Corcoran Consulting Group
A Division of Ardare Corporation

MEDICARE REIMBURSEMENT FOR SCODI OF THE ANTERIOR SEGMENT

1

QUESTION: What is SCODI of the anterior segment performed with CIRRUS HD-OCT?

ANSWER: Scanning computerized ophthalmic diagnostic imaging of the anterior segment (SCODI-A) is a diagnostic test that provides digital images of the ocular structures from the cornea to the lens along with quantitative information such as length or depth. Particular attention is given to corneal thickness and anterior chamber angles.

2

QUESTION: What are the indications for SCODI of the anterior segment?

ANSWER: There are a number of indications for SCODI-A. These include assessment of both corneal flap thickness and residual stromal thickness following LASIK, measurement of corneal thickness, evaluation of anterior segment ocular structures, and measurement of anterior chamber angles.

3

QUESTION: What CPT code should we use to describe SCODI-A?

ANSWER: Use CPT 92132 (*Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral*) to report this diagnostic test.

4

QUESTION: Is SCODI-A covered by Medicare?

ANSWER: Usually. Some (but not all) MACs cover SCODI-A for evaluation of narrow angles and a few other disorders of the cornea, iris and ciliary body. Check local coverage policies for more information.

5

QUESTION: What is the reimbursement for 92132?

ANSWER: The 2019 Medicare Physician Fee Schedule allowable is $32.07. Of this amount, $15.14 is assigned to the technical component of the test, and $16.94 to the professional component (*i.e.*, interpretation). These amounts are modified by local wage indices so actual payment rates will vary. The code is defined by Medicare as bilateral, so this is for one or both eyes. Other payers set their own rates, which may differ significantly from the Medicare published fee schedule.

92132 is 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.

6

QUESTION: Is the physician's presence required while SCODI-A is being performed?

ANSWER: Under Medicare program standards, this test requires *general supervision*. General supervision 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.

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7 ***QUESTION:*** What documentation is required in the medical record to support claims for SCODI-A?

ANSWER: In addition to the images, a physician's interpretation and report are required. In addition to the images, the medical record should include:

- order for the test with medical rationale
- date of the test
- the reliability of the test (*e.g.*, cloudy due to cataract)
- test findings (*i.e.*, narrow anterior chamber angles)
- comparison with prior tests (if applicable)
- a diagnosis (if possible)
- the impact on treatment and prognosis
- physician's signature

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

8 ***QUESTION:*** How frequently may this test be performed?

ANSWER: In general, this and all diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required. Too-frequent testing can garner unwanted attention from Medicare and other third party payers.

As a point of reference, Medicare utilization rates for claims paid in 2017 show that SCODI-A was associated with only about 0.2% of all office visits by ophthalmologists and optometrists. That is, for every 1,000 eye exams performed on Medicare beneficiaries, Medicare paid for this service 2 times.

9 ***QUESTION:*** If coverage of SCODI-A is unlikely or uncertain, how should we proceed?

ANSWER: Explain to the patient why SCODI-A is necessary, and that Medicare or other third party payer will likely deny the claim. Ask the patient to assume financial responsibility for the charge. A financial waiver can take several forms, depending on insurance.

- 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 commercial insurance beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN.
- 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.

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