# Medicare Reimbursement for Visual Field Testing with objectiveFIELD®

*Prepared for*

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# Medicare Reimbursement for Visual Field Testing with objectiveFIELD®

*by*


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# INTRODUCTION

This monograph describes reimbursement for visual field (VF) testing with Konan Medical USA's objectiveFIELD® analyzer (OFA®). VF testing can be performed by a variety of methods; however, the most popular ones require patient cooperation and a subjective response.[1] The OFA is different because it is an objective VF test that does not rely on a response from the patient.

Figure 1 **objectiveFIELD analyzer (OFA)**

Image courtesy Konan Medical USA.

Much of the information in this document is taken from official publications of the Medicare program. The reader is encouraged to check with the local Medicare Administrative Contractor (MAC) for additional information and instructions. For other third-party payors, we have used the coding concepts contained in CPT and published by the American Medical Association; diagnosis codes are from ICD-10-CM. Documentation of a diagnostic test, and whether there is medical rationale for it, are key to reimbursement so we describe the required elements in detail.

[1] AAO. EyeWiki Standard Automated Perimetry. Link here. Accessed 10/06/24

Since economic analyses are a necessary part of any capital budgeting decision, we incorporated Medicare's payment rates for visual field testing, as well as recent Medicare utilization rates.

## THE INSTRUMENT

The OFA uses multifocal pupillographic objective perimetry (mfPOP), an objective and reliable method to test both eyes quickly without a patient's subjective responses. In comparison, "*Subjective visual field tests, including standard automated perimetry, are limited by high test-retest variability, learning effects, variability due to under-sampling, and the principle of redundancy.*"[2]

FDA treats perimeters as class 1 medical devices.[3] As such, perimeters, including OFA,[4] are exempt from premarket notification requirements.

Using a combination of hardware and software, each eye's field of vision is optically separated, and the patient's view is fused (cyclopean view). Novel stimuli are presented to each eye individually, interleaved, with non-overlapping timing every 0.25 seconds. Pupillary responses are recorded using infrared video cameras and analyzed using pupil tracking. Sensitivity is measured objectively by the amplitude of the pupillary response based on the relative change in pupil size and converted to the familiar decibel scale. Latency (time-to-peak constriction) of the pupillary responses are measured in milliseconds, which is new information not available in other perimeters. The result is four visual fields per eye:

1. OD/OS sensitivity, direct
2. OD/OS sensitivity, consensual
3. OD/OS latency, direct
4. OD/OS latency, consensual

Analytics combine these data into two reports: sensitivity and latency for both eyes following a familiar reporting structure with VF maps and indices (MP, PSD, SF, CPSD) so there is no learning curve to interpret them (Figure 2). The OFA can print and save the VF report separately from the instrument via printer or electronic health record (EHR) interfaces.

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[2] Rai BB, Sabeti F, Carle CF, Maddess T. Visual Field Tests: A narrative review of different perimetric methods. J Clin Med 2024 May;13(9):2458 Link here. Accessed 10/4/24

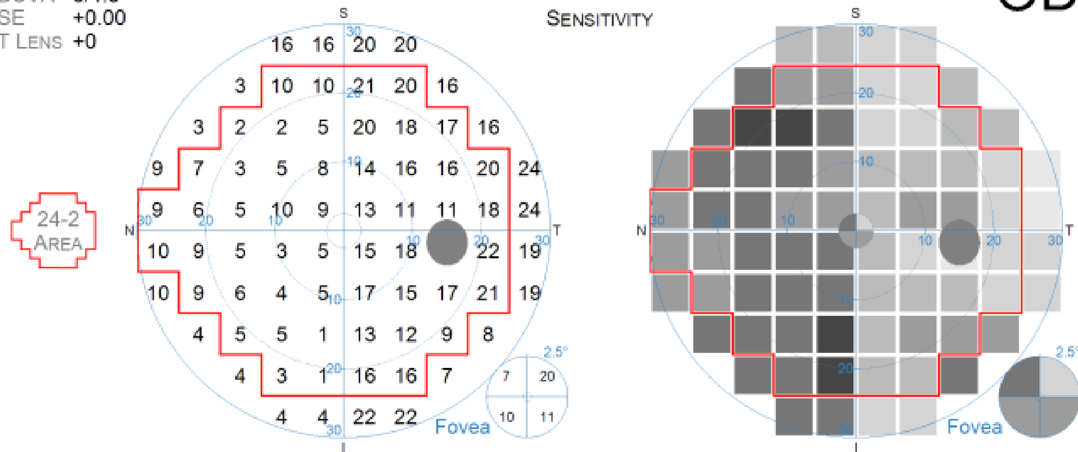
[3] FDA Regulation No. 886.1605 Link here. Accessed 10/4/24

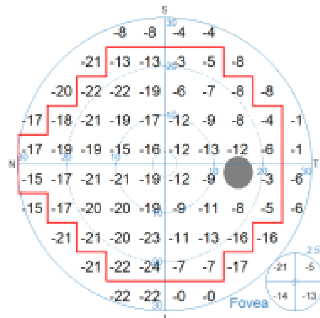
[4] FDA Premarket Submission No. K063310 Link here. Accessed 10/7/24

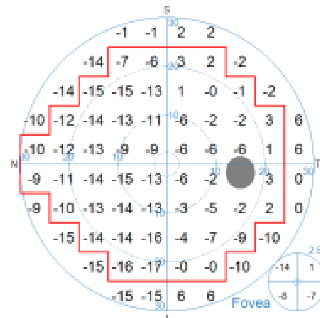
## Figure 2 **OFA Report**

TEST: OFA30 @ 3/26/2013 | 7:40 AM | 6:31 mins REPORT: Legacy OD Sensitivity

dB 0 5 10 15 20 25 30 35 40 45 50

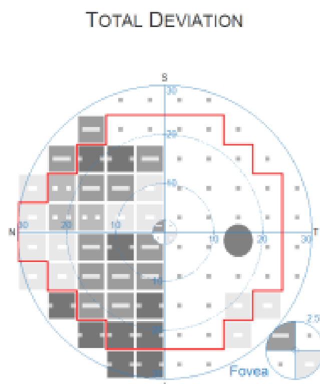


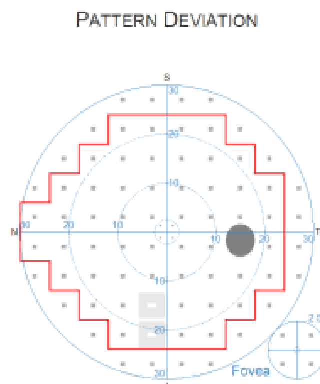



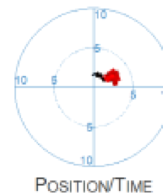




| | (dB) | (p<%) |
|---|---|---|
| GHp | | 6.1 |
| | (dB) | (p<%) |
| MD | -13.9 | 1 |
| PSD | 7 | - |

TOTAL DEVIATION PATTERN DEVIATION




p(%): <0.5 <1 <2 <5 >5 <5 <2 <1 <0.5

HYPOSENSITIVE HYPERSENSITIVE

PROBABILITIES

# INDICATIONS FOR USE

A VF test assesses visual function and is useful in the diagnosis and management of a wide variety of ophthalmic and neurologic conditions, as well as to monitor certain drugs for potential retinal toxicity.[5,6]

Coverage Guidelines

Medical necessity for diagnostic testing begins with pertinent signs, symptoms, or a medical condition for which the treating physician needs further information to manage the beneficiary's specific medical problem.[7] Medicare's longstanding National Coverage Determination (NCD §80.9) for "Computer Enhanced Perimetry" states VF testing "*is a covered service when used in assessing visual fields in patients with glaucoma or other neuropathologic defects*."[8] If VF testing is performed for baseline documentation of a healthy eye it is not covered. If it is performed as a preventative measure to screen for potential disease, it is generally not covered unless specific exceptions exist in statute or regulation.[9] MACs issue local coverage determination policies that provide more detailed information, although they don't necessarily agree.[10,11,12] Other third-party payors frequently emulate Medicare policies but are not obligated to do so. We recommend checking the applicable policy for the beneficiary prior to testing.

National Government Services (NGS), the MAC for a number of states, instructs:

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

First Coast Service Options, Inc. (FCSO), the MAC for Florida, Puerto Rico, and the U.S. Virgin Islands, instructs:

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5 National Government Services Article A56551 Billing and Coding: Visual Fields Testing Link here. Accessed 10/06/24

6 American Academy of Ophthalmology Preferred Practice Patterns. See those for glaucoma and retinal disease. Link here. Accessed 10/06/24

7 42 CFR 410.32 Diagnostic tests Link here. Accessed 10/06/24

8 CMS National Coverage Determination on Computer Enhanced Perimetry (NCD 80.9). Link here. Accessed 10/06/24.

9 CFR 411.15(a)(1). Particular services excluded from coverage. Link here. Accessed 10/06/24

10 National Governmental Services LCD L33574 Link here. Accessed 10/06/24

11 First Coast Service Options LCD L33766 Link here. Accessed 10/06/24

12 Wisconsin Physicians Service Insurance Corporation LCD L34615 Link here. Accessed 10/06/24

*"Medical record documentation ... must clearly indicate the medical necessity of the service being billed. In addition, documentation that the service was performed must be included in the patient's ... record and available upon request ... This information is normally found in the office/progress notes, hospital notes, and/or procedure report … Documentation should support the criteria for coverage ..."*

For chronic disease, such as glaucoma, periodic VF testing is the standard of care.[13] Repeat VF testing may also be prompted by disease progression, the advent of new disease, or in planning for surgical treatment. FCSO states:

*"... stabilization or progression of glaucoma can be monitored only by a visual field examination, and the frequency of such examinations is dependent on the variability of intraocular pressure measurements (e.g., progressive increases despite treatment indicate a worsening condition), the appearance of new hemorrhages, and progressive cupping of the optic nerve ... patients with a previously diagnosed retinal detachment do not need a pretreatment visual field examination. Additionally, patients with an established diagnosed cataract do not need a follow-up visual field unless other presenting symptomatology is documented. In patients about to undergo cataract extraction, who do not have glaucoma and are not glaucoma suspects, a visual field is not indicated ..."*

In general, all diagnostic tests are reimbursed when medically indicated and properly documented. Some Medicare contractors and other payors place a restriction on how frequently a test may be reimbursed. Too-frequent testing can garner unwanted attention from Medicare and other payors. Specific to VF testing, many payors follow the AAO's preferred practice pattern for primary open-angle glaucoma.[14] For newly diagnosed patients, three times per year in the first 2 years is recommended.[15] Annual VF testing is a common guideline but there is poor adherence.[16] Typically one field per year is warranted for borderline or controlled glaucoma, twice a year for uncontrolled glaucoma, and three times a year for extreme cases such as one-eyed patients or when the disease is progressing rapidly.

FCSO notes the following when re-testing is done for macular degeneration or central field loss:

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[13] AAO EyeWiki Glaucoma Data Standards. Link here. Accessed 10/06/24

[14] AAO. Primary Open-Angle Glaucoma Preferred Practice Pattern 2020. Link here. Accessed 10/06/24

[15] Crabb DP *et al*. Frequency of visual field testing when monitoring patients newly diagnosed with glaucoma: mixed methods and modeling. Health Services and Delivery Research No 2.27 Link here. Accessed 10/4/24

[16] Stagg BC *et al*. The frequency of visual field testing in the US nationwide cohort of individuals with open-angle glaucoma. Ophthalmol Glaucoma 2022 Nov-Dec;5(6):587-593. Link here. Accessed 10/4/24

> “… *repeated examinations for a diagnosis of macular degeneration or an experienced central vision loss are not necessary unless changes in vision are documented or to evaluate the results of a surgical intervention*.”

Screening and Visual Fields

Some ophthalmologists and optometrists use standing orders for VF testing for all patients prior to an eye exam to screen for disease. As a general rule most payors, including Medicare, do not cover screening services or preventive medicine.[17] Patients must be given the opportunity to choose between an exam with or without visual fields. Practices should use a financial waiver to document the beneficiary’s acceptance of financial responsibility for the screening service. Screening occurs when the test is performed for one or more of the following reasons.

- Part of a wellness program to check for disease that may otherwise go undetected
- Not required by medical necessity; the reason for doing them is optional
- Recommended *prior to* an eye examination
- Performed *before* the patient is examined by the eye care provider
- Done for all patients as a matter of course, unless they decline

Finding disease on a screening test does not confer eligibility for reimbursement. It frequently leads to additional evaluation and management services, albeit not necessarily on the same day. Redoing a VF later the same day as screening does not confer coverage.

## DOCUMENTATION

The description in CPT for VF testing includes the phrase *“with interpretation and report*”.[18] What exactly is meant by this phrase, and what kind of chart note is required? This question takes on added urgency since insufficient chart documentation is reason enough to require repayment of any reimbursement.

Medicare Regulations and Guidance

The Medicare guidelines for interpretation of diagnostic tests are discussed in the Medicare

[17] CFR 410.32(a). Link here. Accessed 10/06/24

[18] Current Procedural Terminology (CPT) 2024 edition.

Claims Process Manual (MCPM) Chapter 13 §100, Interpretation of Diagnostic Tests.[19] CMS makes a distinction between a "review" of a test and an "interpretation and report":

> "*Carriers generally distinguish between an "interpretation and report" … and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service. This is because the review is already included in the … E/M payment.*"

The review of a test is not separately payable because it is part of an evaluation and management (E/M) service:

> "*For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available).*"

Simple, brief notations such as "normal" or "abnormal" are construed as a review of the test rather than as an interpretation and report. As a condition of payment,[20] 42 CFR 415.120 (a) states:

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

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

- Physician's order – *Why is the test desired?*
- Date performed – *When was it performed?*
- Technician's initials – *Who did it?*
- Reliability of the test – *Was the test of any value?*
- Patient cooperation – *Was the patient at fault?*

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[19] Medicare Claims Process Manual (MCPM) Chapter 13 §100. Interpretation of Diagnostic Tests. Link here. Accessed 10/06/24

[20] Code of Federal Regulations: 42 CFR 415.120(a) Conditions for payment: Radiology services, to beneficiaries. Link here. Accessed 10/06/24

- Test findings – *What are the results of the test?*
- Comparison – *How do today's results differ from prior test(s)?*
- Assessment, diagnosis – *What do the results mean?*
- Impact on treatment, prognosis – *What's next?*
- Physician's signature – *Who is the physician?*

In ophthalmology, VF testing is more valuable for making decisions about treatment when there is a series. Then, the concept of "comparative data" cited above is particularly meaningful. Does the series demonstrate disease progression? For VF, the "interpretation and report" might read as follows:

- VF for primary open-angle glaucoma
- January 5, 2024
- Technician: Mary Smith, COA
- Some fixation losses
- Good patient cooperation
- New arcuate changes OD with nasal step. Small scotoma in central area, OS
- POAG, shows progression OU since last visit
- Add another anti-glaucoma medication
- *Signed: I. C. Better, M.D.*

Where to write?

An interpretation can be written on its own separate page in the medical record or in the blank space on the printout of the test result. If the interpretation is written as part of the office visit note, it might appear to be an element of the evaluation and management service. Better to keep it separate or differentiate it from the rest of the eye exam by surrounding the notations with a box and a title like "Visual Field Report". Within an electronic medical record, we often find a designated spot or separate screen to record the physician's interpretation of a test as a report.

Timing

Ideally, the interpretation of a test follows immediately after the technical component is finished. In practice, there may be a delay; however, the delay should not be lengthy or

affect patient care. Since VF testing requires only general supervision,[21] and the physician need not be present during the performance of the test, the interpretation might take place the next day. If a weekend intervenes, there may be two days' delay. It is important to note that CMS understands that delays are a fact of life and, in 2009, proposed regulations to require claims for reimbursement to identify on two separate lines the technical and professional components of a diagnostic test when performed on different dates of service. These proposed regulations (Transmittals 1823 and 1873) were subsequently withdrawn, yet there is still concern about this topic. As a practical alternative, bill the entire test upon completion after the interpretation is documented in the medical record since it is not clear what diagnosis would be used for the technical component alone.

## Payment Considerations

In the Medicare Physician Fee Schedule (MPFS), different payment rates are established for the professional and technical components of a diagnostic test where there is discrete reimbursement for an "interpretation and report". Respectively, modifiers 26 and TC are used to make the distinction between the professional and technical portions of the test. As a practical matter, this segregation permits a technician or medical assistant to perform the technical component, with appropriate supervision; however, only the physician can interpret test results. When modifiers TC and 26 are not appended to a CPT code, then the payor understands that reimbursement is sought for both the technical and professional components together in a single payment.

## Standing Orders

Standing orders for tests may improve office efficiency, but they often create problems with reimbursement. The Office of Inspector General and the MACs have published several reports identifying standing orders as troublesome and problematic because they are routine screenings and non-covered services.[22,23,24] The Centers for Medicare & Medicaid Services (CMS) states "*the physician must clearly document, in the medical record, his or her intent that the test be performed.*"[25,26] To avoid this difficulty with

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[21] 42 CFR 410.32(b)(3)(i). Definition of general supervision. Link here. Accessed 10/06/24.

[22] United States General Accounting Office. Beneficiary Use of Clinical Preventive Services. GAO-02-422. April 2002. Link here. Accessed 10/06/24

[23] Office of Inspector General. Report: St. Francis Hospital, Tulsa, OK. Estimated Medicare Overpayment. February 12, 2002. Link here. Accessed 10/06/24

[24] Department of Justice. Archived Press Release. GAMBRO Healthcare Inc. agrees to pay $53 million of overcharging Medicare, Medicaid, & Tricare. July 13, 2000. Link here. Accessed 10/06/24

[25] CMS. Medicare Benefit Policy Manual, Chapter 15, §80.6.1. Requirements for Orders for Diagnostic Tests- Definitions. Link here. Accessed 03/19/19.

[26] Palmetto GBA. Jurisdiction M Part B. Signature Requirements, Acceptable and Unacceptable Practices. Published 02/13/23. Link here. Accessed 10/06/24

reimbursement, physicians should examine the patient first and then determine which tests, if any, are necessary *before* ordering them. Alternately, and less commonly, a physician may formulate an order for testing prior to any examination based on information about an individual patient's unique illness, injury, or medical condition provided by another physician, health care professional, or the patient themselves.

## SUPERVISION

In July, 2001, Medicare revised its supervision rules for many ophthalmic diagnostic tests. VF testing requires *general* supervision. This means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during performance of the test. Under general supervision rules, the training of the non-physician personnel who actually perform the diagnostic test and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.[24]

## BILLING ISSUES

Procedure Codes

The following CPT code is used to report VF testing with Konan's OFA.

92083 ...… Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30°, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

This extended VF requires at least three isopters. A full threshold test provides quantitative data (in decibels) for each location.

VFs are defined in CPT as "*unilateral or bilateral*" so a single charge is made whether one or both eyes are tested. A physician's order in the medical record and written interpretation are required.

Of note, the CPT manual lists gross (basic confrontation) visual field as a required exam element of a comprehensive eye exam (920x4), and it is commonly a part of many eye exams. As such, it is a component of the exam and not separately reimbursed.

## Modifiers

The following modifiers may be applicable on claims for the above codes.

AQ ……… Services provided in a Health Professional Shortage Area (HPSA, *Medicare modifier only; replaces QB and QU*)

GA ……… Medicare probably does not cover this service. Advance Beneficiary Notice (ABN) signed (*Medicare modifier only*)

GY ……… Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit.

GZ ……..… Medicare probably does not cover this service. No ABN on file (*Medicare modifier only*)

TC ……… Technical component of a diagnostic test

26 ………. Professional component of a diagnostic test

## Sample Claims

*Example 1* Open-angle glaucoma - Exam with VF

During dilated fundus exam of the posterior pole with binocular indirect ophthalmoscopy, changes in the optic nerve cup to disc ratio and a small Drance hemorrhage was noted in each eye at the disc margin. You order VF OU to establish a baseline for possible glaucomatous damage and to permit re-evaluation later to monitor for change. Your interpretation and report note mild stage open-angle glaucoma, OU. In addition to the exam (shown as 9xxxx), the claim will read as follows.

| 17 REFERRING/ORDERING PROVIDER | | 17a. | | |
|---|---|---|---|---|
| DK | J Emdy MD | 17b. | NPI | 1234567890 |
| 19 ADDITIONAL CLAIM INFORMATION | | | | |
| 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | | ICD Ind. | 0 | |
| A. H40.1131 | B. | C. | D. | |

| 24. A. DATES OF SERVICE From MM | DD | YY | To MM | DD | YY | B. POS | C. EMG | D. PROCEDURES, SVCS CPT/HCPCS | MODIFIER | | | | E. DX POINTER | F. $ CHARGES | | G. UNITS | H. EPSDT | I. ID QUAL. | J. RENDERING PROVIDER I.D. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| mm | dd | yyyy | | | | 11 | | 9xxxx | | | | | A | xxx | xx | 1 | | NPI | 1234567890 |
| mm | dd | yyyy | | | | 11 | | 92083 | | | | | A | xxx | xx | 1 | | NPI | 1234567890 |

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

Your 74 y/o established Medicare patient with mild stage open-angle glaucoma, OU, is in for her yearly comprehensive examination. The cup to disc ratio is enlarged compared with the last exam and image. She notes she hasn't used the prescribed IOP-lowering medication regularly as instructed. You order and perform fundus photography and VF today, OU. The visual field damage has progressed to moderate stage in each eye. In addition to the exam (shown as 9xxxx), the claim will read as follows.

| 17 REFERRING/ORDERING PROVIDER | 17a. | | |
|---|---|---|---|
| DK J Emdy MD | 17b. | NPI | 1234567890 |
| 19 ADDITIONAL CLAIM INFORMATION | | | |
| 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | ICD Ind. 0 | | |
| A. H40.1132 B. C. D. | | | |

| 24. A. DATES OF SERVICE From MM DD YY | To MM DD YY | B. POS | C. EMG | D. PROCEDURES, SVCS CPT/HCPCS | MODIFIER | E. DX POINTER | F. $ CHARGES | G. UNITS | H. EPSDT | I. ID QUAL. | J. RENDERING PROVIDER I.D. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| mm dd yyyy | | 11 | | 9xxxx | | A | xxx xx | 1 | | NPI | 1234567890 |
| mm dd yyyy | | 11 | | 92250 | | A | xxx xx | 1 | | NPI | 1234567890 |
| mm dd yyyy | | 11 | | 92083 | | A | xxx xx | 1 | | NPI | 1234567890 |

Financial Waivers

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

The format of an ABN cannot be modified to any significant degree. You must add your name, address and telephone to the header. You may add your logo and other information if you wish. The "Items or Services," "Reason Medicare May Not Pay," and "Estimated Cost" boxes are customizable so you can add pre-printed lists of common items and services or denial reasons. Anything you add in the boxes must be high contrast ink on a pale background. Blue or black ink on white paper is preferred. You may not make any

[27] Advance Beneficiary Notice of Noncoverage. Link here. 10/06/24

other alterations to the form. It must be one page, single-sided, although an addendum is allowed.

The patient must *sign* and *date* the form; an unsigned or undated form is not valid. Once the patient has signed the completed form, he or she must receive a legible copy. The same guidelines apply to the copy as to the original: blue or black ink on white paper is preferred; a photocopy is fine. You keep the original in your files.

You must complete your portion of the form before asking the beneficiary to sign. Fill in the beneficiary's name and identification number (but not HIC number) at the top of the form. Complete the "Items or Services" box, describing what you propose to provide. Use simple language the beneficiary can understand. You may add CPT or HCPCS codes, but codes alone are not sufficient without a description. Complete the "Reason Medicare May Not Pay" box with the reason(s) you expect a denial. The reason(s) must be specific to the particular patient; general statements such as "medically unnecessary" are not acceptable. The "Estimated Cost" field is required.

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

- ☐ Option 1 *I want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but* ***I can appeal to Medicare*** *by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.*
- ☐ Option 2 *I want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and* ***I cannot appeal if Medicare is not billed.***
- ☐ Option 3 *I don't want the items or services listed above. I understand with this choice I am* ***not*** *responsible for payment, and* ***I cannot appeal to see if Medicare would pay.***

If the beneficiary chooses Option 1, you must file a claim and append an appropriate modifier to the reported item(s) or service(s). Option 2 applies to situations where Medicare is precluded from paying for the item or service and the beneficiary does not dispute the point; you are not required to file a claim. If the beneficiary chooses Option 3, there is no claim to file or charge to make; the service is not provided because the patient declines.

You do not need an ABN for items or services that are statutorily (*i.e.,* by law) non-covered by Medicare. Statutorily non-covered services in an eye care practice include refractions and cosmetic procedures such as refractive surgery. Instructions, published on September

5, 2008,[28] allow the use of an ABN *voluntarily* for items excluded from Medicare coverage. At your discretion, you may choose to notify a beneficiary that these services are never covered using the ABN. Written notification is strongly recommended to avoid confrontations with beneficiaries about payment.

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

- Modifier GA is now defined as "Waiver of Liability Statement Issued as Required by Payor Policy". It applies when you believe Medicare will consider a service not medically necessary in a particular situation. Ask the patient to sign an ABN and submit your claim with modifier GA, allowing the payor to decide if the service is covered.
- Modifier GX is defined as "Notice of Liability Issued, Voluntary Under Payor Policy". It applies when a service is always noncovered; it addresses the fact that most beneficiaries will elect Option 1 in the hope that Medicare might pay, despite your assurances to the contrary. Therefore, if the patient selects Option 1, append modifiers GX and GY to that claim to obtain a denial.
- Modifier GY is defined as "Item or service statutorily excluded or does not meet the definition of any Medicare benefit".

Note that Medicare Advantage plans (Medicare Part C) are prohibited from using the regular Medicare ABN form but may still require prior financial notice. In many cases, they are required to provide a coverage or non-coverage determination in advance. Check plan websites for appropriate instructions.

For non-Medicare beneficiaries, some of the principles outlined above are just as applicable. While the concept of waiver of liability may not be present, or at least not as vigorously, it is still prudent to ensure that patients appreciate the distinction between covered and non-covered services and accept financial responsibility for the latter.

## Prohibited Code Combinations

In 1996, CMS developed the National Correct Coding Initiative (NCCI)[30] to control improper coding leading to inappropriate payments in Part B claims.[31] NCCI consists of a

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[28] CMS. Medicare Learning Network, MLN Matters MM6136. Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage. Link here. Accessed 10/06/24

[29] CMS. Transmittal R1921CP. Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs). February 19, 2010. Link here. Accessed 10/06/24

[30] CMS. National Correct Coding Initiative Edits. Link here. Accessed 10/06/24

[31] Medicare Claims Processing Manual, Chapter 23, §20.9. Correct Coding Initiative. Link here. Accessed 10/06/24

series of edits to analyze codes reported on claims for reimbursement. They ensure the most comprehensive groups of codes are billed rather than the component parts; this is the concept informally known as "bundles". Additionally, the edits check for mutually exclusive code pairs – procedures that are medically incompatible – so just one of the pair may be reimbursed. New edits are published quarterly by the National Technical Information Service (NTIS). Some carriers have also published local policies with additional limitations. Of note, you may not use an ABN to circumvent the NCCI edits.

The current NCCI edits for VFs are shown below; only common ophthalmic codes are included; check the full listing for other possible code exclusions. The edits mean that just one service will be reimbursed when both are performed on the same day; it behooves you to bill just one, usually the greater one, assuming that both tests have clinical utility.

Table 2 **NCCI Edits** [32]

| Primary Code | Do Not Bill These Codes With Primary Code | Do Not Bill Primary Code With These Codes |
|---|---|---|
| 92083 | 99211 | 0378T 0379T 15820$^0$ 15821$^0$ 15822$^0$ 15823$^0$ 67901$^0$ 67902$^0$ 67903$^0$ 67904$^0$ 67906$^0$ 67908$^0$ 92081$^0$ 92082$^0$ |

Note: NCCI edits in effect as of October 1, 2024.

Purchased Diagnostic Tests / Anti-Markup Rule

If you order and bill for a test and either the technical component or the professional interpretation is performed by another physician, you may be prohibited from marking up the test (*i.e.*, receiving payment from Medicare in excess of the amount you paid to the physician who performed the technical component or professional interpretation) unless the physician who performs the test "shares a practice" with you.[33] However, if the performing physician meets the Medicare criteria for "sharing a practice" with you, the prohibition would not apply for that diagnostic test. The prohibition against marking up the test is referred to as the Medicare Anti-Markup Rule and was formerly known as the Purchased Diagnostic Test Rule.

If the Medicare Anti-Markup Rule applies because the performing physician is not deemed to share a practice with the billing physician, the payment to the billing physician (less the applicable deductibles and coinsurance paid by the beneficiary or on behalf of the

[32] Codes marked with superscript $^0$ may not be unbundled for any reason. Other codes may be unbundled in some situations (*e.g.*, different session). Bundles shown are common ophthalmic edits. Check the complete NCCI edits for all bundles.

[33] CMS. Transmittal 135, April 2, 2004. CR 1658. §20.2.4.1 Link here. Accessed 10/06/24

beneficiary) for the technical component or the professional component of the diagnostic test may not exceed the lowest of the following amounts:

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

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

## PAYMENT LEVELS

Medicare reimbursement for CPT code 92083, defined as "unilateral or bilateral", is the same if both eyes are tested or only one.[35] The 2024 national Medicare Physician Fee Schedule allowable amounts are shown below (Table 3); these amounts are adjusted in each area by local indices. Other payors set their own rates, which may differ significantly from the Medicare published fee schedule.

Table 3 **Medicare National Allowable Rates**

| Code | Description | | PAR Allowable | Non-PAR Allowable | Limiting Charge for Non-PAR[36] |
|---|---|---|---|---|---|
| 92083 | VF, Extended | Global | $63.25 | $60.08 | $69.10 |
| | | TC | $36.95 | $35.10 | $40.37 |
| | | PC | $26.30 | $24.98 | $28.73 |

Multiple Procedure Payment Reduction

Medicare has implemented a payment reduction when multiple tests are performed at the

[34] Medicare Claims Processing Manual, Chapter 1, Section 30.2.9. Link here. Accessed 10/06/24

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

[36] Participating physicians (PAR) agree to accept Medicare allowed amounts on all covered services as their maximum payment from all sources. This is known as "accepting assignment". Non-participating physicians (Non-PAR) may accept assignment on a case-by-case basis, but are also limited in the amount they may charge the patient if they do not accept assignment. For additional discussion, see information published by CMS for patients here. Accessed 10/06/24

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same encounter. Known as the Multiple Procedure Payment Reduction (MPPR),[37] it has been in effect since January 1, 2013. This payment policy reduces the *technical component* of the second and any subsequent ophthalmic diagnostic tests by 20% when more than one eligible diagnostic test is performed at one patient encounter on the same day by the same physician or group. The list of tests[38] includes ultrasounds, imaging, and VFs. Tests not on the list are not subject to the MPPR reduction.

*MPPR Example*

The MPPR would affect Medicare payment amounts in Sample Claim 2, above, as follows.

| Test | Professional | Technical | Total |
|---|---|---|---|
| 92083 Visual Field | $26.30 | $36.95 (No reduction) | $63.25 |
| 92250 Fundus Photo | $20.31 | $16.64 less $3.329 (20%) = $13.315 | $33.62 |

2024 National Medicare Physician Fee Schedule, PAR allowable

The payment reduction is taken only on the lesser of the two *technical* portions – which is the fundus photography in this example for 2024. Note that the professional portions of each of the respective tests are unaffected and paid in full.

## Health Professional Shortage Area (HPSA)

Medicare pays a quarterly 10% premium to physicians who provide services in a Health Professional Shortage Area (HPSA). Historically, modifiers QU (urban) and QB (rural) designated services eligible for a HPSA bonus. Modifier AQ replaced these modifiers on January 1, 2006; the distinction between rural and urban HPSAs no longer exists. No modifier is necessary if your zip code is listed as HPSA eligible. The bonus payment will be automatic. Eligible services provided at locations not listed will continue to need the modifier AQ.

This premium is pertinent only to professional services and does not apply to the technical component (TC) of diagnostic tests. It is not necessary to separate the professional and technical components in order to receive bonuses; the carrier will automatically calculate bonus payments on the professional component. As an illustration, if the test in Sample Claim 1, above, had been performed in a HPSA not receiving automatic bonus payments,

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[37] CMS. Medicare Learning Network, MLN Matters MM7848, Eff. January 1, 2013. Link here. Accessed 10/06/24

[38] CMS Transmittal 1149, dated November 6, 2012, identifies the specific tests by CPT code that are subject to the MPPR. The Medicare Physician Fee Schedule multiple procedure indicator also identifies these codes each year (multiple procedure indicator 7). Link here. Accessed 10/06/24

then both the exam and the VF would be billed with modifier AQ (9xxxx-AQ and 92083-AQ).

## UTILIZATION

Medicare utilization rates for claims paid in 2018 show that 92083 was associated with 11% of all office visits by ophthalmologists. That is, for every 100 exams performed on Medicare beneficiaries, Medicare paid for one of these services 11 times. For optometrists, the utilization rate is 9%. Probably these values represent too-little testing.

Medicare utilization rates are published and are noted above; commercial utilization rates are not readily available. In general, these and all diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required. If your utilization rate exceeds the expected norms, you will likely garner attention from Medicare and other payors. Careful attention to documentation of the test and the reasons it was performed are your best defense against reproach in the event of postpayment review.

## CONCLUSION

Standard automated perimetry is not fun for patients, technicians, or physicians. VF testing induces anxiety and anxiety itself affects the performance of the test.[39] Not surprisingly, everyone connected with VF testing would like to avoid that experience so adherence to VF testing protocols is poor and the interval between tests is longer than recommended. "*An objective, non-contact, highly reproducible, and reliable diagnostic test that takes less than 90 seconds to test both eyes and with easy structure–function correlation will be a game changer in busy clinics for providing standard eye care services.*"[40]

The VF results have utility for people other than an ophthalmologist or optometrist. For example, they are helpful in neurology (*e.g.*, with stroke), during litigation (*e.g.,* malpractice), as part of criminal investigations (*e.g.,* with head trauma), for teaching purposes, and for low vision providers (*e.g.,* for mobility).

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[39] Ali, MS. Commentary: Visual field testing: a distressing or unpleasant experience! Indian J Ophthalmol 2022 Aug;70(8):2887-2888 Link here. Accessed 10/7/24

[40] Rai BB, Sabeti F, Carle CF, Maddess T. Visual Field Tests: A Narrative Review of Different Perimetric Methods. J Clin Medicine April 2024 13(9):2458 Link here. Accessed 10/7/24

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

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

**Practice Management Tips**

- Store the electronic file of a VF test within the electronic medical record, or in a secure, retrievable location; reference the location within the medical record.
- Document the physician's interpretation of the VF test in a report within a short time, preferably within 24-72 hours. Be sure to address the quality of the test, the findings and the assessment; include a comparison with prior tests when applicable. Sign the note.
- Some conditions warrant repeat testing to assess progressive disease or a worsening condition. Schedule repeat tests only when the required information cannot be obtained through clinical exam alone. Clearly document the rationale for repeat services.
- Coding for laterality and staging was added to some of the common eye conditions in the ICD-10-CM codes effective October 1, 2016.
- Notify the patient, prior to testing, of financial responsibility if your diagnosis is not on the covered list for the payor, the VF test is to screen for possible disease, routine, or otherwise not covered by insurance. Document acceptance with an ABN (for Medicare), NEHB, or predetermination of benefits.
- Reimbursement for VF tests is subject to Medicare's MPPR rules. When performed concurrently or with other tests on the same day, payment may be reduced.
- If you use an independent contractor to perform VF tests, that is, someone who provides all the equipment and technician and is not an employee, get assistance with Medicare's arcane anti-markup rules.