Reimbursement FAQs for:

OCT (SCODI) of the Posterior Segment

1 Can OCT be performed with Optos devices?

Yes; "SCODI" (scanning computerized ophthalmic diagnostic imaging) is the procedure name used for ophthalmic OCT imaging, and SCODI-P (posterior OCT) describes OCT of the retina or optic nerve head. Posterior OCT is offered on two different Optos devices: Monaco (spectral domain OCT) and Silverstone (UWF-guided, swept source OCT).

There are two CPT codes that describe these tests:

92133 SCODI, posterior segment, optic nerve

92134 SCODI, posterior segment, retina

Both require interpretation and report and are unilateral or bilateral.

2 What are the indications for this test?

Posterior OCT is used to assess the status of the retina or ONH in a variety of conditions such as DR, AMD, and glaucoma.

3 Does Medicare cover OCT of the posterior segment?

Medicare covers posterior OCT 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 is 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.

4 What documentation is required in the medical record to support these claims?

A physician's interpretation and report are required. A brief notation such as "abnormal" does not suffice. In addition to the images or a reference to where they are stored, the medical record should include:

- order for the test with medical rationale
- date of the test
- reliability of the test (*e.g.*, cloudy with cataract)
- test findings (*e.g.*, retinal hemorrhages, neovascularization)
- comparison with prior tests (if applicable)
- a diagnosis (if possible)
- the impact on treatment and prognosis
- physician's signature and date

5 What is the Medicare payment amount for this test?

For national payment rate and notes on National Correct Coding Initiative (NCCI) edits please visit heir website.

Please note, this CPT code is subject to Medicare's Multiple Procedure Payment Reduction (MPPR). This reduces the allowable for the technical component of the lesser-valued test when more than one test is performed on the same day.

As always, health care providers should check local coverage polices before billing.

This information is based on publicly available information from CMS and other sources. The reader is strongly encouraged to review applicable laws, regulations and instructions promulgated by Medicare and other payers. This document is not an official source nor is it a complete guide on reimbursement. We believe this information is accurate at the time of publication; however, this information changes over time, and may be incorrect at any time following publication.

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6 Are there other CPT codes that may not be billed on the same day as this test?

Medicare's National Correct Coding Initiative (NCCI) treats fundus photography (92250) as mutually exclusive with posterior OCT. CPT also notes that 92133 and 92134 may not be reported at the same patient encounter and Medicare has imposed the same edit, even if performed for different diagnoses.

6b If How often may posterior OCT be repeated on a patient?

Repeat OCT imaging may be necessitated by disease progression, the advent of new disease, or planning for additional treatment (*e.g.*, laser). Repeated imaging of the same, unchanged, condition is unwarranted.

Some MACs have published policies with 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). Too- frequent testing can garner unwanted attention from payers.

7 If coverage is unlikely or uncertain, how should we proceed?

Explain to the patient why the test is necessary, and that their insurance provider is likely to deny the claim. Ask the patient to assume financial responsibility for the charge. There are different documentation options; the correct choice depends on the insurance provider.

- For Part B Medicare, an Advance Beneficiary Notice of Noncoverage (ABN) is required for services when coverage is ambiguous, doubtful, or never covered. You may collect your fee from the patient at the time of service or wait for a Medicare denial. If both the patient and Medicare pay, promptly refund the patient or show why Medicare paid in error.

7 cont.

- For Part C Medicare/Medicare Advantage (MA), determination of benefits is required to identify beneficiary financial responsibility prior to performing noncovered services. MA Plans have their own waiver processes and are not permitted to use the Medicare ABN form.
- For commercial insurance beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN.

8 Is the physician's presence required during testing?

According to Medicare guidelines, this test requires 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 procedure.

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