



Corcoran
Consulting
Group

A Division of Ardare Corporation

Medicare Reimbursement For Fundus Photography

Prepared for



April 2011

Medicare Reimbursement for Fundus Photography

by

Corcoran Consulting Group
A Division of Ardare Corporation
560 E. Hospitality Lane ~ Suite 360
San Bernardino, California 92408

(800) 399-6565
www.corcoranccg.com

© Copyright 2007 - 2011 All rights reserved.

Except as permitted under the United States Copyright Act of 1976, no part of this publication may be reproduced or distributed in any form or by any means, or stored in a database or retrieval system, without the prior written permission of the author. From time to time, changes may occur in the content of this report and it is the user's responsibility to assure that current issues of this report are utilized. This additional information is also copyrighted as expressed above.

Other copyright: *CPT and all CPT codes are copyrighted by the American Medical Association with all the rights and privileges pertaining.*

Objective: *This report is provided as a general discussion of reimbursement for fundus photography and related issues. Local variations between Medicare administrative contractors may occur which are not described here. The user is strongly encouraged to review official instructions promulgated by the Centers for Medicare and Medicaid Services (CMS) and its contractors; this document is not an official source nor is it a complete guide on all matters pertaining to reimbursement. In addition, users should check local coverage policies for usage guidelines for the services discussed.*

Acknowledgement: *This paper was underwritten by a grant from Nidek, Inc. as an aid to customers and other interested parties. Nidek is not the author of, and therefore not responsible for, the content of the reimbursement and billing information provided herein.*

Disclaimer: *The reader is reminded that this information can and does change over time, and may be incorrect at any time following publication.*

INTRODUCTION

This monograph describes reimbursement for fundus photography. Fundus photography has been a staple ophthalmic diagnostic test for decades. It is a useful tool to screen for disease as well as aid in assessing anomalies and diseases of the fundus and optic nerve.

Much of the information in this document is taken from official publications of the Medicare program. However, the reader is encouraged to check with the local contractor for additional information and instructions. In the case of other third party payers, we have used the coding concepts contained in CPT and published by the American Medical Association; diagnosis codes are from ICD-9-CM. Documentation of the test, as well as the reason for it, are the key to reimbursement, so we describe the required elements in detail.

Since economic analyses are a necessary part of any capital budgeting decision, we incorporated Medicare's payment rates for the procedure, as well as estimated utilization rates.

THE DEVICES

Nidek offers several fundus cameras. The AFC-Pro-Photographer is an auto-focus, auto-tracking, non-mydratiac fundus camera. It takes 45-degree images without any cropping and provides high-resolution images of 21.1 mega-pixels. This camera can also perform external photography using the anterior eye photography mode.¹ The camera's automated design allows for technicians with limited experience to take professional-quality retina images.

Nidek's MP1 Retinal Micro Perimeter allows an accurate analysis of the retinal functionality, combining non-mydratiac digital retinography

¹ For additional information, please see our FAQ, [Medicare Reimbursement for External Photography with Nidek AFC.](#)

and computerized perimetry in one diagnostic instrument.²

Figure 1 **AFC Pro-Photographer**



Figure 2 **MP-1**



INDICATIONS FOR USE

According to the American Academy of Ophthalmology's (AAO) Preferred Practice Patterns (PPP) for age-related macular degeneration, primary open-angle glaucoma, and diabetic retinopathy, fundus photography provides objective documentation and is the best routine approach to establish a baseline for future comparisons.

² For additional information, please see our monograph, [Reimbursement for MP1 Micro Perimeter.](#)

Fundus photographs facilitate detailed evaluation of the optic nerve head, finding landmarks for retinal lesions, assist in determining the size of detachments, and evaluating dry age-related macular degeneration. The AAO's PPPs further point out that fundus photography is a more reproducible technique than clinical examination for detecting posterior segment disease.

In general, fundus photography is performed to:

- evaluate abnormalities in the fundus,
- follow the progress of a disease,
- plan the treatment for a disease,
- assess the therapeutic effect of recent surgery (e.g., photocoagulation).

Fundus photographs are not medically necessary simply to document the existence of a condition.³

*Photographs are medically necessary to establish a baseline to judge later if a disease is progressive ... The fundus photography should aid in making a clinical decision.*⁴

Medical necessity is based on evidence of signs, symptoms, and medical history. A variety of disease entities justify testing (Table 1). It is important to note that Medicare Administrative Contractors (MACs) do not all agree on a common list of diagnoses. Careful review of local coverage determinations (LCDs) is necessary. The Appendix includes a representative policy.

Diagnostic tests, including fundus photography, are ordered and performed when the information garnered from the eye exam is insufficient to adequately assess the patient's disease. Medicare also covers fundus photography as an adjunct to management and treatment of a known disease.

If the images are taken as baseline documentation of a healthy eye or as preventive medicine to

³ Noridian, LCD L24307, October 2008 (See Appendix)
⁴ Wisconsin Physician Services, LCD L26712, March 2008

screen for potential disease, then the test is not covered, even if disease is identified.⁵

Table 1 Common ICD-9 Diagnosis Codes

| | |
|--------|---|
| 250.5x | Diabetes with ophthalmic manifestations |
| 360.50 | Foreign body, magnetic, intraocular |
| 360.60 | Foreign body, intraocular |
| 361.10 | Retinoschisis |
| 361.3x | Retinal defects w/o detachment |
| 362.01 | Background diabetic retinopathy |
| 362.02 | Proliferative diabetic retinopathy |
| 362.10 | Background retinopathy |
| 362.11 | Hypertensive retinopathy |
| 362.12 | Exudative retinopathy |
| 362.17 | Retinal microvascular abnormalities |
| 362.18 | Retinal vasculitis |
| 362.30 | Retinal vascular occlusion |
| 362.33 | Partial arterial occlusion |
| 362.50 | Macular degeneration |
| 362.51 | Nonexudative macular degeneration |
| 362.52 | Exudative macular degeneration |
| 362.53 | Cystoid macular degeneration |
| 362.63 | Lattice degeneration |
| 362.75 | Other retinal dystrophies |
| 362.76 | RPE dystrophies |
| 362.82 | Retinal exudates and deposits |
| 362.84 | Retinal ischemia |
| 365.xx | Glaucoma |
| 377.0x | Papilledema |
| 377.1x | Optic atrophy |
| 377.3x | Optic neuritis |
| 377.4x | Disorders of optic nerve |
| 379.34 | Posterior dislocation of lens |
| 743.52 | Fundus coloboma |
| 743.55 | Congenital macular changes |
| 871.x | Open wound of eyeball |

NOTE: Listed codes are representative of covered diagnoses but differences in payment policies exist for many payers. This list is neither exhaustive nor universally accepted. See your payer bulletins.

Some ophthalmologists and optometrists have standing orders for non-mydratic fundus photography for all patients prior to an eye exam so the doctor can screen for posterior segment

⁵ CFR 411.15 (a)(1)

disease as well as educate patients about the back of the eye. As a general rule most payers, including Medicare, do not cover screening services or preventive medicine.⁶ Patients must be given the opportunity to choose between an exam with or without the retinal screening. Practices should use a financial waiver for non-Medicare patients or a Notice of Exclusion from Medicare Benefits (NEMB) for Medicare beneficiaries to inform beneficiaries of their financial responsibilities for the screening service (see Appendix). Non-covered services do not need to be reported on a claim unless the beneficiary specifically asks you to do so.

Telescreening for diabetic retinopathy is another use for fundus photography that is growing rapidly, particularly in underserved areas. As cited above, Medicare does not cover screening.

*Retinal photography alone, including “tele-screening”, in the absence of a concurrent personal examination by an ophthalmologist or optometrist, is a screening test and, as such, is not covered by Medicare. Fundus photography is considered medically reasonable and necessary, and, therefore, covered, when furnished by an ophthalmologist or optometrist in the course of ocular evaluation and/or treatment (IOM – Pub 100-03, Ch 1 §80.6). Therefore, the digital imaging systems used for the detection of diabetic retinopathy, which acquire images and transmit them to a remote area for interpretation are considered screening and do not meet Medicare’s reasonable and necessary criteria for reimbursement.*⁷

Repeated fundus photography is necessitated by disease progression, the advent of new disease, or planning for additional surgical treatment (e.g., laser). Otherwise, repeated photographs of the same, unchanged condition are unwarranted.

⁶ CFR 410.32 (a)

⁷ Wisconsin Physician Services, 2007 News Archives.

BILLING ISSUES

Procedure Code

Use CPT Code 92250 (*Fundus photography with interpretation and report*) to report this diagnostic test.

Modifiers

The following modifiers may be applicable on claims for fundus photography.

- AQ Services provided in a Health Professional Shortage Area (HPSA, *Medicare modifier only; replaces QB and QU*)
- GA Medicare probably does not cover this service. Advance Beneficiary Notice of Noncoverage (ABN) signed as required by payer policy
- GX Medicare probably does not cover this service. Advance Beneficiary Notice (ABN) signed, voluntary notice given under payer policy
- GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit.
- GZ Medicare probably does not cover this service. No ABN on file (*Medicare modifier only*)
- TC Technical component of a diagnostic test
- 26 Professional component of a diagnostic test
- 52 Reduced service (e.g., only one eye tested)

Sample Claim

During evaluation of the posterior pole with binocular indirect ophthalmoscopy, several small drusen were

noted. Fundus photography was ordered OU to establish the extent of the nonexudative age-related macular degeneration and to permit re-evaluation at a later date. The claim will read as follows:

| | | | | | |
|--------------------|-----|-------------------|-----|--------|-----|
| 17 J. Jones, MD | | 17a | | | |
| | | 17b 1234567890 | | | |
| 19 | | | | | |
| 21 1. 362.51 | | | | | |
| 24a | 24b | 24d | 24e | 24f | 24g |
| mm/dd/yyyy | 11 | 92250 | 1 | xxx.xx | 1 |
| | | | | | |

Advance Beneficiary Notice of Non-Coverage

An ABN is a written notice a physician, or other provider, gives to a Medicare beneficiary before items or services are furnished when the physician believes that Medicare probably will not pay for some or all of the items or services. It is required for both assigned and non-assigned claims.

By signing an ABN, the Medicare beneficiary acknowledges that he or she has been advised that Medicare will probably or certainly not pay, and agrees to be responsible for payment, either personally or through other insurance. Medicaid qualifies as “other insurance” so get an ABN even for dual-eligible patients.

In June, 2002, CMS published an official ABN form (CMS-R-131-G) which was mandated by HIPAA (PM AB-02-114). A revised ABN form (CMS-R-131) became available in March, 2008. The revised ABN replaced the existing ABN-G (Form CMS-R-131G) and ABN-L (Form CMS-R-131L). It may also be used in lieu of the NEMB (Form CMS-20007). All providers were required to begin using the revised ABN no later than March 1, 2009. (See Appendix for sample form)

The ABN must be signed before you provide the items or services. Keep the original in your file and provide a copy to the patient. The “Estimated Cost” field is required. The patient

must *personally* choose from Option 1, 2 or 3. The patient must *sign* and *date* the form; an unsigned form is not valid. Without the Medicare beneficiary’s advance acceptance of financial responsibility, you will be required to refund any payment you collected for non-covered services.

In October, 2009, and effective April 1, 2010, CMS issued new instructions regarding modifiers to use on claims to indicate that a signed ABN is on file. Modifier GA has been redefined as “Waiver of liability statement issued as required by payer policy”. It should be used when an ABN was required for a service. Modifier GX has been added, with the definition of “Notice of liability issued, voluntary under payer policy”. It should be used when an ABN was not required by the payer’s policy for a service but was given voluntarily.

Prohibited Code Combinations

The Centers for Medicare and Medicaid Services (CMS) instructs the Medicare carriers to treat some concurrent procedures as a “bundle” for payment purposes. This means that no separate payment is made for the test outside of the bundled procedure. In addition, some procedures are considered “mutually exclusive” with others. This means that, when two procedures or tests are performed on the same day on the same patient, only one of the procedures will be paid; generally the one of lesser value. The National Correct Coding Initiative (NCCI) is the regulation that updates these payment rules, usually on a quarterly basis. Some carriers have also published local policies with additional limitations. You may not use an ABN to circumvent the NCCI edits.

Fundus photography (92250) is considered mutually exclusive with scanning computerized ophthalmic diagnostic testing of the posterior segment (92133, 92134). It is also bundled with ICG angiography (92240).

Since the April 2003 edition of the NCCI edits, minimal eye exams (99211) performed by a

medical assistant or technician are bundled with concurrent diagnostic tests. Examinations or consultations by a physician on the same day as a diagnostic test are not bundled.

Practice Management Tips

- For any covered test, get a physician's order with appropriate medical rationale before providing the service.
- Document the physician's interpretation of the diagnostic test within a short time, generally within 72 hours. Be sure to address the quality of the test, the findings and the assessment. Sign the note.
- Differentiate covered and non-covered testing based on the reason for the service.
- Screening photographs, or photos on the basis of standing orders, are non-covered. Obtain patients' acceptance of financial responsibility for non-covered services in writing (*i.e.*, ABN or similar notice).
- Watch that repeated testing is merited due to disease progression.
- Monitor NCCI bundles (*e.g.*, FP with SCODI, ICG)
- Check your Local Coverage Determination (LCD) for specific guidance in your area. Investigate the policies of other third party payers as well.
- Place a note in the medical record that identifies where digital photos are stored.
- Don't use fundus photographs as a surrogate for a dilated fundus evaluation during a comprehensive eye exam. Ophthalmoscopy is obligatory and non-mydriatic images do not substitute for it.
- If you use an independent contractor to perform diagnostic tests - that is, someone who provides all the equipment and technician, and is not an employee - then get assistance with the arcane rules associated with purchased diagnostic tests.

Purchased Diagnostic Tests

In some instances, the physician may have access to this instrument but may not own it, or may not employ a skilled technician to operate it. Under the Medicare physician fee schedule, reimbursement for some tests is subdivided into a technical component (*i.e.*, the test itself) and a professional component, which is the physician service associated with the test. In the situation where (a) a physician does not own a specialized

diagnostic instrument and/or (b) the physician doesn't employ a technician to operate the device, different reimbursement issues exist. Note that a written rental agreement or lease arrangement qualifies as "ownership" of the equipment.

If another entity provides either the equipment or the operator, or both, the physician (or the physician's medical group) can charge for the technical component by following these criteria.

- 1) The purchasing physician or group may not "mark up" the "purchase price" of the test.
- 2) The purchaser must perform the interpretation.
- 3) The physician or other supplier that furnished the technical component must be enrolled in the Medicare program. No formal reassignment is necessary.
- 4) The "purchase price" cannot be based on volume, (*i.e.*, "a volume discount").
- 5) The purchaser must accept the lowest of the following as full payment for the test even if assignment is not accepted:
 - a) the Medicare fee schedule amount for the technical component,
 - b) the physician's actual charge, or
 - c) the supplier's net charge to the purchasing physician.

To submit a claim for a purchased diagnostic test, Box 20 of the CMS-1500 claim form must be completed when the diagnostic test is subject to purchase price limitations (*i.e.*, those with a technical component). The purchase price under charges must be shown if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates that "*no purchased tests are included on the claim.*" When "yes" is annotated, item 32 must be completed with the supplier's name, address, zip code and NPI. When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form.

As an alternative, the ordering physician may claim reimbursement for the professional component alone, and ask the performing physician or supplier to bill for the technical component.

Health Professional Shortage Area (HPSA)

Medicare pays a quarterly 10% premium to physicians who provide services in a Health Professional Shortage Area (HPSA). Historically, modifiers QU (urban) and QB (rural) designated services eligible for a HPSA bonus. Modifier AQ replaced these modifiers on January 1, 2006. A distinction between rural and urban HPSAs no longer exists. No modifier is necessary if your zip code is listed as HPSA eligible. The bonus payment will be automatic. Eligible services provided at locations not listed will continue to need the modifier AQ. This premium is pertinent only to professional services, and does not apply to the technical component (TC) of diagnostic tests. Until recently, it was necessary to separate the professional and technical components in order to receive bonuses, but no longer. The carrier will automatically calculate bonus payments on the professional component.

As an illustration, if the test in the Sample Claim, above, had been performed in a HPSA not receiving automatic bonus payments, then the claim would read as follows:

| | | | | | |
|--------------------|-----------|--------------------------|----------|---------------|----------|
| 17 J. Jones, MD | | 17a 17b 1234567890 | | | |
| 19 | | | | | |
| 21 1. 362.51 | | | | | |
| 24a mm/dd/yyyy | 24b 11 | 24d 92250-AQ | 24e 1 | 24f xxx.xx | 24g 1 |
| | | | | | |

PAYMENT LEVELS

CPT code 92250 is defined as bilateral so reimbursement is for both eyes. In 2011 the Medicare Physician Fee Schedule allowable for 92250 is \$73.39. The amount is adjusted in each

area by local indices. Other payers set their own rates, which may differ significantly from the Medicare published fee schedule.

Table 2 **Medicare National Payment Rates**

| <u>Code</u> | <u>PAR</u> | <u>Non-PAR</u> | <u>Limiting Charge *</u> |
|-------------|------------|----------------|--------------------------|
| 92250 | \$73.39 | \$69.73 | \$80.18 |
| 92250-TC | \$50.29 | \$47.77 | \$54.94 |
| 92250-26 | \$23.10 | \$21.95 | \$25.24 |

* Limiting charge for non-participating physicians

SUPERVISION

Effective July 1, 2001, Medicare revised its supervision rules for many ophthalmic diagnostic tests. Fundus photography requires *general* supervision. This means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during performance of the test. Under general supervision rules, the training of the non-physician personnel who actually perform the diagnostic test and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.⁸

DOCUMENTATION

In addition to the photos or proof that digital images exist, the chart should contain:

- an order for the test with medical rationale
- the date of the test
- the reliability of the test (*e.g.* cloudy due to cataract)
- the test findings (*e.g.* hemorrhage)
- a diagnosis (if possible)
- the impact on treatment and prognosis
- the signature of the physician

⁸ CFR 410.32 (b)(3)(i)

Figure 3 is a form that may be used for interpreting fundus photography.

Figure 3 **Interpretation Report**

| <u>INTERPRETATION REPORT</u> | |
|---|------------|
| Name _____ | Date _____ |
| <input type="checkbox"/> Fundus Photography <input type="checkbox"/> OU <input type="checkbox"/> OD <input type="checkbox"/> OS | |
| Technician's Comments: | |
| Performed By: _____ | |
| Reliability: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor | |
| Patient Cooperation: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor | |
| Physician's Interpretation: | |
| Test Results: | |
| OD _____ OS _____ | |
| Diagnosis _____ | |
| Impact on Treatment/Prognosis: _____ | |
| _____ Physician's Signature & Date | |

UTILIZATION

Medicare utilization rates are published and are noted below. Commercial utilization rates are not readily available. There are no published limitations for repeated testing. In general, this and all diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required. If your utilization rate exceeds the expected norms, you will likely garner attention from Medicare and other payers. Careful attention to documentation of the test and the reasons it was performed are your best defense against reproach in the event of postpayment review.

Medicare utilization rates for claims paid in 2008 show that fundus photography was performed in 6% of all office visits by ophthalmologists. That is, for every 100 exams and consultations performed on Medicare beneficiaries, Medicare paid

for this service 6 times. For optometrists, the utilization rate is 11%.

CONCLUSION

A well known proverb says a picture is worth a thousand words. This is particularly true for ophthalmologists and optometrists, for whom visualization of a problem in the eye can lead to better vision for the patient. Unlike ophthalmoscopy where the examiner must be content with a brief look at the fundus while the patient grudgingly submits to an uncomfortable examination, fundus photography provides crisp, detailed, close-up pictures of the posterior pole and the opportunity for leisurely study of abnormalities as well as subsequent use as a benchmark for comparison purposes. Fundus photos even have utility for people other than the examining physician. For example, the photos are helpful: in telemedicine (*i.e.*, screening), during litigation (*e.g.*, malpractice), as part of criminal investigations (*e.g.*, shaken baby), for teaching purposes, and for other caregivers when patients desire a transfer of medical records.

As more fundus cameras come to market, and as new ways for using them proliferate, reimbursement considerations loom large. Some applications of fundus photography, particularly as an aid to screening, are not covered by Medicare and most other third party payers. For covered services, documentation of the physician's interpretation is crucial; where it is abbreviated or missing, reimbursement is jeopardized.

This discussion is meant to assist the reader to better understand the rules and regulations regarding reimbursement for fundus photography, however the responsibility for appropriate usage, adequate documentation and proper coding are always the physician's.

APPENDIX

Sample ABN Form

(Customize top of form with name, address & phone)

(Provide 1 copy to patient, keep original in your files.)

Patient Name:

Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items or services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

| Items or Services | Reason Medicare May Not Pay: | Estimated Cost: |
|-------------------|------------------------------|-----------------|
| | | |

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.
- Choose an option below about whether to receive the _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS:

Check only one box. We cannot choose a box for you.

OPTION 1. I want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and **I cannot appeal if Medicare is not billed.**

OPTION 3. I don't want the items or services listed above. I understand with this choice I am **not responsible for payment, and I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227 / TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:

Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08)

Form Approved OMB No. 0938-0566

Sample NEMB Form

(Customize top of form with name, address & phone)

(Provide 1 copy to patient, keep original in your files.)

Patient's Name:

Medicare # (HICN):

NOTICE OF EXCLUSION FROM MEDICARE BENEFITS

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.
- When you receive an item or service that is not a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$_____**)

Medicare will not pay for:

Screening fundus photos of the posterior segment of your eye.

Because of the following exclusion from Medicare benefit:

Medicare policy prohibits payment for most tests for screening.

Medicare will only pay for:

Medically necessary tests as an adjunct to diagnosing, managing and treating disease. Images taken as baseline documentation of a healthy eye or as preventative medicine to screen for potential disease are not considered medically necessary and therefore excluded by §1862(a)(1) of the Medicare law.

I understand and agree.

Date

Signature of patient or person acting on patient's behalf

Sample NEHB Form

(Customize top of form with name, address & phone)

(Provide 1 copy to patient; keep original in your files.)

Patient's Name: _____

NOTICE OF EXCLUSION FROM HEALTH PLAN BENEFITS

- Health insurance does **not** pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not insurance benefits and your insurance plan will not pay for them.
- When you receive an item or service that is not a covered benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why your insurance won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: \$_____)

Your health plan will not pay for:

Screening fundus photos of the posterior segment of your eye.

Because it does not meet the definition of any covered benefit:

Your insurance plan prohibits payment for most tests for screening.

Your health plan will only pay for:

Medically necessary tests as an adjunct to diagnosing, managing and treating disease. Insurance does not cover images taken as baseline documentation of a healthy eye or as preventative medicine to screen for potential disease.

I understand and agree.

Date

Signature of patient or person acting on patient's behalf

Sample Medicare Coverage Policy

Contractor Name [back to top](#)

[Noridian Administrative Services](#)

Contractor Number [back to top](#)

03102

Contractor Type [back to top](#)

MAC - Part B

LCD Information

LCD ID Number [back to top](#)

L24307

LCD Title [back to top](#)

Fundus Photography

Contractor's Determination Number [back to top](#)

J3 CB2006.18 R2

AMA CPT / ADA CDT Copyright Statement [back to top](#)

CPT codes, descriptions and other data only are copyright 2008 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. Current Dental Terminology, (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. © 2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

CMS National Coverage Policy [back to top](#)

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.

Primary Geographic Jurisdiction [back to top](#)

Arizona

Oversight Region [back to top](#)

Region VIII

Original Determination Effective Date [back to top](#)

For services performed on or after 12/01/2006

Original Determination Ending Date [back to top](#)

Revision Effective Date [back to top](#)

For services performed on or after 10/01/2008

Revision Ending Date [back to top](#)

Indications and Limitations of Coverage and/or Medical Necessity [back to top](#)

Fundus photography uses a special camera to photograph structures behind the lens of the eye. This procedure does not include laser scanning of the retina.

In order to document a disease process, plan its treatment, or follow the progress of a disease, fundus photographs may be necessary.

Fundus Photography is not covered for routine screening.

Fundus photographs are not medically necessary simply to document the existence of a condition. However, photographs may be medically necessary to establish a baseline to judge later whether a disease is progressive. Examples are as follows:

(1) It does not add to the patient's care to photograph dry age-related maculopathy to document its existence.

(2) Fundus photography may be necessary to establish the extent of retinal edema in moderate non-proliferative diabetic retinopathy. Then, in four to six months the baseline photograph can be compared to the clinical appearance of the current diabetic retinal edema to see if it is progressing to clinically significant diabetic macular edema. This information can then be used to decide whether or not to advise the patient to undergo focal laser photocoagulation.

The intent of these examples is to point out how in the former there is not a therapeutic decision being made, while in the latter there is. The fundus photography should aid in making a clinical decision.

Compliance with the provisions in this policy is subject to monitoring by post payment data analysis and subsequent medical review.

Coverage Topic [back to top](#)

Diagnostic Tests and X-Rays

Coding Information

Bill Type Codes: [back to top](#)

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

| | |
|---------|--|
| 190.0 | MALIGNANT NEOPLASM OF EYEBALL EXCEPT CONJUNCTIVA CORNEA RETINA AND CHOROID |
| 190.5 | MALIGNANT NEOPLASM OF RETINA |
| 190.6 | MALIGNANT NEOPLASM OF CHOROID |
| 198.4 | SECONDARY MALIGNANT NEOPLASM OF OTHER PARTS OF NERVOUS SYSTEM |
| 224.0 | BENIGN NEOPLASM OF EYEBALL EXCEPT CONJUNCTIVA CORNEA RETINA AND CHOROID |
| 224.5 | BENIGN NEOPLASM OF RETINA |
| 224.6 | BENIGN NEOPLASM OF CHOROID |
| 225.1 | BENIGN NEOPLASM OF CRANIAL NERVES |
| 228.03 | HEMANGIOMA OF RETINA |
| 238.8 | NEOPLASM OF UNCERTAIN BEHAVIOR OF OTHER SPECIFIED SITES |
| 249.00* | SECONDARY DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, NOT STATED AS UNCONTROLLED, OR UNSPECIFIED |
| 249.01* | SECONDARY DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, UNCONTROLLED |
| 249.10* | SECONDARY DIABETES MELLITUS WITH KETOACIDOSIS, NOT STATED AS UNCONTROLLED, OR UNSPECIFIED |
| 249.11* | SECONDARY DIABETES MELLITUS WITH KETOACIDOSIS, UNCONTROLLED |
| 249.20* | SECONDARY DIABETES MELLITUS WITH HYPEROSMOLARITY, NOT STATED AS UNCONTROLLED, OR UNSPECIFIED |
| 249.21* | SECONDARY DIABETES MELLITUS WITH HYPEROSMOLARITY, UNCONTROLLED |
| 249.30* | SECONDARY DIABETES MELLITUS WITH OTHER COMA, NOT STATED AS UNCONTROLLED, OR UNSPECIFIED |
| 249.31* | SECONDARY DIABETES MELLITUS WITH OTHER COMA, UNCONTROLLED |
| 249.40* | SECONDARY DIABETES MELLITUS WITH RENAL MANIFESTATIONS, NOT STATED AS UNCONTROLLED, OR UNSPECIFIED |
| 249.41* | SECONDARY DIABETES MELLITUS WITH RENAL MANIFESTATIONS, UNCONTROLLED |
| 249.50* | SECONDARY DIABETES MELLITUS WITH OPHTHALMIC MANIFESTATIONS, NOT STATED AS UNCONTROLLED, OR UNSPECIFIED |
| 249.51* | SECONDARY DIABETES MELLITUS WITH OPHTHALMIC MANIFESTATIONS, UNCONTROLLED |
| 250.00 | DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED |
| 250.01 | DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE I [JUVENILE TYPE], NOT STATED AS UNCONTROLLED |
| 250.02 | DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, UNCONTROLLED |
| 250.03 | DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE I [JUVENILE TYPE], UNCONTROLLED |
| 250.50 | DIABETES WITH OPHTHALMIC MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE |

NOT STATED AS UNCONTROLLED

| | |
|--------|---|
| 250.51 | DIABETES WITH OPHTHALMIC MANIFESTATIONS, TYPE I [JUVENILE TYPE], NOT STATED AS UNCONTROLLED |
| 250.52 | DIABETES WITH OPHTHALMIC MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, UNCONTROLLED |
| 250.53 | DIABETES WITH OPHTHALMIC MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED |
| 264.7 | OTHER OCULAR MANIFESTATIONS OF VITAMIN A DEFICIENCY |
| 340 | MULTIPLE SCLEROSIS |
| 348.2 | BENIGN INTRACRANIAL HYPERTENSION |
| 360.00 | PURULENT ENDOPHTHALMITIS UNSPECIFIED |
| 360.01 | ACUTE ENDOPHTHALMITIS |
| 360.02 | PANOPHTHALMITIS |
| 360.03 | CHRONIC ENDOPHTHALMITIS |
| 360.04 | VITREOUS ABSCESS |
| 360.11 | SYMPATHETIC UVEITIS |
| 360.12 | PANUVEITIS |
| 360.13 | PARASITIC ENDOPHTHALMITIS UNSPECIFIED |
| 360.14 | OPHTHALMIA NODOSA |
| 360.19 | OTHER ENDOPHTHALMITIS |
| 360.20 | DEGENERATIVE DISORDER OF GLOBE UNSPECIFIED |
| 360.21 | PROGRESSIVE HIGH (DEGENERATIVE) MYOPIA |
| 360.23 | SIDEROSIS OF GLOBE |
| 360.24 | OTHER METALLOSIS OF GLOBE |
| 360.30 | HYPOTONY OF EYE UNSPECIFIED |
| 360.31 | PRIMARY HYPOTONY OF EYE |
| 360.32 | OCULAR FISTULA CAUSING HYPOTONY |
| 360.33 | HYPOTONY ASSOCIATED WITH OTHER OCULAR DISORDERS |
| 360.43 | HEMOPHTHALMOS EXCEPT CURRENT INJURY |
| 360.44 | LEUCOCORIA |
| 360.50 | FOREIGN BODY MAGNETIC INTRAOCULAR UNSPECIFIED |
| 360.54 | FOREIGN BODY MAGNETIC IN VITREOUS |
| 360.55 | FOREIGN BODY MAGNETIC IN POSTERIOR WALL |
| 360.59 | INTRAOCULAR FOREIGN BODY MAGNETIC IN OTHER OR MULTIPLE SITES |
| 360.60 | FOREIGN BODY INTRAOCULAR UNSPECIFIED |
| 360.64 | FOREIGN BODY IN VITREOUS |
| 360.65 | FOREIGN BODY IN POSTERIOR WALL OF EYE |
| 360.69 | INTRAOCULAR FOREIGN BODY IN OTHER OR MULTIPLE SITES |

| | |
|---------|---|
| 361.00 | RETINAL DETACH WITH RETINAL DEFECT UNSPECIFIED |
| 361.01 | RECENT RETINAL DETACH PARTIAL WITH SINGLE DEFECT |
| 361.02 | RECENT RETINAL DETACH PARTIAL WITH MULTIPLE DEFECTS |
| 361.03 | RECENT RETINAL DETACH PARTIAL WITH GIANT TEAR |
| 361.04 | RECENT RETINAL DETACH PARTIAL WITH RETINAL DIALYSIS |
| 361.05 | RECENT RETINAL DETACH TOTAL OR SUBTOTAL |
| 361.06 | OLD RETINAL DETACH PARTIAL |
| 361.07 | OLD RETINAL DETACH TOTAL OR SUBTOTAL |
| 361.10 | RETINOSCHISIS UNSPECIFIED |
| 361.11 | FLAT RETINOSCHISIS |
| 361.12 | BULLOUS RETINOSCHISIS |
| 361.13 | PRIMARY RETINAL CYSTS |
| 361.14 | SECONDARY RETINAL CYSTS |
| 361.19 | OTHER RETINOSCHISIS AND RETINAL CYSTS |
| 361.2 | SEROUS RETINAL DETACH |
| 361.30 | RETINAL DEFECT UNSPECIFIED |
| 361.31 | ROUND HOLE OF RETINA WITHOUT DETACH |
| 361.32 | HORSESHOE TEAR OF RETINA WITHOUT DETACH |
| 361.33 | MULTIPLE DEFECTS OF RETINA WITHOUT DETACH |
| 361.81 | TRACTION DETACH OF RETINA |
| 361.89 | OTHER FORMS OF RETINAL DETACH |
| 361.9 | UNSPECIFIED RETINAL DETACH |
| 362.01 | BACKGROUND DIABETIC RETINOPATHY |
| 362.02 | PROLIFERATIVE DIABETIC RETINOPATHY |
| 362.03* | NONPROLIFERATIVE DIABETIC RETINOPATHY NOS |
| 362.04* | MILD NONPROLIFERATIVE DIABETIC RETINOPATHY |
| 362.05* | MODERATE NONPROLIFERATIVE DIABETIC RETINOPATHY |
| 362.06* | SEVERE NONPROLIFERATIVE DIABETIC RETINOPATHY |
| 362.07* | DIABETIC MACULAR EDEMA |
| 362.10 | BACKGROUND RETINOPATHY UNSPECIFIED |
| 362.11 | HYPERTENSIVE RETINOPATHY |
| 362.12 | EXUDATIVE RETINOPATHY |
| 362.13 | CHANGES IN VASCULAR APPEARANCE OF RETINA |
| 362.14 | RETINAL MICROANEURYSMS NOS |
| 362.15 | RETINAL TELANGIECTASIA |
| 362.16 | RETINAL NEOVASCULARIZATION NOS |
| 362.17 | OTHER INTRARETINAL MICROVASCULAR ABNORMALITIES |

| | |
|---------|---|
| 362.18 | RETINAL VASCULITIS |
| 362.21 | RETROLENTAL FIBROPLASIA |
| 362.22* | RETINOPATHY OF PREMATUREITY, STAGE 0 |
| 362.23* | RETINOPATHY OF PREMATUREITY, STAGE 1 |
| 362.24* | RETINOPATHY OF PREMATUREITY, STAGE 2 |
| 362.25* | RETINOPATHY OF PREMATUREITY, STAGE 3 |
| 362.26* | RETINOPATHY OF PREMATUREITY, STAGE 4 |
| 362.27* | RETINOPATHY OF PREMATUREITY, STAGE 5 |
| 362.29 | OTHER NONDIABETIC PROLIFERATIVE RETINOPATHY |
| 362.30 | RETINAL VASCULAR OCCLUSION UNSPECIFIED |
| 362.31 | CENTRAL RETINAL ARTERY OCCLUSION |
| 362.32 | RETINAL ARTERIAL BRANCH OCCLUSION |
| 362.33 | PARTIAL RETINAL ARTERIAL OCCLUSION |
| 362.34 | TRANSIENT RETINAL ARTERIAL OCCLUSION |
| 362.35 | CENTRAL RETINAL VEIN OCCLUSION |
| 362.36 | VENOUS TRIBUTARY (BRANCH) OCCLUSION OF RETINA |
| 362.37 | VENOUS ENGORGEMENT OF RETINA |
| 362.40 | RETINAL LAYER SEPARATION UNSPECIFIED |
| 362.41 | CENTRAL SEROUS RETINOPATHY |
| 362.42 | SEROUS DETACH OF RETINAL PIGMENT EPITHELIUM |
| 362.43 | HEMORRHAGIC DETACH OF RETINAL PIGMENT EPITHELIUM |
| 362.50 | MACULAR DEGENERATION (SENILE) OF RETINA UNSPECIFIED |
| 362.51 | NONEXUDATIVE SENILE MACULAR DEGENERATION OF RETINA |
| 362.52 | EXUDATIVE SENILE MACULAR DEGENERATION OF RETINA |
| 362.53 | CYSTOID MACULAR DEGENERATION OF RETINA |
| 362.54 | MACULAR CYST HOLE OR PSEUDOHOLE OF RETINA |
| 362.55 | TOXIC MACULOPATHY OF RETINA |
| 362.56 | MACULAR PUCKERING OF RETINA |
| 362.57 | DRUSEN (DEGENERATIVE) OF RETINA |
| 362.60 | PERIPHERAL RETINAL DEGENERATION UNSPECIFIED |
| 362.61 | PAVING STONE DEGENERATION OF RETINA |
| 362.62 | MICROCYSTOID DEGENERATION OF RETINA |
| 362.63 | LATTICE DEGENERATION OF RETINA |
| 362.64 | SENILE RETICULAR DEGENERATION OF RETINA |
| 362.65 | SECONDARY PIGMENTARY DEGENERATION OF RETINA |
| 362.66 | SECONDARY VITREORETINAL DEGENERATIONS |
| 362.70 | HEREDITARY RETINAL DYSTROPHY UNSPECIFIED |

| | |
|--------|---|
| 362.71 | RETINAL DYSTROPHY IN SYSTEMIC OR CEREBRORETINAL LIPIDOSES |
| 362.72 | RETINAL DYSTROPHY IN OTHER SYSTEMIC DISORDERS AND SYNDROMES |
| 362.73 | VITREORETINAL DYSTROPHIES |
| 362.74 | PIGMENTARY RETINAL DYSTROPHY |
| 362.75 | OTHER DYSTROPHIES PRIMARILY INVOLVING THE SENSORY RETINA |
| 362.76 | DYSTROPHIES PRIMARILY INVOLVING THE RETINAL PIGMENT EPITHELIUM |
| 362.77 | RETINAL DYSTROPHIES PRIMARILY INVOLVING BRUCH'S MEMBRANE |
| 362.81 | RETINAL HEMORRHAGE |
| 362.82 | RETINAL EXUDATES AND DEPOSITS |
| 362.83 | RETINAL EDEMA |
| 362.84 | RETINAL ISCHEMIA |
| 362.85 | RETINAL NERVE FIBER BUNDLE DEFECTS |
| 362.89 | OTHER RETINAL DISORDERS |
| 362.9 | UNSPECIFIED RETINAL DISORDER |
| 363.00 | FOCAL CHORIORETINITIS UNSPECIFIED |
| 363.01 | FOCAL CHOROIDITIS AND CHORIORETINITIS JUXTAPAPILLARY |
| 363.03 | FOCAL CHOROIDITIS AND CHORIORETINITIS OF OTHER POSTERIOR POLE |
| 363.04 | FOCAL CHOROIDITIS AND CHORIORETINITIS PERIPHERAL |
| 363.05 | FOCAL RETINITIS AND RETINOCHOROIDITIS JUXTAPAPILLARY |
| 363.06 | FOCAL RETINITIS AND RETINOCHOROIDITIS MACULAR OR PARAMACULAR |
| 363.07 | FOCAL RETINITIS AND RETINOCHOROIDITIS OF OTHER POSTERIOR POLE |
| 363.08 | FOCAL RETINITIS AND RETINOCHOROIDITIS PERIPHERAL |
| 363.10 | DISSEMINATED CHORIORETINITIS UNSPECIFIED |
| 363.11 | DISSEMINATED CHOROIDITIS AND CHORIORETINITIS POSTERIOR POLE |
| 363.12 | DISSEMINATED CHOROIDITIS AND CHORIORETINITIS PERIPHERAL |
| 363.13 | DISSEMINATED CHOROIDITIS AND CHORIORETINITIS GENERALIZED |
| 363.14 | DISSEMINATED RETINITIS AND RETINOCHOROIDITIS METASTATIC |
| 363.15 | DISSEMINATED RETINITIS AND RETINOCHOROIDITIS PIGMENT EPITHELIOPATHY |
| 363.20 | CHORIORETINITIS UNSPECIFIED |
| 363.21 | PARS PLANITIS |
| 363.22 | HARADA'S DISEASE |
| 363.30 | CHORIORETINAL SCAR UNSPECIFIED |
| 363.31 | SOLAR RETINOPATHY |
| 363.32 | OTHER MACULAR SCARS OF RETINA |
| 363.33 | OTHER SCARS OF POSTERIOR POLE OF RETINA |
| 363.34 | PERIPHERAL SCARS OF RETINA |
| 363.35 | DISSEMINATED SCARS OF RETINA |

| | |
|--------|---|
| 363.40 | CHOROIDAL DEGENERATION UNSPECIFIED |
| 363.41 | SENILE ATROPHY OF CHOROID |
| 363.42 | DIFFUSE SECONDARY ATROPHY OF CHOROID |
| 363.43 | ANGIOID STREAKS OF CHOROID |
| 363.50 | HEREDITARY CHOROIDAL DYSTROPHY OR ATROPHY UNSPECIFIED |
| 363.51 | CIRCUMPAPILLARY DYSTROPHY OF CHOROID PARTIAL |
| 363.52 | CIRCUMPAPILLARY DYSTROPHY OF CHOROID TOTAL |
| 363.53 | CENTRAL DYSTROPHY OF CHOROID PARTIAL |
| 363.54 | CENTRAL CHOROIDAL ATROPHY TOTAL |
| 363.55 | CHOROIDEREMIA |
| 363.56 | OTHER DIFFUSE OR GENERALIZED DYSTROPHY OF CHOROID PARTIAL |
| 363.57 | OTHER DIFFUSE OR GENERALIZED DYSTROPHY OF CHOROID TOTAL |
| 363.61 | CHOROIDAL HEMORRHAGE UNSPECIFIED |
| 363.62 | EXPULSIVE CHOROIDAL HEMORRHAGE |
| 363.63 | CHOROIDAL RUPTURE |
| 363.70 | CHOROIDAL DETACH UNSPECIFIED |
| 363.71 | SEROUS CHOROIDAL DETACH |
| 363.72 | HEMORRHAGIC CHOROIDAL DETACH |
| 363.8 | OTHER DISORDERS OF CHOROID |
| 363.9 | UNSPECIFIED DISORDER OF CHOROID |
| 364.24 | VOGT-KOYANAGI SYNDROME |
| 365.00 | PREGLAUCOMA UNSPECIFIED |
| 365.01 | OPEN ANGLE WITH BORDERLINE GLAUCOMA FINDINGS |
| 365.02 | ANATOMICAL NARROW ANGLE BORDERLINE GLAUCOMA |
| 365.03 | STEROID RESPONDERS BORDERLINE GLAUCOMA |
| 365.04 | OCULAR HYPERTENSION |
| 365.10 | OPEN-ANGLE GLAUCOMA UNSPECIFIED |
| 365.11 | PRIMARY OPEN ANGLE GLAUCOMA |
| 365.12 | LOW TENSION OPEN-ANGLE GLAUCOMA |
| 365.13 | PIGMENTARY OPEN-ANGLE GLAUCOMA |
| 365.14 | GLAUCOMA OF CHILDHOOD |
| 365.15 | RESIDUAL STAGE OF OPEN ANGLE GLAUCOMA |
| 365.20 | PRIMARY ANGLE-CLOSURE GLAUCOMA UNSPECIFIED |
| 365.21 | INTERMITTENT ANGLE-CLOSURE GLAUCOMA |
| 365.22 | ACUTE ANGLE-CLOSURE GLAUCOMA |
| 365.23 | CHRONIC ANGLE-CLOSURE GLAUCOMA |
| 365.24 | RESIDUAL STAGE OF ANGLE-CLOSURE GLAUCOMA |

| | |
|--------|---|
| 365.31 | CORTICOSTEROID-INDUCED GLAUCOMA GLAUCOMATOUS STAGE |
| 365.32 | CORTICOSTEROID-INDUCED GLAUCOMA RESIDUAL STAGE |
| 365.41 | GLAUCOMA ASSOCIATED WITH CHAMBER ANGLE ANOMALIES |
| 365.42 | GLAUCOMA ASSOCIATED WITH ANOMALIES OF IRIS |
| 365.43 | GLAUCOMA ASSOCIATED WITH OTHER ANTERIOR SEGMENT ANOMALIES |
| 365.44 | GLAUCOMA ASSOCIATED WITH SYSTEMIC SYNDROMES |
| 365.51 | PHACOLYTIC GLAUCOMA |
| 365.52 | PSEUDOEXFOLIATION GLAUCOMA |
| 365.59 | GLAUCOMA ASSOCIATED WITH OTHER LENS DISORDERS |
| 365.60 | GLAUCOMA ASSOCIATED WITH UNSPECIFIED OCULAR DISORDER |
| 365.61 | GLAUCOMA ASSOCIATED WITH PUPILLARY BLOCK |
| 365.62 | GLAUCOMA ASSOCIATED WITH OCULAR INFLAMMATIONS |
| 365.63 | GLAUCOMA ASSOCIATED WITH VASCULAR DISORDERS OF EYE |
| 365.64 | GLAUCOMA ASSOCIATED WITH TUMORS OR CYSTS |
| 365.65 | GLAUCOMA ASSOCIATED WITH OCULAR TRAUMA |
| 365.81 | HYPERSECRETION GLAUCOMA |
| 365.82 | GLAUCOMA WITH INCREASED EPISCLERAL VENOUS PRESSURE |
| 365.83 | AQUEOUS MISDIRECTION |
| 365.89 | OTHER SPECIFIED GLAUCOMA |
| 365.9 | UNSPECIFIED GLAUCOMA |
| 368.54 | ACHROMATOPSIA |
| 368.61 | CONGENITAL NIGHT BLINDNESS |
| 377.00 | PAPILLEDEMA UNSPECIFIED |
| 377.01 | PAPILLEDEMA ASSOCIATED WITH INCREASED INTRACRANIAL PRESSURE |
| 377.02 | PAPILLEDEMA ASSOCIATED WITH DECREASED OCULAR PRESSURE |
| 377.03 | PAPILLEDEMA ASSOCIATED WITH RETINAL DISORDER |
| 377.04 | FOSTER-KENNEDY SYNDROME |
| 377.10 | OPTIC ATROPHY UNSPECIFIED |
| 377.11 | PRIMARY OPTIC ATROPHY |
| 377.12 | POSTINFLAMMATORY OPTIC ATROPHY |
| 377.13 | OPTIC ATROPHY ASSOCIATED WITH RETINAL DYSTROPHIES |
| 377.14 | GLAUCOMATOUS ATROPHY (CUPPING) OF OPTIC DISC |
| 377.15 | PARTIAL OPTIC ATROPHY |
| 377.16 | HEREDITARY OPTIC ATROPHY |
| 377.21 | DRUSEN OF OPTIC DISC |
| 377.22 | CRATER-LIKE HOLES OF OPTIC DISC |
| 377.23 | COLOBOMA OF OPTIC DISC |

| | |
|--------|--|
| 377.24 | PSEUDOPAPILLEDEMA |
| 377.30 | OPTIC NEURITIS UNSPECIFIED |
| 377.31 | OPTIC PAPILLITIS |
| 377.32 | RETROBULBAR NEURITIS (ACUTE) |
| 377.33 | NUTRITIONAL OPTIC NEUROPATHY |
| 377.34 | TOXIC OPTIC NEUROPATHY |
| 377.39 | OTHER OPTIC NEURITIS |
| 377.41 | ISCHEMIC OPTIC NEUROPATHY |
| 377.42 | HEMORRHAGE IN OPTIC NERVE SHEATHS |
| 377.43 | OPTIC NERVE HYPOPLASIA |
| 377.49 | OTHER DISORDERS OF OPTIC NERVE |
| 379.00 | SCLERITIS UNSPECIFIED |
| 379.07 | POSTERIOR SCLERITIS |
| 379.09 | OTHER SCLERITIS |
| 379.21 | VITREOUS DEGENERATION |
| 379.22 | CRYSTALLINE DEPOSITS IN VITREOUS |
| 379.23 | VITREOUS HEMORRHAGE |
| 379.24 | OTHER VITREOUS OPACITIES |
| 379.25 | VITREOUS MEMBRANES AND STRANDS |
| 379.26 | VITREOUS PROLAPSE |
| 379.29 | OTHER DISORDERS OF VITREOUS |
| 379.60 | INFLAMMATION (INFECTION) OF POSTPROCEDURAL BLEB, UNSPECIFIED |
| 379.61 | INFLAMMATION (INFECTION) OF POSTPROCEDURAL BLEB, STAGE 1 |
| 379.62 | INFLAMMATION (INFECTION) OF POSTPROCEDURAL BLEB, STAGE 2 |
| 379.63 | INFLAMMATION (INFECTION) OF POSTPROCEDURAL BLEB, STAGE 3 |
| 710.0 | SYSTEMIC LUPUS ERYTHEMATOSUS |
| 743.51 | VITREOUS ANOMALIES CONGENITAL |
| 743.52 | FUNDUS COLOBOMA |
| 743.53 | CHORIORETINAL DEGENERATION CONGENITAL |
| 743.54 | CONGENITAL FOLDS AND CYSTS OF POSTERIOR SEGMENT |
| 743.55 | CONGENITAL MACULAR CHANGES |
| 743.56 | OTHER RETINAL CHANGES CONGENITAL |
| 743.57 | SPECIFIED CONGENITAL ANOMALIES OF OPTIC DISC |
| 743.58 | VASCULAR ANOMALIES CONGENITAL |
| 743.59 | OTHER CONGENITAL ANOMALIES OF POSTERIOR SEGMENT |
| 759.5 | TUBEROUS SCLEROSIS |
| 759.6 | OTHER CONGENITAL HAMARTOSES NOT ELSEWHERE CLASSIFIED |

| | |
|--------|--|
| 759.82 | MARFAN SYNDROME |
| 771.0 | CONGENITAL RUBELLA |
| 871.5 | PENETRATION OF EYEBALL WITH MAGNETIC FOREIGN BODY |
| 871.6 | PENETRATION OF EYEBALL WITH (NONMAGNETIC) FOREIGN BODY |
| 950.0 | OPTIC NERVE INJURY |
| 950.1 | INJURY TO OPTIC CHIASM |
| V10.84 | PERSONAL HISTORY OF MALIGNANT NEOPLASM OF EYE |
| V58.63 | LONG-TERM (CURRENT) USE OF ANTIPLATELETS/ANTITHROMBOTICS |
| V58.64 | LONG-TERM (CURRENT) USE OF NONSTEROIDAL ANTI-INFLAMMATORIES |
| V58.65 | LONG-TERM (CURRENT) USE OF STEROIDS |
| V58.69 | LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS |
| V67.51 | FOLLOW-UP EXAMINATION FOLLOWING COMPLETED TREATMENT WITH HIGH-RISK MEDICATION NOT ELSEWHERE CLASSIFIED |

* ICD-9-CM codes 362.03-362.07 added effective 12/01/2006.

*Diagnosis codes 249.00, 249.01, 249.10, 249.11, 249.20, 249.21, 249.30, 249.31, 249.40, 249.41, 249.50, 249.51, 362.22, 362.23, 362.24, 362.25, 362.26, 362.27 were added to the policy with an effective date of 10/01/2008.

Diagnoses that Support Medical Necessity [back to top](#)

All ICD-9-CM codes listed in this policy under ICD-9-CM Codes that Medical Necessity above.

ICD-9 Codes that DO NOT Support Medical Necessity [back to top](#)

All ICD-9-CM codes **not** listed in this policy under ICD-9-CM Codes that Support Medical Necessity above.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation [back to top](#)

Diagnoses that DO NOT Support Medical Necessity [back to top](#)

All ICD-9-CM codes **not** listed in this policy under ICD-9-CM Codes that Support Medical Necessity above.

General Information

Documentation Requirements [back to top](#)

In order to determine medical necessity, NAS may request a copy of the clinical records, which must justify the diagnosis listed on the claim and the reason(s) that fundus photographs and the frequency with which they were repeated were necessary for planning therapy and monitoring the progress of the disease diagnosed.

Documentation must support the medical necessity of this service as outlined in the Indications and Limitations of Coverage and/or Medical Necessity section of this policy.

Documentation in the patient's medical record should include all of the following:

1. A current, pertinent history and physical examination, and progress notes describing and supporting the covered indication
2. Pertinent prior diagnostic testing and completed report(s). This would include, when appropriate, previous fundus photographs.
3. The medical record must be made available to Medicare upon request.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.

When requesting a written redetermination (formerly appeal), providers must include all relevant documentation with the request.

Appendices [back to top](#)

Utilization Guidelines [back to top](#)

Fundus Photography will not be covered at a frequency that exceeds what is medically reasonable and necessary.

Fundus photography may be covered as a baseline prior to implantation of a Ganciclovir Vitreal Implant (GIOD) and at 2 week intervals following implantation of the GIOD. Physician discretion should determine whether or not there is an end point beyond which fundus photographs are no longer necessary.

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Sources of Information and Basis for Decision [back to top](#)

- . American Academy of Ophthalmology Primary Open-Angle Glaucoma-Preferred Pattern (revised September 2005)
- . Duane's Clinical Ophthalmology 2005
- . American Academy of Ophthalmology Diabetic Retinopathy Preferred Practice Pattern (updated 6/21/2002)
- . Yanoff, Ophthalmology, 2nd edition (2004)
- . Braunwald et al, eds. **Harrison's Principles of Internal Medicine**, 16th edition (2005)
- . Other carriers' policies
- . NAS Carrier Advisory Committee members

Advisory Committee Meeting Notes [back to top](#)

Notice of this DRAFT medical policy was made available to providers and the public in the

following states:

Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming.

This policy does not reflect the sole opinion of the contractor or the Contractor Medical Director(s). Although the final decision rests with the contractor, this policy was developed in cooperation with the Carrier Advisory Committee(s), which include representatives of various medical specialty societies.

The Section titled "Does the 'CPT 30% Rule' Apply?" needs clarification. This rule comes from the AMA (American Medical Association), the organization that holds the copyrights for all CPT codes. The rule states that if, in a given section (e.g., **surgery**) or subsection (e.g., surgery, **integumentary**) of CPT Manual, more than 30% of the codes are listed in the LCD, then the short descriptors must be used rather than the long descriptors found in the CPT Manual.

This policy is subject to the reasonable and necessary guidelines and the limitation of liability provision.

This medical policy consolidates and replaces all previous policies and publications on this subject by Noridian Administrative Services (NAS) and its predecessors for Medicare Part B.

Start Date of Comment Period [back to top](#)

09/15/2006

End Date of Comment Period [back to top](#)

10/31/2006

Start Date of Notice Period [back to top](#)

11/01/2006

Revision History Number [back to top](#)

R2

Revision History Explanation [back to top](#)

J3 CB2006.18

This LCD is a combination of the policy previously in place in five of the J3 states. All diagnoses were consolidated in the policy with one single exception that was felt to be inappropriate.

J3 CB2006.18 R1

This is the first revision to this LCD. ICD-9-CM codes 362.03-362.07 were added, effective 12/01/2006, as they were inadvertently omitted from the LCD previously.

J3 CB2006.18 R2

2008-2009 ICD-9-CM Annual Updates were applied. The following diagnosis codes were added with an effective date of October 01, 2008: 249.00, 249.01, 249.10, 249.11, 249.20.

249.21, 249.30, 249.31, 249.40, 249.41, 249.50, 249.51, 362.22, 362.23, 362.24, 362.25, 362.26, 362.27

Reason for Change [back to top](#)

ICD9 Addition/Deletion

Last Reviewed On Date [back to top](#)

09/18/2008

Related Documents [back to top](#)

This LCD has no Related Documents.

LCD Attachments [back to top](#)

[Coding Guidelines - Fundus Photography - J3 CB2006.18](#) (PDF - 58,674 bytes)

[Coding Guidelines - Fundus Photography - J3 CB2006.18 R1](#) (PDF - 20,216 bytes)

[Coding Guidelines - Fundus Photography - J3 CB2006.18 R2](#) (PDF - 10,369 bytes)

Other Versions [back to top](#)

[Updated on 08/09/2007 with effective dates 12/01/2006 - 09/30/2008](#)

[Updated on 11/20/2006 with effective dates 12/01/2006 - N/A](#)

