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A Division of Ardare Corporation

Medicare Reimbursement for Imaging with the Topcon 3D OCT-1 Maestro

Prepared for

TOPCON®

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Medicare Reimbursement for Imaging with the Topcon 3D OCT-1 Maestro

by

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Objective: *This report is provided as a general discussion of billing and documentation for fundus photography, SCODI-P and related issues. Variations in coverage and payment policies among Medicare Administrative Contractors (MACs) may occur which are not described here. Other non-Medicare payers may promulgate policies that differ from those of Medicare and its contractors. The user is strongly encouraged to review federal and state laws, regulations and official instructions of the Centers for Medicare & Medicaid Services (CMS), the MACs, and other third party payers.*

Notice: *All fee schedule amounts noted in this document are the national Medicare allowed amounts. Actual fee schedule amounts and payments vary by locality.*

Disclaimer: *This document is not an official source nor is it a complete guide on all matters pertaining to coding (CPT, HCPCS, ICD-9, or ICD-10) and reimbursement. Neither Topcon Medical Systems nor the Corcoran Consulting Group guarantees that the use of this information will result in payment for services. The reader is reminded that this information can and does change over time, and may be incorrect at any time following publication. The continued availability of cited references as hyperlinks, whether embedded or not, cannot be ensured.*

This document does not constitute legal or medical advice. Physicians and other providers should use independent judgment when selecting codes that most appropriately describe the services provided to a patient. Physicians and hospitals are solely responsible for compliance with applicable laws, Medicare regulations, and other payers' requirements and should confirm the applicability of any coding or billing practice with applicable payers prior to submitting claims.

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INTRODUCTION

This monograph describes reimbursement for fundus photography (FP) and scanning computerized ophthalmic diagnostic imaging of the posterior segment of the eye (SCODI-P) using Topcon Medical System's 3D OCT-1 Maestro instrument. Both FP and SCODI-P are common ophthalmic diagnostic tests that are useful for medical monitoring, screening, and telemedicine.

Much of the information in this document is taken from official publications of the Medicare program. The reader is encouraged to check with the local Medicare Administrative Contractor (MAC) for additional information and instructions. For 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 and ICD-10-CM.

Documentation of diagnostic tests, and the medical rationale for them, is 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 fundus imaging, as well as recent Medicare utilization rates.

THE DEVICE

The Topcon Medical Systems' 3D OCT-1 Maestro is a high-resolution non-mydriatic fundus camera combined, in a single instrument, with a spectral-domain OCT (SD-OCT).[1] According to Topcon, it captures 30- or 45-degree color fundus images and offers the capability of showing a red-free image as well as external images. Additionally, the software enables the ability to "knit" and save a mosaic image from multiple images digitally when needed. It can auto-center on the macula and optic disc when desired, and has both full-auto and manual operation options for both FP and OCT applications. The SCODI-P images are wide field, having a scan range of up to 12 mm horizontally and 9 mm vertically at a rate of 50,000 scans per second for retinal nerve fiber layer (RNFL) and other retinal and optic disc measurements. The simultaneous, high-resolution images for FP and OCT are captured digitally.[2] The instrument received FDA 510(k) clearance on July 29, 2016.[3]

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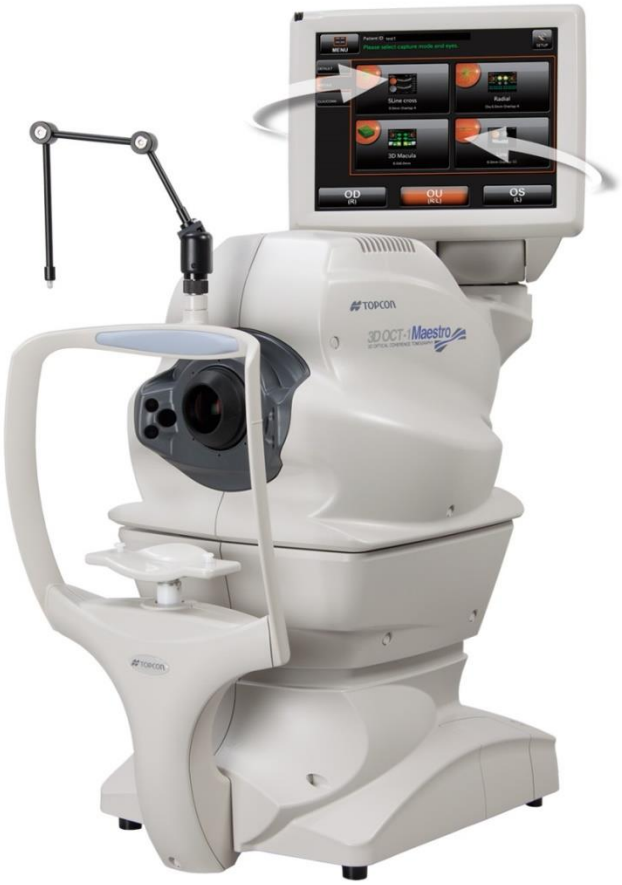
[1] Topcon Medical Systems. General Information. 3D OCT-1 Maestro. Link here. Accessed 09/12/16.

[2] Product information provided by Topcon Medical Systems.

[3] Topcon Medical Systems. Press Release July 29, 2016. Link here. Accessed 09/12/16.

Figure 1 **Topcon Medical System's 3D OCT-1 Maestro**



INDICATIONS FOR USE

According to the American Academy of Ophthalmology's (AAO) Preferred Practice Patterns (PPP)[4] for age-related macular degeneration, primary open-angle glaucoma, primary angle-closure, idiopathic epiretinal membrane and vitreomacular traction, retinal vein occlusion, idiopathic macular hole, and diabetic retinopathy, fundus photography and/or SCODI-P provide objective documentation and can be used to establish a baseline for future comparisons as well as to follow disease progression.

The AAO's PPPs further point out that these tests are more reproducible technique than clinical examination for detecting posterior segment disease.

[4] American Academy of Ophthalmology. Preferred Practice Patterns. Link here Accessed 09/12/16.

In general, SCODI-P and FP are both performed to:

- evaluate abnormalities in the vitreous, fundus, macula, and optic nerve
- follow the progress of a disease,
- plan the treatment for a disease, and/or
- assess the therapeutic effect of recent surgery (*e.g.*, photocoagulation).

Merely documenting a static condition does not provide medical necessity for either test.

Coverage Guidelines

Medical necessity for diagnostic testing begins with pertinent signs, symptoms, or medical history of a condition for which the examining physician needs further information. A variety of disease entities justify testing (Tables 1, 2, and 3).

Initial diagnostic testing is ordered and performed when the information garnered from the eye exam is insufficient to adequately assess the patient's disease. Medicare covers imaging-related tests as an adjunct to evaluation and management of a known disease (even a systemic one). If the images are taken as baseline documentation of a healthy eye or as preventive medicine to screen for potential disease, then they are not covered, even if disease is identified.[5]

Repeated imaging is necessitated by disease progression, the advent of a new or different disease, or planning for additional surgical treatment (*e.g.*, laser). Otherwise, repeated images of the same, unchanged, condition are unwarranted if they could be also seen during an exam (*e.g.*, fundus photography).

In our research for this monograph, we found no published strict limitations for repeated fundus photography, although some payers have guidance. For SCODI-P, frequency for testing is dependent on the disease and its activity. In general, this and all other diagnostic tests are reimbursed when medically indicated and properly documented. Too-frequent testing can garner unwanted attention from Medicare and other payers.

Palmetto GBA, the MAC for South Carolina, in their local coverage determination (LCD) L33467 on Fundus Photography,[6] notes,

> *"In general, fundus photography is considered medically necessary only when it would assist in:*

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[5] 42 CFR 411.15(a)(1). Particular services excluded from coverage. Link here. Accessed 09/12/16.

[6] Palmetto GBA. LCD L33467. Ophthalmology: Extended Ophthalmoscopy and Fundus Photography. South Carolina. Revision Effective Date 12/15/16. Link here. Accessed 12/21/16.

1. *monitoring potential progression of a disease process; or*
2. *guidance in evaluating the need for or response to a specific treatment or intervention.*

In other words, medical necessity for fundus photography should guide a clinical decision. Therefore, baseline photos to document a condition that is reasonably expected to be static and/or not require future treatment would not be medically necessary."

Table 1 **Common Diagnosis Codes for Fundus Photography**

ICD-10	ICD-9	Description
E10.3-, E11.3-	362.01	Background diabetic retinopathy
H35.01-	362.10	Background retinopathy
Q14.8	743.55	Congenital macular changes
H35.35-	362.53	Cystoid macular degeneration
E10.3-, E11.3-	250.5x	Diabetes with ophthalmic manifestations
H47.0-	377.4x	Disorders of optic nerve
H35.32	362.52	Exudative macular degeneration
H35.02-	362.12	Exudative retinopathy
H44.7-	360.60	Foreign body, intraocular
H44.6-	360.50	Foreign body, magnetic, intraocular
Q14.8	743.52	Fundus coloboma
H40.-, H42	365.xx	Glaucoma
H35.03-	362.11	Hypertensive retinopathy
H35.41-	362.63	Lattice degeneration
H35.3-	362.50	Macular degeneration
C69.3-	190.6	Malignant neoplasm of choroid
C69.2-	190.5	Malignant neoplasm of retina
H35.31	362.51	Nonexudative macular degeneration
H47.2-	377.1x	Optic atrophy
H46.-	377.3x	Optic neuritis and neuropathies
H47.1-	377.0x	Papilledema
H34.2-	362.33	Partial arterial occlusion
E10.35-, E11.35-	362.02	Proliferative diabetic retinopathy
H33.3-	361.3x	Retinal defects w/o detachment
H35.89	362.82	Retinal exudates and deposits
H35.82	362.84	Retinal ischemia

Table 1 **Common Diagnosis Codes for Fundus Photography**

ICD-10	ICD-9	Description
H35.09	362.17	Retinal microvascular abnormalities
H34.-	362.30	Retinal vascular occlusion
H35.06-	362.18	Retinal vasculitis
H33.1-	361.10	Retinoschisis
H35.54	362.76	RPE dystrophies

NOTE: Listed codes are representative of covered diagnoses for 92250, but differences in payment policies exist for many payers. This list is neither exhaustive nor universally accepted. The ICD-10 codes shown are not a precise crosswalk; the ending "dash" means a longer code may be required and contains greater specificity than the corresponding ICD-9 code.

Some ophthalmologists and optometrists may feel that a retinal or optic nerve photograph is indicated for a particular condition, but when the patient's diagnosed condition does not appear on the payer's coverage list reimbursement cannot be expected. Then, if payment is expected, it is important to notify patients in writing, prior to testing, of their financial responsibility for the test. See the discussion below on Financial Waivers.

Many LCDs for SCODI-P focus on indications for the diagnosis and management of early glaucoma and optic nerve disease (Table 2).

Table 2 **Common Glaucoma and Optic Nerve Diagnosis Codes for SCODI-P**

ICD-10	ICD-9	Description
Q15.0	743.20 - 743.22	Buphthalmos
H40.6-	365.31 to 365.32	Corticosteroid-induced glaucoma
H47.4-	377.51 to 377.54	Disorders of optic chiasm
H47.3-	377.21 to 377.24	Disorders of optic disc
H47.0-	377.41 to377.49	Disorders of optic nerve
H47.5-	377.61 to 377.63	Disorders of other visual pathways
Q15.0	365.41 to 365.44	Glaucoma associated with congenital anomalies, dystrophies, and systemic syndromes
H40.14-	365.51 to 365.59	Glaucoma associated with disorders of the lens
H40.3-, H40.4-, H40.5-	365.60 to 365.65	Glaucoma associated with other ocular disorders
-----[7]	365.70 to 365.74	Glaucoma severity stage [8]

[7] This concept is now integrated into some ICD-10 codes.

[8] Glaucoma severity stage codes added October 1, 2011

Table 2 **Common Glaucoma and Optic Nerve Diagnosis Codes for SCODI-P**

ICD-10	ICD-9	Description
H40.0-	365.00 to 365.04	Glaucoma suspect
H40.40x-	364.22	Glaucomatocyclitic crises
H21.52-	364.73	Goniosynechiae
H47.2-	377.10 to 377.16	Optic atrophy
H40.89	365.81 to 365.89	Other specified forms of glaucoma
H47.1-	377.00 to 377.04	Papilledema
H21.23-	364.53	Pigmentary iris degeneration
H40.2-	365.20 to 365.24	Primary angle closure glaucoma
H40.11x-	365.10 to 365.15	Primary open angle glaucoma
H21.4-	364.74	Pupillary membranes
H21.55-	364.77	Recession of chamber angle
H47.9	377.9	Unspecified disorder of optic nerve and visual pathways
H40.9	365.9	Unspecified glaucoma
H53.15	368.14	Visual distortions
H53.4-	368.40 to 368.47	Visual field defects

NOTE: Listed codes are representative of covered diagnoses for 92133, but differences in payment policies exist for many payers. This list is neither exhaustive nor universally accepted. The ICD-10 codes shown are not a precise crosswalk; the ending "dash" means a longer code may be required and contains greater specificity than the corresponding ICD-9 code.

SCODI-P has also become an important tool in the detection and monitoring of many diseases of the vitreous, retina, and choroid. Many MACs have expanded the scope of indications to include them (Table 3). It is important to note that MACs and other payers do not all agree on a common list of diagnoses or technologies. Review your payer policies.

Wisconsin Physician Services (WPS), the MAC for Iowa, in their LCD L34760 on Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI),[9] notes for glaucoma the following:

[9] Wisconsin Physicians Service Insurance Corporation. LCD L34760. Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI). Iowa. Revision Effective Date 10/01/16. Link here. Accessed 12/21/16.

> *Technological improvements have rendered SCODI as a valuable diagnostic tool in the diagnosis and treatment of glaucoma. These improvements enable discernment of changes of the optic nerve … It is expected that only two (SCODI) exams/eye/year would be required …* [for] *the patient who has glaucoma or is suspected of having glaucoma.*

They go on to note, with respect to retinal testing performed via SCODI-P technology:

> *It is expected that no more than one exam per eye every two months would be required …* [when the] *condition is related to a retinal disease. Patients with retinal conditions undergoing active intravitreal drug treatment may be allowed one scan per month per eye … In addition, other conditions which may undergo rapid clinical changes monthly requiring aggressive therapy and frequent follow-up, such as macular hole and traction retinal detachment, may also require monthly scans.*

Table 3 **Common Diagnosis Codes for SCODI-P – Retina**

ICD-10	ICD-9	Description
D31.3-	224.6	Benign neoplasm of choroid
H44.-	360.30 to 360.34	Disorder of globe
D18.09	228.03	Hemangioma of retina
H35.5-	362.70 to 362.77	Hereditary retinal dystrophies
H35.3-	362.50 to 362.57	Macular degeneration[10]
C69.-	190.8	Malignant neoplasm of eye
H35.2-	362.29	Other nondiabetic proliferative retinopathy
H35.4-	362.60 to 362.66	Peripheral retinal degenerations
H33.3-	361.30 to 361.33	Retinal defect
H33.0-, H33.2-	361.00 to 360.07	Retinal detachment
H33.4-	361.81	Retinal detachment
H33.1-	361.10 to 361.19	Retinal detachment or Retinoschisis
H35.7-	362.40 to 362.43	Retinal separation
H34.-	362.30 to 362.37	Retinal vascular occlusion
E11.31- to E11.35-, H35.0- to H35.2-	362.01 to 362.18	Retinopathy[11]
H35.17-	362.21	Retrolental fibroplasias

[10] Laterality and staging for age-related macular degeneration are in effect for claims with dates of service after 10/01/16, so these codes may need to be seven characters in length.

[11] Laterality and other changes to diabetic eye disease are in effect for claims with dates of service after 10/01/16.

Table 3 **Common Diagnosis Codes for SCODI-P – Retina**

H30.-, H31.-	363.00 to 363.43	Chorioretinal disease
H31.32-	363.63	Choroidal rupture
H31.4-	363.70 to 363.72	Choroidal detachment
H53.4-	368.40 to 368.45	VF defect
H05.-	376.00 to 376.9	Orbital disease
H47.1-	377.00 to 377.04	Papilledema
H47.2-	377.10 to 377.16	Optic atrophy
H47.3-	377.21 to 377.24	Optic disc disease
H47.0-	377.41 to 377.49	Optic neuropathy
H47.9	377.9	Other disorders of optic nerve
H43.-	379.21 to 379.29	Vitreous disorders
Q14.-	743.57 to 743.59	Congenital abnormalities
S06.-	854.0 to 854.1	Intracranial injury
S05.1-	921.3	Contusion of eyeball
Z79.899	V58.69*	Long term (current) use of high risk medication
Z09	V67.51*	Following completed treatment with high risk medication

NOTE: Listed codes are representative of covered diagnoses for 92134, but differences in payment policies exist for many payers. This list is neither exhaustive nor universally accepted. The ICD-10 codes shown are not a precise crosswalk; the ending "dash" means a longer code may be required and contains greater specificity than the corresponding ICD-9 code. Some policies may not use ALL the codes in a particular range as listed.

* Applicable for SD-OCT only as a secondary diagnosis code. A systemic disease is often the primary diagnosis, and if so, must be listed first on the claim.

Screening

Some ophthalmologists and optometrists use standing orders for non-mydriatic fundus photography for all patients prior to an eye exam, so the doctor can screen for posterior segment disease as well as educate patients about the back of the eye. Other times, SCODI-P of the retina is used as part of a package of items related to cosmetic refractive services. As a general rule most payers, including Medicare, do not cover screening services or preventive medicine.[12] Patients must be given the opportunity to choose between an exam with or without these imaging services. Practices should use a financial waiver[13] to document the beneficiaries' acceptance of financial responsibility for the screening service. Screening occurs when the images are taken for one or more of the following reasons.

[12] 42 CFR 410.32 (a). Ordering diagnostic tests. Link here. Accessed 09/12/16.

[13] Corcoran's web site includes sample forms. Link here.

- Part of a wellness program to check for disease that may otherwise go undetected
- Not required by medical necessity; the reason for imaging is optional
- The beneficiary has no symptom or documented eye or systemic condition that would support imaging
- Recommended *prior to* a physician order for an individual patient's unique illness, injury, or medical condition
- Done for all patients as a matter of course, unless they decline

Finding disease on a screening test does not confer eligibility for reimbursement. It frequently leads to additional evaluation and management services, albeit not necessarily on the same day. Re-taking an image later on the same day (or another day close in time to the initial test) as the screening image does not provide coverage.

Standing Orders

Standing orders for tests may improve office efficiency, but they often create problems with reimbursement. The Office of Inspector General and the MACs have published several reports identifying standing orders as troublesome and problematic because they are routine screenings and non-covered services.[14,15,16] The Centers for Medicare & Medicaid Services (CMS) states "*the physician must clearly document, in the medical record, his or her intent that the test be performed."*[17,18] To avoid this difficulty with reimbursement, physicians should examine the patient first and then determine which tests, if any, are necessary *before* ordering them. Alternately, and less commonly, a physician may formulate an order for imaging prior to any examination based on information about an individual patient's unique illness, injury, or medical condition provided by another physician, health care professional, or the patient themselves.

Telemedicine

The hallmark of telehealth is the utilization of information technology as an aid to providing health care and improving access to care. Healthcare IT News predicts that

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[14] United States General Accounting Office. Beneficiary Use of Clinical Preventive Services. GAO-02-422. April 2002. Link here. Accessed 09/12/16.

[15] Office of Inspector General. Report: St. Francis Hospital, Tulsa, OK. Estimated Medicare Overpayment. February 12, 2002. Link here. Accessed 09/12/2016.

[16] Department of Justice. Archived Press Release. GAMBRO Healthcare Inc. agrees to pay $53 million of overcharging Medicare, Medicaid, & Tricare. July 13, 2000. Link here. Accessed 09/12/16.

[17] CMS. Medicare Benefit Policy Manual, Chapter 15, §80.6.1. Requirements for Orders for Diagnostic Tests- Definitions. Link here. Accessed 09/12/16.

[18] Palmetto GBA. Jurisdiction 11 Part B. Orders for Diagnostic Tests. Link here. Accessed 09/12/16.

telehealth will reach a market value of $30 billion by the year 2020.[19]

Likely, one area of growth will be screening for diabetic retinopathy. Diabetic eye disease is the leading cause of new onset blindness in the United States. With early detection and treatment of diabetic eye disease, vision loss can be mitigated. Unfortunately, various resources indicate that only about 60% of diabetics receive an eye exam. Can remote imaging reduce the number of diabetic patients not being screened for eye disease? Many believe it can.

The standard of care for diabetic patients is an annual dilated eye exam by a qualified eye care provider.[20,21,22,23,24] Also, some patients may need seven standard field, stereoscopic, color 30° fundus photos which is the standard of care for photographing diabetic eye disease.[25] Recently, some experts have questioned whether annual eye exams are the most cost-effective way of screening for eye problems in diabetics and have suggested telemedicine as a plausible alternative.[26,27]

The use of remote imaging, especially for diabetics, is not new. Many centers already exist whereby patients receive fundus photos and the photos are sent to a reading center interpreted by an ophthalmologist, and a formal report is generated. Likely, this use will rapidly expand in the future.

SUPERVISION

Effective July 1, 2001, Medicare revised its supervision rules for many ophthalmic diagnostic tests. Fundus photography and SCODI require *general* supervision. This means the procedure is furnished under the physician's overall direction and control, but

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19 Monegain, B. Telemedicine market to soar past $30B. *Healthcare IT News*. August 4, 2015. Link here. Accessed 09/12/16.

20 American Academy of Ophthalmology. Preferred Practice Pattern Guidelines. Comprehensive Adult Medical Eye Evaluation. November 2015. Link here to list of documents. Accessed 09/12/16.

21 National Eye Institute. Facts About Diabetic Eye Disease. Last Reviewed June 2012. Link here. Accessed 09/12/16.

22 National Institutes for Health. NIH encourages annual dilated eye exams during National Diabetes Month. November 3, 2011. Link here. Accessed 09/12/16.

23 Joslin Diabetes Center. Annual Eye Exam. Link here. Accessed 09/12/16.

24 Utah Diabetes Prevention and Control Program. Utah Facts. Link here. Accessed 09/12/16.

25 Fong, SD, et al. Evaluation of Diabetic Retinopathy. *Diabetes Care*. Vol 26, No Suppl 1 S99-S102. January 2003. Link here. Accessed 09/12/16.

26 Rein, DB, et al. The Cost-Effectiveness of Three Screening Alternatives for People with Diabetes with No or Early Diabetic Retinopathy. *Health Services Research*. Vol 46, Issue 5, p. 1534-1561. October 2011. Link here to abstract. Accessed 09/12/16.

27 Davis, RM et al. Telemedicine Improves Eye Examination Rates in Individuals with Diabetes. *Diabetes Care*. Vol 26, No 8, p. 2476. August 2003. Link here. Accessed 09/12/16.

the physician's presence is not required during performance of the test.[28] 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.[29]

DOCUMENTATION

The descriptions in CPT for fundus photography and SCODI-P of the retina and optic nerve include the phrase *"with interpretation and report"*.[30] What exactly is meant by this phrase, and what kind of chart note is required? This question takes on added urgency since insufficient chart documentation is reason enough to require repayment of any reimbursement.

Medicare Regulations and Guidance

The Medicare guidelines for interpretation of diagnostic tests are discussed in the Medicare Claims Process Manual (MCPM) Chapter 13 §100, Interpretation of Diagnostic Tests.[31] CMS makes a distinction between a "review" of a test and an "interpretation and report".

> *"Carriers generally distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service. This is because the review is already included in the … E/M payment."*

The review of a test is not separately payable because it is part of an evaluation and management (E/M) service.

> *"For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An "interpretation and report" should*

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28 Some state laws may have different requirements.

29 42 CFR 410.32(b)(3)(i). Definition of general supervision. Link here. Accessed 09/12/16.

30 Current Procedural Terminology (CPT) 2016 edition.

31 Medicare Claims Process Manual (MCPM), Chapter 13, §100. Interpretation of Diagnostic Tests. Link here. Accessed 09/12/16.

address the findings, relevant clinical issues, and comparative data (when available).”

Simple, brief notations such as “normal” or “abnormal” are construed as a review of the test rather than as an interpretation and report. As a condition of payment,[32] 42 CFR 415.120 (a) states:

> ***“(a) Services to beneficiaries.*** *The carrier pays for radiology services furnished by a physician to a beneficiary on a fee schedule basis only if the services meet the conditions for fee schedule payment in § 415.102(a) and are identifiable, direct, and discrete diagnostic or therapeutic services furnished to an individual beneficiary, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures. The carrier pays for interpretations only if there is a written report prepared for inclusion in the patient's medical record maintained by the hospital.”*

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?*
- Comparison – *How do today’s results differ from prior test(s)?*
- Assessment, diagnosis – *What do the results mean?*
- Impact on treatment, prognosis – *What’s next?*
- Physician’s signature – *Who is the physician?*

In ophthalmology, tests such as fundus photography and SCODI-P are more valuable for making decisions about treatment when there is a series. Then, the concept of “comparative data” cited above is particularly meaningful. Does the series demonstrate disease progression? For a fundus photograph, the “interpretation and report” might read as follows.

- August 15, 2016
- Technician: Mary Smith, COA

[32] 42 CFR 415.120(a). Conditions for payment: Radiology services, to beneficiaries. Link here. . Accessed 09/12/16.

- Cloudy images due to cataracts
- Good patient cooperation
- Cupping OU; optic disc hemorrhage, OU
- POAG, shows progression since last visit
- Add another anti-glaucoma medication
- *Signed: I. C. Better, M.D.*

For SCODI-P of the optic nerve on the same patient at another visit date, the "interpretation and report" might read as follows.

- August 15, 2016
- Technician: Mary Smith, COA
- Test reliable, nice image capture
- Good patient cooperation
- RNFL thinning, OU
- POAG, shows RNFL worsening since last test
- Add another anti-glaucoma medication
- *Signed: I. C. Better, M.D.*

Timing

Ideally, the interpretation of a test follows immediately after the technical component is finished. In practice, there may be a delay; however, the delay should not be lengthy or affect patient care. Since fundus photography requires only general supervision,[33] and the physician need not be present during the performance of the test, the interpretation might take place the next day. If a weekend intervenes, there may be two days' delay.

It is important to note that CMS understands that delays are a fact of life and, in 2009, proposed regulations to require claims for reimbursement to identify on two separate lines the technical and professional components of a diagnostic test when performed on different dates of service. Transmittals 1823 and 1873 were subsequently withdrawn, yet there is still concern about this topic. As a practical alternative, bill the entire test upon completion after the interpretation is documented in the medical record since it is not clear what diagnosis would be used for the technical component alone.

[33] 42 CFR 410.32(b)(3)(i). Definition of general supervision. Link here. Accessed 04/01/15.

Where to write?

An interpretation can be written on its own separate page in the medical record or in the blank space on the printout of the test result. Within an electronic medical record, we often find a designated spot to record the physician's interpretation of a test as a report. If the interpretation is written as part of the office visit note, it might appear to be an element of the evaluation and management service. Better to keep it separate, or differentiate it from the rest of the eye exam by surrounding the notations with a box and a title like "fundus photo report" or "OCT report".

Payment Considerations

In the Medicare Physician Fee Schedule, different payment rates are established for the professional and technical components of a diagnostic test where there is discrete reimbursement for an "interpretation and report". Respectively, modifiers 26 and TC are used to make the distinction between the professional and technical portions of the test. As a practical matter, this segregation permits a technician or medical assistant to perform the technical component, with appropriate supervision; however only the physician can interpret test results. When TC and 26 are not appended to a CPT code, then the payer understands that reimbursement is sought for both the technical and professional components together in a single payment.

BILLING ISSUES

Procedure Codes

The following CPT codes might be used to report testing using the Topcon Medical Systems 3D OCT-1 Maestro.

92133 …..	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
92134 …..	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina
92250 ..…	Fundus photography with interpretation and report
92227 …..	Remote imaging for detection of retinal disease (*e.g.*, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
92228 …..	Remote imaging for monitoring and management of active retinal disease

(*e.g.*, diabetic retinopathy) with physician review, interpretation, and report, unilateral or bilateral

While CPT codes 92133, 92134, and 92250 are readily understandable, CPT 92227 and 92228 are not as clear. The AMA publication, CPT Changes: An Insider's View 2011, indicated that these telemedicine codes were established to "*…meet the needs of diabetic retinopathy screening programs which provide remote imaging and data submission to a centralized reading center*."

CPT 92227 reports a screening examination. This patient has no visual complaints but has a history of diabetes. Images are taken but there is no physician involvement. Coverage for this screening service varies among payers with some Medicare contractors considering this service noncovered. [34]

CPT 92228 reports remote imaging for monitoring and management of patients with active retinal disease. Images are taken remotely, sent to a reading center, and reviewed by a physician who generates an interpretation and report. Many payers consider this a covered service but some consider it noncovered.[35,36] The parenthetical instructions in CPT immediately below these codes preclude the use of office visit CPT codes (92002-92014 and 99201-99350) as well as other diagnostic tests (92133, 92134, and 92250) at the same encounter.

Modifiers

The following modifiers may be applicable on claims for the above codes.

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 (ABN) signed (*Medicare modifier only*)
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.

[34] National Government Services. Local Coverage Determination L33567. Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography). Illinois. Revision Effective Date 10/10/16. Link here. Accessed 12/21/16.

[35] CGS Administrators. Local Coverage Article A52398, Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) – Supplemental Instructions Article. Ohio. Revision Effective Date 10/01/15. Link here. Accessed 12/21/16.

[36] Palmetto GBA. Local Coverage Article A53060. Coding article for Ophthalmology: Extended Ophthalmoscopy and Fundus Photography. South Carolina. Revision Effective Date 02/19/16. Link here. Accessed 12/21/16.

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 Claims

Example 1 Age-related macular degeneration

During dilated fundus exam of the posterior pole with binocular indirect ophthalmoscopy, a few small drusen were noted OU. You order fundus photography OU to establish the extent of the early stage, nonexudative age-related macular degeneration (AMD) and to permit re-evaluation at a later date. In addition to the exam (shown as 9xxxx), the claim will read as follows.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. H35.3131 B. C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92250		A	xxx xx	1		NPI	1234567890

Note: For dates of service before October 1, 2016, the code would be H35.31 without the additional characters.

One year later, the patient is seen again and no change in the AMD is noted on the dilated fundus examination. Repeating the fundus photography would not be warranted; the earlier photographs suffice.

Example 2 Diabetes with retinopathy

Your 74 y/o established Medicare patient with Type II diabetes on oral hypoglycemics presents for a yearly examination. You note an abnormal fundus with mild non-proliferative diabetic retinopathy and no diabetic macular edema is noted in either eye. For a more detailed evaluation and to permit re-evaluation at a later date, you order and

perform fundus photos. In addition to the exam (shown as 9xxxx), the claim will read as follows.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. E11.3293 B. C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A,B	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92250		A,B	xxx xx	1		NPI	1234567890

Note: For dates of service before October 1, 2016, the code would be E11.329 without the additional 7th character.

Example 3 Monocular photography

You are a retina specialist consulted by another eyecare provider concerning a 78 y/o woman with blurred and distorted vision in her only useful eye; her other eye is NLP. Your dilated fundus exam identifies a macular pucker OS; remember that OD is a blind eye. You order SCODI-P of the retina of the affected eye and document your findings in your report. In addition to the exam (shown as 9xxxx), the claim will read as below.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION Only left eye photographed			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. H35.372 B. C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92134	52	A	xxx xx	1		NPI	1234567890

Note: In this case, there is no difference in the ICD-10 codes "before" or "after" October 1, 2016 dates of service since the update did not affect this code.

Note: Some payers require modifier 52 when only one eye is tested; note also the box 19 comment, which some payers also require. Reduced reimbursement may apply when only one eye is imaged.[37]

[37] National Government Services. LCD L33567. Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography), MN. Revision Eff 10/01/16. Link here. Accessed 12/21/16.

Multiple Procedure Payment Reduction

Medicare has implemented a payment reduction when multiple tests are performed on a patient at the same encounter. Known as the Multiple Procedure Payment Reduction (MPPR), it is effective for dates of service beginning January 1, 2013. This payment policy reduces the technical component of the second and any subsequent diagnostic tests by 20% when more than one eligible diagnostic test is performed at one patient encounter on the same day by the same physician or group. The list of tests includes imaging, ultrasounds and visual fields.[38] Tests not on the list are not subject to the MPPR reduction. CPT codes 92133, 92134, 92250, 92227, and 92228 are included in the list.

Example 4 Multiple Procedure Payment Reduction (MPPR)

A patient returns for her 3 month glaucoma check and threshold visual field. During the exam, the IOP is elevated and the optic nerves show increased cupping compared to the last fundus photos. Repeat fundus photographs are ordered and performed today. Both tests are properly interpreted. Payment for these tests from Medicare would be as follows.

Test	Professional	Technical	Total
92250 Fundus Photo	$22.25	$44.50 (No reduction)	$66.75
92083 Visual Field	$28.35	$36.97 less $7.39 (20%) = $29.57	$57.92

2017 National Medicare Physician Fee Schedule, PAR allowable
Note: Calculations are subject to rounding and might not be exactly mathematically correct.

The payment reduction is taken only on the lesser of the two *technical* portions – which is the visual field test in this example. Note that the professional portions of each of the respective tests are unaffected and paid in full.

Financial Waivers

An Advance Beneficiary Notice of Noncoverage[39] is a written notice a health care provider gives to a Medicare beneficiary when the provider believes that Medicare will not pay for items or services. It is required for both assigned and non-assigned claims.

[38] CMS Transmittal 1104, dated August 2, 2012, identifies the specific tests by CPT code that are subject to the MPPR. The Medicare Physician Fee Schedule multiple procedure indicator also identifies these codes each year (multiple procedure indicator 7). Link here. Accessed 09/12/16.

[39] Advance Beneficiary Notice of Noncoverage. Link here to Corcoran Consulting Group's website for downloadable versions of this form. Accessed 09/12/16.

By signing an ABN, the Medicare beneficiary acknowledges that he or she has been advised that Medicare will not pay and agrees to be responsible for payment, either personally or through another insurance plan. For an ABN to have any utility, it must be signed before providing the item or service.

You do not need an ABN for items or services that are statutorily (*i.e.*, by law) non-covered by Medicare. Statutorily non-covered services in an eye care practice include refractions and cosmetic procedures such as refractive surgery. Instructions, published on September 5, 2008,[40] allow the use of an ABN *voluntarily* for items excluded from Medicare coverage. At your discretion, you may choose to notify a beneficiary that these services are never covered using the ABN. Written notification is strongly recommended to avoid confrontations with beneficiaries about payment.

The format of an ABN cannot be modified to any significant degree. You must add your name, address and telephone to the header. You may add your logo and other information if you wish. The "Items or Services," "Reason Medicare May Not Pay," and "Estimated Cost" boxes are customizable so you can add pre-printed lists of common items and services or denial reasons. Anything you add in the boxes must be high contrast ink on a pale background. Blue or black ink on white paper is preferred. You may not make any other alterations to the form. It must be one page, single-sided, although an addendum is allowed.

You must complete your portion of the form before asking the beneficiary to sign. Fill in the beneficiary's name and identification number (but not HIC number) at the top of the form. Complete the "Items or Services" box, describing what you propose to provide. Use simple language the beneficiary can understand. You may add CPT or HCPCS codes, but codes alone are not sufficient without a description. Complete the "Reason Medicare May Not Pay" box with the reason(s) you expect a denial. The reason(s) must be specific to the particular patient; general statements such as "medically unnecessary" are not acceptable. The "Estimated Cost" field is required.

The beneficiary must *personally* choose Option 1, 2 or 3. The patient must *sign* and *date* the form; an unsigned or undated form is not valid. Once the patient has signed the completed form, he or she must receive a legible copy. The same guidelines apply to the copy as to the original: blue or black ink on white paper is preferred; a photocopy is fine. You keep the original in your files.

If the beneficiary chooses Option 1, you must file a claim and append an appropriate modifier to the reported item(s) or service(s). In CMS Transmittal R1921CP,[41] effective

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[40] CMS. *MedLearn Matters* (MM6136). Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage. Link here. Accessed 09/12/16.

[41] CMS. Transmittal R1921CP. Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs). February 19, 2010. Link here. Accessed 09/12/16.

April 1, 2010, two modifiers were updated to distinguish between *voluntary* and *required* use of liability notices. This change addresses the fact that most beneficiaries will elect Option 1 in the hope that Medicare might pay, despite your assurances to the contrary.

Modifier GA was redefined as "Waiver of Liability Statement Issued as Required by Payer Policy". When coverage is uncertain, you ask the patient to sign an ABN and submit your claim with modifier GA, allowing the payer to decide if the test is covered. Modifier GX is new and defined as "Notice of Liability Issued, Voluntary Under Payer Policy". If the patient selects Option 1, append modifiers GX and GY to that claim as those services are non-covered. Modifier GY is defined as "Item or service statutorily excluded or does not meet the definition of any Medicare benefit".

Option 2 applies to situations where Medicare is precluded from paying for the item or service and the beneficiary does not dispute the point. Do not file a claim; do post the item or service in your computer system with modifier GY.

Note that Medicare Advantage plans (Medicare Part C) are prohibited from using the regular Medicare ABN form but may still require prior financial notice. In many cases, they are required to provide a coverage or non-coverage determination in advance. Check plan websites for appropriate instructions.

For non-Medicare beneficiaries, some of the principles outlined above are just as applicable. While the concept of waiver of liability may not be present, or at least not as vigorously, it is still prudent to ensure that patients appreciate the distinction between covered and non-covered services, and accept financial responsibility for the latter.

Prohibited Code Combinations

In 1996, CMS developed the National Correct Coding Initiative (NCCI) to control improper coding leading to inappropriate payments in Part B claims.[42] NCCI consists of a series of edits to analyze codes reported on claims for reimbursement. They ensure the most comprehensive groups of codes are billed rather than the component parts; this is the concept informally known as "bundles". Additionally, the edits check for mutually exclusive code pairs – procedures that are medically incompatible – so just one of the pair may be reimbursed. New edits are published quarterly by the National Technical Information Service (NTIS). Some carriers have also published local policies with additional limitations. Of note, you may not use an ABN to circumvent the NCCI edits.

[42] Medicare Claims Processing Manual, Chapter 23, §20.9. Correct Coding Initiative. Link here. Accessed 09/12/16.

In the current NCCI edits, CPT 92250 is bundled with ICG angiography (92240) and mutually exclusive with scanning computerized ophthalmic diagnostic imaging (SCODI) of the posterior segment (92133, 92134). It is also likely to be bundled with the new 2017 CPT code for simultaneous ICG and fluorescein angiography (92242). A bundle means that just one service will be reimbursed when both are performed on the same day; it behooves you to bill just one, usually the greater one, assuming that both tests have clinical utility.

Additionally, other diagnostic tests exist to diagnose and monitor retinal disease and, although not prohibited by an NCCI edit, might not be allowed on the same date. If, for example, extended ophthalmoscopy (CPT 92225, 92226) is performed on the same date of service as fundus photography, it may not be considered medically necessary if it merely duplicates information secured by fundus photography. One MAC, National Government Services, Inc., states in its policy L33567 for extended ophthalmoscopy,[43] "*When other ophthalmologic tests (e.g., fundus photography, fluorescein angiography, ultrasound, optical coherence tomography, etc.) have been performed, extended ophthalmoscopy will be denied as not medically unnecessary unless there was a reasonable medical expectation that the multiple imaging services might provide additive (non-duplicative) information.*" Not all carriers agree on this point.

Other Important Coding Issues

Since the 3D OCT-1 Maestro generates both a fundus image and a SCODI-P image simultaneously, the selection of the proper code might present some challenges. This issue was addressed in CPT Assistant, a companion publication to CPT itself. In the November, 2014, edition is an article, "Coding Clarification: Special Ophthalmological Services (92133, 92134)", which states,[44]

> ***Q:*** *Our office performs fundus photography examinations using a scanning laser which produces a fundus photograph. Is it appropriate to report CPT code 92135 [now code 92133 and 92134] for this method of examination of the fundus?"*
>
> ***A:*** *If the scanner produces an image of the retina or optic nerve along with other data and imaging for quantitative analysis, it would be appropriate to report a single service from the appropriate scanning computerized ophthalmic diagnostic imaging code range (92133-92134). If only an image is obtained, then code 92250 would be reported … It is important to note that if the only necessary service provided is generating a fundus photograph without the need to quantify the nerve fiber layer and*

[43] NGS, Inc.. LCD L33567. Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography). Revision effective date 10/01/2015. Link here. Accessed 09/12/16.

[44] American Medical Association. *CPT Assistant*. November 2014.

to analyze the data via a computer, then reporting code 92250 is appropriate, even if the photograph was taken with a scanning laser."

Since 92250 is assigned more RVUs than 92133 or 92134 within the Medicare Physician Fee Schedule, billers are tempted to choose the CPT code that pays the most because the NCCI edits bundle these codes. The following examples illustrate appropriate code selection based on the purpose of the tests.

- You order and perform concurrent FP and SCODI-P for progressive diabetic macular edema (DME). The swelling in the macula is quantified and interpreted. Bill only 92134. The assessment of the extent of the progression of DME depends on quantification of the swelling, which is better suited to SCODI-P than FP.
- You order and perform concurrent FP and SCODI-P for progressive vision loss. Prior binocular indirect ophthalmoscopy is unremarkable and inconclusive. The images reveal a new epiretinal membrane (ERM). Bill only 92134. The differential diagnosis of ERM, absent any visible macular distortion with BIO, depends on the cross sectional capabilities of SCODI-P rather than FP.
- You order and perform concurrent stereo FP and SCODI-P of the optic nerve for acute papilledema. Bill only 92250. The differential diagnosis for papilledema depends on identifying qualitative vascular changes with flame-shaped hemorrhages, which are better suited to FP than SCODI-P.
- You order and perform concurrent FP and SCODI-P for new onset central retinal vein occlusion (CRVO). Bill only 92250. The differential diagnosis for new onset CRVO depends largely on identifying the qualitative vascular changes, intraretinal hemorrhages, and cotton wool spots.

Purchased Diagnostic Tests / Anti-Markup Rule

If you order and bill for a test and either the technical component or the professional interpretation is performed by another physician, you may be prohibited from marking up the test (*i.e.*, receiving payment from Medicare in excess of the amount you paid to the entity who performed the technical component or professional interpretation) unless the physician who performs the test "shares a practice" with you. However, if the performing physician meets the Medicare criteria for "sharing a practice" with you, the prohibition would not apply for that diagnostic test. The prohibition against marking up the test is referred to as the Medicare Anti-Markup Rule and was formerly known as the Purchased Diagnostic Test Rule.

If the Medicare Anti-Markup Rule applies because the performing physician is not deemed to share a practice with the billing physician, the payment to the billing physician

(less the applicable deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the technical component or the professional component of the diagnostic test may not exceed the lowest of the following amounts:

- The performing supplier's net charge to the billing physician or other supplier;
- The billing physician or other supplier's actual charge; or
- The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

For further information about the Medicare Anti-Markup Rule and the "sharing a practice" criteria, please refer to CMS instructions.[45]

Claims Processing Tips

- Notify the patient, prior to testing, of financial responsibility if the test is to screen for possible disease, routine, or otherwise not covered by insurance, and document acceptance on the Advance Beneficiary Notice of Noncoverage (ABN) form for Medicare beneficiaries or Notice of Exclusion from Health Plan Benefits for other beneficiaries.
- Use the ordering physician's NPI.
- Follow Medicare's NCCI edits. They are updated quarterly and describe bundles and mutually exclusive codes.
- When both FP and SCODI-P can be generated with a single push of a button, the purpose of the test - not the level of reimbursement - governs code selection.

[45] Medicare Claims Processing Manual, Chapter 1, Section 30.2.9. Link here. Accessed 09/12/16.

PAYMENT LEVELS

Medicare defines CPT codes 92133, 92134, and 92250 as bilateral so reimbursement is for both eyes in nearly all cases.[46,47] These amounts are adjusted in each area by local indices. Other payers set their own rates, which may differ significantly from the Medicare published fee schedule. Tables 5, 6, and 7 show the participating (PAR), non-participating (Non-PAR), and non-participating limiting charge[48] values for Medicare in 2017.

Table 5 **Medicare National Payment Rates**

Code	PAR	Non-PAR	Limiting Charge
92250	$66.75	$63.42	$72.93
92250-TC	$44.50	$42.28	$48.62
92250-26	$22.25	$21.14	$24.31

Table 6 **Medicare National Payment Rates**

Code	PAR	Non-PAR	Limiting Charge
92133	$38.04	$36.14	$41.56
92133-TC	$15.07	$14.32	$16.47
92133-26	$22.97	$21.82	$25.09

[46] American Medical Association. *CPT Assistant*. Modifiers 50 and 52: Special Ophthalmological Services. October 2012.

[47] National Government Services. LCD L33567. Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography). Minnesota. Revision Effective 10/01/16. Link here. Accessed 12/21/16.

[48] Participating physicians (PAR) agree to accept Medicare allowed amounts on all covered services as their maximum payment from all sources. This is known as "accepting assignment". Non-participating physicians (Non-PAR) may accept assignment on a case-by-case basis, but are also limited in the amount they may charge the patient if they do not accept assignment. For additional discussion, see information published by CMS for patients here. Accessed 09/12/16.

Table 7 **Medicare National Payment Rates**

Code	PAR	Non-PAR	Limiting Charge
92134	$41.63	$39.55	$45.48
92134-TC	$15.43	$14.66	$16.86
92134-26	$26.20	$24.89	$28.62

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; the 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. It is not necessary to separate the professional and technical components in order to receive bonuses; the MAC will automatically calculate bonus payments on the professional component. As an illustration, if the test in Sample Claim 1, above, had been performed in a HPSA not receiving automatic bonus payments, then the claim would be billed as 92250-AQ.

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 2015 show that CPT code 92250 was performed in 9% of all office visits by ophthalmologists. That is, for every 100 exams

performed on Medicare beneficiaries, Medicare paid for this service 9 times. For optometrists, the utilization rate is 14%.

For SCODI-P via CPT codes 92133 and 92134, the utilization rates for ophthalmologists were 9% and 26%, respectively. For optometrists, utilization rates were 9% and 6%.

CONCLUSION

A well-known proverb says a picture is worth a thousand words. Unlike ophthalmoscopy where the examiner must be content with a brief look at the fundus, fundus photography (FP) provides crisp, detailed, close-up pictures of the posterior pole for intensive study, as well as for subsequent use as a benchmark for monitoring subtle changes that allow for better disease management. The images also have utility for people other than the examining physician. For example, fundus photos are helpful in telemedicine, during litigation (*e.g.*, malpractice), as part of criminal investigations (*e.g.*, shaken baby), for teaching purposes, and for other caregivers.

SCODI-P can help identify and quantify minute details that are otherwise invisible to ophthalmologists and optometrists even with high magnification. Objective quantified data is particularly helpful for gauging disease progression and planning treatment.

Some applications of ophthalmic imaging, particularly screening, are not covered by Medicare and most other third party payers. For covered services, documentation of the physician's order and interpretation are 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 and scanning computerized ophthalmic diagnostic imaging, however the responsibility for appropriate usage, adequate documentation and proper coding are always the physician's.

Practice Management Tips

- Get a physician's order with appropriate medical rationale before providing FP or SCODI-P with the expectation of reimbursement.
- Document the physician's interpretation of the diagnostic test in a report within a short time, preferably within 24 - 72 hours. Be sure to address the quality of the test, the findings and changes over time, and the assessment. Sign and date the note.
- Differentiate covered and non-covered testing based on the reason for the service and the diagnosis.
- For most payers, screening and standing orders do not support coverage. Obtain patients' acceptance of financial responsibility for non-covered services in writing using a financial waiver form (*i.e.*, ABN or similar notice).
- Repeated testing is merited due to disease progression, otherwise it is likely dubious.
- Monitor NCCI edits.
- Check Local Coverage Determinations (LCDs) for specific guidance in your area. Covered indications and claims submission instructions vary over time and between Medicare Administrative Contractors. Investigate the policies of other third party payers; they vary.
- Place a note in the medical record that identifies where digital images are electronically stored.
- Don't use fundus photographs as a surrogate for a dilated fundus evaluation during a comprehensive eye exam.
- 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 Medicare's anti-markup rules.