Corcoran Consulting Group

A Division of Ardare Corporation

Medicare Reimbursement for Melbourne Rapid Fields

Prepared for

M&S® TECHNOLOGIES

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Medicare Reimbursement for Melbourne Rapid Fields

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

Objective: *This report is provided as a general discussion of billing and documentation for visual field testing and related issues. Local variations between payers may occur which are not described here. The user is strongly encouraged to review official instructions promulgated by the Centers for Medicare & Medicaid Services (CMS) and their Medicare carriers; this document is not an official source nor is it a complete guide on all matters pertaining to reimbursement. In addition, users should check with their local Medicare Administrative Contractor (MAC) for approved diagnosis codes and usage.*

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

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

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

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INTRODUCTION

This monograph describes reimbursement for visual field (VF) testing with M&S Technologies' Melbourne Rapid Fields (MRF) software program. This web-based software works on multiple platforms (*e.g.*, laptop, iPad) and in different settings (*e.g.*, in-clinic, at-home). For the purpose of a claim for reimbursement, testing is identified in a number of different ways depending on several factors: site of service (office, home), testing paradigm (threshold, non-threshold), and reason for testing (screening, disease management).

Much of the information in this document is taken from official publications of the Medicare program. The reader is encouraged to check with the local Medicare Administrative Contractor (MAC) for additional information and instructions. For other third party payers, we have used the coding concepts contained in CPT and published by the American Medical Association; diagnosis codes are from ICD-10-CM.

Documentation of diagnostic tests, and the medical rationale for them, is key to reimbursement so we describe the required elements in detail. Since economic analyses are a necessary part of any capital budgeting decision, we incorporated Medicare's payment rates for VFs testing as well as recent Medicare utilization rates.

THE PROGRAM

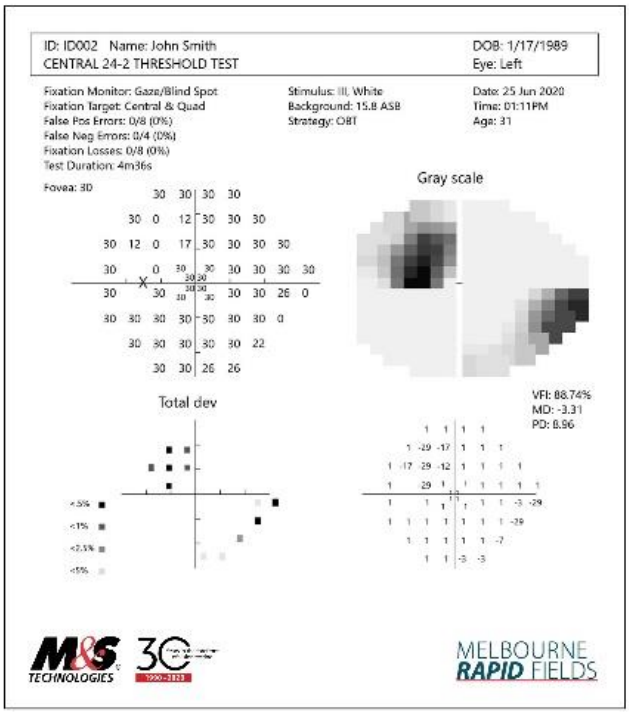
M&S offers two MRF versions: 1) in-clinic VF testing (Figure 1), and 2) web-based VF testing (Figure 2). The in-clinic version uses a Microsoft Surface Pro 7 mini laptop and responder. The at-home VF test relies on the MRF web-based VF program that supports physician monitoring of the test results. MRF is optimized for cloud storage, but also works well for enterprise storage.

Figure 1 **In-Clinic MRF**

Figure 2 **At-Home MRF**

When performed in the clinic setting, disinfection between patients is an additional consideration. This process is faster and more convenient than disinfecting a bowl-type perimeter which might be damaged or compromised by the constant need for disinfection. Only the laptop and immediate surrounding hard-surface areas require disinfection.

Figure 3. **Sample Printout**



M&S' MRF is intended for use as a diagnostic tool to aid in the detection and management of ocular diseases due to nerve damage including, but not limited to, glaucoma. It uses published and peer-reviewed algorithms. The software has been shown to be similar in detection to other threshold protocols in VFs.[1,2] Additionally, the efficacy of home use as an aid in monitoring field progression has been demonstrated.[3] Upon completion of the test, results can be printed or exported (Figure 3). Table 1 describes the features of the MRF.

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1 Kong, YXG, Mingguang, H, et. al. A Comparison Of Perimetric Results From A Tablet Computer And Humphrey Field Analyzer In Glaucoma Patients. *Translational Vision Science and Technology*. Nov 2016, Vol 5(2). Link here. Accessed 03/11/21.

2 Prea, SM, Kong, YXG, et. al. Six-month Longitudinal Comparison of a Portable Tablet Perimeter With the Humphrey Field Analyzer. Am J Ophthalmol. 2018; Vol 190 (9):9-16. Link here for PubMed abstract. Accessed 03/11/21.

3 Anderson, AJ, Bedggood, PA, et. al. Can Home Monitoring Allow Earlier Detection of Rapid Visual Field Progression in Glaucoma? *Ophthalmology*. 2017; Vol 124 (12). Link here. Accessed 03/11/21.

Table 1 **Melbourne Rapid Fields Testing Options**

Test Options	Methodology	Features
• Full field 30-2 • Full grid 24-2 • Macular 10-2 • Screening	Bayes predication of threshold	• Straightforward disinfection • Rapid testing time of 3-4 minutes per eye • Advanced test/retest algorithm • Portable

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 VF testing (Table 2).

Table 2 **Common Diagnosis Codes for Visual Fields** [4]

ICD-10	Description
A18.53	Tuberculous chorioretinitis
A18.52-	Syphilitic and neurosyphilitic conditions
C69.-, C70.-, C71.-, C72.-, C75.-	Malignant neoplasms of the eye and visual pathways
D31.-, D32.0, D33.-, D35.-, D44.-, D49.7	Benign and uncertain behavior neoplasms of the eye, visual pathway, and cerebral nerves and glands
E10.3-, E11.3-	Diabetes with ophthalmic manifestations
G00.-, G03.-	Meningitis
G35	Multiple sclerosis
G37.-	Demyelinating diseases
G43.-	Migraine (various)
G93.2	Benign intracranial hypertension
E10.3-, E11.3-	Background diabetic retinopathy
E10.35-E11.35-	Proliferative diabetic retinopathy
H02.3-	Blepharochalasis
H02.4-	Ptosis (various)

[4] Listed codes are representative of covered diagnoses but differences in payment policies exist for many carriers. The ICD-10 codes shown may contain laterality and other granularity; the ending dash (-) means a longer code is required and contains greater specificity. This list is neither exhaustive nor universally accepted. See your payer bulletins.

Table 2 **Common Diagnosis Codes for Visual Fields** [4]

ICD-10	Description
H30.-	Focal chorioretinal inflammation
H31.-	Choroidal atrophies, dystrophies, and detachments
H33.-	Retinal detachments (various)
H34.-	Retinal vascular occlusion
H35.3-	Macular degeneration
H40.-, H42*	Glaucoma
H46.-	Optic papillitis, retrobulbar neuritis
H47.1-	Papilledema
H47.2-	Optic atrophy
H47.3-	Optic disc lesions and disorders
H47.4-	Disorders of optic chiasm
H47.5-	Disorders of visual pathways
H47.6-	Disorders of visual cortex
H49.-	Cranial nerve palsies and ophthalmoplegias
H51.-, H53.-	Convergence, internuclear ophthalmoplegia, and other visual loss
H54.-	Low vision, blindness
I60.-, I61.-, I62.-	Intracranial and intracerebral hemorrhage and infarction
M31.5, M31.6	Giant cell arteritis
Q10.0	Congenital ptosis
Q14.-	Congenital malformations of eye
Q15.0	Congenital glaucoma
S04.-**	Injuries to optic nerve and cranial nerves
Z04.7-	Encounter for physical abuse
Z09	Encounter for follow-up after completed treatment (not malignant neoplasm)
Z76.5	Malingerer (conscious simulation)
Z79.899	Other long term (current) drug therapy

* This "3-character only" code has an instruction to "Code First" the underlying condition.

** These codes in Chapter 19 generally require a 7th character (A/D/S) for initial, subsequent, or sequela designations.

It is important to note that MACs and other third party payers do not universally agree on a common list of covered diagnoses for these tests. Careful review of local coverage determinations (LCDs) and private payer policies is necessary.[5,6,7]

The longstanding National Coverage Determination (NCD 80.9)[8] for "Computer Enhanced Perimetry" notes that it "*…involves the use of a micro-computer to measure visual sensitivity at preselected locations in the visual field*." NCD 80.9 was written in 1984 when most VF tests were performed manually and computerized perimetry was new. Today, most VFs are performed via these computerized instruments with rare exceptions. NCD 80.9 also notes that, within Medicare, computerized perimetry "*is a covered service when used in assessing visual fields in patients with glaucoma or other neuropathologic defects*." For reimbursement purposes, it does not matter that the MRF is web-based; there is no requirement for integration of the software and hardware.

Initial diagnostic testing is ordered and performed when the information garnered from an eye exam is insufficient to assess the patient's disease or abnormal condition. Medicare covers VF tests as an adjunct to evaluation and management of an illness or injury,[9] including glaucoma suspect. The definition of glaucoma suspect incorporates abnormal characteristics not found in a normal healthy eye. If the test is performed for baseline documentation of healthy eyes, it is not covered.[10]

National Government Services (NGS) notes the following for documentation in the chart for VF testing[11] in their Local Coverage Article (LCA) #A56551: "*The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD … This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.*"

First Coast Service Options, Inc. (FCSO), the MAC for Florida, Puerto Rico, and the US Virgin Islands, in their LCD #L33766 on Visual Fields, notes that: "*Medical record documentation must clearly indicate the medical necessity of the visual field testing and the results of the visual field test must be maintained in the patient's medical record …*

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5 A representative VF policy may be found at National Governmental Services, Inc. LCD L33574. Rev. Eff. date 09/19/19. Link here. Accessed 03/11/21.

6 Another representative VF policy may be found at First Coast Service Options, Inc. (FCSO). LCD L33766. Rev. Eff. Date 01/08/19. Link here. Accessed 03/11/21.

7 Another representative VF policy may be found at Wisconsin Physicians Service Insurance Corporation (WPS). LCD L34615. Rev. Eff. Date 10/31/19. Link here. Accessed 03/11/21.

8 National Coverage Determination on Computer Enhanced Perimetry (NCD 80.9). Effective date 02/15/1984. Link here. 03/11/21.

9 Social Security Act §1862(a) Exclusions From Coverage And Medicare As A Secondary Payer

10 CFR 411.15(a)(1). Particular services excluded from coverage. Link here. Accessed 03/11/21.

11 National Governmental Services, Inc. (NGS) LCA #A56551 on Billing and Coding: VFs Testing. Rev. Eff. date 10/01/20. Link here. Accessed 03/11/21.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act … [and] *There must always be a reason for performing the test since routine exams are considered screening and thus are not covered as medically reasonable and necessary.*"

Some Medicare contractors and other payers place a restriction on how frequently they expect a test to be performed. 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. Specific to VF testing, many payers follow the AAO's PPP, which notes the following in the Primary Open-Angle Glaucoma document, "*In certain cases, follow-up visual field testing may be required more frequently than the recommended intervals (e.g., a second test to establish a baseline for future comparisons, to clarify a suspicious test result, or to overcome an apparent testing artifact). For example, a patient with glaucomatous damage who has shown long-term stability can be followed every 6 to 12 months, depending on how severe the damage is, whereas a patient with evidence of glaucomatous progression may receive a change in care plan with more frequent follow-up.*"[12]

FCSO notes the following in their LCD on VFs[13] when re-testing if the diagnosis is macular degeneration or central field loss: "*…repeated examinations for a diagnosis of macular degeneration or an experienced central vision loss are not necessary unless changes in vision are documented or to evaluate the results of a surgical intervention."* They also state, *"… patients with a previously diagnosed retinal detachment do not need a pretreatment visual field examination. Additionally, patients with an established diagnosed cataract do not need a follow-up visual field unless other presenting symptomatology is documented. In patients about to undergo cataract extraction, who do not have glaucoma and are not glaucoma suspects, a visual field is not indicated.*"

Additionally, in the above LCD document, FCSO covers VF testing when, "*The patient is receiving or has completed treatment of a high-risk medication that may cause visual side effects (e.g., a patient on plaquenil may develop retinopathy).*"

Screening and Visual Fields

Some ophthalmologists and optometrists use standing orders for VFs for all patients prior to an eye exam, so the doctor can screen for disease. As a general rule, most payers,

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[12] American Academy of Ophthalmology. Preferred Practice Patterns (PPP). The listing shows multiple document access). Link here. PPP for Primary Open-Angle Glaucoma. Page Accessed 03/11/21.

[13] First Coast Service Options, Inc. (FCSO). LCD L33766. Rev. Eff. Date 01/08/19. Link here. Accessed 03/11/21.

including Medicare, do not cover screening services or preventive medicine.[14] Patients must be given the opportunity to choose between an exam with or without VFs. Practices should use a financial waiver to document the beneficiary's acceptance of financial responsibility for the screening service. Screening occurs when the test is performed for one or more of the following reasons.

- Part of a wellness program to check for disease that may otherwise go undetected
- Not required by medical necessity; the reason for doing them is optional
- Recommended *prior to* an eye examination
- Taken *before* the patient is examined by the eye care provider
- Done for all patients as a matter of course, unless they decline

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

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.[15,16,17] The Centers for Medicare & Medicaid Services (CMS) states "*the physician must clearly document, in the medical record, his or her intent that the test be performed.*"[18,19] 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 VF 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.

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14 CFR 410.32 (a). Link here. 03/11/21.

15 United States General Accounting Office. Beneficiary Use of Clinical Preventive Services. GAO-02-422. April 2002. Link here. Accessed 03/11/21.

16 Office of Inspector General. Report: St. Francis Hospital, Tulsa, OK. Estimated Medicare Overpayment. February 12, 2002. Link here. Accessed 03/11/21.

17 Department of Justice. Archived Press Release. GAMBRO Healthcare Inc. agrees to pay $53 million of overcharging Medicare, Medicaid, & Tricare. July 13, 2000. Link here. Accessed 03/11/21.

18 CMS. Medicare Benefit Policy Manual, Chapter 15, §80.6.1. Requirements for Orders for Diagnostic Tests- Definitions. Link here. 03/11/21.

19 Palmetto GBA. Jurisdiction M Part B. Orders for Diagnostic Tests. Link here. Accessed 04/07/21.

DOCUMENTATION

Medicare Regulations and Guidance

Some guidance is specific to the setting where the test takes place, while other guidance applies regardless of place of service.

Home-Based Testing Considerations

There must be a valid order for a test, even if the patient does the test at home. The technical portion of the VF test is not billable by the physician with a home place of service (12). A VF policy from Wisconsin Physicians Service Corporation notes the following,[20]

"*The technical component may be billed in the following places of service:*

- *Office (11), nursing facility (32), independent clinic (49), federally qualified health center (50) and rural health clinic (72).*"

It is important to note that home (12) is not included in this list. To further explain that the technical portion is not billable, Medicare explains that when a provider incurs no costs (*i.e.*, equipment, space, or technical/staff support), there is nothing to reimburse.[21]

The professional portion of the VF is a billable service for the interpretation, and modifier 26 is appended to the visual field CPT code. The place of service on the claim for the interpretation is where the provider performs the service, usually office (11).

General Guidance For All Settings

The descriptions in CPT for VF testing include the phrase *"with interpretation and report.*"[22] 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.

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[20] Wisconsin Physicians Service Corporation. Local Coverage Article (LCA) #A57483. Rev. Eff. Date 10/01/20. Link here. Accessed 03/11/21.

[21] CMS. MLN Booklet, "Items And Services Not Covered Under Medicare". December 2020. Link here. (See next-to-last bullet on page 17). Accessed 03/11/21.

[22] Current Procedural Terminology (CPT) 2021 Professional Edition.

The Medicare guidelines for interpretation of diagnostic tests are discussed in the Medicare Claims Process Manual (MCPM) Chapter 13 §100, Interpretation of Diagnostic Tests.[23] CMS makes a distinction between a "review" of a test and an "interpretation and report".

> "*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,[24] 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?*

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[23] Medicare Claims Process Manual (MCPM) Chapter 13 §100. Interpretation of Diagnostic Tests. Link here. Accessed 03/11/21.

[24] Code of Federal Regulations: 42 CFR 415.120(a) Conditions for payment: Radiology services, to beneficiaries. Link here. Accessed 03/11/21.

- Patient cooperation – *Was the patient at fault?*
- Test findings – *What are the results of the test?*
- Comparison – *How do today's results differ from prior test(s)?*
- Assessment, diagnosis – *What do the results mean?*
- Impact on treatment, prognosis – *What's next?*
- Physician's signature – *Who is the physician?*

In ophthalmology, tests such as VFs 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 VF, the "interpretation and report" might read as follows.

- VF for primary open-angle glaucoma
- July 6, 2020
- Technician: Mary Smith, COA
- Some fixation losses
- Good patient cooperation
- New arcuate changes OD with nasal step. Small relative scotoma in central area, OS
- POAG, shows progression OU since last visit
- Add another anti-glaucoma medication, discussed required compliance with medications
- *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 "VF 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 VF testing requires only general supervision,[25] and the physician need not be present during the performance of the test, the interpretation might take place the next day. If a weekend intervenes, there may be two days' delay. It is important to note that CMS understands that delays are a fact of life and, in 2009, proposed regulations to require claims for reimbursement to identify on two separate lines the technical and professional components of a diagnostic test when performed on different dates of service. These proposed regulations (Transmittals 1823 and 1873) were subsequently withdrawn, yet there is still concern about this topic. When the test is done in the office setting, the practical alternative is to 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. When the test is done by the patient at home, only the professional component (interpretation and report) is billed.

Payment Considerations

In the Medicare Physician Fee Schedule (MPFS), 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

In July, 2001, Medicare revised its supervision rules for many ophthalmic diagnostic tests. VF testing 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

[25] 42 CFR 410.32(b)(3)(i). Definition of general supervision. Link here. Accessed 03/11/21.

are the continuing responsibility of the physician.[24]

BILLING ISSUES

Procedure Codes

The following CPT codes are used to report VF testing.

92081 …... Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

92082 …... Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)

92083 ...… Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann VFs with at least 3 isopters plotted and static determination within the central 30°, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey VF analyzer full threshold programs 30-2, 24-2, or 30/60-2)

Limited VF (92081) may be performed to screen for potential disease, or to determine the extent of VF impairment secondary to ptosis or dermatochalasis. When a limited VF is performed to determine the extent of impairment prior to possible lid surgery (*e.g.*, ptosis, blepharoptosis, or dermatochalasis), it is frequently performed with the lids in taped and untaped positions. The American Medical Association's publication, CPT Assistant, in answer to a question about concurrent taped and untaped VFs, stated in September, 2010, "*It is only reported once per session, even when the exam includes evaluations with and without lid taping as in evaluation for blepharoplasty. Therefore, it should be reported once, regardless of whether the examination is performed more than once unilaterally or bilaterally.*"[26]

Automated intermediate visual field (92082) are typified by an abbreviated testing protocol that results in the determination of an absolute defect or not. For a manual test, 92082 requires at least two isopters.

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[26] Medicine: Ophthalmology. Q&A, Coding VISUAL FIELD test … with eyelids taped and … without. American Medical Association. CPT Assistant. September, 2010.

The extended VF (92083) requires at least three isopters or a full threshold automated VF. A full threshold test provides quantitative data (in decibels) for each location.

VFs are defined in CPT as "*unilateral or bilateral*" so a solitary charge is made whether one or both eyes are tested.

The CPT manual lists gross (basic confrontation) visual field as a required exam element of a comprehensive eye exam (920x4), and it is commonly a part of many other eye exams. As a component of the office visit, it is not separately reimbursed. A sample policy from NGS, the Medicare Administrative Contractor for a number of states, has the following in their policy, *"Gross visual field testing (e.g., confrontation testing) is a part of general ophthalmological service and should not be reported separately."* [27]

Modifiers

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

AQ ……	Services provided in a Health Professional Shortage Area (HPSA, *Medicare modifier only; replaces QB and QU*)
GA ……	Medicare probably does not cover this service. Advance Beneficiary Notice (ABN) signed (*Medicare modifier only*)
GY ……	Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit.
GZ ……..…	Medicare probably does not cover this service. No ABN on file (*Medicare modifier only*)
TC ……	Technical component of a diagnostic test
26 …….	Professional component of a diagnostic test
52 …….	Reduced service (*e.g.,* only one eye tested when the code is defined as bilateral and the payer requires it)

Sample Claims For Office-Based VF Testing

Example 1 Open-Angle Glaucoma - Exam and VF

[27] National Government Services. National Governmental Services, Inc. LCD L33574. Rev. Eff. date 09/19/19. Link here. Accessed 03/11/21.

During dilated fundus exam of the posterior pole with binocular indirect ophthalmoscopy, changes in the optic nerve cup:disc ratio of both eyes and a small optic disc hemorrhage on the right were noted. You ordered an automated threshold VF OU to establish a baseline for glaucomatous damage and to permit re-evaluation later to monitor for progression. Your impression of the VF noted mild open-angle glaucoma, OU. 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. H40.1131 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		92083		A	xxx xx	1		NPI	1234567890

Example 2 Open-Angle Glaucoma – Exam with VF and Fundus Photography

Your established Medicare patient with mild open-angle glaucoma, OU, is in for her yearly comprehensive examination. The cup:disc ratio is enlarged compared with the last exam and image. She hasn't been able to use the prescribed anti-glaucoma medication as often as ordered. You order and perform automated threshold VF and fundus photography to establish a new baseline OU. The VF damage has progressed to moderate-stage OU. In addition to the exam (shown as 9xxxx), the claim for today's services 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. 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
mm dd yyyy		11		92083		A	xxx xx	1		NPI	1234567890

Note: Diagnosis reflects today's interpretation.

Sample Claims for Home-Based VF Testing

Your patient has travel limitations. She is doing fairly well with bilateral moderate open-angle glaucoma. VF testing at home would provide clinically useful closer monitoring. She agrees to try it, and is trained by your technician. An order is entered in the chart. Using her home computer and a link to the MRF program, she does a VF as instructed. You review it today. Her moderate-stage open-angle glaucoma shows no progression. The results are communicated to her via your EMR portal. The claim for the interpretation 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. 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		92083	26	A	xxx xx	1		NPI	1234567890

Financial Waivers

An Advance Beneficiary Notice of Noncoverage (ABN)[28] 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.

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

[28] Advance Beneficiary Notice of Noncoverage. Link here to Corcoran Consulting Group's website for downloadable versions of this form. Accessed 03/11/21.

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.

- Option 1 *I want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but* ***I can appeal to Medicare*** *by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.*
- Option 2 I *want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and* ***I cannot appeal if Medicare is not billed.***
- Option 3 *I don't want the items or services listed above. I understand with this choice I am* ***not*** *responsible for payment, and* ***I cannot appeal to see if Medicare would pay.***

If the beneficiary chooses Option 1, you must submit a claim and append an appropriate modifier to the reported item(s) or service(s). 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. The question is moot if the beneficiary chooses Option 3, since you will not provide the 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,[29] 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.

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[29] CMS. MedLearn Matters (MM6136). Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage. Link here. Accessed 03/11/21. Link here to the "Advance Beneficiary Notice of Non-Coverage Interactive Tutorial" for additional information.

In CMS Transmittal R1921CP,[30] 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".

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)[31] to control improper coding leading to inappropriate payments in Part B claims.[32] 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

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30 CMS. Transmittal R1921CP. Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs). February 19, 2010. Link here. Accessed 03/11/21.

31 CMS. National Correct Coding Initiative Edits. Link here. Accessed 03/11/21.

32 Medicare Claims Processing Manual, Chapter 23, §20.9. Correct Coding Initiative. Link here. Accessed 03/11/21.

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 VFs are shown below. The edits mean 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 3 **NCCI Edits** [33]

Primary Code	Do Not Bill These Codes With Primary Code	Do Not Bill Primary Code With These Codes
92081	92082[0] 92083[0] 99211	15820[0] 15821[0] 15822[0] 15823[0] 67901[0] 67902[0] 67903[0] 67904[0] 67906[0] 67908[0]
92082	92083[0] 99211	15820[0] 15821[0] 15822[0] 15823[0] 67901[0] 67902[0] 67903[0] 67904[0] 67906[0] 67908[0]
92083	99211	15820[0] 15821[0] 15822[0] 15823[0] 67901[0] 67902[0] 67903[0] 67904[0] 67906[0] 67908[0]

NCCI edits in effect as of January 1, 2021.

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 VF would be billed as 92083-AQ.

[33] Codes marked with superscript [0] may not be unbundled for any reason. Other codes may be unbundled in some situations (*e.g.*, different session). Bundles shown are common ophthalmic edits. Check the complete NCCI edits for all bundles.

PAYMENT LEVELS

Medicare defines CPT codes 92081, 92082, and 92083 as bilateral so reimbursement is for both eyes in nearly all cases.[34] The 2021 national Medicare Physician Fee Schedule allowable amounts are shown below (Table 4); these amounts are adjusted in each area by local indices. Other payers set their own rates, which may differ significantly from the Medicare published fee schedule.

Table 4 **Medicare National Allowable Rates**

Code	Description		PAR Allowable	Non-PAR Allowable	Limiting Charge for Non-PAR [35]
92081	VF, Basic	Global	$34.21	$32.49	$37.36
		TC	$18.14	$17.24	$19.82
		PC	$16.05	$15.25	$17.54
92082	VF, Intermediate	Global	$48.15	$45.74	$52.61
		TC	$26.87	$25.52	$29.35
		PC	$21.28	$20.22	$23.25
92083	VF, Extensive	Global	$64.20	$60.99	$70.14
		TC	$36.99	$35.14	$40.41
		PC	$27.22	$25.86	$29.73

Multiple Procedure Payment Reduction

Medicare has implemented a payment reduction when multiple tests are performed at the same encounter. Known as the Multiple Procedure Payment Reduction (MPPR),[36] it was effective for dates of service beginning 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

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

[35] 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. 03/11/21.

[36] CMS. Medicare Learning Network, MLN Matters MM7848, Eff. January 1, 2013. Link here. Accessed 03/11/21.

same day by the same physician or group. The list of tests[37] includes ultrasounds, imaging, and VFs. Tests not on the list are not subject to the MPPR reduction. All the codes discussed in this monograph are subject to MPPR.

Example MPPR

A patient returns for her 3 month glaucoma check. A threshold VF in the office today was ordered at the prior visit. During the exam, the IOP is elevated and the optic nerves show increased cupping compared to the last fundus photos. Repeat fundus photographs are ordered and performed today in addition to the VFs already ordered and performed. Both tests are properly interpreted. Medicare payment for these tests would be as follows.

The payment reduction is taken only on the lesser of the two *technical* portions – which is the fundus photography test in this example for 2020. Note that the professional portions of each of the respective tests are unaffected and paid in full.

Test	Professional	Technical	Total
92083 Visual Field	$27.22	$36.99 (No reduction)	$64.20
92250 Fundus Photo	$21.28	$18.49 less $3.70 (20%) = $14.79	$36.08

2021 National Medicare Physician Fee Schedule, PAR allowable

UTILIZATION

Medicare utilization rates are published and are noted below; commercial utilization rates are not readily available. There are no published limitations for repeated testing. In general, these and all diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required. If your utilization rate exceeds the expected norms, you will likely garner attention from Medicare and other payers. Careful attention to documentation of the test and the reasons it was performed are your best defense against reproach in the event of postpayment review.

Medicare utilization rates for all VF claims paid in 2018 (*i.e.*, 92081, 92082, 92083) were associated with 11% of office visits performed by ophthalmologists. That is, for every 100 exams performed on Medicare beneficiaries, Medicare paid for a VF 11 times. For optometrists, the utilization rate is 9%. 92083 accounts for the vast majority of VF claims.

[37] CMS Transmittal 1149, dated November 6, 2012. Attachment 2 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 03/11/21.

CONCLUSION

M&S' MRF permits in-clinic and at-home VF testing. During the COVID public health emergency, cleaning the VF equipment between patients is easier with M&S' equipment. Also, for patients who cannot or will not come to the office, at-home VF testing is a reliable way to monitor disease. Both the technical and professional component of the VF can be billed for in-clinic testing, but only the professional component for at-home testing.

Coverage of VFs depends on the indication for testing. Screening is not covered; evaluation and management of disease or abnormalities is covered. Reimbursement for VF depends on chart documentation. An order with medical rationale and a physician interpretation of the test results are required.

VF testing is popular and useful for a wide variety of conditions, not just glaucoma. For example, they are helpful in neurology (*e.g.*, with stroke), during litigation (*e.g.*, malpractice), as part of criminal investigations (*e.g.*, trauma where the head and central nervous system is involved), for teaching purposes, and for other caregivers such as optometrists who specialize in low vision.

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

Practice Management Tips

- Do not bill for the technical component of the VF when the patient performs the ordered test at home.
- Document the physician's interpretation of the VF 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. Document the rationale for repeat services.
- Using ICD-10, code laterality and stage as appropriate.
- Notify the patient, prior to testing, of financial responsibility if your diagnosis 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).
- Reimbursement for VF is subject to Medicare's MPPR rules. When performed with other tests on the same day, payment may be reduced.
- Store the electronic file for the VF in a secure, retrievable location; reference the location within the medical record.