Priority Health	BILLING POLICY No. 057
OPHTHALMOLOGY AND VISION	
Date of origin: Nov. 12, 2024	**Review dates: 2/2025, 2/2026**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

This policy outlines proper billing and coding for ophthalmology and vision services.

An ophthalmologist is a medical doctor who can diagnose and treat all diseases, perform eye surgery, and correct vision problems with glasses and contacts.

An optometrist isn't a medical doctor but receives a doctor in optometry. An optometrist can perform eye examinations, detect certain eye abnormalities, and prescribe corrective lenses.

MEDICAL POLICY

- Vision Care (#91538)
- Refractive Keratoplasty/LASIK (#91529)

Get information on Priority Health medical policies in our Provider Manual.

Get specific information in our Provider Manual on routine vision, Medicaid vision, medical vision, Medicare vision, cataract surgery and optometrist scope of service.

For Medicare
For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) is required. Get additional details on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

For Medicare and Medicaid, routine eye exams, retinal imaging, and refraction are administered through EyeMed. See our Provider Manual for details.

General ophthalmological services

92002-92004 (new patient)
92012-92014 (established patient)

- Shouldn't be billed for "routine eye exams"
- Categorized by new, established, intermediate and comprehensive
- Intermediate services include (see CPT for complete listing)
    - External ocular/adnexal examination
    - General medical observation
    - History
    - Biomicroscopy
    - Mydriasis
    - Ophthalmoscopy
    - Tonometry

- Comprehensive services include (See CPT for complete listing)
    - Basic sensorimotor exam
    - Biomicroscopy
    - Dilation
    - External exam
    - General medical observation
    - Gross visual fields
    - History
    - Initiation of diagnostic/treatment program(s)
    - Mydriasis
    - Ophthalmoscopy exam
    - Other diagnostic procedures
    - Prescription medication
    - Tonometry
- Shouldn't be reported in addition to other evaluation and management (E/M) codes (e.g., 99201-99215). The E/M service codes include general ophthalmological services.

Routine ophthalmological exam including refraction

Find additional information in our Provider Manual. See Priority Health Vision Care medical policy (#91538) for information for Priority Health Medicaid and Medicare

- **S0620**: New Patient
- **S0621**: Established Patient

Visual field examination (92081-92083)

- Different methods of this procedure include a tangent screen, Goldmann perimeter, and computerized automated perimeters.
- CPT code description is unilateral or bilateral
- Taped and un-taped visual field testing is considered one unit of service
- Gross visual field testing is inclusive, not reported separately

Modifiers

- **26**: Professional component
- **TC**: Technical component
- **Global service** (no modifiers)

Place of service

- 11 – Office
- 32 – Nursing Facility
- 49 – Independent Clinic
- Technical component (TC modifier)
    - 11 – Office
    - 32 – Nursing Facility
    - 49 – Independent Clinic
    - 50 – Federally Qualified Health Center
    - 72 – Rural Health Clinic
- Professional component (26 modifier)
    - 11 – Office
    - 19 – Off-campus Outpatient Hospital
    - 21 – Inpatient Hospital
    - 22 – On-Campus Outpatient Hospital
    - 22 – Emergency Room
    - 23 – Skilled Nursing Facility
    - 32 – Nursing Facility

- 49 – Independent Clinic
- 62 – Comprehensive Outpatient Rehab Facility

Documentation requirements

- Medical reason for the test
- Assessment of reliability
- Any changes from prior and current visual fields
- Impression

Extended ophthalmoscopy (92201-92202)

This service may be performed by the physician when a more detailed exam including periphery is needed, following routine ophthalmoscopy.

- Included in posterior segment surgical procedures if performed during the operative procedure or post-operatively on the same DOS.

Documentation requirements

- Supporting documentation of medical necessity
- Retinal drawings which include
- A detailed sketch of 3-4 inches
- All items noted must be identified and labeled (see LCA A56726 for a complete listing)
- Whether the pupil was dilated, and which drug was used
- All findings and a plan of action

Fundus photography

See our Fundus photography billing policy for details.

Scanning computerized ophthalmic diagnostic imaging (SCODI)

See our SCODI billing policy for details.

Glaucoma screenings

G0117: Glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist

G0118: Glaucoma screening for high-risk patient furnished under the direct supervision of an optometrist or ophthalmologist

This service includes:

- A dilated eye examination with an intraocular pressure measurement
- A direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination
- This service is allowed 1x annually

Type of bill:

- 13x
- 22x
- 23x
- 71x
- 73x
- 75x
- 85x

Revenue codes:

- 0520 for RHC, FQHC

- 0521 for RHC, FQHC
- 0700
- 096x
- 097x
- 098x

Cataracts
See our Provider Manual for more information on cataract surgery here and here.

Modifiers

- RT – right side
- LT – Left side
- 50 – Bilateral
- 78 – Unplanned return to the operating/procedure room by the same physician or other qualified health professional following initial procedure for a related procedure during the postoperative period
- 79 – Unrelated procedure or service by the same physician during the postoperative period.

Refractive lenses
When an item meets the medical condition criteria described in the vision care medical policy, the below criteria may apply:

- Vision Care (#92310) – Contact lens fitting and adaptation; Modifier 52, if done on one eye

Place of service
Review specific information regarding DME place of service billing requirements in our Durable Medical Equipment (DME) place of services (POS) billing policy.

Documentation requirements
We align with the Centers for Medicare & Medicaid Services (CMS) standard documentation requirements for supplies and DME. Reference CMS Article A55426 – Standard Documentation Requirements for All Claims Submitted to DME MACs for documentation requirements.

Modifiers

- **KX**: Requirements specified in the medical policy have been met
- **GA**: Pre-service notice of non-coverage was provided by the plan
- **GY**: No pre-service determination was made
- **GZ**: Service is not covered by Medicare

Intravitreal injections
A procedure to inject medication directly into the vitreous cavity. Most common conditions treated are age-related macular degeneration, diabetic retinopathy, and retinal vein occlusion.

See the Priority Health medical benefit drugs list for specific indications.

- **67028**: Intravitreal injection of pharmacologic agent (separate procedure)
- **J3490**: Unclassified drugs
- **J7999**: Compounded drug, not otherwise classified
- **C9257**: Injection, bevacizumab, 0.25 mg
    - Reported in an ambulatory surgical center (ASC) setting

When an unlisted drug code is billed, the following must be on the claim:

- Name of drug
- NDC

- Dosage

Get more information in our Provider Manual.

Modifiers

- RT – Right side
- LT – Left side
- 50 - Bilateral

Place of service

Unless outlined above, coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. This documentation includes, but isn't limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

- **LT**: Left side (used to identify procedures performed on the left side of the body)
- **RT**: Right side (used to identify procedures performed on the right side of the body)
- **50**: Bilateral procedure
- **54**: Surgical care only
- **55**: Postoperative management only
- **56**: Preoperative management only
- **26**: Professional component
- **TC**: Technical component
- **78**: Unplanned return to the operating/procedure room by the same physician or other qualified health professional following initial procedure for a related procedure during the postoperative period
- **79**: Unrelated procedure or service by the same physician during the postoperative period.
- **GA**: Pre-service notice of non-coverage was provided by the plan
- **GY**: No pre-service determination was made
- **GZ**: Service is not covered by Medicare
- **KX**: Requirements specified in the medical policy have been met

Find additional information on global surgery modifiers from CMS.

Find additional information on GA, GY and GZ, Medicare non-coverage in our Provider Manual.

REFERENCES

- Medicare NCCI 2023 Coding Policy Manual – Chapter 11 (CMS)
- MLN907165 – Medicare Vision Services (CMS)
- What Is an Ophthalmologist vs Optometrist? (America Academy of Ophthalmology)
- Billing and Coding: Visual Fields – A57483 (CMS)
- Intravitreal Injections – Patients (The American Society of Retina Specialists)
- Billing and Coding: Bevacizumab and biosimilars – A52370 (CMS)
- Billing and Coding: Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) – A56726 (CMS)

- Medicare Claims Processing Manual – Section 70 (glaucoma screening) (CMS)
- Refractive Lenses - Policy Article – A52499 (CMS)

RELATED POLICIES

- Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) billing policy

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section
Feb. 23, 2026	Reviewed, no changes