations of intraocular pressure, for example, acute angle-closure glaucoma
- When used to assess diurnal variations of intraocular pressure in the evaluation of established glaucoma
- To establish or exclude glaucoma in patients with optic nerve damage or other signs/symptoms of glaucoma without documented elevation of intraocular pressure

The following documentation must be included with claims for CPT-4 code 92100:

- Intraocular pressure measurements (in mmHg) for either eye, measured at a minimum of three different times during the day, and the times the measurements were performed

Note: CPT-4 code 92100 is a covered service only if performed serially (not as a one-time measurement, which would be included in the general comprehensive eye examination service). A one-time measurement of intraocular pressure is not separately reimbursable.

Reasons for denial:

- When services are not medically necessary and reasonable
- When performed as a screening process
- Measurements of intraocular pressure by one or more methods during the course of an Evaluation and Management (E&M) service are included in the allowance for the E&M code, and are not separately reimbursable as code 92100
- Confirmatory measurement of a particular finding with the same or different tonometers, or with different personnel, does not constitute serial tonometry
- Bilateral tonometry is not serial tonometry

Extended Ophthalmoscopy

The following documentation regarding extended ophthalmoscopy (CPT-4 code 92225) services must be maintained in the recipient's medical record.

Note: CPT-4 codes 92225 and 92250 cannot be billed for the patient on the same date of service.

- The technique used and a drawing of the retina showing anatomy in the patient as seen at the time of the examination, including the pathology that was found

Note: The slit lamp examination, including Hruby lens, hand held lens and contact lens examinations of macula, indirect, as well as direct ophthalmoscopy for fundus examination are part of the E&M service. These services are not reimbursed separately and should not be billed in addition to the E&M service.

- Another diagnostic technique in addition to routine direct and indirect ophthalmoscopy is necessary and documented (for example, 360 degree scleral depression, fundus contact lens or 90-diopter lens)
- Preprinted diagrams of the retina are not an acceptable alternative
- A legible narrative report of the findings

The following major criteria must be met:

- Extended ophthalmoscopy is considered to be a reasonable and necessary service for evaluation of tumors of the retina and choroid (the tumor may be too peripheral for an accurate photograph), retinal tears, detachments, hemorrhages, exudative detachments and retinal defects without detachment, as well as other ocular defects. These codes are reserved for the meticulous evaluation of the eye and detailed documentation of a severe ophthalmologic problem when photography is not adequate or appropriate.
- Frequency for providing these services depends upon the medical necessity in each patient and this relates to the diagnosis. A serious retinal condition must exist, or be suspected, based on routine ophthalmoscopy, which requires further detailed study.
- In all instances, extended ophthalmoscopy must be medically necessary. It must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. It is not medically necessary, for example, to confirm information already available by other means.

- A serious retinal condition is present based on ophthalmoscopy, which requires further study, such as the detailed study of pre-retinal membrane, a retinal tear detachment, a suspected retinal tear with sudden onset of symptomatic floaters or vitreous hemorrhage.

Extended ophthalmoscopy may be medically justified for the following conditions:

- The patient has a malignant neoplasm of the retina or choroids. This may appear as a single, round or oval, slightly elevated, gray or nonpigmented lesion.
- The patient has a retained (old) intraocular foreign body, either magnetic or nonmagnetic. Signs and symptoms may include a statement by the patient that something has hit his/her eye (foreign body sensation), normal or blurred vision, pain or no discomfort, and tearing.
- The patient has retinal hemorrhage, edema, ischemia, exudates and deposits, hereditary retinal dystrophies or peripheral retinal degeneration.
- The patient has retinal detachment with or without retinal defect. The patient may complain of light flashes, dark floating specks, and blurred vision that becomes progressively worse. The patient may describe this as “a curtain came down over my eyes.”
- The patient has symptoms suggestive of retinal defect (for example, flashes and/or floaters).
- The patient has retinal defects without retinal detachment.
- The patient has diabetic retinopathy (for example, background retinopathy or proliferative retinopathy), retinal vascular occlusion, or separation of the retinal layers. This may be evidenced by microaneurysms, cotton wool spots, exudates, hemorrhages, or fibrous proliferation.
- The patient has experienced sudden visual loss or transient visual loss. This may be described as “trouble seeing or vision going in and out.”
- The patient has chorioretinitis, chorioretinal scars or choroidal degeneration, dystrophies, hemorrhage and rupture, or detachment.
- The patient has sustained a penetrating wound to the orbit, resulting in the retention of a foreign body in the eye.
- The patient has sustained a blunt injury to the eye or pariorbita.

- The patient has disorders of the vitreous body (for example, vitreous hemorrhage or posterior vitreous detachment). Spots before the eyes (floaters) and flashing lights (photopsia) can be signs/symptoms of these disorders.
- The patient has posterior scleritis. Signs and symptoms may include severe pain and inflammation, proptosis, limited ocular movements, and a loss of a portion of the visual field.
- The patient has Vogt-Koyanagi syndrome. This disease is characterized by bilateral uveitis, dysacusia, meningeal irritation, whitening of patches of hair (poliosis), vitiligo, and retinal detachment. The disease can be initiated by a severe headache, deep orbital pain, vertigo, and nausea.
- The patient has degenerative disorders of the globe.
- The patient has retinoschisis and retinal cysts. Patients may complain of light flashes and floaters.
- The patient has signs and symptoms of endophthalmitis, which may include severe pain, redness, photophobia, and profound loss of vision.
- The patient has glaucoma or is a glaucoma suspect. This may be evidenced by increased intraocular pressure or progressive cupping of the optic nerve.
- Systemic disorders which may be associated with retinal pathology.
- High axial length myopia.
- Retinal edema.
- Metamorphopsia.
- High-risk medication for retinopathy or optic neuropathy.
- Choroidal nevus being evaluated for malignant transformation.

Fundus Photography

The following documentation regarding fundus photography (CPT-4 code 92250) services must be maintained in the recipient's medical record:

- Documentation indicating the condition being photographed and whether the condition is progressive or stable.
- If prognosis is stable, there must be documentation stating why the procedure was medically necessary.
- If prognosis is progressive, indicate the treatment and follow-up plan, and whether a referral was indicated.
- If additional services are warranted, a statement indicating why additional benefits are medically necessary for the patient.

Note: CPT-4 codes 92225 and 92250 cannot be billed for the patient on the same date of service.

Unilateral

The eye procedure code CPT-4 92225 is considered a unilateral service.

<u>CPT-4 Code</u>	<u>Description</u>
92225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment melanoma), with interpretation and report: initial

When performed on one eye, this procedure must be billed with a quantity of "1" and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, this procedure must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "2."

Bilateral

These CPT-4 90000 series of codes for eye procedures are considered bilateral services. Therefore, a code should be billed only once, regardless of whether one or both eyes were involved. However, in the case of eye surgeries, this does not apply, and the appropriate code should be used to specify whether the procedure was unilateral or bilateral.

When performed as a bilateral procedure, claims must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1" for CPT-4 codes 92132 – 92134, 92227 and 92228. The allowed service is one per day, whether it is unilateral or bilateral. No documentation is required for the CPT-4 codes listed above.

CPT-4 Code	Description
* 92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
* 92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
* 92134	retina
92227	Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
* 92228	Remote imaging for monitoring and maintenance of active retinal disease (e.g., diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral
*	This code is split-billable. When billing for <u>both</u> the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC.

When performed on one eye, these procedures must be billed with a quantity of "1" and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, these procedures must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "1."

CPT-4 codes 92227 and 92228 are not reimbursable for the same recipient on the same date of service by any provider in conjunction with codes 92002 – 92014, 92133, 92134, 92227/92228, 92250 or E&M codes 99201 – 99350.

Prescription for Ophthalmic Eyewear Form (DHS 6086) for Dispensing Providers

Although not mandatory, providers prescribing eyewear to be dispensed by other providers should use the *Prescription for Ophthalmic Eyewear* form (see *Figure 1*) to supply the dispensing provider with the basic information needed to bill Medi-Cal. (Do not send the dispensing provider a *CMS-1500* claim form.) These prescriptions are bound 50 to a pad and can be ordered from the DHCS FI by using the *Provider Forms Reorder Request for Vision Care*. See the *Forms Reorder Request: Vision Care* section in this manual.

PRESCRIPTION FOR OPHTHALMIC EYEWEAR				Department of Health Services			
State of California – Health and Welfare Agency							
Patient's Name:						P.D.	
PRIOR RX	Far RX R	VA Old RX	VA No RX	NEW RX	Far RX R	Corr. VA	
	L				L		
ADD	Near RX R			ADD	Near RX R		
	L				L		
<input type="checkbox"/> Glass <input type="checkbox"/> Plastic <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Contact Lenses				<input type="checkbox"/> Glass <input type="checkbox"/> Plastic <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Contact Lenses			
<input type="checkbox"/> 367.0 Hyperopia <input type="checkbox"/> 367.1 Myopia <input type="checkbox"/> 367.2 Astigmatism <input type="checkbox"/> 367.31 Anisometropia <input type="checkbox"/> 367.4 Presbyopia <input type="checkbox"/> 379.31 Aphakia <input type="checkbox"/> 378 Disorder of binocular eye movement requiring prism <input type="checkbox"/> Other ADDITIONAL INSTRUCTIONS				Provider's/Examiner's Name type, print or stamp State License Number			
Signature				<input type="checkbox"/> M.D. <input type="checkbox"/> O.D.		Date of Refraction:	

NOTE — This form is intended to assist practitioners and patients when ophthalmic services have been or are to be provided under a state or federal program and the eyewear are supplied by different providers of services. It is not a purchase order and does not guarantee payment for any services or material supplied.

DHS 6086

Figure 1. Prescription for Ophthalmic Eyewear Form (DHS 6086).