

MEDICARE REIMBURSEMENT FOR SCODI OF THE POSTERIOR SEGMENT

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QUESTION: Does Medicare cover scanning computerized ophthalmic diagnostic imaging of the posterior segment (SCODI-P)?

ANSWER: Sometimes. Medicare covers SCODI-P 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. If the images are taken as baseline documentation of a healthy eye or as preventative medicine to screen for potential disease, then the test not covered (even if disease is identified). Also, this test is not covered if performed for an indication that is not cited in the local contractor's coverage policy. Check with your Medicare administrative contractor (MAC) for specific coverage limitations.

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QUESTION: What CPT code should we use to describe SCODI-P?

ANSWER: Effective January 1, 2011, there are two new codes to describe SCODI-P. They are:

- 92133 *Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve*
- 92134 *Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina*

Note the distinction between a test performed on the optic nerve (usually glaucoma) and the retina (retinal or macular diseases such as AMD or diabetic retinopathy). Prior to 2011, CPT code 92135 was used to describe this test for either glaucoma or retina/macula disease.

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QUESTION: What are the indications for SCODI-P?

ANSWER: Medicare will reimburse for SCODI-P based on the medical necessity of the service. The list of valid diagnoses includes glaucoma and posterior segment disease such as exudative macular degeneration. We anticipate new LCDs will be published that will address these two codes; currently, the policies overlap.

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QUESTION: How much does Medicare allow for this test?

ANSWER: The 2011 Medicare Physician Fee Schedule allowable for either code is \$44.51. Of this amount, \$15.29 is assigned to the technical component of the test, and \$29.22 to the professional component (*i.e.*, interpretation). Since Medicare now defines the codes as bilateral, this rate applies whether one or both eyes are tested. These amounts are adjusted in each area by local wage indices. Other payers set their own rates, which may differ significantly from the Medicare published fee schedule.

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QUESTION: Is the physician's presence required while SCODI-P is being performed?

ANSWER: No. Under the Medicare program standards, SCODI-P only needs general supervision. *General supervision* means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the test. The physician's prompt interpretation of the test results is still required.

January 1, 2011

The reader is strongly encouraged to review official instructions promulgated by Medicare and other payers; this document is *not an official source* nor is it a complete guide on all matters pertaining to reimbursement. The reader is also reminded that this information can and does change over time, and may be incorrect at any time following publication.

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QUESTION: Do payment restrictions or bundles exist with SCODI-P and other ophthalmic services?

ANSWER: In 2011, Medicare's National Correct Coding Initiative (NCCI) treats fundus photography (92250) as mutually exclusive with SCODI-P. The E/M service 99211 is bundled with this test, as is SCODI-A. CPT also notes that these codes may not be reported at the same patient encounter and Medicare has imposed the same edit.

Several Medicare administrative contractors (MACs) have published local policies that impose restrictions when performing SCODI-P with B-scans (76512) and extended ophthalmoscopy (92225, 92226) unless for unrelated reasons. Some MACs and other third party payers have also questioned the need for visual fields and SCODI-P on the same day. Check your local coverage policies.

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QUESTION: What documentation is required in the medical record to support claims for SCODI-P?

ANSWER: Documentation requirements for SCODI-P are similar to those for other diagnostic tests. They include:

1. an order for the test with medical rationale
2. the date of the test
3. the reliability of the test
4. the test findings
5. a diagnosis (if possible)
6. the impact on treatment and prognosis
7. the signature of the physician

A form suitable for documenting the interpretation of SCODI-P and other tests is available on our website.

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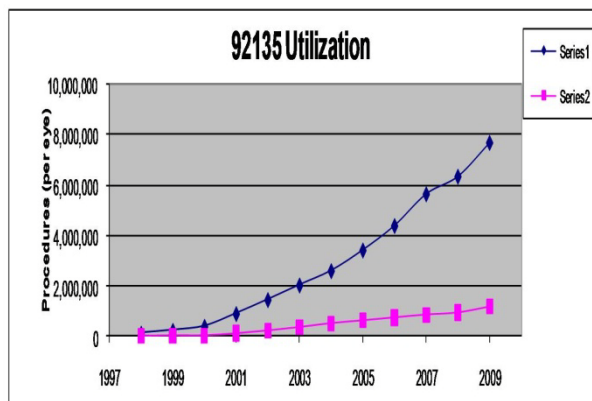
QUESTION: How often may SCODI-P be repeated?

ANSWER: In general, diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required. Most often, the justification is an indication of progression of a chronic disease. Some MACs publish policies that provide upper limits on the number of tests that will be reimbursed in a year. Commonly, the policies state 1 or 2 times per year for glaucoma (92133), and more often for some retinal diseases (92134). Check your MAC's website for specific policies in your area. Too-frequent testing can garner unwanted attention from Medicare and other third party payers.

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QUESTION: How frequently is SCODI-P performed?

ANSWER: There is no history for the new codes, of course. As a point of reference, Medicare utilization rates for claims paid for 92135 in 2009 show that ophthalmologists were paid for this code 36 times for every 100 exams and consultations (36%). Note that this service was billed per eye, and the 36% represents tests rather than patients. For optometrists, the utilization rate is about 13%. The following graphic shows the growth rate of this test since 1998.



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