
Professional Services

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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-10-CM diagnosis code on the claim for payment.

General Information

Claims 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® codes: 68761, 92002 thru 92060, 92071 thru 92284, 92310 thru 92353, 92370, 92371 and 92499

HCPCS codes: S0500, S0512, S0514, S0516, V2020 thru V2499, V2500, V2501, V2510, V2511, V2513 thru V2521, V2523, V2531, V2599, V2600 thru V2615, V2623 thru V2629, V2702 thru V2718, V2744 thru V2755, V2760 thru V2770, V2781 thru 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 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 code 92015) must be separately reported when billed in conjunction with CPT 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 codes 66840, 66850, 66852, 66920, 66930, 66940 and 66982 thru 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 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 codes 92004 and 92014 must include the appropriate ICD-10-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-10-CM diagnosis codes required with CPT 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 codes ‹‹99202›› thru 99215 ‹‹and 99417››) should not be billed with eye examination codes (CPT 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 code 68761)
- Computerized corneal topography (CPT code 92025)

Contact lens evaluation (CPT codes 92071, 92072 and 92310 thru 92312), including necessary professional follow-up services for a period of six months

Note: CPT codes 92071, 92072 and 92310 thru 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 codes 65435 and 65436)

Corneal pachymetry (CPT code 76514)

Note: Refer to the *Radiology: Diagnosis Ultrasound* section in the appropriate Part 2 manual for ICD-10-CM diagnosis codes to bill in conjunction with code 76514.

- Corneal scraping (CPT code 65430)
- Dilation and irrigation of lacrimal punctum (CPT code 68801)
- Extended ophthalmoscopy of peripheral retina with retinal drawing and scleral depression (CPT code 92201)
- Extended ophthalmoscopy with retinal drawing of optic nerve or macula (CPT code 92202)
- Epilation (CPT code 67820)
- Fundus photography (CPT code 92250)
- Gonioscopy (CPT code 92020)
- Low vision services (billed with CPT code 92499), including evaluation, fitting of low vision devices and six months follow-up care
- Out-of-office call (CPT code 99056)
- Removal of foreign body (CPT codes 65205, 65210, 65220, 65222, 67938)
- Serial tonometry (CPT code 92100)
- Unlisted service or procedure (CPT code 92499)
- Visual field examinations (CPT 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.

«For additional telehealth requirements, providers may refer to the *Medicine: Telehealth* section in Part 2 of the Medi-Cal provider manual»

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 codes:

CPT Code	E&M Description
«99242 and 99243»	Office consultation, new or established patient

When billing these CPT 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 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-10-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 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-10-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 code 92015) is not covered by Medicare and may be billed directly to Medi-Cal.

Refer to the *Medicare Non-Covered Services: CPT® Codes* section in this manual for a list of ICD-10-CM diagnosis codes that may be billed directly to Medi-Cal for CPT 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 California MMIS Fiscal Intermediary 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 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 (prescription of optical and physical characteristics of and fitting of contact lenses, with medical supervision of adaptation; corneal lens for aphakia, one eye) and 92312 (prescription of optical and physical characteristics of and fitting of contact lenses, with medical supervision of adaptation; 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 codes 92071, 92072 and 92310 thru 92312.

Ocular Prosthesis

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

Consultations

«Optometry providers billing office consultations (CPT codes 99242 and 99243) must document the name and identification number of the referring provider in the *Name of Referring Provider or Other Source* (Box 17) and *NPI* (Box 17B) fields on the *CMS-1500* claim.»

Out-of-Office Calls

Out-of-office calls (CPT code 99056) require a justification letter – either an original or a copy – attached to the *CMS-1500*. The letter must include the following:

- 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

CPT-code 99056 must be billed as a concurrently supplied professional service or procedure (CPT codes 92002, 92004, 92012, 92014, 92310 thru 92312, 99202 thru 99215, 99417 and 92499) or the claim will be denied. This service cannot be billed for dispensing eye appliances.

Modifiers

Appropriate modifier(s) may be required when billing ophthalmological services and eye appliances. Refer to the *Modifiers Used With Vision Care Procedure Codes* section in this manual for a list of required or allowable modifiers and their corresponding procedure codes.

Closure of Lacrimal Punctum

For CPT 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."

Note: CPT 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.

Removal of Foreign Body, External Eye

For CPT 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 thru 92312 (contact lens evaluation) use either modifier 22 or SC.

Corneal Pachymetry

CPT code 76514 is payable only once-in-a-lifetime when billed with the glaucoma-related diagnosis codes indicated in the *Professional Services: Diagnosis Code* section in this manual.

Diagnosis Codes

The following CPT codes require an ICD-10-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-10-CM code will result in denial of the claim.

CPT Codes Requiring an ICD-10-CM Code

CPT Code	Description
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 thru 92083	Visual field examination
92100	Serial tonometry
92132 thru 92134	Scanning computerized ophthalmic imaging
92201	Extended ophthalmoscopy, with retinal drawing and scleral depression of peripheral retina
92202	Extended ophthalmoscopy, with drawing of optic nerve or macular
92227	«Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral»
92228	«Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral»
92250	Fundus photography

Note: Medi-Cal only accepts the first two ICD-10-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 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.

CPT Codes Requiring a Medical Justification

CPT Code	Description
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 thru 92312	Contact lens evaluations
92499	Unlisted ophthalmological service or procedure
99205, 99215, <<99417>>	Evaluation and Management
99506	Out-of-Office call *

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 codes 92020 thru 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 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 a Foreign Body Eyelid

The following documentation must be included with claims for CPT 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

The following documentation must be included with claims for CPT code 68761 (closure of lacrimal punctum, by plug, each):

- 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 *Modifiers Used With Vision Care Procedure Codes* section in this manual for additional information.

Closure of Lacrimal Punctum More Than Once Per Lifetime

The documentation of additional services (CPT code 68761 billed more than once per lifetime, same recipient, same provider) must include one of the following circumstances:

- 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

The following documentation must be included with claims for CPT code 68801 (dilation of lacrimal punctum):

- 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:
 - 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 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-10-CM diagnosis codes H17.00 thru H18.9)
- 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 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 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 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 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 codes 92201 and 92202) services must be maintained in the recipient's medical record.

Note: Extended ophthalmoscopy (CPT codes 92201 and 92202) cannot bill 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.

Fundus Photography

The following documentation regarding fundus photography (CPT 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 code 92250 cannot be billed in conjunction with codes 92201 or 92202 for the patient by the same provider on the same date of service.

Bilateral

These CPT 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 codes 92132 thru 92134, 92227 and 92228. The allowed service is one per day, whether it is unilateral or bilateral. No documentation is required for the CPT codes listed above.

Bilateral Procedure Codes

CPT 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 ‡	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina
92201	Ophthalmoscopy, extended; with retinal
92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula, with interpretation and report, unilateral or bilateral
92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral
92228 ‡	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral
<<92229	Imaging of retina for detection or monitoring of disease; point-of-care autonomous analysis and report, unilateral or bilateral>>

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 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 thru 92014, 92133, 92134, 92227, 92228, 92250 or E&M codes 99202 thru 99216, 99221 thru 99223, 99227 thru 99240, 99242 thru 99250, 99252 thru 99317, 99319 thru 99323, 99329 thru 99333, 99338, 99341, 99342, 99344 thru 99350 and 99417>>.

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 CA-MMIS 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"/> H27.00 – H27.03 <u>Aphakia</u> <input type="checkbox"/> H49.00 – H51.9 <u>Disorders of binocular eye movement requiring prism</u> <input type="checkbox"/> H52.00 – H52.03 <u>Hypermetropia</u> <input type="checkbox"/> H52.10 – H52.13 <u>Myopia</u> <input type="checkbox"/> H52.201 – H52.229 <u>Astigmatism</u> <input type="checkbox"/> H52.31 <u>Anisometropia</u> <input type="checkbox"/> H52.4 <u>Presbyopia</u> <input type="checkbox"/> Other <input type="checkbox"/>				Provider's/Examiner's Name type, print or stamp State License Number			
ADDITIONAL INSTRUCTIONS <input type="checkbox"/>							
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)

«Legend»

«Symbols used in the document above are explained in the following table.»

Symbol	Description
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	For optometrists only.
‡	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.