

Billing and Coding Guidelines

Contractor Name

Wisconsin Physicians Service Insurance Corporation

Title

Billing and Coding Guidelines for Ophthalmic Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography). OPTH-855

Original Determination Effective Date:

07/16/2012

Revision Effective Date

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CMS National Coverage

Text

The information in this document contains coding or other guidelines that complement the Local Coverage Determination for Ophthalmic Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography).

Coding Guidelines:

General Guidelines for claims submitted to carriers or intermediaries or Part A or Part B MAC:

1. Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.
2. For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.
3. The diagnosis code(s) must best describe the patient's condition for which the service was performed. For diagnostic tests, report the result of the test if known; otherwise the symptoms prompting the performance of the test should be reported.
4. Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines
An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, for complete instructions.

For claims submitted to the carrier or Part B MAC:

All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim.

Extended Ophthalmoscopy

1. Codes 92225 and 92226 are unilateral codes and must be submitted with a site modifier (LT, RT or 50). A claim without the appropriate modifier (RT, LT or 50) will be returned as incomplete. Each service must be billed with an NOS of 001, even if performed bilaterally and billed with a modifier 50.
2. An initial ophthalmoscopy (CPT code 92225) and a subsequent ophthalmoscopy (CPT code 92226) will not be reimbursed on the same day for the same eye by the same provider. If an initial ophthalmoscopy (CPT code 92225) and a subsequent ophthalmoscopy (CPT code 92226) are performed on different eyes modifier RT and LT should be reported to indicate that the services were performed on different eyes.
3. Extended ophthalmoscopy is classified as a professional service. The use of professional or technical component modifiers (26, TC), with these codes, is not appropriate.
4. Code 92225 is payable with ophthalmological examination codes 92002, 92004, 92012 and 92014. Code 92226 is payable only with exam codes 92012 and 92014.
5. If extended ophthalmoscopy is performed during a global surgery period, unrelated to the condition for which the surgery was performed (same provider), then the extended ophthalmoscopy should be coded with a modifier 79 attached (in addition to the appropriate site modifier).
6. The initial extended ophthalmoscopy code (92225) may be billed if the patient has had extended ophthalmoscopy (of the same eye) by the same physician/physician group within the last three (3) years.
7. Indirect ophthalmoscopy done without a drawing may not be billed separately and is part of a general ophthalmologic exam (92002-92014).
8. Acceptable places of service are office (11), assisted living facility (13), urgent care (20), inpatient hospital (21), outpatient hospital (22), emergency room (23), and skilled nursing facility (31), nursing facility (32), custodial care facility (33), and independent clinic (49).

Fundus Photography

1. CPT codes 92250 and 92228 describe services that are performed bilaterally. Modifier 50 is never appropriate with these codes. Modifiers LT and RT should only be used if a unilateral service is performed.
2. CPT codes 92250 and 92228 are global services, which include a professional and a technical component. The components should be reported with modifiers 26 or TC as appropriate, if the entire global service is not performed.
3. CPT code 92227 (Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral) is considered screening and will be denied as non-covered. Claims for this service should be submitted with modifier GY.
4. Acceptable places of service for the global service are office (11), assisted living facility (13), urgent care (20), nursing facility for patients in a Part B stay (32), and independent clinic (49).

5. The technical component may be billed in office (11), assisted living facility (13), urgent care (20), nursing facility for patients in a Part B stay (32), independent clinic (49), federally qualified health center (50), and rural health clinic (72).
6. The professional component may be billed in office (11), assisted living facility (13), urgent care (20), inpatient hospital (21), outpatient hospital (22), skilled nursing facility for patients in a Part A stay (31), nursing facility for patients in a Part B stay (32) and independent clinic (49).

For claims submitted to the fiscal intermediary or Part A MAC:

Hospital Inpatient Claims:

1. The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. The principal diagnosis is the condition established after study to be chiefly responsible for this admission.
2. The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.
3. For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

1. The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).
2. The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.
3. For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.

Date Published

06/01/2012

Revision History Number

06/01/2012: This document is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12

Adaptation of NGS article A44439 - Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography).

Notes:

Italicized lettering (font) indicates CMS wording

* An asterisk indicates most recent publishing or revision

NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.