2020

Dark Adaptation Reimbursement Overview

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REIMBURSEMENT CODES AND BILLING PRACTICES CHANGE OVER TIME. ALL INFORMATION IS SUBJECT TO THE DESCRIPTIONS AND DISCLAIMERS CONTAINED IN THIS GUIDE.

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Disclaimer: The information contained within this guide was gathered from several sources and is subject to change. The information provided is general information only and is not legal advice or advice about how to code, complete, or submit any particular claim for payment for health care services. The information within this guide provides only an overview of MacuLogix's understanding of current reimbursement policies and may not provide all of the information necessary to understand a particular situation. It is the responsibility of the provider to submit complete, accurate and appropriate bills or claims for payment that comply with applicable laws and regulations and third-party payer requirement, and to determine the appropriate codes, charges and modifiers that the provider uses for those purposes. Third-party payers may have policies and coding requirements that differ from those described here, and such policies can change over time

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 in this guide. 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 any questions or concerns regarding this guide, please contact the MacuLogix at (717) 914-4067 or email info@maculogix.com

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.

Ophthalmologists and optometrists who are fully licensed are eligible for reimbursement for dark adaptation testing procedures. Dark adaptation testing currently has no Medicare NCDs, and there currently exists only one Medicare Administrative Contractor (MAC) LCD (First Coast Service Options LCD L33925 applicable to Florida, Puerto Rico and the Virgin Islands), which specifically allows reimbursement for dark adaptation testing for selected diagnoses.

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, 2020 Medicare National Average Rates and CMS RVUs.

Physician Coding					
CPT Code	**CPT Description**	**Total RVUs 2020**	**Medicare National Average Payment 2020**		
			Global	Phy (26)	Tech (TC)
92284	Dark adaptation examination with interpretation and report	1.41	$60.63	$12.99	$47.64

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 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

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 and only a single applicable LCD in force. First Coast Service Options LCD L33925 (applicable to Florida, Puerto Rico and the Virgin Islands) limits coverage to specific diagnosis codes, but it does not prohibit reimbursement.

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.

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 2016:

- 56.68% Optometry
- 40.07% Ophthalmology
- 2.8% Internal Medicine

Most often if the provider is fully licensed to perform a procedure, they are eligible to receive coverage and reimbursement. Additionally, as long as 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 in order to track patient encounters and process claims. Healthcare providers should always follow payer guidelines for individual cases.

Q. Are there 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. Below are the January 1, 2020 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 Code	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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Diagnosis Codes for Dark Adaptation Testing

Ophthalmologists and optometrists who are fully licensed are eligible for reimbursement for dark adaptation testing procedures. Dark adaptation testing currently has no Medicare NCDs, and there currently exists only one Medicare Administrative Contractor (MAC) LCD (First Coast Service Options LCD L33925 applicable to Florida, Puerto Rico and the Virgin Islands), which specifically allows reimbursement for dark adaptation testing for selected diagnoses (these codes are bolded).

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
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

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ICD-10-CM	Description
	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
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***

***For Florida, Puerto Rico and the Virgin Islands, First Coast Service Options LCD L33925 allows reimbursement for only these ICD-10-CM diagnosis codes.**

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2020 CMS Reimbursements for CPT 92284 by Region

Medicare Locality Code**	Locality	Medicare 2020 National Average Payment
0	**National Average**	**$60.63**
1010200	Alabama	$54.66
210201	Alaska	$70.60
310200	Arizona	$58.48
710213	Arkansas	$52.94
111254	Bakersfield, CA	$64.12
111255	Chico, CA	$63.95
111271	El Centro, CA	$63.95
111256	Fresno, CA	$63.95
111257	Hanford/Corcoran	$63.95
118218	Los Angeles, Cnty	$69.70
111258	Madera, CA	$63.95
111259	Merced, CA	$63.95
111260	Modesto, CA	$63.95
111251	Napa, CA	$72.62
111207	Oakland/Berkeley, CA	$77.32
118226	Orange County, CA	$63.97
118217	Oxnard-Thousand Oaks-Ventura	$69.70
111261	Redding, CA	$63.95
111262	Riverside/San Bernardino/Ontario	$64.22
111263	Sacramento/Roseville/Arden/Arcade	$64.43
111264	Salinas, CA	$66.32
118272	San Diego/Carlsbad	$67.10
111205	San Francisco, CA	$77.32
111252	San Francisco-Oakland-Hayward	$75.87
111265	San Jose/Sunnyvale/Santa Clara	$75.00
118273	San Luis Obispo/Paso Robles/Arroy	$64.61
111206	San Mateo, CA	$77.32
111209	Santa Clara, CA	$79.53
111266	Santa Cruz/Watsonville	$68.65
118274	Santa Maria/Santa Barbara	$67.60
111267	Santa Rosa, CA	$67.73
111268	Stockton/Lodi	$63.95
111253	Vallejo/Fairfield	$72.62
111269	Visalia/Porterville	$63.95
111270	Yuba City, CA	$63.95
111275	Rest of California	$69.59
411201	Colorado	$62.21
1310200	Connecticut	$66.73
1210201	Delaware	$61.78
1220201	DC + MD/VA Suburbs	$72.60
910203	Ft. Lauderdale, FL	$61.83
910204	Miami, FL	$63.68
910299	Rest of Florida	$58.31
1020201	Atlanta, GA	$60.52
1020299	Rest of Georgia	$54.97
121201	Hawaii/Guam	$67.62
220200	Idaho	$54.45
610212	East St. Louis, IL	$58.31
610215	Suburban Chicago, IL	$64.18
610216	Chicago, IL	$63.67
610299	Rest of Illinois	$56.57
810200	Indiana	$55.42
510200	Iowa	$55.27
520200	Kansas	$55.55
1510200	Kentucky	$54.03

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Medicare Locality Code**	Locality	Medicare 2020 National Average Payment
720201	New Orleans, LA	$58.37
720299	Rest of Louisiana	$54.75
1411203	Southern Maine	$60.37
1411299	Rest of Maine	$55.68
1230201	Baltimore/Surr. Cntys, MD	$66.02
1230299	Rest of Maryland	$62.58
1421201	Metropolitan Boston	$70.65
1421299	Rest of Massachusetts	$64.03
820201	Detroit, MI	$60.99
820299	Rest of Michigan	$56.30
620200	Minnesota	$60.54
730200	Mississippi	$52.78
530202	Metropolitan Kansas City, MO	$58.52
530201	Metropolitan St. Louis, MO	$58.97
530299	Rest of Missouri	$53.26
320201	Montana	$60.96
540200	Nebraska	$55.22
131200	Nevada	$60.81
1431240	New Hampshire	$62.75
1240201	Northern, NJ	$70.63
1240299	Rest of New Jersey	$67.55
421205	New Mexico	$56.17
1320201	Manhattan, NY	$71.76
1320202	NYC Suburbs/Long I., NY	$73.44
1320203	Poughkpsie/N NYC Suburbs, NY	$65.77
1329204	Queens, NY	$73.49
1328299	Rest of New York	$57.83
1150200	North Carolina	$56.81
330201	North Dakota	$60.07
1520200	Ohio	$56.36
431200	Oklahoma	$54.69
230201	Portland, OR	$63.40
230299	Rest of Oregon	$58.07
1250201	Metropolitan Philadelphia, PA	$65.15
1250299	Rest of Pennsylvania	$57.38
920220	Puerto Rico	$61.02
1441201	Rhode Island	$63.32
1120201	South Carolina	$55.49
340202	South Dakota	$59.95
1030235	Tennessee	$54.86
441231	Austin, TX	$62.28
441220	Beaumont, TX	$56.94
441209	Brazoria, TX	$61.03
441211	Dallas, TX	$61.43
441228	Ft. Worth, TX	$59.88
441215	Galveston, TX	$61.49
441218	Houston, TX	$61.78
441299	Rest of Texas	$57.60
350209	Utah	$56.69
1451250	Vermont	$60.59
920250	Virgin Islands	$61.02
1130200	Virginia	$60.07
240202	Seattle (King Cnty), WA	$69.39
240299	Rest of Washington	$61.05
1140216	West Virginia	$53.62
630200	Wisconsin	$57.30
360221	Wyoming	$60.48

**2020 Current Physician Fee Schedule (PFS) Locality Structure, www.cms.gov

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Disclaimer: 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.

The information contained in this document has been prepared to assist you in understanding the reimbursement process. It is intended to assist providers in accurately obtaining reimbursement for health care services. It is not intended to increase or maximize reimbursement by any payer. We strongly suggest that you consult your payer organization with regard to local reimbursement policies. The information contained in this document is provided for information purposes only, and represents no statement, promise or guarantee concerning levels of reimbursement, payment, charge, or that third-party reimbursement will be made.