Final Comments for Low Vision Services (OPHTH-026) DL32007

A comprehensive line by line review of the draft policy OPHTH-026 was done by WPS Medicare J5 and Legacy B CAC Ophthalmologists along with esteemed colleagues of theirs that are considered nationally to be experts on the topic of Low Vision Services. WPS Medicare was provided a white paper authored by this group specifically for the Low Vision Services LCD. All of the suggestions and corrections were carefully evaluated and have been incorporated into the policy. The next twelve (12) comments are from their much appreciated review.

Comment:
1. The content of the Low Vision Evaluation (LVE) is not represented by the ophthalmic examination codes 92002-92004, 92012 and 92014. It is accurately represented by Evaluation and Management codes (E&M) 99203-99215 and 99354. The rationale for this is that the ophthalmic examination codes assess the disease process in the eye, whereas the LVE is consistent with the levels of complexity and decision making of the E&M codes.
Response:
WPS Medicare agrees and has removed for visual ophthalmic CPT codes 92002, 92003, 92004, 92012 and 92014. These codes have been replaced with E&M codes 99203-99215 and 99354. Instructions for add-on CPT code 99354 have been added to this LCD that state; CPT 99354 is an add-on code and should be used in conjunction with 99203-99215, to denote a prolonged low vision evaluation of greater than 90 minutes.

Comment:
2. The code for fundus photography (92250) should be included to be used in combination with codes for visual fields. This is the way Fundus Monitored Perimetry has been coded for a decade.
Response:
WPS Medicare evaluated the inclusion of CPT code 92250 (fundus photography) and has added this code to the policy. The evidence provided shows it is standard in providing accurate central field visual evaluations. In addition, the following section and statement have been added to the Billing and Coding Guidelines for OPHTH-026.

> **Fundus Photography and Low Vision Service**
> Fundus Monitored Perimetry (FMP) is the state-of-the-art technology for precise macular mapping. The scanning laser ophthalmoscope and other FMP technology allows for visualizing of the macula in real time and simultaneously delineating scotomata (blind spots) and locating the fixation point (Preferred Retinal Locus or PRL: the substitute fixation point when the fovea is not functioning). This technology produces a fundus photograph with a precise central field superimposed on it and thus it is appropriately billed as a combination of fundus photography (92250) and visual field examination (92081-92083).

Comment:
3. CPT codes 92270 and 92275 are not relevant to low vision rehabilitation and should be removed. Fundus Monitored Perimetry (FMP), coded as CPT 92250, should be included to be used in combination with codes for visual fields. The rationale for this is that FMP is the only technology available that shows the position, size, shape density and pattern of central blind spots, including those that form a ring around the patient's remaining vision, which

creates idiosyncratic scotoma patterns invisible in other examinations that impact patient function.

Response:

WPS Medicare agrees with the recommendation and rationale given to remove CPT codes 92270 and 92275. These two CPT codes have been deleted from this LCD.

Comment:

4. The policy suggests that "criteria for services" apply to both the low vision evaluation (LVE) and rehabilitation therapy. The LVE, however, establishes the patient's visual and functional deficits as a preliminary to rehabilitation services. We suggest the inclusion of the following statement;

> The criteria for a low vision evaluation (LVE) by a physician is self reported functional deficit secondary to any level of visual impairment that cannot be resolved by standard glasses, medicine or surgery.

Response:

The statement directly above has been added to the policy. (See section titled Indications for Low Vision Services).

Comment:

5. The draft policy sets forth legal blindness as the definitive parameter and requires additional calculation for patients with moderate visual impairment (<20/60) in spite of;

1. the provision of a comprehensive low vision evaluation that confirms and delineates the functional deficits, and
2. Substantial evidence moderate visual impairment imposes significant functional deficits.

The requirement for a visual efficiency calculation should not be imposed when a comprehensive low vision evaluation is provided. Further calculations are redundant, inefficient and non-contributory when a comprehensive low vision evaluation is provided.

Response:

The criteria for low vision rehabilitation therapy have been amended, and now state the following;

> **Indications for Low Vision Service**
>
> The criteria for a low vision evaluation (LVE) by a physician are self-reported functional deficit secondary to any level of visual impairment that cannot be resolved by standard glasses, medicine or surgery.
>
> The criteria for rehabilitation therapy for low vision are met when any of the following categories are fulfilled, and functional deficit compromising daily activities has been confirmed and delineated by a low vision evaluation:
>
> 1. 369.00-369.25: Impairment of central visual acuity remaining vision in the better eye after best correction is documented at less than 20/60.
> 2. 368.41: A central scotoma is demonstrated.
> 3 A visual field reduction is demonstrated, including 368.45 (generalized constriction), 368.46 (homonymous bilateral field constriction), or 368.47 (heteronymous bilateral field constriction).

Comment:

6. The requirement for completing the Visual Function Questionnaire (VFQ, also referred to as a Health Related Quality of Life or HRQOL) and achieving a score of 70 or less (1) fail to

acknowledge the content of a comprehensive low vision evaluation and (2) are redundant and repetitive when a low vision (LVE) is provided. The VFQ was designed as a general measure of quality of life in the presence of ophthalmic disease, not as an assessment tool for use in vision rehabilitation. It is not as accurate, specific or individualized as the low vision evaluation (LVE). It repeats some information, omits some and includes some that is not relevant. The Visual Functional Questionnaire (VFQ) should be required only when a comprehensive low vision examination (LVE) by a physician is not available and provided.

Response:

The section, Indications for Low Vision Service, now reads;

> When a comprehensive low vision evaluation by a physician that confirms and delineates functional deficits compromising daily activities is not available and provided, a score of 70 on the Visual Function Questionnaire (VFQ) is required for rehabilitation therapy

Comment:

7. A suggestion was made to separate statements explaining providers of service services from "incident to" services.

Response:

WPS Medicare agrees with this suggestion. The explanation of who can provide low vision services is now in a section entitled Providers of Service. The policy now reads as follows;

> **Providers of Service**
>
> A team usually performs low vision services. The responsible physician may be one who diagnoses and treats the disease or may be one who performs the comprehensive low vision evaluation (LVE). In either case, the physician is the treatment planner and manager. Qualified assistants may assist the physician in collecting information such as medical history and performing visual field testing. Rehabilitation therapy to implement the vision rehabilitation plan is provided by occupational therapists.

Comment:

8. The policy grants non-occupational therapists the privilege of billing "incident to" for therapy services using rehabilitation codes in conflict with section 1862(a)(2) of the Social Security Act and 2005 CMS ruling on qualification standards in 42 CFR § 484.4. The "incident to" section should specify that services billed to CMS under rehabilitation codes should be performed by a licensed occupational therapist or a properly supervised occupational therapy assistant in accordance with current Social Security Act and CMS rulings on qualification standards. Paragraph one of PM AB -02-078, CR 2083, Medicare Coverage of Rehabilitation services for Beneficiaries with Vision Impairment, states that:

> *Medicare beneficiaries who are blind or visually impaired are eligible for physician prescribed rehabilitation services from approved health care professionals on the same basis as beneficiaries with other medical conditions that result in reduced physical functioning*.

Further, CMS recognizes occupational therapists as qualified licensed health providers and has identified procedural codes to bill occupational therapy services for beneficiaries with low vision.

Response:

WPS agrees and has added, to the Billing and Coding Guidelines, the statement found in CR 2083 and has amended the section in the LCD with the heading Incident To, to read as follows:

> **Incident To:**

Incident to provisions apply only when those who assist the managing physician are employees defined in the Medicare Benefit Policy Manual, (Pub.100-2, Chapter 15, §50) and fulfill all the "incident to" requirements. Incident to services are integral but incidental to the physician's services. This may include history taking as part of the low vision evaluation and performance of peripheral and central visual field testing. Non-occupational therapists may not conduct rehabilitation therapy and any services they provide may not be billed under occupational therapy codes.

A non-occupational therapist, serving in any capacity incident to a physician must be directly supervised by that physician. For example, a certified technician may not go to a patient's home to collect data incident to a physician unless the physician is there in the residence with the technician

Comment:
9. This policy requires the administering of the Mini-mental Examination (MME) to all patients regardless of clear evidence of unimpaired mental function and precludes rehabilitation for those with scores <20. This requirement would appear to be based on the perception that vision rehabilitation is training to use optical devices. A requirement for Mini-Mental Examination as a prerequisite for services is inconsistent with rehabilitation for other conditions such as stroke or hip fracture patients with cognitive impairment. Patients who are both visually and cognitively impaired are still at risk for falls, burns and injuries.
Response:
WPS Medicare agrees and has removed reference to the Mini-Mental Examination as criteria for low visions services. The Documentation Requirement section of this policy has been amended to read as follows:

Physicians knowledgeable about delivering low vision rehabilitation state that cognitive, psychological, physiologic or other limitations may preclude effective low vision rehabilitation training. Those with cognitive deficits however may benefit from environmental adaptations and caregiver training to insure their safety. Established regulations for occupational therapists already dictate that when no progress is achieved in two consecutive sessions, therapy must be discontinued.

Once coverage criteria for low vision rehabilitation identified in the indications section are established, an individualized Plan of Care must be entered into the patient's record. Minimum documentation requirements in the Plan of Care and sessions executing the plan are as follows;

1. Patient's perceptions of visual function and Functional Independence Measure (FIM Scores) for each goal documented at the onset of therapy. FIM scores are the standard measures employed by occupational therapists for documenting progress for patients with any type of impairment.

Comment:
10. The policy’s stipulation that the VQ (HRQOL) is used as the tool for assessing initial function and monitoring rehabilitation progress is in conflict with the documentation guidelines already established by CMS for all rehabilitation therapy as set by the Medicare Benefit Policy Manual, Section 220.
Response:

The stipulation that VQ (HRQOL) is used as the tool for assessing initial function and monitoring rehabilitation has been removed from OPHTH-026.

Comment:
11. The policy should (a) confirm to the documentation standards for rehabilitation services in medicine, including plan of care, rehabilitation goals, therapy and progress assessment at each session, and determination of discharge
Response:
WPS Medicare agrees and has added the following statement to the section titled Documentation Requirements:

> A plan of care includes rehabilitation goals, progress assessment at each session and determination of discharge

Comment:
12. The standard terminology for medical rehabilitation is "Plan of Care" and this should be used consistently in the LCD.
Response:
The policy has been amended to contain consistent language.

Note: Please note that other knowledgeable providers made similar comments that support the information listed in comments one (1) through twelve (12).

Comment:
A major hospital provider questioned the inclusion of several CPT codes that report occupational therapy services that can and are provided appropriately for patients with indications other than visual impairment stating;

> "If WPS uses system edits to identify ICD-9 codes in this LCD that support medical necessity, and applies these edits to all CPT codes included in this LCD, claims for medically necessary occupational therapy services will be denied inappropriately. We request that the following CPT codes be removed from this LCD, or the ICD-9 codes that support medical necessity for low vision services not apply to these."

CPT codes: 97003 – 97004, 97110, 97112, 97116, 97530, 97532 – 97533, 97535, 97537.
Response:
WPS Medicare recognizes that CPT codes for occupational therapy services encompass a broad range of medical necessity. Therefore, a diagnosis of a visual deficit is only a requirement when low vision services are rendered.

Comment:
A CAC member recommended that the following CMS references that pertain to physical therapy and occupational therapy be added:

> Medicare Benefit Policy Manual, Pub 100-02, Chapter 15, §220. Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech –Language Pathology Services) Under Medical Insurance.
>
> Medicare Benefit Policy Manual, Pub 100-02, Chapter 15, §230. Practice of Physical Therapy, Occupational Therapy, and Speech –Language Pathology.

PHYS MED -001: Outpatient Physical Therapy, Occupational Therapy and Speech-Language Pathology, Section XIII. Counting minutes for Timed Codes in 15 Minute Units.

Response:
Medicare Benefit Policy Manual, Pub 100-02, Chapter 15, §220 and Medicare Benefit Policy Manual, Pub 100-02, Chapter 15, §230.4 are referenced in the Low Vision LCD. WPS Medicare document PHYS Med-001 is retired. Information contained in PHYS MED-001 can be found in the CMS manuals.

Comment:
This same CAC member found an error under the heading, "Incident To:" in the draft policy. The reference to the Medicare Benefit Policy Manual is incorrectly listed as §60 and should be §50.

Response:
The policy has been corrected to state §50.

Comment:
A request was made to add the reference to therapy services provided incident to the services of physicians and non-physician practitioners found in Pub 100-02, Chapter 15, §230.5.

Response:
WPS Medicare agrees that the incident to therapy services detailed in Pub 100-02, Chapter 15, §230.5 provides guidance to providers of low vision services and has added the following section to the Billing and Coding Guidelines attachment document:

Excerpt from Pub. 100-02, Chapter 15, §230.5 - Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Non-Physician Practitioners (NPP)

Incident to a Therapist. There is no coverage for services provided incident to the services of a therapist. Although PTAs and OTAs work under the supervision of a therapist and their services may be billed by the therapist, their services are covered under the benefit for therapy services and not by the benefit for services incident to a physician/NPP. The services furnished by PTAs and OTAs are not incident to the therapist's service.

Comment:
A physical therapist requested the inclusion in the list of CPT codes CPT, code 97001 (Physical therapy evaluation) or 97002 (Physical therapy re-evaluation). The rationale for the request stated that the policy lists physical therapists as providers, so codes that describe the evaluation and re-evaluation services should be included.

Response:
Because low vision are unique services and usually performed by a professional team that is comprised of an M.D./D.O. or O.D.who performs the low vision evaluation and an occupational therapist who conducts rehabilitation training, WPS Medicare will not add codes specific for physical therapy services. Paragraph one of PM AB-02-078, CR#2083, Medicare Coverage of Rehabilitation Services for Beneficiaries with Vision Impairment, states that:

Medicare beneficiaries who are blind or visually impaired are eligible for physician prescribed rehabilitation services from approved health care

professionals on the same basis as beneficiaries with other medical conditions that result in reduced physical functioning."

It is the intent of WPS Medicare that beneficiaries with visual impairments should receive the same standard of rehabilitation therapy as received by those with any other physical impairment. CMS recognizes occupational therapists as qualified licensed health providers and has identified specific procedural codes to bill occupational therapy service for beneficiaries with low vision. However, the low vision codes may be used by qualified rehabilitation therapists, defined by CMS as physical, speech, or occupational therapists.

Comment

WPS Medicare reviewed two comments on reporting timed codes. Both providers said the statement on reporting timed codes, listed in the Documentation Requirements section does not reflect the nuances of reporting timed units as defined in CMS Pub.100-04, Chapter 5, §20.2.

Response:

WPS Medicare agrees and has amended sentence number 8 (eight) in the Documentation Requirements to state:

> Each session using time dependent codes, either therapeutic procedures or prolonged services, must have the face-to-face time between the patient and physician or therapist documented to the minute. Units are calculated as described in prolonged services. A description of counting minutes for timed codes in 15 minutes can be found in the Billing and Coding Guidelines for this LCD under header Reporting of Service Units With HCPCS; Counting Minutes for Timed Codes in 15 Minute Unit.. Additional information is provided in the attached Billing and Coding Guidelines under header *Reporting of Service Units With HCPCS; Counting Minutes for Timed Codes in 15 Minute Unit***.**

To provide further instructions for reporting of timed therapy codes WPS Medicare has added to the Billing and Coding Guidelines a section entitled;

Excerpt from CMS Publication 100-04, Chapter 5, § 20.2

Reporting of Service Units with HCPCS

Counting Minutes for Timed Codes in 15 Minute Units

Comment:

A provider stated "that this LCD applies to Skilled Nursing Facility (SNF) 21X type of bills, as well as services billed under Medicare Part B as Outpatient Services." A suggestion for the inclusion of reference of the following to the list of CMS National Coverage Indications was requested:

1. Medicare Benefit Policy Manual, Pub 100-2, Chapter 8, §30 for skilled nursing facility skilled rehabilitation services
2. Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, §220.3 for documentation requirements for therapy services
3. Medicare Claims Processing Manual, Pub 100-4, Chap 5, §20.2 for reporting of outpatient therapy services service units with HCPCS

Response:

Regulations cited are related to information found in the policy or attached Billing and Coding Guidelines. Upon review of the LCD, WPS Medicare is now including in the list of references Pub 100-02, Chapter 15, §220.3 …

Comment:
In regard to the screening and assessment tools that are specified in the LCD (VFQ/HRQOL, MMSE), it was suggested by a panel of Occupational Therapists that the LCD include language to indicate that these are recommended rather than required tools, and that other tools may be used to establish eligibility for low vision services. In CMS Pub. 100-02, Chapter 15, §220.3, it is indicated that rehabilitation therapists may use either one of four specific measurement instruments (NOMS, FOTO, AM-PAC or OPTIMAL) or

1. Documentation required to indicate objective, measurable beneficiary physical function including, e.g.
2. Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or
3. Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or
4. Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.

Response:
The purpose of this LCD is to provide guidance for Low Vision Services. Because of that, the focus of this LCD is kept as much as possible to information specific for Low Vision Services.

Comment:
It was further suggested by an Occupational Therapy provider that consideration be given for the use of broader language in the LCD to indicate that the VFQ/QHRQOL and MMSE or similar tools that provide measure of health related quality of life, visual function and cognitive function are included in the initial comprehensive therapy evaluation.
Response:
The stipulation that VQ (HRQOL) is used as the tool for assessing initial function and monitoring rehabilitation has been removed from OPHTH-026. While evaluation and rehabilitation for all physical impairments should be addressed, this LCD was developed to specifically address the complex needs of those with visual impairment.

Comment:
It was suggested by an Occupational Therapy provider that the following statement under the header <u>Indications for Low Vision Service</u> be amended to reflect improvement:

> Furthermore criteria which will provide proof the patient is remembering the new training must be stated in the original treatment plan. For example upon return for each follow up visit the patient will be asked to demonstrate the use of aids and techniques from previous sessions. The demonstration will be undertaken without help or prompting from any other individual. If the patient fails to demonstrate competency on two different occasions the rehabilitation services will be considered to have reached a stable state or plateau and training will be considered maintenance, which is non-covered.

Response:
The statements referenced above have been deleted from the draft LCD.

Comment:

A request to expand the list of CPT/HCPCS Codes to include CPT code 97542 (wheelchair management) be added to the policy was evaluated. The provider cited safety issues.

Response:

The focus of the LCD is to identify and establish eligibility of low vision services. It is expected that any rehabilitation plan of care will identify safety risks. While wheelchair management may be identified as a safety risk, it is not a specific indication for low vision services and therefore will not be added to this LCD.

Comment:

WPS Medicare evaluated a request from Occupational Therapy providers to expand the wording and examples so that there is a focus on the need for goals to be functional and measurable, including goal examples that address basic functional abilities. The following examples of possible measurable goals were provided:

1. Patient will be able to independently set-up, adjust, and operate (device) in order to manage medications, using tactile location techniques, sequencing strategies, and color contrast modifications in 1 week.
2. Patient will be able to independently set-up and use adaptive writing device to legibly sign name on checks and other legal documents in 3 sessions.
3. Patient will be able to independently setup (device) and adjust lighting source in kitchen to allow for reading a recipe, to promote independent food preparation in one week.
4. Patient will demonstrate ability to independently set-up and adjust (device) to facilitate at least 3 different types of reading tasks in 10 sessions.

Response:

Again, this LCD is specific for low vision services. WPS Medicare has provided minimum documentation guidelines and expects that those rendering low vision rehabilitation services have an understanding of what constitutes standards of care and the knowledge to accurately develop and document a Plan of Care that meets on an individual basis the needs of their patient

Comment:

A request to amend number 6 (six) in the Documentation Requirements section to indicate that more frequent visits may be needed, but should be justified in documentation was evaluated. The rationale is that such an addition would allow for individual needs to be considered, such as when a patient with mild cognitive impairment initially needs more frequent instruction to master new learning. Statement number 6 (six) reads as follows:

> Sufficient time between visits is necessary for the patient to apply low vision training to their activities of daily living. Following practice by the patient with techniques to minimize disability the low vision specialist can assess the patient's improvement. This may require five (5) or more days between visits.

Response:

WPS Medicare does not see any value to adding a statement related to additional visits. All services eligible for reimbursement from Medicare must have documentation that supports medical necessity. Additional low vision services are no different than all other services covered by Medicare and thus, will also be considered based on documentation of medical necessity.

.**Comment:**

An Occupational Therapy provider requested clarification to the specification of item number 6 (six) in the Documentation Requirements which states,

> When there is no progress in a quantitative measurement of performance on two occasions, following the maximal measure of performance, subsequent treatment for that goal will be considered maintenance and is a non-covered benefit.

Response:

The statement partially referenced above has been modified and now reads as follows:

> WPS Medicare considers the medical necessity for LVR ends when the patient demonstrates no progress in two consecutive visits. Subsequent treatment for goals that have been met or are determined to be unattainable will be considered maintenance and are a non-covered benefit. Therefore WPS Medicare may require documentation with the medical rationale for continuing LVR when no progress has been made in two consecutive visits.
>
> For example, a patient with central and peripheral visual field deficits has learned to use a large diameter concave lens to locate and avoid objects in a room; CPT codes 97535 and 97537 would no longer be covered. However, there could be a need for additional visual scanning training, CPT code 97112. This would teach the patient to use a typoscope or the more difficult task of reorienting the text to track reading material into a sighted area. In this case additional units of 97112 would be covered.

Comment:

A suggestion was reviewed that asked for the addition of a sentence that indicates that documentation of quantitative measures may reflect incremental progress to support the need for continued services along with the addition of a sentence that acknowledges that documentation may be needed to explain the influence of co-morbidities, e.g. a CVA or Parkinson's disease, on the course of treatment.

Response:

OPHTH-026 is specific for Low Vision Services. The section under the header Documentation Requirements explains the specific documentation for this service. WPS Medicare directs those with further questions related to LVR and general rehabilitation documentation to review CMS Publication 100-02, Chapter 15, §220.3 which states in part

> *Goals should be measurable and pertain to identified functional impairments*

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Comment:

A request for clarification of item number 8 (eight), under the header Documentation requirements, that refers to documentation for "E&M" service was reviewed. .

Response:

A section that explains the rationale for the use of E & M codes has been added to the Billing and Coding document for OPHTH-026 and now says the following:

> **Evaluation and Management CPT Codes for Low Vision Service**
>
> Patients referred for a low vision evaluation (LVE) have already had an ophthalmic examination to evaluate the disease. The MD or OD performing the LVE evaluates the impairment, not the disease. Thus a low vision evaluation has very different content from an ophthalmic evaluation and ophthalmic codes do not reflect the content of a low vision evaluation. Evaluation and Management Codes (E & M codes) are appropriate for low

vision evaluations (LVE), with levels of complexity reflected by the inclusion of specific elements unique to the service.