

OPHTHALMOLOGY AND VISION

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Review dates: None yet recorded

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 problem 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 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](#)
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CHANGE / REVIEW HISTORY

Date	Revisions made