2022

Dark Adaptation Reimbursement Overview

Provided courtesy of MacuLogix, Inc.
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REIMBURSEMENT CODES AND BILLING PRACTICES CHANGE OVER TIME.
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MM-688 (REV 2)

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CPT 92284

DISCLAIMER:

MacuLogix provides this information for your convenience only. It does not constitute legal advice or a recommendation regarding clinical practice. Information provided is gathered from third-party sources and is subject to change without notice due to frequently changing laws, rules, and regulations. The provider has the sole responsibility to determine medical necessity and to submit appropriate codes and charges that accurately describe the service provided to a patient based on a patient's medical condition. Providers should follow payer-specific billing and coding requirements and contact the payer if they have questions. MacuLogix makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other payers as to the correct form of billing or the amount that will be paid to providers of service.

Please note that the existence of a code for a procedure does not guarantee coverage or payment. Where reimbursement is sought for use of a product that may be inconsistent with, or not expressly specified in, the FDA cleared or approved labeling (e.g., instructions for use, operator's manual or package insert), consult with your billing advisors or payers on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service.

The codes denoted within are suggestions only. This information should not be construed as authoritative. Codes and values are subject to frequent change without notice. The entity billing Medicare and/or third-party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Therefore, heath care providers must use great care and validate billing and coding requirements ascribed by payors with whom they work. When making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims.

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Overview

Use of dark adaptation testing procedures must meet the requirements established by Medicare and other third-party payers to be a covered service. Medicare provides coverage guidelines in National Coverage Determinations (NCDs). Local Medicare contractors provide detailed coverage guidelines in the form of Local Coverage Determinations (LCDs) or supplemental Local Coverage Articles (LCAs). Payer coverage policies are available in coverage manuals and on payer websites to help identify the products and services that are eligible for payment. Payers generally provide coverage for services when they are medically necessary for diagnosis or treatment of an illness or injury. Providers should contact Medicare, Medicaid and private payers directly for specific guidelines on reimbursement for a particular type of provider and to identify any special instructions for claims submission.

Board-certified ophthalmologists, neurologists and optometrists who are fully licensed are eligible for reimbursement for dark adaptation testing procedures. At the time this overview was published, dark adaptation testing had no Medicare NCDs or LCDs.

When submitting claims to Medicare and other third-party payers, hospitals and physicians list codes that describe patient conditions and reflect procedures performed. The following sections review some of the codes which may be appropriate for billing dark adaptation testing procedures. Providers, however, are ultimately responsible for choosing codes that accurately describe actual services performed in any given patient encounter.

CPT Code for Dark Adaptation Testing Procedures

Dark adaptation testing is reported with **CPT code 92284** (Dark adaptation examination with interpretation and report). The following table provides the CPT code description, 2022 Medicare National Average Rates and CMS Relative Value Unit (RVU).

Physician Coding					
CPT Code	**CPT Description**	**Total RVUs 2022**	**Medicare National Average Payment 2022**		
			Global	Phy (26)	Tech (TC)
92284	Dark adaptation examination with interpretation and report	1.43	**$58.83**	$12.11	$46.72

The characteristics of CPT code 92284 are as follows:

- Active code as designated by the Center for Medicare & Medicaid Services (CMS)
- CMS provides coverage for application of AdaptDx or AdaptDx Pro when medically indicated
- CPT 92284 accurately reports dark adaptation examination procedures performed utilizing the AdaptDx technology, including interpretation and report, by the physician or other qualified health care professional
- CPT 92284 is considered, per AMA/CPT and CMS guidelines, to be an inherently unilateral/bilateral code that can be reported once per session when performed in one eye or both eyes, without the use of code modifiers for laterality

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2022 CMS Reimbursements for CPT 92284 by Region

Medicare Administrative Contractor	Medicare Locality Code	State	Fee Schedule Area	Medicare 2022 National Average Payment
10112	00	Alabama	Statewide	$53.21
02102	01	Alaska	Statewide	$68.42
03102	00	Arizona	Statewide	$56.26
07102	13	Arkansas	Statewide	$50.70
01112	54	California	Bakersfield	$62.06
01112	55		Chico	$61.85
01182	71		El Centro	$61.88
01112	56		Fresno	$61.85
01112	57		Hanford-Corcoran	$61.85
01182	18		Los Angeles-Long Beach-Anaheim (Los Angeles Cnty)	$67.64
01182	26		Los Angeles-Long Beach-Anaheim (Orange Cnty)	$67.64
01112	58		Madera	$61.85
01112	59		Merced	$61.85
01112	60		Modesto	$61.85
01112	51		Napa	$69.57
01182	17		Oxnard-Thousand Oaks-Ventura	$67.63
01112	61		Redding	$61.85
01112	62		Riverside-San Bernardino-Ontario	$62.22
01112	63		Sacramento-Roseville-Folsom	$62.74
01112	64		Salinas	$65.53
01182	72		San Diego-Chula Vista-Carlsbad	$66.66
01112	07		San Francisco-Oakland-Berkeley (Alameda/Contra Costa Cnty)	$75.19
01112	52		San Francisco-Oakland-Berkeley (Marin Cnty)	$75.24
01112	05		San Francisco-Oakland-Berkeley (San Francisco Cnty)	$75.19
01112	06		San Francisco-Oakland-Berkeley (San Mateo Cnty)	$75.19
01112	65		San Jose-Sunnyvale-Santa Clara (San Benito Cnty)	$78.16
01112	09		San Jose-Sunnyvale-Santa Clara (Santa Clara Cnty)	$77.97
01182	73		San Luis Obispo-Paso Robles	$63.04
01112	66		Santa Cruz-Watsonville	$68.93
01182	74		Santa Maria-Santa Barbara	$67.41
01112	67		Santa Rosa-Petaluma	$67.55
01112	68		Stockton	$61.85

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Medicare Administrative Contractor	Medicare Locality Code	State	Fee Schedule Area	Medicare 2022 National Average Payment
01112	53	California	Vallejo	$69.57
01112	69		Visalia	$61.85
01112	70		Yuba City	$61.85
01112	75		Rest of California	$61.85
04112	01	Colorado	Statewide	$60.92
13102	00	Connecticut	Statewide	$64.71
12102	01	DC	DC + MD/VA Suburbs	$71.26
12202	01	Delaware	Statewide	$59.88
09102	03	Florida	Fort Lauderdale	$59.77
09102	04		Miami	$61.66
09102	99		Rest of Florida	$56.26
10212	01	Georgia	Atlanta	$58.63
10212	99		Rest of Georgia	$52.69
01212	01	Hawaii, Guam	Statewide	$65.65
02202	00	Idaho	Statewide	$52.14
06102	16	Illinois	Chicago	$62.00
06102	12		East St. Louis	$56.65
06102	15		Suburban Chicago	$62.47
06102	99		Rest of Illinois	$54.66
08102	00	Indiana	Statewide	$53.33
05102	00	Iowa	Statewide	$53.63
05202	00	Kansas	Statewide	$53.72
15102	00	Kentucky	Statewide	$52.17
07202	01	Louisiana	New Orleans	$55.77
07202	99		Rest of Louisiana	$52.81
14112	03	Maine	Southern Maine	$58.32
14112	99		Rest of Maine	$53.42
12302	01	Maryland	Baltimore/Surr. Cntys	$64.14
12302	99		Rest of Maryland	$60.83
14212	01	Massachusetts	Metropolitan Boston	$69.12
14212	99		Rest of Massachusetts	$61.90
08202	01	Michigan	Detroit	$59.33
08202	99		Rest of Michigan	$54.40
06202	00	Minnesota	Statewide	$58.80
07302	00	Mississippi	Statewide	$50.67
05302	02	Missouri	Metropolitan Kansas City	$56.49
05302	01		Metropolitan St. Louis	$57.53
05302	99		Rest of Missouri	$51.33
03202	01	Montana	Statewide	$58.81
05402	00	Nebraska	Statewide	$53.48
01312	00	Nevada	Statewide	$59.24

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Medicare Administrative Contractor	Medicare Locality Code	State	Fee Schedule Area	Medicare 2022 National Average Payment
14312	40	New Hampshire	Statewide	$60.62
12402	01	New Jersey	Northern NJ	$69.04
12402	99		Rest of New Jersey	$66.07
04212	05	New Mexico	Statewide	$53.86
13202	01	New York	Manhattan	$70.41
13202	02		NYC Suburbs/Long Island	$72.02
13202	03		Poughkpsie/N NYC Suburbs	$64.92
13292	04		Queens	$72.30
13282	99		Rest of New York	$56.35
11502	00	North Carolina	Statewide	$55.08
03302	01	North Dakota	Statewide	$58.24
15202	00	Ohio	Statewide	$54.62
04312	00	Oklahoma	Statewide	$52.72
02302	01	Oregon	Portland	$61.65
02302	99		Rest of Oregon	$55.72
12502	01	Pennsylvania	Metropolitan Philadelphia	$63.33
12502	99		Rest of Pennsylvania	$55.70
09202	20	Puerto Rico	Puerto Rico	$59.21
14412	01	Rhode Island	Statewide	$61.36
11202	01	South Carolina	Statewide	$53.71
03402	02	South Dakota	Statewide	$58.15
10312	35	Tennessee	Statewide	$52.96
04412	31	Texas	Austin	$61.27
04412	20		Beaumont	$55.59
04412	09		Brazoria	$59.77
04412	11		Dallas	$59.84
04412	28		Fort Worth	$58.24
04412	15		Galveston	$59.92
04412	18		Houston	$60.43
04412	99		Rest of Texas	$56.17
03502	09	Utah	Statewide	$54.61
14512	50	Vermont	Statewide	$58.43
09202	00	Virginia	Statewide	$58.48
11302	50	Virgin Islands	Virgin Islands	$59.21
02402	02	Washington	Seattle (King Cnty)	$68.50
02402	99		Rest of Washington	$59.26
11402	16	West Virginia	Statewide	$52.01
06302	00	Wisconsin	Statewide	$55.23
03602	21	Wyoming	Statewide	$58.67

Search the current CMS Physician Fee Schedule at www.cms.gov/medicare/physician-fee-schedule/search

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ICD-10-CM DIAGNOSIS CODES

The diagnosis codes listed below are applicable to dark adaptation testing. This list is not intended to be exhaustive. Conversely, Medicare, Medicaid, and private insurers may not cover all the conditions listed. Providers who are fully licensed and eligible for reimbursement for dark adaptation testing procedures should check with specific insurers to determine if there are any limitations or special instructions for claim submission.

ICD-10-CM	Description
E50.5	Vitamin A deficiency with night blindness
H35.30	Unspecified macular degeneration
	Codes below only applicable to adult patients aged 15-124 years inclusive.
H35.3110	Nonexudative age-related macular degeneration, right eye, stage unspecified
H35.3111	Nonexudative age-related macular degeneration, right eye, early dry stage
H35.3112	Nonexudative age-related macular degeneration, right eye, intermediate dry stage
H35.3113	Nonexudative age-related macular degeneration, right eye, advanced atrophic without subfoveal involvement
H35.3114	Nonexudative age-related macular degeneration, right eye, advanced atrophic with subfoveal involvement
	Codes below only applicable to adult patients aged 15-124 years inclusive.
H35.3120	Nonexudative age-related macular degeneration, left eye, stage unspecified
H35.3121	Nonexudative age-related macular degeneration, left eye, early dry stage
H35.3122	Nonexudative age-related macular degeneration, left eye, intermediate dry stage
H35.3123	Nonexudative age-related macular degeneration, left eye, advanced atrophic without subfoveal involvement
H35.3124	Nonexudative age-related macular degeneration, left eye, advanced atrophic with subfoveal involvement
	Codes below only applicable to adult patients aged 15-124 years inclusive.
H35.3130	Nonexudative age-related macular degeneration, bilateral, stage unspecified
H35.3131	Nonexudative age-related macular degeneration, bilateral, early dry stage
H35.3132	Nonexudative age-related macular degeneration, bilateral, intermediate dry stage
H35.3133	Nonexudative age-related macular degeneration, bilateral, advanced atrophic without subfoveal involvement
H35.3134	Nonexudative age-related macular degeneration, bilateral, advanced atrophic with subfoveal involvement
	Codes below only applicable to adult patients aged 15-124 years inclusive.
H35.3190	Nonexudative age-related macular degeneration, unspecified eye, stage unspecified
H35.3191	Nonexudative age-related macular degeneration, unspecified eye, early dry stage
H35.3192	Nonexudative age-related macular degeneration, unspecified eye, intermediate dry stage
H35.3193	Nonexudative age-related macular degeneration, unspecified eye, advanced atrophic without subfoveal involvement
H35.3194	Nonexudative age-related macular degeneration, unspecified eye, advanced atrophic with subfoveal involvement
	Codes below only applicable to adult patients aged 15-124 years inclusive.
H35.3210	Exudative age-related macular degeneration, right eye, stage unspecified
H35.3211	Exudative age-related macular degeneration, right eye, with active choroidal neovascularization

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ICD-10-CM	Description
H35.3212	Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization
H35.3213	Exudative age-related macular degeneration, right eye, with inactive scar
	Codes below only applicable to adult patients aged 15-124 years inclusive.
H35.3220	Exudative age-related macular degeneration, left eye, stage unspecified
H35.3222	Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization
H35.3223	Exudative age-related macular degeneration, left eye, with inactive scar
	Codes below only applicable to adult patients aged 15-124 years inclusive.
H35.3230	Exudative age-related macular degeneration, bilateral, stage unspecified
H35.3231	Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization
H35.3232	Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization
H35.3233	Exudative age-related macular degeneration, bilateral, with inactive scar
	Codes below only applicable to adult patients aged 15-124 years inclusive.
H35.3290	Exudative age-related macular degeneration, unspecified eye, stage unspecified
H35.3291	Exudative age-related macular degeneration, unspecified eye, with active choroidal neovascularization
H35.3292	Exudative age-related macular degeneration, unspecified eye, with inactive choroidal neovascularization
H35.3293	Exudative age-related macular degeneration, unspecified eye, with inactive scar
	Codes below only applicable to adult patients aged 15-124 years inclusive.
H35.361	Drusen (degenerative) of macula, right eye
H35.362	Drusen (degenerative) of macula, left eye
H35.363	Drusen (degenerative) of macula, bilateral
H35.369	Drusen (degenerative) of macula, unspecified eye
H35.50	Unspecified hereditary retinal dystrophy
H35.52	Pigmentary retinal dystrophy
H35.53	Other dystrophies primarily involving the sensory retina
H35.54	Dystrophies primarily involving the retinal pigment epithelium
H40.20X0	Unspecified primary angle-closure glaucoma, stage unspecified
H40.20X1	Unspecified primary angle-closure glaucoma, mild stage
H40.20X2	Unspecified primary angle-closure glaucoma, moderate stage
H40.20X3	Unspecified primary angle-closure glaucoma, severe stage
H40.20X4	Unspecified primary angle-closure glaucoma, indeterminate stage
H53.60	Unspecified night blindness
H53.61	Abnormal dark adaptation curve
H53.62	Acquired night blindness
H53.63	Congenital night blindness
H53.69	Other night blindness

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FREQUENTLY ASKED QUESTIONS

Q: Is there a National Coverage Determination (NCD) or any Local Coverage Determination (LCD) prohibiting reimbursement for dark adaptation testing?

A: No. At the time of this writing there were no applicable NCDs or LCDs. In the absence of any formal policy, claims will be reviewed and paid based on medical necessity.

Q: What are some of the ICD-10 diagnosis codes that are commonly covered when submitting claims for the procedure?

A: The AdaptDx automated dark adaptometer is generally indicated (but may not be approved – please check with the individual carrier) for the following conditions:

- Nonexudative age-related macular degeneration (ICD-10-CM codes now include staging)
- Exudative age-related macular degeneration (ICD-10-CM codes now include staging)
- Drusen (degenerative)
- Pigmentary retinal dystrophy
- Vitamin A deficiency with night blindness
- Night blindness (unspecified, congenital, or acquired)
- Previously documented abnormal dark adaptation

Although payers will generally cover dark adaptation testing for these indications, insurers may have their own set of specific guidelines and restrictions. Providers are always responsible for selecting the diagnosis codes to report as documented in the medical record.

Q: If I perform a dark adaptation test on only one eye of a patient, how do I bill insurers?

A: CPT 92284 is considered to be an inherently unilateral/bilateral code that can be reported once per session when performed in one eye or both eyes, without the use of code modifiers for laterality. Per AMA/CPT and CMS guidelines the CPT code is reported once per patient session when either one or both eyes are tested. Please check with your patient's specific insurer to determine the appropriate coding guidelines for individual cases.

Q: What type of supervision is required for dark adaptation testing?

A: According to Medicare guidelines, general supervision is required for dark adaptation examinations. This means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

Q: Do optometrists have more difficulty getting reimbursed for procedures than ophthalmologists? Are there differences in payment depending on the provider type billing for the procedure?

A: CPT coding conventions define a qualified health care professional to be "an individual who is qualified by education, training, licensure/regulation who performs a professional service within his/her scope of practice and independently reports that professional service". State and Federal Regulations, as well as specific health plan guidelines, may impact the determination of "scope of practice" and may differ per provider locale.

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Medicare data provided by the AMA RBRVS Data Manager subscription publication, provides the following percentage of use by medical specialty based on Medicare claims data for CPT code 92284 in 2019:

- 79.8% Optometry
- 20.1% Ophthalmology

Most often if the provider is fully licensed to perform a procedure, they are eligible to receive coverage and reimbursement. Additionally, if the payer covers the procedure, there should be no difference in payment rates to optometrists and ophthalmologists. Physician payment is determined by evaluating the costs associated with physician work, practice expense, professional liability insurance and geographic wage indices. If you have specific payment inquiries, please contact individual payers directly for the most accurate reimbursement information.

Q. Are modifiers required for reimbursement?

A. AMA/CPT and CMS reporting guidelines do not require the use of laterality modifiers for CPT 92284 procedures. Some private payer guidelines, however, may require the use of modifiers depending on the actual procedure(s) performed. It may be necessary to append certain modifiers to the procedure codes indicated on claim forms for specific payer guideline requirements. Modifiers are designed to provide payers with additional information that may be necessary to track patient encounters and process claims. Healthcare providers should always follow payer guidelines for individual cases.

Q. Are their restrictions on other codes that may be billed the same day?

A. In general, there are no restrictions on billing multiple procedures in addition to dark adaptation that have been performed on a single patient during a single patient encounter. Providers should bill for all procedures that have been performed, as long as the CPT codes are not duplicative or in conflict with each other as per a NCCI edit. It is the provider's responsibility to determine appropriate codes, charges, and modifiers, and submit bills for the services consistent with the patient's insurer requirements. In addition, there are no restrictions other than appropriate medical necessity and standards of care on the frequency of dark adaptation testing.

Q. Does Multiple Procedure Payment Reduction (MPPR) apply to CPT 92284?

A. Effective January 2013, CMS is applying the multiple procedure payment reduction policy to the technical component of certain ophthalmology diagnostic services, including CPT code 92284. For these services, CMS will make full payment for the technical component (TC) of the highest paid service. Payment is made at 80 percent for subsequent TC services furnished by the same physician or group practice to the same patient on the same day. Currently, the MPPR does not apply to the professional component services.

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Q. Are their specific codes that cannot be billed on the same patient on the same date of service if performed by the same provider?

A. Yes. Following are the January 1, 2022 edits from the NCCI file. Providers should always refer to the latest edits from the CMS website. When these codes are submitted together and an edit exists, Column 1 codes are eligible for payment, and Column 2 codes are not. There are no Column 1 edits for 92284 as of the publication of this overview.

CPT Code Conflicts with 92284	Administrative Explanation	Modifier Allowed	Rule Status
36591	CPT Manual or CMS Manual Coding Instructions	NO	ACTIVE
36592	CPT Manual or CMS Manual Coding Instructions	NO	ACTIVE
96523	CPT Manual or CMS Manual Coding Instructions	NO	ACTIVE
99211	Misuse of Column Two Code with Column One	OK	ACTIVE

Q. What is required to support medical necessity?

A. CMS Medicare defines medical necessity as: “Services or supplies that are proper and needed for the diagnosis or treatment of the patient’s medical conditions, are provided for the diagnosis, direct care and treatment of the patient’s medical condition, meet the standards of good medical practice in the local area and aren’t mainly for the convenience of the patient or the physician.”

The provider who treats a beneficiary must order all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests for a specific medical problem. The physician uses the results to manage the beneficiary’s specific medical problem and may furnish a consultation. Tests not ordered by the physician are not considered reasonable and necessary. The physician should clearly indicate all tests to be performed when completing progress notes. Documentation in the patient’s medical record must support the medical necessity for ordering the service(s) per Medicare regulations and applicable Local Coverage Determinations (LCDs).

Avoid the use of standing orders or panel testing. Diagnostic test orders should be specific to an individual patient and generated on a case-by-case basis. Medicare carrier Wisconsin Physician Services stipulates that “standing” or “routine” orders for diagnostic tests are not reimbursable. The value of an “interpretation and report” derives from the answers to important questions about the diagnostic test:

- Physician’s order – Why is the test desired?
- Date performed – When was it performed?
- Technician’s initials – Who did it?
- Reliability of the test – Was the test of any value?
- Patient cooperation – Was the patient at fault?
- Test findings – What are the results of the test?
- Assessment, diagnosis – What do the results mean?
- Impact on treatment, prognosis – What’s next?
- Physician’s signature – Who is the physician?

The documentation of the answers would constitute an interpretation.

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Please note that MacuLogix cannot guarantee success in obtaining third-party payment. It is the responsibility of the provider to determine and submit claims with appropriate codes, charges, and modifiers for the services rendered. Providers should contact insurers directly for specific information on policies for procedures mentioned in this overview. The key in all coding and billing to payers is to be truthful and not misleading and make full disclosures to the payer about how the product has been used.

If you have additional questions about this overview, please contact MacuLogix at 717.914.4067 or email info@maculogix.com.