Corcoran Consulting Group

A Division of Ardare Corporation

External Ocular Photography and AOS® Anterior Software

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External Ocular Photography and AOS® Anterior Software

by

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Objective: *This report is provided as a general discussion of billing and documentation for use of Advanced Ophthalmic Systems (AOS®) Anterior software during external ocular photography and related issues. Variations in coverage and payment policies among Medicare Administrative Contractors (MACs) may occur which are not described here. Other non-Medicare payers may promulgate policies that differ from those of Medicare and its contractors. The user is strongly encouraged to review federal and state laws, regulations and official instructions of the Centers for Medicare & Medicaid Services (CMS), the MACs, and other third-party payers.*

Notice: *All fee schedule amounts noted in this document are the national Medicare allowed amounts. Actual fee schedule amounts and payments vary by locality.*

Disclaimer: *The reimbursement information is provided by Corcoran Consulting Group based on publicly available information from the CMS, the AMA, and other sources. This document is not an official source nor is it a complete guide on all matters pertaining to coding (CPT, HCPCS or ICD-10) and reimbursement. Neither Sparca Corporation nor Corcoran Consulting Group guarantees that the use of this information will result in payment for services. The reader is reminded that this information can and does change over time, and may be incorrect at any time following publication. The continued availability of cited references as hyperlinks, whether embedded or not, cannot be ensured.*

This document does not constitute legal or medical advice. Physicians and other providers should use independent judgment when selecting codes that most appropriately describe the services provided to a patient. Physicians and hospitals are solely responsible for compliance with applicable laws, Medicare regulations, and other payers' requirements and should confirm the applicability of any coding or billing practice with applicable payers prior to submitting claims.

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INTRODUCTION

Advanced Ophthalmic Systems (AOS®) Anterior is a software system[1] that analyzes images of the exterior part of the eye. The software aims to consistently grade redness of the cornea, conjunctiva, vessels, and eyelid using an automated objective grading scale. The results are accurate and repeatable to aid the clinician in diagnosing and treating the eye. A recent study demonstrated that the AOS Anterior resulted in higher repeatability and accuracy in grading redness than both the established Efron and CCLRU grading scales.[2] Images can be captured directly with the companion software application or via a slit lamp adaptor which securely transfers these images to the AOS Anterior platform for analysis.

Reimbursement for external ocular photography depends on many factors, particularly medical necessity for the service, so the mere taking of images does not automatically support payment. A listing of commonly covered diagnosis codes is included in the Appendix.[3] Software systems, such as AOS Anterior, are an incidental part of the technical component of the service and not separately reimbursed.

INDICATIONS

The AOS Anterior software assists clinicians in the assessment of patients with eye redness that may result from contact lenses intolerance, dry eye disease, blepharitis, allergic conjunctivitis, and any disease or condition which affects the bulbar redness, ocular surface staining, and palpebral eyelid redness. Other indications that go beyond redness include rigid contact lens fitting, monitoring corneal pannus progression, and fluorescein staining of keratopathies.

THE SOFTWARE

AOS Anterior is an agnostic software system that allows ophthalmologists and optometrists to take and analyze images of the anterior part of the eye; this includes cornea, conjunctiva, blood vessels, and the inner surface of the eyelid. These images of the eye

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1 Sparca Corp. Product information. Link here. Accessed 05/20/20.

2 Validation of AOS software for anterior eye complications. Dr. Byki Huntjents, City, University of London. May 25, 2018. Link here. Accessed 05/20/20.

3 The Appendix contains a list of commonly accepted diagnosis codes for the diagnostic test discussed in this monograph. Listed codes are representative of covered diagnoses, but differences in payment policies exist for many payers. The lists are neither exhaustive nor universally accepted.

are typically captured with a camera attached to a slit lamp, but can also be captured by other camera devices, such as tablets and smartphones.

The analysis provided by Version 2.0 of the software quantifies several parameters:

- the number of vessels over the user-defined areas of conjunctiva,
- the levels of redness of the eye graded from 0 to 4 (bulbar and palpebral conjunctivae can be graded separately), and
- the level of fluorescein staining in the corneal and conjunctival regions.

The system stores these parameters which clinicians utilize for initial evaluation as well as follow-up assessments. The AOS Anterior software does not make recommendations regarding diagnosis or treatments.

The user interface (UI) permits analysis of any uploaded image with three modes for use on various anterior segment images: 1) bulbar redness, 2) palpebrae redness, and 3) fluorescein staining. A digital ruler permits area calculations over images (Figures 1 and 2). The digital ruler feature is available in any mode to measure areas of interest and set a predetermined baseline (Figures 1 and 5). Once the baseline is set and the unit measurement selected, multiple points can be evaluated and measured.

Fluorescein mode (Figure 1) analyses images of the cornea and/or conjunctiva to quantify overall staining, punctates, and conjunctival folding. Analysis of fluorescein pooling is useful for fitting corneal or scleral rigid contact lenses. Bulbar redness mode (Figures 3 and 4) grades the level of redness in defined areas on a 0 to 4 standard scale of the bulbar conjunctiva. Results might appear as whole numbers, but when the software calculates it between two standardized values, the results reflect the fractional nature. Lid redness mode (Figure 5) analyses palpebral conjunctival redness.

Figure 1 **AOS® Digital Ruler Applied Over Fluorescein Mode**

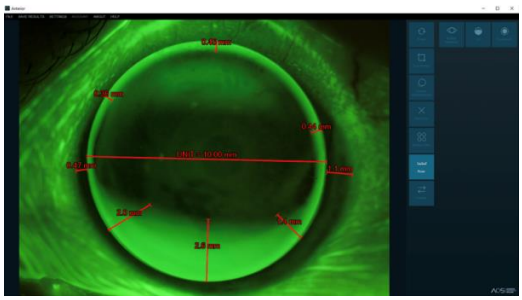
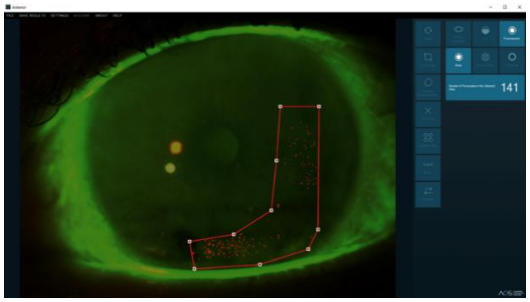


Figure 2 **Area Calculation Function**



Other features of the software include the ability to add filters to enhance images; red-free and yellow "barrier filters" are currently available. This is performed on the entire image by automatically removing the digital noise. The software also permits cropping of digital images.

Figure 3 **AOS® Bulbar Redness**

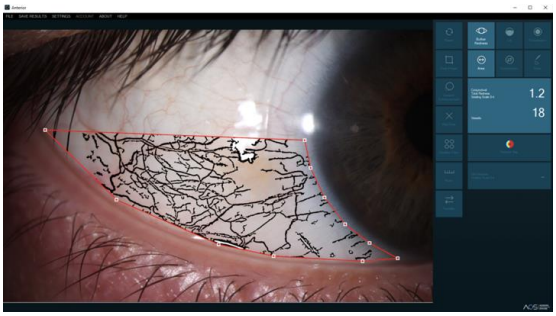


Figure 4 **AOS® Bulbar Redness**

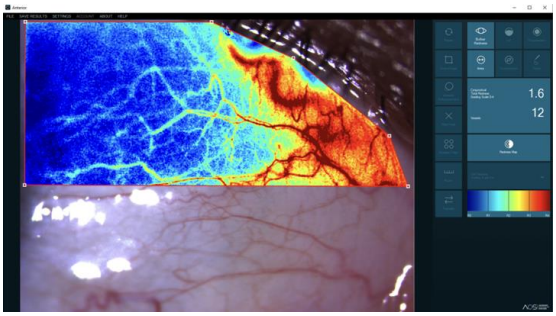
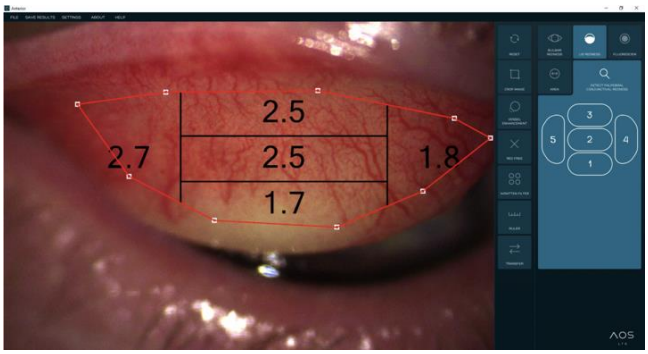


Figure 5 **AOS® Lid (Palpebral) Redness**



DOCUMENTATION

There are only a few policies within the Part B Medicare program for external ocular photography. CGS Administrators is one Medicare Administrative Contractor (MAC) that has a current policy.[4] As with most MAC Local Coverage Determinations (LCD), there is an accompanying Local Coverage Article (LCA)[5] which lists covered diagnoses and related information.

[4] CGS Administrators, LLC. Local Coverage Determination #L34293. Ocular Photography – External. Rev. Eff. 10/31/19. Link here. Accessed 05/20/20.

[5] CGS Administrators, LLC. Local Coverage Article #A57068. Billing and Coding: Ocular Photography – External. Rev. Eff. 10/31/19. Link here. Accessed 05/20/20.

The LCD for CGS notes in "Indications",

> "*This procedure may be indicated when photo-documentation is required to track the progression or lack of progression of an eye condition, or to document the progression of a particular course of treatment.*
>
> *External ocular photography is covered when a special camera is used to obtain magnified photographs of lesions (e.g., the cornea, iris or lids) for the purpose of following the patient's condition. Medical quality images may be digital, Polaroid Macro 3 SLF or equivalent.*"

Under "Limitations" on coverage, CGS notes,

> "*While many conditions of the eye could be photographed, this procedure should not be used to simply document the existence of a condition in order to enhance the medical record.*
>
> *Photographs for the purpose of documentation for medical legal purposes or preauthorization (e.g., gross trauma, amount of ptosis or redundant lid tissue for blepharoplasty) are not separately reportable or reimbursable.*
>
> *Photography may be reported only once per session, even though multiple views may be taken …*
>
> *External ocular photography without accompanying patient identification and date permanently affixed to the photograph will be considered not to be reasonable or necessary and will be denied.*"

The description in CPT for external ocular photography includes the phrase *"with interpretation and report"*.[6] 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 a reason to require repayment of any reimbursement.

Medicare Regulations and Guidance

The Medicare guidelines for interpretation of diagnostic tests are discussed in the Medicare Claims Process Manual (MCPM) Chapter 13 §100, Interpretation of Diagnostic Tests.[7] CMS makes a distinction between a review of a test and an interpretation and report.

> *"Carriers generally distinguish between an "interpretation and report" of an x-ray or an EKG procedure 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*

[6] American Medical Association. Current Procedural Terminology (CPT) 2020 Professional Edition.

[7] Medicare Claims Process Manual (MCPM), Chapter 13, §100. Interpretation of Diagnostic Tests. Link here. Accessed 05/20/20.

> *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,[8] 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, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures. The carrier pays for interpretations only if there is a written report prepared for inclusion in the patient's medical record maintained by the hospital.*"

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?*
- 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?*

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[8] 42 CFR 415.120(a). Conditions for payment: Radiology services, to beneficiaries. Link here. Accessed 05/20/20.

- Impact on treatment, prognosis – *What's next?*
- Physician's signature – *Who is the physician?*

In ophthalmology and optometry, tests such as external eye photography are more valuable for making decisions about treatment when there is a series. There are coverage considerations as well. CGS, in their Local Coverage Article, notes the following regarding repeat photos.

> "*If additional photographs are taken to track changes in the patient's condition, written documentation describing changes is required and must be maintained in the patient's medical record. An interpretation of the photograph(s) with comparison to prior photographs, if available, must be maintained in the patient's medical record and available for review, if requested.*
>
> *The frequency with which external ocular photography should be performed is based on the patient's underlying condition and the usual progression of that condition. This service should not be repeated if there has been no change in the patient's conditions.*
>
> *In some cases, it is expected that this service would be reasonable once yearly. However, in certain conditions, this test may be appropriate more frequently.*"

It is clear that the concept of comparative data cited above is particularly meaningful and, as an objective measure, AOS software may help. Does the series demonstrate disease progression? For an external photograph, the interpretation and report might read as follows.

- May 15, 2020
- Technician: Mary Smith, COA
- Recent change in size and redness of conjunctival lesion. Prior measurement was 2 mm smaller in horizontal and 3 mm smaller vertically. AOS Anterior software shows an increase in redness from last exam.
- Good patient cooperation
- Documented change in lesion size but patient remains asymptomatic
- Patient advised to call if changes observed
- Follow-up in 3 months, if growth or other characteristics change, consider possible malignancy and excise with specimen sent to pathology
- *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. Within an electronic medical record, we often find a designated spot to record the physician's interpretation of a test as a report. 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 "external photo 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 external photography requires only general supervision,[9] 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. 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, 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 TC and 26 are not appended to a CPT code, then the payer understands that reimbursement is sought for both the technical and professional components together in a single payment.

[9] 42 CFR 410.32(b)(3)(i). Definition of general supervision. Link here. Accessed 05/20/20.

SUPERVISION

Medicare's supervision rules for many ophthalmic diagnostic tests have been stable since July 1, 2001. External photography 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.[10]

BILLING ISSUES

Procedure Codes

For in-office use on a medically necessary external ocular photograph, including AOS Anterior software analysis, billers should report CPT code 92285.

92285 … *External ocular photography with interpretation and report for documentation of medical progress (e.g., close-up photography, slit lamp photography, stereo-photography*

If a patient has Part B Medicare as their primary insurance and downloads the AOS Anterior software onto their smartphone or tablet with photo capability, HCPCS code G2010 may apply under certain conditions instead of 92285.

G2010… *Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment*

For G2010, the patient takes an image of the eye(s) that is securely forwarded to the ophthalmologist or optometrist. The AOS Anterior software is a secure platform consistent with privacy protection under HIPAA. In order to use this HCPCS code on a claim for reimbursement, there are several requirements. The patient must be an established patient – not a new patient.[11] The patient must give documented consent for billing, either verbal

[10] 42 CFR 410.32(b)(3)(i). Definition of general supervision. Link here. Accessed 05/20/20.

[11] Medicare defines a new patient as a "*patient who has not received any professional services, i.e., evaluation and management (E/M) service or other face-to-face service (e.g., surgical procedures) from*

or written. The evaluation of the images must be provided by a physician or other qualified healthcare professional, not a technician or medical assistant. Finally, the G2010 service cannot result from an evaluation and management (E/M) service within the past 7 days or result in an E/M service in the next 24 hours or next available appointment. G2010 is subject to the usual deductibles and co-payments. Other third party payers make their own coverage and payment determinations and might or might not accept G2010 for reimbursement.

Modifiers

Modifiers provide additional information about the services provided. Following are some modifiers frequently associated with surgical claims. Check your Medicare bulletins and the CPT handbook for additional modifiers and expanded descriptions.

22 …..	Unusual procedural services
52	Reduced services
59 …..	Distinct procedural service (see also X-modifiers)
GA ….	Medicare probably does not cover this service; Advance Beneficiary Notice of Non-coverage (ABN) signed, as required by payer policy
GX …	Medicare probably does not cover this service. Advance Beneficiary Notice (ABN) signed, voluntary notice given under payer policy
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 (used to obtain a denial)
GZ ….	Item or service expected to be denied as not reasonable and necessary (no ABN on file) (*Medicare only*)
XE ….	Separate encounter (use in lieu of modifier 59)
XS ….	Separate structure (use in lieu of modifier 59)
XP ….	Separate practitioner (use in lieu of modifier 59)
XU ….	Unusual non-overlapping service (use in lieu of modifier 59)

the physician or physician group practice (same physician specialty) within the previous three years". Medicare identifies ophthalmologists as one specialty (18) and optometrists as another (41). During the COVID-19 Declared Public Health Emergency (PHE) the "established patient" requirement for G2010 is waived.

Prohibited Code Combinations

In 1996, CMS developed the National Correct Coding Initiative (NCCI)[12] to control improper coding leading to inappropriate payments in Part B claims.[13] NCCI consists of a 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.

According to the April 1, 2020, NCCI edits, both gonioscopy (92020) and the technician exam (99211) are bundled with external photos (92285). In addition, 92285 is bundled with some common eyelid surgery codes 15820-15823.[6]

G2010 is not currently bundled with any codes.

Sample Claims

Example 1 New conjunctival lesion - pterygium

During an eye exam, nasal pterygia are noted OU which have progressed according to the patient. You order external ocular photography OU and use the AOS Anterior software to enhance the images and to permit objective re-evaluation in 6 months. No excision is scheduled. In addition to the exam (shown as 9xxxx), the claim will read as follows.

17 REFERRING/ORDERING PROVIDER J Emdy, MD	17a 17b 12345678
19 ADDITIONAL CLAIM INFORMATION	
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind | 0 | A.H11.053 B. C. D.	

24a DATES OF SERVICE FROM	TO	24b POS	24d PROCEDURES, SVCS CPT/HCPCS	MODIFIER	24e DX POINTER	24f $ CHARGES	24g UNIT	24i ID QUAL	24j RENDERING PROV ID
mm/dd/yyyy		11	9xxxx	| | | |	A	xx.xx	1	NPI	1234567890
mm/dd/yyyy		11	92285	| | | |	A	xx.xx	1	NPI	1234567890

[12] CMS. National Correct Coding Initiative Edits. Link here. Accessed 05/20/20.

[13] Medicare Claims Processing Manual, Chapter 23, §20.9. Correct Coding Initiative. Link here. Accessed 05/20/20.

If subsequent re-evaluation in 6 months reveals no change, repeating the external photos would not be warranted; the earlier photographs suffice. If the patient had elected surgery at either visit, external photography would not have been warranted since there would be nothing to compare it to later, after excision.

Example 2 Eyelid lesion

Your 70 y/o established patient presents for a yearly examination. You note an abnormal lesion on the right lower eyelid. You decide to monitor the lesion and not remove it at this time. You order and perform external ocular photographs and enhance the image with AOS software. In addition to the exam (shown as 9xxxx), the claim will read as follows.

17 REFERRING/ORDERING PROVIDER J Emdy, MD	17a 17b 12345678
19 ADDITIONAL CLAIM INFORMATION	
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind | 0 | A. D48.5 B. C. D.	

24a DATES OF SERVICE FROM	TO	24b POS	24d PROCEDURES, SVCS CPT/HCPCS	MODIFIER	24e DX POINTER	24f $ CHARGES	24g UNIT	24i ID QUAL	24j RENDERING PROV ID
mm/dd/yyyy		11	9xxxx	| | | |	A, B	xx.xx	1	NPI	1234567890
mm/dd/yyyy		11	92285	| | | |	A, B	xx.xx	1	NPI	1234567890

Example 3 Patient sends external eye image to eye doctor

Through the practice's secure patient portal, a patient emails you a photo of conjunctival redness in the left eye. The patient cannot travel now. You review the image and respond within 24 hours via the secure portal. It appears to be a subconjunctival hemorrhage. Your note in the chart and to the patient explains your assessment and no visit is scheduled. If it recurs, you may have to see her. The claim will read as follows.

17 REFERRING/ORDERING PROVIDER J Emdy, MD	17a 17b 12345678
19 ADDITIONAL CLAIM INFORMATION Only left eye photographed	
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind | 0 | A.H11.32 B. C. D.	

24a DATES OF SERVICE FROM	TO	24b POS	24d PROCEDURES, SVCS CPT/HCPCS	MODIFIER	24e DX POINTER	24f $ CHARGES	24g UNIT	24i ID QUAL	24j RENDERING PROV ID
mm/dd/yyyy			G2010	| | | |	A	xx.xx	1	NPI	1234567890

Financial Waivers

An Advance Beneficiary Notice of Non- Coverage (ABN, CMS-R-131)[14] 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. You must use the most recent version[15] of the ABN form that CMS publishes, or it could be considered invalid.

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 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*

[14] Advance Beneficiary Notice of Noncoverage. Link here. Accessed 05/22/20.

[15] During the current COVID-19 PHE, an updated form has been delayed and CMS has issued instructions to continue using the prior form dated 03/2020. CMS, Medicare, General Information. Link here.

*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,[16] 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,[17] 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 Payer 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 payer to decide if the service is covered.
- Modifier GX is defined as "Notice of Liability Issued, Voluntary Under Payer 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.

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[16] CMS. *MLN Matters* (MM6136). Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage. Link here. Accessed 05/20/20.

[17] CMS. Transmittal R1921CP. Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs). February 19, 2010. Link here. Accessed 05/20/20.

- Modifier GY is defined as "Item or service statutorily excluded or does not meet the definition of any Medicare benefit".

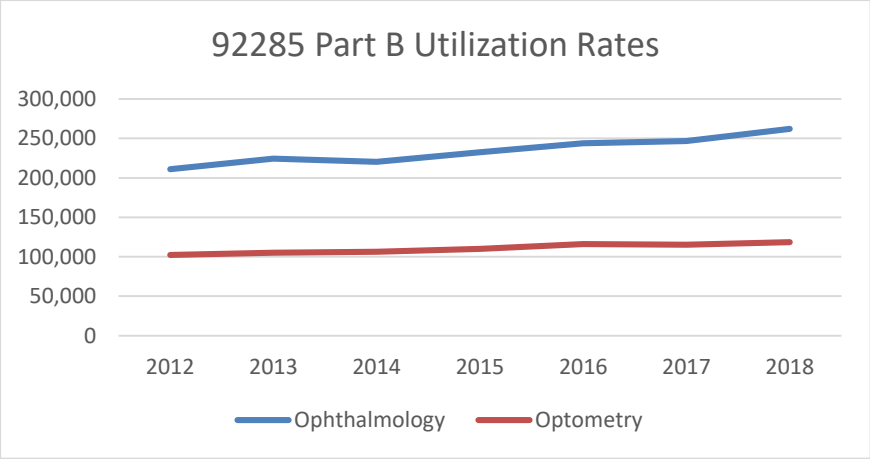
Note that Medicare Advantage plans (Medicare Part C) are prohibited from using the regular Medicare ABN form but may still require prior financial notice. In many cases, they are required to provide a coverage or non-coverage determination in advance. Check plan websites for appropriate instructions.

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.

UTILIZATION

For 2018, the most recent year for which there is Medicare public data, the Part B national utilization rate for CPT code 92285 for ophthalmologists was 262,056. For optometrists, it was 118,497. Figure 6 shows a steadily increasing use of 92285 over the past few years, more so for ophthalmology than for optometry.

Figure 6 **Utilization Trend of 92285 Over Time, Medicare Part B Data**



PAYMENT RATES

Medicare defines code 92285 as bilateral, so reimbursement is for both eyes. Billing with RT and LT on separate lines, or with modifier 50, does not increase payment and causes the entire claim to fail. No modifiers are required at all. The 2020 national Medicare Physician Fee Schedule allowable amounts are shown in Table 1.[18] Medicare allowable amounts are adjusted in each area by local wage indices. Other third party payers set their own rates, which may differ significantly from Medicare's fee schedule.

Table 1 **2020 Medicare Physician Fee Schedule**

Code		PAR Allowable	Non-PAR Allowable	Limiting Charge for Non-PAR
92285	Global	$22.38	$21.26	$24.45
	TC	$19.13	$18.17	$20.90
	PC	$3.25	$3.09	$3.55
G2010	Global	$12.27	$11.66	$13.41
	TC	N/A	N/A	N/A
	PC	N/A	N/A	N/A

In the Medicare Physician Fee Schedule, 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, such as 92285. 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.

Multiple Procedure Payment Reduction

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

[18] 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. Link accessed 05/20/20.

same encounter. Known as the Multiple Procedure Payment Reduction (MPPR),[19] 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[20] includes ultrasounds, imaging, and visual fields. Tests not on the list are not subject to the MPPR reduction. All the codes listed in this monograph are subject to MPPR.

Example MPPR

A patient returns for her 3 month glaucoma check and threshold visual field. During the history and exam, the patient notes an area of conjunctival redness in the right eye that was not there before. On exam, it is confirmed that this is unilateral and unrelated to the glaucoma eye drops which can also be the cause of increased redness. External photographs are also ordered and performed today. Both tests are properly interpreted. Medicare payment for these tests would be as follows.

Test	Professional	Technical	Total
92083 Visual Field	$28.15	$36.09 (No reduction)	$64.24
92285 External Photo	$3.25	$19.13 less $ (20%) = $18.48	$21.73

2020 National Medicare Physician Fee Schedule, PAR allowable

The payment reduction is taken only on the lesser of the two *technical* portions – which is 92285 in this example. Note that the professional portions of each of the respective tests are unaffected and paid in full.

CONCLUSION

External ocular photography is useful to ophthalmologists and optometrists. Care should be exercised to ensure the test is covered before billing the service to payers. Patients might send images of their eye and this may also be a covered service. Use of the AOS Anterior software to enhance the images for the ophthalmologist or optometrist is helpful, but it is not separately billable to payers or patients.

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[19] CMS Manual System, Pub 100-20 Notification. Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of diagnostic Cardiovascular and Ophthalmology Procedures. Link here. Accessed 05/20/20.

[20] CMS Transmittal 1149, dated November 6, 2012, identifies the specific tests that are subject to the MPPR. The Medicare Physician Fee Schedule multiple procedure indicator "7" identifies these codes each year. Link here. Accessed 05/20/20.

APPENDIX

Common Diagnosis Codes for External Ocular Photography

ICD-10	Description
A18.51	Tuberculous episcleritis
A18.52	Tuberculous keratitis
A50.31	Late congenital syphilitic interstitial keratitis
B00.52	Herpesviral keratitis
B00.53	Herpesviral conjunctivitis
B02.31	Zoster conjunctivitis
B02.33	Zoster keratitis
B02.34	Zoster scleritis
B30.0	Keratoconjunctivitis due to adenovirus
B60.12	Conjunctivitis due to acanthamoeba
B60.13	Keratoconjunctivitis due to acanthamoeba
C43.111 – C43.122	Malignant melanoma of eyelid, including canthus, specified eyelid
C44.1121 – C44.1192	Basal cell carcinoma of skin, including canthus, specified eyelid
C69.01 – C69.02	Malignant neoplasm of conjunctiva, specified eye
C69.11 – C69.12	Malignant neoplasm of cornea, specified eye
D03.111 – D03.122	Melanoma in situ of eyelid, including canthus, specified eyelid
D04.111 – D04.122	Carcinoma in situ of skin of eyelid, including canthus, specified eyelid
D22.111 – D22.122	Melanocytic nevi of eyelid, including canthus, specified eyelid
D23.111 – D23.122	Other benign neoplasm of skin of eyelid, including canthus, specified eyelid
D31.01 – D31.02-	Benign neoplasm of conjunctiva, specified eye
D31.11 – D31.12-	Benign neoplasm of cornea, specified eye
H02.881 – H02.882	Meibomian gland dysfunction, specified eyelid
H02.884 – H02.885	Meibomian gland dysfunction, specified eyelid
H02.88A – H02.88B	Meibomian gland dysfunction, specified eyelids
H02.89	Other specified disorders of eyelid
H04.121 – H04.123	Dry eye syndrome of specified lacrimal glands
H11.011 – H11.013-	Amyloid pterygium of specified eyes
H11.021 – H11.023-	Central pterygium of specified eyes
H11.031 – H11.033-	Double pterygium of specified eyes
H11.041 – H11.043-	Peripheral pterygium, stationary, of specified eyes
H11.051 – H11.053-	Peripheral pterygium, progressive, of specified eyes
H11.061 – H11.063-	Recurrent pterygium of specified eyes
H11.111 – H11.113-	Conjunctival deposits of specified eyes
H11.121 – H11.123-	Conjunctival concretions of specified eyes

Common Diagnosis Codes for External Ocular Photography

ICD-10	Description
H11.131 – H11.133-	Conjunctival pigmentations of specified eyes
H11.141 – H11.143-	Conjunctival xerosis of specified eyes
H11.221 – H11.223-	Conjunctival granuloma of specified eyes
H11.821 – H11.823-	Conjunctivochalasis of specified eyes
H15.041 – H15.043-	Scleritis with corneal involvement of specified eyes
H16.011 – H16.013-	Central corneal ulcer of specified eyes
H16.021 – H16.023-	Ring corneal ulcer of specified eyes
H16.031 – H16.033-	Corneal ulcer with hypopyon of specified eyes
H16.041 – H16.043-	Marginal corneal ulcer of specified eyes
H16.051 – H16.053-	Mooren's corneal ulcer of specified eyes
H16.061 – H16.063-	Mycotic corneal ulcer of specified eyes
H16.071 – H16.073-	Perforated corneal ulcer of specified eyes
H16.111 – H16.113-	Macular keratitis, specified eyes
H16.121 – H16.123-	Filamentary keratitis, specified eyes
H16.141 – H16.143-	Punctate keratitis, specified eyes
H16.211 – H16.213-	Exposure keratoconjunctivitis, specified eyes
H16.221 – H16.223-	Keratoconjunctivitis sicca, not specified as Sjogren's, specified eyes
H16.231 – H16.233-	Neurotrophic keratoconjunctivitis, specified eyes
H16.311 – H16.313-	Corneal abscess, specified eyes
H16.321 – H16.323-	Diffuse interstitial keratitis, specified eyes
H16.401 – H16.403-	Unspecified corneal neovascularization, specified eyes
H16.421 – H16.423-	Pannus (corneal), specified eyes
H17.11 – H17.13-	Central corneal opacity, specified eyes
H17.821 – H17.823-	Peripheral opacity of cornea, specified eyes
H17.89	Other corneal scars and opacities
H18.421 – H18.423-	Band keratopathy, specified eyes
H18.831 – H18.833-	Recurrent erosion of cornea, specified eyes

This is a list of commonly accepted diagnosis codes for external ocular photography (92285). Listed codes are intended to be representative of covered diagnoses, but differences in payment policies exist for many payers. The list is neither exhaustive nor universally accepted.

A dash (-) following a diagnosis code indicates that additional characters are required.