Corcoran Consulting Group
A Division of Ardare Corporation

MEDICARE REIMBURSEMENT FOR FLUORESCEIN ANGIOGRAPHY

1 ***QUESTION:*** What is fluorescein angiography (FA)?

ANSWER: FA is a test that allows imaging of the vascular system in the retina and choroid. It is performed by injecting fluorescein into a vein, and taking a series of photographs of the retina and choroid as the dye flows through the blood vessels in the eye.

2 ***QUESTION:*** What are the indications for FA?

ANSWER: FA allows the clinician to evaluate a wide variety of retinal diseases, such as proliferative diabetic retinopathy, macular edema, vascular occlusive disease, age related macular degeneration, and ocular tumors, as well as other retinal pathology. Many third party payers publish policies identifying covered indications for testing.

3 ***QUESTION:*** Does Medicare cover FA?

ANSWER: Yes, for covered indications and as part of the overall evaluation and management of disease. Medical necessity for FA usually occurs in the presence of a change in the clinical assessment. For example, FA following treatment of choroidal neovascularization (CNV) is necessary to monitor for recurrence or to detect additional treatable lesions. FA may also be performed following treatment without clinical change in order to detect an occult lesion. Check your local coverage determination (LCD) policy for guidance.

4 ***QUESTION:*** What CPT code should we use for FA?

ANSWER: Use CPT code 92235, *Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral* to report this test. For dates of service prior to 2017, the code was defined as unilateral; now, it is billed once whether one or both eyes are tested.

5 ***QUESTION:*** What documentation is required in the medical record to support claims for FA?

ANSWER: In addition to the images, a physician's interpretation and report are required. A brief notation such as "abnormal" does not suffice. In addition to the images, the medical record should include:

- order for the test with medical rationale
- date of the test
- reliability of the test (*e.g.*, cloudy due to cataract)
- test findings (*e.g.*, retinal hemorrhages)
- comparison with prior tests (if applicable)
- a diagnosis, if possible
- the impact on treatment and prognosis
- physician's signature

6 ***QUESTION:*** May we be reimbursed for both FA and an exam or other diagnostic test on the same day?

ANSWER: According to Medicare's National Correct Coding Initiative (NCCI) edits, separate reimbursement is allowed for FA when performed in conjunction with an exam, although the tech exam 99211 is bundled with FA. Most other diagnostic tests, including fundus photography, are also permitted, although fluorescein angioscopy (92230) is bundled with 92235.

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7 ***QUESTION:*** What is the reimbursement for FA?

ANSWER: CPT 92235 is defined as "unilateral or bilateral", so reimbursement is the same whether one or both eyes are tested. The 2019 national Medicare Physician Fee Schedule participating amount is $93.34. Of this amount, $49.01 is assigned to the technical component, and $44.33 is the value of the professional component (interpretation). These amounts are adjusted in each area by local indices so actual payments differ. Other payers set their own rates, which may differ significantly from the Medicare published fee schedule.

92235 is subject to Medicare's Multiple Procedure Payment Reduction (MPPR). This reduces the allowable for the technical component of the second or lesser-valued test when more than one test is performed on the same day.

8 ***QUESTION:*** Is the physician's presence required during testing?

ANSWER: Yes. Because an intravenous dye is being introduced, *direct supervision* is indicated. Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the test. The physician is not required to be in the room. The claim for reimbursement must identify the supervising physician as the billing physician.[1,2]

9 ***QUESTION:*** How frequently may FA be performed?

ANSWER: In general, diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required. A few payers have published policies, but most do not; check your MAC for guidance.

10 ***QUESTION:*** If coverage of FA is unlikely or uncertain, how should we proceed?

ANSWER: Explain why the test is necessary, and that Medicare or other third party payer will likely deny the claim. Ask the patient to assume financial responsibility for the charge. A financial waiver can take several forms, depending on insurance.

- An Advance Beneficiary Notice of Noncoverage (ABN) is required for services where Part B Medicare coverage is ambiguous or doubtful, and may be useful where a service is never covered. You may collect your fee from the patient at the time of service or wait for a Medicare denial. If both the patient and Medicare pay, promptly refund the patient or show why Medicare paid in error.
- For Part C Medicare (Medicare Advantage), determination of benefits is required to identify beneficiary financial responsibility prior to performing noncovered services; MA Plans may have their own waiver forms and processes and are not permitted to use the Medicare ABN form.
- For commercial insurance beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN.

1 42 CFR 410.26(b)(5). Billing physician as the supervising physician.

2 80 FR 70885 CMS-1631-FC. 2016 Medicare Program; revisions to payment policies under the physician fee schedule. Published Nov 16, 2015.

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