New Glaucoma Surgeries

Table 1 describes the most common glaucoma procedures performed on Medicare beneficiaries based on the most recent available data from 2007. Interestingly, on a year-over-year basis, only two procedures showed increased procedure volume: endoscopic cyclophotocoagulation (27%) and aqueous shunt (18%). All of the other glaucoma procedures in the table declined in frequency.

Table 1  Common Glaucoma Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT</th>
<th>Freq. (000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Laser trabeculoplasty</td>
<td>65855</td>
<td>170</td>
</tr>
<tr>
<td>2 Laser peripheral iridotomy</td>
<td>66761</td>
<td>85</td>
</tr>
<tr>
<td>3 Trabeculectomy</td>
<td>66170</td>
<td>19</td>
</tr>
<tr>
<td>4 Aqueous shunt</td>
<td>66180</td>
<td>10</td>
</tr>
<tr>
<td>5 Trabeculectomy, with scarring</td>
<td>66172</td>
<td>9</td>
</tr>
<tr>
<td>6 Endoscopic cyclophotocoagulation</td>
<td>66711</td>
<td>8</td>
</tr>
<tr>
<td>7 Cyclophotocoagulation, transcleral</td>
<td>66710</td>
<td>4</td>
</tr>
<tr>
<td>8 Laser iridoplasty</td>
<td>66762</td>
<td>3</td>
</tr>
</tbody>
</table>

Endoscopic cyclophotocoagulation (ECP) is commonly, although not necessarily, performed as a combined procedure along with phacoemulsification.¹ It works by reducing the amount of aqueous produced by the ciliary processes. Advocates for ECP describe the procedure as an effective way to reduce reliance on antiglaucoma medications with relatively low risk and fewer postoperative complications compared with filtration surgery and a short learning curve that can be achieved by any competent cataract surgeon.

The growth in aqueous shunt procedures is largely attributable to a single product, Optonol’s Ex-PRESS mini glaucoma shunt.² Unlike other external shunts (e.g., Ahmed, Baerveldt, Krupin, Molteno), the Ex-PRESS is implanted under a scleral flap to create an egress for aqueous under a diffuse bleb. This product has evolved considerably since it was first introduced in the U.S. in 2003 and enjoys widespread popularity among surgeons and coverage by most payers due to the excellent results. In mid-2008, CPT was amended with a new Category III code, 0192T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach), to report this procedure; formerly, 66180 was used. Subsequently, Medicare reimbursement rates dramatically increased for the new procedure in 2009 over 2008. At present, about half of all aqueous shunts implanted in the U.S. are the Ex-PRESS.

Several companies have invested millions of dollars to bring new products to market to help ophthalmologists treat glaucoma surgically instead of with pharmaceuticals (Table 2).

Table 2  Innovators in Glaucoma Surgery

<table>
<thead>
<tr>
<th>Company</th>
<th>Product</th>
<th>Class</th>
<th>CPT  Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaukos Corp.</td>
<td>i-Stent</td>
<td>Shunt</td>
<td>0191T</td>
</tr>
<tr>
<td>iScience Interventional</td>
<td>iCath</td>
<td>Microcatheter</td>
<td>0176T</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0177T</td>
</tr>
<tr>
<td>NeoMedix Corp.</td>
<td>Trabectome</td>
<td>Electrosurgical instrument</td>
<td>65820*</td>
</tr>
<tr>
<td>SOLX Inc.</td>
<td>Gold Shunt</td>
<td>Shunt</td>
<td>0191T</td>
</tr>
<tr>
<td>SOLX Inc.</td>
<td>Titanium sapphire laser</td>
<td>Laser</td>
<td>65855</td>
</tr>
<tr>
<td>Transcend Medical Inc.</td>
<td>CyPass</td>
<td>Shunt</td>
<td>0191T</td>
</tr>
</tbody>
</table>

¹ For more information, visit the manufacture’s website at www.endooptiks.com
² For more information, visit the manufacture’s website at www.optonol.com

Please turn to Page 2
These new products use different approaches to reduce IOP in eyes with uncontrolled open angle glaucoma (Table 3).

Table 3  How Do They Work?

<table>
<thead>
<tr>
<th>Product</th>
<th>Mechanism of Action</th>
<th>FDA Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>i-Stent</td>
<td>Increase aqueous outflow through the trabeculum into Schlemm's canal via shunt</td>
<td>No</td>
</tr>
<tr>
<td>iCath</td>
<td>Increase aqueous outflow into Schlemm's canal by canaloplasty</td>
<td>Yes</td>
</tr>
<tr>
<td>Trabectome</td>
<td>Increase aqueous outflow into Schlemm's canal by ablating trabeculum</td>
<td>Yes</td>
</tr>
<tr>
<td>Gold Shunt</td>
<td>Increase aqueous outflow into the suprachoroidal space via shunt</td>
<td>No</td>
</tr>
<tr>
<td>Titanium sapphire laser</td>
<td>Increase aqueous outflow by laser trabecuoplasty</td>
<td>Yes</td>
</tr>
<tr>
<td>CyPass</td>
<td>Increase aqueous outflow into the suprachoroidal space via shunt</td>
<td>No</td>
</tr>
</tbody>
</table>

Some of these new products (i.e., i-Stent, CyPass) have been evaluated in clinical trials with concurrent cataract surgery, which contributes some intraocular pressure reduction as well.

Another interesting new product is not a treatment or therapy; it’s an implantable IOP sensor to continuously monitor patients. Since clinicians only take sporadic measurements of IOP during office visits, and diurnal fluctuations are well known, more information about this vital statistic offers potential to significantly improve care for glaucoma patients, particularly those at the greatest risk for loss of vision.

Reimbursement

Payers are generally skeptical about new procedures and resist paying claims until there is ample supportive evidence. See the practice management tips on page 3 for guidance.

Category III CPT Codes

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.

Prior Authorization

The mere issuance of a Category III CPT code to report a procedure does not guarantee reimbursement. In the introductory remarks for this section of CPT, it states “The Category III codes simply provide a mechanism to identify and review emerging services and procedures.” In light of the fact that reimbursement for Category III codes is uncertain and coverage policies are scarce for new procedures, we recommend obtaining prior authorization from third party payers, except Medicare, on a case-by-case basis. Along with a letter explaining your request and reasoning, include comprehensive information about the new procedure. Within the Medicare system, no preauthorization system has yet been established although the Medicare Modernization Act required CMS to institute a process to do so. For now, the approach is less formal but the intent is the same.

Advance Beneficiary Notice

In cases where Medicare coverage is uncertain, an Advanced Beneficiary Notice (ABN) is warranted. For other payers, use a financial waiver form such as a Notice of Exclusion from Health Plan Benefits. Both forms are available on our website.

Please turn to Page 3
Conclusion

Treatment of glaucoma with pharmaceuticals remains problematic due to poor compliance and high cost. Laser trabeculoplasty is popular, particularly in Europe, in large part because it reduces the need for anti-glaucoma medications. Filtration surgery, while still in widespread use, is declining in popularity in the U.S. as other efficacious and lower risk options emerge. Just as intracapsular cataract surgery in the 1970s was generally postponed as long as possible, likewise filtration surgery is postponed when other good options exist. In the future, ophthalmologists can look forward to a series of innovative products and procedures to help them treat the “sneak thief of sight”.

Kevin J. Corcoran, COE, CPC, FNAO
President

Practice Management Tips
For New Glaucoma Surgeries

- Investigate the policies of the health plan or third party payer prior to surgery.
- Obtain prior authorization from the health plan or third party payer if possible.
- Notify the patient before surgery about financial responsibility if insurance won’t cover the new glaucoma surgery. Get written agreement.
- Provide financing options for non-covered procedures.
- Some claim denials or rejection of prior authorization are based on categorizing new glaucoma surgeries as experimental or investigational. In that case, the patient is financially responsible.
- Denial of claims may be erroneous. Was the claim correct? Was all the support material sent? Follow-up? It may take several attempts to reach a resolution.
- Encourage patients to write letters to their health plans or third party payers requesting coverage of the new glaucoma surgery. They should also ask the assistance of their employers’ benefits group to lobby the health plan or third party payer.
- Physicians should speak to the Medical Director of the health plan or third party payer and explain why treatment of POAG by means of a new glaucoma surgery may be preferable in some cases to trabeculectomy.

Billing Questions? Need an Answer?

Did you know Corcoran Consulting Group has consultants standing by at a toll-free number ready to answer your billing question?

By simply signing our Consulting Agreement that is available at our web site, you may contact our trained and capable staff for any billing and coding question.

The time is billed in 0.1 hour increments. Invoices are processed once a month.
**Laser Defined**

A laser is a device that emits uniform, coherent “light” at a single wavelength (i.e., frequency) of the electromagnetic spectrum. Laser, which is an acronym for light amplification by stimulated emission of radiation, usually deliver energy in nearly perfectly parallel light beams (i.e., collimated) which are focused on a very small target about a few hundred nanometers in size. A nanometer is one billionth of a meter.

While the process of generating laser light is common to all lasers, they differ in the amount of energy produced, the wavelength of the light emitted and the material which is used to generate photons. Some lasers produce visible light in the 400-700 nanometer spectrum while others produce ultraviolet or infrared radiation which is not visible.

**Ophthalmic Applications**

Lasers are used to cut, burn or ablate various tissues in a very precise fashion. Corcoran’s Laser Matrix (see page 6) provides a detailed list of common laser procedures in ophthalmology. Most laser procedures are relatively painless and can be done on an outpatient basis, oftentimes in the surgeon’s office. This combination of precision and convenience make lasers one of the most successful medical tools available to ophthalmologists.

**Coding**

Most superbills contain abbreviated lists of popular CPT and ICD-9 codes; they are not all-inclusive or exhaustive lists of procedures and diagnoses. Consequently, a surgeon will commonly pick “something close” from the available choices on his/her superbill. While the reader will immediately recognize the flaw in this approach and the propensity for error, Corcoran’s Laser Matrix provides a handy remedy for the busy doctor who wants a quick answer to the question “Which code is right and can I bill it?”. Using the matrix, there are just four questions to answer in order to bill the procedure.

1) What ocular structure did the surgeon target?

Identify the part of the eye which was lasered. For example, if the surgeon focused the laser beam on the trabecular meshwork, there is just one CPT code that applies. Alternately, if the surgeon aimed the laser at the retina, there are many choices.

2) Is this laser procedure the first or one of a series?

CPT includes the phrase “one or more sessions” in the description for almost all ophthalmic lasers. This means that the surgeon receives just one payment for the procedure even if the same laser treatment is repeated during the postoperative period. The “one or more sessions” rule applies to professional services only and not facility fees. Hospitals and ambulatory surgery centers (ASCs) may be reimbursed again even if the surgeon is not. For example, if a patient requires a peripheral iridotomy (66761) and re-treatment within 90 days on the same eye, the physician is only reimbursed for a single claim associated with the first procedure – a second claim for the follow-up procedure would be denied. The hospital outpatient department (HOPD) and ASC collect a facility fee for both procedures, assuming both are reasonable and medically necessary.

Patients may require retreatment for a recurrent condition. Reimbursement is made for the repeated laser when performed outside the post-operative period of the first session. Documentation should indicate a recurrence requiring a new surgical plan rather than continuation of the initial surgery. CPT’s description of laser trabeculoplasty includes the following instruction: “If re-treatment is necessary after several months because of disease progression, a new treatment or treatment series should be reported with a modifier, if necessary, to indicate lesser or greater complexity.” So, if the first session attains the desired target intracocular pressure, but the IOP gradually increases over the next several months, then the treatment of the second half of the angle is eligible for reimbursement.
Focus on Ophthalmic Lasers

Continued from Page 4

3) Why was the laser procedure performed?

Determine the reason for the laser surgery. Under the heading, indication, there are broad descriptions that identify the purpose of the procedure. For example, lasering the trabecular meshwork is indicated for glaucoma. Note that the specific type of glaucoma is not listed, but that is readily determined from the diagnosis in the operative report.

4) How is the laser procedure described?

An operative report always contains a short title which identifies the procedure, generally in a few words. That description is the last bit of information that is needed to select an appropriate CPT code. A sample form for documenting laser procedures is available free on our website at www.corcoranccg.com.

In addition to the CPT code, Corcoran’s Laser Matrix also provides the postoperative period for each laser procedure. While most of them have a 90-day global surgery period, there are several that are 0 or 10 days. Those with a 90-day period are “major” surgeries, while those with a shorter follow-up interval are “minor” procedures. From a billing perspective, this distinction has a bearing on whether to bill an eye exam on the same day as the procedure. When the decision for surgery is made on the same day as a major surgery, use modifier -57 with the eye exam; it should always be paid. However, an eye exam on the day of a minor procedure is not usually paid separately although there are exceptional circumstances that merit reimbursement under the rules governing the use of modifier -25. (For additional assistance, request our FAQ on this topic.)

CPT uses broad descriptions for procedures; the authors avoid naming specific instruments, product brand names or narrow technical qualifiers such as the wavelength of a specific laser. For the sake of reimbursement, payers assume that the laser used to perform the procedure is FDA approved; otherwise the operation is considered to be “experimental and investigational” and non-covered. For example, there are many lasers available to perform trabeculoplasty including: argon, Nd:YAG, infrared diode lasers and a new excimer laser. SOLX’s titanium sapphire laser (790 nm) was recently FDA approved for trabeculoplasty. Excimer laser trabeculostomy (ELT) ab interno is an exciting new procedure which is being evaluated in Europe but is not yet available in the U.S.

Category III codes describe emerging technology, services or procedures. The purpose of these codes is to provide a means for collection of data on these services or procedures. The inclusion of these codes in CPT does not indicate endorsement, approval or safety. It is a means to identify and report them. Released semiannually by the American Medical Association (AMA), they include:

- 0016T – Destruction of localized lesion of choroid (e.g., choroidal neovascularization, transpupillary thermotherapy)
- 0017T – Destruction of macular drusen, photocoagulation

Reimbursement for Category III codes is at the discretion of your Medicare administrative contractor. Check your local coverage determination (LCD) policy for additional information on specific codes.

Corcoran’s Laser Matrix is meant to assist in coding and does not address medical necessity issues. The decision to perform surgery is based on individual circumstances and accepted standards of practice.

Kevin J. Corcoran, COE, CPC, FNAO
President
<table>
<thead>
<tr>
<th>LOCATION</th>
<th>QTY</th>
<th>GLOBAL</th>
<th>INDICATION</th>
<th>DESCRIPTION</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior chamber</td>
<td>Eye</td>
<td>90</td>
<td>Adhesions</td>
<td>Synechialysis (separate procedure)</td>
<td>65860</td>
</tr>
<tr>
<td>Anterior segment</td>
<td>Eye</td>
<td>90</td>
<td>Failed operative wound</td>
<td>Wound revision</td>
<td>66250</td>
</tr>
<tr>
<td>Choroid</td>
<td>≥ 1</td>
<td>90</td>
<td>Choroidalopathy</td>
<td>Focal destruction of choroidal lesion</td>
<td>67220</td>
</tr>
<tr>
<td>Choroid</td>
<td>Eye</td>
<td>-</td>
<td>Adhesions</td>
<td>Transpupillary thermotherapy (TTT)</td>
<td>0016T</td>
</tr>
<tr>
<td>Ciliary body</td>
<td>Eye</td>
<td>90</td>
<td>Glaucoma</td>
<td>Transscleral cyclophotoagulation (TSP)</td>
<td>66710</td>
</tr>
<tr>
<td>Ciliary body</td>
<td>Eye</td>
<td>90</td>
<td>Glaucoma</td>
<td>Endoscopic cyclophotoagulation (ECP)</td>
<td>66711</td>
</tr>
<tr>
<td>Cornea</td>
<td>≥ 1</td>
<td>90</td>
<td>Corneal scar</td>
<td>Phototherapeutic keratoplasty (PTK)</td>
<td>65450</td>
</tr>
<tr>
<td>Cornea</td>
<td>Eye</td>
<td>-</td>
<td>Refractive error</td>
<td>Laser in situ keratomileusis (LASIK)</td>
<td>S0800</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>65760</td>
</tr>
<tr>
<td>Cornea</td>
<td>Eye</td>
<td>-</td>
<td>Refractive error</td>
<td>Photorefractive keratectomy (PRK)</td>
<td>S0810</td>
</tr>
<tr>
<td>Eyelid margin</td>
<td>Eye</td>
<td>10</td>
<td>Trichiasis</td>
<td>Epilation by laser surgery</td>
<td>67825</td>
</tr>
<tr>
<td>Eyelid margin</td>
<td>Eye</td>
<td>10</td>
<td>Lesion</td>
<td>Destruction of eyelid lesion ≤ 1 cm</td>
<td>67850</td>
</tr>
<tr>
<td>Iris</td>
<td>≥ 1</td>
<td>90</td>
<td>Glaucoma</td>
<td>Laser peripheral iridotomy (LPI) or (PI)</td>
<td>66761</td>
</tr>
<tr>
<td>Macula</td>
<td>Eye</td>
<td>0</td>
<td>Macular degeneration</td>
<td>Photodynamic therapy (PDT) Primary eye.</td>
<td>67221</td>
</tr>
<tr>
<td>Macula</td>
<td>Eye</td>
<td>0</td>
<td>Macular degeneration</td>
<td>Photodynamic therapy (PDT) Fellow eye same day.</td>
<td>67225</td>
</tr>
<tr>
<td>Macula</td>
<td>Eye</td>
<td>-</td>
<td>Macular drusen</td>
<td>Destruction of macular drusen</td>
<td>0017T</td>
</tr>
<tr>
<td>Posterior capsule (lens)</td>
<td>≥ 1</td>
<td>90</td>
<td>Posterior capsular opacity</td>
<td>YAG capsulotomy</td>
<td>66821</td>
</tr>
<tr>
<td>Punctum</td>
<td>Eye</td>
<td>10</td>
<td>Dry eyes</td>
<td>Punctal occlusion by laser or cautery</td>
<td>68760</td>
</tr>
<tr>
<td>Retina</td>
<td>≥ 1</td>
<td>90</td>
<td>Retinal break</td>
<td>Prevention of retinal detachment (RD)</td>
<td>67145</td>
</tr>
<tr>
<td>Retina</td>
<td>Eye</td>
<td>90</td>
<td>Retinal detachment</td>
<td>Retinal detachment (RD) laser</td>
<td>67105</td>
</tr>
<tr>
<td>Retina</td>
<td>Eye</td>
<td>90</td>
<td>Retinal detachment</td>
<td>Retinal detachment (RD) laser with scleral buckle</td>
<td>67107</td>
</tr>
<tr>
<td>Retina</td>
<td>Eye</td>
<td>90</td>
<td>Retinal detachment</td>
<td>Retinal detachment (RD) laser with vitrectomy</td>
<td>67108</td>
</tr>
<tr>
<td>Retina</td>
<td>Eye</td>
<td>-</td>
<td>Retinopathy</td>
<td>Feeder vessel technique</td>
<td>G0186</td>
</tr>
<tr>
<td>Retina</td>
<td>Eye</td>
<td>90</td>
<td>Retinopathy</td>
<td>Focal with vitrectomy</td>
<td>67039</td>
</tr>
<tr>
<td>Retina</td>
<td>Eye</td>
<td>90</td>
<td>Retinopathy</td>
<td>Pan-retinal photoagulation (PRP) with vitrectomy</td>
<td>67040</td>
</tr>
<tr>
<td>Retina</td>
<td>≥ 1</td>
<td>90</td>
<td>Retinopathy</td>
<td>Focal destruction of retinal lesion.</td>
<td>67210</td>
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<tr>
<td>Retina</td>
<td>≥ 1</td>
<td>90</td>
<td>Retinopathy</td>
<td>Panretinal photoagulation (PRP)</td>
<td>67228</td>
</tr>
<tr>
<td>Retina</td>
<td>≥ 1</td>
<td>90</td>
<td>Retinopathy of Prematurity (ROP)</td>
<td>Panretinal photoagulation (PRP)</td>
<td>67229</td>
</tr>
<tr>
<td>Retina</td>
<td>Eye</td>
<td>90</td>
<td>Subretinal membrane</td>
<td>PPV w/ laser to remove subretinal membrane</td>
<td>67043</td>
</tr>
<tr>
<td>Skin</td>
<td>1st</td>
<td>10</td>
<td>Lesion</td>
<td>Destruction of benign lesion, first</td>
<td>17000</td>
</tr>
<tr>
<td>Skin</td>
<td>2-14</td>
<td>-</td>
<td>Lesions</td>
<td>Destruction of benign lesion, 2-14</td>
<td>17003</td>
</tr>
<tr>
<td>Skin</td>
<td>≥15</td>
<td>10</td>
<td>Lesions</td>
<td>Destruction of benign lesion, ≥15</td>
<td>17004</td>
</tr>
<tr>
<td>Trabecular meshwork</td>
<td>≥ 1</td>
<td>10</td>
<td>Glaucoma</td>
<td>Argon Laser Trabeculoplasty (ALT) Selective Laser Trabeculoplasty (SLT)</td>
<td>65855</td>
</tr>
<tr>
<td>Vitreous</td>
<td>≥ 1</td>
<td>90</td>
<td>Vitreous strands, etc.</td>
<td>Severing vitreous strands, adhesions, membranes or opacities</td>
<td>67031</td>
</tr>
</tbody>
</table>

*NOTE: For quantity ≥ 1, the “one or more sessions” rule applies*
1) Medicare’s National Coverage Determinations
   (choose one)
   a. Supersede local coverage determinations
   b. Are replaced by local coverage determinations
   c. Are additive with local coverage determinations
   d. Can only be established by Congress

2) The interpretation and report for a visual field test does NOT need to state (choose one)
   a. Physician’s impression
   b. Time of day when the perimetry was administered
   c. Comparative changes from prior visual field (if any)
   d. Reliability of the test

3) Which visual field test is most common?
   a. Single stimulus
   b. Kinetic
   c. Threshold
   d. Suprathreshold

4) How many visual field tests are reasonable and reimbursed within 1 year?
   a. 1
   b. 2
   c. 3
   d. Varies. Depends on many criteria.

5) Medicare’s National Correct Coding Initiative (NCCI) edits define these two glaucoma tests as “mutually exclusive” (choose one)
   a. SCODI (92135) and fundus photography (92250)
   b. Fundus photography (92250) and visual field testing (9208x)
   c. Visual field testing (9208x) and SCODI (92135)
   d. Gonioscopy (92020) and extended ophthalmoscopy (9222x)

6) Category III CPT codes are NOT (choose one)
   a. Temporary
   b. Covered by Medicare and other third party payers
   c. Eligible for reimbursement in an ASC setting
   d. Equal in stature or longevity to Category I CPT codes

7) Laser trabeculoplasty cannot be performed with (choose one)
   a. Argon laser
   b. CO2 laser
   c. Nd:YAG laser
   d. Titanium sapphire laser

8) The operative report for a laser procedure does NOT need to state (choose one)
   a. Anesthesia given
   b. Dilating agent given
   c. Type of laser used
   d. Name of the medical assistant

9) Within the Medicare system, laser trabeculoplasty has how many postop days?
   a. 0
   b. 10
   c. 90
   d. Undefined

10) When a procedure’s description in CPT includes the phrase “one or more sessions” (choose one)
    a. The procedure requires use of a laser
    b. It’s inconsequential for almost all payers except Medicare
    c. It's inconsequential for HOPD or ASC reimbursement
    d. It requires the surgeon to wait until the postop period has ended before applying any more laser treatment

11) What is the CPT code for phototherapeutic keratoplasty (PTK) of the cornea to remove an opacity?
    a. 65450
    b. 65760
    c. 65860
    d. 67825

12) Laser output is NOT (choose one)
    a. Coagulated
    b. Coherent
    c. Collimated
    d. Uniform

Find the answer key on page 9.
Within the Medicare program, 10% of all eye exams performed by ophthalmologists are accompanied by perimetry (CPT 92081, 92082 or 92083), usually a threshold visual field test (95% of the total), which raises a provocative question: How often can perimetry reasonably be performed in a year? In order to answer the question, we must consider: 1) the standard of care for visual fields, 2) the local Medicare payment policy, and 3) the individual circumstances of each case. The Local Coverage Determination (LCD) for many Medicare contractors includes a provision such as: “Claims for visual field testing submitted at a frequency greater than is necessary for the reasonable medical management of the disease may be denied.”

**Standard of Care**

The American Academy of Ophthalmology’s Preferred Practice Patterns provide a useful point of reference for the standard of care. While the use of visual fields as an aid in the management of glaucoma is well established, the frequency of testing is variable and depends on a number of factors including:

- Severity of glaucomatous damage (mild, moderate, severe)
- The rate of disease progression
- The extent to which intraocular pressure (IOP) exceeds the target pressure
- The number and significance of other risk factors for damage to the optic nerve
- Reliability of the test (e.g., learning effect, suspicious finding)

Consequently, recommended frequency of visual field evaluation varies considerably. Typically, one field per year is warranted for borderline or controlled glaucoma, twice a year for uncontrolled glaucoma, and three times a year for unusual cases such as one-eyed patients.

Clearly, there is no single number of visual fields that is appropriate for a 12-month period.

**Payment Policy**

Medicare’s National Coverage Determination 80.9 – Computer Enhanced Perimetry (Rev.1, 10-03-03), CIM 50-49 states, “Computer enhanced perimetry involves the use of a microcomputer to measure visual sensitivity at preselected locations in the visual field. It is a covered service when used in assessing visual fields in patients with glaucoma or other neuropathologic defects.” By way of amplification, the introduction to the NCD manual states, “Where coverage of an item or service is provided for specified indications or circumstances but is not explicitly excluded for others, or where the item or service is not mentioned at all in the CMS Manual System the Medicare contractor is to make the coverage decision, in consultation with its medical staff, and with CMS when appropriate, based on the law, regulations, rulings and general program instructions”. Consequently, it is necessary to check your local Medicare carrier policy for additional information regarding covered indications, limitations and diagnoses beyond the NCD. Not uncommonly, the Local Coverage Determination (LCD) contains language such as:

“Visual Field testing may be medically necessary in a glaucoma suspect or a patient with glaucoma, mild damage and good control only once a year. Field testing may be necessary in patients with moderate or advanced glaucoma and good control once a year. Field testing may be necessary in mild, moderate or advanced glaucoma and borderline control two times a year. Finally, visual field testing in patients with uncontrolled glaucoma may be necessary up to four times a year.”

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As a practical matter, the limitations in the LCD provide an indication that the beneficiary could be financially responsible for testing beyond these ceilings. In such cases, an Advance Beneficiary Notice of Noncoverage (ABN) should be used prior to more frequent testing.

Choice of Visual Field

The kind of visual field test performed may have a bearing on frequency of testing. While automatic static threshold perimetry is the preferred technique, other tests may be useful too (e.g., short wavelength automated perimetry, frequency doubling perimetry, motion detection perimetry). Sometimes, two visual fields are performed on the same day, one abbreviated and one intensive. According to the National Correct Coding Initiative (NCCI), visual field testing codes are mutually exclusive with each other. For example, if you performed 92082 and, based on the results, decided to perform 92083, the test with the highest value would be billed and the lower level code would not. In addition, the E/M service 99211 (i.e., established, minimal exam) is bundled with these tests. Although the visual field codes are not bundled with scanning computerized ophthalmic diagnostic imaging (92135), some Medicare administrative contractors and other third party payers question the medical necessity for both tests on the same day. As a practical matter, staggering these tests over several consecutive office visits is a simple solution to avoid strange payment policies.

Denied Claims

The reviewer uses the notations in the chart to answer the question “Should a claim for reimbursement be paid?”. Some classic reasons for denial of payment are listed below.

• Visual field testing was performed based on “standing orders”
• Visual field testing was ordered by someone who is not treating the beneficiary (CFR 410.32)
• Visual field testing was ordered for an indication that is not covered by the payment policy
• Visual field testing was not performed under the supervision of an individual meeting the definition of a ‘physician’ (PM B-01-28)
• There is no interpretation of the visual field

In some cases, it is apparent that the test is worthless and should not be billed at all. This may occur when the test instrument malfunctions, the patient does not follow instructions, or the test is aborted prior to completion. However, an imperfect test, such as the first visual field administered to a patient, is not worthless and merits reimbursement if performed for a covered indication.

Conclusion

How often can perimetry reasonably be performed in a year? It depends. In severe cases, more frequent testing is justified. There is no single number which is the right answer. Overall, our experience with chart reviews has shown that visual field testing is more often underutilized than overutilized.

Kevin J. Corcoran, COE, CPC, FNAO
President

Answer Key

A tiny part of the Medicare program covers durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for beneficiaries’ use in the home. For ophthalmologists and optometrists, this benefit applies to eyeglasses or contact lenses for aphakic patients as well as a limited benefit for pseudophakic patients (i.e., up to one pair of eyeglasses or contact lenses following cataract surgery with implantation of an IOL).

Unfortunately, the Medicare program has long been beset by unscrupulous suppliers of DMEPOS, mainly medical equipment and supplies. CMS and law enforcement agencies have made many attempts to prevent supplier fraud and abuse and continue to do so. For example, enrollment as a supplier is elaborate and time consuming; Medicare purposely does not make it simple. Among other requirements, new suppliers are subject to an unannounced site visit by Medicare representatives. This site visit is made to ensure that the applicant conducts a legitimate business with a physical location serving patients. While this seems very strange to physicians, your optical dispensary is subject to the same rules that govern other suppliers whose reputation is less sterling.

In 1997, as part of the Balanced Budget Act, Congress authorized a number of requirements for suppliers following reports of widespread Medicare fraud. One result was that Medicare added a requirement that suppliers of DMEPOS become accredited. Fortunately, our professional societies were successful in getting physicians exempted, at least for now.

The latest measure to protect Medicare from fraudulent suppliers is a requirement for DMEPOS suppliers to provide the government with a Surety Bond not less than $50,000 per location. The bonding agency guarantees repayment to the Medicare program of payments made to unscrupulous suppliers. There are exceptions to the Surety Bond requirement. Physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act, are exempted if the items are furnished only to the physician’s own patients as part of his or her physician service. States vary in their definition of doctor-patient relationships and you may need to check your state law to see if such a definition is broad enough to allow you to provide these services, or may wish to contact a local attorney or your state society.

Effective May 4, 2009, DMEPOS suppliers submitting: (1) an initial enrollment application to enroll in the Medicare program for the first time, (2) an initial application to establish a new practice location, or (3) an enrollment application to change the ownership of an existing supplier, are required to obtain and submit a copy of the required surety bond to the National Supplier Clearinghouse (NSC) with their CMS-855S enrollment application. All existing DMEPOS suppliers subject to the bonding requirements must submit a copy of the required surety bond to the NSC no later than October 2, 2009. Failure to do so will result in the revocation of the supplier’s billing privileges. According to CMS’ website, the cost of the bond is estimated to be about $1,500 per location. We have not seen an estimate of renewal costs.

What does all of this mean for you? You are exempt from Medicare’s Surety Bond requirement if you provide postcataract eyeglasses or contact lenses only to your own patients as part of your professional services. You are not exempt if you accept walk-in Medicare customers and/or fill eyeglass prescriptions for covered products from outside doctors. Remember that this rule applies only to Medicare patients for covered services, i.e., postcataract eyeglasses or contact lenses. In some states, it may also apply to covered Medicaid services. It does not apply to the general public or to Medicare beneficiaries who purchase noncovered eyewear or CLs.

**Suzanne L. Corcoran, COE**

*Executive Vice President*

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1 The list of sureties from which a bond can be secured is found at the Department of the Treasury’s “Listing of Certified (Surety Bond) Companies” website at [http://www.fms.treas.gov/570/e570_c570_e570.html](http://www.fms.treas.gov/570/e570_c570_e570.html) on the Internet. For purposes of the surety bond requirement, these sureties are considered “authorized”.

**2009 SCHEDULE**

- **June 18**: Houston TX
- **June 25**: Chicago IL
- **June 25**: Charleston SC
- **July 9**: San Diego CA
- **July 16**: Columbus OH
- **July 23**: Baltimore MD
- **August 6**: Kansas City MO
- **August 13**: Foxwoods CT
- **August 22**: Anchorage AK
- **September 3**: Minneapolis MN
- **September 9**: Rochester NY
- **September 10**: Albany NY
- **September 16**: Teaneck NJ
- **September 17**: Long Island NY
- **September 17**: Memphis TN
- **September 17**: Las Vegas NV
- **October 8**: Charlotte NC
- **October 15**: Boston MA
- **October 15**: Jacksonville FL
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