Reimbursement for Self-Tonometry

Prepared for icare USA

March 2017
Reimbursement for Self-Tonometry

by

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Objective: This report is provided as a general discussion of billing for self-tonometry and related issues. Local variations between payers may occur which are not described here. The user is strongly encouraged to review federal and state laws, regulations and official instructions promulgated by the Centers for Medicare & Medicaid Services (CMS) and their contractors; this document is not an official source nor is it a complete guide on all matters pertaining to reimbursement. In addition, users should check with their local Medicare Administrative Contractor (MAC) for approved diagnosis codes and usage.

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: 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. Icare and Corcoran Consulting Group cannot guarantee 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.

Acknowledgement: This paper was underwritten by a grant from Icare USA as an aid to customers and other interested parties. Icare is not the author of, and therefore not responsible for, the content of the reimbursement and billing information provided herein. A number of individuals provided helpful suggestions for which we are grateful. For further information about their products, contact the company at (888) 422-7313 or www.icare-usa.com.
INTRODUCTION

This monograph addresses the practice management and reimbursement issues associated with self-tonometry, or measurement of intraocular pressure (IOP) by the patient, using the Icare® HOME tonometer. Figure 1 shows a side view of the instrument.

Figure 1  Icare® HOME Tonometer

![Image of Icare HOME Tonometer](image-url)

Image courtesy of Icare

Much of the information is taken from official publications of the Medicare program. Even so, the reader is encouraged to check with the regional Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) for additional information and instructions. For recordkeeping purposes, we identify the applicable CPT and HCPCS codes. Relevant modifiers are noted as well.

In the Appendix, there are several model forms for your use. These forms may be used as notification for patients and payers, as well as to document the boundary between insurance payments and patient financial responsibility.
INTRAOCULAR PRESSURE AND TONOMETRY

There are many ways to measure intraocular pressure. In-office tonometry is usually accomplished with indentation tonometry or applanation tonometry. Indentation tonometry with Schiotz or similar instrument is inherently less accurate because the elasticity of the tissues is not constant. Applanation tonometry is based on the Imbert-Fick principle from Hans Goldmann and is the scientific basis of the most common form of applanation tonometer. It has some limitations due to variations in corneal thickness but has remained the standard against which other tonometers are compared. There are also electronic tonometers which use both indentation and applanation.

The Icare® HOME tonometer utilizes rebound tonometry, which compares favorably to applanation methodology.1,2,3 The rebound technology in this device is based on the rebound measuring principle in which a light-weight probe is used to make a momentary contact with the cornea. An induction based coil system is used for measuring motion parameters of the probe. An advanced algorithm, combined with state-of-the-art software, analyzes deceleration and contact time of the probe when it touches the cornea. Deceleration and contact time of the probe change as a function of IOP. For example, the higher the IOP the faster the probe decelerates and shorter the contact time.

Compared with Goldmann applanation tonometry (GAT), the Icare® HOME measurements agreed with GAT within 5 mm Hg in 91% of patients. The mean difference between Icare® HOME and GAT was -0.33 mm Hg (SD 3.11).

THE DEVICE

The Icare® HOME tonometer is designed for use by the patient or caregiver after proper training. It is FDA cleared4 for use in the US.5 No drops of any kind are required. The results, along with date and time, are stored, but not displayed, and can

only be downloaded with a suitable computer and software at the ophthalmologist’s or optometrist’s office so there is less chance of bias on the part of the person doing the measurement.

The Icare® HOME tonometer does not require any maintenance, calibration or regular service. The manufacturer recommends cleaning the probe base every six months and replacing the probe base yearly. Probe base cleaning is simple and described in the user manual. Figures 2A and 2B show the device from other views.

Figures 2A (back) and 2B (patient-side)  Icare® HOME Tonometer

Images courtesy of Icare

Figure 3  Patient Using the Icare® HOME Tonometer

Image courtesy of Icare
The patient or caregiver taking the IOP readings (“the operator”) needs to be certified to use it. As might be expected, operator certification is not difficult. A member of the eye doctor’s staff instructs the operator on instrument use. The patient must demonstrate successful use and measurement under the supervision of the staff member. Then, they are instructed in the care and storage of the tonometer and considered certified. Most patients (84%) can be certified to use the Icare® HOME, but a small percentage (6%) had difficulty using the device even after training.\(^6\)

**INDICATIONS FOR USE**

Self-tonometry is useful to gather additional IOP measurements at various times of day to better appreciate the variability of the measurements.\(^7\) Some potential reasons for ophthalmologists and optometrists to recommend self-tonometry include: suspicion of diurnal IOP variability that sometimes exceeds the target pressure,\(^8\) during the postoperative period following glaucoma surgery, or to measure the effect of self-administered anti-glaucoma medication(s).

**BILLING ISSUES**

**CPT Codes**

There is no procedure code for self-tonometry in either the Current Procedural Terminology (CPT) or Health Care Procedure Coding System (HCPCS). When performed as part of an eye exam by an ophthalmologist or optometrist, measurement of IOP is an element of the eye exam and not separately billable.

CPT does contain code 92100 (serial tonometry), but this service is performed by a physician – not a patient. It would be inappropriate for patients to file a claim for reimbursement – they are not providers. Additionally, CPT 92100 may not be reported by the eyecare provider on behalf of the patient since: 1) the provider or their

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designated staff did not obtain the measurements, and 2) the measurements did not take place in the provider’s office setting.

Another consideration is telemedicine. Since there is no “live examination component” in play, nor is one necessary, no current telemedicine codes or modifiers apply to self-tonometry.

There is no supply code for the device. HCPCS contains A9999 *(Miscellaneous DME supply or accessory, not otherwise specified)*. For internal tracking purposes within your practice management system, this code may be useful, or it may be used, together with an appropriate modifier, when a beneficiary requests that you file a claim for the purpose of getting a denial.

**Modifiers**

The following modifiers may be applicable on a claim.

GA ...... Waiver of liability statement issued as required by payer policy, individual case

GX ...... Notice of liability issued, voluntary 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.

GZ ..... Item or service expected to be denied as not reasonable and necessary

**Durable Medical Equipment**

Rental of medical equipment for use within the patient’s home falls within Medicare’s policies for durable medical equipment. Equipment eligible for coverage\(^9\) has all of the following characteristics:

- It can stand repeated use.
- It is primarily and customarily used for a medical purpose.
- It is not useful in the absence of illness or injury.
- It is appropriate for use in the home.
- It is intended for periods of use of a month or longer (rental or purchase).

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Since use of the Icare® HOME tonometer is intended for a few days – not a month – no coverage under the Medicare DME program is available and beneficiaries are financially responsible for payment.10

Financial Waivers

An Advance Beneficiary Notice of Noncoverage (ABN CMS-R-131)11 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 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, 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, 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

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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. The Appendix contains a Notice of Exclusion from Health Plan Benefits for this purpose.

**ABN and DME Enrollment**

When an ophthalmologist or optometrist is not formally enrolled with Medicare as a DME supplier, a beneficiary must be notified using the ABN that the provider has no means to file a claim for reimbursement and that the beneficiary may not do so on their own behalf. See the Appendix for a suitable ABN that mentions the administrative blockage.

When an ophthalmologist or optometrist is a Medicare DME supplier, as is the case when you likewise bill Medicare for post-cataract eyeglasses, then there are additional considerations. As mentioned above, when a beneficiary elects Option 1 on the ABN that mentions short term rentals, you must submit a claim; this is not the case for Option 2. A sample claim follows.

**Sample Claim**

Your exam of a 58 y/o new patient identified mild POAG OU. You start the patient on Latanoprost OU. You ask the patient to rent the Icare® HOME tonometer for three to five days to perform self-tonometry so you can determine the effectiveness of the anti-glaucoma medication and whether the target IOP is reached. You are concerned about compliance with the pharmaceutical treatment regimen. You file a claim with
your MAC for the eye exam; you file a second claim with the DMEMAC as follows because the beneficiary elected Option 1 on the ABN.

<table>
<thead>
<tr>
<th>17 REFERRING/ORDERING PROVIDER</th>
<th>17a.</th>
<th>17b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DK J Em dys MD</td>
<td></td>
<td>NPI 1234567890</td>
</tr>
</tbody>
</table>

19 ADDITIONAL CLAIM INFORMATION
Short term rental of self-tonometer for 3 days

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. EMG CPT/HCPCS MODIFIER
C. PROCEDURES, SVCS
D. $ CHARGES UNITS
E. POS
F. ERSID
G. EPSDT
H. ID QUAL
J. RENDERING PROVIDER I.D.

<table>
<thead>
<tr>
<th>From MM DD YY</th>
<th>To MM DD YY</th>
<th>EMG</th>
<th>CPT/HCPCS</th>
<th>MODIFIER</th>
<th>PROCEDURES, SVCS</th>
<th>$ CHARGES</th>
<th>UNITS</th>
<th>POS</th>
<th>EPSDT</th>
<th>ID QUAL</th>
<th>RENDERING PROVIDER I.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234567890</td>
<td></td>
<td></td>
<td>A9999</td>
<td>GY</td>
<td>GX</td>
<td>A</td>
<td>xxx</td>
<td>xx</td>
<td>1</td>
<td>NPI</td>
<td>1234567890</td>
</tr>
</tbody>
</table>

Note: The place of service is 12 (home); it’s never 11 (office). Note that ICD-10 has a combination code for POAG and the stage of glaucoma, so only one ICD-10 code is needed for this claim because both eyes have mild disease.

**DOCUMENTATION**

The order for self-tonometry should be made by the treating physician. The order should appear in the clinical record with a medical rationale. The IOP measurements retrieved from the Icare® HOME tonometer should be preserved in the medical record along with the physician’s other evaluation and management notes.

**CONCLUSION**

Self-tonometry may provide the eyecare practitioner with additional information not readily available, but no coverage exists under current Medicare DME regulations, or for other third-party payers, so the beneficiary is responsible for payment. Providing proper notification of noncoverage is an important consideration.

This discussion is meant to assist the reader to better understand the rules and regulations regarding reimbursement for the Icare® HOME tonometer, however the responsibility for appropriate usage, adequate documentation and proper coding are always the physician’s.
Print your name, address and telephone number. Logo is optional.

Patient Name:  Identification Number: 

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn’t pay for the items or services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

<table>
<thead>
<tr>
<th>Items or Services</th>
<th>Reason Medicare May Not Pay:</th>
<th>Estimated Cost:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rental of Icare® HOME tonometer</td>
<td>Short-term rental of equipment for a few days is not covered by Medicare. Source: Medicare Claims Processing Manual Chapter 1 §60</td>
<td></td>
</tr>
</tbody>
</table>

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.
- Choose an option below about whether to receive the _____________________ listed above.
  
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

[ ] 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 copays 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.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227 / TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature: Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11)  Form Approved OMB No. 0938-0566
Patient Name: ___________________________ Identification Number: ___________________________

**Advance Beneficiary Notice of Noncoverage (ABN)**

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Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

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<thead>
<tr>
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<th>Reason Medicare May Not Pay</th>
<th>Estimated Cost:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rental of Icare® HOME tonometer</td>
<td>Medicare will not pay for rental of equipment because we are unable to file a claim with a durable medical equipment (DME) Medicare Administrative Contractor (MAC). Medicare will not pay us or reimburse you.</td>
<td></td>
</tr>
</tbody>
</table>

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.
- Choose an option below about whether to receive the _____________________ listed above.
  
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**OPTIONS:** Check only one box. We cannot choose a box for you.

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Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566
NOTICE OF EXCLUSION FROM HEALTH PLAN BENEFITS

You need to make a choice about renting the Icare® HOME tonometer for a few days so you can perform self-tonometry at home. This rental equipment is not a covered benefit and consequently your health plan will not pay for it. When you receive an item that is not a covered benefit, you are responsible to pay for it.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive this item knowing that you will have to pay for it yourself. Before you make a decision about your options, you should read this entire notice carefully. Ask us to explain, if you don’t understand why your health care service plan won’t pay.

Your doctor has recommended rental of the Icare® HOME tonometer for a few days so you can measure your intraocular pressure at various times of the day. The measurements are useful because the pressure within your eyes fluctuates – sometimes by a large amount. It is important to control your intraocular pressure within certain boundaries to minimize or prevent damage to your optic nerve. Self-tonometry is not medically necessary; it is optional. The major difference between self-tonometry and serial tonometry by your eye doctor is where the measurement of intraocular pressure is performed. It is probably more convenient to do at home.

You are responsible for all of the fees associated with a non-covered item or service. The charge for the rental of the Icare® HOME tonometer is $__________.

Beneficiary Agreement

Accordingly, the undersigned accepts full financial responsibility for the non-covered services described above.

______________________________
Signature of patient or person acting on patient’s behalf

______________________________
Date