Select Health

CODING/REIMBURSEMENT POLICY

MULTIPLE PROCEDURE REDUCTION FOR DIAGNOSTIC OPHTHALMOLOGY PROCEDURES

Policy # 74
Implementation Date: 1/1/13
Review Dates:
Revision Dates:11/6/24

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Based on CMS policy, a multiple procedure reduction applies to diagnostic ophthalmology procedures. All diagnostic ophthalmology services are considered part of a single family. A reduction is applied to the technical component (TC) only.

- The professional (PC/26) represents the physician work, i.e., the interpretation
- The technical (TC) component represents Practice Expense (PE), i.e., clinical staff, supplies, and equipment
- The global service represents both the professional (PC/26) and technical (TC) components

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Select Health follows the CMS policy that applies a payment reduction for multiple units or multiple diagnostic ophthalmology services. When multiple units of diagnostic ophthalmology services and/or multiple procedures are billed for the same patient by the same provider on the same date of service, a payment reduction will be made to the Technical (-TC) portion of the services rendered.

- Full payment will be made for the unit or the procedure with the highest PE payment
- For subsequent units and procedures, a 20 percent reduction will be applied for the Technical (-TC) portion of the services rendered

The reduction will be applied regardless of the provider type/specialty providing the services.

The reduction will apply to the codes listed below.

SELECT HEALTH MEDICARE

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the Select Health Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website https://medicaid.utah.gov/manuals/ or the Utah Medicaid code Look Up tool

Billing/Coding Information
CPT CODES

CPT	Description
0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report
0507T	Near-infrared dual imaging (ie, simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter
76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)
76513	Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
76516	Ophthalmic biometry by ultrasound echography, A-scan;
76519	; with intraocular lens power calculation
92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report
92060	Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees or quantitative, automated threshold perimetry, Octopus program G-1, 32 or

	42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
92133	; optic nerve
92134	; retina
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral
92229	Imaging of retina for detection or monitoring of disease; point-of-care autonomous analysis and report, unilateral or bilateral
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral
92250	Fundus photography with interpretation and report
92265	Needle oculoelectromyography, 1 or more extraocular muscles, 1 or both eyes, with interpretation and report
92270	Electro-oculography with interpretation and report
92273	Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld ERG)
92274	Electroretinography (ERG), with interpretation and report; multifocal (mfERG)
92283	Color vision examination, extended, eg, anomaloscope or equivalent
92284	Dark adaptation examination with interpretation and report
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)
92286	Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis

Sources

1. Application of the Multiple Procedure Payment Reduction (MPPR) on Imaging Services to Physicians in the Same Group Practice. August 2, 2012. Retrieved on September 5, 2024. From https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r1104otn.pdf
2. Centers for Medicare & Medicaid Services (CMS). (2012, August 2). Application of the Multiple Procedure Payment Reduction (MPPR) on the Professional Component (PC) and Technical Component (TC) of Certain Diagnostic Imaging Procedures to

Physicians in the Same Group Practice. Retrieved October 15, 2024, from http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1104OTN.pdf
3. Centers for Medicare & Medicaid Services (CMS). (2012, August 2). Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services. Retrieved on October 15, 2024, from http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R826OTN.pdf
4. *Current Procedural Terminology (CPT®),* (2017) – American Medical Association.
5. Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures. November 6, 2012. Retrieved on September 5, 2024, from https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r1149otn.pdf

Disclaimer
This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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