Corcoran Consulting Group

A Division of Ardare Corporation

Medicare Reimbursement for Visual Fields Testing

Prepared for

ZEISS

January 2020

Medicare Reimbursement for Visual Fields Testing

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

© Copyright 2015 - 2020 All rights reserved.

Except as permitted under the United States Copyright Act of 1976, no part of this publication may be reproduced or distributed in any form or by any means, or stored in a database or retrieval system, without the prior written permission of the author. From time to time, changes may occur in the content of this report and it is the user's responsibility to assure that current issues of this report are utilized. This additional information is also copyrighted as expressed above.

Other copyright: *CPT and all CPT codes are copyrighted by the American Medical Association with all the rights and privileges pertaining.*

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 Carl Zeiss Meditec, Inc. 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.

Acknowledgement: *This paper was underwritten by a grant from Carl Zeiss Meditec, Inc. as an aid to customers and other interested parties. Carl Zeiss Meditec, Inc. is not the author of, and therefore not responsible for, the content of the reimbursement and billing information provided herein. A number of individuals provided helpful suggestions for which we are grateful. For further information about their products, contact the company at www.zeiss.com/us/med.*

INTRODUCTION

This monograph describes reimbursement for visual field testing with Carl Zeiss Meditec, Inc. devices. For the purposes of procedure coding on claims for reimbursement, this testing is identified in a number of different ways depending on context:

- Testing modality
    - Threshold-based
    - Threshold-related
    - Non-threshold
- Purpose of testing
- Screening

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 a diagnostic test, and whether there is medical rationale for it, are key to reimbursement so we describe the required elements in detail.

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 visual fields testing, as well as recent Medicare utilization rates.

THE INSTRUMENTS

The Humphrey® Field Analyzer is an automated perimeter intended to identify visual field defects for the purposes of screening, monitoring, and assisting in the diagnosis and management of ocular diseases such as glaucoma and related neurological disorders.

The Carl Zeiss Meditec, Inc. Guided Progression Analysis™ (GPA™) is a software analysis module for the Humphrey Field Analyzer that assists practitioners with the detection, measurement, and management of progression of visual field loss. It aids in assessing change over time, including change from baseline and rate of change. It is intended for use as a diagnostic device to aid in the detection and management of ocular diseases including, but not limited to, glaucoma. Note: The HFA3 is not intended to be used as the sole diagnostic method for disease.

ZEISS currently produces a number of visual fields (VF) instruments with varying features (Table 1). All of these devices test the visual fields of a patient who can respond appropriately. All models in Table 1 are capable of printing the test results obtained.

All ZEISS VF instruments except the FDT have the ability to print or save the image printout separately from the instrument itself via printer, hardware and/or software interfaces. Many are DICOM compliant and capable of network interface, and the ability to move the printout image to an electronic health record (EHR). Please check with the company or their representative for further information and other specifics.

Table 1 **ZEISS Visual Field Instruments**

Model	Maximum Degrees of VF Temporally	Test Options	Methodology	Other Features
Humphrey Field Analyzer 3 Series Exact features vary slightly by model (840, 850, 860) [1]	90º	Full threshold: • 24-2 • 30-2 • 10-2 • Macula • 60-4 • Nasal Step Suprathreshold: • C40 • C64 • C-Armaly • C76 • C80 • Peripheral test pattern Kinetic and Custom Kinetic testing Esterman & Social Security testing • Monocular • Binocular	**Testing:** Threshold Suprathreshold (age-corrected or threshold-related) • SITA™ Standard • SITA Fast • SITA Faster • FastPac • SITA SWAP **Reporting:** Single Field Analysis (SFA) Glaucoma Hemifield Test (GHT) Mixed Guided Progression Analysis (GPA) Serial field overview STATPAC Visual Field Index (VFI)	• Table mount • Video eye and blind-spot monitoring • Head and gaze tracking • Vertex monitoring • Liquid lens correction to minimize trial lens recall issues • Touchscreen CRT and keyboard input • White-on-white, red- or blue-on-white, and blue-on-yellow (SITA-SWAP) stimuli presentation • Foveal threshold testing • Automatic pupil size measurement • Network compatible • Transferability of legacy data from HFA II and HFA II-*i* • DICOM compliant • 500 GB hard drive • USB port

[1] Carl Zeiss Meditec, Inc.. Products. Ophthalmology-Optometry. Glaucoma. Diagnostics. Perimetry. Humphrey Field Analyzer 3. Link here. Accessed 04/20/19.

Table 1 **ZEISS Visual Field Instruments**

Model	Maximum Degrees of VF Temporally	Test Options	Methodology	Other Features
HFA II-*i* Exact features vary slightly by model (740i, 745i, 750i) [2]	89°	Full threshold: • 24-2 • 30-2 • 10-2 • Macula • 60-4 • Nasal Step Suprathreshold: • C40 • C64 • C-Armaly • C76 • C80 • Peripheral test pattern Kinetic testing Custom Testing Superior 36 and Superior 64 testing (eyelids, ptosis) Social Security testing • Monocular • Binocular	**Testing:** Threshold Suprathreshold (age-corrected or threshold-related) • SITA-Standard • SITA Fast • FastPac • SITA SWAP **Reporting:** Single Field Analysis (SFA) Glaucoma Hemifield Test (GHT) Guided Progression Analysis (GPA) Serial field overview STATPAC Visual Field Index (VFI)	• Table mount • Video eye and blind-spot monitoring • Remote video eye monitoring • Head and gaze tracking • Vertex monitoring • Liquid lens correction to minimize trial lens recall issues • Touchscreen CRT and keyboard input • White-on-white, red- or blue-on-white, and blue-on-yellow (SWAP) stimuli presentation • Foveal threshold testing • Automatic pupil size measurement • Network compatible • DICOM compliant • 160 GB hard drive • Capable of integrating with the Cirrus OCT results for a combined structure-and-function report • Capable of data transfer to the Humphrey Field Analyzer 3 model (HFA3)

[2] Carl Zeiss Meditec, Inc.. Products. Ophthalmology-Optometry. Glaucoma. Diagnostics. Perimetry. Humphrey Field Analyzer II-i (HFA II-i). Technical Data. Link here. Accessed 04/20/19.

Table 1 **ZEISS Visual Field Instruments**

Model	Maximum Degrees of VF Temporally	Test Options	Methodology	Other Features
Matrix 800 [3]	30°	FDT Full-threshold: • 24-2 • 30-2 • N-30 • 10-2 • Macula	Frequency-doubling	• Table-top, portable design • Self-contained LCD screen, video eye and blind-spot monitoring • Can use in low ambient light, no need for special dark testing room • Short testing times (~40 seconds per eye) • Patients can use own glasses during testing • Large age-related normative database
FDT [4]	30°	C-20, N-30	Frequency-doubling	• Compact design, small footprint • Low-cost, built-in thermal printer and self-contained LCD screen • Can use in low ambient light, no need for special dark testing room • Short testing times (~40 seconds per eye) • Patients can use own glasses during testing • Large age-related normative database

Figures 1A through 1D show images of these ZEISS VF instrument models. Figure 2A shows a sample FDT printout. Figure 2B shows a sample Humphrey Field Analyzer (HFA) printout. (All images courtesy of ZEISS. Not shown to scale.)

[3] Carl Zeiss Meditec, Inc.. Products. Ophthalmology-Optometry. Glaucoma. Diagnostics. Perimetry. Humphrey Matrix 800. Technical Data. Link here. Accessed 04/20/19.

[4] Carl Zeiss Meditec, Inc.. Products. Ophthalmology-Optometry. Glaucoma. Diagnostics. Perimetry. Humphrey FDT. Technical Data. Link here. Accessed 04/20/19.

Figure 1A **ZEISS Humphrey Field Analyzer 3**

Figure 1B **ZEISS Humphrey Field Analyzer (HFA) II-*i***

Figure 1C **ZEISS Humphrey Matrix 800**

Figure 1D **ZEISS Humphrey FDT**

Figure 2A **ZEISS Humphrey FDT Printout**

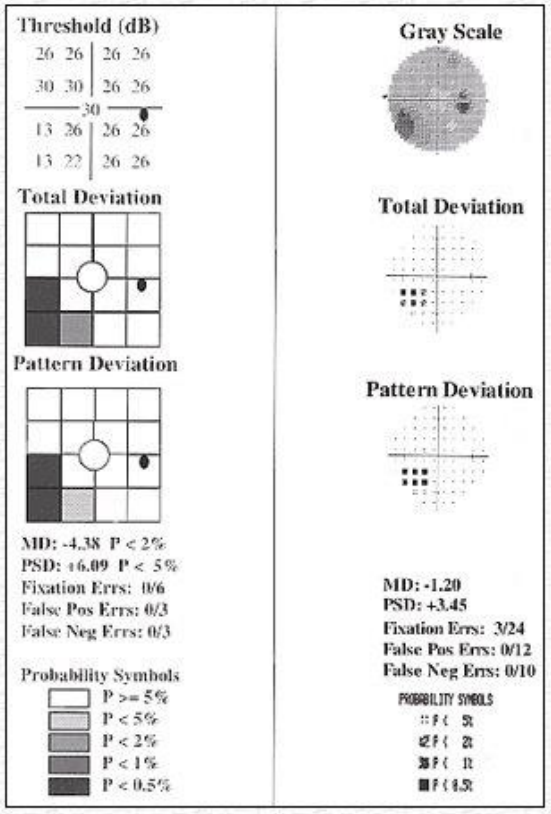
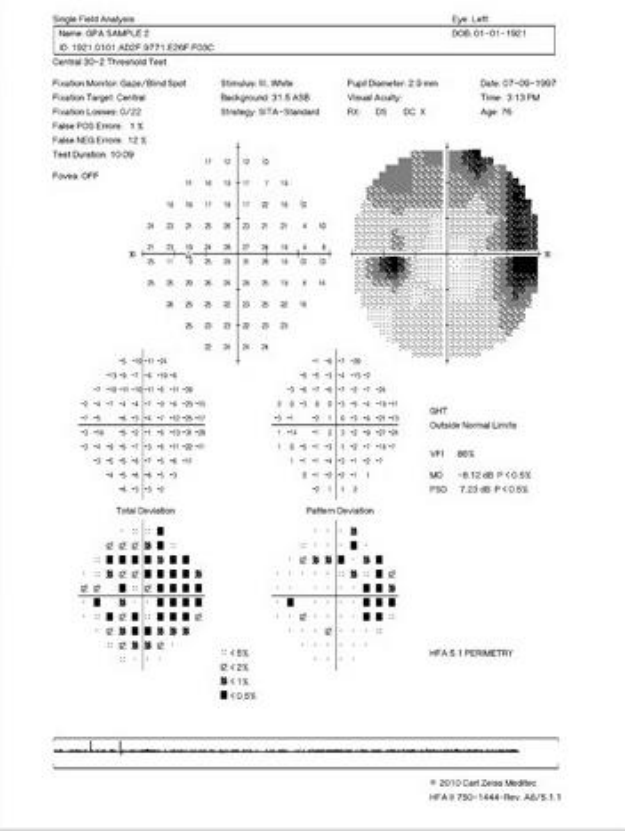


Figure 2B **ZEISS HFA Printout**



COVERAGE GUIDELINES

Medical necessity for diagnostic testing begins with pertinent signs, symptoms, or medical history of a condition for which the examining physician needs further information.

A variety of disease entities justify testing (Table 2).

Table 2 **Common Diagnosis Codes for Visual Fields** [5]

ICD-10	Description
A18.53	Tuberculous chorioretinitis
A18.52-	Syphilitic and neurosyphilitic conditions

[5] 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 issues; the ending "dash" means a longer code is required and contains greater specificity. This list is neither exhaustive nor universally accepted. See your carrier bulletins.

Table 2 **Common Diagnosis Codes for Visual Fields** [5]

ICD-10	Description
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-	Blepharochalsis
H02.4-	Ptosis (various)
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

Table 2 **Common Diagnosis Codes for Visual Fields** [5]

ICD-10	Description
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 as of 10/01/17

** 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 do not agree on a common list of diagnoses for each of these tests. Furthermore, there is variability among payers for the same tests. Careful review of local coverage determinations (LCDs) and private payer policies is necessary.[6,7,8] Not all MACs have current coverage policies for this test, so carefully document the medical rationale for the tests in the medical record in those areas where no active policy exists.

There is a longstanding National Coverage Determination (NCD 80.9)[9] for "Computer Enhanced Perimetry" which notes that "*Computer enhanced perimetry involves the use of a micro-computer to measure visual sensitivity at preselected locations in the visual field*." NCD 80.9 was written long enough ago (1984) that most visual field tests at the time were performed manually, and computer use in perimetry was new. Most VFs now are performed via these computerized instruments except in oculoplastics (*e.g.*, ptosis) and in some other less common situations. NCD 80.9 also notes that within the Medicare program, computerized VF testing "*is a covered service when used in assessing visual fields in patients with glaucoma or other neuropathologic defects*."

Initial diagnostic testing is ordered and performed when the information garnered from an eye exam is insufficient to assess the patient's disease. Medicare covers VF tests as an adjunct to evaluation and management of a known disease. If the test is performed for baseline documentation of a healthy eye it is not covered, but when performed as

6 A representative Visual Fields policy may be found at National Governmental Services, Inc. LCD L33574 on Visual Fields Testing. Rev. Eff. date 10/01/18. Link here. Accessed 04/20/19.

7 Another representative VF policy may be found at First Coast Service Options, Inc. (FCSO). LCD L33766 on Visual Field Examination. Rev. Eff. Date 10/01/18. Link here. Accessed 04/20/19.

8 Another representative VF policy may be found at Wisconsin Physicians Service Insurance Corporation (WPS). LCD L34615 on Visual Fields. Rev. Eff. Date 10/01/18. Link here. Accessed 04/20/19.

9 National Coverage Determination on Intraocular Photography (NCD 80.9). Effective date 02/15/1984. Link here. Accessed 04/20/19.

preventive medicine to screen for certain potential diseases, then there may or may not be coverage, depending on the policy.[10] Importantly, glaucoma suspect is one of these "known diseases" for purposes of coding, coverage, and payment.

National Government Services (NGS), the MAC for a number of states, notes the following for documentation in the chart for VF testing[11] in their LCD #33574: "*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., the MAC for FL, PR, 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 service being billed. In addition, documentation that the service was performed must be included in the patient's … record and available upon request … This information is normally found in the office/progress notes, hospital notes, and/or procedure report … Documentation should support the criteria for coverage …*"

Repeated testing is necessitated by disease progression (identified by examination or other appropriate testing), the advent of new disease, or planning for additional surgical treatment.

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 (directly or indirectly) 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]

---

[10] CFR 411.15(a)(1). Particular services excluded from coverage. Link here. Accessed 04/20/19.

[11] National Governmental Services, Inc. (NGS) LCD L33574 on Visual Fields Testing. Rev. Eff. date 10/01/18. Link here. Accessed 04/20/19.

[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 04/20/19.

FCSO, the MAC for Florida, notes the following in their LCD on Visual Fields[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*."

Screening and Visual Fields

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

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

[13] First Coast Service Options, Inc. (FCSO). LCD L33766 on Visual Field Examination. Rev. Eff. Date 10/01/18. Link here. Accessed 04/20/19.

[14] CFR 410.32 (a). Link here. Accessed 04/20/19.

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 imaging prior to any examination based on information about an individual patient's unique illness, injury, or medical condition provided by another physician, health care professional, or the patient themselves.

DOCUMENTATION

The descriptions in CPT for visual field testing all include the phrase *"with interpretation and report*".[20] What exactly is meant by this phrase, and what kind of chart note is required? This question takes on added urgency since insufficient chart documentation is reason enough to require repayment of any reimbursement.

Medicare Regulations and Guidance

The Medicare guidelines for interpretation of diagnostic tests are discussed in the Medicare Claims Process Manual (MCPM) Chapter 13 §100, Interpretation of Diagnostic Tests.[21] 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.*"

---

15 United States General Accounting Office. Beneficiary Use of Clinical Preventive Services. GAO-02-422. April 2002. Link here. Accessed 04/20/19.

16 Office of Inspector General. Report: St. Francis Hospital, Tulsa, OK. Estimated Medicare Overpayment. February 12, 2002. Link here. Accessed 04/20/2019.

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 04/20/19.

18 CMS. Medicare Benefit Policy Manual, Chapter 15, §80.6.1. Requirements for Orders for Diagnostic Tests- Definitions. Link here. Accessed 04/20/19.

19 Palmetto GBA. Jurisdiction 11 Part B. Orders for Diagnostic Tests. Link here. Accessed 04/20/19.

20 Current Procedural Terminology (CPT) 2019 edition.

21 Medicare Claims Process Manual (MCPM) Chapter 13 §100. Interpretation of Diagnostic Tests. Link here. Accessed 04/20/19.

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,[22] 42 CFR 415.120 (a) states:

> "***(a) Services to beneficiaries.*** *The carrier pays for radiology services furnished by a physician to a beneficiary on a fee schedule basis only if the services meet the conditions for fee schedule payment in § 415.102(a) and are identifiable, direct, and discrete diagnostic or therapeutic services furnished to an individual beneficiary… The carrier pays for interpretations only if there is a written report prepared for inclusion in the patient's medical record …*"

The value of an "interpretation and report" derives from the answers to important questions about the diagnostic test.

- Physician's order – *Why is the test desired?*
- Date performed – *When was it performed?*
- Technician's initials – *Who did it?*
- Reliability of the test – *Was the test of any value?*
- Patient cooperation – *Was the patient at fault?*
- Test findings – *What are the results of the test?*
- Comparison – *How do today's results differ from prior test(s)?*
- Assessment, diagnosis – *What do the results mean?*
- Impact on treatment, prognosis – *What's next?*
- Physician's signature – *Who is the physician?*

In ophthalmology, tests such as visual fields are more valuable for making decisions about treatment when there is a series. Then, the concept of "comparative data" cited above is

[22] Code of Federal Regulations: 42 CFR 415.120(a) Conditions for payment: Radiology services, to beneficiaries. Link here. . Accessed 04/20/19.

particularly meaningful. Does the series demonstrate disease progression? For VF, the "interpretation and report" might read as follows.

- VF for primary open-angle glaucoma
- January 5, 2018
- 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 "Visual Field 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 visual field testing requires only general supervision,[23] 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

[23] 42 CFR 410.32(b)(3)(i). Definition of general supervision. Link here. Accessed 04/20/19.

subsequently withdrawn, yet there is still concern about this topic. As a practical alternative, bill the entire test upon completion after the interpretation is documented in the medical record since it is not clear what diagnosis would be used for the technical component alone.

Payment Considerations

In the Medicare Physician Fee Schedule (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. Visual field 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 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 visual fields 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 visual field 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 visual fields, 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.*"[24]

Automated intermediate VF (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.

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. A physician's order in the medical record and written interpretation are required.

Of note, 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 eye exams. As such, it is a component of the exam and not separately reimbursed.

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

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

Example 1 Open-angle glaucoma - Exam with VF alone

During dilated fundus exam of the posterior pole with binocular indirect ophthalmoscopy, changes in the optic nerve cup:disc ratio and a small Drance hemorrhage was noted in each eye at the disc margin. You order VF OU to establish a baseline for possible glaucomatous damage and to permit re-evaluation later to monitor for change. Your impression of the VF notes mild stage 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

One year later, the patient is seen and no change in the cupping is noted on the dilated fundus examination when comparing it to the exam from the prior year. Even if there is an OCT (SCODI) of the optic nerve present in the chart, repeating the VF is acceptable since neither the physician nor the optic nerve OCT "sees" the field damage the way that a VF may be able to.

Example 2 Open-angle glaucoma – Exam with VF and fundus photography

Your 74 y/o established Medicare patient with mild stage 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 notes she hasn't been able to use the prescribed anti-glaucoma medication as often as desired. As a result, you order and perform both fundus photography and VF today OU. The visual field damage has progressed to moderate-stage in each eye. In addition to the exam (shown as 9xxxx), the claim will read as follows.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. H40.1132 B. 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: Code the stage based on the stage of the disease as it exists following testing since that is part of today's Impression and Plan on exam.

Example 3 Blepharoptosis – Exam and VF

You are an oculoplastics specialist consulted by another eyecare provider concerning a 78 y/o woman with droopy lids that affect her lifestyle. Your exam identifies both ptosis and dermatochalasis of both upper lids. You order VF testing with untaped and taped results (taped VF are performed in the desired post-operative position) and document your findings in your report today. The patient meets coverage criteria based on the current local LCD. You diagnose mechanical ptosis and dermatochalasis and recommend surgery at a later date. 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. H02.413 B. H02.831 C. H02.834 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		92081		A, B, C	xxx xx	1		NPI	1234567890

Note: The mechanical ptosis code has an option for "bilateral" but dermatochalasis does not and must be coded for each side.

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),[25] 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 same day by the same physician or group. The list of tests[26] includes ultrasounds, imaging, and visual fields. 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 and threshold visual field 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.

---

[25] CMS. Medicare Learning Network, MLN Matters MM7848, Eff. January 1, 2013. Link here. Accessed 04/20/19.

[26] 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 04/20/19.

Test	Professional	Technical	Total
92083 Visual Field	$28.15	$36.09 (No reduction)	$64.24
92250 Fundus Photo	$22.01	$23.82 less $4.76 (20%) = $19.06	$41.07

2020 National Medicare Physician Fee Schedule, PAR allowable

Financial Waivers

An Advance Beneficiary Notice of Non-Coverage (ABN, CMS-R-131)[27] 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 applies to both assigned and non-assigned claims. By signing an ABN, the Medicare beneficiary acknowledges that he or she has been advised that Medicare will not pay and agrees to be responsible for payment, either personally or through another insurance plan. For an ABN to have any utility, it must be signed before providing the item or service.

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.

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.

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.

[27] Advance Beneficiary Notice of Noncoverage. Link here. Accessed 04/20/19.

The beneficiary must *personally* choose from Option 1, 2 or 3.

- 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 file 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; you are not required to file a claim. If the beneficiary chooses Option 3, there is no claim to file or charge to make; the service is not provided because the patient declines.

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,[28] 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.

In CMS Transmittal R1921CP,[29] effective April 1, 2010, two modifiers were updated to distinguish between *voluntary* and *required* use of liability notices.

- Modifier GA is now defined as "Waiver of Liability Statement Issued as Required by Payer Policy". It applies when you believe Medicare will consider a service not medically necessary in a particular situation. Ask the patient to sign an ABN and submit your claim with modifier GA, allowing the payer to decide if the service is covered.

---

[28] CMS. Medicare Learning Network, MLN Matters MM6136. Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage. Link here. Accessed 04/20/19.

[29] CMS. Transmittal R1921CP. Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs). February 19, 2010. Link here. Accessed 04/20/19.

- Modifier GX is defined as "Notice of Liability Issued, Voluntary Under Payer Policy". It applies when a service is always noncovered; it addresses the fact that most beneficiaries will elect Option 1 in the hope that Medicare might pay, despite your assurances to the contrary. Therefore, if the patient selects Option 1, append modifiers GX and GY to that claim to obtain a denial.
- 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)[30] to control improper coding leading to inappropriate payments in Part B claims.[31] NCCI consists of a series of edits to analyze codes reported on claims for reimbursement. They ensure the most comprehensive groups of codes are billed rather than the component parts; this is the concept informally known as "bundles". Additionally, the edits check for mutually exclusive code pairs – procedures that are medically incompatible – so just one of the pair may be reimbursed. New edits are published quarterly by the National Technical Information Service (NTIS). Some carriers have also published local policies with additional limitations. Of note, you may not use an ABN to circumvent the NCCI edits.

The current NCCI edits for visual fields 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.

---

[30] CMS. National Correct Coding Initiative Edits. Link here. Accessed 04/20/19.

[31] Medicare Claims Processing Manual, Chapter 23, §20.9. Correct Coding Initiative. Link here. Accessed 04/20/19.

Table 3 **NCCI Edits** [32]

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]

Note: NCCI edits in effect as of January 1, 2020.

Purchased Diagnostic Tests / Anti-Markup Rule

If you order and bill for a test and either the technical component or the professional interpretation is performed by another physician, you may be prohibited from marking up the test (*i.e.*, receiving payment from Medicare in excess of the amount you paid to the physician who performed the technical component or professional interpretation) unless the physician who performs the test "shares a practice" with you.[33] 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 and was formerly known as the Purchased Diagnostic Test Rule.

If the Medicare Anti-Markup Rule applies because the performing physician is not deemed to share a practice with the billing physician, the payment to the billing physician (less the applicable deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the technical component or the professional component of the diagnostic test may not exceed the lowest of the following amounts:

- The performing supplier's net charge to the billing physician or other supplier;
- The billing physician or other supplier's actual charge; or
- The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

For further information about the Medicare Anti-Markup Rule and the "sharing a practice" criteria, please refer to CMS instructions.[34]

---

[32] 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.

[33] CMS. Medicare Learning Network, MLN Matters MM6371, July 1, 2009. Link here. Accessed 04/20/19.

[34] Medicare Claims Processing Manual, Chapter 1, Section 30.2.9. Link here. Accessed 04/20/19.

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.

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 claims paid in 2017 show that VFs collectively (92081, 92082, 92083) were associated with 11% of all office visits by ophthalmologists. That is, for every 100 exams performed on Medicare beneficiaries, Medicare paid for one of these services 11 times. For optometrists, the utilization rate is 9%. 92083 accounts for the vast majority of VF claims, followed by 92081; 92082 is the least common.

PAYMENT LEVELS

Medicare defines CPT codes 92081, 92082, and 92083 as bilateral so reimbursement is for

both eyes in nearly all cases.[35] The 2019 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 [36]
92081	VF, Basic	Global	$34.29	$32.57	$37.46
		TC	$17.68	$16.80	$19.32
		PC	$16.60	$15.77	$18.14
92082	VF, Intermediate	Global	$48.36	$45.94	$52.83
		TC	$26.35	$25.03	$28.78
		PC	$22.01	$20.91	$24.05
92083	VF, Extensive	Global	$64.24	$61.03	$70.18
		TC	$36.09	$34.29	$39.43
		PC	$28.15	$26.74	$30.75

CONCLUSION

Unlike confrontation fields, which are a part of an exam, formal visual field testing provides the opportunity for intensive study of abnormalities, as well as subsequent use as a benchmark for monitoring subtle changes that allow for better disease management in a number of ophthalmic conditions. The results also have utility for people other than the examining physician. 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 low vision providers who teach mobility.

---

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

[36] 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 here. Accessed 04/20/19.

Some applications of visual fields, particularly screening, are not covered by Medicare and most other third party payers. For covered services, documentation of the physician's order and interpretation are crucial; where it is abbreviated or missing, reimbursement is jeopardized.

This discussion is meant to assist the reader to better understand the rules and regulations regarding reimbursement for visual fields testing, 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.
- Coding for laterality and staging was added to some of the common eye conditions in the ICD-10-DM codes effective October 1, 2016. Instructions for other, less commonly used, codes (H42 and the Low Vision and Blindness area, H54.-) also changed on October 1, 2017.
- 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 these tests is subject to Medicare's MPPR rules. When performed concurrently 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.