Corcoran Consulting Group
A Division of Ardare Corporation

# REIMBURSEMENT FOR TESTS WITH THE OCULUS PENTACAM

**1** ***QUESTION:*** What tests can be performed with the OCULUS Pentacam® and Pentacam AXL?

***ANSWER:*** The Pentacam is a multipurpose diagnostic instrument for evaluating the anterior segment; there are several models with different features. Tests performed with Pentacam, either alone or as part of another service, include:

- Corneal topography (CPT 92025)
- Optical tomography of the anterior segment (SCODI-A, CPT 92132)
- Ophthalmic biometry white-to-white and anterior chamber depth (part of CPT 92136)
- Optical corneal pachymetry (CPT 92499)
- Zernike and wavefront analysis (CPT 92015)
- Planning phakic IOL (part of refractive surgery)
- Lens densitometry (part of an eye exam)
- Cornea/sclera elevation (part of CL service)
- External ocular photography (CPT 92285)
- Scleral topography (incidental service)

**2** ***QUESTION:*** Does Medicare cover anterior segment SCODI (SCODI-A)?

***ANSWER:*** Yes, to a limited degree. SCODI-A is most often covered for narrow angle, suspected narrow angle, and mixed mechanism glaucoma for patients where anatomic features, corneal opacity, or corneal edema preclude gonioscopy, or a patient who is otherwise unable to undergo gonioscopy.

**3** ***QUESTION:*** Does Medicare cover corneal topography and external ocular photography?

***ANSWER:*** Yes, although no national Medicare policy exists for either test. Coverage is at the discretion of each Medicare contractor.

**4** ***QUESTION:*** Does Medicare cover corneal pachymetry?

***ANSWER:*** Yes; most MACs have published policies to cover this test. Coverage is based on two distinctly different indications: (1) corneal disease, and (2) ocular hypertension and glaucoma. CPT code 76514, by virtue of its designation as a radiological procedure, only describes pachymetry when using ultrasound. When the Pentacam is used for optical corneal pachymetry, it is reported with CPT code 92499 (*unlisted ophthalmological service or procedure*).

**5** ***QUESTION:*** What about coverage for Zernike and wavefront analyses?

***ANSWER:*** No. These are refractive in nature; although they exceed the familiar sphere, cylinder and axis that is commonly found in refraction (CPT 92015). Refraction is not covered by Medicare. Nonetheless, they are additive with the basic service, and deserve an additional charge.

**6** ***QUESTION:*** What are Medicare's reimbursement rates for the covered tests?

***ANSWER:*** In 2021, the national Medicare Physician Fee Schedule rates are as follows (rounded).

| | 92025 | 92132 | 92136 | 92285 |
|---|---|---|---|---|
| Global | $37 | $32 | $55 | $23 |
| Professional (-TC) | $18 | $16 | $25 | $20 |
| Technical (-26) | $20 | $16 | $31 | $3 |

These values are modified by local wage indices so actual payment rates vary. Other payers set their own rates, which may vary considerably.

**March 11, 2021**

The reimbursement information is provided by Corcoran Consulting Group based on publicly available information from CMS, the AMA, and other sources. The reader is strongly encouraged to review federal and state laws, regulations, code sets, and official instructions promulgated by Medicare and other payers. This document is *not an official source* nor is it a complete guide on reimbursement. Although we believe this information is accurate at the time of publication, the reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

© 2021 Corcoran Consulting Group. All rights reserved. No part of this publication may be reproduced or distributed in any form or by any means, or stored in a retrieval system, without the written permission of the publisher. CPT is a registered trademark of the American Medical Association.

Corcoran Consulting Group
A Division of Ardare Corporation

# REIMBURSEMENT FOR TESTS WITH THE OCULUS PENTACAM

## 7

***QUESTION:*** What documentation is required in the medical record?

***ANSWER:*** In addition to the images, the chart should contain:

- an order for the test with medical rationale
- the date of the test
- the reliability of the test
- the test findings (*e.g.,* thinning, thickening)
- comparison with prior tests
- a diagnosis (if possible)
- the impact on treatment and prognosis
- the signature of the physician

Document the location of the images if they are stored separately from the medical record.

## 8

***QUESTION:*** Is it possible to bill for more than one test on the same day?

***ANSWER:*** Yes. Multiple tests may occur and be billed on the same day as long as there is sufficient justification for each service and the services are not duplicative, bundled, or mutually exclusive. For instance, assessing different parts of the eye using different tests is one justification, as occurs when corneal topography is performed concurrent with SCODI-A. Additionally, patients may have several co-morbidities that warrant investigation using different tests.

Obvious duplication occurs when the same digital image of the eye is billed twice. For example, we do not advocate billing external photography and SCODI-A concurrently because the individual digital slices are collectively the tomogram.

92025, 92132 and 92285 are subject to Medicare's Multiple Procedure Payment Reduction (MPPR). This reduces the allowable for the technical component of the lesser-valued test when more than one test is performed on the same day.

## 9

***QUESTION:*** How frequently may tests with the OCULUS Pentacam be performed?

***ANSWER:*** Generally, tests may be repeated as often as is medical necessary. Some reasons are:

- During the eye exam that precedes the order for a repeat test, the physician suspects that the patient's condition has changed for the worse due to:
  - objective evidence of vision loss
  - new symptoms or complaints
  - a recent surgical intervention
  - exam findings of disease progression
- Earlier tests are no longer reliable.
- The AAO's Preferred Practice Patterns may suggest repeat testing at specific intervals which vary based on the disease progression.

## 10

***QUESTION:*** If coverage of a test is unlikely or uncertain, how should we proceed?

***ANSWER:*** Explain the necessity and that the claim will likely be denied. Ask the patient to assume financial responsibility for the charge.

- An Advance Beneficiary Notice of Noncoverage (ABN) is required for services where Part B Medicare coverage is ambiguous or doubtful, and may be useful where a service is never covered. You may collect your fee from the patient at the time of service or wait for a Medicare denial. If both the patient and Medicare pay, promptly refund the patient or show why Medicare paid in error.
- For Part C Medicare (Medicare Advantage), determination of benefits is required to identify beneficiary financial responsibility prior to performing noncovered services. MA Plans have their own waiver processes and are not permitted to use the Medicare ABN form.
- For commercial insurance beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN.

**March 11, 2021**

The reimbursement information is provided by Corcoran Consulting Group based on publicly available information from CMS, the AMA, and other sources. The reader is strongly encouraged to review federal and state laws, regulations, code sets, and official instructions promulgated by Medicare and other payers. This document is *not an official source* nor is it a complete guide on reimbursement. Although we believe this information is accurate at the time of publication, the reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

© 2021 Corcoran Consulting Group. All rights reserved. No part of this publication may be reproduced or distributed in any form or by any means, or stored in a retrieval system, without the written permission of the publisher. CPT is a registered trademark of the American Medical Association.