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Medicare Reimbursement for Imaging with the SPECTRALIS®

Prepared for

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Medicare Reimbursement for Imaging with the SPECTRALIS®

by

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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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INTRODUCTION

This monograph describes reimbursement for fundus photography (FP), fluorescein and indocyanine angiography (FA and ICG), and computerized ophthalmic diagnostic imaging of the anterior (OCT-AS) and posterior segments (OCT and OCT-A) of the eye using Heidelberg Engineering's SPECTRALIS® instrument and its associated add-on modules.

Much of the information in this document is taken from official publications of the Medicare program. The reader is encouraged to check with the local Medicare Administrative Contractor (MAC) for additional information and instructions. For other third-party payors, we have used the coding concepts contained in CPT and published by the American Medical Association; diagnosis codes are from ICD-10-CM.

Documentation of diagnostic tests, and the medical rationale for them, is key to reimbursement so we describe the required elements in detail. Since economic analyses are a necessary part of any capital budgeting decision, we incorporated Medicare's payment rates for these tests, as well as recent Medicare utilization rates.

THE DEVICE

The SPECTRALIS is an expandable diagnostic imaging platform that combines scanning laser fundus imaging with high-quality spectral-domain OCT. As of this writing, the OCT2 module is being used on the International Space Station (ISS) to study the effects of microgravity on vision; the earlier-generation SPECTRALIS had been in service on the ISS since 2013.[1] Depending on the instrument and configuration, the SPECTRALIS can perform fundus photography (autofluorescence via BluePeak™, infrared, and other wavelengths via MultiColor™), anterior- and posterior-segment OCT, OCT angiography (OCT-A), fluorescein angiography (FA), and indocyanine green (ICG) angiography. SPECTRALIS with SHIFT technology is the first commercially available OCT that allows you to switch between 20, 85 and 125 kHz A-scan rates – three OCT scan speeds to find the ideal balance of image quality and clinical workflow. Varying the scan speed for different applications supports you in achieving the best outcomes for image quality, sharpness, and contrast. Imaging can also be done in a 55 degree widefield field of view. Non-contact ultra-widefield (102 degree) angiography is also available.

Figures 1 and 2 show the device and specialty lenses, respectively. Figure 3 shows the High Magnification lens mounted in place of the standard SPECTRALIS objective lens and some sample high magnification images. Table 1 shows the instruments, base

[1] Heidelberg Engineering. Press Release. SPECTRALIS OCT2 Module Improves Speed and Efficiency on the International Space Station. Link here. Accessed 03/17/25.

capabilities, and module options. Heidelberg notes: "*SPECTRALIS is an ophthalmic imaging platform with an upgradable, modular design. This platform allows clinicians to configure each SPECTRALIS to the specific diagnostic workflow in the practice or clinic. Options include: OCT, multiple scanning laser fundus imaging modalities, widefield and ultra-widefield modules and scanning laser angiography.*"[2]

Figure 1 **Heidelberg Engineering's SPECTRALIS**

Figure 2 **Heidelberg Engineering's SPECTRALIS Optional Lenses**

L to R: Standard (30º), Widefield (55º), Anterior Segment, Ultra-widefield (102º)

[2] Heidelberg Engineering. Products. SPECTRALIS. Link here. Accessed 03/17/25.

Figure 3 **Heidelberg Engineering's SPECTRALIS High Magnification Module**

Top: High Magnification Lens (hot pink) Affixed to the SPECTRALIS Camera Head
Bottom: High Magnification Images

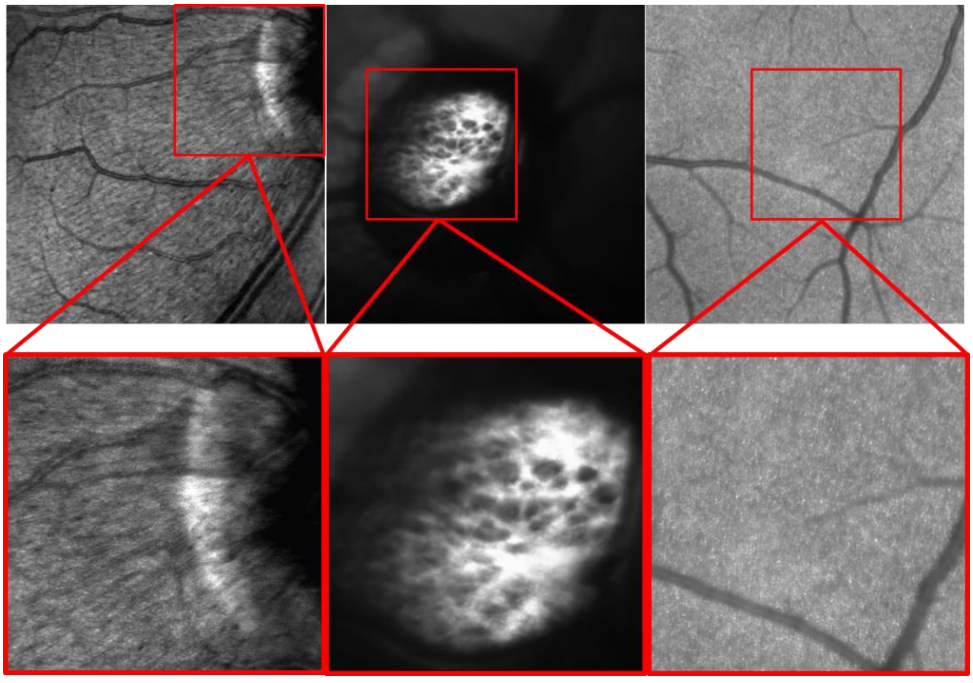

Table 1 **SPECTRALIS Modules**

		OCT SPECTRALIS	HRA + OCT SPECTRALIS	HRA SPECTRALIS
OCT	Retina	√	√	←
	Glaucoma	√	√	←
	Anterior Segment	Optional	Optional	←
	Glaucoma Module Premium Edition	Optional	Optional	←
	OCT 2 Module 85 kHz	Optional	Optional	←
Fundus	Infrared Reflectance	√	√	√
	BluePeak (Autofluorescence)	Optional	√	√
	MultiColor	Optional	Optional	Optional
	High Magnification Module	Optional	Optional	←
Widefield	Panning Camera	Optional	√	√
	Widefield Imaging (55º)	Optional	Optional	Optional
Angiography	Fluorescein Angiography	→	√	√
	ICG Angiography	→	√	√
	Ultra-Widefield Angiography	→	Optional	Optional
	OCT Angiography w/ SHIFT Technology 125 kHz	Optional	Optional	←
	OCT Angiography 85 kHz	Optional	Optional	←
√ Standard modules → Optional after upgrading to HRA+OCT Link here for more detail				

Heidelberg Engineering notes the following for BluePeak and MultiColor:

> "*BluePeak is a non-invasive, scanning laser fundus imaging modality that reveals metabolic stress in the retina using lipofuscin as an indicator. BluePeak images can reveal RPE and photoreceptor cell malfunctions, offering diagnostic insights into retinal conditions such as AMD and hereditary diseases. By combining the segmentation of retinal layers in OCT with the metabolic mapping of BluePeak™ autofluorescence, morphologic alterations associated with functional change can be seen*

more clearly. With the RegionFinder™ software, diseased areas seen in BluePeak™ images can be quantified and followed over time."[3]

"*MultiColor Scanning Laser Imaging uses three laser wavelengths simultaneously to provide diagnostic images that show distinct structures at different depths within the retina. The high-resolution, detailed MultiColor images can highlight structures and pathologies not visible on ophthalmoscopy and fundus photography. MultiColor images may even be acquired in patients with cataracts or nystagmus. Available only on the SPECTRALIS platform, the combination of MultiColor with OCT brings a new dimension of detail and versatility to ophthalmic imaging.*"[4]

For the Glaucoma Module Premium Edition, they note:

The SPECTRALIS® Glaucoma Module Premium Edition combines the proprietary Anatomic Positioning System (APS) with a series of unique scan patterns to assess the optic nerve head, the retinal nerve fiber layer, and the macular ganglion cell layer. These APS-based scan patterns are automatically matched to each eye's unique anatomic landmarks and to the characteristics of fine anatomic structures relevant in glaucoma diagnostics.

The Glaucoma Module Premium Edition compares patients' eyes to a reference database of normal eyes, noting even very small deviations. The precision of the SPECTRALIS AutoRescan function allows confident identification and monitoring of structural changes from visit to visit.

INDICATIONS FOR USE

The American Academy of Ophthalmology (AAO) publishes Preferred Practice Patterns (PPPs)[5] for many conditions, including: age-related macular degeneration, primary open-angle glaucoma, primary angle-closure glaucoma, idiopathic epiretinal membrane and vitreomacular traction, retinal vein occlusion, idiopathic macular hole, and diabetic retinopathy. According to the PPPs, fundus photography (FP), retinal and choroidal angiography (FA and ICG), OCT anterior segment (OCT-AS), OCT, and OCT-A provide objective documentation and can be used to establish a baseline for future comparisons and to follow disease progression. The AAO's PPPs point out that these imaging tests are a more reproducible technique than clinical examination for detecting posterior segment disease.

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[3] Heidelberg Engineering. SPECTRALIS®. BluePeak. Link here. Accessed 03/17/25.

[4] Heidelberg Engineering. SPECTRALIS. MultiColor. Link here. Accessed 03/17/25.

[5] American Academy of Ophthalmology. Preferred Practice Patterns. Link here Accessed 03/17/25.

In general, OCT-AS, OCT, OCT-A, FP, FA, and ICG angiography are all performed to:

- evaluate abnormalities in the eye,
- follow the progression of a disease,
- plan the treatment for a disease, and/or
- assess the therapeutic effect of recent surgery (*e.g.*, photocoagulation).

A variety of disease entities justify testing with OCT-AS. These include, but are not limited to, assessment of narrow or closed anterior chamber angles, corneal edema, iris cysts, failed or failing corneal transplants, and anterior segment neoplasms.

Coverage Guidelines

Medical necessity for diagnostic testing begins with pertinent signs, symptoms, or medical history of a condition for which the examining physician needs further information. A variety of disease entities justify testing.

Initial diagnostic testing is ordered and performed when the information garnered from the eye exam is insufficient to adequately assess the patient's disease. Medicare covers imaging-related tests as an adjunct to evaluation and management of a known disease. If the images are taken as baseline documentation of a healthy eye or as preventive medicine to screen for potential disease, then they are not covered, even if disease is identified.[6]

Repeated imaging is necessitated by disease progression, the advent of a new or different disease, or planning for additional surgical treatment (*e.g.*, laser). Otherwise, repeated images of the same, unchanged, condition are unwarranted.

Some ophthalmologists and optometrists may feel that a test is indicated for a particular condition, but when the patient's diagnosed condition does not appear on the payor's coverage list reimbursement cannot be expected. If payment is not expected, it is important to notify patients in writing, prior to testing, of their financial responsibility for the test. See the discussion below on Financial Waivers.

Frequency of testing is dependent on the disease and its activity. In general, these and all diagnostic tests are reimbursed when medically indicated and properly documented. Too-frequent testing can garner unwanted attention from Medicare and other payors.

Fundus Photography

Palmetto GBA, the MAC for some mid-Atlantic states, in their local coverage

[6] 42 CFR 411.15(a)(1). Particular services excluded from coverage. Link here. Accessed 03/17/25.

determination (LCD) L33467 on Fundus Photography,[7] notes,

> "*In general, fundus photography is considered medically necessary only when it would assist in:*
>
> 1. *monitoring potential progression of a disease process; or*
> 2. *guidance in evaluating the need for or response to a specific treatment or intervention.*
>
> *In other words, medical necessity for fundus photography should guide a clinical decision. Therefore, baseline photos to document a condition that is reasonably expected to be static and/or not require future treatment would not be medically necessary.*"

Fundus photography may be performed using SPECTRALIS imaging via BluePeak, MultiColor, and High Magnification options.

Optical Coherence Tomography (OCT)

LCDs and Local Coverage Articles (LCAs) for OCT include indications for a wide variety of diagnoses including but not limited to: glaucoma, retinal disease, and choroidal disease. It is important to note that MACs and other payors do not all agree on a common list of diagnoses or technologies. Review your payor policies.

Wisconsin Physician Services (WPS), the MAC for some Midwestern states, in their LCD L34760 on OCT,[8] notes for glaucoma:

> "*Technological improvements have rendered SCODI as a valuable diagnostic tool in the diagnosis and treatment of glaucoma. These improvements enable discernment of changes of the optic nerve … It is expected that only two (SCODI) exams/eye/year would be required to manage the patient who has glaucoma or is suspected of having glaucoma.*"

They go on to note, with respect to retinal testing performed using OCT:

> "*It is expected that no more than one exam per eye every two months would be required …* [when the] *condition is related to a retinal disease. Patients with retinal conditions undergoing active intravitreal drug treatment may be allowed 1 scan per month per eye. These conditions include age-related macular degeneration (wet), choroidal neovascularization, macular edema,*

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[7] Palmetto GBA. LCD L33467. Ophthalmology: Extended Ophthalmoscopy and Fundus Photography. South Carolina. Revision effective date 05/11/23. Link here. Accessed 03/17/25.

[8] Wisconsin Physicians Service Insurance Corporation. LCD L34760. Scanning Computerized Ophthalmic Diagnostic Imaging. Kansas, Missouri, Nebraska, and Iowa. Revision effective date 06/29/23. Link here. Accessed 03/17/25.

diabetic retinopathy (proliferative and nonproliferative), branch retinal vein occlusion, central retinal vein occlusion, and cystoid macular edema."

The Glaucoma Module Premium Edition can be either FP or OCT, depending on the imaging used, to provide additional detail and the ability to scan the same areas of the image. See the discussion below on "Other Coding Issues".

OCT Angiography (OCT-A)

OCT-A captures images and, through additional analysis, creates detailed images of the blood vessels within the retina and choroid. So, broadly speaking, the term "angiography" is appropriate; however, the historic use of this term predisposes ophthalmic technicians, medical assistants, and billing staff to assume that dye is injected. Prior to OCT-A, angiography of the retina and/or choroid required fluorescein or indocyanine green dye. From the patient's perspective, avoiding an intravenous injection is preferable.

In 2025, a new code, 92137, was added to the CPT Manual to report OCT-A on claims for reimbursement. CPT instructs, *"Do not report 92133, 92134, 92137 at the same patient encounter. Report 92137 separately when performed at the same encounter as 92235, 92240, 92242."* The AAO noted that it is likely that some payors will not agree with this permissive approach.[9]

Fluorescein and ICG Angiography

Fluorescein and indocyanine green angiography are helpful to image the vascular flow of the retina and choroid as indicated. FA shares many (but not all) of the indications for fundus photography. ICG angiography has far more restrictive coverage. Few MAC policies exist for ICG angiography; CGS Administrators has a policy that references ICG[10] as does Palmetto GBA.[11]

The CGS Administrators LCD for ICG angiography notes,

"*The medical record should include documentation of one of the following when indocyanine green angiography is performed:*

- *Evidence of ill-defined subretinal neovascular membrane or suspicious membrane on previous fluorescein angiography*
- *Retinal pigment epithelium (RPE) does not show subretinal neovascular membrane on current fluorescein angiography*

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9 AAO. 2025 Coding Update. 10/18/24. Link here. Accessed 03/17/25.

10 CGS Administrators, LLC. LCD L34175 on Ophthalmic Angiography (Fluorescein and Indocyanine Green). Revision effective date 06/03/21. Link here. Accessed 03/17/25.

11 Palmetto GBA. LCD L34426 on Ophthalmic Angiography (Fluorescein and Indocyanine Green). Revision effective date 07/15/21. Link here. Accessed 03/17/25.

- *Presence of subretinal hemorrhage or hemorrhagic retinal pigment epithelium. A fluorescein angiography need not have been done previously.*

Evidence of medical necessity must be documented in the medical record for each eye. Documentation, including photos, must be available to Medicare upon request."

CGS also states,

"*ICG angiography is considered medically necessary no more than nine (9) times per eye in 365 days. Claims exceeding this frequency will be suspended and reviewed for medical necessity.*"

Palmetto adds some additional limitations:

"ICG for the evaluation of patients with background diabetic retinopathy is not considered to be a medically necessary service. ICG angiography of an asymptomatic contralateral eye without new abnormalities on ophthalmoscopic exam, in patients with unilateral AMD or other disease, will be denied as not medically necessary. Evidence of medical necessity must be documented in the medical record for each eye."

Additionally, there are two National Coverage Determination (NCD §80.3 and NCD §80.3.1)[12,13] policies that mention OCT. They were revised and a Final Decision rendered April 3, 2013.[14] As revised, an OCT can be used to determine the need for ocular photodynamic therapy.

Screening

Some ophthalmologists and optometrists use standing orders for non-mydriatic fundus photography for all patients prior to an eye exam, so the doctor can screen for posterior segment disease as well as educate patients about the back of the eye. Other times, OCT of the retina is used as part of a package of items related to astigmatism- and/or presbyopia-correcting intraocular lenses or cosmetic refractive services. As a general rule, most payors, including Medicare, do not cover screening services or preventive medicine.[15]

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12 CMS. National Coverage Determination 80.3. Indocyanine Green Angiography. Effective date 04/03/2013. Link here. Accessed 03/17/25.

13 CMS. National Coverage Indication 80.3.1. Verteporfin. Effective date 04/03/13. Link here. Accessed 03/17/25.

14 CMS. NCA Final Decision Memorandum for Ocular Photodynamic Therapy (OPT) with Verteporfin for Macular Degeneration (CAG-00066R4). 04/03/2013. Link here. Accessed 03/17/25.

15 42 CFR 410.32 (a). Ordering diagnostic tests. Link here. Accessed 03/17/25.

Patients must be given the opportunity to choose between an exam with or without these imaging services. Practices should use a financial waiver to document the beneficiaries' acceptance of financial responsibility for the screening service. Screening occurs when the images are taken for one or more of the following reasons.

- Part of a wellness program to check for disease that may otherwise go undetected
- Not required by medical necessity; the reason for imaging is optional
- The beneficiary has no symptom or documented eye or systemic condition that would support imaging
- Recommended *prior to* a physician order for an individual patient's unique illness, injury, or medical condition
- Done for all patients as a matter of course, unless they decline

Finding disease on a screening test does not confer eligibility for reimbursement. It frequently leads to additional evaluation and management services, albeit not necessarily on the same day. Re-taking an image later on the same day (or another day close in time to the initial test) as the screening image does not provide coverage.

Standing Orders

Standing orders for tests may improve office efficiency, but they often create problems with reimbursement. The Office of Inspector General and the MACs have published several reports identifying standing orders as troublesome and problematic because they are routine screenings and non-covered services.[16,17,18] The Centers for Medicare & Medicaid Services (CMS) states "*the physician must clearly document, in the medical record, his or her intent that the test be performed.*"[19,20] To avoid this difficulty with reimbursement, physicians should examine the patient first and then determine which tests, if any, are necessary *before* ordering them. Alternately, and less commonly, a physician may formulate an order for imaging prior to any examination based on information about an individual patient's unique illness, injury, or medical condition provided by another physician, health care professional, or the patient themselves.

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16 United States General Accounting Office. Beneficiary Use of Clinical Preventive Services. GAO-02-422. April 2002. Link here. Accessed 03/17/25.

17 Office of Inspector General. Report: St. Francis Hospital, Tulsa, OK. Estimated Medicare Overpayment. February 12, 2002. Link here. Accessed 03/17/25.

18 Department of Justice. Archived Press Release. GAMBRO Healthcare Inc. agrees to pay $53 million of overcharging Medicare, Medicaid, & Tricare. July 13, 2000. Link here. Accessed 03/17/25.

19 CMS. Medicare Benefit Policy Manual, Chapter 15, §80.6.1. Requirements for Orders for Diagnostic Tests- Definitions. Link here. Accessed 03/17/25.

20 Palmetto GBA. Jurisdiction M Part B. Orders for Diagnostic Tests. Published 05/29/20. Link here. Accessed 03/17/25.

SUPERVISION

Since 2001, Medicare identifies its supervision rules for most ophthalmic diagnostic tests. FP, OCT and OCT-A require *general* supervision. This means the procedure is furnished in the office under the physician's overall direction and control, but the physician's presence is not required during performance of the test.[21] 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.[22] In the Medicare Physician Fee Schedule, a supervision indicator of "1" denotes general supervision.

FA and ICG angiography require *direct* supervision. 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 procedure. It does not mean that the physician must be present in the room when the procedure is performed. In the Medicare Physician Fee Schedule, a supervision indicator of "2" denotes direct supervision.

DOCUMENTATION

The descriptions in CPT for tests discussed in this monograph include the phrase "*with interpretation and report*".[23] What exactly is meant by this phrase, and what kind of chart note is required? This question takes on added urgency since insufficient chart documentation is reason enough to require repayment of any reimbursement.

Medicare Regulations and Guidance

The Medicare guidelines for interpretation of diagnostic tests are discussed in the Medicare Claims Process Manual (MCPM) Chapter 13 §100, Interpretation of Diagnostic Tests.[24] CMS makes a distinction between a "review" of a test and an "interpretation and report".

> "*Carriers generally distinguish between an "interpretation and report" ... and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field,*

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21 Some state laws may have different requirements.

22 42 CFR 410.32(b)(3)(i). Definition of general supervision. Link here. Accessed 03/17/25.

23 Current Procedural Terminology (CPT) 2024 edition.

24 Medicare Claims Process Manual (MCPM), Chapter 13, §100. Interpretation of Diagnostic Tests. Link here. Accessed 03/17/25.

> *does not meet the conditions for separate payment of the service. This is because the review is already included in the … E/M payment.*"

The review of a test is not separately payable because it is part of an evaluation and management (E/M) service.

> *"For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available)."*

Simple, brief notations such as "normal" or "abnormal" are construed as a review of the test rather than as an interpretation and report. As a condition of payment,[25] 42 CFR 415.120 (a) states:

> "***(a) Services to beneficiaries.*** *The carrier pays for … services furnished by a physician to a beneficiary on a fee schedule basis only if the services meet the conditions for fee schedule payment in § 415.102(a) and are identifiable, direct, and discrete diagnostic or therapeutic services furnished to an individual beneficiary, such as interpretation of … procedures. The carrier pays for interpretations only if there is a written report prepared for inclusion in the patient's medical record maintained by the hospital.*"

The value of an "interpretation and report" derives from the answers to important questions about the diagnostic test.

- Physician's order – *Why is the test desired?*
- Date performed – *When was it performed?*
- Technician's initials – *Who did it?*
- Reliability of the test – *Was the test of any value?*
- Patient cooperation – *Was the patient at fault?*
- Test findings – *What are the results of the test?*
- Comparison – *How do today's results differ from prior test(s)?*
- Assessment, diagnosis – *What do the results mean?*
- Impact on treatment, prognosis – *What's next?*
- Physician's signature – *Who is the physician?*

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[25] 42 CFR 415.120(a). Conditions for payment: Radiology services, to beneficiaries. Link here. Accessed 03/17/25.

In ophthalmology, tests such as FP and OCT are more valuable for making decisions about treatment when there is a series. Then, the concept of "comparative data" cited above is particularly meaningful. Does the series demonstrate disease progression? For a fundus photograph, the "interpretation and report" might read as follows.

- January 5, 2025
- Technician: Mary Smith, COT
- Cloudy images due to cataracts
- Good patient cooperation
- Cupping OU; optic disc hemorrhage, OU
- POAG, shows progression since last visit
- Add another anti-glaucoma medication
- *Signed:* *I. C. Better, M.D.*

For OCT of the optic nerve on the same patient at another visit date, the "interpretation and report" might read as follows.

- January 5, 2025
- Technician: Alex Smith, COA
- Test reliable, good image capture
- Good patient cooperation
- RNFL thinning, OU
- POAG, shows RNFL worsening since last test
- Change to another anti-glaucoma medication, consider other treatments if no improvement at next visit
- *Signed:* *I. C. Better, M.D.*

Timing

Ideally, the interpretation of a test follows immediately after the technical component is finished. In practice, there may be a delay; however, the delay should not be lengthy or affect patient care. Since OCT-AS, FP, OCT and OCT-A require only general supervision,[26] and the physician need not be present during the performance of the test, the interpretation might take place the next day. If a weekend intervenes, there may be two days' delay. Even when direct supervision pertains as for FA or ICG, the interpretation should be done promptly.

[26] 42 CFR 410.32(b)(3)(i). Definition of general supervision. Link here. Accessed 03/17/25.

It is important to note that CMS understands that delays are a fact of life and, in 2009, proposed regulations to require claims for reimbursement to identify on two separate lines the technical and professional components of a diagnostic test when performed on different dates of service. Transmittals 1823 and 1873 were subsequently withdrawn, yet there is still concern about this topic. As a practical alternative, bill the entire test upon completion after the interpretation is documented in the medical record since it is not clear what diagnosis would be used for the technical component alone.

Where to write?

An interpretation can be written on its own separate page in the medical record or in the blank space on the printout of the test result. Within an electronic medical record, we often find a designated spot to record the physician's interpretation of a test as a report. If the interpretation is written as part of the office visit note, it might appear to be an element of the evaluation and management service. Better to keep it separate or differentiate it from the rest of the eye exam by surrounding the notations with a box and a title like "Fundus photo report" or "OCT report".

Payment Considerations

In the Medicare Physician Fee Schedule, different payment rates are established for the professional and technical components of a diagnostic test where there is discrete reimbursement for an "interpretation and report". Respectively, modifiers 26 and TC are used to make the distinction between the professional and technical portions of the test. As a practical matter, this segregation permits a technician or medical assistant to perform the technical component, with appropriate supervision; however, only the physician can interpret test results. When TC and 26 are not appended to a CPT code, then the payor understands that reimbursement is sought for both the technical and professional components together in a single payment.

BILLING ISSUES

Procedure Codes

The following CPT codes may be used to report testing with the SPECTRALIS.

92132 ….. Computerized ophthalmic diagnostic imaging (eg, optical coherence tomograph [OCT]), anterior segment, with interpretation and report,

unilateral or bilateral

92133 ….. Computerized ophthalmic diagnostic imaging (eg, optical coherence tomograph [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

92134 ….. Computerized ophthalmic diagnostic imaging (eg, optical coherence tomograph [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina

92137 ….. Computerized ophthalmic diagnostic imaging (eg, optical coherence tomograph [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina, including OCT angiography

92235 ….. Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral

92240 ….. Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral

92242 ..... Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral

92250 ...… Fundus photography with interpretation and report

<u>Modifiers</u>

The following modifiers may be applicable on claims for the above codes.

AQ …… Services provided in a Health Professional Shortage Area (HPSA, *Medicare modifier only; replaces QB and QU*)

GA …… Medicare probably does not cover this service. Advance Beneficiary Notice (ABN) signed (*Medicare modifier only*)

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 …...… Medicare probably does not cover this service. No ABN on file (*Medicare modifier only*)

TC …… Technical component of a diagnostic test

26 ……. Professional component of a diagnostic test

52 ……. Reduced service (*e.g.*, only one eye tested)

Sample Claims

Example 1 Age-related macular degeneration

During dilated fundus exam of the posterior pole of a new patient with binocular indirect ophthalmoscopy, a few small drusen were noted OU. You order fundus photography OU to establish the extent of the early stage, nonexudative age-related macular degeneration (AMD) and to permit re-evaluation in the future. In addition to the exam (shown as 9xxxx), the claim will read as follows.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. H35.3131 B. C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92250		A	xxx xx	1		NPI	1234567890

One year later, the patient is seen again. Repeat FP is warranted with disease progression and vice versa.

Example 2 Diabetes with retinopathy

Your 74 y/o established Medicare patient with Type II diabetes on oral hypoglycemics presents for a yearly examination. You note moderate non-proliferative diabetic retinopathy and no diabetic macular edema is noted in either eye. Prior exams showed only mild non-proliferative retinopathy. For a more detailed evaluation and to permit re-evaluation at a later date, you order and perform fundus photos. In addition to the exam (shown as 9xxxx), the claim will read as follows.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. E11.3393 B. Z79.84 C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A,B	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92250		A,B	xxx xx	1		NPI	1234567890

Note: Some payors require the "Z" diagnosis code while others do not.

Example 3 Monocular imaging

You are a retina specialist consulted by another eyecare provider concerning a 78 y/o woman with blurred and distorted vision in her only useful eye (OS); her right eye has been NLP by history for many years due to a dense corneal scar. Your dilated fundus exam identifies a macular pucker OS; OD is a blind eye for which no image is obtainable or useful. You order OCT of the retina OD and document your findings in your report. In addition to the exam (shown as 9xxxx), the claim will read as below.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION Only left eye photographed			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. H35.372 B. C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92134		A	xxx xx	1		NPI	1234567890

Note: Infrequently, a payor may require modifier -52 when only one eye is imaged even though CPT states "unilateral or bilateral"; see comment in box 19. Reduced reimbursement may apply.[27]

Example 4 Fluorescein angiography for diabetic retinopathy

You are a retina specialist consulted by another eyecare provider concerning a 28 y/o man with blurred vision in both eyes; he is a Type I diabetic and takes insulin. Your dilated fundus exam identifies proliferative retinopathy without macular edema in both eyes. You

[27] National Government Services. LCD L33567. Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography), MN. *"Services performed unilaterally are subject to a reduction in fee."* Revision eff date 10/01/19. Link here. Accessed 03/17/25.

order FA and FP of the retina of both eyes and document your findings in your report. In addition to the exam (shown as 9xxxx), the claim will read as below.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. E10.3593 B. C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92250		A	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92235		A	xxx xx	1		NPI	1234567890

Note: Type I diabetics (E10.-) are assumed to be on insulin, omit Z79.4 diagnosis code for insulin use.

Example 5 OCT-Angiography of the retina for diabetic retinopathy

You are a retina specialist consulted by another eyecare provider concerning a 28 y/o man with blurred vision in both eyes; he is a Type I diabetic and takes insulin. Previously, he reacted badly to IV fluorescein. Your dilated fundus exam identifies proliferative diabetic retinopathy in both eyes. You order OCT angiography (OCT-A) and document your findings in your report. Traditional OCT shows no DME. In addition to the exam (shown as 9xxxx), the claim will read as below.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. E10.3593 B. C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92137		A	xxx xx	1		NPI	1234567890

Note: CPT instructs to bill only 92137 and not 92134. Type I diabetics (E10.-) are assumed to be on insulin, omit Z79.4 diagnosis code for insulin use.

Example 6 Fluorescein and ICG angiography on same patient, same day

You are a retina specialist consulted by another eyecare provider concerning a 68 y/o woman with blurred vision in the right eye. Your dilated fundus exam identifies active exudative age-related macular degeneration with choroidal neovascularization in the right

eye. The left eye has only early stage, nonexudative age-related macular degeneration. You order fundus photography, fluorescein angiography, and indocyanine angiography of the retina of both eyes and document your findings in your report. In addition to the exam (shown as 9xxxx), the claim will read as below.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. H35.3211 B. H35.3121 C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A,B	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92242		A	xxx xx	1		NPI	1234567890

Note: CMS' NCCI edits bundle 92250 with 99242 but not with 92235.

Example 7 Open-angle Glaucoma

Your established glaucoma patient returns for routine follow-up. Her IOPs are stable and there are no optic nerve changes. You ordered OCT of the optic nerve at the last visit and it is performed and interpreted today. You diagnose stable, moderate stage, primary open-angle glaucoma in both eyes. In addition to the exam (shown as 9xxxx), the claim will read as below.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. H40.1132 B. C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92133		A	xxx xx	1		NPI	1234567890

Example 8 Narrow anterior chamber angle and dry AMD

You are seeing a new patient referred to you with suspected narrow angles and visual acuity is not as expected. During your exam, you are unable to perform gonioscopy due to poor patient cooperation. You order OCT-AS. It is performed today and the findings show moderate narrowing of the angles but safe to dilate. After dilation, you note no glaucomatous damage to the nerves as well as several drusen indicative of early, dry, age-

related macular degeneration, OU. You order and perform OCT of the retina. It is properly interpreted. In addition to the exam (shown as 9xxxx), the claim will read as below.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. H40.033 B. H35.3131 C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A,B	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92132		A	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92134		B	xxx xx	1		NPI	1234567890

Note: CMS' NCCI edits do not bundle 92132 with 92134.

Example 9 Fundus Imaging with BluePeak autofluorescence

You are a retina specialist consulted by another eyecare provider concerning a 65 y/o woman with blurred vision in the right eye. Your dilated fundus exam identifies drusen in the right central retina. The left eye has small abnormal changes. You order both color and autofluorescence fundus photography of both eyes and properly document your findings. You diagnose early, dry, age-related macular degeneration in both eyes. In addition to the exam (shown as 9xxxx), the claim will read as below.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. H35.3131 B. C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92250		A	xxx xx	1		NPI	1234567890

Note: Fundus autofluorescence is an element of FP and not billed separately.

Multiple Procedure Payment Reduction

Medicare has implemented a payment reduction when multiple tests are performed on a patient at the same encounter. Known as the Multiple Procedure Payment Reduction

(MPPR),[28] it is effective for dates of service beginning January 1, 2013. This payment policy reduces the technical component of the second and any subsequent diagnostic tests by 20% when more than one eligible diagnostic test is performed at one patient encounter on the same day by the same physician or group. The list of tests includes imaging, ultrasounds and visual fields.[29] Tests not on the list are not subject to the MPPR reduction. All of the CPT codes discussed in this monograph are included in the list. The payment reduction is taken only on the lesser of the two *technical* portions – which is the fundus photo in this example. Note that the professional portions of each of the respective tests are unaffected and paid in full.

MPPR Example

A patient returns for her 3 month glaucoma check and threshold visual field. During the exam, the IOP is elevated and the optic nerves show increased cupping compared to the last fundus photos. Repeat fundus photographs are ordered and performed today. Both tests are properly interpreted. Payment for these tests from Medicare would be as follows.

Test	Professional	Technical	Total
92083 Visual Field	$25.55	$35.58 (No reduction)	$61.13
92250 Fundus Photo	$19.73	$15.85 less $3.17 (20%) = $12.68	$32.41

2025 National Medicare Physician Fee Schedule eff 01/01/25, PAR allowable
Note: Calculations are subject to rounding. Actual payments vary by location.

Prohibited Code Combinations

In 1996, CMS developed the National Correct Coding Initiative (NCCI)[30] to control improper coding leading to inappropriate payments in Part B claims.[31] NCCI consists of a series of edits to analyze codes reported on claims for reimbursement. They ensure the most comprehensive groups of codes are billed rather than the component parts; this is the concept informally known as "bundles". Additionally, the edits check for mutually exclusive code pairs – procedures that are medically incompatible – so just one of the pair may be reimbursed. New edits are published quarterly by the National Technical

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[28] CMS. Medicare Learning Network, MLN Matters MM7848, Eff. 01/07/13. Link here. Accessed 03/17/25.

[29] CMS Transmittal 1149, dated November 6, 2012, identifies the specific tests by CPT code that are subject to the MPPR. The Medicare Physician Fee Schedule multiple procedure indicator also identifies these codes each year (multiple procedure indicator 7). Link here. Accessed 03/17/25.

[30] Centers for Medicare & Medicaid Services. National Correct Coding Initiative Edits. Link here. Access 03/17/25.

[31] Medicare Claims Processing Manual, Chapter 23, §20.9. Correct Coding Initiative. Link here. Accessed 03/17/25.

Information Service (NTIS). Some carriers have also published local policies with additional limitations. Of note, you may not use an ABN to circumvent the NCCI edits.

In the current NCCI edits, CPT 92250 is bundled with ICG angiography codes (*i.e.*, 92240 and 92242) and mutually exclusive with computerized ophthalmic diagnostic imaging (OCT) of the posterior segment (92133, 92134). A bundle means that just one service will be reimbursed when both are performed on the same day; it behooves you to bill just one, usually the greater one, assuming that both tests have clinical utility. At the time of this writing, there are no published NCCI edits for the new code, 92137.

Additionally, other diagnostic tests exist to diagnose and monitor retinal disease and, although not prohibited by an NCCI edit, might not be allowed on the same date. If, for example, extended ophthalmoscopy (CPT 92225, 92226) is performed on the same date of service as fundus photography, it may not be considered medically necessary if it merely duplicates information secured by fundus photography. One MAC, National Government Services, Inc., states in its policy L33567 for extended ophthalmoscopy,[32] "*When other ophthalmologic tests (e.g., fundus photography, fluorescein angiography, ultrasound, optical coherence tomography, etc.) have been performed, extended ophthalmoscopy will be denied as not medically unnecessary unless there was a reasonable medical expectation that the multiple imaging services might provide additive (non-duplicative) information.*"

Other Coding Issues

Selecting the Proper Code

Since SPECTRALIS generates both a fundus image and an OCT image simultaneously, the selection of the proper code presents some challenges. This issue was addressed in CPT Assistant, a companion publication to CPT itself. In the November 2014, edition is an article, "Coding Clarification: Special Ophthalmological Services (92133, 92134)", which states,[33]

> "***Q:*** *Our office performs fundus photography examinations using a scanning laser which produces a fundus photograph. Is it appropriate to report CPT code 92135 [now code 92133 and 92134] for this method of examination of the fundus?"*
>
> ***A:*** *If the scanner produces an image of the retina or optic nerve along with other data and imaging for quantitative analysis, it would be appropriate to report a single service from the appropriate scanning computerized*

[32] National Government Services. LCD L33567. Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography), MN. Revision eff date 10/01/19. Link here. Accessed 03/17/25.

[33] American Medical Association. *CPT Assistant*. November 2014.

ophthalmic diagnostic imaging code range (92133-92134). If only an image is obtained, then code 92250 would be reported … It is important to note that if the only necessary service provided is generating a fundus photograph without the need to quantify the nerve fiber layer and to analyze the data via a computer, then reporting code 92250 is appropriate, even if the photograph was taken with a scanning laser."

Since 92250 is assigned more RVUs than 92133 or 92134 within the Medicare Physician Fee Schedule, billers are tempted to choose the CPT code that pays the most because the NCCI edits bundle these codes. The following examples illustrate appropriate code selection based on the purpose of the tests.

- You order and perform concurrent FP and OCT for progressive diabetic macular edema (DME). The swelling in the macula is quantified and interpreted. Bill only 92134. The assessment of the extent of the progression of DME depends on quantification of the swelling, which is better suited to OCT than FP.
- You order and perform concurrent FP and OCT for progressive vision loss. Prior binocular indirect ophthalmoscopy was unremarkable and inconclusive. The images reveal a new epiretinal membrane (ERM). Bill only 92134. The differential diagnosis of ERM, absent any visible macular distortion with BIO, depends on the cross-sectional capabilities of OCT rather than FP.
- You order and perform concurrent stereo FP and OCT of the optic nerve for acute papilledema. Bill only 92250. The differential diagnosis for papilledema depends on identifying qualitative vascular changes with flame-shaped hemorrhages, which are better suited to FP than OCT.

Autofluorescence

It has been suggested that AF is a separate and distinct service, but one that does not have a CPT code, so billers ought to use CPT code 92499, *unlisted ophthalmological service or procedure,* to report it on claims for reimbursement. According to the *CPT Assistant* December 2014 issue,[34] CPT code 92250, *Fundus photography with interpretation and report,* is appropriate to report AF as part of a series of fundus images or as a stand-alone service. This clarification in *CPT Assistant* removes any doubt about coding for AF because it is an incidental part of concurrent fundus photography and not an additional service.

Using CPT code 92499 to report AF has significant consequences. With few exceptions, most payors, including Medicare, habitually deny claims for 92499, so the beneficiary is financially liable for payment to the ophthalmologist or optometrist. Since claims for

[34] American Medical Association. *CPT Assistant*. December 2014.

fundus photography are reimbursed for a wide variety of pathology in the fundus, and AF is an incidental part of fundus photography, the beneficiary is only liable for the usual deductible and copayments for covered indications. Stipulating that AF is not reimbursed is an error that resulted from a misunderstanding about the proper coding for AF. Any payment by the beneficiary for a noncovered service represents an overpayment if the fundus photograph would have been reimbursed by the payor.

Financial Waivers

An Advance Beneficiary Notice of Noncoverage (ABN)[35] 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 is required for 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.

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,[36] 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.

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.

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

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[35] CMS. FFS ABN discussion and forms. Link here. Accessed 03/17/25.

[36] AAPC. CMS. *MedLearn Matters* (MM6136). Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage. Link here. Accessed 03/17/25.

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 specific patient; general statements such as "medically unnecessary" are not acceptable. The "Estimated Cost" field is required.

The beneficiary must *personally* choose Option 1, 2 or 3. 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.

If the beneficiary chooses Option 1, you must file a claim and append an appropriate modifier to the reported item(s) or service(s). In CMS Transmittal R1921CP,[37] effective April 1, 2010, two modifiers were updated to distinguish between *voluntary* and *required* use of liability notices. This change addresses the fact that most beneficiaries will elect Option 1 in the hope that Medicare might pay, despite your assurances to the contrary.

Modifier GA was redefined as "Waiver of Liability Statement Issued as Required by Payor Policy". When coverage is uncertain, you ask the patient to sign an ABN and submit your claim with modifier GA, allowing the payor to decide if the test is covered. Modifier GX is new and defined as "Notice of Liability Issued, Voluntary Under Payor Policy". If the patient selects Option 1, append modifiers GX and GY to that claim as those services are non-covered. Modifier GY is defined as "Item or service statutorily excluded or does not meet the definition of any Medicare benefit".

Option 2 applies to situations where Medicare is precluded from paying for the item or service and the beneficiary does not dispute the point. Do not file a claim; do post the item or service in your computer system with modifier GY.

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.

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[37] AAPC. CMS. Transmittal R1921CP. Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs). February 19, 2010. Link here. Accessed 03/17/25.

Purchased Diagnostic Tests / Anti-Markup Rule

If you order and bill for a test and either the technical component or the professional interpretation is performed by another physician, you may be prohibited from marking up the test (*i.e.*, receiving payment from Medicare in excess of the amount you paid to the entity who performed the technical component or professional interpretation) unless the physician who performs the test "shares a practice" with you.[38] However, if the performing physician meets the Medicare criteria for "sharing a practice" with you, the prohibition would not apply for that diagnostic test. The prohibition against marking up the test is referred to as the Medicare Anti-Markup Rule and was formerly known as the Purchased Diagnostic Test Rule.

If the Medicare Anti-Markup Rule applies because the performing physician is not deemed to share a practice with the billing physician, the payment to the billing physician (less the applicable deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the technical component or the professional component of the diagnostic test may not exceed the lowest of the following amounts:

- The performing supplier's net charge to the billing physician or other supplier;
- The billing physician or other supplier's actual charge; or
- The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

For further information about the Medicare Anti-Markup Rule and the "sharing a practice" criteria, please refer to CMS instructions.[39]

Health Professional Shortage Area (HPSA)

Medicare pays a quarterly 10% premium to physicians who provide services in a Health Professional Shortage Area (HPSA). No modifier is necessary if your zip code is listed as HPSA eligible. The bonus payment will be automatic. Eligible services provided at locations not listed need the modifier AQ.

This premium is pertinent only to professional services, and does not apply to the technical component (TC) of diagnostic tests. It is not necessary to separate the professional and technical components in order to receive bonuses; the MAC will automatically calculate bonus payments on the professional component. As an illustration, if the test in Sample

[38] CMS Medicare Learning Network. MLN Matters MM6371, implementation effective date 07/06/09. Link here. Accessed 03/17/25.

[39] Medicare Claims Processing Manual, Chapter 1, Section 30.2.9. Link here. Accessed 03/17/25.

Claim 1, above, had been performed in a HPSA not receiving automatic bonus payments, then the claim would be billed as 92250-AQ.

PAYMENT LEVELS

Medicare defines all of these codes as bilateral so reimbursement is for both eyes. Table 2 shows the participating (PAR), non-participating (Non-PAR), and non-participating limiting charge[40] values for Medicare in 2025. These amounts are adjusted in each area by local indices. Other payors set their own rates, which may differ significantly from the Medicare published fee schedule.

Table 2 **2025 Medicare Physician Fee Schedule**

Code	Description		PAR Allowable	Non-PAR Allowable	Limiting Charge for Non-PAR
92132	OCT-AS	Global	$28.79	$27.35	$31.45
		TC	$13.91	$13.21	$15.20
		PC	$14.88	$14.14	$16.26
92133	OCT Optic Nerve	Global	$29.76	$28.27	$32.51
		TC	$13.91	$13.21	$15.20
		PC	$15.85	$15.06	$17.32
92134	OCT Retina	Global	$31.38	$29.81	$34.28
		TC	$14.23	$13.52	$15.55
		PC	$17.14	$16.29	$18.73
92137	OCT Angiography	Global	$56.93	$54.08	$62.20
		TC	$23.29	$22.13	$25.44
		PC	$33.64	$31.96	$36.75
92235	FA	Global	$152.68	$145.04	$166.80
		TC	$112.24	$106.63	$122.62
		PC	$40.43	$38.41	$44.17

[40] 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. Accessed 03/17/25

Table 2 **2025 Medicare Physician Fee Schedule**

Code	Description		PAR Allowable	Non-PAR Allowable	Limiting Charge for Non-PAR
92240	ICG	Global	$229.01	$217.56	$250.20
		TC	$184.05	$174.85	$201.08
		PC	$44.96	$42.71	$49.12
92242	FA & ICG	Global	$314.41	$298.69	$343.49
		TC	$262.65	$249.52	$286.95
		PC	$51.75	$49.17	$56.54
92250	FP	Global	$35.58	$33.80	$38.87
		TC	$15.85	$15.06	$17.32
		PC	$19.73	$18.74	$21.56

UTILIZATION

Medicare utilization rates are published and are noted below (Table 3). Commercial utilization rates are not readily available. In general, this and all diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required. If your utilization rate exceeds the expected norms, you will likely garner attention from Medicare and other payors. Careful attention to documentation of the test and the reasons it was performed are your best defense against reproach in the event of post payment review.

Table 3 **Medicare Utilization Rates**

Code	Description	Ophthalmology (18)	Optometry (41)
92132	OCT-AS	0.1%	0.1%
92133	OCT Optic Nerve	10.8%	9.1%
92134	OCT Retina	39.9%	10.3%
92235	FA	1.7%	nil
92240	ICG	nil	nil
92242	FA & ICG	0.2%	nil
92250	FP	10.0%	17.6%

Medicare claims adjudicated in 2022.

Note: CPT 92137 was inaugurated January 1, 2025 so there is no prior utilization data.

CONCLUSION

A well-known proverb says a picture is worth a thousand words. Unlike ophthalmoscopy where the examiner must be content with a brief look, anterior segment, optic nerve, and fundus imaging provide crisp, detailed, close-up pictures of the eye for intensive study, as well as for subsequent use as a benchmark for monitoring subtle changes that allow for better disease management.

The images also have utility for people other than the examining physician. For example, fundus photos are helpful in telemedicine, during litigation (*e.g.*, malpractice), as part of criminal investigations (*e.g.*, shaken baby), for teaching purposes, and for other caregivers.

OCT can help identify and quantify minute details that are otherwise invisible to ophthalmologists and optometrists even with high magnification. Objective quantified data is particularly helpful for gauging disease progression and planning treatment.

FA and ICG angiography are helpful to image the vascular flow of the retina and choroid as indicated. OCT-A provides similar information without the need for injections of dye.

Some applications of ophthalmic imaging, particularly screening, are not covered by Medicare and most other third-party payors. For covered services, documentation of the physician's order and interpretation are crucial; where it is abbreviated or missing, reimbursement is jeopardized.

This discussion is meant to assist the reader to better understand the rules and regulations regarding reimbursement for imaging tests discussed in this monograph, however the responsibility for appropriate usage, adequate documentation and proper coding are always the physician's.

Practice Management Tips

- Other than for screening, get a physician's order with appropriate medical rationale before providing these tests with the expectation of reimbursement.
- Document the physician's interpretation of the diagnostic test in a report within a short time, preferably within 24 - 72 hours. Be sure to address the quality of the test, the findings and changes over time, and the assessment. Sign and date the note.
- Place a note in the medical record that identifies where digital images are electronically stored.
- For most payors, screening and standing orders do not support coverage. Notify the patient, prior to testing, of financial responsibility if the test is to screen for possible disease, routine, or otherwise not covered by insurance, and document acceptance on the Advance Beneficiary Notice of Noncoverage (ABN) form for Medicare beneficiaries or Notice of Exclusion from Health Plan Benefits for other beneficiaries. For Medicare Advantage enrollees, follow plan instructions for prior determination of coverage.
- Differentiate covered and non-covered testing based on the reason for the service and the diagnosis. When both FP and OCT can be generated with a single push of a button, the purpose of the test, not the level of reimbursement, governs code selection.
- Check the covered diagnoses when ICG angiography is performed (92240 or 92242) as they are not the same as fluorescein angiography (92235).
- BluePeak and other wavelength (MultiColor) fundus imaging is coded as 92250.
- When BluePeak or MultiColor with SPECTRALIS are performed on the same day as other fundus photography, only CPT code 92250 applies and no additional charge pertains.
- When autofluorescence and other wavelength fundus imaging is performed on the same day as other fundus photography, only one instance of CPT code 92250 applies and no additional charge pertains to either payor or patient.
- Repeated testing is merited due to disease progression, otherwise it may be dubious.

- Monitor NCCI edits quarterly. Corcoran Consulting Group's Medicare Quick Reference Guide can help.
- Check Local Coverage Determinations (LCDs) for specific guidance in your area. Covered indications and claims submission instructions vary over time and between Medicare Administrative Contractors. Investigate the policies of other third-party payors; they vary.
- Fundus photographs may supplement a dilated fundus evaluation during a comprehensive eye exam but does not replace binocular indirect ophthalmoscopy through a dilated pupil.
- If you use an independent contractor to perform diagnostic tests - that is, someone who provides all the equipment and technician, and is not an employee - then get assistance with the arcane instructions associated with Medicare's anti-markup rules.