Reimbursement for
Self-Tonometry

Prepared for
icare
USA

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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.

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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

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. 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 cleared for use in the US.4,5 No drops of any kind are required. The results, along with date and time, are stored, but not displayed, and can only be uploaded to the ophthalmologist or optometrist with a suitable device and internet connection.

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

![Icare® HOME Tonometer](image_url)

Images courtesy of Icare

Figure 3  Patient Using the Icare® HOME Tonometer

![Patient Using the Icare® HOME Tonometer](image_url)

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**

Self-tonometry may be recommended by an ophthalmologist or optometrist on a short-term or long-term basis. From a billing perspective, short-term means less than a month, while long-term means months or years. Under the Medicare program, short-term use of the Icare® HOME tonometer is not covered, and the only associated professional service is an eye exam in the doctor’s office. Beginning in 2019, long-term use of the Icare® HOME tonometer as an element of remote physiologic monitoring (RPM) is covered by the Medicare program and described by new CPT codes: 99453-99457.⁹ In this monograph, we describe both approaches.


⁸ Ibid.

Billing for Short-Term Use

When a physician measures intraocular pressure, it is a professional service and usually billed as an element of an eye exam, and infrequently billed as a separate procedure – serial tonometry (CPT 92100).\(^{10}\) When a patient performs self-tonometry at home for a less than a month (\textit{i.e.}, \(<16\) days),\(^ {11}\) the physician’s involvement is limited to reviewing the IOP measurements at a subsequent office visit. It would be inappropriate for patients to file a claim for reimbursement for self-tonometry as a professional service – they are not physicians. Additionally, CPT 92100 may not be reported by the ophthalmologist or optometrist on behalf of the patient since: 1) the physician or their designated staff did not obtain the measurements, and 2) the measurements did not take place in the physician’s office setting.

While it is clear that any professional service associated with self-tonometry occurs after the fact in the physician’s office, the supply of the Icare\textsuperscript{®} HOME tonometer is a different matter. Rental of medical equipment for use within the patient’s home falls within Medicare’s policies for durable medical equipment. Equipment eligible for coverage\(^ {12}\) 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).

Since use of the Icare\textsuperscript{®} HOME tonometer for a few days – not a month – is not covered under the Medicare DME program, beneficiaries are financially responsible for payment.\(^ {13}\)

There is no unique supply code for the Icare\textsuperscript{®} HOME tonometer; HCPCS contains A9999 \textit{(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.

\(^{10}\) For a thorough discussion of serial tonometry (92100), see Corcoran’s monograph on \textit{Medicare Reimbursement for Ophthalmic Diagnostic Tests}.\(^ {11}\) 2019 CPT Professional Edition

\(^{11}\) CMS. Medicare Benefit Policy Manual Chapter 15 \S110.1. \textit{Link here}. Accessed 09/01/19.

\(^{12}\) CMS. Medicare Claims Processing Manual Chapter 1 \$60. \textit{Link here}. Accessed 09/01/19.
Billing for Long-Term Use

According to CMS, “Studies note that remote patient monitoring has a positive impact on patients as it allows patients to share more live-time data with their providers and caregivers, which will lead to more tailored care and better health outcomes.” Self-tonometry fits nicely in this idea because glaucoma is the sneak thief of sight and largely asymptomatic. As proof of this point, a large percentage of patients in the United States with glaucoma are undiagnosed and untreated.

Administrator Seema Verma said, “There has been a telehealth benefit mostly for rural providers, but access to care is not just a rural issue, it’s something that patients struggle with across the country.” For the Medicare expansion of telehealth to occur, some legal gymnastics were required. There are very broad constraints on Medicare coverage and payment for telehealth in the Social Security Act §1834(m)(4)(C). In the statute, Congress gave latitude to the Secretary of HHS to define a list of telehealth services that are subject to those constraints. So, in a subtle move, CMS designated some new services as “inherently non face-to-face” so they would not be added to the list of telehealth services subject to limited Medicare coverage and payment. Instead, chronic care remote physiologic monitoring was added to the Medicare Physician Fee Schedule. For 2019, RPM is covered and reimbursed by Medicare avoiding the broad constraints of the Social Security Act.

For CMS, RPM is associated with chronic care management (CCM) of two or more serious conditions expected to last at least a year. Here, the focus is on moderate to severe glaucoma with above-average risk for disease progression with co-existing chronic conditions – either systemic or ophthalmic. Candidates for RPM using the Icare® HOME tonometer are Medicare beneficiaries currently under care of an ophthalmologist or optometrist for two or more serious conditions, one of which is glaucoma, who would benefit significantly from CCM. These patients are likely poorly controlled. The ophthalmologist or optometrist provides the Icare® HOME tonometer for the patient’s use, reviews the collected IOP measurements, and telephones the patient or caregiver each month to discuss the findings and treatment plan. It is hoped that CCM with RPM engages the patient in their treatment, improves disease management, and reduces the cost of care.

To report RPM on a claim, the device used must be a medical device as defined by the FDA, and it must be ordered by a physician or other qualified health care professional to manage a patient under a specific treatment plan initiated during a face-to-face visit with the billing practitioner. The Icare® HOME tonometer satisfies this requirement.

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14 mHealth Intelligence, November 2, 2018 [Link here](#). Accessed 09/01/19.
15 CMS Medicare Learning Network, Chronic Care Management [Link here](#). Accessed 09/01/19.
because it is a prescription device cleared in March 2017 by the FDA as an adjunct to the routine clinical monitoring of intraocular pressure of adult patients.

In 2019, CPT added three new procedure codes to report various aspects of RPM:

**99453** – Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment

**99454** – Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

**99457** – Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

Significantly, the 20 minute requirement is cumulative throughout the month of physician and staff time. Although not explicitly stated in CPT, it assumes 15 minutes of work by the billing practitioner per month.

“**99453 is reported once for each episode of care. An episode of care is defined as beginning when the RPM service is initiated, and ends with attainment of targeted treatment goals.**”

It may be used to report the set-up and patient education on use of the Icare HOME tonometer.

99454 is reported once per month on a claim when an ophthalmologist or optometrist prescribes and dispenses a device for RPM of IOP to a patient, arranges Internet connection to receive IOP measurements, and programs alarm settings for the Icare HOME tonometer. This code is used to report RPM services during a 30-day period. Do not report if RPM is less than 16 days.

99457 is reported once per month on a claim when an ophthalmic technician or medical assistant downloads IOP measurements from a secure file from the Internet for the last month (not less than 16 days) and enters or moves that data into the chart. The ophthalmologist or optometrist reviews the downloaded IOP data and interprets it. During a monthly telephone call with the patient, the physician reviews this data and the glaucoma care plan and makes any appropriate changes. Importantly, 99457 cannot be reported on the day of an eye exam.

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16 FDA 510(k) Number K163343, March 2017 [Link here](#). Accessed 09/01/19.

17 2019 CPT Professional Edition
Prior to the introduction of 99453, 99454, and 99457, CPT used 99091 to report collection and interpretation of physiologic data. This code was not widely accepted within the physician community and not used frequently. It should be avoided in favor of 99454 and 99457.

CCM is separately reported, when appropriate, with CPT 99490 and 99491. This level of service requires a comprehensive care plan for all of the patient’s chronic conditions, expected outcomes and prognosis, measurable treatment goals, symptom management, planned interventions and identification of the individuals responsible for each intervention, medication management, orders for social services, a description of how services of agencies and specialists outside the practice will be coordinated or directed, and a schedule for periodic review and, when applicable, revision of the care plan. It seems likely that an ophthalmologist or an optometrist would not create, implement, revise as needed, and monitor a comprehensive care plan for all of a patient’s chronic diseases, abnormalities, and injuries. That responsibility would most commonly rest with an internist, gerontologist, or family practitioner. Only if the patient’s diseases were exclusively ophthalmic, would the ophthalmologist or optometrist consider creating the comprehensive care plan. We think that is probably infrequent because most Medicare patients have multiple other conditions that need to be monitored – they are not exclusively eye-related. In our view, it is likely that the ophthalmologist or optometrist would prefer to work with the chronic care management physician (assuming there is one) and not as the chronic care management physician.

Only one clinician can bill for CCM for any particular patient therefore it may be necessary to coordinate with the sub-specialists who may be providing a significant amount of care and treatment for one or more of the patient’s conditions. It will be important that the patient understands only one of their likely multiple physicians will be able to bill for CCM services. Inform the patient of their right to stop CCM services at any time (effective at the end of the calendar month). Each of these points, particularly the first one, reinforces our view that the CCM physician is probably not an ophthalmologist or optometrist.

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
Financial Waivers

An Advance Beneficiary Notice of Noncoverage (ABN CMS-R-131)\(^{18}\) 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.

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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 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”.

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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.

**Sample Claims**

**Example 1  *Short-term Use***

Your exam of a 68 y/o established patient identified uncontrolled, severe POAG OU; it’s noteworthy that the patient is also hypertensive. You start the patient on a new regimen of four anti-glaucoma medications. You ask the patient to rent the Icare® HOME tonometer for 4 days to perform self-tonometry so you can determine the effectiveness of the new treatment plan 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.
Example 2  *Initiation of Long-term Use*

At the beginning of the postoperative period after implantation of a tube shunt in the left eye of a patient with uncontrolled, severe POAG OU, you ask the patient to rent the Icare® HOME tonometer for several months to perform self-tonometry so you can determine the effectiveness of the surgery and whether the target IOP is reached and maintained. It is noteworthy that the patient has intermediate atrophic age-related macular degeneration in both eyes. Your medical assistant provides training to the patient on the proper use of the Icare® HOME tonometer and certifies the patient after he demonstrates successful use of the device. In addition to the exam (shown as 9xxxx), the claim will read as follows.

Example 3  *Long-term Use Data Collection, Interpretation, Counseling*

After 3 weeks, the IOP measurements for the above patient are retrieved and collated by your ophthalmic technician and logged in the patient’s medical record; the IOPs generally fall within the expected range following surgery yet it is still too early to say if the surgery has been successful or not. During a scheduled phone call with the patient,
you go over the IOP measurements, the current postoperative medications, and ask the patient to continue the current treatment plan as well as RPM for another two months. The patient is scheduled for another postop visit in 4 weeks. Your claim will read as follows.

17 REFERRING/ORDERING PROVIDER
DK J Emdy MD

17a. NPI 1234567890

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

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
A. H40.1133 B. H35.3132 C. D.

24. A. DATES OF SERVICE
From mm dd yyyy To mm dd yyyy B. C. D. PROCEDURES, SVCS
POS EMG CPT/HCPCS MODIFIER E. DX POINTER F. CHARGES G. UNITS H. EPISDT I. QUAL. J. RENDERING PROVIDER ID.

Note: It is not necessary to bill 99454 and 99457 on the same date of service; they are can be billed at different times but not more than once each month, and not less than 16 days.

SUPERVISION

Medicare’s supervision rules have been stable since July 1, 2001. Supremacy requirements, as designated in the Medicare Physician Fee Schedule (MPFS) with a “1” necessitates general supervision. General supervision means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence in the office 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. Both optometrists and ophthalmologists meet the definition of physician under Medicare for billing and supervision purposes. Nearly all other payers agree.

Because there is no separation of technical and professional components for RPM, the MPFS designates “9” for CPT 99453, 99454, and 99457 meaning the “supervision concept does not apply”, so we infer that these services are furnished under the physician’s control as would be the case for general supervision. For example, a medical assistant can train a patient to use the Icare® HOME tonometer; the physician does not have to personally perform the training. Following collection of the IOP measurements

by the staff and analysis by the physician, the monthly phone call to review the data and the treatment plant with the patient must be performed by the physician.

**DOCUMENTATION**

IOP monitoring is only recommended by an ophthalmologist or optometrist who is treating the patient’s glaucoma after a thorough eye exam. The order for RPM must appear in the clinical record with a medical rationale in a specific glaucoma care plan for the patient. A detailed, written explanation is provided to the patient with a provision to stop RPM at any time (See Appendix for Consent Form). A structured chart note is used to record the IOP data, physician’s interpretation, and physician’s treatment plan including changes. The staff follow a billing protocol consistent with CPT instructions (i.e., per episode for 99453, monthly for 99454 and 99457).

**PAYMENT RATES**

National Medicare Physician Fee Schedule payment rates for the codes discussed in this monograph in 2019 are shown below.

<table>
<thead>
<tr>
<th></th>
<th>PAR Allowable</th>
<th>Non-PAR Allowable</th>
<th>Limiting Charge for Non-PAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>99453</td>
<td>$19.46</td>
<td>$18.49</td>
<td>$21.26</td>
</tr>
<tr>
<td>99454</td>
<td>$64.15</td>
<td>$60.94</td>
<td>$70.08</td>
</tr>
<tr>
<td>99457</td>
<td>$51.54</td>
<td>$48.96</td>
<td>$70.08</td>
</tr>
</tbody>
</table>

23 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 08/15/19.
CONCLUSION

Self-tonometry may provide an ophthalmologist or optometrist with additional information not readily available. In 2019, there are two different approaches: short-term use and long-term use. The former is not covered within the Medicare program but the latter is new and covered under chronic care remote physiologic monitoring.

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.

Practice Management Tips

- After a thorough eye exam, select a patient who would benefit from IOP monitoring at home. Here, the focus is on moderate to severe glaucoma with above-average risk for disease progression with co-existing chronic conditions – either systemic or ophthalmic.
- Choose between short-term (<16 days) and long-term use of the Icare® HOME tonometer.
- Short-term use is not covered by Medicare. Long-term use is handled as remote physiologic monitoring and is covered as of 1/1/19.
- Use a financial waiver, such as an ABN, for noncovered items and services.
- Use a consent for RPM.
- A medical assistant or ophthalmic technician can train and certify a patient to use the Icare® HOME tonometer. Most patients, but not all, can be certified.
- For long-term use, the ophthalmologist or optometrist provides the Icare® HOME for the patient’s use, reviews the collected IOP measurements, and telephones the patient or caregiver each month to discuss the findings and treatment plan.
- A structured chart note is used to record the IOP data, physician’s interpretation, and physician’s treatment plan including changes. The staff follow a billing protocol consistent with CPT instructions (i.e., per episode for 99453, monthly for 99454 and 99457).
APPENDIX
Print your name, address and telephone number. Logo is optional.

**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 durable medical equipment for a few days is not covered by Medicare.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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 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.

**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.
**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</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>
<tr>
<td>tonometer</td>
<td></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.

<table>
<thead>
<tr>
<th>OPTIONS:</th>
<th>Check only one box. We cannot choose a box for you.</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] 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.</td>
<td></td>
</tr>
<tr>
<td>[ ] 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.</td>
<td></td>
</tr>
<tr>
<td>[ ] 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.</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information:**

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

**Signature:** [ ] [ ] **Date:**

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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 $_____________. If you do not return the Icare® HOME tonometer to your doctor, the charge for the device 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
Patient's Name: 

Consent for Remote Physiologic Monitoring

You need to make a choice about monitoring your intraocular pressure (IOP) at home. Your doctor has recommended using the Icare® HOME tonometer for at least a month (possibly more) so you can measure your IOP 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 IOP within certain boundaries to minimize or prevent damage to your optic nerve. Self-tonometry can help your doctor to better evaluate and treat your glaucoma. The major difference between self-tonometry and serial tonometry by your eye doctor is where the measurement of IOP is performed. It can be performed more frequently at home.

The measurements of your IOP will be recorded and sent to your doctor for evaluation using a secure connection to the Internet. At the end of the month, your doctor will review the IOPs with you during a telephone call, answer your questions, and, if necessary, adjust your treatment plan, without requiring a simultaneous office visit. If necessary, the doctor may reach out to you during the month if the IOPs fall outside the acceptable range to a meaningful extent. If you have questions or concerns about your glaucoma, you may call your doctor rather than wait for your doctor to call you.

The purpose of this notice is to help you make an informed choice about whether you want to receive this service knowing that a deductible and/or copayment will apply. Your doctor may recommend that you continue to monitor your IOP at home for another month (possibly more), however you may choose not to do so. Then, it will probably be necessary to check your IOP more frequently in the doctor's office instead. **Ask us to explain, if you don’t understand why monitoring your intraocular pressure at home is beneficial.**

You are responsible for the applicable deductible and/or copayments for monthly remote physiologic monitoring of IOP. Where appropriate, we will submit claims for reimbursement with any applicable secondary payer who might cover and pay for your deductible and/or copayment. Also, if you do not return the Icare® HOME tonometer to your doctor in good working order, the charge for the device is $____________.

<table>
<thead>
<tr>
<th>Beneficiary Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accordingly, the undersigned understands and accepts financial responsibility for any applicable deductible and/or copayments for remote physiologic monitoring of IOP.</td>
</tr>
</tbody>
</table>

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

__________________________
Date