heru

Dark Adaptation

Reimbursement Overview

DISCLAIMER:

Heru 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. Heru 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.

DARK ADAPTATION REIMBURSEMENT OVERVIEW
CPT 92284

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 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 Heru Dark Adaptation exam when medically indicated
- CPT 92284 accurately reports dark adaptation examination procedures performed utilizing the Heru 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

DARK ADAPTATION REIMBURSEMENT OVERVIEW

CPT 92284

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	California	Chico	$61.85
01182	71	California	El Centro	$61.88
01112	56	California	Fresno	$61.85
01112	57	California	Hanford-Corcoran	$61.85
01182	18	California	Los Angeles-Long Beach-Anaheim (Los Angeles Cnty)	$67.64
01112	58	California	Madera	$61.85
01112	60	California	Modesto	$61.85
01182	17	California	Oxnard-Thousand Oaks-Ventura	$67.63
01112	61	California	Redding	$61.85
01112	62	California	Riverside-San Bernardino-Ontario	$62.22
01112	63	California	Sacramento-Roseville-Folsom	$62.74
01112	64	California	Salinas	$65.53
01182	72	California	San Diego-Chula Vista-Carlsbad	$66.66
01112	07	California	San Francisco-Oakland-Berkeley (Alameda/ Contra Costa Cnty)	$75.19
01112	52	California	San Francisco-Oakland-Berkeley (Marin Cnty)	$75.24
01112	05	California	San Francisco-Oakland-Berkeley (San Francisco Cnty)	$75.19
01112	06	California	San Francisco-Oakland-Berkeley (San Mateo Cnty)	$75.19
01112	65	California	San Jose-Sunnyvale-Santa Clara (San Benito Cnty)	$78.16
01112	09	California	San Jose-Sunnyvale-Santa Clara (Santa Clara Cnty)	$77.97
01182	73	California	San Luis Obispo-Paso Robles	$63.04
01112	66	California	Santa Cruz-Watsonville	$68.93
01182	74	California	Santa Maria-Santa Barbara	$67.41
01112	67	California	Santa Rosa-Petaluma	$67.55
01112	68	California	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	California	Visalia	$61.85
01112	70	California	Yuba City	$61.85
01112	75	California	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	Florida	Miami	$61.66
09102	99	Florida	Rest of Florida	$56.26
10212	01	Georgia	Atlanta	$58.63
10212	99	Georgia	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	Illinois	East St. Louis	$56.65
06102	15	Illinois	Suburban Chicago	$62.47
06102	99	Illinois	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	$52.77
07202	99	Louisiana	Rest of Louisiana	$52.81
14112	03	Maine	Southern Maine	$58.32
14112	99	Maine	Rest of Maine	$53.42
12302	01	Maryland	Rest of Maryland	$60.83
14212	01	Massachusetts	Metropolitan Boston	$69.12
14212	99	Massachusetts	Rest of Massachusetts	$61.90
08202	01	Michigan	Detroit	$59.33
08202	99	Michigan	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	Missouri	Metropolitan St. Louis	$57.53
05302	99	Missouri	Rest of Missouri	$51.33
03202	01	Montana	Statewide	$58.81
05402	00	Nebraska	Statewide	$53.48
01312	00	Nevada	Statewide	$59.24

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	New Jersey	Rest of New Jersey	$66.07
04212	05	New Mexico	Statewide	$53.86
13202	01	New York	Manhattan	$70.41
13202	02	New York	NYC Suburbs/Long Island	$72.02
13202	03	New York	Poughkpsie/N NYC Suburbs	$64.92
13292	04	New York	Queens	$72.30
13282	99	New York	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	Oregon	Rest of Oregon	$55.72
12502	01	Pennsylvania	Metropolitan Philadelphia	$63.33
12502	99	Pennsylvania	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	Texas	Beaumont	$55.59
04412	09	Texas	Brazoria	$59.77
04412	11	Texas	Dallas	$59.84
04412	28	Texas	Fort Worth	$58.24
04412	15	Texas	Galveston	$59.92
04412	18	Texas	Houston	$60.43
04412	99	Texas	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	Washington	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

DARK ADAPTATION REIMBURSEMENT OVERVIEW
CPT 92284

ICD-10 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
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

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

DARK ADAPTATION REIMBURSEMENT OVERVIEW
CPT 92284

FREQUENTLY ASKED QUESTIONS

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.

Q: Do I bill differently if the test is performed unilaterally/only on one eye?

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: 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: Heru Dark Adaptation may be indicated 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)
- Vitamin A deficiency with night blindness
- Night blindness (unspecified, congenital, or acquired)
- Previously documented abnormal dark adaptation

Please be sure to check with the individual carriers to see if these conditions will be approved. 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: Are modifiers required for reimbursement?

A: AMA/CPT and CMS reporting guidelines do not require the use of laterality modifiers for CPT 2284 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 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.

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 Heru 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.