

Reimbursement Reductions for OCT

WITH TREXLER M. TOPPING, MD

On January 1, 2011, the Centers for Medicare and Medicaid Services (CMS) implemented major changes in reimbursement for several vitreoretinal codes. Specifically, the Current Procedure Terminology (CPT) coding and reimbursement for optical coherence tomography (OCT) was essentially cut in half. In an interview with Retina Today, Trexler M. Topping, MD, of Ophthalmic Consultants of Boston, discussed the history behind these cuts, their effect on vitreoretinal practices, and potential reimbursement changes for other imaging modalities.

Retina Today: What are the most recent OCT coding and reimbursement guidelines, and how have they changed in recent years?

In October 2008, code 92135 (OCT) was identified by the Relative Value Scale Update Committee (RUC) as one of the fastest growing codes in terms of utilization, triggering a RUC review and revaluation of the code. The American Academy of Ophthalmology then went to CPT and split the code in 2: 92133, which is the optic nerve OCT, and 92134, which is the retina OCT. We were forced to survey OCT, and by sending to CPT to split into 2 codes, we accomplished several items. First, we were able to separate 2 distinctly different services (optic nerve vs retinal scanning), which had a significant need in terms of utilization screens employed by Medicare and insurance companies.

Specifically, optic nerve scans were permitted once or twice a year. Retinal scans were becoming much more frequently required to guide the retreatment of patients with age-related macular degeneration (AMD) receiving intravitreal injections of anti-VEGF drugs. In addition, virtually all optic nerve scans were done on both eyes, while for retina, we projected only about 75% were done bilaterally. At this time at CPT, there is a very strong sentiment to make all eye imaging codes bilateral, so the 2 new codes became bilateral. As one

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works through the CPT process for a new code, then goes to RUC for code valuation, usually a year or more passes.

Currently, the reimbursement guidelines of Medicare and insurance companies vary widely. However, we in retina are quite fortunate, as the CATT study showed the value of as needed (prn) dosing of anti-VEGF agents in AMD, and the DRCR-I has shown the benefit of anti-VEGF therapy in diabetic macular edema, with frequent OCTs needed to aid in treatment decisions. Thus, many carriers have very liberal policies for 92134 retinal OCT. In Medicare, the screens will be posted on your local carrier's website in its compendium of local coverage determinations (LCDs). Many medical insurance companies also post their coverage determinations on their sites. Keep in mind that for Medicare and insurance companies, there must be medical necessity to perform a test. Your chart must document why the test is being done to justify it. Also, there should not be standing orders to always have a test performed on every patient, as that tends to suggest a lack of medical necessity.

RT: What is the reasoning behind the declining reimbursement for OCT?

Why are we getting paid so much less? This goes back to the original issue of the OCT showing up on the RUC scan as 1 of the most rapidly increasing codes in frequency back in 2008, which caused automatic revaluation by RUC (after the CPT changes). Surveys were sent

to 225 ophthalmologists (mostly retina specialists), and 49 responded. They were asked to estimate the time, effort, skill, and iatrogenic risk associated with performing OCT interpretation. Typically, the RUC uses the 25th percentile of survey work relative value units (RVU). It gave both kinds of OCT 0.50 work RVUs, just slightly below the 25th percentile. The physician work time is 17 minutes to interpret both eyes. (For comparison, one gets 0.81 work RVUs for fluorescein angiography interpretation and is paid for 28 minutes of physician time.) The lesson here is that when a test becomes more common and is used more frequently, the time for interpretation decreases, as does the payment.

RT: What are the potential consequences of these reimbursement cutbacks?

Obviously we have seen a significant revenue loss, as the reimbursement for OCT has virtually been halved. When the payment for intravitreal injections 67028 was also decimated, retinal physicians saw a significant revenue loss.

RT: How can physicians ensure they are in compliance with Medicare's regulations?

Take the time to go to your Medicare carrier's website and look up the rules for the codes you use most. Next, make sure you have documented medical necessity for performing the test. Then ensure that the proper ICD9 code is linked to the test. (Obviously make sure that AMD is linked to the OCT code, not ptosis!)

RT: Is it likely that there will be reimbursement changes for other imaging modalities, such as fundus photography, fluorescein angiography, fundus autofluorescence, etc?

Fluorescein angiography was reviewed by the RUC in January, and we will find out how CMS has dealt with this code in the proposed and the final rule published in the fall. It certainly will NOT increase the value.

CMS is in the process of assessing what diagnostic tests are performed together in the same sitting, which is really intended for radiologic studies. It will then implement a multiple-procedure reduction in those cases. CMS is looking at the performance

of fundus photos with fluorescein angiography on the same day and is considering a reduction there. Fundus autofluorescence is and will be bundled with fundus photography. ■

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