Priority Health	BILLING POLICY No. 030
SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING (SCODI)	
Date of origin: Aug. 2024	**Review dates: 2/2025, 6/2025, 3/2026, 6/2026, 7/2026**

DEFINITION

Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) is a non-invasive, non-contact imaging technique. SCODI produces high resolution, cross-sectional tomographic images of ocular structures and is used for the evaluation of anterior segments, posterior segments, and retina.

SCODI includes the following tests

- Confocal Laser Scanning Ophthalmoscopy- an advanced eye-imaging technique that sweeps a low-power laser across the retina.
- Scanning Laser Polarimetry- a non-invasive laser eye test used to measure the thickness of the retinal nerve fiber layer.
- Optical Coherence Tomography- a non-invasive, high resolution imaging test that uses light waves to take cross-sectional pictures of tissue.

POLICY SPECIFIC INFORMATION

Billing

SCODI is used in the evaluation and treatment planning of diseases affecting the cornea, iris and other anterior chamber structures. These procedures are allowed to be billed in the office setting, nursing home, a Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC).

Priority Health allows two exams per year, per eye when a patient has glaucoma and if glaucoma is suspected. When there's damage to the retina, Priority Health will allow one exam per eye every two months. If the patient receives intravitreal injections, Priority Health will allow one scan per eye per month.

The codes referenced in the table below will be reimbursed when billed with a diagnosis code included in LCD L34760.

Code	Description
92132	Computerized ophthalmic diagnostic imaging (OCT) of the anterior segment, including interpretation and report; unilateral or bilateral.
92133	Computerized ophthalmic diagnostic imaging (OCT) of the posterior segment (optic nerve), including interpretation and report; unilateral or bilateral.
92134	Computerized ophthalmic diagnostic imaging (OCT) of the posterior segment (retina), including interpretation and report; unilateral or bilateral.
92137	Computerized ophthalmic diagnostic imaging (OCT) of the posterior segment (retina), including OCT angiography, with interpretation and report; unilateral or bilateral.

Global billing for SCODI is allowed in the following places of service:

- **11**: Office
- **32**: Nursing home
- **49**: Independent clinic

Technical billing for SCODI is allowed in the following places of service:

- **11**: Office
- **32**: Nursing home
- **49**: Independent clinic
- **FQHC**
- **RHC**

Documentation requirements

Priority Health doesn't typically reimburse the following services when billed with SCODI unless documentation supports the need for both services performed together. **Documentation would be reviewed upon appeal.**

1. Fundus photography with interpretation and report
2. Ophthalmoscopy extended with retinal drawing (i.e., for retinal detachment, melanoma) with interpretation and report initial
3. Subsequent ophthalmoscopy
4. B-scan (with or without superimposed non-quantitative A-scan)

REFERENCES

- Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) – L34760 (CMS)
- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) – A56916 (CMS)

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 13, 2025	Added "Disclaimer" section
June 4, 2025	No changes made
June 27, 2025	Added "Related denial language" section, including the following prism denial code: - E4E - Deny duplicate service. This denial will be effective July 26, 2025.
March 25, 2026	Removed "Applies to" section and updated "Disclaimer" section
June 9, 2026	Added aligned code definitions.
July 28, 2027	dated to state that assessments will be reimbursed when billed with diagnosis codes from LCD L34760.