

# Local Coverage Article: Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) – Supplemental Instructions Article (A52398)

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## Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
<a href="#">CGS Administrators, LLC</a>	MAC - Part A	15101 - MAC A	N/A	Kentucky
<a href="#">CGS Administrators, LLC</a>	MAC - Part B	15102 - MAC B	N/A	Kentucky
<a href="#">CGS Administrators, LLC</a>	MAC - Part A	15201 - MAC A	N/A	Ohio
<a href="#">CGS Administrators, LLC</a>	MAC - Part B	15202 - MAC B	N/A	Ohio

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## Article Information

### General Information

**Article ID**  
A52398

**Original Article Effective Date**  
10/01/2015

Original ICD-9 Article ID  
[A50832](#)

**Revision Effective Date**  
N/A

**Article Title**  
Ophthalmology: Posterior Segment Imaging (Extended  
Ophthalmoscopy and Fundus Photography) –  
Supplemental Instructions Article

**Revision Ending Date**  
N/A

**Retirement Date**  
N/A

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## Article Guidance

### Article Text:

The information in this Supplemental Instructions Article (SIA) contains coding or other guidelines that complement the Local Coverage Determination for Ophthalmic Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography). The LCD can be accessed through our contractor Web site at [www.cgsmedicare.com](http://www.cgsmedicare.com). It can also be found on the Medicare Coverage Database at [www.cms.gov/mcd](http://www.cms.gov/mcd).

### Coding Guidelines:

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

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.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

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.

#### 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.

Effective from April 1, 2010, non-covered services should be billed with modifier -GA, -GX, -GY, or -GZ, as appropriate.

The -GA modifier ("Waiver of Liability Statement Issued as Required by Payer Policy") should be used when physicians, practitioners, or suppliers want to indicate that they anticipate that Medicare will deny a specific service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. Modifier GA applies only when services will be denied under reasonable and necessary provisions, sections 1862(a)(1), 1862(a)(9), 1879(e), or 1879(g) of the Social Security Act. Effective April 1, 2010, Part A MAC systems will automatically deny services billed with modifier GA. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Part A MAC, occurrence code 32 and the date of the ABN is required.

Modifier GX ("Notice of Liability Issued, Voluntary Under Payer Policy") should be used when the beneficiary has signed an ABN, and a denial is anticipated based on provisions *other* than medical necessity, such as statutory exclusions of coverage or technical issues. An ABN is not required for these denials, but if non-covered services are reported with modifier GX, Part A MAC systems will automatically deny the services.

The -GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier. An ABN is not required for these denials, and the limitation of liability does not apply for beneficiaries. Services with modifier GY will automatically deny.

## **For claims submitted to the 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

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.

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.

Extended ophthalmoscopy is classified as a professional service. The use of professional or technical component modifiers (26, TC), with these codes, is not appropriate.

Code 92225 is payable with ophthalmological examination codes 92002, 92004, 92012 and 92014. Code 92226 is payable only with exam codes 92012 and 92014.

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).

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.

Indirect ophthalmoscopy done without a drawing may not be billed separately and is part of a general ophthalmologic exam (92002-92014).

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

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.

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.

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.

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).

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).

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 Part A MAC:**

### Hospital Inpatient Claims:

- 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.*

- *The hospital enters ICD-10-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.*
- 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:

- *The hospital should report the full ICD-10-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-10-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (Z00.00-Z13.9).*
- *The hospital enters the full ICD-10-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

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. [Back to Top](#)

## Coding Information

### **Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

<b>Bill Type Code</b>	<b>Bill Type Description</b>
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
021x	Skilled Nursing - Inpatient (Including Medicare Part A)
071x	Clinic - Rural Health
073x	Clinic - Freestanding
077x	Clinic - Federally Qualified Health Center (FQHC)
085x	Critical Access Hospital

### **Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

<b>Revenue Code</b>	<b>Revenue Code Description</b>
0409	Other Imaging Services - Other Imaging Services
0450	Emergency Room - General Classification
051X	Clinic - General Classification
052X	Freestanding Clinic - General Classification
0962	Professional Fees - Ophthalmology

**CPT/HCPCS Codes**  
**Group 1 Paragraph:** N/A

**Group 1 Codes:**

<b>Group 1 CPT/HCPCS Code</b>	<b>Group 1 CPT/HCPCS Code Description</b>
92225	OPHTHALMOSCOPY, EXTENDED, WITH RETINAL DRAWING (EG, FOR RETINAL DETACHMENT, MELANOMA), WITH INTERPRETATION AND REPORT; INITIAL
92226	OPHTHALMOSCOPY, EXTENDED, WITH RETINAL DRAWING (EG, FOR RETINAL DETACHMENT, MELANOMA), WITH INTERPRETATION AND REPORT; SUBSEQUENT
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
92228	REMOTE IMAGING FOR MONITORING AND MANAGEMENT OF ACTIVE RETINAL DISEASE (EG, DIABETIC RETINOPATHY) WITH PHYSICIAN REVIEW, INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL
92250	FUNDUS PHOTOGRAPHY WITH INTERPRETATION AND REPORT

**ICD-10 Codes that are Covered** N/A

**ICD-10 Codes that are Not Covered** N/A

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## **Revision History Information**

N/A [Back to Top](#) **Related Local Coverage Document(s)** N/A

**Related National Coverage Document(s)** N/A

**Statutory Requirements URL(s)** N/A

**Rules and Regulations URL(s)** N/A

**CMS Manual Explanations URL(s)** N/A

**Other URL(s)** N/A

**Public Version(s)** Updated on 06/16/2015 with effective dates 10/01/2015 - N/A [Back to Top](#)

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## **Keywords**

N/A Read the [Article Disclaimer](#) [Back to Top](#)