Corcoran Consulting Group

A Division of Ardare Corporation

Reimbursement Guidelines for Scanning Computerized Ophthalmic Diagnostic Imaging

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Reimbursement Guidelines for Scanning Computerized Ophthalmic Diagnostic Imaging

by

Corcoran Consulting Group
A Division of Ardare Corporation
560 E. Hospitality Lane ~ Suite 360
San Bernardino, California 92408

(800) 399-6565
www.corcoranccg.com

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Objective: *This report is provided as a general discussion of billing and documentation for scanning computerized ophthalmic diagnostic imaging (SCODI) 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 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.*

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INTRODUCTION

This monograph describes reimbursement for scanning computerized ophthalmic diagnostic imaging including both posterior segment testing (SCODI-P) and anterior segment testing (SCODI-A) performed using Optovue's iVue®, iFusion™ (iVue combined with the iCam® fundus camera) and Avanti™ instruments.

Much of the information is taken from official publications of the Medicare program. However, the reader is encouraged to check with the local Medicare Administrative Contractor (MAC) for additional information and instructions. In the case of 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-10-CM. Documentation of the test, the medical rationale for it, and then proper interpretation are 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, as well as utilization rates.

THE DEVICES [1]

At this time, eye care professionals can choose between a number of devices to perform SCODI, including the Avanti and iVue from Optovue, Inc.

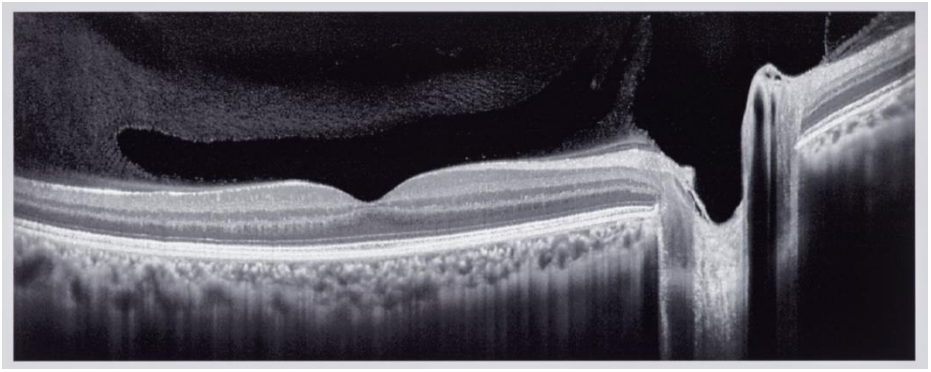
Figure 1 **Optovue Avanti with AngioVue (Operator view on right)**

These devices offer a suite of options that include SCODI-P and SCODI-A imaging modalities which vary by instrument and available options. All Optovue instruments are DICOM (Digital Imaging and Communications in Medicine) compatible.

[1] All product information and images provided by Optovue Corp.

- For SCODI-P applications:
    - High-speed and high-resolution images and mapping with a comparison to a normative database for both retinal and optic nerve analysis
    - Pharmacological dilation is not required
    - Serial registration for change analysis to aid the clinician in assessing for disease progression in both RNFL and Ganglion Cell Complex
    - The ability to select full, inner and outer retinal thickness as well as retinal pigment epithelium elevation mapping
    - 3D views of the macula and optic disc
    - Ganglion Cell Complex (GCC) mapping
    - Wide field (9x12mm) En Face for visualization of separate retinal layers
    - Avanti offers in addition to the above:
        - AngioVue for OCT Angiography (OCTA)
            - Motion Correction technology (DualTrac™)
            - En Face Visualization which separates the retina into distinct structural layers for assessment of the microvasculature. The instrument can use a standardized color scheme to differentiate the retinal layers.
            - AngioMontage allows "automatic stitching" of macula and optic disc images together for a widefield view of the OCTA images
        - Widefield imaging (including Widefield Cube) (see Figure 2)
        - An estimate of future progression using trend analysis software

Figure 2 **Widefield SCODI-P Image from Optovue Avanti**



- For SCODI-A applications:
    - Pachymetry mapping of the cornea over a 6 mm diameter area
    - Epithelial thickness mapping over a 6 mm diameter area
    - Angle visualization and measurement
    - Both anterior and posterior corneal surfaces are measured directly, not extrapolated
    - Scleral Contact lens imaging
    - Total Cornea Power® measures the front and back of the cornea for precise calculation of the corneal power in post-refractive surgery patients

The Avanti is a wide-field OCT; when imaging the retina it can capture up to 40 degrees of the retina in a single scan as well as images up to 3 mm deep. The eye tracking feature improves repeatability. The iVue instrument is smaller and portable. There is an optional rolling case, and iVue can be mounted to a universal positioning stand that permits supine patient scanning.

Figure 3 **iVue Instrument**

INDICATIONS FOR USE

Medicare covers SCODI-A and SCODI-P for medically necessary indications that are enumerated in the MAC's local coverage determination. If your MAC does not include a particular indication in its local coverage determination (LCD), claims for these indications may be denied. If the test is performed as baseline documentation of a healthy eye or as preventive medicine to screen for potential disease, then it is not

covered, even if an otherwise-covered disease is identified.[2] Follow-up imaging of the disease may be covered if medically appropriate. For instance, this may occur when today's exam documents clinically significant changes from a prior visit and another test is expected to aid evaluation and management of the disease.

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. 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 tests as an adjunct to evaluation and management of a known disease.

Repeated testing is necessitated by disease progression, the advent of new disease, or planning for surgical treatment. Otherwise, repeated tests of the same, unchanged, condition are unwarranted. 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.

SCODI-A

A variety of disease entities and conditions justify testing with SCODI-A. These include assessment of both corneal flap thickness and residual stromal thickness following LASIK, measurement of corneal thickness, visualization of IOLs and other implants in the anterior segment, evaluation of anterior segment ocular structures, and measurement of anterior chamber angles, anterior chamber depth and anterior chamber diameter. Table 1 includes a listing of commonly covered diagnoses

Table 1 **Common ICD Diagnosis Codes for SCODI-A (92132)** [3]

ICD-10	Description
C69.9-	Malignant neoplasm of eyeball
C69.1-	Malignant neoplasm of cornea

[2] 42 CFR 411.15(a)(1). Particular services excluded from coverage. Link here. Accessed 01/29/20.

[3] NOTE: Listed codes are representative of covered diagnoses but differences in payment policies exist for many payers. This list is neither exhaustive nor universally accepted. See your payer bulletins. An ending "dash" means a longer code may be required and contains greater specificity. Some policies may not use all the codes in a particular range as listed.

Table 1 **Common ICD Diagnosis Codes for SCODI-A (92132)** [3]

ICD-10	Description
D31.9-	Benign neoplasm of eyeball
D31.1-	Benign neoplasm of cornea
H21.1-	Degenerations of iris and ciliary body
H21.3-	Cysts of iris, ciliary body and anterior chamber
H21.4- to H21.5-	Adhesions and disruptions of iris and ciliary body
H21.8-	Other disorders of iris and ciliary body
H40.03-	Anatomical narrow angle
H40.2-	Primary angle-closure glaucoma
H17.-	Corneal scars and opacities
H18.2-	Corneal edema
H18.7-	Other corneal deformities
H27.0-	Disorders of lens
T85.3-	Complication of corneal graft
T85.2-	Complication of IOL
T85.3-	Complication of ocular prosthesis

SCODI-P

Where SCODI-P is directed at the optic nerve, LCDs include indications for the diagnosis and management of early glaucoma (Table 2). Where SCODI-P is directed at the retina, LCDs include a much broader list of indications, particularly diseases of the macula and choroid (Table 3).

Table 2 **Common Diagnosis Codes for SCODI-P – Glaucoma (92133)** [4]

ICD-10	Description
H40.40x-	Glaucomatocyclitic crises
H21.23-	Pigmentary iris degeneration

[4] NOTE: Listed codes are representative of covered diagnoses, but differences in payment policies exist for many payers. This list is neither exhaustive nor universally accepted. See your payer bulletins. An ending "dash" means a longer code may be required and contains greater specificity. Some policies may not use all the codes in a particular range as listed.

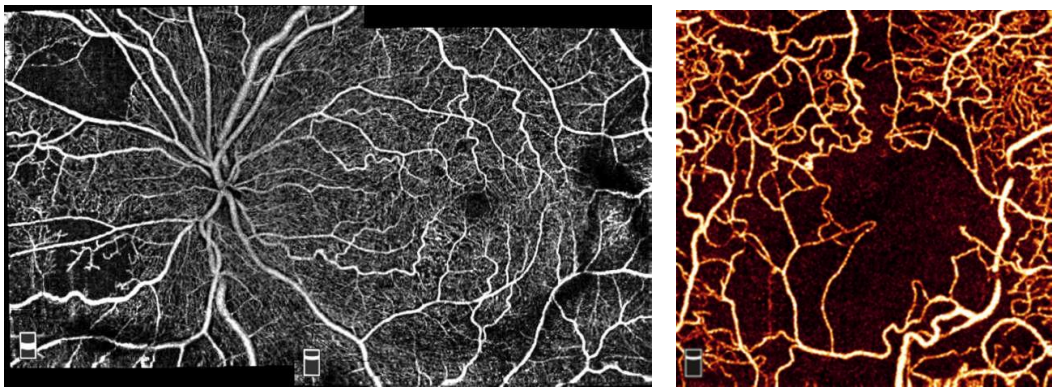
Table 2 **Common Diagnosis Codes for SCODI-P – Glaucoma (92133)** [4]

ICD-10	Description
H21.52-	Goniosynechiae
H21.4-	Pupillary membranes
H21.55-	Recession of chamber angle
H40.0-	Glaucoma suspect
H40.11x-	Primary open angle glaucoma
H40.2-	Primary angle closure glaucoma
H40.6-	Corticosteroid-induced glaucoma
Q15.0	Glaucoma associated with congenital anomalies, dystrophies, and systemic syndromes
H40.14-	Glaucoma associated with disorders of the lens
H40.3-, H40.4-, H40.5-	Glaucoma associated with other ocular disorders
H40.89	Other specified forms of glaucoma
H40.9	Unspecified glaucoma
H53.15	Visual distortions
H53.4-	Visual field defects
H47.1-	Papilledema
H47.2-	Optic Atrophy
H47.3-	Disorders of optic disc
H47.0-	Disorders of optic nerve
H47.4-	Disorders of optic chiasm
H47.5-	Disorders of other visual pathways
H47.9	Unspecified disorder of optic nerve and visual pathways
Q15.0	Buphthalmos

OCT Angiography

OCT Angiography (OCTA) captures images and, through additional analysis, creates detailed images of the blood vessels within the retina and choroid.

Figure 4 **OCT Angiography Images from Avanti with AngioVue**



Images courtesy Optovue, Inc.

Therefore, broadly speaking, the term "angiography" is appropriate; however, the historic use of this term predisposes ophthalmic technicians, medical assistants, and billing staff to assume that dye is injected. Prior to OCTA, angiography of the retina and/or choroid required fluorescein or indocyanine green dye. In CPT, fluorescein angiography is reported with 92235, and indocyanine green angiography is reported with 92240. The tests described by these codes require the use of specific intravenous dyes, so neither code is an accurate description of OCTA. According to the American Academy of Ophthalmology's Coding Program Manager,[5] OCTA should not be reported with other angiography codes of the eye that involve the use of intravenous dye.

Because OCTA provides additional information beyond traditional OCT of the retina and macula, it is more useful to the ophthalmologist or optometrist. From the patient's perspective, avoiding an intravenous injection is preferable. So, the question is asked: "Can I use another CPT code, in addition to 92134, to describe the added utility of this service?" The code that is sometimes suggested is 92499, *Unlisted ophthalmological procedure or service*. Since 92134 does adequately describe OCTA, another CPT code is not necessary – it's duplicative. An unlisted code is only used when a CPT code describing the service is not available.

Adding CPT code 92499 to a claim for 92134 represents a billing error. If the payer allows both procedures, it constitutes an overpayment – only 92134 should be paid. If the third party payer pays 92134 and denies 92499, no overpayment exists. However, collecting any additional payment from the beneficiary for 92499 is a fragmentation error, whether a financial waiver is used or not. An ABN or similar document cannot be used to split a single complete service into two parts for the purpose of collecting additional payment from the beneficiary. Under the provisions of the assignment agreement used by almost all ophthalmologists, the beneficiary is only responsible for copayments and deductibles associated with the covered service reported as 92134.

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[5] Vicchrilli, S. American Academy of Ophthalmic Executives. Q&A. 2016.

Table 3 **Common Diagnosis Codes for SCODI-P – Retina (92134)** [6]

ICD-10	Description
C69.-	Malignant neoplasm of eye
D31.3-	Benign neoplasm of choroid
D18.09	Hemangioma of retina
H44.-	Disorder of globe
H33.0-, H33.2-	Retinal detachment
H33.1-	Retinal detachment or Retinoschisis
H33.3-	Retinal defect
H33.4-	Retinal detachment
E11.31- to E11.35-, H35.0- to H35.2-	Retinopathy
H35.17-	Retrolental fibroplasias
H35.2-	Other nondiabetic proliferative retinopathy
H34.-	Retinal vascular occlusion
H35.7-	Retinal separation
H35.3-	Macular degeneration
H35.4-	Peripheral retinal degenerations
H35.5-	Hereditary retinal dystrophies
H30.-, H31.-	Chorioretinal disease
H31.32	Choroidal rupture
H31.4-	Choroidal detachment
H53.4-	VF defect
H05.-	Orbital disease
H47.1-	Papilledema
H47.2-	Optic Atrophy
H47.3-	Optic disc disease
H47.0-	Optic Neuropathy
H47.9	Other disorders of optic nerve

[6] NOTE: Listed codes are representative of covered diagnoses, but differences in payment policies exist for many payers. This list is neither exhaustive nor universally accepted. See your payer bulletins. An ending "dash" means a longer code may be required and contains greater specificity. Some policies may not use all the codes in a particular range as listed.

Table 3 **Common Diagnosis Codes for SCODI-P – Retina (92134)** [6]

ICD-10	Description
H43.-	Vitreous disorders
Q14.-	Congenital abnormalities
S06.-	Intracranial injury
S05.1-	Contusion of eyeball
Z79.899 **	Long term (current) use of high risk medication
Z09 **	Following completed treatment with high risk medication

** Applicable as a secondary diagnosis code for SD- or HD-OCT only. Most payers do not accept lower resolution OCT devices in this situation. A systemic disease is the primary diagnosis (*e.g.,* rheumatoid arthritis).

Screening

Some ophthalmologists and optometrists have standing orders for SCODI-P 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. Screening is differentiated from other diagnostic testing by several features.

- Screening is part of a wellness program to check for disease that may otherwise go undetected.
- Screening is not required by medical necessity; it's optional.
- The ophthalmologist or optometrist recommends SCODI-P prior to every complete eye examination.
- SCODI-P is performed by a technician without an individual order by the examining physician.

Some Optovue models have software designed for screening. It is known as "iWellness" or "Wellness" on the Avanti OCT system. Significantly, SCODI-P performed as baseline documentation of a healthy eye, or as preventative medicine to screen for potential disease is not covered by Medicare and most third party payers, so the patient is financially responsible for the service. Finding a 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. Repeating SCODI-P later on the same day as the test was initially done for screening 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.[7,8,9] CMS states "*the physician must clearly document, in the medical record, his or her intent that the test be performed.*"[10,11] 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.

DOCUMENTATION

The descriptions in CPT for SCODI-A and SCODI-P include the phrase "*with interpretation and report*".[12] 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.[13] CMS makes a distinction between a "review" of a test and an "interpretation and report".

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7 United States General Accounting Office. Beneficiary Use of Clinical Preventive Services. GAO-02-422. April 2002. Link here. Accessed 01/29/20.

8 Office of Inspector General, Report: St. Francis Hospital, Tulsa, OK. Estimated Medicare Overpayment. February 12, 2002. Link here. Accessed 01/29/20.

9 Department of Justice. Press Release. GAMBRO Healthcare Inc. agrees to pay $53 million of overcharging Medicare, Medicaid, and Tricare. July 13, 2000. Link here. Accessed 01/29/20.

10 CMS. Medicare Benefit Policy Manual, Chapter 15. Diagnostic Tests. §80.6.1. Definitions (Order). Link here. Accessed 01/29/20.

11 Palmetto GBA. Jurisdiction 11 Part B. Orders for Diagnostic Tests. Link here. Accessed 01/29/20.

12 Current Procedural Terminology (CPT) 2020 edition.

13 Medicare Claims Process Manual (MCPM) Chapter 13 §100. Interpretation of Diagnostic Tests. Link here. Accessed 01/29/20.

> "*Carriers generally distinguish between an "interpretation and report" … 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 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,[14] 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… The carrier pays for interpretations only if there is a written report prepared for inclusion in the patient's medical record …*"

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?*

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[14] Code of Federal Regulations: 42 CFR 415.120(a) Conditions for payment: Radiology services, to beneficiaries. Link here. . Accessed 01/29/20.

- Impact on treatment, prognosis – *What's next?*
- Physician's signature – *Who is the physician?*

In ophthalmology, tests such as SCODI 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 SCODI-P of the optic nerve, the "interpretation and report" might read as follows.

- SCODI of optic nerve OU again to reassess POAG progression
- January 30, 2017
- Technician: Mary Smith, COA
- Reliable images
- Good patient cooperation
- RNFL thinning, both eyes (OD>OS)
- POAG, shows progression since last visit
- Add another anti-glaucoma medication
- *Signed: I. C. Better, M.D.*

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 "SCODI report".

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 SCODI requires only general supervision,[15] 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

[15] 42 CFR 410.32(b)(3)(i). Definition of general supervision. Link here. Accessed 01/29/20.

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. These proposed regulations (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.

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 modifiers 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.

SUPERVISION

Medicare's supervision rules for many ophthalmic diagnostic tests have been stable since July 1, 2001. SCODI-P requires *general* supervision. This means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during performance of the test. 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.[16]

[16] 42 CFR 410.32(b)(3)(i). General supervision. Link here. Accessed 01/29/20.

BILLING ISSUES

Procedure Codes

There are three codes to describe these tests.

92132….....	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
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

CPT describes these tests as "unilateral or bilateral" and Medicare assigns a bilateral indicator of "3" to these codes; payment is "per patient" and not "per eye".

Modifiers

The following modifiers may be applicable on claims for SCODI.

AQ ……	Services provided in a Health Professional Shortage Area (HPSA, *Medicare modifier only*)
GA ……	Medicare probably does not cover this service; Advance Beneficiary Notice of Non-coverage (ABN) signed, as required by payer policy
GX ……	Medicare probably does not cover this service. Advance Beneficiary Notice (ABN) signed, voluntary notice given under payer policy
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
GZ ….....…	Medicare probably does not cover this service. No ABN on file
TC ……	Technical component of a diagnostic test
26 …….	Professional component of a diagnostic test

Sample Claims

Example 1 Intermittent Angle Closure

A 68 year old new patient has intermittent pain and visual haloes in the right eye. During the examination, you find high hyperopia indicative of a short, small eye. Goldmann 3-mirror gonioscopy shows narrow angles, OD>OS. SCODI-A is performed and results show narrowing, too. You diagnose intermittent angle closure right eye (H40.231) and anatomical narrow angle left eye (H40.032). 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. H40.231 B. H40.032 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	92020		A, B	xxx xx	1		NPI	1234567890

Note: Palmetto GBA wrote, "*Current recommended practice patterns by the American Academy of Ophthalmology endorse gonioscopy as the preferred means of performing evaluation of the anterior chamber angle. Although there remains insufficient evidence to endorse anterior segment OCT as a substitute for gonioscopy, anterior segment OCT is a recommended option in cases where angle closure is suspected and the angle anatomy is not conducive to gonioscopic assessment.*"

Example 2 Pigmentary Glaucoma

A 73 year old patient with pigmentary glaucoma OU (H40.133-) returns as scheduled for reevaluation. Previous visual fields showed the glaucoma as moderate stage OU (7th ICD-10 character is "2"). SCODI-P of the optic nerve is ordered and performed, and some progressive thinning of the RNFL is noted. Another VF is ordered for the next visit. 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. H40.1332 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	92133		A	xxx xx	1		NPI	1234567890

Example 3 Diabetic Macular Edema

A 71 year old female Type II diabetic patient complains of decreased vision OS>OD. She admits to currently uncontrolled blood sugar levels. SCODI-P of the macula was performed today OU. You determine that she has diabetic macular edema and moderate nonproliferative diabetic retinopathy OU (E11.3313). 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. E11.3313 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		A	xxx xx	1		NPI	1234567890

Example 4 SCODI-P of Optic nerve and Retina (Same Day)

A 63 year old female with early dry macular degeneration OU (H35.3131) and moderate stage primary open-angle glaucoma OU (H40.1132) returns for evaluation. SCODI of the retina *and* optic nerve are performed today and properly interpreted. 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. H40.1132 B. H35.3131 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	92133		A	xxx xx	1		NPI	1234567890

Note: NCCI bundles CPT 92134 with 92133 and they cannot be unbundled when done on the same date of service, even if performed for different reasons. Only 92133 is billed.

Example 5 Fundus Photography and SCODI-P for Diabetic Retinopathy

You are a retina specialist consulted by another ophthalmologist concerning a 28 year old man with blurred vision in both eyes; he is a Type I diabetic and takes insulin. Your dilated fundus exam identifies proliferative diabetic retinopathy in both eyes but no diabetic macular edema (DME) in either eye (H10.3593). You order FP and SCODI-P of the retina of both eyes and document your findings and impression 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			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. E10.3593 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

NCCI bundles 92250 with 92134. Since the results of the FP are clinically significant and can be used to monitor the patient, and the SCODI-P is not significant here absent DME, bill only the FP.

Example 6 OCT Angiography and SCODI-P for Diabetic Retinopathy

You are a retina specialist consulted by another ophthalmologist concerning a 38 year old woman with blurred vision OU; she is a Type I diabetic and takes insulin. She has had difficulty in the past with venipuncture at the lab. Your dilated fundus exam identifies proliferative diabetic retinopathy OU. You order SCODI-P of the retina with OCTA of both eyes and document your findings and impression in your report – there is no diabetic macular edema (E10.3593). 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			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. E10.3593 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		A	xxx xx	1		NPI	1234567890

Other Coding Issues

Selecting the Proper Code

Since some models of Optovue OCT instruments can generate both a fundus image using a widefield *en face* quad-image format 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,[17]

> "***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).*

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

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

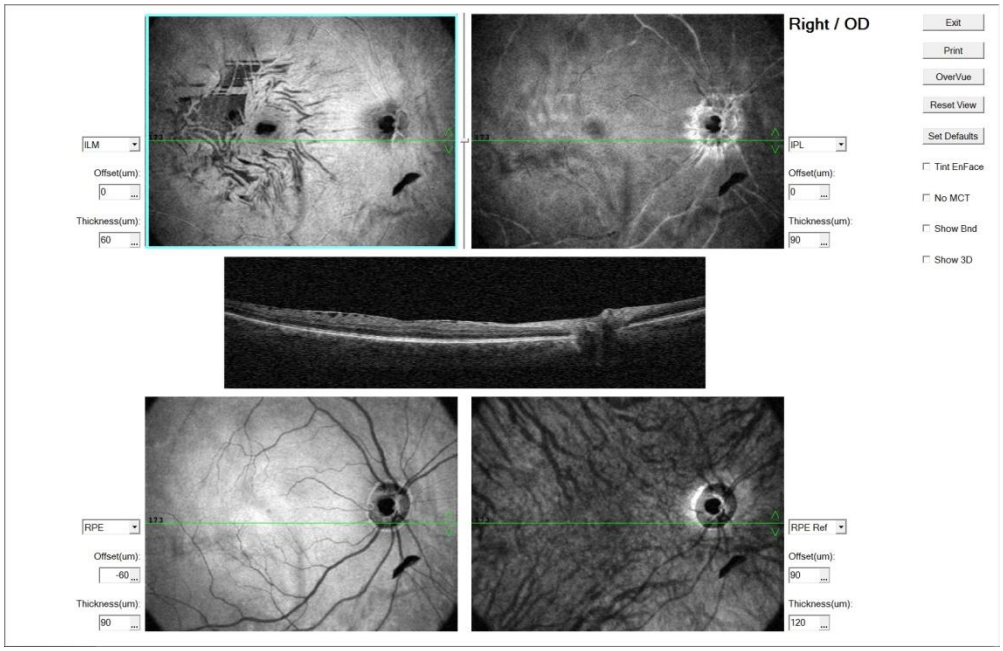
Since 92250 is assigned more RVUs than 92133 or 92134 within the Medicare Physician Fee Schedule, billers are tempted to choose the CPT code that pays the most because the NCCI edits bundle these codes. The following examples illustrate appropriate code selection based on the purpose of the tests.

- You order and perform concurrent FP and SCODI-P using an Optovue widefield *en face* quad-image format 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 using an Optovue widefield *en face* quad-image format for diabetes without macular edema. FP (OD) reveals small dot hemorrhages and areas of exudates, as well as areas of RPE change and drusen. In contrast, *en face* imaging reveals the extent of RPE thinning not easily seen on FP. Because the physician will receive more quantitative information about thinning from the widefield *en face* quad-image, bill 92134 rather than FP.
- You order and perform concurrent FP and SCODI-P using an Optovue widefield *en face* quad-image format for progressive vision loss. Binocular indirect ophthalmoscopy shows extensive surface-wrinkling indicative of a large epiretinal membrane (ERM). Smaller ERMs would normally be imaged best with SCODI-P and billed with 92134, but SCODI-P is unhelpful in this case. Bill 92250. Figure 5 is an example of this unusual case; note particularly the top left image.
- You order and perform concurrent FP and SCODI-P of the optic nerve using an Optovue widefield *en face* quad-image format 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 using an Optovue widefield *en face* quad-image format 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.
- You order and perform concurrent FP and SCODI-P using an Optovue widefield *en face* quad-image format for re-evaluation of exudative age-related macular

degeneration. The patient is scheduled for an intravitreal injection of an anti-VEGF agent today. Bill only 92134. The differential diagnosis for wet AMD depends on the cross-sectional capabilities of SCODI-P rather than FP. Figure 6 shows an image which is illustrative.

- You re-evaluate a patient with nonexudative age-related macular degeneration. The patient complains of fleeting spots in his central vision. You order and perform concurrent FP and SCODI-P using an Optovue widefield *en face* quad-image format; you compare the results of today's test with the prior test for the size and quantity of drusen. Bill only 92134. The assessment of the risk of progression in dry AMD depends on the specific pattern and volume analysis for the drusen, with is better suited to SCODI-P than FP.[18]
- You re-evaluate a patient with moderate open-angle glaucoma. Your binocular indirect ophthalmoscopy notes cup-to-disc ratio unchanged. You order and perform concurrent FP and SCODI-P using an Optovue widefield *en face* quad-image format; you compare the results of today's test with the prior test for the retinal nerve fiber layer and note disease progression. Bill only 92133. The assessment of the extent of the progression of OAG depends on quantification of the thickness of the RNFL, which is better suited to SCODI-P than FP, especially since the cup-to-disc was unchanged on exam.

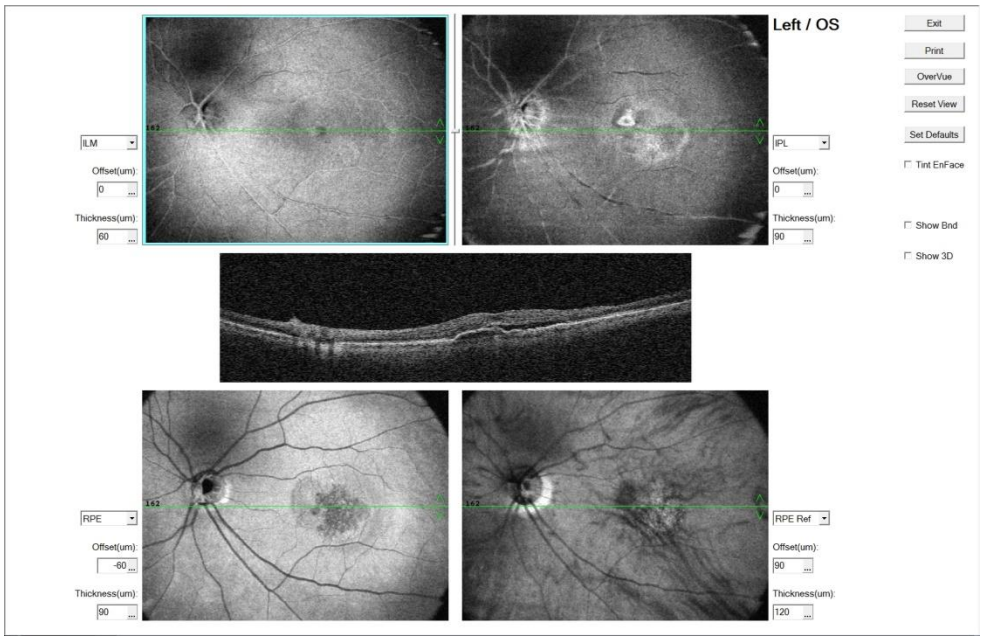
Figure 5 Widefield *en face* Quad Image of a very large ERM



Images courtesy Optovue, Inc.

[18] Lujan, BJ. Practical Applications of SD-OCT Imaging in Dry AMD. *Retinal Physician*. April 1, 2010 Link here. Accessed 01/29/20.

Figure 6 Widefield *en face* Quad Image of Exudative AMD



Images courtesy Optovue, Inc.

Multiple Procedure Payment Reduction (MPPR)

Medicare has implemented a new payment reduction when multiple tests are performed at the same encounter. Known as the Multiple Procedure Payment Reduction (MPPR),[19] it has been in effect since January 1, 2013. This payment policy reduces the *technical component* of the second and any subsequent ophthalmic 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[20] includes ultrasounds, imaging, and visual fields. Tests not on the list are not subject to the MPPR reduction. All the codes listed in this monograph are subject to MPPR.

MPPR Example

A patient returns for her 3 month glaucoma check with SCODI-P of the optic nerve and threshold visual field. During the exam, the IOP is elevated and SCODI-P of the optic nerve shows thinning of the RNFL compared to the prior SCODI-P. Both tests are properly interpreted.

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[19] Centers for Medicare & Medicaid (CMS). Medicare Learning Network, MLN Matters MM7848, Eff. January 1, 2013. Link here. Accessed 01/29/20.

[20] CMS Transmittal 1149, dated November 6, 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 01/29/20.

Test	Professional	Technical	Total
92083 Visual field	$28.15	$36.09 (No reduction)	$64.24
92133 SCODI-P optic nerve	$22.74	$15.16 less $3.03 (20%) = $12.13	$37.89

2020 National Medicare Physician Fee Schedule, PAR allowable

The payment reduction is taken only on the lesser of the two *technical* portions – which is SCODI-P 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 (ABN)[21] 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. 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,[22] 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.

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[21] Advance Beneficiary Notice of Noncoverage. Link here to Corcoran Consulting Group's website for downloadable versions of this form. Accessed 01/29/20.

[22] Centers for Medicare & Medicaid (CMS). *MedLearn Matters* (MM6136). Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage. Link here. Accessed 01/29/20.

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,[23] effective 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.

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[23] Centers for Medicare & Medicaid (CMS). Transmittal R1921CP. Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs). February 19, 2010. Link here. Accessed 01/29/20.

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, the Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI)[24] to control improper coding leading to inappropriate payments in Part B claims.[25] 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. The current NCCI edits for SCODI are shown below. 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. Table 4 shows the current NCCI edits affecting SCODI codes.

Table 4 **SCODI Code Edits**

Primary Code	Do Not Bill These Codes With Primary Code	Do Not Bill Primary Code With These Codes
92132	99211	76513 92133 92134
92133	92132 92134^{0} 92227^{0} 92250 99211	76513 92228^{0}
92134	92132 92227^{0} 92250 99211	76513 92133^{0} 92228^{0}

NCCI Edits in effect as of January 1, 2020

Codes marked with superscript 0 are not eligible for unbundling under any circumstances.

[24] Centers for Medicare & Medicaid Services (CMS). National Correct Coding Initiative Edits. Link here. Accessed 01/29/20.

[25] Medicare Claims Processing Manual, Chapter 23, §20.9. Correct Coding Initiative. Link here. Accessed 01/29/20.

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. Until recently, it was necessary to separate the professional and technical components in order to receive bonuses, but no longer. The carrier 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 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. H40.231 B. H40.032 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	AQ	A, B	xxx xx	1		NPI	1234567890
mm dd yyyy			11	92020	AQ	A, B	xxx xx	1		NPI	1234567890

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 physician who performed the technical component or professional interpretation) unless the physician who performs the test "shares a practice" with you.[26] 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

[26] CMS. Medicare Learning Network, MLN Matters MM6371, July 1, 2009. Link here. Accessed 01/29/20.

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.[27]

UTILIZATION

Medicare utilization data for SCODI and FP are shown in Table 5. Commercial utilization rates are not readily available.

In general, 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.

Table 5 **Utilization Rates**

Code	Description	Ophthalmology (18)	Optometry (41)
92132	SCODI-A	< 1%	< 1%
92133	SCODI-P Optic Nerve	10%	8%
92134	SCODI-P Retina	31%	8%

CMS data from claims adjudicated in 2018

[27] Medicare Claims Processing Manual, Chapter 1, Section 30.2.9. Link here. Accessed 01/29/20.

PAYMENT LEVELS

National Medicare allowable amounts for 92132, 92133 and 92134 are shown in Table 6, including the professional component (PC), the technical component (TC), and the global total. Amounts are shown for participating and non-participating physicians.[28]

Table 6 **2020 Medicare Fee Schedule**

Code	Description		PAR Allowable	Non-PAR Allowable	Limiting Charge for Non-PAR
92132	SCODI-A	PC	$16.96	$16.11	$18.53
		TC	$15.16	$14.40	$16.56
		Global	$32.12	$30.51	$35.09
92133	SCODI-P Optic Nerve	PC	$22.74	$21.60	$24.84
		TC	$15.16	$14.40	$16.56
		Global	$37.89	$36.00	$41.40
92134	SCODI-P Retina	PC	$25.98	$24.69	$28.39
		TC	$15.52	$14.74	$16.95
		Global	$41.50	$39.43	$45.34

Actual payment amounts vary geographically according to local wage indices. Other payers set their own rates, which may differ significantly from Medicare.

CONCLUSION

SCODI-P is the most popular diagnostic test in ophthalmology and it is growing. It also serves as an excellent example of the advancement in the practice of medicine due to technology as well as the development of new payment policies to address it. SCODI-P can help identify and quantify minute details that are otherwise invisible to ophthalmologists and optometrists during exams even with high magnification.

[28] 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. Link here. Accessed 01/29/20.

Objective quantified data is particularly helpful for gauging disease progression and planning treatment.

SCODI-A is newer, but it is a welcome addition to the physician's test armamentarium. SCODI-A is useful following LASIK for flap assessment, measurement of corneal thickness, evaluation of anterior segment ocular structures, and measurement of anterior chamber angles.

This discussion is meant to assist the reader to better understand the rules and regulations regarding reimbursement for these services, however the responsibility for appropriate usage, adequate documentation and proper coding are always the physician's.

Practice Management Tips

- Store the electronic file of a diagnostic test within the electronic medical record, or in a secure, retrievable location; reference the location within the medical record.
- Document the physician's interpretation of the test(s) in a report within a short time, preferably within 24-72 hours. Be sure to address the quality of the test, the findings and the assessment. Sign the note.
- Some conditions warrant repeat testing to assess progressive disease or a worsening condition. Schedule repeat tests only when the required information cannot be obtained through clinical exam alone. Clearly document the rationale for repeat services.
- When both FP and SCODI-P are performed concurrently, the purpose of the test - not the level of reimbursement - governs code selection.
- OCT Angiography (OCTA) uses no dye and is an incidental part of 92134 – not a separate service.
- Notify the patient, prior to testing, of financial responsibility if the diagnosis for SCODI is not on the covered list for the payer, the test is to screen for possible disease, routine, or otherwise not covered by insurance. Document acceptance with an ABN (for Medicare) or prior coverage determination (for other payers).
- Medicare's NCCI edits treat fundus photography (92250) and ultrasonic biomicroscopy (UBM, 76513) as *mutually exclusive* with SCODI. Payment for the lesser-valued test is made if claims are filed for mutually exclusive services. A few payers have established policies that bundle SCODI with B-scan and extended ophthalmoscopy. Concurrent SCODI testing with visual fields is viewed unfavorably by some payers even though no NCCI edits currently exist.
- SCODI reimbursement is subject to Medicare's MPPR rules. When performed with other tests on the same day, payment may be reduced.
- 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, get assistance with Medicare's arcane anti-markup rules.