Reimbursement Guidelines for Scanning Computerized Ophthalmic Diagnostic Imaging

Prepared for

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Reimbursement Guidelines for Scanning Computerized Ophthalmic Diagnostic Imaging

by

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Objective: *This report is provided as a general discussion of Medicare reimbursement for anterior and posterior scanning computerized ophthalmic diagnostic imaging and related issues. Local variations between Medicare administrative contractors may occur which are not described here. The user is strongly encouraged to review official instructions promulgated by the Centers for Medicare and Medicaid Services (CMS) and its contractors; this document is not an official source nor is it a complete guide on all matters pertaining to reimbursement. In addition, users should check local coverage policies for usage guidelines for the services discussed.*

This discussion is intended to assist the reader to better understand the rules and regulations regarding scanning computerized ophthalmic diagnostic imaging, however the responsibility for appropriate usage, adequate documentation, and proper coding are always the physician's.

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Disclaimer: *The reader is reminded that this information can and does change over time, and may be incorrect at any time following publication.*

INTRODUCTION

This monograph describes reimbursement for scanning computerized ophthalmic diagnostic imaging including both posterior segment testing (SCODI-P) and anterior segment testing (SCODI-A).[1]

Much of the information is taken from official publications of the Medicare program. However, the reader is encouraged to check with the local carrier for additional information and instructions. In the case of other third party payers, we have used the coding concepts contained in CPT and published by the American Medical Association; diagnosis codes are from ICD-9-CM. Documentation of the test, and the medical rationale for it, are key to reimbursement so we describe the required elements in detail.

Since economic analyses are a necessary part of any capital budgeting decision, we incorporated Medicare's 2009 payment rates for SCODI-P, as well as utilization rates. As yet, no payment rates or utilization data exists for SCODI-A.

THE DEVICE

At this time, eye care professionals can choose between a number of devices to perform SCODI including RTVue from Optovue, Inc. The special features and benefits of the RTVue and its suite of options include:

- Performs SCODI-P and SCODI-A using Fourier/spectral domain OCT,
- High-speed and high-resolution,
- Pharmacological dilation is not required,
- Serial registration allows progression and change analysis,
- Infra-red fundus imaging without a flash or visible light to irritate patients' eyes.

[1] For additional information about reimbursement for fundus photography, anterior segment photography, gonioscopy, pachymetry and other allied tests, contact Corcoran Consulting Group at (800) 399-6565 or help@www.corcoranccg.com

INDICATIONS FOR SCODI-P

Medicare covers SCODI for the posterior segment if the patient presents with a complaint that leads you to perform this test or as an adjunct to management and treatment of a known disease. A variety of disease entities justify testing with SCODI-P (Figure 2). Many Medicare coverage policies for SCODI-P focus on indications for the diagnosis and management of early glaucoma however it is also an important tool in detection and monitoring of diseases of the retina and choroid.

It is important to note that Medicare's Administrative Contractors (MACs) and other third party payers do not all agree on a common list of diagnoses or technologies. Careful review of local coverage policies is necessary. A representative policy is included in the Appendix.

Figure 1 **RTVue**

If your MAC does not include a particular indication in its local coverage determination policy (LCD), claims for that indication may be denied. Also, if the images are taken as baseline documentation of a healthy eye or as preventative medicine to screen for potential disease, then it is not covered (even if disease is identified).

Figure 2 **Common ICD-9 Diagnosis Codes for SCODI-P (92135)**

190.8	Neoplasm
191.0-198.3	Neoplasm
224.5-224.6	Neoplasm
228.03	Neoplasm
361.00-360.19	Retinal detachment
361.30-361.33	Retinal defect
361.81	Retinal detachment
362.01-362.02	Diabetic retinopathy
362.10-362.18	Retinopathy, vascular changes
362.21-362.29	Proliferative retinopathy
362.31-362.37	Vascular occlusion
362.40-362.43	Retinal separation
362.50-362.57	Macular degeneration
362.81-362.82	Retinal hemorrhage
363.00-363.35	Chorioretinal disease
363.43	Choroidal disease
363.63	Choroidal disease
363.70-363.72	Choroidal detachment
364.22	Iridocyclitis
364.53	Iris degeneration
364.73	Anterior synechiae
364.77	Angle recession
367.74	Papillary membranes
368.40-368.47	Visual field defect
376.00-376.9	Orbital disease
377.00-377.04	Papilledema
377.10-377.16	Optic atrophy
377.21-377.24	Optic disc disease
377.41-377.49	Optic neuropathy
377.51-377.54	Optic chiasm disease
377.61-377.75	Other disorders
377.9	Other disorders
379.11-379.19	Scleral disease
379.21-379.29	Vitreous disorders
743.57-743.59	Congenital disease
854.0-854.1	Intracranial injury
921.3	Contusion

NOTE: Listed codes are representative of covered diagnoses but differences in payment policies exist for many payers. This list is neither exhaustive nor universally accepted.

INDICATIONS FOR SCODI-A

There are many indications for SCODI of the anterior segment including: assess corneal flap thickness and residual stromal thickness following LASIK, measure corneal thickness, visualization of IOLs and other implants in the anterior segment, evaluation of anterior segment ocular structures, measurement of anterior chamber angles, anterior chamber depth and anterior chamber diameter. As mentioned above, Medicare and other third party payers do not agree on coverage policy; some of the indications described above might not be covered. It is essential that the reader check the local coverage policy (if any) for specific guidance. A representative policy is included in the Appendix.

Figure 3 **Common ICD-9 Diagnosis Codes for SCODI-A (0187T)**

190.0	Malignant neoplasm
190.4	Malignant neoplasm
224.0	Benign neoplasm
224.4	Benign neoplasm
364.51-364.59	Degeneration of iris, ciliary body
364.60-364.64	Cysts of iris, CB, AC
364.70-364.77	Adhesions of iris, CB
364.81-364.82	Iris syndrome
364.89	Other disorders of iris, CB
365.02	Narrow angle glaucoma
365.20-365.24	Angle closure glaucoma
365.41-365.44	Other glaucoma
365.51-365.59	Glaucoma associated with lens
365.60-365.65	Other glaucoma
365.81-365.89	Other glaucoma
370.04-370.06	Corneal ulcer
371.03	Opacity of cornea
371.71-371.73	Corneal deformity
379.31	Aphakia
379.33	Dislocation of lens
996.51	Complication of corneal graft
996.53	Complication of IOL
996.69	Reaction to implant, graft

NOTE: Listed codes are representative of covered diagnoses but differences in payment policies exist for many payers. This list is neither exhaustive nor universally accepted.

BILLING ISSUES

Procedure Codes

The AMA revised CPT code 92135 in 2008. It now reads: *"Scanning computerized ophthalmic diagnostic imaging, posterior segment (e.g., scanning laser with interpretation and report, unilateral)"*. The words "posterior segment" were added in January 2008 when Category III CPT code 0187T (S*canning computerized ophthalmic diagnostic imaging, anterior segment with interpretation and report, unilateral*) was introduced.

CPT contains Category III emerging technology codes which allow the collection of data on new services and procedures that would otherwise be treated as unlisted or miscellaneous. Category III codes are probationary – they expire in five years if the procedure is not elevated to a Level 1 code through widespread adoption and recognition. The assignment of a Category III code does not mean that the service or procedure is endorsed, approved, safe or has applicability to clinical practice. The utility of a new procedure only becomes known with experience, time and careful study. Pronouncements of this sort appear in peer-reviewed scientific journals, not in CPT.

Modifiers

The following modifiers may be applicable on claims for SCODI.

26 ………. Professional component of a diagnostic test

AQ ……… Services provided in a 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*)

RT or LT ... Right or Left eye

TC ……… Technical component of a diagnostic test

Claims Processing Tips for SCODI (P or A)

When submitting claims for reimbursement, the following guidelines apply.

- Make a separate charge for each eye when both eyes are tested and both tests are medically necessary. Otherwise, don't assume that testing OU is necessary.
- Notify the patient, prior to testing, of financial responsibility if the test is to screen for possible disease, routine, or otherwise not covered by insurance, and document acceptance on the Advance Beneficiary Notice of Noncoverage form for Medicare beneficiaries or Notice of Exclusion from Health Plan Benefits for other beneficiaries (see Appendix).
- Use the ordering physician's NPI.
- Pay attention to Medicare's NCCI edits. They change quarterly and describe bundles and mutually exclusive codes.
- Retain original printouts with the physician's interpretation in the patient's medical record.
- Some conditions warrant repeat testing to assess progressive disease or worsening of the condition. Schedule repeat tests only when the required information cannot be obtained through clinical exam alone. Clearly document the rationale for repeat services.

Sample Claims

Example 1

A 60 year old male patient with poorly controlled chronic open angle glaucoma returns for reevaluation. SCODI-P was ordered OU to assess changes in the morphology of the optic disk and associated nerve fiber layer. The claim will read as follows:

17 J. Jones, MD		17a 17b 12345678			
21 1. 365.11					
24a	24b	24d	24e	24f	24g
mm/dd/yyyy	11	92135 RT	1	xxx.xx	1
mm/dd/yyyy	11	92135 LT	1	xxx.xx	1

Example 2

A 76 year old female patient, who complains of decreased vision in her left eye, appears to have a macular hole or pseudohole. SCODI-P was ordered OS to aid the differential diagnosis. The claim will read as follows:

17 J. Jones, MD		17a 17b 12345678			
21 1. 362.54					
24a	24b	24d	24e	24f	24g
mm/dd/yyyy	11	92135 LT	1	xxx.xx	1

Example 3

A 50 year old male patient with anatomically narrow angles returns for reevaluation. SCODI-A was ordered OU to assess disease progression and plateau iris syndrome was identified. The claim will read as follows:

17 J. Jones, MD		17a 17b 12345678			
21 1. 364.82					
24a	24b	24d	24e	24f	24g
mm/dd/yyyy	11	0187T RT	1	xxx.xx	1
mm/dd/yyyy	11	0187T LT	1	xxx.xx	1

Example 4

A 44 year old female patient with an iris nevus OS returns for reevaluation. Following slit lamp biomicroscopy where the physician noted some pigment changes in the nevus, SCODI-A was ordered OS to assess any changes to the size, shape and elevation of the nevus; minimal changes were found. The claim will read as follows:

17 J. Jones, MD		17a 17b 12345678			
21 1. 224.0					
24a	24b	24d	24e	24f	24g
mm/dd/yyyy	11	0187T LT	1	xxx.xx	1

Reimbursement Pitfalls

- New technology is often met with objections by payers as experimental, investigational, or not the standard of care. Only a few payers have established policies concerning SCODI-A so coverage is uncertain. Where no local coverage policy exists, obtain a signed ABN or NEHB prior to performing this test based on the likelihood that this service will be treated as "experimental and investigational" and noncovered.
- Some payers are unfamiliar with these services and request additional information.
- A few payers (not Medicare) have established policies that bundle SCODI-P with B-scan and extended ophthalmoscopy.
- Concurrent testing of SCODI-P with visual fields is viewed unfavorably by some (but not all) payers.
- Frequency of repeat testing is an important concern and requires appropriate medical necessity documentation. Once or twice per year is the norm for SCODI-P where the indication is glaucoma. Retinal or choroidal disease may require much more frequent testing with SCODI-P.
- High utilization of SCODI-P relative to other physicians in the community is likely to garner attention.
- In several states, some optometrists are not licensed or have limited licenses to treat glaucoma. Payers in those states might not reimburse those optometrists for diagnostic testing of glaucoma.

Advance Beneficiary Notice of Noncoverage

An ABN is a written notice a physician, or other provider, gives to a Medicare beneficiary before items or services are furnished when the physician believes that Medicare probably will not pay for some or all of the items or services.

In June, 2002, CMS published an official ABN

form (CMS-R-131-G) which was mandated by HIPAA (PM AB-02-114). A revised ABN (CMS-R-131) became available in March 2008. The revised ABN replaces the existing ABN-G (Form CMS-R-131G) and ABN-L (Form CMS-R-131L). It may also be used in lieu of the NEMB (Form CMS-20007). All providers must begin using the revised ABN no later than March 1, 2009. (See Appendix for sample form)

An ABN is required for both assigned and non-assigned claims. Submit your claim with modifier GA appended to the appropriate CPT or HCPCS code.

By signing an ABN, the Medicare beneficiary acknowledges that he or she has been advised that Medicare will probably or certainly not pay, and agrees to be responsible for payment, either personally or through other insurance. Medicaid qualifies as "other insurance" so get an ABN even for dual-eligible patients.

The ABN must be signed before you provide the items or services. Keep the original in your file and provide a copy to the patient. The "Estimated Cost" field, formerly optional, is now required. The patient must *personally* choose from Option 1, 2 or 3. The patient must *sign* and *date* the form; an unsigned form is not valid. Without the Medicare beneficiary's advance acceptance of financial responsibility, you will be required to refund any payment you collected for non-covered services.

You do not need an ABN for services that are statutorily (by law) non-covered by Medicare. Statutorily non-covered services in an eye care practice include refractions, as well as cosmetic surgery and the associated testing. A Notice of Exclusions from Medicare Benefits (NEMB) form notifies the beneficiary that this service is non-covered, and that the patient will be responsible for the charges associated with the procedure. For non-Medicare beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) serves the same purpose (see Appendix for a sample form). By signing a form, the beneficiary accepts financial responsibility.

Practice Management Tips

- For any covered test, get a physician's order with appropriate medical rationale before providing the service.
- Document the physician's interpretation of the diagnostic test within a short time, generally within 72 hours. Be sure to address the quality of the test, the findings and the assessment. Sign the note.
- Differentiate covered and non-covered testing based on the reason for the service.
- Screening or testing on the basis of standing orders are non-covered. Obtain patients' acceptance of financial responsibility for non-covered services in writing (*i.e.,* ABN or similar notice).
- Watch that repeated testing is merited due to disease progression.
- Monitor NCCI edits on a quarterly basis.
- Check your Local Coverage Determination (LCD) for specific guidance in your area. Investigate the policies of other third party payers as well.
- Place a note in the medical record that identifies where digital test results are stored.
- 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 - then get assistance with the arcane rules associated with purchased diagnostic tests.

Prohibited Code Combinations

The Centers for Medicare and Medicaid Services (CMS) instructs the Medicare carriers to treat some concurrent procedures as a "bundle" for payment purposes. This means that no separate payment is made for the test outside of the bundled procedure. In addition, some procedures are considered "mutually exclusive" with others. This means that, when two procedures or tests are performed on the same day on the same patient, only one of the

procedures will be paid; generally the one of lesser value. The National Correct Coding Initiative (NCCI) is the regulation that updates these payment rules, usually on a quarterly basis. Some carriers have also published local policies with additional limitations. You may not use an ABN to circum-vent the NCCI edits.

SCODI-A is bundled with SCODI-P when performed on the same day; only SCODI-P will be reimbursed if both are billed.

Fundus photography (92250) is considered mutually exclusive with SCODI-P (92135). This means that you will be paid for the fundus photos instead of the SCODI-P if both are performed and billed on the same day.

Since the April 2003 edition of the NCCI edits, minimal eye exams (99211) performed by a medical assistant or technician are bundled with concurrent diagnostic tests. Examinations or consultations by a physician on the same day as a diagnostic test are not bundled.

Purchased Diagnostic Tests

In some instances, the physician may have access to this instrument but may not own it, or may not employ a skilled technician to operate it. Under the Medicare physician fee schedule, reimbursement for some tests is subdivided into a technical component (*i.e.,* the test itself) and a professional component, which is the physician service associated with the test. In the situation where a) a physician does not own a specialized diagnostic instrument and/or b) the physician doesn't employ a technician to operate the device, different reimbursement issues exist. Note that a written rental agreement or lease arrangement qualifies as "ownership" of the equipment.

If another entity provides either the equipment or the operator, or both, the physician (or the physician's medical group) can charge for the technical component by following these criteria.

1) The purchasing physician or group may not "mark up" the "purchase price" of the test.
2) The purchaser must perform the interpretation.
3) The physician or other supplier that furnished the technical component must be enrolled in the Medicare program. No formal reassignment is necessary.
4) The "purchase price" cannot be based on volume, (*i.e.,* "a volume discount").
5) The purchaser must accept the lowest of the following as full payment for the test even if assignment is not accepted:
    a) the Medicare fee schedule amount for the technical component,
    b) the physician's actual charge, or
    c) the supplier's net charge to the purchasing physician.

To submit a claim for a purchased diagnostic test, Box 20 of the CMS-1500 claim form must be completed when the diagnostic test is subject to purchase price limitations (i.e., those with a technical component). The purchase price under charges must be shown if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates that "no purchased tests are included on the claim." When "yes" is annotated, item 32 must be completed with the supplier's name, address, zip code and NPI (PIN). When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form. As an alternative arrangement, the ordering physician may claim reimbursement for the professional component alone, and ask the performing physician or supplier to bill for the technical component.

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. A 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 tests in Example 1 above had been performed in a HPSA not receiving automatic bonus payments, then the claim would read as follows:

17 J. Jones, MD		17a / 17b 12345678			
19					
21 1. 365.11					
24a	24b	24d	24e	24f	24g
mm/dd/yyyy	11	92135 AQRT	1	xxx.xx	1
mm/dd/yyyy	11	92135 AQLT	1	xxx.xx	1

DOCUMENTATION

Chart documentation should include the following elements:

- an order for the test, with medical rationale, per eye
- the date of the test(s)
- the reliability of the test(s)
- the test results (*i.e.,* printout) and findings (*e.g.,* cupping of optic disc) per eye
- a diagnosis (if possible) per eye
- the impact on treatment and prognosis
- the signature of the physician

The order for SCODI-A and SCODI-P should be made by the treating physician. The interpretation may be written directly on the printout or elsewhere in the clinical record, although it should be readily identifiable as the test interpretation and not part of an exam. Figure 4 is a form that may be used for interpreting SCODI.[2]

Figure 4 **Interpretation Report**

☐ SCODI-P ☐ OU ☐ OD ☐ OS
☐ SCODI-A ☐ OU ☐ OD ☐ OS

Indication: ______________________________

Technician Comments:

Date Performed _________ Performed By:____________

Reliability: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Patient Cooperation: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Physician Interpretation:

Test Results: OD_______________OS_______________

Diagnosis: OD__________________OS_______________

Impact on Treatment/Prognosis: ______________________

____

Physician Signature Date

SUPERVISION

As of July 1, 2001, Medicare's supervision rules for many ophthalmic diagnostic tests changed. 92135 now 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 (CFR 410.32 (b)(3)(i)).

[2] A template form for interpreting ophthalmic diagnostic tests is available, at no charge, on our website at www.corcoranccg.com

There is no supervision policy published for SCODI-A. In our opinion, it seems reasonable to use general supervision since 92135 falls under that requirement.

PAYMENT LEVELS

CPT code 92135 is defined as unilateral so reimbursement is for each eye when the test is medically necessary. The 2009 national Medicare Physician Fee Schedule allowable is $42.20. The amount is adjusted in each area by local indices. Other payers set their own rates, which may differ significantly from the Medicare published fee schedule.

Table 2 **Medicare National Payment Rates**

Code	PAR	Non-PAR	Limiting Charge *
92135	$42.20	$40.09	$46.10
92135-TC	$24.17	$22.96	$26.40
92135-26	$18.03	$17.13	$19.70

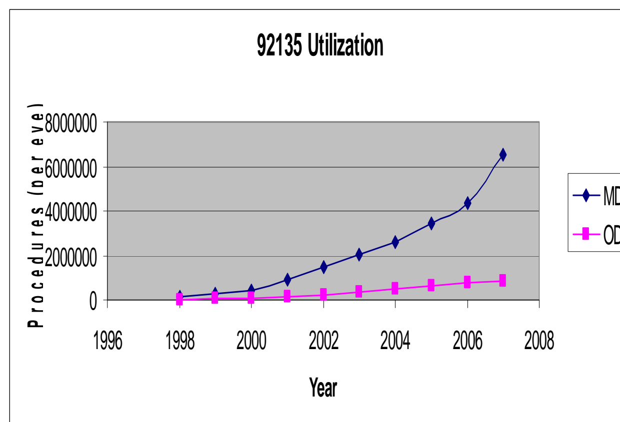
* Limiting charge for non-participating physicians

No Medicare payment rates are established for 0187T. Claims are processed individually.

UTILIZATION

Since 1999, Part B Medicare has paid claims for 92135 in ever-increasing numbers (Figure 5). This expanding utilization coincides with the rapid adoption of this new technology by ophthalmologists and optometrists. We expect this geometric growth to continue because many eye care professionals are only now purchasing this equipment, as well as the increased utilization for retina indications.

Figure 5 **Utilization of 92135**



According to the most recent CMS utilization data available for the Medicare Part B program (2007), this procedure is performed by ophthalmologists about 5.6 million times per year, or about 26 times per 100 eye exams. Optometrists performed the procedure about 863 thousand times per year or about 12 times per 100 eye exams. Commercial utilization rates are not readily available.

The new code, 0187T for anterior segment SCODI, was only established in 2008 so utilization data is not yet available.

CONCLUSION

SCODI-P has become the most popular diagnostic test in ophthalmology and its use is expanding. It also serves as an excellent example of the advancement in the practice of medicine due to new technology as well as the development of new payment policies to address it. SCODI-A is an emerging technology not yet widely used.

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

APPENDIX

Sample ABN FORM

Print your name, address and telephone number. Logo is optional.

Patient's Name: Patient ID:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items or services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

Items or Services	Reason Medicare May Not Pay:	Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.
- Choose an option below about whether to receive the ____________________ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

[ ] **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.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227 / **TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566

Sample NEHB Form

(Customize top of form with name, address & phone) (Provide 1 copy to patient; keep original in your files.)

Patient's Name:

NOTICE OF EXCLUSION FROM HEALTH PLAN BENEFITS

You need to make a choice about having your eyes evaluated with scanning computerized ophthalmic diagnostic imaging (SCODI). This service is not a covered benefit and consequently your health plan will not pay for it. When you receive a service that is not a covered benefit, you are responsible to pay for it.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully. ***Ask us to explain, if you don't understand why your health care service plan won't pay for SCODI.***

Your doctor has recommended SCODI because ____.

You are responsible for all of the fees associated with a non-covered service. The charge for the surgeon's professional fee is $______ and the charge for hospital facility fee (if applicable) is $_______.

Beneficiary Agreement	
Accordingly, the undersigned accepts full financial responsibility for the non-covered services described above.	
______________________________________ Signature of patient or person acting on patient's behalf	______________________ Date

Representative Local Policy

LOCAL COVERAGE DETERMINATION

LCD for Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) (L28488)

Contractor Information

Contractor Name

National Government Services, Inc.

Contractor Number

Number	Type	State(s)
00130	FI	IN
00131	FI	IL
00160	FI	KY
00180	FI	ME
00181	FI	MA
00270	FI	NH, VT
00332	FI	OH
00450	FI	WI
00452	FI	MI
00453	FI	VA, WV
00630	Carrier	IN
00660	Carrier	KY
13101	MAC	CT – Part A
13102	MAC	CT – Part B
13201	MAC	NY – Part A
13202	MAC	NY – Part B
13282	MAC	NY- Part B
13292	MAC	NY – Part B

Contractor Type

Carrier
Fiscal Intermediary
MAC - Part A
MAC - Part B

LCD Information

LCD ID Number

L28488

LCD Title

Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

Contractor's Determination Number

L28488

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CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

<u>Title XVIII of the Social Security Act (SSA):</u>

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

<u>Code of Federal Regulations:</u>

42 CFR, Section 410.32, indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements).

<u>CMS Publications:</u>

CMS Publication 100-03, *Medicare National Coverage Determinations Manual, Chapter 1:*

80.6 Intraocular Photography
80.9 Computer Enhanced Perimetry
140.5 Laser Procedures
220.1 Computerized Tomography

Primary Geographic Jurisdiction

Number	Type	State(s)
00130	FI	IN
00131	FI	IL
00160	FI	KY
00180	FI	ME
00181	FI	MA
00270	FI	NH, VT
00332	FI	OH
00450	FI	WI
00452	FI	MI
00453	FI	VA, WV
00630	Carrier	IN
00660	Carrier	KY
13101	MAC	CT – Part A
13102	MAC	CT – Part B
13201	MAC	NY – Part A
13202	MAC	NY – Part B
13282	MAC	NY- Part B
13292	MAC	NY – Part B

Oversight Region

Region I, II, III, V

Original Determination Effective Date

For services performed on or after 01/01/2009

Original Determination Ending Date

Not applicable

Revision Effective Date

For services performed on or after 01/01/2009

Revision Ending Date

Not applicable

Indications and Limitations of Coverage and/or Medical Necessity

Abstract:

Glaucoma is a leading cause of blindness, and a disease for which treatment methods clearly are available and in common use. Glaucoma also is diagnostically challenging. Almost 50% of glaucoma cases remain undetected.

Elevated intraocular pressure is a clear risk factor for glaucoma, but over 30% of those suffering from the disease have pressures in the normal range. Further, most patients having abnormally high pressures will never suffer glaucomatous damage to their vision. Scanning computerized ophthalmic diagnostic imaging (SCODI) allows for early detection of glaucomatous damage to the nerve fiber layer or optic nerve of the eye. It is the goal of these diagnostic imaging tests to discriminate among patients with normal intraocular pressures (IOP) who have glaucoma, patients with elevated IOP who have glaucoma, and patients with elevated IOP who do not have glaucoma. These tests can also provide precise methods of observation of the optic nerve head and can more accurately reveal subtle glaucomatous changes over the course of follow-up exams than visual field and/or disc photos. This can allow earlier and more efficient treatment of the disease process.

Retinal disorders are the most common causes of severe and permanent vision loss. Scanning computerized ophthalmic diagnostic imaging (SCODI) is a valuable tool for the evaluation and treatment of patients with retinal disease, especially macular abnormalities. SCODI is able to detail the microscopic anatomy of the retina and the vitreo-retinal interface. SCODI is useful to measure the effectiveness of therapy, and in determining the need for ongoing therapy, or the safety of cessation of that therapy.

Many forms of scanning computerized ophthalmic diagnostic imaging tests currently exist (e.g., confocal laser scanning ophthalmoscopy [topography], scanning laser polarimetry, optical coherence tomography [OCT], and retinal thickness analysis). Although these techniques are different, their objective is the same. Medicare will consider scanning computerized ophthalmic diagnostic imaging (SCODI) medically reasonable and necessary in evaluating retinal disorders and glaucoma as documented in this local coverage determination (LCD).

Indications and Limitations:

Glaucoma

Glaucoma commonly causes a spectrum of related eye and vision changes, including erosion of the optic nerve and the associated retinal nerve fibers, and also loss of peripheral vision. A diagnosis of glaucoma seldom is made on the basis of a single clinical observation, but instead relies upon analysis of an assemblage of clinical data, including: optic nerve, retinal nerve fiber, and anterior chamber structure, as well as looking for hemorrhages of the optic nerve, pigment in the anterior chamber, and, especially visual field loss. Each of these methods has its own strengths and limitations, and none is immune to error -- thus the dependence upon multiple observations. Careful reliance upon all available clinical data can allow early treatment and can prevent unnecessary end-stage therapies.

SCODI allows earlier detection of those patients with normal tension glaucoma and more sophisticated analysis for ongoing management. This technology can distinguish patients with glaucomatous damage irrespective of the status of intraocular pressure. It may separate patients with elevated intraocular pressure and early glaucoma damage from those without glaucoma. This allows early treatment of the disease, preventing unnecessary medical or surgical therapy.

The following codes would generally not be necessary with SCODI. When needed the same day, documentation must justify the procedures.

- 92250 - Fundus photography with interpretation and report
- 92225 - Ophthalmoscopy, extended with retinal drawing (e.g., for retinal detachment, melanoma) with interpretation and report; initial
- 92226 - Subsequent ophthalmoscopy
- 76512 - B-scan (with or without superimposed non-quantitative A-scan)

Scanning computerized ophthalmic diagnostic imaging is not considered medically reasonable and necessary

when performed to provide additional confirmatory information regarding a diagnosis or treatment which has already been determined. However, the physician is not precluded from performing one of the listed procedures on the same eye of the patient on the same day, when each is necessary to evaluate and treat the patient. The reason for SCODI in addition to one of the above procedures must be clearly stated in the record.

Glaucoma may be diagnosed as mild, moderate, or severe and SCODI can be utilized as documented below.

Glaucoma Suspect or Mild Damage

SCODI can be used to follow pre-glaucoma patients or those with “mild” damage and who would demonstrate any or all of the following:

Visual Field

- no detectable VF defect;
- "mild" generalized reduction in retinal sensitivity;
- "mild" constriction of isopters;
- nasal step peripheral to 20 degrees; and/or
- small relative defects of the Bjerrum area, peripheral to 9 degrees.

Optic Nerve

- symmetric or vertically elongated cup enlargement; neural rim intact, rim: disc ratio> 0.2; cup:disc ratio <0.8;
- focal notch; rim:disc ratio > 0.2; cup:disc ratio <0.8
- no definite pathologic cupping; and/or
- previously observed disc hemorrhage.

Moderate Glaucomatous Damage

In patients with moderate glaucomatous damage, alternating the use of SCODI and visual field tests within correct time intervals will be considered appropriate, and may increase the sensitivity of detecting glaucomatous damage. Performance of SCODI and visual field tests on the same day, or separated by a short period of time (within three [3] months) is usually not considered medically necessary. However, there may be instances in which each test is needed to determine the patient's status and thus, treatment. The contractor expects use of both tests on the same day or during short intervals will be the exception rather than the rule.

Examples in which each test could be medically necessary include situations in which the clinical examination suggests progression of the glaucoma, yet the visual fields do not show new deficits. SCODI could be used to determine whether there is a change in the nerve fiber loss. Similarly, if the clinical examination showed progression and SCODI was unchanged, the visual field testing might be medically necessary to ascertain whether there is a functional loss of vision. If each test is performed on the same day or within short intervals, the medically necessary rationale must be present in the medical record.

Patients with moderate glaucomatous damage would demonstrate any or all of the following:

Visual Field

- "moderate" generalized reduction in retinal sensitivity;
- "moderate" constriction of isopters absolute defects to within 9 degrees of fixation; and/or
- temporal wedge.

Optic Nerve

- enlarged optic nerve cup with neural rim remaining but sloped or pale;

- focal notches with rim:disc ratio> 0.1 but <0.2; cup:disc ratio > 0.8 but <0.9; and/or
- prominent lamina cribrosa.

Advanced Glaucomatous Damage

Scanning computerized ophthalmic diagnostic imaging is not considered medically reasonable and necessary for patients with “advanced” glaucomatous damage. Instead, visual field testing should be performed. (Late in the course of glaucoma, when the nerve fiber layer has been extensively damaged, visual fields are more likely to detect small changes than scanning computerized ophthalmic diagnostic imaging). Patients with “advanced” glaucomatous damage would demonstrate any or all of the following:

Visual Field

- "severe" generalized reduction in retinal sensitivity;
- "severe" constriction of isopters (i.e., 14e <10 degrees);
- absolute defects to within 3 degrees of fixation;
- loss of central acuity; and/or
- temporal island remains.

Optic Nerve

- diffuse enlargement of optic nerve cup; rim:disc ratio<0.1; cup:disc ratio > 0.9; and/or
- wipe out of all or a portion of the neuroretinal rim.

Retinal Disorders

Retinal disorders are the most common causes of severe and permanent vision loss. Scanning computerized ophthalmic diagnostic imaging (SCODI) is a valuable tool for the evaluation and treatment of patients with retinal disease, especially macular abnormalities. SCODI is able to detail the microscopic anatomy of the retina and the vitreo-retinal interface. SCODI is useful to measure the effectiveness of therapy, and in determining the need for ongoing therapy, or the safety of cessation of that therapy. SCODI is useful in evaluating retinal disorders and glaucoma.

Retinal thickness analysis is a non-invasive and non-contact imaging technique that takes direct cross-sectional images of the retina. These high resolution images capture ocular structures and provide data to create thickness maps of the retina. Retinal thickness is directly correlated to ocular disease, including retinal disorders and glaucoma.

In contrast, Scanning Laser Polarimetry is not an appropriate diagnostic technique for the management of retinal disorders.

Other Comments:

LCD Category - Clinical Diagnostic Tests

This LCD consolidates and replaces all previous policies and publications on this subject by the carrier and fiscal intermediary predecessors of National Government Services (AdminaStar Federal, Anthem Health Plans of New Hampshire, Associated Hospital Service, Empire Medicare Services, Group Health Incorporated (GHI), HealthNow, First Coast Service Options (CT) and United Government Services).

This Local Coverage Determination (LCD) (L28488) is presented for comment to all National Government Services contracts, including all Jurisdiction 13 Medicare Administrative Contractor (J13 MAC) contracts. For J13 MAC Part A contracts, this document addresses the same topic as one which will take effect on 11/14/2008. The anticipated effective date of LCD L28488 is 1/1/2009 for all National Government Services contracts.

For claims submitted to the fiscal intermediary: This coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

Bill type codes only apply to providers who bill these services to the fiscal intermediary. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier.

Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

Notice to beneficiaries related to discharge and coverage notification, as described in CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Sections 60 – 60.1.1, applies.

Hospitals have been instructed to provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is:

- Not medically necessary;
- Not delivered in the most appropriate setting; or
- Is custodial in nature.

For outpatient settings other than CORFs, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care for SCODI services as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

Coverage Topic

Diagnostic Tests and X-Rays
Eye Care - Glaucoma Screening

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

11x	Hospital-inpatient (including Part A)
12	Hospital-inpatient or home health visits (Part B only)

x	
13x	Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
18x	Hospital-swing beds
21x	SNF-inpatient, Part A
22x	SNF-inpatient or home health visits (Part B only)
23x	SNF-outpatient (HHA-A also)
28x	SNF-swing beds
71x	Clinic-rural health
73x	Clinic-independent provider based FQHC (eff 10/91)
79x	Clinic-other
85x	Special facility or ASC surgery-rural primary care hospital (eff 10/94)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

Revenue codes 096X, 097X and 098X are to be used only by Critical Access Hospitals (CAHs) choosing the optional payment method (also called Option 2 or Method 2) and only for services performed by physicians or practitioners who have reassigned their billing rights. When a CAH has selected the optional payment method, physicians or other practitioners providing professional services at the CAH may elect to bill their carrier or assign their billing rights to the CAH. When professional services are reassigned to the CAH, the CAH must bill

the FI using revenue codes 096X, 097X or 098X.

0459	Emergency room-other
0510	Clinic-general classification
0517	Clinic-family practice clinic (eff 10/96)
0519	Clinic-other
052X	Free-standing clinic-general classification
0761	Treatment or observation room-treatment room (eff 9/93)
0920	Other diagnostic services-general classification
0929	Other diagnostic services-other
0960	Professional fees-general classification
0982	Professional fees-outpatient services
0983	Professional fees-clinic

CPT/HCPCS Codes

92135	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT, (EG, SCANNING LASER) WITH INTERPRETATION AND REPORT, UNILATERAL

ICD-9 Codes that Support Medical Necessity

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

115.02	HISTOPLASMA CAPSULATUM RETINITIS
115.12	HISTOPLASMA DUBOISII RETINITIS
115.92	HISTOPLASMOSIS RETINITIS UNSPECIFIED
190.6	MALIGNANT NEOPLASM OF CHOROID
224.6	BENIGN NEOPLASM OF CHOROID
228.03	HEMANGIOMA OF RETINA
361.00	RETINAL DETACH WITH RETINAL DEFECT UNSPECIFIED
361.01	RECENT RETINAL DETACH PARTIAL WITH SINGLE DEFECT
361.02	RECENT RETINAL DETACH PARTIAL WITH MULTIPLE DEFECTS
361.03	RECENT RETINAL DETACH PARTIAL WITH GIANT TEAR
361.05	RECENT RETINAL DETACH TOTAL OR SUBTOTAL

361.06	OLD RETINAL DETACH PARTIAL
361.07	OLD RETINAL DETACH TOTAL OR SUBTOTAL
361.10	RETINOSCHISIS UNSPECIFIED
361.11	FLAT RETINOSCHISIS
361.12	BULLOUS RETINOSCHISIS
361.13	PRIMARY RETINAL CYSTS
361.14	SECONDARY RETINAL CYSTS
361.19	OTHER RETINOSCHISIS AND RETINAL CYSTS
361.2	SEROUS RETINAL DETACH
361.30	RETINAL DEFECT UNSPECIFIED
361.31	ROUND HOLE OF RETINA WITHOUT DETACH
361.32	HORSESHOE TEAR OF RETINA WITHOUT DETACH
361.33	MULTIPLE DEFECTS OF RETINA WITHOUT DETACH
361.81	TRACTION DETACH OF RETINA
361.9	UNSPECIFIED RETINAL DETACH
362.01	BACKGROUND DIABETIC RETINOPATHY
362.02	PROLIFERATIVE DIABETIC RETINOPATHY
362.03	NONPROLIFERATIVE DIABETIC RETINOPATHY NOS
362.04	MILD NONPROLIFERATIVE DIABETIC RETINOPATHY
362.05	MODERATE NONPROLIFERATIVE DIABETIC RETINOPATHY
362.06	SEVERE NONPROLIFERATIVE DIABETIC RETINOPATHY
362.07	DIABETIC MACULAR EDEMA
362.10	BACKGROUND RETINOPATHY UNSPECIFIED
362.11	HYPERTENSIVE RETINOPATHY
362.12	EXUDATIVE RETINOPATHY
362.13	CHANGES IN VASCULAR APPEARANCE OF RETINA
362.14	RETINAL MICROANEURYSMS NOS
362.15	RETINAL TELANGIECTASIA
362.16	RETINAL NEOVASCULARIZATION NOS
362.17	OTHER INTRARETINAL MICROVASCULAR ABNORMALITIES
362.18	RETINAL VASCULITIS
362.21	RETROLENTAL FIBROPLASIA

362.29	OTHER NONDIABETIC PROLIFERATIVE RETINOPATHY
362.30	RETINAL VASCULAR OCCLUSION UNSPECIFIED
362.31	CENTRAL RETINAL ARTERY OCCLUSION
362.32	RETINAL ARTERIAL BRANCH OCCLUSION
362.34	TRANSIENT RETINAL ARTERIAL OCCLUSION
362.35	CENTRAL RETINAL VEIN OCCLUSION
362.36	VENOUS TRIBUTARY (BRANCH) OCCLUSION OF RETINA
362.37	VENOUS ENGORGEMENT OF RETINA
362.40	RETINAL LAYER SEPARATION UNSPECIFIED
362.41	CENTRAL SEROUS RETINOPATHY
362.42	SEROUS DETACH OF RETINAL PIGMENT EPITHELIUM
362.43	HEMORRHAGIC DETACH OF RETINAL PIGMENT EPITHELIUM
362.50	MACULAR DEGENERATION (SENILE) OF RETINA UNSPECIFIED
362.51	NONEXUDATIVE SENILE MACULAR DEGENERATION OF RETINA
362.52	EXUDATIVE SENILE MACULAR DEGENERATION OF RETINA
362.53	CYSTOID MACULAR DEGENERATION OF RETINA
362.54	MACULAR CYST HOLE OR PSEUDOHOLE OF RETINA
362.55	TOXIC MACULOPATHY OF RETINA
362.56	MACULAR PUCKERING OF RETINA
362.60	PERIPHERAL RETINAL DEGENERATION UNSPECIFIED
362.66	SECONDARY VITREORETINAL DEGENERATIONS
362.70	HEREDITARY RETINAL DYSTROPHY UNSPECIFIED
362.71	RETINAL DYSTROPHY IN SYSTEMIC OR CEREBRORETINAL LIPIDOSES
362.72	RETINAL DYSTROPHY IN OTHER SYSTEMIC DISORDERS AND SYNDROMES
362.73	VITREORETINAL DYSTROPHIES
362.74	PIGMENTARY RETINAL DYSTROPHY
362.75	OTHER DYSTROPHIES PRIMARILY INVOLVING THE SENSORY RETINA
362.76	DYSTROPHIES PRIMARILY INVOLVING THE RETINAL PIGMENT EPITHELIUM
362.77	RETINAL DYSTROPHIES PRIMARILY INVOLVING BRUCH'S MEMBRANE
362.81	RETINAL HEMORRHAGE
362.82	RETINAL EXUDATES AND DEPOSITS
362.83	RETINAL EDEMA

362.84	RETINAL ISCHEMIA
362.85	RETINAL NERVE FIBER BUNDLE DEFECTS
363.00	FOCAL CHORIORETINITIS UNSPECIFIED
363.01	FOCAL CHOROIDITIS AND CHORIORETINITIS JUXTAPAPILLARY
363.03	FOCAL CHOROIDITIS AND CHORIORETINITIS OF OTHER POSTERIOR POLE
363.04	FOCAL CHOROIDITIS AND CHORIORETINITIS PERIPHERAL
363.05	FOCAL RETINITIS AND RETINOCHOROIDITIS JUXTAPAPILLARY
363.06	FOCAL RETINITIS AND RETINOCHOROIDITIS MACULAR OR PARAMACULAR
363.07	FOCAL RETINITIS AND RETINOCHOROIDITIS OF OTHER POSTERIOR POLE
363.08	FOCAL RETINITIS AND RETINOCHOROIDITIS PERIPHERAL
363.10	DISSEMINATED CHORIORETINITIS UNSPECIFIED
363.11	DISSEMINATED CHOROIDITIS AND CHORIORETINITIS POSTERIOR POLE
363.12	DISSEMINATED CHOROIDITIS AND CHORIORETINITIS PERIPHERAL
363.13	DISSEMINATED CHOROIDITIS AND CHORIORETINITIS GENERALIZED
363.14	DISSEMINATED RETINITIS AND RETINOCHOROIDITIS METASTATIC
363.15	DISSEMINATED RETINITIS AND RETINOCHOROIDITIS PIGMENT EPITHELIOPATHY
363.20	CHORIORETINITIS UNSPECIFIED
363.21	PARS PLANITIS
363.22	HARADA'S DISEASE
363.40	CHOROIDAL DEGENERATION UNSPECIFIED
363.41	SENILE ATROPHY OF CHOROID
363.42	DIFFUSE SECONDARY ATROPHY OF CHOROID
363.43	ANGIOID STREAKS OF CHOROID
363.70	CHOROIDAL DETACH UNSPECIFIED
363.71	SEROUS CHOROIDAL DETACH
363.72	HEMORRHAGIC CHOROIDAL DETACH
364.04	SECONDARY IRIDOCYCLITIS NONINFECTIOUS
364.22	GLAUCOMATOCYCLITIC CRISES
364.53	PIGMENTARY IRIS DEGENERATION
364.73	GONIOSYNECHIAE
364.74	ADHESIONS AND DISRUPTIONS OF PUPILLARY MEMBRANES
364.77	RECESSION OF CHAMBER ANGLE OF EYE

365.00	PREGLAUCOMA UNSPECIFIED
365.01	OPEN ANGLE WITH BORDERLINE GLAUCOMA FINDINGS
365.02	ANATOMICAL NARROW ANGLE BORDERLINE GLAUCOMA
365.03	STEROID RESPONDERS BORDERLINE GLAUCOMA
365.04	OCULAR HYPERTENSION
365.10	OPEN-ANGLE GLAUCOMA UNSPECIFIED
365.11	PRIMARY OPEN ANGLE GLAUCOMA
365.12	LOW TENSION OPEN-ANGLE GLAUCOMA
365.13	PIGMENTARY OPEN-ANGLE GLAUCOMA
365.14	GLAUCOMA OF CHILDHOOD
365.15	RESIDUAL STAGE OF OPEN ANGLE GLAUCOMA
365.20	PRIMARY ANGLE-CLOSURE GLAUCOMA UNSPECIFIED
365.21	INTERMITTENT ANGLE-CLOSURE GLAUCOMA
365.22	ACUTE ANGLE-CLOSURE GLAUCOMA
365.23	CHRONIC ANGLE-CLOSURE GLAUCOMA
365.24	RESIDUAL STAGE OF ANGLE-CLOSURE GLAUCOMA
365.31	CORTICOSTEROID-INDUCED GLAUCOMA GLAUCOMATOUS STAGE
365.32	CORTICOSTEROID-INDUCED GLAUCOMA RESIDUAL STAGE
365.41	GLAUCOMA ASSOCIATED WITH CHAMBER ANGLE ANOMALIES
365.42	GLAUCOMA ASSOCIATED WITH ANOMALIES OF IRIS
365.43	GLAUCOMA ASSOCIATED WITH OTHER ANTERIOR SEGMENT ANOMALIES
365.44	GLAUCOMA ASSOCIATED WITH SYSTEMIC SYNDROMES
365.51	PHACOLYTIC GLAUCOMA
365.52	PSEUDOEXFOLIATION GLAUCOMA
365.59	GLAUCOMA ASSOCIATED WITH OTHER LENS DISORDERS
365.60	GLAUCOMA ASSOCIATED WITH UNSPECIFIED OCULAR DISORDER
365.61	GLAUCOMA ASSOCIATED WITH PUPILLARY BLOCK
365.62	GLAUCOMA ASSOCIATED WITH OCULAR INFLAMMATIONS
365.63	GLAUCOMA ASSOCIATED WITH VASCULAR DISORDERS OF EYE
365.64	GLAUCOMA ASSOCIATED WITH TUMORS OR CYSTS
365.65	GLAUCOMA ASSOCIATED WITH OCULAR TRAUMA
365.81	HYPERSECRETION GLAUCOMA

365.82	GLAUCOMA WITH INCREASED EPISCLERAL VENOUS PRESSURE
365.83	AQUEOUS MISDIRECTION
365.89	OTHER SPECIFIED GLAUCOMA
365.9	UNSPECIFIED GLAUCOMA
368.40	VISUAL FIELD DEFECT UNSPECIFIED
368.41	SCOTOMA INVOLVING CENTRAL AREA
368.42	SCOTOMA OF BLIND SPOT AREA
368.43	SECTOR OR ARCUATE VISUAL FIELD DEFECTS
368.44	OTHER LOCALIZED VISUAL FIELD DEFECT
368.45	GENERALIZED VISUAL FIELD CONTRACTION OR CONSTRICTION
377.00	PAPILLEDEMA UNSPECIFIED
377.01	PAPILLEDEMA ASSOCIATED WITH INCREASED INTRACRANIAL PRESSURE
377.02	PAPILLEDEMA ASSOCIATED WITH DECREASED OCULAR PRESSURE
377.03	PAPILLEDEMA ASSOCIATED WITH RETINAL DISORDER
377.04	FOSTER-KENNEDY SYNDROME
377.14	GLAUCOMATOUS ATROPHY (CUPPING) OF OPTIC DISC
377.15	PARTIAL OPTIC ATROPHY
377.21	DRUSEN OF OPTIC DISC
377.24	PSEUDOPAPILLEDEMA
377.30	OPTIC NEURITIS UNSPECIFIED
377.31	OPTIC PAPILLITIS
377.32	RETROBULBAR NEURITIS (ACUTE)
377.41	ISCHEMIC OPTIC NEUROPATHY
377.9	UNSPECIFIED DISORDER OF OPTIC NERVE AND VISUAL PATHWAYS
743.20	BUPHTHALMOS UNSPECIFIED
743.21	SIMPLE BUPHTHALMOS
743.22	BUPHTHALMOS ASSOCIATED WITH OTHER OCULAR ANOMALIES

Diagnoses that Support Medical Necessity
Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity

Not applicable

Diagnoses that DO NOT Support Medical Necessity
Not applicable

General Information

Documentation Requirements

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Appendices

Not applicable

Utilization Guidelines

Glaucoma

CPT code 92135 will be considered medically necessary one (1) time per year for patients with "mild" damage.

CPT code 92135 will be considered medically necessary usually only for one (1) or two (2) tests of either SCODI or visual fields per year for patients with "moderate" damage. If visual field testing and SCODI are used on the same day or within a three (3) month interval, the medically necessary rationale must be included in the record. Only one (1) of each test would usually be considered medically necessary per year.

CPT code 92135 would rarely be necessary or beneficial with patients who have "advanced" damage. It would be rarely necessary to perform more than four (4) visual field tests a year for these patients.

Retinal Damage

It is expected that no more than four (4) tests per year would be appropriate with the following exceptions. Patients with retinal conditions undergoing active intravitreal drug treatment may be allowed one scan per month per eye. These conditions include age-related macular degeneration (wet), choroidal neovascularization, macular edema, diabetic retinopathy (proliferative and non-proliferative), branch retinal vein occlusion, central retinal vein occlusion, and cystoid macular edema. In addition, other conditions which may undergo rapid clinical changes monthly requiring aggressive therapy and frequent follow-up, such as macular hole and traction retinal detachment, may also require monthly scans.

Sources of Information and Basis for Decision

This bibliography presents those sources that were obtained during the development of this policy. National Government Services is not responsible for the continuing viability of Web site addresses listed below.

National Government Services and other Medicare contractors' local coverage determinations. The original version of this policy was adopted from a Kansas/Nebraska/Western Missouri LMRP.

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Advisory Committee Meeting Notes

Carrier Advisory Committee Meeting Date(s):

Connecticut: 09/16/2008
Indiana: 09/22/2008
Kentucky: 09/25/2008
New York: 09/10/2008

This coverage determination does not reflect the sole opinion of the contractor or contractor Medical Director. Although the final decision rests with the contractor, this determination was developed in consultation with representatives from Advisory Committee members and/or from various state and local provider organizations.

Start Date of Comment Period

09/02/2008

End Date of Comment Period

10/16/2008

Start Date of Notice Period

11/17/2008

Revision History Number

Not applicable

Revision History Explanation

Not applicable

Reason for Change

Last Reviewed On Date

11/17/2008

Related Documents

Article(s)
A48003 - Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) – Supplemental Instructions Article

LCD Attachments

Comment & Response Article - Comment and Response (203,926 bytes)

Article for Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) – Supplemental Instructions Article (A48003)

Contractor Information

Contractor Name

National Government Services, Inc.

Contractor Number

Number	Type	State(s)
00130	FI	IN
00131	FI	IL
00160	FI	KY
00180	FI	ME
00181	FI	MA
00270	FI	NH, VT
00332	FI	OH
00450	FI	WI
00452	FI	MI
00453	FI	VA, WV
00630	Carrier	IN
00660	Carrier	KY
13101	MAC	CT – Part A
13102	MAC	CT – Part B
13201	MAC	NY – Part A
13202	MAC	NY – Part B
13282	MAC	NY- Part B
13292	MAC	NY – Part B

Contractor Type

Carrier
Fiscal Intermediary
MAC - Part A
MAC - Part B

Article Information

Article ID Number

A48003

Article Type

Article

Key Article

Yes

Article Title

Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) – Supplemental Instructions Article

Primary Geographic Jurisdiction

Number	Type	State(s)
00130	FI	IN
00131	FI	IL
00160	FI	KY
00180	FI	ME
00181	FI	MA
00270	FI	NH, VT
00332	FI	OH
00450	FI	WI
00452	FI	MI
00453	FI	VA, WV
00630	Carrier	IN
00660	Carrier	KY
13101	MAC	CT – Part A
13102	MAC	CT – Part B
13201	MAC	NY – Part A
13202	MAC	NY – Part B
13282	MAC	NY- Part B
13292	MAC	NY – Part B

Original Article Effective Date

01/01/2009

Article Revision Effective Date

01/01/2009

Article Text

The information in this Supplemental Instructions Article (SIA) contains coding or other guidelines that complement the Local Coverage Determination (LCD) for Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI). The LCD can be accessed on our contractor Web site at www.NGSMedicare.com. It can also be found on the Medicare Coverage Database at www.cms.hhs.gov/mcd.

Coding Guidelines:

General Guidelines for claims submitted to Carriers or Intermediaries:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-9-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

CPT 92135 is a unilateral code. For unilateral services, the modifier RT or LT must be submitted with the CPT code to indicate the eye being treated. For bilateral services, report CPT code 92135 with the –50 modifier.

The following codes would generally not be necessary with SCODI. When needed the same day, documentation must justify the procedures.

92250 - Fundus photography with interpretation and report
92225 - Ophthalmoscopy, extended with retinal drawing (e.g., for retinal detachment, melanoma) with interpretation and report; initial
92226 - Subsequent ophthalmoscopy
76512 - B-scan (with or without superimposed non-quantitative A-scan).

It should be noted that there are National Correct Coding Initiative (NCCI) mutually exclusive edits for CPT codes 92135 and 92250. A modifier is allowed if performed on separate eyes. However, CPT code 92250 has a bilateral indicator of "2' on the Medicare Physician Fee Schedule Database. Therefore, the fee schedule amount represents photography of both eyes. Modifier -52 should be appended if only one eye is photographed.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines (for outpatient services):

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons.

Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ.

The –GA modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect

that Medicare will deny a specific service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary, occurrence code 32 and the date of the ABN is required.

The –GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier.

For claims submitted to the carrier:

Claims for Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) services (CPT code 92135) are payable under Medicare Part B in the following places of service:

- the global service is payable in the office (11), nursing facility (32- for Medicare patient not in a Part A stay), and independent clinic (49).
- the technical component (modifier TC) is payable in the office (11), nursing facility (32- for Medicare patient not in a Part A stay), independent clinic (49), federally qualified health center (50), and rural health clinic (72).
- the professional component (modifier 26) is payable in the office (11), inpatient hospital (21), outpatient hospital (22), skilled nursing facility (31), nursing facility (32- for Medicare patient not in a Part A stay), and independent clinic (49).

For claims submitted to the fiscal intermediary:

Hospital Inpatient Claims:

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67.* If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider *should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*
- *The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

Bill Type Guidelines

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100(B) states that *no type of*

technical services, such as…a technical component of a diagnostic or screening service, is ever billed on TOBs 71x or 73x...Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers…Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base-provider on the TOB for the base-provider and submitted to the FI.

Per CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100(B), *only four types of services are billed on TOBs 71X and 73X: Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s) using revenue code 052X; services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900 (previously 0910); …telehealth originating site facility fees under revenue code 0780 [and] FQHC supplemental payments are billed under revenue code 0519, effective for dates of service on or after 01/01/2006.*

For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplement payment…: 0521, 0522, 0524, 0525, 0527 and 0528 (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100[B].)

Coverage Topic

Diagnostic Tests and X-Rays
Eye Care - Glaucoma Screening

Coding Information

CPT/HCPCS Codes

92135	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT, (EG, SCANNING LASER) WITH INTERPRETATION AND REPORT, UNILATERAL

ICD-9 Codes that are Covered

Please see LCD

ICD-9 Codes that are Not Covered

Not applicable

Other Information

Other Comments

These supplemental instructions apply within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

Revision History Explanation

Article published January 2009

Related Documents

LCD(s)
L28488 - Draft LCD for Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

LOCAL COVERAGE DETERMINATION

Article for Anterior segment scanning computerized ophthalmic diagnostic imaging (0187T) – Related to LCD L25275 (A48043)

Contractor Information

Contractor Name

National Government Services, Inc.

Contractor Number

13201

Contractor Type

MAC - Part A

Article Information

Article ID Number

A48043

Article Type

Article

Key Article

Yes

Article Title

Anterior segment scanning computerized ophthalmic diagnostic imaging (**0187T**) – Related to LCD L25275

AMA CPT / ADA CDT Copyright Statement

CPT codes, descriptions and other data only are copyright 2008 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. Current Dental Terminology, (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. © 2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Primary Geographic Jurisdiction

New York - Entire State

Original Article Effective Date

09/01/2008

Article Revision Effective Date

01/01/2009

Article Text

Abstract:

"Optical coherence tomography (OCT) is a cross sectional and three dimensional imaging modality that uses low-coherence interferometry to achieve axial (depth) resolutions in the range of 3 to 20 µm. OCT has several theoretical advantages when compared with current imaging modalities for imaging the anterior segment of the eye. Unlike ultrasound, OCT employs light; therefore it does not require fluid immersion or probe contact. Furthermore, OCT has a spatial resolution that easily surpasses that of even ultrahigh-frequency ultrasound. Although confocal scanning microscopy can obtain even higher resolution than OCT, it requires short focal distances and can image only a small area of the eye at a time. OCT uses interferometry for depth resolution; therefore it can have a long working distance and a wide field of transverse scanning." (*Ophthalmol Clin N Am*. 2004;17[1]:1-6).

Indications:

OCT will be covered for evaluation of narrow angle and other specified glaucoma and disorders of the cornea, iris and ciliary body.

Limitations:

Other indications for OCT remain not medically necessary or investigational.

Coding Guidelines:

General Guidelines for claims submitted to Carriers or Intermediaries or Part A or Part B MAC:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-9-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines (for outpatient services):

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, revised 09/05/2008, for complete instructions.

Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ.

The –GA modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a specific service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary or Part A MAC, occurrence code 32 and the date of the ABN is required.

The –GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier.

CPT code 0187T is a unilateral service. For unilateral services, the modifier RT or LT must be submitted with the CPT code to indicate the eye being treated. For bilateral services, report CPT code 0187T with the –50 modifier.

For claims submitted to the carrier or Part B MAC:

Claims for OCT are payable under Medicare Part B in the following places of service: office (11), assisted living facility (13), urgent care (20), inpatient hospital (21), outpatient hospital (22), emergency room (23), ambulatory surgical center (24), skilled nursing facility (31), nursing facility (32), custodial care facility (33), independent clinic (49), federally qualified health center (50) and rural health clinic (72).

OTC is classified as a professional service. The use of professional or technical component modifiers (26, TC), with these codes, is not appropriate.

For claims submitted to the fiscal intermediary or Part A MAC:

<u>Hospital Inpatient Claims:</u>

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not*

duplicate the principal diagnosis listed in FL 67.

- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67.* If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider *should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*
- *The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

Bill Type Guidelines

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100(B) states that *no type of technical services, such as…a technical component of a diagnostic or screening service, is ever billed on TOBs 71x or 73x…Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers…Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base-provider on the TOB for the base-provider and submitted to the FI.*

Per CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100(B), *only four types of services are billed on TOBs 71X and 73X: Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s) using revenue code 052X; services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900 (previously 0910); …telehealth originating site facility fees under revenue code 0780 [and] FQHC supplemental payments are billed under revenue code 0519, effective for dates of service on or after 01/01/2006.*

For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplement payment...: 0521, 0522, 0524, 0525, 0527 and 0528 (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100[B].)

Hospitals have been instructed to provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is:

- Not medically necessary;

- Not delivered in the most appropriate setting; or
- Is custodial in nature.

Coverage Topic

Diagnostic Tests and X-Rays

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

11x	Hospital-inpatient (including Part A)
12x	Hospital-inpatient or home health visits (Part B only)
13x	Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
21x	SNF-inpatient, Part A
22x	SNF-inpatient or home health visits (Part B only)
23x	SNF-outpatient (HHA-A also)
71x	Clinic-rural health
75x	Clinic-CORF
85x	Special facility or ASC surgery-rural primary care hospital (eff 10/94)

Revenue Codes: back to top

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the article services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to

the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

032X	Radiology diagnostic-general classification
040X	Other imaging services-general classification
051X	Clinic-general classification
052X	Free-standing clinic-general classification
092X	Other diagnostic services-general classification

CPT/HCPCS Codes back to top

0187T	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, ANTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL

ICD-9 Codes that are Covered back to top

190.0	MALIGNANT NEOPLASM OF EYEBALL EXCEPT CONJUNCTIVA CORNEA RETINA AND CHOROID
190.4	MALIGNANT NEOPLASM OF CORNEA
224.0	BENIGN NEOPLASM OF EYEBALL EXCEPT CONJUNCTIVA CORNEA RETINA AND CHOROID
224.4	BENIGN NEOPLASM OF CORNEA
364.51	ESSENTIAL OR PROGRESSIVE IRIS ATROPHY
364.52	IRIDOSCHISIS
364.53	PIGMENTARY IRIS DEGENERATION
364.54	DEGENERATION OF PUPILLARY MARGIN
364.55	MIOTIC CYSTS OF PUPILLARY MARGIN
364.56	DEGENERATIVE CHANGES OF CHAMBER ANGLE
364.57	DEGENERATIVE CHANGES OF CILIARY BODY
364.59	OTHER IRIS ATROPHY
364.60	IDIOPATHIC CYSTS OF IRIS AND CILIARY BODY
364.61	IMPLANTATION CYSTS OF IRIS AND CILIARY BODY
364.62	EXUDATIVE CYSTS OF IRIS OR ANTERIOR CHAMBER
364.63	PRIMARY CYST OF PARS PLANA
364.64	EXUDATIVE CYST OF PARS PLANA
364.70	ADHESIONS OF IRIS UNSPECIFIED

364.71	POSTERIOR SYNECHIAE OF IRIS
364.72	ANTERIOR SYNECHIAE OF IRIS
364.73	GONIOSYNECHIAE
364.74	ADHESIONS AND DISRUPTIONS OF PUPILLARY MEMBRANES
364.75	PUPILLARY ABNORMALITIES
364.76	IRIDODIALYSIS
364.77	RECESSION OF CHAMBER ANGLE OF EYE
364.81	FLOPPY IRIS SYNDROME
364.82	PLATEAU IRIS SYNDROME
364.89	OTHER DISORDERS OF IRIS AND CILIARY BODY
365.02	ANATOMICAL NARROW ANGLE BORDERLINE GLAUCOMA
365.20	PRIMARY ANGLE-CLOSURE GLAUCOMA UNSPECIFIED
365.21	INTERMITTENT ANGLE-CLOSURE GLAUCOMA
365.22	ACUTE ANGLE-CLOSURE GLAUCOMA
365.23	CHRONIC ANGLE-CLOSURE GLAUCOMA
365.24	RESIDUAL STAGE OF ANGLE-CLOSURE GLAUCOMA
365.41	GLAUCOMA ASSOCIATED WITH CHAMBER ANGLE ANOMALIES
365.42	GLAUCOMA ASSOCIATED WITH ANOMALIES OF IRIS
365.43	GLAUCOMA ASSOCIATED WITH OTHER ANTERIOR SEGMENT ANOMALIES
365.44	GLAUCOMA ASSOCIATED WITH SYSTEMIC SYNDROMES
365.51	PHACOLYTIC GLAUCOMA
365.52	PSEUDOEXFOLIATION GLAUCOMA
365.59	GLAUCOMA ASSOCIATED WITH OTHER LENS DISORDERS
365.60	GLAUCOMA ASSOCIATED WITH UNSPECIFIED OCULAR DISORDER
365.61	GLAUCOMA ASSOCIATED WITH PUPILLARY BLOCK
365.62	GLAUCOMA ASSOCIATED WITH OCULAR INFLAMMATIONS
365.63	GLAUCOMA ASSOCIATED WITH VASCULAR DISORDERS OF EYE
365.64	GLAUCOMA ASSOCIATED WITH TUMORS OR CYSTS
365.65	GLAUCOMA ASSOCIATED WITH OCULAR TRAUMA
365.81	HYPERSECRETION GLAUCOMA
365.82	GLAUCOMA WITH INCREASED EPISCLERAL VENOUS PRESSURE
365.83	AQUEOUS MISDIRECTION

365.89	OTHER SPECIFIED GLAUCOMA
370.04	HYPOPYON ULCER
370.05	MYCOTIC CORNEAL ULCER
370.06	PERFORATED CORNEAL ULCER
371.03	CENTRAL OPACITY OF CORNEA
371.71	CORNEAL ECTASIA
371.72	DESCEMETOCELE
371.73	CORNEAL STAPHYLOMA
379.31	APHAKIA
379.32	SUBLUXATION OF LENS
379.33	ANTERIOR DISLOCATION OF LENS
379.39	OTHER DISORDERS OF LENS
996.51	MECHANICAL COMPLICATION OF PROSTHETIC CORNEAL GRAFT
996.53	MECHANICAL COMPLICATION OF PROSTHETIC OCULAR LENS PROSTHESIS
996.69	INFECTION AND INFLAMMATORY REACTION DUE TO OTHER INTERNAL PROSTHETIC DEVICE IMPLANT AND GRAFT

Other Information

Other Comments

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Revision History Explanation

Article published 01/01/2009: Source of revision – Internal – Minor changes were made to reflect current template language. Article attached to Category III LCD L25275.

Correction (published 09/25/2008) (effective 09/01/2008): In the "Coding Guidelines" section of the article, "ambulatory service center" has been corrected to "ambulatory surgical center."

Article published September 2008:This article is effective for all National Government Services jurisdictions on September 1, 2008 with these exceptions: for New York and Connecticut – Part A, the article is effective on November 14, 2008. For New York – Part A (contract 00308), the content of this article is effective September 1, 2008 but the article will be transferred to the J-13 contract number 13201 on November 14, 2008.

11/14/2008 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00308 is removed from this article. Effective on this date, claims processing for Delaware is performed by Highmark Medicare Services, the Part A/Part B MAC contractor for this state, and the claims processing for New York and Connecticut is performed by National Government Services under the J-13 MAC contract; carrier number 00805 is removed, and claims processing for New Jersey is performed by Highmark Medicare Services, the Part A/Part B MAC contractor for this state.

Related Documents

LMRP(s)
Article(s)
A44880 - Category III CPT® Codes – Supplemental Instructions Article

LCD(s)
L25275 - Category III CPT ® Codes

Other Versions
Updated on 11/07/2008 with effective dates 11/14/2008 - N/A
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