Corcoran Consulting Group

A Division of Ardare Corporation

Reimbursement for Tests with Visionix VX-120 and VX-130

Prepared for

VISIONIX

The Vision of the Future

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Reimbursement for Tests with Visionix VX-120 and VX-130

by

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Objective: *This document provides general reimbursement guidance for diagnostic tests performed with the Visionix VX-120/130 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 and 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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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 tests performed with the Visionix VX-120/130, either alone or as part of another service. The VX-120/130 are multipurpose diagnostic instruments that can perform multiple tests depending upon the patient's and provider's needs.

Much of the information is taken from official publications of the Medicare program, including the Centers for Medicare and Medicaid (CMS) and the Medicare Administrative Contractors (MAC). The reader is encouraged to check with the local MAC for additional information and instructions as not all guidelines are the same. 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 medical necessity of any diagnostic test is a prerequisite 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 the procedures as well as utilization rates.

THE INSTRUMENT

The Visionix VX-120/130 provides the user with the ability to perform multiple measurements of the eye.

Figure 1 **Visionix VX-120/130**

Image courtesy Visionix

The VX-120/130 takes a large series of digital images of the cornea, anterior chamber, iris, and lens. By using a tomographic reconstruction software algorithm processed by a computer, a

three dimensional tomogram is created. Depending on the needs of the examiner, the VX-120/130 allows the user to selectively measure and analyze one or more parts of the eye. These tests and features include:

- Angle kappa
- Corneal pachymetry
- Corneal topography
- Intraocular pressure
- Keratometry
- Refraction
- Scanning computerized ophthalmic diagnostic imaging of the anterior chamber
- Virtual contact lens fitting
- Wavefront aberrometry

These tests supplement the ophthalmologist's or optometrist's eye exam. Some features of the Visionix VX-120/130 are particularly useful for patient education.

REIMBURSEMENT

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 and other third party payers cover 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, all diagnostic tests are reimbursed when medically indicated and properly documented. Too-frequent testing can garner unwanted attention from Medicare and other payers.

Visionix VX-120/130 are capable of performing a variety of tests – some medical and some refractive. Vision plans (*e.g.,* EyeMed Vision Care) cover refractive services while medical insurance (*e.g.,* Medicare) covers conditions that result from disease or injury. Beneficiaries may have a vision plan and/or a medical plan. The specific coverage policies, with limitations, are published by the Medicare Administrative Contractors (MACs) and other third party payers in their local coverage determinations (LCDs).

Tests performed as baseline documentation of a healthy eye or as preventive medicine to screen for potential disease are not covered even if an otherwise-covered disease is identified.[1] Follow-up testing of previously identified disease is generally covered.

Refraction (CPT 92015)

Refraction is not a covered procedure under the traditional Medicare program,[2] nevertheless it remains one of the most frequent and important tests performed by eye care providers. Prior to 1992, no separate CPT code existed to codify this service and refraction was often treated as an element of an eye exam. At present, 92015 describes this service on claims for reimbursement and refraction is generally treated as a separate service for coverage and payment purposes. Under the traditional Medicare program, the beneficiary is financially responsible for refraction even when Medicare covers the concurrent eye exam. This policy creates a need to specify a discrete charge for refraction. For some Medicare Advantage plans, refraction is covered as an added benefit.

This service does not need to be included on a CMS-1500 claim form to Part B Medicare unless a denial is sought, generally due to a secondary insurance, or the patient specifically requests it. Then, it is most accurate to append a modifier GY to alert the MAC that the claim is being submitted for denial, although all MACs have edits to automatically deny it.

The Federal Trade Commission Prescription Release Rule entitles the patient to a copy of the prescription, even if the results of the refraction are unchanged from a prior visit.[3] When the refraction is indeterminate, incomplete, unreliable, or otherwise unsatisfactory to the physician, then no final Rx exists to give the patient and a charge is not warranted. A charge is merited when a refraction is complete and a prescription is given. An Advance Beneficiary Notice of Noncoverage (ABN) is not required for Medicare beneficiaries because this service is statutorily excluded from coverage and CMS expects that beneficiaries understand it, yet it is always a good idea to be candid with patients about their financial responsibility.

Figure 2 shows a screenshot image of the refraction at the top of the screen as well as other results. Simulated Snellen acuity with various pupil sizes can be displayed. For example, this feature is shown as the slightly out-of-focus “E” optotypes.

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1 42 CFR 411.15(a)(1). Particular services excluded from coverage. Link here. Accessed 06/09/17.

2 Medicare Benefit Policy Manual (MBPM), Chapter 16, §90. Link here. Accessed 06/16/2017.

3 Advertising of Ophthalmic Goods and Services, Statement of Basis and Purpose and Final Trade Regulation Rule, 43 FR 23992, 23998 (June 2, 1978). Link here. Accessed 06/16/2017.

Figure 2 **Visionix Display**

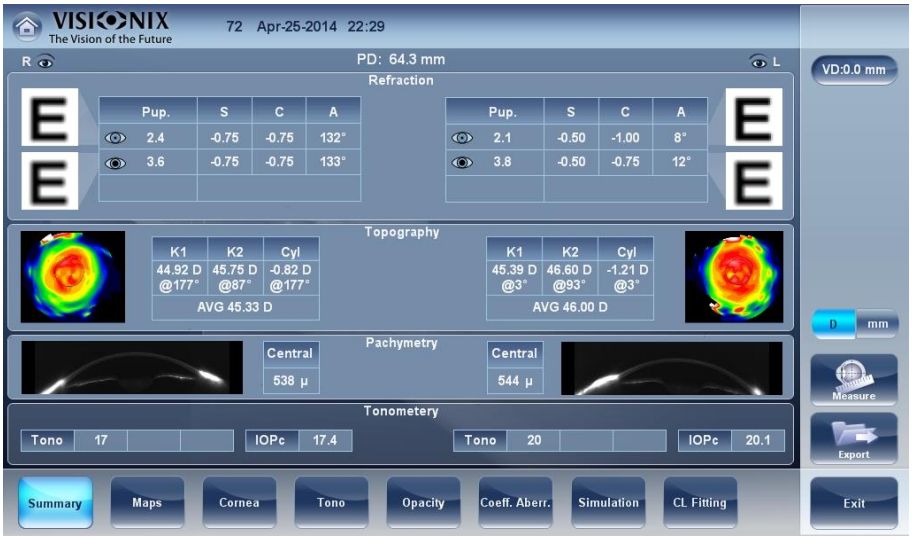

Image courtesy Visionix

Wavefront Aberrometry (CPT 92015)

Wavefront aberrometry is a refractive test, but one that measures higher-order optical aberrations including:

- Spherical aberration
- Coma
- Trefoil
- Image distortion
- Field curvature
- Chromatic aberration

There are many different forms of optical aberration;[4] the most common are lower-order aberrations including:

- Defocus (sphere)
- Astigmatism
- Tilt (prism)

In routine refraction, the examiner measures lower-order aberrations that can be corrected with an eyeglass prescription containing sphere, cylinder, axis, near add, and prism. Some patients return repeatedly to their eye care provider with symptoms that strongly suggest a refractive error

[4] Optical Aberrations. Wikipedia. Link here. Accessed 06/16/2017.

as the cause, but the capability to measure and diagnose obscure or esoteric errors requires a specialized aberrometer. In many of these cases, the cause of the vague complaint is higher-order optical aberrations.

There can be differences in the aberrations when measured in well-lit (photopic) and dim (mesopic) conditions. The VX-120/130 can display these for the user, who has the option to select and display only certain zone diameters if needed. The operator also has the option to display only higher-order or lower-order aberrations in addition to displaying a composite with all aberrations detected. Additionally, the VX-120/130 can display simulated Snellen acuity with the aberrations present. These can be displayed to the patient for confirmation as well as educational purposes.

Figure 3 shows images from the Visionix VX-120/130 of an aberrometry printout and the corresponding simulated Snellen chart visual acuity.

Figure 3 **Aberrometry Comparison and Simulated Acuity with Aberration**

Images courtesy Visionix

Within CPT, there is only a single, albeit broad, code to report refraction, regardless of methodology: 92015, *Determination of refractive state*. Since aberrometry is more extensive than the traditional method of refraction, CPT gives us the option to report a greater-than-usual service using modifier 22. CPT instructs, "*When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier -22 … Documentation must support the additional work and the reason … (i.e., increased intensity, time, technical difficulty of procedure …)*".

Computerized Corneal Topography (CPT 92025)

CPT 92025 is defined as: *"Computerized corneal topography, unilateral or bilateral, with interpretation and report"*. Corneal topography (CT) is used for the diagnosis and management of corneal disease, disorders, abnormalities, or injury. It is helpful as an adjunct to contact lens fitting, particularly in difficult cases such as keratoconus. In the refractive surgery setting, CT

helps the surgeon plan the procedure and monitor the results. Following other corneal surgery, such as penetrating keratoplasty, CT is valuable for postoperative management, including planning surgical enhancement, wound revision and suture removal.

The Visionix VX-120/130 utilizes placido-disk technology to obtain CT; it projects a high number of rings – 24 – and measures over 6,000 data points during a routine CT. It allows a wide range of curvatures to be measured and can show the data as dioptric or as radius of curvature in millimeters. The operator can modify the CT Placido Rings used during a measurement to alter the resulting display as well as display the CT result in a 3-D modality. Other display options (*e.g.*, eccentricity and sagittal radius) are also available.

Figure 4 **Corneal Topography Image**

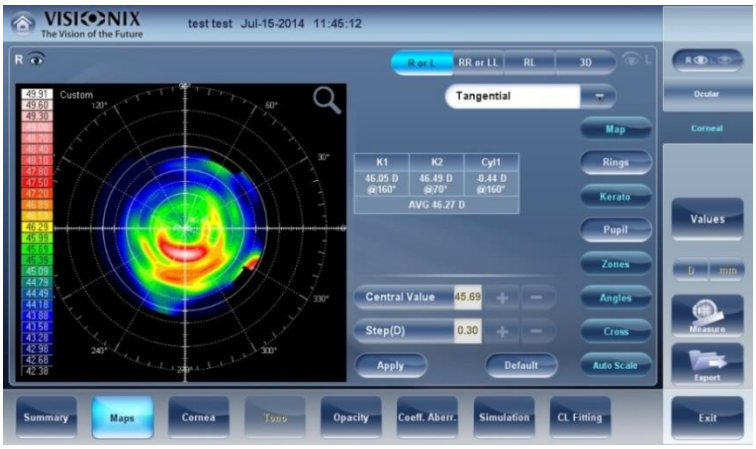

Image courtesy Visionix

CT is helpful prior to cataract surgery with concurrent refractive surgery, such as keratotomy (*e.g.*, limbal relaxing incisions). In the case where the surgeon plans to insert a toric intraocular lens (IOL), CT helps determine the proper alignment for the lens to reduce or eliminate astigmatism. A sample local coverage determination (LCD) for corneal topography by CGS Administrators, LLC,[5] the Medicare Administrative Contractor (MAC) for Ohio, notes:

> *"Computerized corneal topography is considered medically necessary under any of the following conditions:*
>
> - *diagnosis of early keratoconus;*
> - *post-surgical or post-traumatic astigmatism, measuring at a minimum of 3.5 diopters;…*
> - *post-penetrating keratoplasty surgery;*
> - *post-surgical or post-traumatic irregular astigmatism;*

[5] CGS. LCD L34008. Computerized Corneal Topography. Ohio. Rev. eff. 10/01/2015. Link here. Accessed 06/16/2017.

- *certain corneal dystrophies;*
- *complications of transplanted cornea;*
- *post-traumatic corneal scarring; and/or*
- *pterygium and/or corneal ectasia that cause visual impairment."*

The same LCD also notes some limitations on coverage for corneal topography.

> *"Repeat testing is only indicated if a change of vision is reported in connection with one of the above listed conditions … Services performed for screening purposes or in the absence of associated signs, symptoms, illness or injury as indicated above, will be denied as non-covered … Corneal topography will be non-covered if performed pre- or post-operatively in relation to a Medicare non-covered procedure, e.g., radial keratotomy."*

Table 1 includes a listing of commonly covered diagnoses.

Table 1 **Common Diagnosis Codes for Corneal Topography**[6]

ICD-10	Description
Q13.4	Congenital anomalies of cornea size and shape
H18.71-	Corneal ectasia
H18.1-, H18.2-	Corneal edema
H17.-	Corneal opacities
Q13.3	Corneal opacities, interfering with vision, congenital
Z98.85	Corneal transplant (current)
Z94.7	Corneal transplant (previous)
H16.0-	Corneal ulcer
H18.5-	Hereditary corneal dystrophy
H52.21-	Irregular astigmatism
H18.6-	Keratoconus
T85.2-	Mechanical complication due to ocular lens prosthesis
T85.398-	Mechanical complication of corneal graft
H18.46-	Peripheral degeneration of cornea
H11.0-	Pterygium
H18.83-	Recurrent erosion of cornea

[6] 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.

Following CT, the Visionix VX-120/130 can also report a suspicion-based appraisal using indices based on the corneal shape (Figure 5). These indices are an integral part of CT; they are not separately billable.

Figure 5 **Corneal Indices Image**

Images courtesy Visionix

Optical Corneal Pachymetry (CPT 92499)

The VX-120/130 uses optical technology to measure corneal thickness, so code 76514 (*Ophthalmic ultrasound, diagnostic; corneal pachymetry*) does not apply. Instead, CPT instructs billers to use 92499 (*unlisted ophthalmologic service or procedure*), since no other code suits.

Pachymetry has many uses. It is customarily ordered when a diseased cornea is edematous or ectatic; it is commonly used prior to corneal refractive surgery to evaluate the candidacy of patients and help plan the procedure. The Ocular Hypertension Treatment Study (OHTS) showed that measurement of corneal thickness plays an important role in glaucoma detection. A sample image from the VX-120/130 is shown in Figure 6.

Figure 6 **Optical Corneal Pachymetry Image**

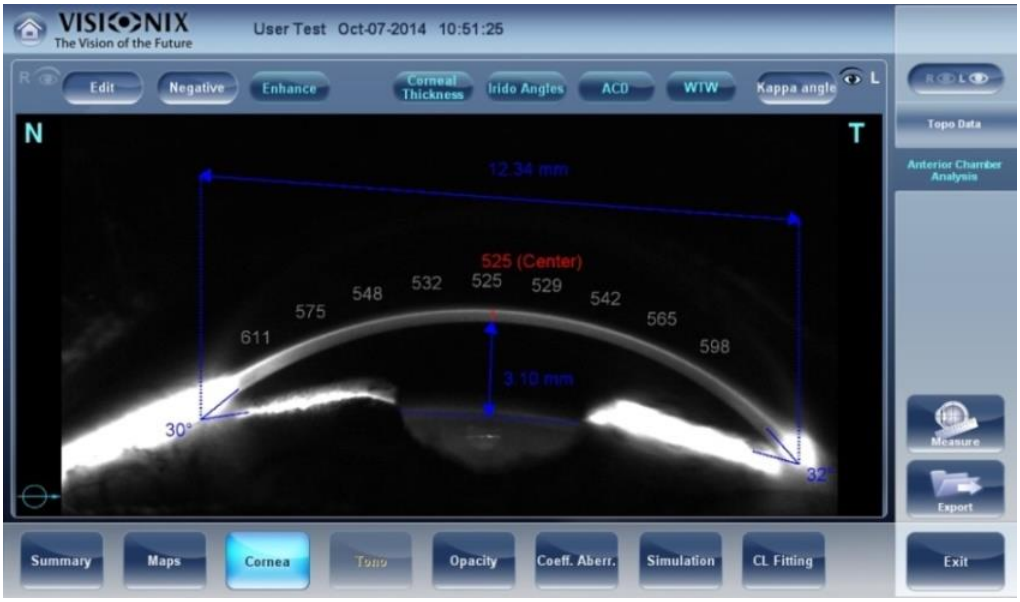

Image courtesy Visionix

Table 2 shows some commonly covered diagnosis codes for corneal pachymetry. Many payers cover pachymetry (optical or ultrasonic) only once in the beneficiary's lifetime when performed for glaucoma; check the payer's coverage policy.

Table 2 **Common Diagnosis Codes for Corneal Pachymetry**[7]

ICD-10	Description
H18.71-	Corneal ectasia
H18.-	Corneal edema
T85.398-	Corneal rejection post PK
H40.-	Glaucoma
H18.5	Hereditary corneal dystrophies
Z86.-	Personal history of disorders of cornea

SCODI of the Anterior Segment (CPT 92132)

Precise quantitative measurements and imaging of the anterior chamber and related structures using non-contact optical coherence and a Scheimpflug technique can aid evaluation and

[7] 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.

management. There are many indications for this technology, including: assess corneal flap thickness and residual stromal bed thickness following LASIK, measure corneal thickness, visualize IOLs and other implants while they are in the anterior segment, evaluate anterior segment ocular structures, as well as measure anterior chamber angles, anterior chamber depth and anterior chamber diameter.

Where the patient is dilated, it may be possible to measure the lens thickness as well. Figure 7 shows a sample SCODI-A image.

Figure 7 **SCODI-A Image**

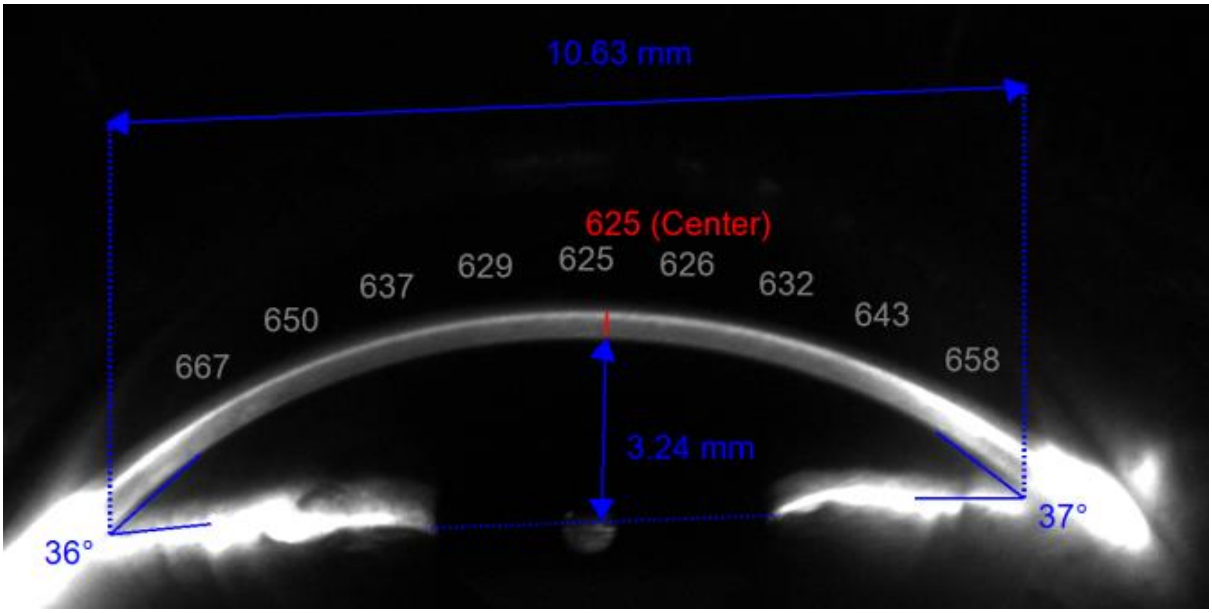

Image courtesy Visionix

At the time of this writing, there are few published coverage and payment policies for SCODI-A so the reader should not assume that reimbursement is readily available. The policies that have been published generally limit coverage to evaluation and treatment of diseases affecting the cornea, iris and other anterior chamber structures, or to provide additional information during the planning and follow-up for surgery for these conditions.[8] Some policies include narrow angle glaucoma as a covered indication.[9] Check your local MAC and other third party payer policies for coverage specifics. Table 3 shows a sample diagnosis codes approved for SCODI-A.

[8] National Governmental Services, Inc. (NGS). LCD #L34380. Scanning Computerized Ophthalmic Diagnostic Imaging. Rev. eff. date 10/01/2016. Link here. Accessed 06/17/2017.

[9] Wisconsin Physicians Service Insurance Corporation. (WPS). LCD #34760. Scanning Computerized Diagnostic Imaging (SCODI). Rev. eff. date 10/01/2016. Link here. Accessed 06/17/2017.

Table 3 **Common Diagnosis Codes for SCODI-A**[10]

ICD-10	Description
H21.4- to H21.5-	Adhesions and disruptions of iris and ciliary body
H40.03-	Anatomical narrow angle
D31.1-	Benign neoplasm of cornea
D31.9-	Benign neoplasm of eyeball
T85.3-	Complication of corneal graft
T85.2-	Complication of IOL
T85.3-	Complication of ocular prosthesis
H18.2-	Corneal edema
H17.-	Corneal scars and opacities
H21.3-	Cysts of iris, ciliary body and anterior chamber
H21.1-	Degenerations of iris and ciliary body
H27.0-	Disorders of lens
C69.1-	Malignant neoplasm of cornea
C69.9-	Malignant neoplasm of eyeball
H18.7-	Other corneal deformities
H21.8-	Other disorders of iris and ciliary body
H40.2-	Primary angle-closure glaucoma

Virtual Contact Lens Fitting (CPT 92310-92317)

The VX-120/130 has the parameters of various manufacturers' contact lenses pre-programmed in the instrument. The operator can select the desired lens, base curve, and diameter, together with the patient's measurements, and display the virtual result. Figure 8 shows two sample images of this feature on a keratoconic cornea; the right image shows the same lens with some alternative display options. The use of the VX-120/130 CL fitting software to pre-design a lens is an incidental part of the overall service of CL fitting and not separately billable.

[10] 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.

Figure 8 **Virtual Contact Lens Fitting Display**

Images courtesy Visionix

Keratometry, Intraocular Pressure (IOP), and Angle Kappa

Keratometry measurement occurs during CT; it is not a separate service.

The VX-120/130 measures the IOP using a small air-puff. The instrument has a demonstration mode to show the hesitant patient how comfortable the puff is. The operator can direct the instrument to obtain more than one measurement if desired. From a reimbursement perspective, intraocular pressure (IOP) is an element of an eye exam. The IOP display screenshot is shown in Figure 9.

Figure 9 **Intraocular Pressure Measurement Screenshot**

Image courtesy Visionix

Angle kappa is defined as the angle between the visual axis and the pupillary axis. It can be identified clinically by the nasal displacement of the corneal light reflex from the pupil center. It is an incidental part of an eye exam and not separately billable. For example, a large angle kappa

is clinically significant and may lead to alignment errors during photoablation in laser refractive surgery. Figure 10 shows a screenshot from the VX-120/130.

Figure 10 **Angle Kappa Screenshot**

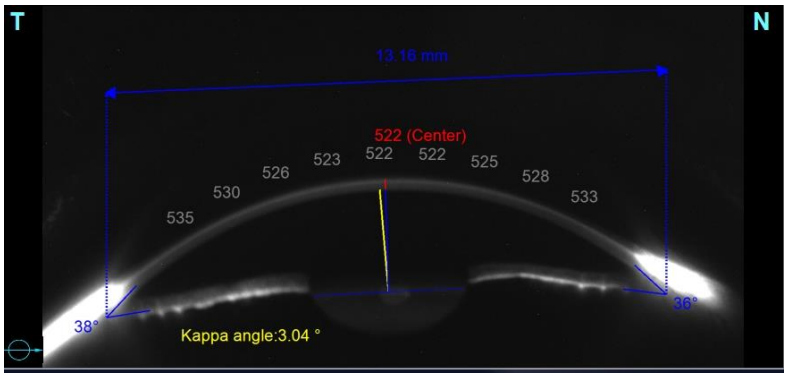

Image courtesy Visionix

BILLING ISSUES

The functions of the Visionix VX-120/130 are numerous, as are the CPT codes which describe them. A multitude of tests may occur on the same day, and each be billed, 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 often justified.

Although you may bill several tests concurrently, don't assume they will all be covered and reimbursed. For example, within traditional Medicare, refraction is never covered. Significantly, when a specific CPT code is unavailable, an unlisted code must be used.

CPT Codes

92015 ……...	Determination of refractive state
92025 ……...	Computerized corneal topography, unilateral or bilateral, with interpretation and report
92132 ……...	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
92499 ……...	Unlisted ophthalmologic service or procedure
9231x ……...	Contact lens fitting

Modifiers

The following modifiers may be applicable on claims for tests performed with the Visionix VX-120/130.

AQ …….……	Services provided in a HPSA (*Medicare modifier only; replaces QB and QU*)
GA …….……	Waiver of liability statement issued as required by payer policy (signed ABN on file)
GX …….……	Notice of liability issued, voluntary under payer policy (signed ABN on file)
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 (*Medicare modifier only*)
RT or LT ……...	Right or left eye
TC …….……	Technical component of a diagnostic test
22 …….	Unusual service
26 …….	Professional component of a diagnostic test
52 ……..	Reduced services (unilateral measurement of bilateral test)

Sample Claims

Example 1 Keratoconus

Your established patient is a 35 y/o female with keratoconus OU causing irregular astigmatism. She complains of intermittent haloes at night with a headache. You order CT OU to evaluate the corneal shape and to serve as a basis for comparison later. You change the contact lenses OU since the keratoconus has changed some. 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. H18.613 B. H52.213 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		92025		A,B	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92310		A,B	xxx xx	1		NPI	1234567890

Example 2 Keratoconus

You have been following a 30 y/o female patient over a number of years for suspicion of keratoconus OU; the vision had remained normal although previous CT showed abnormalities and suspicion indices that were suggestive for keratoconus. Recently, she has noticed decreasing vision with her hydrophilic soft contact lenses and glasses. A refraction without contact lenses shows no improvement, but a refraction over a trial rigid contact lens yields significantly improved acuity and symptomatic improvement. Today, you obtain CT and wavefront aberrometry. You diagnose keratoconus, irregular astigmatism, coma, and trefoil. You recommend rigid gas-permeable CL fitting in the near future. 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. H18.613 B. H52.213 C. H52.6 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,C	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92025		A,B,C	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92015	22	A,B,C	xxx xx	1		NPI	1234567890

Example 3 Irregular Astigmatism

Your established patient, a 68 y/o male, had penetrating keratoplasty 1 year ago OD and complains of blurry vision that is not corrected with eyeglasses. You order CT OD. Irregular astigmatism was noted and you discuss fitting a contact lens; this is planned for a future visit. 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. H52.211 B. Z94.7 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		92025	RT	A,B	xxx xx	1		NPI	1234567890

Example 4 Intermittent Angle-Closure Glaucoma

You are seeing your established 66 y/o female patient with a long history of intermittent haloes at night - which are present with either eye covered - and occasional but vague eye pain and headache. She has seen various providers but without a diagnosis for her complaints. Physical examination reveals moderately narrow angles OU. The remainder of the anterior and posterior segment examination is non-contributory. You order SCODI-A to better evaluate the anterior chamber angle. An ABN is executed since your MAC does not have a published policy and coverage is uncertain; this Medicare beneficiary selects Option 1 indicating her wish that you file a claim. Based on the SCODI-A results, you diagnose her with intermittent angle-closure glaucoma, OU. 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. H40.233 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		92132	GA	A	xxx xx	1		NPI	1234567890

Note: Use modifier -GA to indicate a signed ABN on file.

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 encounter on the same day by the same physician or group. Payments for the professional components are unaffected. The list of ophthalmic tests[11] includes ultrasound, imaging, and visual fields. Tests not on the list are not subject to the MPPR reduction. Also, tests that do not have a technical component (*e.g.*, refraction) are not subject to the MPPR policy nor do they implicate other tests being reduced.

Example 5 MPPR

A patient returns for her 6 month keratoconus check; the CT was ordered at last visit for performance today. During the exam today, a new iris lesions is noted and SCODI-A ordered. Both tests are interpreted. The claim is filed. In 2017, Medicare payment for these two tests would be as follows.

Test	Professional	Technical (showing reduction)	Total Payment
92025 Corneal Topography	$20.46	$17.94 (No reduction)	$38.40
92132 SCODI-A	$16.87	$14.71 less $2.94 (20%) = $11.77	$28.64

2017 National Medicare Physician Fee Schedule; local rates vary

Note: The payment reduction is taken on the lower-valued of the two technical (TC) portions - in this case, only the TC of the SCODI-A receives the reduction. Providers do not need to place the codes in descending order nor do they need to separate the TC and professional components on separate claim lines; MACs do the calculations automatically.

Financial Waivers

An Advance Beneficiary Notice of Noncoverage (ABN)[12] 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

[11] 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 06/16/2017.

[12] Advance Beneficiary Notice of Noncoverage. (Effective 6/21/17) Link here to Corcoran Consulting Group's website for downloadable versions of this form. Accessed 06/22/17.

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,[13] 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,[14] effective April 1, 2010, two modifiers were updated to distinguish between *voluntary* and *required* use of liability notices.

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[13] CMS. *MedLearn Matters* (MM6136). Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage. Link here. Accessed 01/05/17.

[14] CMS. Transmittal R1921CP. Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs). February 19, 2010. Link here. Accessed 01/05/17.

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, the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to control improper coding leading to inappropriate payments in Part B claims.[15] 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.

Current NCCI edits for 92025 and 92132 are shown below. Non-covered (92015) and unlisted codes (92499) have no bundles. Remember that refractive services are only billable once per date of service even if both refraction and wavefront aberrometry are performed together.

[15] Medicare Claims Processing Manual, Chapter 23, §20.9. Link here. Accessed 06/16/2017.

Table 4 **NCCI Edits for 92025 and 92132**

Primary Code	Do Not Bill These Codes With Primary Code	Do Not Bill Primary Code With These Codes
92025	99211 65760 65765 65767 65771	65730 65750 65755 65756 65770
92132	99211	76513

NCCI edits in effect as of April 1, 2017.

Purchased Diagnostic Tests / Anti-Markup Rule

If you order and bill for a fundus photograph and either the technical component or the professional interpretation is performed by another provider, 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.[16,17] 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.

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.[18]

[16] CMS. *MedLearn Matters* MM6627 (Revised). Eff. June 14, 2010. Link here. Accessed 06/16/2017.

[17] CMS. *MedLearn Matters* MM6371. Eff. July 1, 2009. Link here. Accessed 06/16/2017.

[18] Medicare Claims Processing Manual, Chapter 1, §30.2.9. Link here (see page 67 of the pdf). Accessed 06/16/2017.

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 services in Example 1 above had been performed in a HPSA not included in the automatic bonus payment file, then the claim would be submitted as 92025-AQ.

DOCUMENTATION

For most ophthalmic diagnostic tests, the description in CPT includes the phrase *"with interpretation and report"*.[19] 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 recoup any reimbursement.

Medicare Regulations and Guidance

The Medicare guidelines for interpretation of diagnostic tests are discussed in Medicare Claims Process Manual (MCPM) Chapter 13 §100 *Interpretation of Diagnostic Tests*.[20] 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.*"

[19] Current Procedural Terminology, 2017 Edition.

[20] Medicare Claims Process Manual (MCPM), Chapter 13, §100. Discussion on interpretation of diagnostic tests. Link here. Accessed 06/16/2017.

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,[21] 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 the results compare with prior tests?*
- Assessment, diagnosis – *What do the results mean?*
- Impact on treatment, prognosis – *What's next?*
- Physician's signature – *Who is the physician?*

[21] 42 CFR 415.120(a). Conditions of payment. Link here. Accessed 06/16/2017.

Some tests, such as corneal topography and SCODI-A, 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 corneal topography, the "interpretation and report" might read as follows.

- September 25, 2014
- Technician: Mary Smith, COT
- Good patient cooperation
- Inferior corneal steepening, OU
- Steepening is 2 D greater than last measurement (1 year ago)
- Keratoconus, OU
- Refit with special-design rigid lenses, OU. Advised that disposable soft toric lenses will no longer provide adequate acuity
- *Signed: I. C. Better, O.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 and complete, or differentiate it from the rest of the eye exam by surrounding the notations with a box and a title like "CT Report" or "SCODI-A 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 most of the tests discussed in this monograph do not require the physician's presence, 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 both 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 the diagnosis would be 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 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.

Following a test, your interpretation and report does not need to be book length, but it must answer pertinent questions about the service. A cryptic, one word note isn't an interpretation as Medicare understands that term. Diagnostic tests are a significant part of most practices, so don't underestimate the importance of a thorough "interpretation and report."

SUPERVISION

Medicare's supervision rules for many ophthalmic diagnostic tests have been stable since July 1, 2001. SCODI-A (92132) requires *general* supervision.[22] This means the procedure is furnished under the physician's overall direction and control, but the physician's presence in the office 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.[23]

At this time, no supervision policy has been established for CT (92025). Likewise, optical corneal pachymetry (92499) has no explicit supervision policy, as might be expected for an unlisted procedure. In our opinion, *general* supervision is appropriate in both instances.

[22] 42 CFR 410.32(b)(3)(i). Definition of general supervision. Link here. Accessed 04/30/2015.
[23] 42 CFR 410.32 (b)(3)(i). Definition of general supervision. Link here. Accessed 04/30/2015.

PAYMENT RATES

National Medicare payment rates in 2017 for 92025 and 92132 are shown below, including the technical component (TC), the professional component (PC) and the global total. MPPS reductions apply when multiple tests are performed on the same day.

Table 5 **2017 Medicare Fee Schedule**

Code	Description		PAR Allowable	Non-PAR Allowable	Limiting Charge for Non-PAR
92025	SCODI-A	PC	$20.46	$19.43	$22.35
		TC	$17.94	$17.05	$19.60
		Global	$38.40	$36.48	$41.95
92132	SCODI-A	PC	$16.87	$16.02	$18.43
		TC	$14.71	$13.98	$16.08
		Global	$31.58	$30.00	$34.50

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

UTILIZATION

Commercial utilization rates are not readily available for these services, but CMS publishes utilization data. The most current data available comes from Medicare fee-for-service claims paid in 2015.

In the Medicare program, 92025 was paid about 143,000 times, or only once per 100 exams performed by ophthalmologists. Claims for 92025 among optometrists were much less frequent and were paid about 20,000 times, or only 2 times per 1,000 exams.

In the Medicare program, 92132 was paid about 29,000 times, or only once per 1,000 exams performed by ophthalmologists. Claims for 92132 among optometrists were performed about 14,000 times, or only 2 times per 1,000 exams.

If your utilization rate significantly exceeds expected norms, you will likely garner (unwanted) attention from Medicare and other payers. Careful attention to documentation of tests and their

interpretations, and the reasons they were performed are your best defense against reproach in the event of postpayment review. Having original or electronic copies of other documents (such as ABNs) available is also important if there are questions about whether patients were informed of possible noncoverage.

Since 92499 might apply to many different services, utilization of optical corneal pachymetry cannot be determined from the Medicare data. In addition, as a noncovered service, refraction (including aberrometry) does not have utilization data. Finally, contact lens fitting for keratoconus is not generally a Medicare service, so utilization is likewise not available.

CONCLUSION

The Visionix VX-120/130 provides ophthalmologists and optometrists with a versatile tool to perform a wide variety of tests to assess the cornea and anterior segment. Discrete reimbursement for medically necessary testing is available for SCODI-A and corneal topography. Optical corneal pachymetry is distinct from an eye exam although claims processing might take extra work because it is reported with 92499. Refraction is not covered by Medicare and most health plans; wavefront aberrometry represents an unusually robust refraction. Keratometry, intraocular pressure, and angle kappa are incidental parts of an eye exam or other testing and not separately billed. Where a test is either not covered or in doubt, a financial waiver, such as an ABN, is necessary to ensure that the patient accepts financial responsibility.

This discussion is meant to assist the reader to better understand the rules and regulations regarding reimbursement for these procedures, 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 the patient's condition(s) requires more than one test, bill for each service performed.
- Notify the patient, prior to testing, of financial responsibility if the diagnosis for the test(s) 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).
- Pay attention to Medicare's NCCI edits. They are updated quarterly and describe bundles and mutually exclusive codes.
- Medicare's MPPR rules apply to corneal topography and SCODI-A. When performed together or 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.