Medicare Requirements for Diagnostic Tests

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Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.

Diagnostic Tests

• Special diagnostic tests have specific requirements in order to be billed
  – Medical necessity must be clearly noted or evident in patient chart
  – Chart must be clear as to who ordered test and who performed the service
    • Without an “order,” test will be denied in post-payment audit
      – Order must also be signed by ordering physician

• Ordering physician must be treating physician and responsible for patient’s care
  • If not, test could be determined not reasonable and necessary in post-payment audit

• Diagnostic tests personally performed by physician do not require an order such as:
  • Gonioscopy
  • Extended Ophthalmoscopy

• All special diagnostic tests billable with both “E&M” and “92” codes

Unilateral or Bilateral

• Most diagnostic tests include phrase “unilateral or bilateral” in code description
  – Payment includes both eyes
    • Regardless if only one eye tested
    • Do not use -52 modifier for one eye for Medicare

• A few services can be reported “per eye”
  – 76512 – Contact B-scan

• Medicare does not permit standing orders for diagnostic tests
  • These would be considered routine or screening tests

• New Patient – Physician should examine patient first

• Est. Patient – Order may be in Plan of previous visit
  • If not, physician must see patient and order test before it can be performed
**Unilateral or Bilateral**

- 92225 – Extended ophthalmoscopy (initial)
- 92226 – Extended ophthalmoscopy (subseq)
- 92230 – Fluorescein angiography

• All diagnostic tests are payable during global fee period
  – No modifiers required

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**Supervision**

- **General Supervision**
  – Does not require physician presence
  – Most ophthalmic tests are performed under general supervision
- **Direct Supervision**
  – Physician must be present in clinic but not necessarily present in lane during test
  - B-scans (76510, 76511, 76512, 76513)

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**Supervision**

- Fluoresceins (92230, 92235)
- Indocyanine Green Angiography (92240)
- FA and ICG at same patient encounter (92242)
- Specular microscopy (92287)
- Allergy tests (95004)
- Visual evoked potential (VEP) test (95930)

• **Personal supervision**
  – Physician must be in attendance in the room during the performance of test
  - Needle oculoelectromyography

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**Bundled Services**

- Code 99211, E&M service performed by a technician or other qualified personnel w/o physician
  – Bundled with all diagnostic tests
  – Payment for 99211 is included in reimbursement for diagnostic test
  – Exceptions:
    - B-scans, codes 76512, 76513
    - Corneal pachymetry, code 76514
    - A-scan w/o IOL calculation, code 76516

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**CCI Bundled Services**

- Glaucoma screening, code G0117
  – Bundled with exam codes and other tests
- Fundus photography, code 92250
  – Bundled as mutually exclusive with SCODI, codes 92133 (optic nerve), and 92134 (retina)
  – Bundled with ICG angiography, codes 92240 and 92242
  – Bundled with remote imaging, codes 92227, 92228

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**Documenting Most Frequently Billed Diagnostic Tests**

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B-Scan

- **Code 76512**
  - Unilateral service
    - If billed bilaterally
      - Must have indication or disease in each eye
      - Must have physician order for each eye
      - Must have multiple images of each eye
      - Must have interpretation for each eye
  - Images posterior pole – poor view
    - Vitreous hemorrhage, dense cataract
  - Images orbital lesions
    - Choroidal mass

Corneal Pachymetry

- **Code 76514**
  - Provides measurement of corneal thickness
  - Affects accuracy of IOP measurement
  - Indicates progression of edema or ectasia
  - Covered on a one time basis for glaucoma
    - As medically necessary for some corneal diseases

Corneal Pachymetry

- Code describes ultrasonic pachymetry only
  - Other technology
    - 92499 for optical
    - 92132 for optical coherence tomography
  - Documenting measurements only considered inadequate

A-scan/Ophthalmic Biometry

- **Code 76519 or 92136**
  - Prior to first eye cataract:
    - Submit 76519 or 92136 (no modifiers)
    - Will be paid for technical component of both eyes and one IOL calculation
  - Prior to the second eye surgery
    - Submit code 76519-26 or 92136-26
    - Will be paid for second eye IOL calculation

- Must be billed with date calculation was ordered
  - Some payers may require use of -RT and -LT with first and second eye billing
  - Check MAC for specific billing guidelines
  - Commercial payers may have different billing guidelines as well
  - When both A-scan and IOLMaster performed on same eye for comparison
    - Must only bill test that was used to calculate the IOL

Physician Fee Schedule

- Fee Schedule errors
  - Codes 76519-26 and 92136-26
    - Technical components of A-scan and IOLMaster had wrong payment indicator
      - Prevented payment of second IOL calculation
    - CMS has now corrected payment indicator retroactive to January 1, 2017
      - Any denied claims or outstanding claims should be billed to Medicare for payment

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**Tear Osmolarity**

- **Code 83861**
  - Used for dry eye patients
  - Unilateral test
    - Above 300 is abnormal
  - Must have CLIA Waiver
    - Must be billed with modifier -QW
    - Lab tests do not have TC/PC
      - Supervision designation is “9”

**Gonioscopy**

- **Code 92020**
  - Gonioscopy (separate procedure)
    - Bundled with 92285 (includes goniophotography) and ALT/SLT; code 65865
    - Can only be performed by physician
      - Examination through contact lens using slit lamp or hand-held microscope
      - Gonio lens is applied to surface of cornea under topical anesthesia to evaluate anatomy of angle of anterior chamber of eye
      - Used to manage glaucoma patients

**Gonioscopy**

- Not billable when cataract is only diagnosis
  - Must report glaucoma, narrow angles, cupping of optic disc, etc., as primary diagnosis
  - Cataract as secondary diagnosis
- Typical frequencies
  - Baseline record of angles at initial exam of glaucoma suspect patient
  - Every 1-5 years in phakic patients with lens changes

**Corneal Topography**

- **Code 92025**
  - Mapping of front surface (curvature) of cornea
    - Also known as computer assisted video keratography (CAVK)
  - Bilateral service
    - Payment includes both eyes regardless if both eyes are tested
    - Usually indicated for following conditions
      - Post-op corneal transplants

**Corneal Topography**

- Identification of or follow-up of corneal disease or trauma causing irregular astigmatism
  - Corneal dystrophy
  - Bullous keratopathy
  - Complications of transplanted cornea
    - Not covered by Medicare when cataract only diagnosis
### Sensorimotor Exam

- **Code 92060**
  - Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)
  - Involves ocular measures in more than one field of gaze at distance and/or near
  - In order to bill, chart must include
    - Minimum of 6 primary gazes, or
    - Use of multiple measurements
  - Must document how exam was performed

### Visual Fields

- **Codes 92081-92083**
  - Limited to glaucoma and neuro-ophtalmic conditions
    - Any other diagnosis requires ABN
  - Not billable with condition of blurry vision
  - Copy of graph or computer printout must be in patient chart
    - Or, notation of where test can be found

### Visual Fields

- Required by most MACs prior to lid surgery to establish medical necessity
  - VF is considered a single isopter visual field
  - Bill code 92081 only once for taped and untaped visual fields
  - Even if LCD no longer has visual field requirement
    - May still want to perform visual fields to determine need for surgery
      - Just don’t have to meet specific requirements

### Serial Tonometry

- **Code 92100**
  - Tonometry is the measurement of intraocular pressure
    - Is considered part of the ophthalmic examination unless done in a series
  - At least three separate "timed" pressure readings must be noted
    - Generally a minimum of 30 minutes apart
  - Use extreme caution – highly visible for audit

### SCODI

- **Code 92132**
  - Scanning computerized ophthalmic diagnostic imaging, anterior segment
    - Images anterior segment ocular structures for patients with selected corneal abnormalities and glaucoma
      - Narrow angle or angle closure glaucoma
      - DSAEK patients when there is dehiscence of graft
    - Considered a bilateral procedure
      - Do not append -52 modifier when only one eye tested

### SCODI

- **Code 92133**
  - Scanning computerized ophthalmic diagnostic imaging, posterior segment, optic nerve
    - Allows early detection of patients with normal tension glaucoma and elevated IOP
  - Is considered a bilateral procedure
    - Do not append modifier -52 when only one eye tested
SCODI

- Recommended Medicare contractor frequencies:
  - Pre-glaucoma or mild damage glaucoma - Once a year
  - Moderate damage - Once or twice a year using either SCODI or visual fields, but not both on same day
  - Advanced damage - Visual field expected instead of SCODI - frequency depends on medical necessity

- SCODI
  - Code 92134
    - Scanning computerized ophthalmic diagnostic imaging, posterior segment, retina
    - Used to study retina, macula, vessels
  - Payment for SCODI includes both eyes
    - Even if only one eye tested
    - Do not append -52 modifier when only one eye tested

SCODI

- Suggested frequencies by some Medicare contractors
  - One test every two months for patients whose ophthalmological condition is related to a retinal disease
  - One test per month for patients undergoing active treatment for macular degeneration or diabetic retinopathy
  - Fundus photo and SCODI bundled under CCI
    - Exception - Florida Medicare permits limited number of clinical conditions where both fundus photo and OCT are medically reasonable on ipsilateral eye

Corneal Hysteresis

- Code 92145
  - Corneal hysteresis determination, by air impulse stimulation
  - Measures biomechanical properties of cornea
  - Measures elasticity properties of cornea
  - May be able to identify patients at risk from normal tension glaucoma before vision loss takes place
    - Thus eliminating drug treatment for misdiagnosis of ocular hypertension
  - Also used in screening the cornea for keratoconus and Fuchs dystrophy

Extended Ophthalmoscopy

- Codes 92225 and 92226
  - Physician service only
  - Limited to posterior segment disease or conditions
    - Includes glaucoma when dictated by correlative findings
  - Objective entry must show how test was done and include a large, detailed retinal drawing (usually 2½ to 3 inches)
  - Drawing must be “extended” and anatomically correct
    - Abnormal findings must also be labeled

- Code 92225
  - Initial drawing billable only once in a lifetime

- Code 92226
  - Billed for subsequent drawings to document changes at subsequent examination
  - Cannot bill test for both eyes if pathology found or noted in only one eye
    - Routine ophthalmoscopy is part of a general office visit and not billable separately
### Fluorescein Angiography

- **Code 92235**
  - Is now considered a bilateral service
  - Will be paid only once regardless if one or both eyes are tested
  - Used for retinal blood vessel disease
  - NPDR/PDR, Vascular occlusions, etc.
  - Requires interpretation and report
  - OIG is watching utilization

### Indocyanine Green Angiography

- **Code 92240**
  - ICG is usually an adjunct to FAs
  - Is now considered a bilateral service
  - Will be paid only once regardless if one or both eyes are tested
  - Requires interpretation and report
  - Used for choroidal disease
  - Wet ARMD, choroidal malignancies
  - OIG is watching utilization

### FA and ICG

- **Code 92242**
  - Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter
  - Is a bilateral service
  - Will be paid only once regardless if both eyes are tested
  - Both tests are performed with same equipment
  - Must be able to change filters for each test

### FA and ICG

- Study is evaluated
- Angiogram interpreted and diagnosis documented in chart
- Angiographic findings are compared with previous studies and other diagnostic modalities
  - Determines disease progression/interval change
- Documentation should indicate that angiographic findings were reviewed and discussed with patient
- Representative images are selected for archiving for future comparison

### Fundus Photography

- **Code 92250**
  - Fundus photography
  - Used as a baseline study for:
    - Glaucma suspect, diabetics w/ocular disease
  - Subsequent photos can only be billed when a change in status of nerve is documented
  - Should not be billed routinely for glaucoma patients
  - Location of Photos should be clear
  - Generally bundled with SCODI
  - OIG is watching utilization

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### Fundus Photography

- Glaucoma frequencies absent specific guidelines from Medicare contractor
  - Baseline for glaucoma suspect or new glaucoma patient
  - Compliant patient – 6 months after baseline and 12 – 24 months
  - Non-compliant patient
    - 6-12 months with no changes in vision
    - Every 3-6 months with complaints or changes in vision
    - Every 3 months for advanced glaucoma

### Electroretinography

- **Code 92275**
  - Unilateral service
  - Objective measurement of retinal response
    - Used in pediatrics, non-verbal patients, etc.
    - Recently being used for glaucoma suspects
      - Do not use if other tests confirm the disease

### External Ocular Photography

- **Code 92285**
  - Anterior segment photography
  - Used to document external structures of eye
    - Eyelids, lashes, sclera, conjunctiva, cornea
  - Frequently performed to also document:
    - Lid malposition supporting visual field loss
    - Anterior chamber, iris, crystalline lens and filtration angle
  - Usually not paid by Medicare prior to lid surgery

### Endothelial Cell Count

- **Codes 92286**
  - Primarily covered when presence of corneal disease is noted in slit lamp findings for:
    - Slit lamp evidence of endothelial dystrophy (corneal guttata)
    - Are about to undergo a secondary intraocular lens implantation
    - Have had previous intraocular surgery and require cataract surgery
    - Are about to undergo a surgical procedure associated with a higher risk of corneal endothelium
  - Have evidence of posterior polymorphous dystrophy of the cornea or iridocorneal-endothelium syndrome
  - Will be fitted with extended-wear contact lenses after intraocular surgery
- **Note:** When only visual problem is cataracts, endothelial cell count is considered part of the pre-surgical eye exam and not billable separately
  - Source: NCD 80.8

### Visual Evoked Potential

- **Code 95930**
  - Tests the central nervous system
    - Retina to brain nerve pathway
    - Used for unexplained vision loss
      - Cortical blindness, hysterical/malingering
    - Recently used in glaucoma suspects
      - Do no use if disease confirmed by other testing
Interpretation & Report

• The phrase “with interpretation and report” is found in CPT description of most diagnostic tests
  – Does not mean I&R must be lengthy
  – It does mean that:
    • Physician must look at results of test
    • Make interpretation
    • Place a notation in patient chart within a short period of time after test results are available

• At minimum I&R should include:
  – Date of test and diagnosis (if known)
  – What was seen or not seen but anticipated
    • Glaucoma, for example
  – What findings suggest as to status of illness
    • Stable, worsening, improving
  – What impact results have on treatment
    • Continue present meds, surgery as indicated, etc.
  – Signature of physician
    • Physician MUST sign I&R

Interpretation & Report

• Interpretation can be written on separate page in medical record
  • Should be able to identify as I&R or labeled as such
    • Particularly in EHR
  • Can also be written on the printout of the test results
    • If digitally stored, note equipment where test stored

• Medicare will consider diagnostic test incomplete if interpretation & report not documented in patient chart
  – Will result in refund in event of post-payment audit
  – Be sure doctors review and enter interpretation and reports in a timely fashion

Questions