Priority Health	BILLING POLICY No. 030

SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING (SCODI)

Effective date: July 26, 2025 **Date of origin: Aug. 2024**	**Review dates: 2/2025, 6/2025**

APPLIES TO

- Commercial plans
- For Medicare guidelines, see LCD L34760

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 segment, posterior segment and retina.

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 is receiving intravitreal injections, Priority Health will allow one scan per eye per month.

SCODI is billed by using the following CPT codes:

- **92132** is used when billing for the anterior segment with interpretation and report.
- **92133** is used when billing for the bilateral or unilateral optic nerve.
- **92134** is used when billing for the bilateral or unilateral retina

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

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 for 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 to 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.