

**NHIC**

National Heritage Insurance Company

An EDS Company  
A CMS Contracted Medicare Carrier

# Medicare Part B

## Ophthalmology Optometry Guide

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all health care practitioners  
and managerial members of  
the provider/supplier staff.  
Additional copies are  
available on our web site at:  
[www.medicarenhic.com](http://www.medicarenhic.com)*

**June 2002**

***CMS***  
**CENTERS for MEDICARE & MEDICAID SERVICES**

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## Introduction

National Heritage Insurance Company's Education & Outreach Unit developed this manual to provide you with Medicare Part B information and billing procedures for Ophthalmology/Optometry services.

All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the Centers for Medicare & Medicaid Services (CMS), are revised or implemented. This information manual, in conjunction with the *Medicare B General Office Guide*, *Medicare B Resource* (quarterly provider newsletter), and special program mailings, provides qualified reference resources. Please visit our website at [www.medicarenhic.com](http://www.medicarenhic.com) for the latest information.

Medicare Part B publications frequently contain a reference, such as MCM 2020, which indicates the section number where Medicare Carriers Manual instructions are located or CIM 35-21, which indicates the Coverage Issues Manual that provides the procedures, services or supplies that have national coverage guidelines. This information can be found on the CMS website at [www.hcfa.gov](http://www.hcfa.gov). Information relating to the Social Security Act can be found at [www.ssa.gov](http://www.ssa.gov).

### Physicians Open Door Forums

CMS has launched a series of public listening sessions in Washington and, with the regional offices, around the country to hear and to listen to the various individual suggestions for improvement. For more information, including dates and times of the Forums, visit [www.cms.gov](http://www.cms.gov).

### Medicare Learning Network

The Medicare Learning Network (MedLearn) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals with the proper submission of Medicare claims; ICD-9-CM Coding, Medicare Fraud and Abuse, and Medicare Secondary Payer. For courses and information, visit the website at <http://cms.hhs.gov/medlearn>

If you have questions or suggestions regarding this material, please call your NHIC Customer Service Representative:

Maine	1.877.567.3129
Massachusetts	1.877.567.3130
New Hampshire	1.866.539.5595
Vermont	1.866.539.5595

### Manual Revision History:

Original: June 2002

Added Policy: August 2002; Replaced Page 13:October 2002; Replaced Pgs. 60-66:Dec. 2002

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## General Information

The purpose of this manual is to present providers with information on billing for ophthalmology/optometry services. Please reference the General Office Guide for general billing instructions. All billing guides may be found on our web site at [www.medicarenhic.com](http://www.medicarenhic.com).

Medicare covers only services and functions which physicians or practitioners are legally authorized to perform under Federal and State laws. The performance of services must be consistent with the physician's scope of practice. Medicare covers items or services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part. By submitting a properly completed CMS-1500 claim form or an electronic equivalent, the practitioner certifies that the services or items billed were provided and were medically reasonable and necessary for the diagnosis listed.

## Provider Qualifications

### Ophthalmologist

A physician is defined as a doctor of medicine or osteopathy who is legally authorized to practice in the State in which he/she performs services. The issuance of a license by a State to practice constitutes legal authorization. If State-licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered. Refer to MCM §2020.1 & 2020.2.

### Opticians

Regulations do not allow opticians to enroll in the Medicare program.

### Optometrist

A doctor of optometry is considered a physician with respect to all services the optometrist is authorized to perform under State law or regulation. Refer to MCM §2020.25.

Effective January 1, 2000

Optometrists may refer patients for outpatient rehabilitation services as well as establish and review the plan of treatment.

### Optometrist Limitations

The services must be medically reasonable and necessary for the diagnosis or treatment of an illness or injury, and they must meet all applicable coverage requirements to be covered under Medicare. An optometrist who is certified to use therapeutic pharmaceutical agents may also perform all of the following:

- Removal of foreign body, external eye; conjunctival superficial (65205)
- Corneal, without slit lamp, with slit lamp (CPT 65220 and 65222)
- Scraping of cornea, diagnostic, for smear and/or culture, (CPT 65430)
- Correction of trichiasis; epilation, by forceps only, (CPT code 67820).
- Removal of embedded foreign body, eyelid (CPT 67938)
- Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery; by plug, each (68761)

In addition, certified optometrists are allowed to perform the following. However, they are included in the allowance for the evaluation and management (E&M) or eye exam services and will not be paid separately.

- Use all diagnostic drugs including mydriatics, cycloplegics, and anesthetics;
- Use agents for the reversal of mydriasis;
- Use topical meiotics for diagnostic purposes;
- Use topical lubricants;
- Use topical nonsteroidal antiallergy agents;
- Use topical antibiotic agents;
- Use the entire drug class of oral tetracycline's for treatment of blepharitis;
- Use oral and topical non-prescription drugs;
- Order laboratory tests including smears, cultures, and sensitivities;
- Prescribe therapeutic contact lenses.

**The following codes are payable when performed by an Optometrist (Specialty 41)**

92002-92499	99281-99285	65205	65436	68040
99201-99205	99311-99313	65210	67700	68761
99211-99215	99321-99323	65220	67820	68840
99241-99245	99331-99333	65222	67825	76506-76535
99251-99255	99341-99343	65410	67840	A4263*
99261-99263	99347-99349	65430	67938	G0117
99271-99275	99351-99354	65435	68020	G0118

**\*Not separately paid**

**The following codes are payable when performed by an Optometrist (Specialty 41) with modifier 55. See modifier section**

65091-65175	65450-67599	68100-68160
65235-65265	67710-67810	68770
65270-65290	67830-67835	68850-68899
65400	67850-67935	
65426	67950-67999	

Procedure codes **99301** through **99303** represent comprehensive nursing facility assessments, usually performed by an attending physician. These services require at least a detailed history, a comprehensive physical exam and medical decision-making. These procedures range from low to high complexity. It is not within the scope of practice of an optometrist to perform these services, therefore, not payable by Medicare.

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## National Coverage Issues

The Coverage Issues Manual (CIM) contains national coverage decisions for a number of specific medical services and items related to eye health care. Information for these procedures follows.

### Endothelial Cell Photography (CIM 50-38)

Endothelial cell photography is a covered procedure when reasonable and necessary for patients who meet one or more of the following criteria:

- ◆ Have slit lamp evidence of endothelial dystrophy (cornea guttata),
- ◆ Have slit lamp evidence of corneal edema (unilateral or bilateral),
- ◆ Are about to undergo a secondary intraocular lens implantation,
- ◆ Have had previous intraocular surgery and require cataract surgery,
- ◆ Are about to undergo a surgical procedure associated with a higher risk to corneal endothelium; i.e., phacoemulsification, or refractive surgery (see CIM 35-54),
- ◆ With evidence of posterior polymorphous dystrophy of the cornea or irido-corneal-endothelium syndrome, or
- ◆ Are about to be fitted with extended wear contact lenses after intraocular surgery.

When a pre-surgical examination for cataract surgery is performed and the conditions of this section are met, if the only visual problem is cataracts, endothelial cell photography is covered as part of the presurgical comprehensive eye examination or combination brief/intermediate examination provided prior to cataract surgery, and **not** in addition to it.

### General Anesthesia during Cataract Surgery (CIM 35-44)

The use of general anesthesia in cataract surgery may be considered reasonable and necessary if, for particular medical indications, it is the accepted procedure among ophthalmologists in the local community to use general anesthesia. Anesthesia is **not** paid separately when the ophthalmologist performs both the surgical procedure and the anesthesia.

### Hydrophilic Contact Lenses (CIM 65-1)

Payment **may be made** under the prosthetic device benefit for hydrophilic contact lenses when prescribed for an aphakic patient. Hydrophilic contact lenses are eyeglasses within the meaning of the exclusion in §1862(a)(7) of the law and are **not covered** when used in the treatment of nondiseased eyes with spherical ametropia, refractive astigmatism, and/or corneal astigmatism.

### Hydrophilic Contact Lens for Corneal Bandage (CIM 45-7)

Payment for a hydrophilic contact lens that is approved by the Food and Drug Administration (FDA) and used as a moist corneal bandage incident to a physician's service, is included in the payment for the physician's service. The lens is not paid separately.

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## **Intraocular Photography**

### **(CIM 35-39)**

Intraocular photography is covered when used for the diagnosis of such conditions as:

- macular degeneration,
- retinal neoplasms,
- choroid disturbances and diabetic retinopathy,

or to identify

- glaucoma,
- multiple sclerosis and
- other central nervous system abnormalities.

## **Laser Procedures**

### **(CIM 35-52)**

Medicare recognizes the use of lasers for many medical indications. Procedures performed with lasers are sometimes used in place of more conventional techniques. In the absence of a specific noncoverage instruction, and where a laser has been approved for marketing by the Food and Drug Administration, carrier discretion may be used to determine whether a procedure performed with a laser is reasonable and necessary and, therefore, covered.

The determination of coverage for a procedure performed using a laser is made on the basis that the use of lasers to alter, revise, or destroy tissue is a surgical procedure. Therefore, coverage of laser procedures is restricted to practitioners with training in the surgical management of the disease or condition being treated.



## **Phaco-Emulsification Procedure - Cataract Extraction**

### **(CIM 35-9)**

This technique is an accepted procedure for removal of cataracts. Medicare payment may be made for medically necessary services furnished in conjunction with cataract extraction using the phaco-emulsification procedure.

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## Refractive Keratoplasty

### (CIM 35-54)

Refractive keratoplasty is surgery to reshape the cornea of the eye to correct vision problems such as myopia (nearsightedness) and hyperopia (farsightedness). Refractive keratoplasty procedures include keratomileusis, in which the front of the cornea is removed, frozen, reshaped, and stitched back on the eye to correct either near or farsightedness; keratophakia, in which a reshaped donor cornea is inserted in the eye to correct farsightedness; and radial keratotomy, in which spoke-like slits are cut in the cornea to weaken and flatten the normally curved central portion to correct nearsightedness.

The correction of common refractive errors by eyeglasses, contact lenses or other prosthetic devices is specifically **excluded from coverage**. The use of radial keratotomy and/or keratoplasty for the purpose of refractive error compensation is considered a substitute or alternative to eyeglasses or contact lenses, which are specifically excluded by §1862(a)(7) of the Act (except in certain cases in connection with cataract surgery). In addition, many in the medical community consider such procedures cosmetic surgery, which is excluded by §1862(a)(10) of the Act. Therefore, radial keratotomy and keratoplasty to treat refractive defects are **not covered**.

Keratoplasty that treats specific lesions of the cornea, such as phototherapeutic keratectomy that removes scar tissue from the visual field, deals with an abnormality of the eye and is not cosmetic surgery. Such cases may be covered under §1862(a)(1)(A) of the Act.

The use of lasers to treat ophthalmic disease constitutes ophthalmologic surgery. Coverage is restricted to practitioners who have completed an approved training program in ophthalmologic surgery.

## Scleral Shell

### (CIM 65-3)

The term scleral shell (or shield) identifies different types of hard scleral contact lenses.

A scleral shell fits over the entire exposed surface of the eye as opposed to a corneal contact lens, which covers only the central non-white area encompassing the pupil and iris. Where an eye has been rendered sightless and shrunken by inflammatory disease, a scleral shell may, prevent the need for surgical enucleation and prosthetic implant, as well as support the surrounding orbital tissue. In such a case, the device serves essentially as an artificial eye and would be billed to the appropriate DME regional carrier.

Scleral shells are occasionally used in combination with artificial tears in the treatment of “dry eye” of diverse etiology. The scleral contact lens acts as a protective barrier against the drying action of the atmosphere and substitutes, in part, for the functioning of the diseased lacrimal gland. In this instance the scleral shell would be covered as a prosthetic device in the rare case it is used in the treatment of “dry eye” and billed to the DME regional carrier.

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## **Visual Tests Prior to Cataract Surgery**

### **(CIM 35-44)**

In most cases, a comprehensive eye examination (ocular history and ocular examination) and a single scan to determine the appropriate pseudophakic power of the intraocular lens are sufficient. In most cases involving a simple cataract, a diagnostic ultrasound A-scan is used. For patients with a dense cataract, an ultrasound B-scan may be used. Accordingly, where the only diagnosis is cataract(s), Medicare does not routinely cover testing other than one comprehensive eye examination (or a combination of a brief/intermediate examination not to exceed the charge of a comprehensive examination) and an A-scan or, if medically justified, a B-scan. Claims for additional tests are denied as not reasonable and necessary **unless** there is an additional diagnosis **and** the medical necessity for the additional tests is fully documented.

## **Vitrectomy**

### **(CIM 35-16)**

Vitrectomy may be considered reasonable and necessary for the following conditions:

- vitreous loss incident to cataract surgery;
- vitreous opacities due to vitreous hemorrhage or other causes;
- retinal detachments secondary to vitreous strands;
- proliferative retinopathy; and
- vitreous retraction.

## **Intraocular Lenses (IOLs)**

### **(CIM 65-7)**

An intraocular lens, or pseudophakos, is an artificial lens that may be implanted to replace the natural lens after cataract surgery. Intraocular lens implantation services, as well as the lens itself, may be covered if reasonable and necessary for the individual. Implantation services may include hospital, surgical, and other medical services, including pre-implantation ultrasound (A-scan) eye measurement of one or both eyes. Intraocular lenses inserted during or subsequent to cataract surgery are payable separately when billed by a physician if payment has not been made to an Ambulatory Surgical Center (ASC). An IOL inserted in an ASC is included in the facility payment. The facility payment includes an allowance of \$150.00 for the supply of the lens.

## **Additional Coverage Issues**

### **FDA-Monitored Studies of Intraocular Lenses (IOLs)**

#### **(MCM 2020.25D)**

Special coverage rules apply to situations in which an ophthalmologist is involved in a study monitored by the Food and Drug Administration (FDA) for the safety and efficacy of an investigational IOL. The investigation process for IOLs is unique in that there is a core period and an adjunct period. The core study is a traditional, well-controlled clinical investigation with full record keeping and reporting requirements. The adjunct study is essentially an extended distribution phase for lenses in which only limited safety data are compiled. Depending on the lens being evaluated, the adjunct study may be an extension of the core study, or it may be the only type of investigation to which the lens may be subject.

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The FDA has taken the position that, during the entire investigation period, including the core and adjunct periods, the investigator must provide all eye care services related to the investigation of the IOL. The investigator directs or supervises the IOL implantation procedure by the ophthalmologist or other practitioner (including a doctor of optometry). The implanting practitioner has an agreement with the investigator to provide patient information so that the investigator can report to the IOL manufacturer.

Eye care services furnished by anyone other than the investigator (or a practitioner who assists the investigator, as described in the preceding paragraph) are not covered during the period the IOL is being investigated, unless the services are not related to the investigation. Add modifier **LS** to all procedure codes on initial and subsequent claims for each beneficiary who is implanted with the investigational lens.

### **New Technology Intraocular Lenses (NTIOLs) furnished by Medicare approved Ambulatory Surgical Centers (ASC)**

The payment amounts for two temporary procedure codes for the NTIOLs, furnished by a Medicare approved ASC, were effective for services rendered on and after May 18, 2000:

- Q1001 New Technology Intraocular Lenses category 1
- Q1002 New Technology Intraocular Lenses category 2

The above lenses are eligible for an additional payment of \$50.00 when furnished by an ASC. The model for Q1001 is AMO Array Multifocal Model SA4ON, which is manufactured by Allergan. Q1002 lenses are manufactured by STAAR Surgical Company, and their characteristic is reduction in preexisting astigmatism. The model is an Elastic Ultraviolet-Absorbing Silicone Posterior Chamber. These are the only two NTIOLs that have been approved by CMS for payment. As other manufacturers and models are approved, they will be announced in a Federal Register notice, and CMS will then issue instructions. The above two Q codes are effective for 5 years from May 18, 2000 through May 18, 2005.

To be paid the additional \$50.00, ASCs must bill using 2 line items on the CMS-1500 form or electronic equivalent. One line item must be for one of the following procedures (with modifier SG): 66982, 66983, 66984, 66985, or 66986, whichever appropriately describes the surgical insertion procedure that was performed. Additionally, a second line item must show whichever Medicare approved NTIOL was furnished, either Q1001 or Q1002. If a claim is submitted containing only Q1001 or Q1002 the claim is incomplete and will be returned as unprocessable. The \$50.00 payment is per lens. If a patient had the procedure in June on his/her left eye and then in November had the procedure done on the right eye, the ASC where the service was furnished would receive another \$50.00 payment.

Coverage and payment is limited to Medicare approved NTIOLs furnished by a Medicare approved ASC. Therefore, claims for an NTIOL must indicate the ASC place of service (24) and must be billed by a Medicare approved ASC (specialty 49).

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## A-Mode Scans

The appropriate procedure for an A-mode scan performed to determine the intraocular lens (IOL) calculation prior to surgery is 76519 (Ophthalmic biometry by ultrasound echography, A-mode scan; with intraocular lens power calculation).

The technical component of the A-mode scan (76519-TC) includes payment for **both** eyes since the technical component is typically performed on both eyes at the same time. Therefore, modifier 50 should **not** be reported with the technical component. If the scan is performed on only one eye, modifier 52 may be reported to indicate reduced services.

The professional component of the A-mode scan (76519-26) includes payment for only one eye since it is uncommon for an IOL implant to be required for both eyes at the same time. Modifier 50 should be used only when the professional component is performed on both eyes at the same time. If billing for the global procedure of an A-mode scan, it is not necessary to break down charges for the technical and professional components even if the technical component was performed on one eye. Submit procedure code 76519 with one unit of service. Add modifier 52 if the technical component was performed on only one eye.

Providers performing the global procedure should only split the procedure into component parts when the professional component (76519-26) is performed on both eyes on the same day.

Example of billing:

Billing for technical component only

76519	TC	both eyes
76519	TC 52	one eye

Billing for professional component only

76519	26 50	both eyes
76519	26	one eye

Billing globally when technical performed on both or one eye and professional performed on one eye only

76519		Technical both eyes, professional one eye
76519	52	Technical one eye, professional one eye

Bill as 2 components when performing technical on both or one eye and professional component of both eyes

76519	TC	Both eyes, or
76519	TC 52	One eye,
		and
76519	26 50	

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## Assistant at Cataract Surgery

Assistant at surgery for the following CPT-4 procedure codes require Quality Improvement Organization (QIO) prior approval: 66852, 66920, 66930 and 66940.

### Massachusetts

MassQIO  
235 Wyman Street  
Waltham, MA 02154-1231  
1-800-252-5533

### Maine, New Hampshire, Vermont

Northeast Health Care Quality  
15 Old Rollinsford Road, Suite 302  
Dover, NH 03820-2830  
1-800-772-0151

The QIO prior authorization number for these procedures must be entered in Item 23 of the CMS-1500 claim form or electronic media claim equivalent.

### Bilateral Procedures

Bilateral procedures are procedures performed on both sides of the body or organ site of a paired physiological pair during the same operative session. The terminology for some CPT-4 procedure codes includes the terms bilateral or unilateral. Payment adjustment rules do not apply to such procedures as the relative value units (RVUs) reflect any additional work for bilateral services. The allowance is the lower of the billed amount or fee schedule.

If a procedure is identified by its terminology as a bilateral procedure (or unilateral or bilateral), do **not** report the procedure with CPT-4 Modifier 50. Do **not** report modifier 50 with the following procedures:

67800	67801	67805	67808	67810	67820	67825	67830	67835	67840	67850
67875	67880	67882	67900	67930	67935	67938	67950	67961	67966	67971
67973	67974	67975	67999	68020	68040	68100	68110	68115	68130	68135
68320	68325	68326	68328	68330	68335	68340	68360	68362	68399	68400
68420	68440	68500	68505	68510	68520	68525	68530	68540	68550	68700
68705	68720	68745	68750	68770	68840	68850	68899	76516	*76519	92002
92004	92012	92014	92018	92019	92020	92060	92065	92081	92082	92083
92100	92120	92130	92136	92140	92250	92260	92265	92270	92275	92283
92284	92285	92286	92287	92311	92312	92313	92315	92316	92317	92325
92326	92335	92499								

\*applies to the global and technical component only. Modifier 50 is permissible with the professional component.

### Procedure codes with Professional and Technical Components

When billing for services rendered in a hospital setting (either inpatient, outpatient or the emergency room) only the professional component will be reimbursed. When the services are billed as technical or global procedures in the hospital setting, they will be denied as a Part A service. The facility must bill the Intermediary.

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## **Glaucoma Screening (MCM § 4184.1)**

### *Conditions for Coverage*

Effective for services rendered on and after January 1, 2002, Medicare provides annual coverage for glaucoma screening for beneficiaries in the following high-risk categories:

1. Individuals with diabetes mellitus;
2. Individuals with a family history of glaucoma, or
3. African-Americans age 50 and over.

Medicare will pay for glaucoma screening examinations when they are furnished by or under the direct supervision in the office setting of an ophthalmologist or optometrist, who is legally authorized to perform the services under State law.

### *Screening for glaucoma is defined to include:*

1. A dilated eye examination with an intraocular pressure measurement; and
2. A direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination.

### *Calculating the Frequency of Screenings*

Once the beneficiary has received a covered glaucoma screening procedure, the beneficiary may receive another procedure after 11 full months have passed. To determine the 11 month period, start your count beginning with the month after the month in which the previous covered screening procedure was performed. For example:

If a beneficiary receives a screening on February 15, 2002, begin counting with the next month (March 2002) until 11 full months have elapsed. Payment can be made for a glaucoma screening rendered anytime in February 2003.

### *Procedure code requirements:*

- G0117-Glaucoma screening for high risk patients furnished by a physician; and
- G0118-Glaucoma screening for high risk patients furnished under the direct supervision of a physician.

### *Diagnosis Coding Requirements*

Glaucoma screenings must be submitted with the ICD-9-CM code V80.1 (Special Screening for Neurological, Eye, and Ear Disease, Glaucoma).

### *Payment*

Payment will be made based on the physician's fee schedule. Deductible and co-insurance apply. However, these services are only paid if there are no other services paid to the same provider for the same date of service under the physician's fee schedule. They are bundled into the service for which payment is made.

### **Diabetic Retinopathy Services**

Coverage is allowed under Medicare Part B for diagnostic ophthalmological services provided to diabetic patients at risk for retinopathy. Such tests and evaluations are not considered routine screening services as they are ordered to assess the presence or extent of diabetic retinopathy as part of the appropriate management of a patient with diabetes. Payment is permitted for the following services when performed for assessment of diabetic retinopathy:

- Eye examinations,
- Evaluation and management services,
- Ophthalmoscopy,
- Fluorescein angiography,
- Fluorescein angiography
- Indocyanine-green angiography,
- Fundus photography, and
- Ophthalmodynamometry

The appropriate ICD-9-CM code for diabetes should be reported as the primary diagnosis.

### **Iridotomy/Iridectomy by laser surgery**

Laser iridectomy is used in the treatment of angle-closure glaucoma and for occludible narrow angles. It is often an alternative therapy to surgical peripheral iridectomy. The laser creates an opening in the peripheral iris, improving the outflow of aqueous humor, and relieving actual or potential pupillary block. The medical record should support the medical necessity and frequency of this procedure.

### **Yag Posterior Capsulotomies**

Laser capsulotomies are performed in cases of visually significant opacification of the posterior capsule following cataract extraction.

The medical record should support the medical necessity and frequency of this procedure.

### **Destruction of Localized Lesion of Retina by Photocoagulation (Laser or Xenon Arc)**

Many retinal and choroidal lesions are successfully treated by laser photocoagulation as a primary or adjunctive therapy. The optic and physical properties of different laser wavelengths obliterate pathologic tissue, blood vessels, hemorrhages, and tumors. The medical record should support the medical necessity and frequency of this procedure.

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## **Ganciclovir Intravitreal Implant**

Ganciclovir is a synthetic nucleoside analogue of 2' deoxy-guanosine which inhibits assembly of virions and is one of the agents used in the treatment of cytomegalovirus (CMV) infections.

Coverage is available when:

1. The patient must have a clinical diagnosis of CMV retinitis in one or both eyes. This diagnosis is made by the retinal appearance which usually manifests as a fluffy yellow-white retinal infiltrate.
2. Progression of CMV retinitis in patients receiving the maximum tolerated dosage of IV ganciclovir, foscarnet, and/or cidofovir is a relative indication for implantation of a GIOD.
3. Progression of CMV retinitis in an eye with a GIOD implant may indicate the need for placement of a subsequent GIOD. Progression of CMV retinitis is defined in clinical trials as advancement of retinitis by 1500 microns or more. Clinical circumstances do exist when advancement of less than 1500 microns could cause blindness. Therefore, placement of a subsequent GIOD can be covered when the central vision is threatened by progression.
4. A patient's inability to tolerate systemic anti-viral therapy or to maintain an indwelling intravenous catheter is an indication for insertion of an implant.

The medical record should support the medical necessity and frequency of this procedure.

## **Ophthalmoscopy**

The ophthalmoscopy includes evaluation of the retina through a dilated pupil which includes meticulous comprehensive evaluation with the use of indirect ophthalmoscopy and one of the following:

1. scleral depression
  2. slit lamp biomicroscopy, or
  3. fundus contact lens evaluation
- To support medical necessity vitreoretinal or optic nerve pathology must be evident and documented
  - A sketch or large drawing must be used to document the pathology
  - The reason and technique used for the procedure should be documented in the medical record

## **Ophthalmoscopy with Fundus Photography**

Fundus photography is a procedure in which color photographs are used for diagnostic purposes. Medicare allows payment when considered medically necessary.

## **Supplies**

### **Lacrimal Punctum Plugs**

Effective January 1, 2002 payment for HCPCS procedure code A4263 (permanent, long term, non-dissolvable lacrimal duct implant, each) is bundled into the payment for the physician's service, and is not separately payable.

### **Fitting of Spectacles**

Payment for fitting of spectacles, CPT-4 procedure codes 92352 through 92355, 92358 and 92371, is included in the payment for the spectacles.

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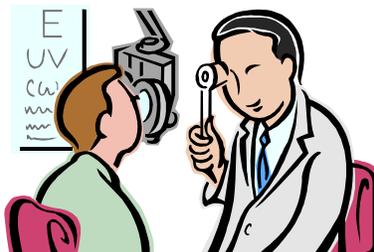
## Payment for Eyeglasses, Contact Lenses, and Related Services

Payment may be made for no more than one pair of conventional eyeglasses or contact lenses furnished after each cataract surgery with insertion of an intraocular lens. In addition, payment may be made for cataract eyeglasses and cataract contact lenses in those cases where an individual is lacking the organic lens of the eye because of surgical removal or congenital absence and does not receive an intraocular lens implant. In both of these situations, the eyeglasses or contact lenses are covered as prosthetic devices. Refer to jurisdictional listing on page 16.

## Eye Examinations and Refractions

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors are **not** covered. Expenses for all refractive procedures, whether performed by an ophthalmologist or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage. Medicare will deny vision services reported with ICD-9-CM diagnosis codes 367.0 through 367.9 and V43.1 as routine eye exams. The exclusions do not apply to physicians services (and services incident to a physician's service) performed in conjunction with an eye disease (e.g., glaucoma or cataracts) or to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease.

The coverage of services rendered by an ophthalmologist is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient's condition. When a beneficiary goes to an ophthalmologist with a complaint or symptoms of an eye disease or injury, the ophthalmologist's services (except for eye refractions) are covered regardless of the fact that only eyeglasses were prescribed. However, when a beneficiary goes to his/her ophthalmologist for an eye examination with no specific complaint, the expenses for the examination are **not** covered even though as a result of such examination the doctor discovered a pathologic condition. Either an E&M or an eye exam may be billed, whichever is most appropriate. Both services will not be paid on the same day. Photokeratotomy, Brightness Acuity, Potential Acuity Metered test and Glare Tests are included in the visit. No separate payment may be made for these services.



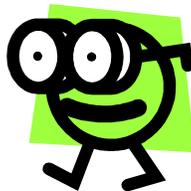
## Claims Processing Jurisdiction

HealthNow NY, Inc.® the Region A Durable Medical Equipment Regional Carrier (DMERC), is the federal contractor responsible for processing Medicare Part B claims for durable medical equipment, prosthetics, orthotics, and supplies.

HealthNow NY®  
 DMERC  
 PO Box 6800  
 Wilkes-Barre, PA 18773-6800  
 866-419-9458  
[www.umd.nycpic.com](http://www.umd.nycpic.com)

Please refer to jurisdictional listing below to determine which carrier to bill.

HCPCS Code	Description	Jurisdiction
A4262 - A4263	Lacrimal Duct Implants	Local Carrier (not separately payable)
V2020 - V2025	Frames	DMERC
V2100 - V2513	Lenses	DMERC
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DMERC.
V2530 - V2531	Contact Lenses, Scleral	DMERC
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DMERC.
V2600 - V2615	Low Vision Aids	DMERC
V2623 - V2629	Prosthetic Eyes	DMERC
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Misc. Vision Service	DMERC
V2781	Progressive Lens	DMERC
V2785	Processing Corneal Tissue	Local Carrier
V2790	Amniotic Membrane	Local Carrier
V2799	Misc. Vision Service	DMERC



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## Global Surgery

The “global surgical fee” includes all necessary services performed by the physician the day before (for major surgeries), the day of (for major and minor surgeries), during, and after a surgical procedure. Medicare payment for a given surgical procedure includes applicable preoperative, intraoperative, complications, and postoperative care.

Procedure codes with 90 follow-up days are considered major surgeries.

Procedure codes with zero or ten follow-up days are considered minor surgeries.

### Services Included in the Global Surgery Fee

- Preoperative visits: Services provided the day before a major surgery and the day of the surgery for minor surgeries.
- Intraoperative services: Services that are normally a usual and necessary part of a surgical procedure.
- Complications following surgery: All additional medical or surgical services required of the surgeon because of complications, which do not require a return trip to the operating room. (The definition of operating room is a place of service specifically equipped and staffed for the sole purpose of performing procedures. It does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit.)
- Postoperative visits: Follow-up visits within the global period of surgery.
- Postsurgical pain management by the surgeon.
- Supplies.
- Miscellaneous services: Items such as dressing changes; local incisional care; removal of cutaneous sutures, staples, exposed K wires, tubes, drains, intraoperative casts, and splints.

### Services Not Included in the Global Surgery Fee

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery.
- The services of **other physicians**, except where the surgeon and the other physician(s) agree on the transfer of care such as when different physicians in a group practice participate in the care of the patient.
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications from the surgery.
- Postoperative complications that require a **return trip** to the operating room.

### Transfer of Care Between Providers

Ordinarily, the global surgery fee schedule allowance includes preoperative evaluation and management services rendered the day of or the day before surgery, the surgical procedure, and the postoperative care services within the defined postoperative period. Postoperative care may be rendered by an ophthalmologist, optometrist, or providers who are licensed to render such services. When a physician transfers the care of a patient to another provider within the global period, it is considered “a transfer of care”. Each provider must document the transfer of care in the medical record. It may be in a letter or written as a notation in the discharge summary/hospital records or Ambulatory Surgical Center. The appropriate CPT-4 modifiers must be added to the surgical procedure code:

- 
- 52 Reduced services
  - 54 Surgical care only
  - 55 Postoperative management only

The claim for the surgical care only, and the claim for the postoperative care only must identify the same *surgical date of service* and the *same surgical procedure code*. Modifier 54 must be reported with the surgical care only. Modifier 52 must be reported in addition to modifier 55 when more than one physician assumes responsibility for the postoperative care.

**NOTE:** If the same physician performs an unrelated procedure during a postoperative period, the procedure should be reported with modifier 79 (unrelated procedure/ by the same physician during a postoperative period). A new global period begins.

Example of billing for 1<sup>st</sup> eye:

Dr. Jones performs procedure code 66983 on March 1<sup>st</sup> and cares for the patient through April 29<sup>th</sup>  
Dr Smith assumes responsibility for the patient on April 30<sup>th</sup> for the remainder of the global period.

Dr Jones' claim contains the following:

03/01/2002 66983 54  
03/01/2002 66983 55 52

Dr. Smith's claim contains the following:

03/01/2002 66983 55 52

Example of billing for 2<sup>nd</sup> eye:

Dr. Jones performs procedure code 66983 on the 2<sup>nd</sup> eye on May 1<sup>st</sup> and cares for the patient through July 29<sup>th</sup>. Dr. Smith assumes responsibility for the patient on July 30<sup>th</sup> for the remainder of the global period.

Dr. Jones' claim contains the following:

05/01/2002 66983 79 54  
05/01/2002 66983 79 55 52

Dr. Smith's claim contains the following:

05/01/2002 66983 79 55 52

For claims where physicians share postoperative care, the assumed and/or relinquished dates of care must be indicated in Item 19 of the CMS-1500 claim form, or electronic media claim equivalent.

Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary's medical record.

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Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service. Once the physician has seen the patient, that physician may bill.

When more than one physician bills for the postoperative care, the postoperative percentage is apportioned based on the number of days each physician was responsible for the patient's care. Based on the example above, reimbursement for the postoperative care is apportioned as follows:

The percentage of the total RVUs for postoperative care for 66983 is 20 percent, and the length of the global period is 90 days.

Example:

Fee schedule amount for 66983 = \$550.00

Post-op days 90.

Post-op care (20%) = \$110.00

Dr. Jones provided care for the first 60 days. To determine the allowed amount, divide the 60 days by the total number of post op days (90). This equals 66.7%. Multiply the 66.7% by the 20% post-op care amount. Reimbursement would equal \$73.37.

60 days divided by 90 days (total post-op) = 66.7%  
66.7% x \$110.00 (20% post-op) = \$73.37

Dr Smith provided care for the last 30 days. To determine the allowed amount, divide the 30 days by the total number of post-op days (90). This equals 33.3%. Multiply the 33.3% by the 20% post-op care amount. Reimbursement would equal \$36.63

30 days divided by 90 days (total post-op) = 33.3%  
33.3% x \$110.00 (20% post-op) = \$36.63

\$73.37 + \$36.63 = \$110.00 Total post-op care

## Modifiers

### Modifiers used for Evaluation & Management (E&M) Services within a Global Surgical Period - 24, 25, and 57

#### **Modifier 24:** *Unrelated E&M Service by the Same Physician During a Postoperative Period*

An E&M service coded with modifier 24 indicates a visit in the postoperative period that is unrelated to the original procedure (surgery). This modifier is only to be used with an E&M visit. It is **not** valid when used with surgeries or other types of services. It is not necessary, or appropriate, for modifier 24 to be used with tests done in the postoperative period. When using modifier 24, ensure that the patient's records and ICD-9 codes recorded on the claim clearly indicate that the E&M visit is unrelated to the original procedure.

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**Modifier 25: Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day**

Medicare allows payment for an E&M service performed on the same day as a surgical procedure, if all requirements are met. The term surgery or service includes therapeutic injections and wound repairs.

The additional E&M service must be *separately identifiable* from the surgical procedure and require significant effort **above and beyond** the usual pre- and post-procedure service routinely required for the procedure. The term *separately identifiable* service means the additional service is not part of the surgery or procedure. Medical records should document the E&M service to such an extent that, upon review, the extra effort may be readily identifiable.

Please note that the diagnosis may be the *same* for both the E&M and the surgery or procedure.

**Modifier 57: Decision for Major Surgery**

An E&M examination coded with modifier 57 indicates a visit that resulted in the initial decision to perform a **major** surgery. Surgeries that have a 90-day follow-up period are considered major surgeries. When coding modifier 57, ensure that the patient's records clearly indicate when the initial decision to perform the surgery was made.

Do not use modifier 57 with an E&M performed on the same day as minor surgery.

**Modifiers Used with Surgical Codes Only During a Global Surgical Period - 58, 78 and 79**

**Modifier 58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period**

Modifier 58 can be used when a second surgery is done in the postoperative period of another surgery when the subsequent procedure:

- Was planned prospectively (or "staged") at the time of the original procedure; or
- Was more extensive than the original procedure; or
- Was for therapy following a diagnostic surgical procedure.

The full global surgical allowance is made for both surgical procedures.

**Modifier 78: Return to the Operating Room for a Related Procedure During the Postoperative Period**

Modifier 78 is used for a return trip to the operating room for a related surgical procedure during the postoperative period of a previous major surgery. The allowance will be reduced, since postoperative care is included in the allowance for the prior surgical procedure.

An "operating room" is defined as a place of service specifically equipped and staffed for the sole purpose of performing surgical procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit unless the patient's condition was so critical there would be insufficient time for transportation to an operating room.

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**Modifier 79: Unrelated Procedure or Service by the Same Physician During the Postoperative Period**

Modifier 79 is used for unrelated procedures by the same physician (or physician of the same specialty in the same surgical group) during the postoperative period. Unrelated procedures are usually reported using a different ICD-9-CM diagnosis code.

**Note:** The use of RT and LT modifiers is helpful and should be used with modifier 79, not in place of it.

**Additional Modifiers****Modifier 22: Unusual Procedure Services**

Modifier 22 is used to identify services which require individual consideration and should not be subject to the automated claims process. Such services include procedures which would otherwise be noncovered, but due to unusual circumstances warrant individual consideration. Claims submitted with modifier 22 **must** be accompanied by documentation explaining the unusual services. Documentation includes, but is not limited to, descriptive statements identifying the unusual circumstances, operative reports, pathology reports, progress notes, office notes, etc.

The submission of a service with modifier 22 does not ensure coverage or additional payment. All claims with modifier 22 and appropriate documentation are reviewed by medical review staff to determine whether payment is justified.

Modifier 22 can be used on all procedure codes with a global period of 0, 10, or 90 days when unusual circumstances warrant consideration of payment in excess of the fee schedule allowance.

**Modifier 50: Bilateral Procedures**

Bilateral surgeries are procedures performed on both sides of the body during the same operative session. Medicare considers bilateral procedures as one payment amount equal to 150 percent of the Medicare Fee Schedule allowance.

**Note:** CPT procedures identified with the terms “bilateral” or “unilateral or bilateral” should not be billed with modifier 50. Modifier 50 will not result in an increased payment for these procedures. Refer to page 11 for bilateral procedures.

**Modifier 51: Multiple Procedures**

Modifier 51 **should not be reported** to Medicare. The carrier will add if appropriate.

**Modifier 53: Discontinued Procedure**

Modifier 53 is used when it is necessary to indicate that a surgical or diagnostic procedure was started but discontinued, due to extenuating circumstances or those that threaten the well being of the patient.

**Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

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## Modifiers GA, GY and GZ

### **GA Waiver of liability statement on file.**

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they do have on file an Advance Beneficiary Notice signed by the beneficiary.

### **GZ Item or service expected to be denied as not reasonable and necessary**

The GZ modifier must 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 Advance Beneficiary Notification signed by the beneficiary.

### **GY Item or services statutorily excluded or does not meet the definition of any Medicare benefit.**

The GY modifier must be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered, or is not a Medicare benefit.

### **Modifier LS**

Modifier LS is used on all procedure codes (initial and subsequent claims), for each beneficiary who is implanted with the investigational lens.

### **Modifier SG**

Modifier SG is used when the Ambulatory Surgical Centers bill for the facility fee.

## **Limitation of Liability**

Services which are denied as not reasonable and necessary under §1862 of the Social Security Act, are subject to the Limitation of Liability provision. To be held liable for the denied charges(s), the beneficiary must be given appropriate written advance notice of the likelihood of noncoverage and agrees to pay. A written notice covering an extended course of treatment is acceptable, provided the notice identifies **all** services for which the physician believes Medicare will not pay. If additional services are furnished for which the physician believes Medicare will not pay, the physician must separately notify the patient in writing. Complete instructions for Limitation of Liability, may be obtained by visiting our web site at [www.medicarenhic.com](http://www.medicarenhic.com) or by contacting Customer Services.

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## Local Medical Review Policies

Local Medical Review Policies are developed by the local Medicare carrier in the absence of a national Medicare payment policy. These policies describe specific criteria, which determines whether an item or service is covered by Medicare and under what circumstances. LMRPs are updated as new information and technology occurs in the field of medicine. NHIC has local medical review policies for the following procedures:

<u>LMRP</u>	<u>CODE</u>
Botulinum Toxin A	Multiple
Corneal Relaxing Incision and Corneal Wedge Resection	65772 & 65775
Corneal Topography	92499
Blepharoplasty	15820-15823, 67901-67908
Indocyanine Green Angiography	92240
Ocular Photodynamic Therapy	67221, 67225 & J3395
Scanning computerized ophthalmic diagnostic imaging	92135
Visual Field Examination	92081, 92082 & 92083
Visual Rehabilitative Therapy	97112, 97530, 97535, 97537
Eyelid and Brow Surgical Procedures	15820-15823, 67900-67904, 67906, 67908-67909, 67914- 67917, 67921-67924

A copy of each policy is attached for reference.

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## Fraud and Abuse

**Fraud** is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent kind of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples are:

- billing for services or supplies that were not provided;
- misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- altering a claim form to obtain a higher amount paid;
- soliciting, offering, or receiving a kickback, bribe or rebate;
- completing Certificates of Medical Necessity (CMN'S) for patients not personally and professionally known by the provider;
- use of another person's Medicare card to obtain medical care.

**Abuse** describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- unbundled charges;
- excessive charges;
- medically unnecessary services;
- improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential Fraud or Abuse should be referred to:

Fraud and Abuse Investigations  
NHIC  
P.O. Box 8888  
Hingham, MA. 02044

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**Final Local Medical Review Policies****CONTRACTOR'S POLICY NUMBER:** 01-D-R2**CONTRACTOR NAME\*:** NHIC-NE**CONTRACTOR NUMBER\*:** 31142-31143-31144-31145**CONTRACTOR TYPE\*:** Part B Carrier**LMRP TITLE:** Botulinum Toxin A**AMA CPT COPYRIGHT STATEMENT\*:**

CPT codes, descriptions, and other data only are copyright 1999 American Medical Association (or such other data of publication of CPT). All rights reserved. Applicable FARS/DFARS clauses apply.

**HCFA NATIONAL COVERAGE POLICY\*:**

- Title XVIII of the Social Security Act, section 1862 (a) (7) and 42 Code of Federal Regulations, section 411.15et. seq.. This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.
- HCFA Publication 14-3, Medicare Carrier Manual, section 2049 describes the coverage and limitations of drugs and biologicals.
- Title XVIII of the Social Security Act, section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary documentation to process the claim.
- Medicare Carrier Manual, section 2329, describes "cosmetic surgery or expenses incurred in connection with such surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose"

**PRIMARY GEOGRAPHIC JURISDICTION\*:**

Massachusetts, Vermont, Maine, New Hampshire

**SECONDARY GEOGRAPHIC JURISDICTION:****HCFA REGION\*:** Region I**HCFA CONSORTIUM\*:** Northeast**ORIGINAL POLICY EFFECTIVE DATE\*:** 1991**ORIGINAL POLICY ENDING DATE\*:** 05/31/1994**REVISION EFFECTIVE DATE\*:** 10/01/2001**REVISION ENDING DATE\*:** 11/01/1997 (1st revision)

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**LMRP DESCRIPTION\*:**

Botulinum Toxin Type A is a neurotoxin. Botulinum Toxin A is used to treat various focal muscle spastic disorders and excessive muscle contractions such as dystonias, spasms, and twitches. Botulinum Toxin A has a paralytic effect when injected into muscles, and produces a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. The resulting chemical denervation of muscle produces local paresis and allows individual muscles to be weakened selectively. Botulinum Toxin A has the advantage of being a potent neuromuscular blocking agent with good selectivity, duration of action, with the smallest antigenicity, and fewest side effects.

**INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY\*:****INDICATIONS OF COVERAGE:**

- Botulinum Toxin A is considered medically necessary to improve function in patients who have one of the following spastic conditions:
  - Strabismus
  - Blepharospasm, characterized by intermittent or sustained closure of the eyelids caused by involuntary contractions of the orbicularis oculi muscle
  - 7th Cranial Nerve hemifacial spasms , characterized by sudden, unilateral, synchronous contractions of muscles innervated by the facial nerve
  - Laryngeal spasm
  - Anal spasm and anal fissure
  - Focal dystonias, e.g.,:
    - Cervical dystonia (i.e., spasmodic torticollis), characterized by dystonia affecting the nuchal muscles
    - Laryngeal dystonia (i.e., adductor spasmodic dysphonia)
    - Jaw-closing oromandibular dystonia, characterized by dystonic movements involving the jaw, tongue, and lower facial muscles
    - Organic Writer's Cramp
    - Symptomatic torsion dystonia
  - Limb spasticity, e.g.,:
    - Hereditary spastic paraplegia
    - Multiple sclerosis
    - Other demyelinating diseases of CNS
    - Spastic hemiplegia
    - Infantile cerebral palsy

- 
- Esophageal achalasia for those patients who have any one of the following:
    - have failed conventional therapy
    - are at high risk of complications of pneumatic dilatation or surgical myotomy
    - have failed a prior myotomy or dilation
    - have had a previous dilation induced perforation
    - have an epiphrenic diverticulum or hiatal hernia (both of which increase the risk of dilation – induced perforation)

**LIMITATIONS OF COVERAGE:**

- Botulinum Toxin A is not covered for treating:
  - any condition, not listed under Indications of Coverage, or
  - wrinkles because this treatment is considered cosmetic, or
  - patients receiving aminoglycosides, which may interfere with neuromuscular transmission; or
  - patients with chronic paralytic strabismus, except to reduce antagonist contracture in conjunction with surgical repair, or
  - patients with other types of spasm, not listed in indications of coverage, including smooth muscle spasms, or
  - patients with other specified hypertrophic and atrophic conditions of skin, or
  - patients with irritable colon, biliary dyskinesia; or
  - strabismus, when the angles are over 50 prism diopters; or
  - restrictive strabismus; or
  - Duane's syndrome with lateral rectus weakness; or
  - Secondary strabismus caused by prior surgical over-recession of the antagonist muscle.
  - **patients for whom there has been no demonstrable, functional benefit following two sequential treatments/sets of injections in a 4-6 month period, using maximum dose for the size of the muscle**

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**CPT/HCPCS SECTION & BENEFIT CATEGORY\*:**

Drugs and Biologicals; Medicine

**TYPE OF BILL CODE:**

**REVENUE CODES:**

**CPT/HCPCS CODES\*:**

J0585 Injection, botulinum toxin type A, per unit  
64612 Chemodenervation of muscle(s); muscles innervated by facial nerve(e.g. for blepharospasm, hemifacial spasm)  
64613 cervical spinal muscles (eg, for spasmodic torticollis)  
64614 extremity(s) and/or trunk muscles ( e.g. cerebral palsy)  
64640 Destruction by neurolytic agent; other peripheral nerve or branch  
67345 Chemodenervation of extraocular muscle  
31513 Laryngoscopy, indirect; with vocal cord injection  
31570 Laryngoscopy,direct, with injection into vocal cord(s), therapeutic;  
31571 with operating microscope

**NOT OTHERWISE CLASSIFIED (NOC):**

**ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY\*:**

333.6 Idiopathic torsion dystonia  
333.7 Symptomatic torsion dystonia  
333.81 Blepharospasm  
333.82 Orofacial dyskinesia  
333.83 Spasmodic torticollis  
333.84 Organic writer's cramp  
333.89 Fragments of torsion dystonia, other  
334.1 Hereditary spastic paraplegia  
340 Multiple sclerosis  
341.0 Neuromyelitis optica  
341.1 Schilder's disease  
341.8 Other demyelinating diseases of central nervous system  
341.9 Demyelinating disease of central nervous system,unspecified  
342.11 Spastic hemiplegia, affecting dominant side  
342.12 Spastic hemiplegia, affecting nondominant side  
343.0-343.4 Infantile cerebral palsy  
343.8 Other specified infantile cerebral palsy  
343.9 Infantile cerebral palsy, unspecified  
351.8 Hemifacial spasm of the nerve  
378.00-378.08 Strabismus and other disorders of binocular eye movements  
378.10-378.18 Exotropia  
378.20-378.24 Intermittent heterotropia  
378.30-378.35 Other and unspecified heterotropia  
378.40-378.45 Heterophoria  
378.50-378.56 Paralytic strabismus  
378.60-378.63 Mechanical strabismus  
378.71-378.73 Other specified strabismus

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378.81-378.87 Other disorders of binocular eye movements  
378.9 Unspecified disorder of eye movements  
478.75 Laryngeal spasm  
530.0 Achalasia and cardiospasm  
564.6 Anal spasm  
565.0 Anal fissure and fistula, anal fissure  
723.5 Torticollis, unspecified  
728.85 Spasm of muscle

**DIAGNOSIS THAT SUPPORT MEDICAL NECESSITY:**

**ICD-9 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:**

All ICD- 9 Codes not listed under the "ICD-9 Codes That Support Medical Necessity" section of this policy will be denied.

**DIAGNOSIS THAT DO NOT SUPPORT MEDICAL NECESSITY:**

**REASONS FOR DENIAL\*:**

- Botulinum Toxin A is not covered for treating:
  - any condition, not listed under Indications of Coverage, or
  - wrinkles because this treatment is considered cosmetic, or
  - patients receiving aminoglycosides, which may interfere with neuromuscular transmission; or
  - patients with chronic paralytic strabismus, except to reduce antagonist contractor in conjunction with surgical repair, or
  - patients who are receiving treatment of other types of spasm, including smooth muscle types, not listed in indications of coverage, or
  - patients receiving treatment for other specified hypertrophic and atrophic conditions of skin, or
  - patients receiving treatment for irritable colon, biliary dyskinesia; or
  - **patients for whom there has been no demonstrable, functional benefit following two sequential treatments/sets of injections in a 4-6 month period, using maximum dose for the size of the muscle**

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**NONCOVERED ICD-9 CODE(S):**

**NONCOVERED DIAGNOSIS:**

**CODING GUIDELINES:**

**DOCUMENTATION REQUIREMENTS:**

- For coverage of Botulinum Toxin Type A treatment, documentation in the medical record should include the following elements:
- Documentation to support medical necessity for this treatment
- Dosage of Botulinum Toxin A, administered per injection and the site(s) of injection
- A covered diagnosis
- Description of improvement in patient's functional status
- Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and made available to Medicare upon request.

**UTILIZATION GUIDELINES:**

- **Medicare will allow payment for one injection per site regardless of the number of injections made into the site, unless the procedure is bilateral or more than one body region is injected. A site is defined as including muscles of a single contiguous body part, such as, a single limb, upper and lower eyelids of the same eye, face, neck, etc.**
- **If the upper and lower lid of the same eye and/or adjacent facial muscles are injected at the same surgery, the procedure is considered unilateral.**
- **Bilateral procedures will be considered when both eyes or both sides of the face are injected.**

**OTHER COMMENTS:**

**SOURCES OF INFORMATION AND BASIS FOR DECISION\*:**

1. Physicians Desk Reference, 2001
2. USPDI, 2001, Drug Information for the Health Care Professional, Volume 1, Levels of Evidence, pages viii and 647.
3. Other Carriers' Policies
4. Current Procedural Terminology ,CPT 4, 2001, American Medical Association.
5. ICD-9-CM, 2001, Volumes 1&2, Medicode.
6. Carrier Advisory Committee Botox A Physician Working Group.

**ADVISORY COMMITTEE NOTES\*:**

This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the carrier, this policy was developed in cooperation with advisory groups, which includes representatives from Ophthalmology, Otolaryngology, Gastroenterology, Neurology, and Physiatry.

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**Advisory Committee Meeting Date:** May 14, 2001

**START DATE OF COMMENT PERIOD\*:** 05/14/2001

**END DATE OF COMMENT PERIOD\*:** 06/27/2001

**START DATE OF NOTICE PERIOD\*:** 09/01/2001

**REVISION HISTORY:**

NUMBER	DATE	CHANGE
R2	10/01/2001	<ul style="list-style-type: none"><li>• Added bolded language</li><li>• Deleted Indication of Coverage , "Other musculoskeletal symptoms referable to limbs" and spasm of muscle</li><li>• Deleted diagnosis code 729.82</li></ul>
R1	11/01/1997	

**BOTULINUM TOXIN A  
SUMMARY OF COMMENTS AND RESPONSES**

1. **Comment:** Add CPT procedure codes 64614 and 64640

**Response:** The above CPT procedure codes were added.

2. **Comment:** Botulinum Toxin A should be allowed as first-line therapy for blepharospasm and hemifacial spasm.

**Response:** NHIC agrees with this comment.

3. **Comment:** Why deny coverage for anal spasm, migraine, and hyperhidrosis?

**Response:** NHIC agrees that the diagnosis of anal spasm supports medical necessity. NHIC disagrees that the diagnoses of migraine and hyperhidrosis support medical necessity at this time because the results reported in the medical literature vary, and further scientifically controlled studies involving large numbers of patients are needed before clinical effectiveness can be proven.

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**REVISED:** FEBRUARY, 2000

**POLICY NUMBER:** 001/2-OPH-21400-R-NT

**SUBJECT:** Corneal Relaxing Incision and Corneal Wedge Resection

**DESCRIPTION:** Corneal relaxing incision and corneal wedge resection are postoperative procedures, performed to correct surgically induced astigmatism.

**POLICY TYPE:** Local Medical Necessity Policy

**HCPCS SECTION AND BENEFIT CATEGORY:** Ophthalmology

**HCPCS CODE:** 65772 Corneal relaxing incision for correction of surgically induced astigmatism  
65775 Corneal wedge resection for correction of surgically included astigmatism

**HCFA NATIONAL COVERAGE POLICY:**

Title XVIII of The Act, Section 1862(a)(1)(A), allows for payment of only those services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

**INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:**

Astigmatism (ICD-9-CM 367.20-367.22) by corneal topography, refraction or keratometry which must be **greater than or equal to 1.5 diopters and astigmatism(not pre-existing), and a result of one of the following surgeries:**

- Corneal transplant(ICD-9-CM V42.5)
- Post-operative cataract surgery, or post-operative glaucoma surgery (ICD-9-CM V45.61); or lens implant surgery (ICD-9-CM V45.89);
- Corneal opacity, unspecified, post traumatic (ICD-9-CM 371.00)
- Mechanical complication of corneal graft (ICD-9-CM 996.51)

**CONTRAINDICATIONS:**

No evidence of **astigmatism greater than 1.5 diopters**, or astigmatism as a result of:

- Post-op cataract, glaucoma, or lens implant surgery, or
- Mechanical complication of corneal graft, or
- Corneal opacity, unspecified, post-traumatic

**ICD-9-CM CODES THAT SUPPORT MEDICAL NECESSITY:**

367.20-367.22	Astigmatism
371.0	Corneal opacity and other disorders of the cornea
V42.5	Corneal transplant
V45.61	Post-cataract surgery
V45.89	Post lens implant surgery
996.51	Mechanical complication due to corneal graft 371.00

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## REASON FOR DENIAL

- Indications listed above have not been met
- Evidence of naturally occurring astigmatism which existed pre-operatively in a cataract patient.

## NON-COVERED ICD-9-CM CODE(S)

- All diagnoses not listed above in “ICD-9-CM Codes that support medical necessity” section.

## SOURCES OF INFORMATION

- Carrier Advisory Committee Ophthalmology Working Group

## CODING GUIDELINES

- Both the V code and the ICD-9-CM diagnosis code must be included claim form.

## DOCUMENTATION REQUIREMENTS

- The medical record should support the medical necessity of this treatment.
- The medical record must clearly indicate post-operative complication (not pre-existing condition) of corneal surgery, corneal transplant, or after trauma.
- For post-operative indications, the medical record must contain evidence of pre-surgical and post-surgical cylindrical diopter measurement.
- Following trauma, evidence that the astigmatism is a result of trauma pre-existing astigmatism.

## OTHER COMMENTS:

## CAC NOTES:

**Start Date of Comment Period:** February 14, 2000

**End Date of Comment Period:** March 31, 2000

**Publication Date:** June, 2000

**Policy Effective Date:** July 31, 1994

**Initial Revision Effective Date:** August 31, 1994 (ICD-9-CM additional digit to V45.89)

**SECOND REVISION DATE** June 15, 2000

(deleted ICD-9-CM code V45.6, added ICD-9-CM code V45.61 and combined corneal wedge resection policy with corneal relaxing incision policy; 2.5 diopters astigmatism reduced to 1.5 diopters; corneal relaxing incision and corneal wedge resection policies were combined).

This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from a variety of specialty groups.

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**REVISED: FEBRUARY, 2000**

**POLICY NUMBER: 003-OPH-21400-R-NT**

**SUBJECT: CORNEAL TOPOGRAPHY**

**DESCRIPTION:**

Corneal topography allows for inspection of full corneal surface curvature and refractive power by computer-assisted video keratography.

**POLICY TYPE:** Local Medical Necessity Policy

**HCPCS SECTION AND BENEFIT CATEGORY:** Ophthalmology

**HCPCS CODE:**

**92499** - Unlisted ophthalmological service or procedure

**HCFA NATIONAL COVERAGE POLICY:**

Title XVIII of The Act, Section 1862(a)(1)(A), allows for payment of only those services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

**INDICATIONS AND LIMITATIONS OF COVERAGE:**

**INDICATIONS:**

- Postoperative corneal transplant (ICD-9-CM V42.5)
- Lamellar keratoplasty (ICD-9-CM V45.6);
- Postoperative high astigmatism, i.e. greater than or equal to 1.5 diopters, after cataract, or glaucoma surgery (ICD-9-CM V45.6, 367.20-367.22); or lens implant surgery (ICD-9-CM V45.89);
- Mooren's ulcer (ICD-9-CM 370.07);
- Corneal deformity (ICD-9-CM 371.70);
- Anomalies of corneal size and shape (ICD-9-CM 743.41);
- Mechanical complication of corneal graft (ICD-9-CM 996.51);
- Nodular degeneration of the cornea (ICD-9-CM 371.46);
- Marginal degeneration of the cornea (ICD-9-CM 371.48);
- Keratoconus (ICD-9-CM 371.60-371.62);
- Corneal ectasia (ICD-9-CM 371.71);
- Pterygium (ICD9-CM 372.40-372.45).

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**CONTRAINDICATIONS:**

No evidence of any indication listed above

**ICD-9-CM CODES THAT SUPPORT MEDICAL NECESSITY:**

**367.20-367.22** Astigmatism

**370.07** Mooren's ulcer

**371.70** Corneal deformity

**371.46** Nodular degeneration of cornea

**371.48** Peripheral degeneration of cornea

**371.60-371.62** Keratoconus

**371.71** Corneal ectasia

**372.40-372.45** Pterygium

**743.41** Anomalies of corneal size and shape

**996.51** Mechanical complication of corneal graft

**V45.6** Lamellar keratoplasty

**V45.89** Lens implant surgery

**REASONS FOR DENIAL:**

- Indications listed above have not been met
- Service does not alter the management of the patient
- Documentation requirements are not met
- Frequency parameters as listed under documentation requirements are exceeded

**NON-COVERED ICD 9 CM CODES:**

All diagnoses not listed above in indications for coverage section

**SOURCES OF INFORMATION:**

Carrier Advisory Committee Ophthalmology/Optometry

**CODING GUIDELINES:**

- Code ICD9CM diagnosis code to highest level of specificity.
- If the procedure is medically necessary and the information provided **will alter the medical management**, the following test frequencies are allowed:
- For post-operative cataract, (**twice** to monitor stability), and (**twice** after each corneal relaxing incision or corneal wedge resection) to monitor progress and need for additional treatment,
- For postoperative corneal transplant (ICD-9-CM V42.5), repeated procedures **6 times in the first post-operative year then twice a year thereafter;**
- For lamellar keratoplasty (ICD-9-CM V45.61), repeated procedures **twice a year;**
- For all other procedures, **once per year**, maximum.
- A bilateral exam is allowed when each eye has corneal pathology, as documented in the medical record.

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## DOCUMENTATION REQUIREMENTS:

- The medical record should support the medical necessity and frequency of this treatment.
- If the procedure is medically necessary and the information provided ***will alter the medical management***, the following test frequencies are allowed:
- For post- operative cataract, (***twice*** to monitor stability), and (***twice*** after each corneal relaxing incision or corneal wedge resection) to monitor progress and need for additional treatment,
- For postoperative corneal transplant (ICD-9-CM V42.5), repeated procedures ***6 times in the first post-operative year then twice a year thereafter;***
- For lamellar keratoplasty (ICD-9-CM V45.61), repeated procedures ***twice a year;***
- For all other procedures, ***once per year***, maximum.
- A bilateral exam is allowed when each eye has corneal pathology, as documented in the medical record.

## CAC NOTES:

**Policy Effective Date:** July 31, 1994

**Initial Revision Effective Date:** August 31, 1994 (ICD-9-CM additional digit to V45.89)

**Start Date of Comment Period:** February 14, 2000

**End Date of Comment Period:** March 31, 2000

**Publication Date:** June, 2000

**Second Revision Effective Date:** July 15, 2000 (ICD9CM code V45.6, added ICD9CM code V45.61 and changed frequency parameters)

This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from a variety of specialty groups.

**REVISED POLICY: October 31, 1996**

**SUBJECT: BLEPHAROPLASTY**

**DESCRIPTION:**

Blepharoplasty is reconstructive surgery of the upper eyelid performed to restore normalcy to an eyelid that has been altered by trauma, infection, inflammation, degeneration, neoplasia, or developmental errors.

**POLICY TYPE:** Local medical necessity policy

**HCPCS SECTION AND BENEFIT CATEGORY:** Surgery

**HCPCS CODES:** 15820 Blepharoplasty, lower eyelid

**15821** Blepharoplasty, lower eyelid; with extensive herniated fat pad

**15822** Blepharoplasty, upper eyelid

**15823** Blepharoplasty, upper eyelid; with excessive skin weighting down lid

**67901** Repair of blepharoptosis; frontalis muscle technique with suture or other material

**67902** Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)

**67903** Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach

**67904** Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

**67906** Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)

**67908** Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)

**POLICY:** None applicable

**INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:**

Blepharoplasty will be considered covered when performed as functional/reconstructive surgery as defined by the following requirements:

1. The upper visual field must improve by at least twenty degrees with the eyelid taped up as compared to the visual field obtained without taping of the eyelid; OR
2. Visual field obstruction by the eyelid or eyebrow must limit the upper visual field to within thirty degrees of fixation; OR
3. Vertical palpebral fissure height of 1 mm. or less in downgaze; OR
4. Change in the distance of the lower eyelid to brow in downgaze of 7 mm. or greater after 10% phenylephrine testing.

**ICD-9-CM CODES THAT SUPPORT MEDICAL NECESSITY:**

368.40 Visual field defect, unspecified  
368.41 Scotoma involving central area  
368.42 Scotoma of blind spot area  
368.43 Sector or arcuate defects  
368.44 Other localized visual field defect  
368.45 Generalized contraction or constriction  
368.46 Homonymous bilateral field defects  
368.47 Heteronymous bilateral field defects  
374.30 Ptosis of eyelid, unspecified  
374.31 Paralytic ptosis  
374.32 Myogenic ptosis of eyelid, unspecified  
374.33 Mechanical ptosis of eyelid, unspecified  
374.34 Blepharochalasis  
374.87 Dermatochalasis  
375.20 Epiphora, unspecified as to cause  
743.61 Congenital ptosis  
V52.2 Artificial eye

**REASONS FOR DENIAL:**

1. 15820 and 15821 are not covered because they are considered cosmetic procedures and are not medically necessary for treatment of a disease.
2. Medicare does not provide coverage for cosmetic procedures according to Social Security Act 1862(A)(10).

**NON-COVERED ICD-9-CM CODE(S):**

All except those listed above.

**SOURCES OF INFORMATION:**

CAC Ophthalmology Workgroup  
CMD Clinical Workgroup Model Policy on "Blepharoplasty"

**CODING GUIDELINES:**

1. The appropriate ICD-9-CM for the covered procedure must be submitted as the line diagnosis on the claim.

**DOCUMENTATION REQUIREMENTS:**

1. The medical record should support the medical necessity and frequency of this procedure.
2. Photographs documenting obvious blepharochalasis, dermatochalasis, ptosis, or brow ptosis compatible with the visual field determinations must be included in the patient's medical record.
3. Documentation in the medical record must include the visual fields and before-surgery photograph.

**OTHER COMMENTS:**

None.

**CAC NOTES:**

None.

**Original Publication Date:** October 30, 1993

**Original Effective Date:** November 30, 1993

**Revision Date:** February 28, 1994

**Revision Date:** June 30, 1996

**Effective Date:** July 31, 1996

**Revision Date:** October 31, 1996

This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from all specialties.

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**REVISED POLICY:** February/March, 1997

**SUBJECT: INDOCYANINE GREEN ANGIOGRAPHY**

**DESCRIPTION:**

Indocyanine Green Angiography (IGA) is a diagnostic test used to better define choroidal neovascularization associated with age-related macular degeneration. It provides greater sensitivity in defining lesions of the choroidal membrane than the more commonly used fluorescein angiography (FA) study.

Indocyanine green dye is injected intravenously, photographs of the retina are taken, and computer enhanced images are developed and analyzed. Information obtained in this manner helps guide laser therapy. IGA may be done after surgery to determine prognosis or complications.

**POLICY TYPE:** Local Medical Necessity Policy

**HCPCS SECTION:** Ophthalmology.

**HCPCS CODES: 92240** Indocyanine-green angiography (includes multiframe imaging) with interpretation and report

**92499** Unlisted ophthalmological service or procedure

**NOTE: 92240** is the new code to be used for services on or after January 1, 1997.

**92499** is the code used for Indocyanine-Green Angiography for services up to December 31, 1996.

**HCFA NATIONAL POLICY:**

None applicable.

**INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:**

This is a covered procedure when the following conditions apply:

1. a previous Fluorescein Angiography (CPT-4 codes 92230, 92235) has failed to define the subretinal neovascular membrane, or
2. a post-operative IGA will provide more accurate definition of the subretinal neovascular membrane than conventional FA, and
3. the information provided will alter the patient's medical management.

**ICD-9-CM CODES THAT SUPPORT MEDICAL NECESSITY:**

1. Subretinal neovascular membrane (ICD-9-CM 362.16);
2. Serous detachment of retinal pigment epithelium (ICD-9-CM 362.42);
3. Hemorrhagic detachment of retinal pigment epithelium (ICD-9-CM 362.43);
4. Exudative Senile Macular Degeneration of Retina (ICD-9-CM 362.52);
5. Retinal hemorrhage (ICD-9-CM 362.81);

- 
6. Allergic reaction to fluorescein (ICD-9-CM 995.2).

**REASONS FOR DENIAL:**

Not applicable.

**INDOCYANINE GREEN ANGIOGRAPHY**

**NONCOVERED ICD-9-CM CODE(S):**

All except those listed above.

**SOURCES OF INFORMATION:**

1. CAC Ophthalmology Work Group.
2. Flower, "Extraction of choriocapillaris hemodynamic data from ICG fluorescence angiograms." Invest Ophthalmol Vis Sci, 34(9): 2720-9. 8/93
3. Freund, et al, "Age-related Macular Degeneration & Choroidal Neovascularization." AJ of Ophthalmology, 115:786-791. June '93
4. Guyer, et al, "Digital ICG videoangiography of central serous chorioretinopathy." Arch Ophthal, 112(8): 1057-62. 8/94
5. le, et al, "ICG in multiple evanescent white-dot syndrome." Am J Ophth, 117(1): 7-12. 1/94
6. Obana, et al, "Survey of compilations of ICG." Am J Oph, 118(6): 749-53. 12/94.
7. Scheider, et al, "Detection of subretinal neovascular membranes with indocyanine green and an infrared scanning laser ophthalmoscope." Am J Oph, 113(1): 45-51. Jan, '92
8. Slakter, et al, "A pilot study of ICG-guided laser photocoagulation of occult choroidal neovascularization in age-related macular degeneration." Arch Ophth, 112(4): 465-72. 4/94
9. Sorenson, et al, "A pilot study of digital ICG for recurrent occult choroidal Neovascularization in age-related macular degeneration." Arch Ophth, 112(4): 473-9. 4/94

**CODING GUIDELINES:**

1. The appropriate ICD-9-CM for the covered procedure must be submitted as the line diagnosis on the claim.
2. This is a unilateral code; use of RT and LT modifier is appropriate.

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## DOCUMENTATION REQUIREMENTS:

1. The medical record should support the medical necessity and frequency of this treatment. This includes:
  - evidence of ill-defined subretinal neovascular membrane or suspicious membrane on previous fluorescein angiography, or
  - subretinal neovascularization not evident on current fluorescein angiogram in patient with biomicroscopic evidence suggesting the possibility of subretinal neovascularization, or
  - presence of subretinal hemorrhage or hemorrhagic retinal pigment epithelial detachment, or
  - clinical retinal pigment epithelial detachment which does not show a subretinal neovascular membrane on current fluorescein angiography.
2. If the test is performed more frequently than twice a year, additional documentation (statement of clinical worsening along with retinal photography or drawing) must be submitted. A simple statement of change in clinical status is not sufficient. Use Modifier 22 when submitting documentation indicating the medical necessity of more frequent tests.
3. A statement that a previous Fluorescein Angiography (CPT-4 codes 92230, 92235) had failed to initially define the subretinal neovascular membrane or that a post-operative IGA will provide more accurate definition of the subretinal neovascular membrane should be placed in the medical record.

## OTHER COMMENTS:

None.

## CAC NOTES:

None.

## INDOCYANINE GREEN ANGIOGRAPHY

**Start Date of Comment Period:** May 19, 1995

**Start Date of Notice Period:** October 31, 1995

**Effective Date:** December 31, 1995

**Revision Date: February/March 1997 (New procedure code for services on or after January 1, 1997).**

This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, including representatives from ophthalmology and all other specialties.

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**FINAL LOCAL MEDICAL REVIEW POLICY**

**CONTRACTOR'S POLICY NUMBER:** 00-9.R3

**CONTRACTOR NAME\*:** NHIC-NE

**CONTRACTOR NUMBER\*:** 31142-31143-31144-31145

**CONTRACTOR TYPE\*:** Part B Carrier

**LMRP TITLE\*:**Ocular Photodynamic Therapy (OPT)

**AMA CPT COPYRIGHT STATEMENT\*:**

CPT codes, descriptions, and other data only are copyright 2001 American Medical Association (or such other data of publication of CPT). All rights reserved. Applicable FARS/DFARS clauses apply.

**CMS NATIONAL COVERAGE POLICY\*:**

- Title XVIII of The Act, Section 1862(a)(1)(A), allows for payment of only those services that are “reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.”
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- *Code of Federal Regulations* 42, Ch. IV, 414.34
- *Medicare Carrier's Manual* 2048.1-4
- *Medicare Carrier's Manual* 15049
- *Fiscal Intermediary Manual*, Section 3103.3

**PRIMARY GEOGRAPHIC JURISDICTION\*:**

Massachusetts, Vermont, Maine, New Hampshire

**SECONDARY GEOGRAPHIC JURISDICTION:**

**CMS REGION\*:** Region I

**CMS CONSORTIUM\*:** Northeast

**DMERC REGION LMRP COVERS:** N/A

**ORIGINAL POLICY EFFECTIVE DATE\*:** 09/14/2000

**ORIGINAL POLICY ENDING DATE\*:** 09/30/2000

**REVISION EFFECTIVE DATE\*:** 01/01/02

**REVISION ENDING DATE\*:** 12/31/2001

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## **LMRP DESCRIPTION\*:**

Ocular Photodynamic Therapy is a treatment for age-related macular degeneration, the leading cause of blindness among Americans over age 50. One type of macular degeneration affects vision by forming a scar-like membrane under the retina. This membrane is called the choroidal neovascularization membrane (CNVM). This membrane can affect the eye by distorting or blocking vision.

The purpose of Ocular Photodynamic Therapy is to slow or stop the growth of this scar-like membrane (CNVM). First, a drug, Visudyne, a photosensitizing agent, is administered intravenously. Next, a low energy laser light is directed at the lesion in the eye. This laser activates the drug, and the Visudyne works on sealing leakage from the scar-like membrane (CNVM).

Age related macular degeneration is the leading cause of new severe vision loss in the US in patients over age 50. The mechanism of visual loss in many patients relates to the secondary effects of subretinal neovascularization. Laser photocoagulation has been shown to be beneficial in the treatment of extrafoveal neovascularization and in selected cases of subfoveal neovascularization. Recent studies have shown the effectiveness in treating patients with subfoveal choroidal neovascularization caused by age-related macular degeneration.

In age-related macular degeneration the patients in whom the treatment is effective, the subfoveal neovascularization is 50% or greater classic. Where the preponderance of neovascularization was occult, the treatment was ineffective.

## **INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY\*:**

**Effective for claims for dates of service on or after April 13, 2000 (FDA Verteporfin Approval Date)**

### **INDICATIONS OF COVERAGE:**

- For coverage of the initial treatment of Ocular Photodynamic Therapy for patients with Choroidal Neovascular Membrane (CNVM), associated with Age-related Macular Degeneration (AMD), all of the following criteria must be met per eye:
  - Choroidal Neovascular Membrane secondary to Age-related Macular Degeneration (ICD-9-CM 362.52 Exudative senile macular degeneration); and
  - CNVM under the geometric center of the foveal avascular zone; and
  - Evidence of classic CNVM on fluorescein angiogram (FA); and
  - Area of classic CNVM at least 50 percent of the total area of the CNVM.
- **For coverage of re-treatments of Ocular Photodynamic Therapy the following criteria must be met per eye:**
  - **The patient must have met all criteria for the initial treatment of Verteporfin, and**
  - **The frequency of these re-treatments must be less than or equal to 4 times during the first year and less than or equal to 3 times in the second and subsequent years; and**
  - For patients who already have received one treatment with Verteporfin, and are returning for another treatment, evidence of leakage of any sort must be present on fluorescein angiography

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**LIMITATIONS OF COVERAGE:**

- This procedure is not covered if any of the following exist per eye for the initial treatment of Ocular Photodynamic therapy for patients with Choroidal Neovascular Membrane (CNVM), associated with Age-related Macular Degeneration(AMD):
  - No Choroidal Neovascular Membrane secondary to Age-related Macular Degeneration(ICD-9-CM 362.52 Exudative senile macular degeneration);
  - No CNVM under the geometric center of the foveal avascular zone; or
  - Active hepatitis or liver disease; or
  - Porphyria or other porphyrin sensitivity; or
  - CNVM not associated with AMD, e.g., high myopia, angioid streaks, histoplasmosis or idiopathic disease;<sup>6-7</sup> or
  - No CNVM under the geometric center of the foveal avascular zone; or
  - No evidence of classic CNVM on fluorescein angiogram (FA); or
  - Area of classic CNVM less than 50 percent of the total area of the CNVM.
  
- **Re-treatments of Ocular Photodynamic Therapy are not covered per eye if:**
  - **The patient has not met all criteria for the initial treatment of Verteporfin; and**
  - **The frequency of these re-treatments has been greater than 4 times during the first year and greater than 3 times in the second and subsequent years; and**
  - The patient who already has received one treatment with Verteporfin, and is returning for another treatment has no evidence of leakage of any sort noted on fluoroscein angiography.

**Note:**

- *The use of Verteporfin with laser activation is the only form of Ocular Photodynamic Therapy (OPT) that is FDA-approved. Other OPT agents and procedures, such as transpupillary thermal therapy, destruction of macular drusen by photocoagulation and photocoagulation (feeder vessel technique) remain experimental.*

**CPT/HCPCS SECTION & BENEFIT CATEGORY\*:** Ophthalmology**TYPE OF BILL CODE:****REVENUE CODES:****CPT/HCPCS CODES\*:*****For services performed on or after 9/14/2000:***

67299 Unlisted procedure, posterior segment  
J3490 Unclassified drug

***For services performed on or after 1/1/2001:***

67221 Photodynamic therapy (includes intravenous infusion)  
J3490 Unclassified drug

***For services performed on or after 7/1/2001:***

67221 Photodynamic therapy (includes intravenous infusion)  
Q3013 Verteporfin injection, 15 mg.

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*For services performed on or after 01/01/02:*

67221 Photodynamic therapy (includes intravenous infusion)  
67225 Photodynamic therapy, second eye, at single session  
J3395 Injection, Verteporfin 15mg (replaces Q3013)

**NOT OTHERWISE CLASSIFIED (NOC)\*:**

**ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY\*:**

362.52 Exudative senile macular degeneration

**DIAGNOSES THAT SUPPORT MEDICAL NECESSITY:**

**ICD-9 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:**

All ICD-9 Codes not listed under the "ICD-9 Codes That Support Medical Necessity" section of this policy will be denied.

**DIAGNOSES THAT DO NOT SUPPORT MEDICAL NECESSITY:**

**REASONS FOR DENIALS\*:**

- Indications for coverage as listed under "Indications and Limitations of Coverage" have not been met.
- Documentation does not support medical necessity.
- Diagnosis submitted does not support medical necessity.
- Use of non-FDA approved agents for OPT and other procedures, such as transpupillary thermal therapy, destruction of macular drusen by photocoagulation and photocoagulation (feeder vessel technique) will be denied as experimental.
- Use of CPT code 67220 to describe OPT.

**NONCOVERED ICD-9 CODE(S):**

- ICD-9-CM 362.51 Nonexudative senile macular degeneration
- Any other ICD-9-CM codes, not listed under "ICD-9-CM codes that support medical necessity".

**NONCOVERED DIAGNOSIS:**

**CODING GUIDELINES:**

The following documentation to support medical necessity should be available upon Request by the Carrier:

For the initial treatment:

***For claims with dates of service from April, 2000 through July 17, 2000...***

- CPT Code 67299 includes Verteporfin, the intravenous infusion service (CPT code 90784 or 90780) for the Verteporfin and the exposure to laser light.

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***For claims with dates of service on or after July 18, 2000, (the effective date of approval of Verteporfin for inclusion in the United States Pharmacopoeia)...***

- Verteporfin should be submitted as a drug with HCPCS Code J3490.
  - CPT Code 67299 includes the intravenous infusion service (CPT code 90784 or 90780) for the Verteporfin and the exposure to laser light.
- Evaluation and management services, fluorescein angiography (CPT code 92235), or other ocular diagnostic services, e.g., fundus photography (CPT code 92250), even when provided on the same date of service as the Ocular Photodynamic Therapy are separately billable.
- The invoice that represents the actual vial(s) of Verteporfin infused. (If Verteporfin was ordered in bulk, a separate invoice for each individual vial is not required; however, the specific bulk invoice that correlates with the actual vial(s) infused should be submitted.)

**For subsequent treatments:**

***For claims with dates of service from April, 2000 through July 17, 2000...***

- CPT Code 67299 includes Verteporfin, the intravenous infusion service (CPT code 90784 or 90780) for the Verteporfin and the exposure to laser light.

***For claims with dates of service on or after July 18, 2000, (the effective date of approval of Verteporfin for inclusion in the United States Pharmacopoeia)...***

- Verteporfin should be submitted as a drug with HCPCS Code J3490.
  - CPT Code 67299 includes the intravenous infusion service (CPT code 90784 or 90780) for the Verteporfin and the exposure to laser light.
- Evaluation and management services, fluorescein angiography (CPT code 92235), or other ocular diagnostic services, e.g., fundus photography (CPT code 92250), even when provided on the same date of service as the Ocular Photodynamic Therapy are separately billable.
- For patients who already have received one treatment with Verteporfin, and are returning for another treatment, evidence of leakage of any sort must be present on fluorescein angiography
- Retreatments *per eye* may be performed less than or equal to 4 times during the first year and less than or equal to 3 times in the second and subsequent years.
- The following should be stated on the claim form:
  - The actual dosage of Verteporfin, infused per treatment, and
  - The Body Surface Area in square meters (m<sup>2</sup>), and
  - An indication of which eye was treated (LT or RT) should be stated on the claim form
- When claims are submitted for OPT, performed on both eyes on the same day, only a single payment for Verteporfin and the infusion of Verteporfin will be made, as a single infusion is adequate for treatment of both eyes. When both eyes are treated on the same day, submit CPT Code 67299 with modifier 50.
- The invoice that represents the actual vial(s) of Verteporfin infused. (If Verteporfin was ordered in bulk, a separate invoice for each individual vial is not required; however, the specific bulk invoice that correlates with the actual vial(s) infused should be submitted.)

***For claims submitted as of 01/01/01....***

- Verteporfin should be submitted as a drug with HCPCS Code J3490 and as of 07/01/01 Verteporfin should be submitted with HCPCS Code Q3013.
  - CPT Code 67221 includes the intravenous infusion service (CPT code 90784 or 90780) for the Verteporfin and the exposure to laser light.

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- Evaluation and management services, fluorescein angiography (CPT code 92235), or other ocular diagnostic services, e.g., fundus photography (CPT code 92250), even when provided on the same date of service as the Ocular Photodynamic Therapy are separately billable.
  - For patients who already have received one treatment with Verteporfin, and are returning for another treatment, evidence of leakage of any sort must be present on fluorescein angiography
  - Retreatments per eye may be performed less than or equal to 4 times during the first year and less than or equal to 3 times in the second and subsequent years.
  - The following should be stated on the claim form:
    - The actual dosage of Verteporfin, infused per treatment, and
    - The Body Surface Area in square meters (m<sup>2</sup>), and
    - An indication of which eye was treated (LT or RT) should be stated on the claim form
  - When claims are submitted for OPT, performed on both eyes on the same day, only a single payment for Verteporfin and the infusion of Verteporfin will be made, as a single infusion is adequate for treatment of both eyes. When both eyes are treated on the same day, submit CPT Code 67299 with modifier 50.
  - The invoice that represents the actual vial(s) of Verteporfin infused. (If Verteporfin was ordered in bulk, a separate invoice for each individual vial is not required; however, the specific bulk invoice that correlates with the actual vial(s) infused should be submitted.)

Note: If a medication is determined not to be reasonable and necessary for the diagnosis or treatment of an illness or injury according to the above guidelines, the entire charge will be excluded from payment (i.e., for both the Verteporfin and its administration). Also exclusion from payment will occur for other services (such as office visits) which were primarily for the purpose of administering a non-covered injection (i.e., an injection that is not reasonable and necessary for the diagnosis or treatment of an illness or injury).

#### **DOCUMENTATION REQUIREMENTS:**

- The medical record should include the following documentation to support medical necessity and should be available upon request by the Carrier:
  - For the initial administration of Verteporfin, the following evidence must be present in the medical record to support medical necessity:
    - Choroidal Neovascular Membrane secondary to Age-related Macular Degeneration (ICD-9-CM 362.52 Exudative senile macular degeneration);
    - CNVM under the geometric center of the foveal avascular zone;
    - Evidence of classic CNVM on fluorescein angiogram (FA);
    - Area of classic CNVM at least 50 percent of the total area of the CNVM;
    - Documentation of the evaluation and management service, fundus Photography, or other ocular diagnostic services;
    - The initial fluorescein angiogram report indicating the exact percentage of classic component of the neovascular membrane;
    - Patient body surface area in square meters (m<sup>2</sup>), and the actual dosage of Verteporfin, infused per treatment; and
    - The invoice that represents the actual vial(s) of Verteporfin infused. (If Verteporfin was ordered in bulk, a separate invoice for each individual vial is not required; however, the specific bulk invoice that correlates with the actual vial(s) infused should be submitted.)

- 
- For the subsequent administration(s) of Verteporfin, the following evidence must be present in the medical record to support medical necessity:
    - Fluorescein angiography report indicating leakage of any sort;
    - Documentation of the evaluation and management service, fundus photography, or other ocular diagnostic services;
    - Patient body surface area in square meters (m<sup>2</sup>), and the actual dosage of Verteporfin, infused per treatment; and
    - The invoice that represents the actual vial(s) of Verteporfin infused. (If Verteporfin was ordered in bulk, a separate invoice for each individual vial is not required; however, the specific bulk invoice that correlates with the actual vial(s) infused should be submitted.)
  - The medical record should support the medical necessity and frequency of this treatment.

#### **UTILIZATION GUIDELINES:**

#### **OTHER COMMENTS:**

#### **SOURCES OF INFORMATION AND BASIS FOR DECISION\*:**

1. Macular Photocoagulation Study Group, "Argon Laser Photocoagulation for Neovascular Maculopathy." *Archives of Ophthalmology*, 1992; 109:1109-1114.
2. Macular Photocoagulation Study Group, "Visual Outcome After Laser Photocoagulation For Subfoveal Choroidal Neovascularization Secondary To Age-Related Macular Degeneration." *Archives of Ophthalmology*, 1994; 112:480-488.
3. Photodynamic Therapy (TAP) Study Group, "Photodynamic Therapy of Subfoveal Choroidal Neovascularization in Age-related Macular Degeneration With Verteporfin. One-Year Results of 2 Randomized Clinical Trials--TAP Report 1." *Archives of Ophthalmology*, October 1999; 117:1329-1345.
4. Photodynamic Therapy (TAP) Study Group, "Study of Photodynamic Therapy Using Verteporfin for Choroidal Neovascularization in pathologic myopia, ocular histoplasmosis syndrome, angioid streaks, and idiopathic causes." *Archives of Ophthalmology*, 2000; 118:327-336.
5. Schmidt-Erfurth, Ursula et al. "Photodynamic Therapy With Verteporfin for Choroidal Neovascularization Caused by Age-related Macular Degeneration. Results of Retreatments in a Phase 1 and 2 Study." *Archives of Ophthalmology*. September 1999; 117:1177-1187.
6. Miller JW et al: "Photodynamic therapy with Verteporfin for choroidal neovascularization caused by age-related macular degeneration: results of a single treatment in a phase 1 and 2 study." *Arch Ophthalmol* 117:1161, 1999.
7. Sickenberg M et al. "Preliminary study of photodynamic therapy using Verteporfin for choroidal neovascularization in pathologic myopia, ocular histoplasmosis syndrome, angioid streaks, and idiopathic causes." *Arch Ophthalmol*, 2000; 118(3):327.
8. Medicare Carriers Manual, Section 2049.3.
9. Medicare Carriers Manual, Section 2049.4.
10. Macular Photocoagulation Study Group: Laser photocoagulation of subfoveal neovascular lesions in age-related macular degeneration; results of a randomized clinical trial. *Arch Ophthalmol*, 1991; 109:1220.
11. Macular Photocoagulation Study Group: Argon laser photocoagulation for neovascular maculopathy; five-year results from randomized clinical trials. *Arch Ophthalmol*, 1991; 109:1109.
12. Macular Photocoagulation Study Group: Laser photocoagulation for juxtavoveal choroidal neovascularization: five-year results from randomized clinical trials. *Arch Ophthalmol*, 1994; 112:500.

13. Macular Photogagulation Study Group: Laser photocoagulation of subfoveal neovascular lesions of age-related macular degeneration: updated findings from two clinical trials. Arch Ophthalmol, 1993; 111:1200.
14. Ciulla TA, Danis RP, Harris A. "Age related macular degeneration: a review of experimental treatments." Surv Ophthalmol, September-October, 1998; 43(2).
15. Physician members of the Carrier Advisory Committee Ophthalmology Working Group.
16. National Carrier Medical Directors' New Technology Medicine Work Group.
17. Ciba Vision unpublished observations.
18. Current Procedural Terminology 2000, Copyright 1999, American Medical Association. All rights reserved.
19. Comments from the Public, received during the 45-day, official comment period.

**ADVISORY COMMITTEE NOTES\*:**

This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the carrier, this policy was developed in cooperation with advisory groups, which includes representatives from Ophthalmology

Advisory Committee Meeting Date:

**START DATE OF COMMENT PERIOD\*:** 05/08/2000

**END DATE OF COMMENT PERIOD\*:** 06/22/2000

**START DATE OF NOTICE PERIOD\*:** 08/14/2000

**REVISION HISTORY\*:**

<b>NUMBER</b>	<b>DATE</b>	<b>CHANGE</b>
R-3	01/01/2002	<b>Add CPT 67225</b> <b>Add: HCPC J3395 (replaces Q3013)</b>
R-2	04/16/2001	For claims submitted as of 01/01/01: Verteporfin should be submitted as a drug with HCPCS Code J3490 and as of 07/01/01, Verteporfin should be submitted with HCPCS code Q3013. <ul style="list-style-type: none"> <li>• CPT Code 67221 includes the intravenous infusion service (CPT code 90784 or 90780) for the Verteporfin and the exposure to laser light.</li> </ul>
R-1	10/01/00	Billing guideline revisions

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**CONTRACTOR'S POLICY NUMBER:** R1-03-01-02

**CONTRACTOR NAME\*:** NHIC-NE

**CONTRACTOR NUMBER\*:** 31142-31143-31144-31145

**CONTRACTOR TYPE\*:** Part B Carrier

**LMRP TITLE\*:** Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

**AMA CPT COPYRIGHT STATEMENT\*:**

CPT codes, descriptions, and other data only are copyright 2001 American Medical Association (or such other data of publication of CPT). All rights reserved. Applicable FARS/DFARS clauses apply.

**CMS NATIONAL COVERAGE POLICY\*:**

Section 1862 (a.) (7.) of the Social Security Act does not extend coverage to screening procedures. "Medicare payment is prohibited for any item or service that is not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Social Security Act Section 1862(a)(1)(A)  
HCFA furthermore interprets "reasonable and necessary" to mean that an item or service is safe and effective, non-experimental, non-investigational and appropriate.

**PRIMARY GEOGRAPHIC JURISDICTION\*:**

Massachusetts, Vermont, Maine, New Hampshire

**SECONDARY GEOGRAPHIC JURISDICTION:**

**CMS REGION\*:** Region I

**CMS CONSORTIUM\*:** Northeast

**DMERC REGION LMRP COVERS:** N/A

**ORIGINAL POLICY EFFECTIVE DATE\*:** 2/1/2000

**ORIGINAL POLICY ENDING DATE\*:** 2/28/2002

**REVISION EFFECTIVE DATE\*:** 3/1/2002

**REVISION ENDING DATE\*:**

**LMRP DESCRIPTION\*:**

Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) allows for earlier detection of optic nerve and retinal nerve fiber layer pathologic changes before there is visual field loss. When appropriately used in the management of the glaucoma patient or glaucoma suspect, therapy can be initiated before there is irreversible loss of vision. This imaging technology provides the capability to discriminate among patients with normal intraocular pressures who have glaucoma, patients with elevated intraocular pressure who have glaucoma, and patients with elevated intraocular pressure who do not have glaucoma.

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**INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY\*:****INDICATIONS OF COVERAGE:**

SCODI is considered to be reasonable and necessary to:

Diagnose early glaucoma and monitor glaucoma treatment

Differentiate causes of other optic nerve disorders when a diagnosis is in doubt.

Diagnose and manage the patient's condition when visual field results are insufficient; or when *reliable* visual field testing cannot be performed, due to visual, physical, mental, or age constraints.

Differentiate when a discrepancy exists between the clinical appearance of the optic nerve and the visual fields

Detect further loss of optic nerve or retinal nerve fiber layer changes in the presence of advanced optic nerve damage and advanced visual field loss

Diagnose and manage medically and surgically neuro-ophthalmic and retinal diseases which involve changes in the optic nerve, subretinal and intraretinal changes, and changes in the nerve fiber layer

Follow glaucoma suspects with significant risk factors.

**LIMITATIONS OF COVERAGE:**

SCODI is *not* considered to be reasonable and necessary unless used for the following circumstances:

Diagnose early glaucoma and monitor glaucoma treatment

Differentiate causes of other optic nerve disorders when a diagnosis is in doubt.

Diagnose and manage the patient's condition when visual field results are insufficient; or when *reliable* visual field testing cannot be performed, due to visual, physical, mental, or age constraints.

Differentiate when a discrepancy exists between the clinical appearance of the optic nerve and the visual fields

Detect further loss of optic nerve or retinal nerve fiber layer changes in the presence of advanced optic nerve damage and advanced visual field loss

Diagnose and manage medically and surgically neuro-ophthalmic and retinal diseases which involve changes in the optic nerve, subretinal and intraretinal changes, and changes in the nerve fiber layer

Follow glaucoma suspects with significant risk factors.

**CONTRAINDICATIONS:**

Absence of an indication

Screening

**CPT/HCPCS SECTION & BENEFIT CATEGORY\*:** Diagnostic Imaging

**TYPE OF BILL CODE:**

**REVENUE CODES:**

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**CPT/HCPCS CODES\*:**

92135 Scanning computerized ophthalmic diagnostic imaging (e.g., scanning laser) with the interpretation and report, unilateral

**NOT OTHERWISE CLASSIFIED (NOC)\*:****ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY\*:**

<b>DIAGNOSIS CODES</b>	<b>NARRATIVE</b>
190.6	Choroidal melanoma
191.0-198.3	Brain neoplasms, malignant
224.6	Choroidal nevus
225.0-239.7	Brain neoplasms, benign
228.03	Retinal hemangioma
376.00-376.9	Orbital disorder
854.00-854.09	Head injury
360.11	Sympathetic uveitis
360.21	Progressive high myopia
360.3-360.34	Hypotony
361.00-361.07	Retinal detachment
361.10	Retinoschisis
361.2	Serous retinal detachment
361.81	Traction retinal detachment
362.01	Background diabetic retinopathy
362.02	Proliferative diabetic retinopathy
362.10-362.18	Retinal vascular changes
362.31-362.32	Retinal artery occlusion
362.35-362.37	Retinal vein occlusion
362.40-362.43	Separation of retinal layers
362.50-362.77	Degeneration of macula
362.81	Retinal hemorrhage
362.82	Retinal exudate
362.83	Retinal edema
362.85	Retinal nerve fiber bundle defects
363.00-363.08	Focal chorioretinitis
363.10-363.15	Disseminated chorioretinitis
363.20-363.35	Other chorioretinitis
363.43	Angioid streaks
363.63	Choroidal rupture
363.70-363.72	Choroidal detachment
364.22	Glaucomatocyclytic crises
364.53	Pigmentary Iris degeneration
364.73	Goniosynechiae
364.74	Pupillary membranes
364.77	Recession of chamber angle
365.00-365.04	Borderline glaucoma(glaucoma suspect)
365.10-365.15	Open-angle glaucoma
365.20-365.24	Primary angle-closure glaucoma

365.31-365.32	Corticosteroid-induced glaucoma
365.41-365.44	Glaucoma associated with congenital anomalies, dystrophies, and systemic syndromes
365.51	Glaucoma associated with disorders of the lens
365.52	Glaucoma associated with disorders of the lens
365.59	Glaucoma associated with disorders of the lens
365.60-365.65	Glaucoma associated with other ocular disorders
365.81-365.89	Other specified glaucoma
368.40-368.45	Visual field defects
376.00-376.9	Disorders of the orbit
377.00-377.03	Papilledema unspecified
<b>377.04</b>	<b>Foster-Kennedy syndrome</b>
377.2	Papilledema associated with decreased ocular pressure
377.9	Unspecified Disorder of optic nerve and visual pathways
377.10	Optic atrophy
377.14-377.16	Glaucomatous atrophy
377.21	Drusen of the optic disc
377.22	Crater-like holes of the optic disc
377.23	Coloboma of the optic disc
377.24	Pseudopapilledema
377.25	Ischemic optic neuropathy
377.41-377.49	Other disorders of the optic nerve
377.51-377.54	Disorders of the optic chiasm
377.51-377.54	Papilledema, associated with retinal disorder
377.61-377.63	Disorders of other visual pathways
379.21-379.29	Disorder of vitreous body
379.11-379.19	Disorders of the sclera
743.20-743.22	Buphthalmos
743.57-743.58	Optic nerve hypoplasia
743.59	Coloboma of choroid
854.00-854.09	Intracranial injury
921.3	Contusion of eyeball

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## **DIAGNOSES THAT SUPPORT MEDICAL NECESSITY:**

### **ICD-9 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:**

All ICD-9 Codes not listed under the "ICD-9 Codes That Support Medical Necessity" section of this policy will be denied.

## **DIAGNOSES THAT DO NOT SUPPORT MEDICAL NECESSITY:**

### **REASONS FOR DENIALS\*:**

SCODI is not medically necessary for those patients who do not meet the indications listed above.

SCODI is performed as screening.

Documentation does not support the indications

### **NONCOVERED ICD-9 CODE(S):**

### **NONCOVERED DIAGNOSIS:**

### **CODING GUIDELINES:**

The appropriate ICD-9-CM for the covered procedure must be submitted as the line diagnosis on the claim.

In the management of a glaucoma patient, when SCODI is rendered more frequently than once in a 6 month period, Modifier 22 must be used on the claim, and documentation supporting medical necessity must be submitted with the claim.

## **DOCUMENTATION REQUIREMENTS:**

Indications for SCODI must be described in the medical record.

The primary diagnosis for SCODI, listed on the claim form, must support the medical necessity of the testing.

The diagnosis must be present for the procedure to be paid.

Medical records need not be submitted with the claim; however, they must be furnished to the Carrier upon request.

Complete ophthalmology examination describing the indications supporting medical necessity must be available in the patient's medical record. This description should include any evidence of the following for patients who are/have:

### **Glaucoma- suspect or mild glaucomatous damage:**

- Anomalous appearing optic nerve

- Intraocular pressure >22mmHg as measured by applanation

- Symmetric or vertically elongated cup enlargement, neural rim intact, cup to disc ratio >0.4

- Focal optic disk notch

- Optic disk hemorrhage or history of optic disk hemorrhage

- Nasal step or small paracentral or arcuate scotoma

- Mild constriction of visual field isopters

### **Moderate glaucomatous damage:**

- Enlarged optic cup with neural rim remaining but sloped or pale, cup to disc ratio >0.5, but <0.9

- Definite focal notch with thinning of the neural rim

- Definite glaucomatous visual field defect, e.g., arcuate or paracentral scotoma, nasal step, pencil wedge, or constriction of isopters.

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**Advanced glaucomatous damage:**

- Severe generalized constriction of isopters (i.e., Goldmann 14e>10 degrees of fixation)
- Absolute visual field defects within 10 degrees of fixation
- Severe generalized reduction of retinal sensitivity
- Loss of central visual acuity, with temporal island remaining
- Diffuse enlargement of optic nerve cup, with cup to disc ratio >0.8
- Wipe-out of all or a portion of the neural retinal rim

**UTILIZATION GUIDELINES:****OTHER COMMENTS:****SOURCES OF INFORMATION AND BASIS FOR DECISION\*:**

- 1. Carrier Advisory Committee Ophthalmology and Optometry Working Group*
- 2. Other Carrier's policies*
- 3. Copyright 1998 CPT Physicians' Current Procedural Terminology, American Medical Association.*
- 4. Copyright 2002 CPT Physicians' Current Procedural Terminology, American Medical Association.*

**ADVISORY COMMITTEE NOTES\*:**

This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the carrier, this policy was developed in cooperation with advisory groups, which includes representatives from The Ophthalmology Advisory Committee.

**ADVISORY COMMITTEE MEETING DATE:**

**START DATE OF COMMENT PERIOD\*:** 8/16/1999

**END DATE OF COMMENT PERIOD\*:** 9/30/1999

**START DATE OF NOTICE PERIOD\*:** 8/16/1999

**REVISION HISTORY\*:**

<b>NUMBER</b>	<b>DATE</b>	<b>CHANGE</b>
<b>R-1</b>	<b>03-01-2002</b>	<b>ADD ICD-9 code 377.04</b>

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**REVISED POLICY: October 31, 1996**

**SUBJECT: VISUAL FIELD EXAMINATION**

**DESCRIPTION:**

Visual field examinations test the functions of the retina, optic nerve, and optic pathways.

**POLICY TYPE:** Local medical necessity policy

**HCPCS SECTION AND BENEFIT CATEGORY:** Medical

**HCPCS CODES: 92081** Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent).

**92082** intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33).

**92083** extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30°, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2).

**HCFA NATIONAL POLICY:** N/A

**INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:**

1. The following diagnoses are covered procedures for all levels of visual field examinations (procedure codes 92081, 92082, 92083):
  - Malignant neoplasm of eye, choroid (ICD-9-CM 190.6)
  - Glaucoma (ICD-9-CM 365.00-365.9);
  - Endocrine exophthalmos (ICD-9-CM 376.21-376.22);
  - Toxic maculopathy (ICD-9-CM 362.55) and hereditary retinal dystrophies (ICD-9-CM 362.70-362.77);
  - Hemiplegic and ophthalmoplegic migraines (ICD-9-CM 346.80-346.81);
  - For exudative senile macular degeneration (ICD-9-CM 362.52) and Cystoid macular degeneration (ICD-9-CM 362.53), visual field examinations are covered procedures only when used to evaluate the possibility of laser therapy;
  - Retinal Detachment (ICD-9-CM 361.00-361.07);
  - Retinoschisis (ICD-9-CM 361.10-361.19);
  - Diabetic Retinopathy (ICD-9-CM 362.01-362.02);

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- Sudden vision loss (ICD-9-CM 368.11);
  - Transient visual loss (ICD-9-CM 368.12);
  - Diplopia (ICD-9-CM 368.2);
  - Visual field defects (ICD-9-CM 368.40-368.47)
  - Disorders of optic nerve and visual pathways (ICD-9-CM 377.00-377.9);
  - Anomalies of pupillary function (ICD-9-CM 379.40-379.49);
  - Subarachnoid hemorrhage (ICD-9-CM 430);
  - Intracerebral hemorrhage (ICD-9-CM 431);
  - Occlusion of carotid artery (ICD-9-CM 433.10-433.11);
  - Cerebral infarction (ICD-9-CM 434.10- 434.11);
  - Transient cerebral ischemia (ICD-9-CM 435.0-435.9);
  - Brain neoplasms: malignant (ICD-9-CM 191.0-198.3); benign (ICD-9-CM 225.0-239.7);
  - Orbital disorders (ICD-9-CM 376.00-376.9);
  - Head injury (ICD-9-CM 854.00-854.09); and
  - Evaluation of patient being treated with plaquenil (ICD-9-CM 362.55).
2. The following diagnoses are covered procedures only for the limited visual field examination (procedure code 92081):
- Ptosis (ICD-9-CM 374.30-374.33);
  - Blepharochalasis (ICD-9-CM 374.34); and
  - Dermatochalasis (ICD-9-CM 374.87).

**COVERED ICD-9-CM CODES:** See above.

**SOURCES OF INFORMATION:**

Other carriers' policies

CAC Ophthalmology Workgroup Members

**CODING GUIDELINES:**

1. The appropriate ICD-9-CM for the covered procedure must be submitted as the line diagnosis on the claim.

**DOCUMENTATION REQUIREMENTS:**

1. The medical record should support the medical necessity and frequency of this procedure.
2. When more than two examinations are performed per year per beneficiary, documentation indicating the medical necessity for the procedure must be submitted with the claim.
3. Use Modifier 22 when submitting documentation indicating the medical necessity of more than two procedures performed.

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4. Special instructions for EMC users: When submitting a claim which requires supporting documentation, this information can be included in the appropriate "narrative" record for your claim submission format.

**OTHER COMMENTS:**

None.

**CAC NOTES:**

None.

**Start Date of Notice Period:** October 30, 1993

**Effective Date:** November 30, 1993

**Revision Date:** December 31, 1994

**Revision Date:** January 31, 1995

**Revision Date:** April 30, 1995 (ICD-9 correction -1t) (854.00 - 854.09)

**Revision Date:** October/November 1995 (additions to diagnoses #1d, 346.80-346.81 and #1L, 377-00-377.9).

**Revision Date:** February/March, 1996 (addition to diagnosis 1a, 1m, 1s; 1996 narrative change 92081).

**Revision Date:** October 31, 1996 (**changed "98082" to "92082" in "HCPCS Codes" section**).

This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from all specialties.

**CONTRACTOR'S POLICY NUMBER:** 01-21 R-1 09-01-02  
**CONTRACTOR NAME:** NHIC-NE  
**CONTRACTOR NUMBER:** 31142-31143-31144-31145  
**CONTRACTOR TYPE:** PART B CARRIER  
**LMRP TITLE:** Visual Rehabilitative Therapy

**AMA CPT COPYRIGHT STATEMENT:**

CPT codes, descriptions, and other data only are copyright 1999 American Medical Association (or such other data of publication of CPT). All rights reserved. Applicable FARS/DFARS clauses apply.

**CMS NATIONAL COVERAGE POLICY:**

- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1862(a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.
- Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.
- HCFA Program Memorandum AB-00-39
- Program Memorandum AB-02-078

**PRIMARY GEOGRAPHIC JURISDICTION:**

Massachusetts, Vermont, Maine, New Hampshire

**SECONDARY GEOGRAPHIC JURISDICTION:**

**HCFA REGION:** Region I

**HCFA CONSORTIUM:** Northeast

**ORIGINAL POLICY EFFECTIVE DATE:** 01/15/2002

**ORIGINAL POLICY ENDING DATE:**

**REVISION EFFECTIVE DATE:**

**REVISION ENDING DATE:**

**LMRP DESCRIPTION:**

Low vision rehabilitative therapy utilizes aids and education to minimize vision-related disability when no restorative process, for example, correction of refractive error, corneal transplantation, or cataract surgery is possible.

The purpose of rehabilitative therapy is to maximize the use of residual vision and provide patients with many practical adaptations for activities of daily living, which can lead to an increased level of functional ability and independence.

**DEFINITIONS:**

- A *moderate visual impairment* is defined as a best-corrected visual acuity of less than 20/60 in the better eye (including 20/70 to 20/160).
- *Severe visual impairment* refers to a best-corrected visual acuity of less than 20/160 (including 20/200 to 20/400); or a visual field diameter of 20 degrees or less (largest field diameter for Goldmann isopter III4e, 1/100 white test object or equivalent) in the better eye.

**INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:****INDICATIONS AND LIMITATIONS OF COVERAGE**

- Coverage of low vision rehabilitation services are considered reasonable and necessary only for patients who have all of the following:
  - A moderate or severe visual impairment, not correctable by conventional refractive means
  - A functional impairment, associated with the visual deficit, such as independent daily living activities
  - A clear potential for significant improvement in function over a reasonable period of time
- Rehabilitative services should be provided in accordance with a written evaluation and treatment plan, which should include all of the following:
  - An initial assessment, documenting the level of visual impairment, and criteria, listed under indications, establishing whether there is a restorative component
  - A plan of care, identifying specific goals to be fulfilled during rehabilitation, and a definition of the specific services to be provided
  - A reasonable estimate of when goals will be reached and the frequency at which services will be provided

**LIMITATIONS OF COVERAGE:**

- Coverage of low vision rehabilitation services is not considered reasonable and necessary for patients who do not have all of the following:
  - A moderate or severe visual impairment, not correctable by conventional refractive means
  - A functional impairment, associated with the visual deficit, such as independent daily living activities
  - A clear potential for significant improvement in function over a reasonable period of time
  - At least a moderate visual impairment
  - A written evaluation and treatment plan, including:
    - An initial assessment, documenting the level of visual impairment, and criteria, listed under indications, establishing whether there is a restorative component

- A plan of care, identifying specific goals to be fulfilled during rehabilitation, and a definition of the specific services to be provided
- A reasonable estimate of when goals will be reached and the frequency at which services will be provided

**CPT/HCPCS SECTION & BENEFIT CATEGORY:**

Physical Medicine and Rehabilitation

**TYPE OF BILL CODE: N/A**

**REVENUE CODES: N/A**

**CPT/HCPCS CODES:**

- 97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility;
- 97112 Therapeutic procedure, one or more areas, each 15 minutes; Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception
- 97116 Gait training (includes stair climbing)
- 97530 Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
- 97532 Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes;
- 97533 Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes;
- 97535 Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes
- 97537 Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis) direct one on one contact by provider, each 15 minutes

**NOT OTHERWISE CLASSIFIED (NOC):**

**ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:**

- 368.41 Scotoma involving the central area
- 368.45 Generalized contraction or constriction
- 368.46 Homonymous bilateral field defects
- 368.47 Heteronymous bilateral field defects
- 369.01 Better eye: total impairment; lesser eye: total impairment
- 369.03 Better eye: near-total impairment; lesser eye: total impairment
- 369.04 Better eye: near-total impairment; lesser eye: near-total impairment
- 369.06 Better eye: profound impairment; lesser eye: total impairment
- 369.07 Better eye: profound impairment; lesser eye: near-total impairment
- 369.08 Better eye: profound impairment; lesser eye: profound impairment
- 369.12 Better eye: severe impairment; lesser eye: total impairment
- 369.13 Better eye: severe impairment; lesser eye: near-total impairment
- 369.14 Better eye: severe impairment; lesser eye: profound impairment
- 369.16 Better eye: moderate impairment; lesser eye: total impairment
- 369.17 Better eye: moderate impairment; lesser eye: near-total impairment
- 369.18 Better eye: moderate impairment; lesser eye: profound impairment
- 369.22 Better eye: severe impairment; lesser eye: severe impairment
- 369.24 Better eye: moderate impairment; lesser eye: severe impairment
- 369.25 Better eye: moderate impairment; lesser eye: moderate impairment

**DIAGNOSIS THAT SUPPORT MEDICAL NECESSITY:**

**ICD-9 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:**

All other ICD-9 codes not listed in "Covered ICD-9 Codes".

**DIAGNOSIS THAT DO NOT SUPPORT MEDICAL NECESSITY:**

**REASONS FOR DENIAL:**

- Coverage of low vision rehabilitation services is not considered reasonable and necessary for patients who do not have all of the following:
  - A moderate or severe visual impairment, not correctable by conventional means
  - A functional impairment, associated with the visual deficit, such as independent daily living activities, and
  - A clear potential for significant improvement in function over a reasonable period of time
  - At least a moderate visual impairment
  - A written evaluation and treatment plan, including:
    - An initial assessment, documenting the level of visual impairment, and criteria, listed under indications, establishing whether there is a restorative component, and

- A plan of care, identifying specific goals to be fulfilled during rehabilitation, and a definition of the specific services to be provided, and
- A reasonable estimate of when goals will be reached and the frequency at which services will be provided
- The physician or therapist did not have direct one-on-one patient contact during rehabilitative sessions
- A course of rehabilitative therapy for low vision (evaluation, therapeutic planning, and execution of the treatment plan) exceeded eight, one-hour sessions, conducted over a 3 month period for severe impairment, or exceeded six, one-hour sessions, conducted over a 3 month period, for moderate impairment
- When the patient has shown no progress in a reasonable period of time, rehabilitation services will be considered to have reached a stable state or plateau and training will be considered "maintenance", which is a non-covered service.
- The provision of conventional refraction aids and the immediate instruction in their use are not covered, unless related to the treatment following cataract surgery.

**NONCOVERED ICD-9 CODE(S):**

**NONCOVERED DIAGNOSIS:**

**CODING GUIDELINES:**

- Rehabilitation programs should be furnished by an Occupational Therapist or the physician, or "incident to" a physician's professional services when performed by non-physician personnel.

**DOCUMENTATION REQUIREMENTS:**

- The medical record should be legible, include the following documentation to support medical necessity, and should be available upon request by the Carrier:
- Documentation in the medical record should include:
  - An evaluation and treatment plan, including:
    - An initial assessment, documenting the level of visual impairment, and criteria, listed under indications, establishing whether there is a restorative component, and
    - A plan of care, identifying specific goals to be fulfilled during rehabilitation, and a definition of the specific services to be provided, and
    - A reasonable estimate of when goals will be reached and the frequency at which services will be provided
  - Progress notes describing the content and the time for each session;

- A discharge summary that provides documentation specific to the extent to which each goal in the plan of care was achieved, which is to be reviewed and signed by the physician.

**UTILIZATION GUIDELINES:**

- Services provided in connection with visual rehabilitation generally are provided in the number of sessions, outlined below, based on the level of visual impairment as follows:

Moderate Impairment	Maximum of six one hour sessions
Severe Impairment	Maximum of eight one hour sessions

- Sessions are generally conducted over a three- month period of time with intervals appropriate to the patient's rehabilitative needs. If additional sessions are necessary, medical record documentation must indicate the need for the additional sessions.
- The program of rehabilitation will have been judged to have been completed when the treatment goals have been attained and any subsequent services would be regarded maintenance of a level functional ability.

**OTHER COMMENTS:**

**SOURCES OF INFORMATION**

- The American Academy of Ophthalmology. Rehabilitation: The Management of Adult Patients with Low Vision. Prepared by the American Academy of Ophthalmology Quality of Care Committee. 1994.
- Beaver, Kathleen A. "Overview of Technology for Low Vision. The American Journal of Occupational Therapy, October. 1995: pp 913-921.
- Colenbrander, August. "Basic Concepts and Terms for Low Vision Rehabilitation." The American Journal of Occupational Therapy, October. 1995: pp 865-869.
- Lampert, Jessica. "Functional Considerations in Evaluation and Treatment of the Client with Low Vision." The American Journal of Occupational Therapy, October. 1995: pp 885-890.
- Massof, Robert W. "A Systems Model for Low Vision Rehabilitation." Optometry and Vision Science, Vol. 72, No. 10, pp 725-736.
- Raasch, Thomas W. "Evaluating the Value of Low-Vision Services." Journal of the American Optometric Association, May. 1997: pp 287-294.
- Other Carriers' Policies
- Carrier Advisory Committee Members in the Specialty of Ophthalmology and Optometry

**ADVISORY COMMITTEE NOTES:**

This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the carrier, this policy was developed in cooperation with advisory groups, which includes representatives from Ophthalmology.

**ADVISORY COMMITTEE MEETING DATE:** 08/13/01

**START DATE OF COMMENT PERIOD:** 08/13/01

**END DATE OF COMMENT PERIOD:** 09/26/01

**START DATE OF NOTICE PERIOD:** 12/01/01

**REVISION HISTORY:**

<b>NUMBER</b>	<b>DATE</b>	<b>CHANGE</b>
R-1	09-01-2002	Added CPT/HCPCS codes: 97110, 97116, 97532, 97533

**REPUBLISHED POLICY:** May/June 1996

**SUBJECT: EYELID AND BROW SURGICAL PROCEDURES**

**DESCRIPTION:**

Eyelid and eyebrow surgical procedures are performed to alter the configuration of the eyelids and eyebrows to correct visual field defects.

**POLICY TYPE:** Local Medical Necessity Policy

**HCPCS SECTION:** Surgery

**HCPCS CODES:**

**15820** - Blepharoplasty, lower eyelid;

**15821** - with extensive herniated fat pad

**15822** - Blepharoplasty, upper eyelid;

**15823** - with excessive skin weighting down lid

**67900** - Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

**67901** - Repair of blepharoptosis; frontalis muscle technique with suture or other material

**67902** - frontalis muscle technique with fascial sling (includes obtaining fascia)

**67903** - (tarso) levator resection or advancement, internal approach

**67904** - (tarso) levator resection or advancement, external approach

**67906** - superior rectus technique with fascial sling (includes obtaining fascia)

**67908** - conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)

**67909** - Reduction of overcorrection of ptosis

**67914** - Repair of extropion; suture

**67915** - thermocauterization

**67916** - blepharoplasty, excision tarsal wedge

**67917** - blepharoplasty; extensive (e.g. Kuhnt-Szymanowski or tarsal strip operations)

**67921** - Repair of entropion; suture

**67922** - thermocauterization

**67923** - blepharoplasty, excision tarsal wedge

**67924** - blepharoplasty; extensive (e.g. Wheeler operation)

**HCFA NATIONAL POLICY:**

Medicare does not provide coverage for cosmetic procedures [Social Security Act 1862(A)(10)].

**POLICY INDICATIONS AND LIMITATIONS:**

A. This is a covered procedures when used for the following;

1. ICD-9-CM 368.40-368.47

**2. ICD-9-CM 375.20**

A. The above procedure codes are **covered procedures, except for 15820 and 15821**, when performed for correction of significant upper visual field defects (ICD-9-CM 368.40-368.47 and **375.20**) as defined by the following requirements:

1. The upper visual field must improve by at least twenty degrees with the eyelid taped up as compared to the visual field obtained without taping of the eyelid; OR
2. Visual field obstruction by the eyelid or eyebrow must limit the upper visual field to within thirty degrees of fixation; OR
3. **Vertical palpebral fissure height of 1 mm. or less in downgaze; OR**
4. **Change in the distance of the lower eyelid to brow in downgaze of 7 mm. or greater after 10% phenylephrine testing.**

**COVERED ICD-9-CM CODES:**

See above.

**REASONS FOR NON-COVERAGE:**

1. 15820 and 15821 are not covered because they are considered cosmetic procedures and are not medically necessary for treatment of a disease.
2. Blepharoplasty is not indicated for:
  - a. Dermatochalasis of the lower lids (ICD-9-CM 374.87)

**NON-COVERED ICD-9-CM CODES:**

All except those listed above.

**SOURCES OF INFORMATION:**

CAC Ophthalmology Workgroup

**CODING GUIDELINES:**

1. The appropriate ICD-09-CM for the covered procedure must be submitted as the line diagnosis on the claim.

**DOCUMENTATION REQUIREMENTS:**

1. The medical record should support the medical necessity and frequency of this procedure.
2. Photographs documenting obvious blepharochalasis, dermatochalasis, ptosis, or brow ptosis compatible with the visual field determinations must be included in the patient's medical record.
3. Documentation in the medical record must include the visual fields and before-surgery photograph.

**CAC NOTES:**

This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from all specialties

**Published:** October 30, 1993

**Effective Date:** November 30, 1993

**Revision Date:** February 28, 1994

**Start Date of Notice**

**& Comment Period:** February 9, 1996 (added CPT-4 codes, diagnosis code, added indications)

**Revision Date:** May/June, 1996 (added CPT-4 Codes 67909, 67914, 67915, 67916, 67917, 67921, 67922, 67923, 67924; addition of diagnosis 375.20; added indications #3 and #4)

**Effective Date:** July 31, 1996 (new CPT-4 codes and policy indications #3 and #4)



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