

REIMBURSEMENT GUIDE

SPECTRALIS

CODE 92240

Indocyanine Green Angiography

SPECTRALIS[®]

The Fusion of Imaging Technologies

SPECTRALIS

SPECTRALIS dual beam imaging system combines high resolution cross-sectional imaging with a simultaneous reference image. It is available in a number of distinct models which offer various combinations of the imaging modalities listed in the table below.

| | HRA+OCT | FA+OCT | HRA | OCT ^{PLUS} with BluePeak | OCT ^{PLUS} | OCT with BluePeak | OCT |
|--------------------------------------|---------|--------|-----|---|---------------------|-------------------------|-----|
| Optical coherence tomography | ● | ● | | ● | ● | ● | ● |
| Infrared imaging | ● | ● | ● | ● | ● | ● | ● |
| Fluorescein angiography | ● | ● | ● | | | | |
| ICG angiography | ● | | ● | | | | |
| Iris angiography | ● | ● | ● | | | | |
| External photography | ● | ● | ● | ● | ● | ● | ● |
| BluePeak blue laser autofluorescence | ● | ● | ● | ● | | ● | |
| Red-free photography | ● | ● | ● | | | | |
| Fundus photography | ● | ● | ● | ● | ● | ● | ● |

This reimbursement guide addresses specifically the Medicare reimbursement and documentation requirements for billing indocyanine green angiography as it relates to the SPECTRALIS imaging system. Providers should note that appropriate diagnosis codes are required to substantiate medical necessity when billing these services.

As with any service billed to Medicare, providers are encouraged to check with their local Medicare contractor for specific billing and documentation guidelines.

ICG**CPT Code 92240****Indocyanine green angiography (includes multiframe imaging) with interpretation and report**

Indocyanine green (ICG) angiography is an infrared-based dye imaging technique that is helpful in the diagnosis and treatment of ill-defined choroidal neovascularization (eg, associated with age-related macular degeneration). Indocyanine green dye is injected intravenously into the patient to highlight the vessels in the retina and those of a deeper tissue layer called the choroid. The green dye fluoresces with invisible infrared light and requires a special camera sensitive to these light rays. Images are then captured of the retina at intervals as increasing intensity of retinal and choroidal circulation is displayed.

Coverage Guidelines

Indocyanine green angiography is a valuable diagnostic adjunct to fluorescein angiography in evaluating such conditions as:

- Retinal neovascularization
- Serous detachment of retinal pigment epithelium
- Hemorrhagic detachment of retinal pigment epithelium
- Retinal hemorrhage
- 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.
- Presence of subretinal hemorrhage or hemorrhagic retinal pigment epithelium (RPE). A fluorescein angiography need not be previously done.

Not all Medicare contractors cover the conditions outlined in the following list of diagnosis codes. The list is intended to provide the most common conditions that might be considered for payment.

| DIAGNOSIS CODES | DIAGNOSIS CODE DESCRIPTION |
|-----------------|--|
| 362.16 | Subretinal neovascular membrane |
| 362.17 | Other intra-retinal micro-vascular abnormalities |
| 362.20 | Retinopathy of prematurity, unspecified |
| 362.22 – 362.27 | |
| 362.41 | Central serous retinopathy |
| 362.42 | Serous detachment of retinal pigment epithelium |

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|---------------|---|
| 362.43 | Hemorrhagic detachment of retinal pigment epithelium |
| 362.52 | Exudative senile macular degeneration (May not be covered by all contractors) |
| 362.53 | Cystoid macular degeneration of retina |
| 362.81-362.84 | Retinal hemorrhage – retinal ischemia |
| 363.00-363.08 | Focal chorioretinitis unspecified – focal retinitis and retinochoroiditis peripheral |
| 363.10-363.15 | Disseminated chorioretinitis unspecified – disseminated retinitis and retinochoroiditis pigment epitheliopathy |
| 363.20 | Chorioretinitis unspecified |
| 363.61 | Choroidal hemorrhage unspecified |
| 363.62 | Expulsive choroidal hemorrhage |
| 363-50-363-57 | Hereditary choroidal dystrophy or atrophy unspecified – other diffuse or generalized dystrophy of choroid total |
| 363.72 | Hemorrhagic choroidal detachment |
| 364.00 | Acute and subacute iridocyclitis unspecified (May not be covered by all contractors) |
| 364.10 | Chronic iridocyclitis unspecified (May not be covered by all contractors) |

Providers should verify with their own Medicare contractor the specific local coverage determination (LCD) guidelines that might support the medical necessity and billing of this test.

Attachment I is a listing of current Medicare Administrative Contractors (MACs) and their website addresses. Providers should access their MAC website periodically for Medicare payment updates and revised or new Local Coverage Determinations (LCDs).

Billing Tips

Indocyanine green angiography, code 92240, is considered by Medicare to be a unilateral service. Therefore, if it is performed on both eyes, each eye should be reported on separate detail lines with the -RT and -LT modifier. Some contractors permit one line time using both the -RT/-LT modifier with a “2” in the units column.

Fundus photography, CPT code 92250, is bundled with ICG under Medicare’s Correct Coding Initiative (CCI) when performed at the same session.

Some Medicare contractors consider the performance of fluorescein angiography to be medically unnecessary if performed within one month of indocyanine green angiography. Others permit ICG within one month and even on the same day when additional diagnostic information is medically necessary.

Generally, only one ICG is medically necessary prior to and following a course of treatment. Services in excess of this standard of care must be reflected in the patient's medical records to support the medical necessity if more frequent testing. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

In the absence of pre-existing chronic disease, clinical signs or symptoms of disease, an ICG angiography is considered screening and is not a benefit of the Medicare program. Also, a bilateral study is not automatically appropriate, or covered, in every case. Therefore, evidence of medical necessity must be documented in the medical record for each eye.

If the service is not medically necessary, an acceptable advance notice of Medicare's denial of payment must be provided to the patient when the physician does not want to accept financial responsibility for the service.

Advance Beneficiary Notice

An Advance Beneficiary Notice (ABN) is a written document a doctor or supplier must give a Medicare beneficiary before items or services are furnished when the doctor or supplier believes Medicare probably or certainly will not pay for some or all of the items or services. The ABN protects the rights of the beneficiary and informs them of choices available for services Medicare might consider medically unnecessary. For example, the doctor may order a diagnostic test for a condition that is not on Medicare's approved list of covered diagnoses, but the physician feels the test would benefit the patient anyway.

The ABN used must be the official published CMS-R-131-G form. An ABN is required for both assigned and non-assigned claims, and the –GA modifier must be appended to the procedure code when submitted to Medicare. The notice must be signed and dated by the patient in advance of the service being rendered. Medicare wants the patient to be able to make a rational, informed consumer decision before proceeding with the procedure.

The ABN must clearly identify the item or service to be performed, and must specifically state the reason Medicare is likely to deny payment. For example, the form might state that "this service is not considered medically necessary for your condition." By signing the form, the patient acknowledges that he or she is fully aware of their financial responsibility should Medicare deny the service as "not medically necessary."

The fee may be collected from the patient at the time service is rendered, or once a Medicare denial is received. Without a signed ABN, the physician will be required to refund any payment collected from the patient should the service be denied.

Chart Notes

Under Medicare rules, all diagnostic tests must be documented as “ordered” by the treating physician. The order for the retinal tomography may be documented as part of the plan of the previous visit or documented in the subjective entry of today’s visit. Without an order documented in the patient chart, the service will be denied in a post-payment audit.

The chart should contain the following information:

- Patient’s name and date of service on each page
- Reasons for test being performed
- Order for the test
- Results of the test (ie, printout) –location of digital media must be noted
- Separate Interpretation & Report - requires physician signature
- Signature of treating physician

I&R

A “separate” interpretation and report (I&R) must be documented in the patient’s medical record when any of the above tests are performed. While there are no set guidelines for information that must be contained in an I&R, it is recommended the following be documented:

1. What was seen or was not seen but anticipated;
2. Whether or not it represents an improvement, stabilization, or worsening of the patient condition; and
3. Whether or not it represents the need for a change in the patient’s Plan of Treatment.

The interpretation and report may be noted on the test result sheets, in the body of the chart, or on a separate form to be included in the chart. Some practices have created “rubber stamps” or labels to simplify the interpretation and report requirements. A sample generic form might look like this:

| |
|---|
| <p>Preliminary Diagnosis: _____</p> <p>Test Results: _____</p> <p>_____</p> <p>_____</p> <p>Disposition: _____</p> <p>_____</p> <p>Provider Signature: _____</p> <p>Date: _____</p> |
|---|

Without a separate, identifiable interpretation and report documented in the chart, Medicare will deny the service in a post-payment audit. Taking these few extra minutes will ensure compliance with the requirements for billing this diagnostic service.

Modifiers

Modifiers Required by Medicare

The following modifiers apply to indocyanine green angiography services:

- 26** Professional component of a diagnostic test. To be used when an outside provider sends test results to you for interpretation only.
- 50** Indicates a bilateral test was performed. Some contractors permit the use of the -50 modifier on one line item and reimbursement is made at 200% of the fee schedule amount. Only use this modifier if your Medicare contractor permits.
- GA** Service may be denied as “not medically necessary.” Signed Advance Beneficiary Notice on file.
- GY** Program exclusion for screening exam, but patient requests service be billed to Medicare for secondary payer denial.
- GZ** No Advance Beneficiary Notice on file. Do not intend to bill patient if denied as “not medically necessary.”

- LT Test performed on the left eye.
- RT Test performed on the right eye.
- TC Technical component of a diagnostic test. To be used when an outside provider has requested the test be performed by you and the results interpreted by the requesting provider.

Special Issues

Purchased Services

In some instances, a physician may not own or lease the equipment needed to perform the indocyanine green angiography. In these cases, the physician may “purchase” the test from another Medicare provider and bill the total component (technical and professional) to Medicare using his or her own provider number.

To submit a claim to Medicare for the purchased service, Item 20 of the CMS-1500 claim form must indicate a “yes.” This indicates that an entity other than the entity billing for the service performed the diagnostic test. Item 20 must also indicate the amount you paid for the “purchased” test. Item 32 must contain the provider’s name, address, zip code and PIN. If more than one test is purchased, each “purchased” test must be submitted on a separate claim form.

Reimbursement will be based on the lower of the purchased amount indicated in Item 20, the physician’s actual charge, or the Medicare fee schedule amount.

Supervision Requirements

Diagnostic tests covered under Medicare require special levels of supervision of the technician performing the test. The three levels designed by Medicare are general, direct and personal. General supervision means the test may be performed without a doctor present in the clinic. Direct supervision requires the doctor to be present in the clinic, but not necessarily in the room where the test is performed. Personal supervision requires the doctor to be present in the same room during the test.

Indocyanine green angiography requires “direct” supervision meaning a physician must be present in the clinic when the test is being performed.

Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA)

Medicare pays a quarterly 10% bonus to doctors who provide services in a Health Professional Shortage Area (HPSA) and a 5% bonus to doctors in a Physician Scarcity Area (PSA). These bonuses apply only to professional services performed by the doctor (e.g., office visits, surgeries, and professional component only of diagnostic tests). Payment will now be made on only the professional component even when a global service (no modifier) is billed.

The HPSA bonus will be paid automatically to physicians who provide care in ZIP code areas that:

- Fall entirely in a county designated as a full-county HPSA;
- Fall entirely within the county, through a determination of dominance by the U.S. Postal Service; or
- Fall entirely within a partial county HPSA.

Physicians who provide care in ZIP code areas that do not fall entirely within a full county HPSA or partial county HPSA must enter the -AQ modifier on the claim to receive the bonus.

The PSA bonus will be automatically paid without the need for a modifier on the claim for services provided in zip code areas that:

- Fall fully within a county designated as a PSA; or
- Which partially fall within a county designated as a PSA and are considered to be dominant for that county, based on a determination of the U.S. Postal service; or
- Fall within a rural area of a metropolitan statistical area identified through the latest modification of the Goldsmith modification that is determined to be a PSA.

In some cases, a service may be provided in a county that is considered to be a PSA, but the zip code is not considered to be dominant for that area. In these cases, the bonus payment cannot be made automatically. In order to receive the bonus for such services, physicians will need to include modifier –AR to reflect a physician service provided in a PSA.

Providers can go to the CMS web page to find out if they are automatically eligible to receive the HPSA or PSA bonus. The CMS web page can be found at:

- <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/>

Medicare Payment

As with all services paid under Medicare Part B, Medicare publishes an annual fee schedule for each CPT code in the Medicare Physician Fee Schedule Data Base (MPFSDB). This fee schedule is usually released in October or November of each year for the following year. The established fees are determined using annual conversion factors and relative values units (work, liability and practice expense) for each CPT procedure code.

Once the national payment rates are established, Medicare contractors then apply a geographic practice cost index (GPCI) to each procedure code to determine the reimbursement amount for a particular payment locality. Some states have a statewide locality. Some states have several payment localities within each state. Medicare contractors publish the fees for each payment locality on their

individual websites. Physicians should review those fee schedules annually to ensure the charges made to Medicare meet or exceed Medicare fee schedule amounts for services performed and billed.

Closing Thought

The intent of this document is to make procedural information and material available to facilitate prompt and accurate documentation and processing of a Medicare claim for indocyanine green angiography using the SPECTRALIS imaging system. This document should not be considered a replacement of published Medicare regulations or implementing guidelines.

The final liability for compliance with all Medicare rules and regulations rests solely with the performing provider. The provider should make every attempt to contact the Medicare contractor for specific guidelines regarding reimbursement, documentation and coding of indocyanine green angiography.

Heidelberg Engineering or Rose & Associates shall not be liable to you, your employees, or any other party for inadvertent errors or omissions in information provided to you by company employees or representatives.

ATTACHMENT I

Medicare Administrative Contractors (MAC) by State

| State | Contractor | Policy Name* | Website Address |
|----------------|--------------|--------------|--|
| Alabama | Cahaba GBA | OCT | www.cahabagba.com |
| Alaska | Noridian | SLGT | www.noridianmedicare.com |
| Arizona | Noridian | SLGT | www.noridianmedicare.com |
| Arkansas | Pinnacle | SCODI | www.arkmedicare.com |
| California | Palmetto GBA | SLGT | www.palmettogba.com |
| Colorado | TrailBlazer | SLGT | www.trailblazerhealth.com |
| Connecticut | NGS | SCODI | www.ngsmedicare.com |
| DC | Highmark | SCODI | www.highmarkmedicareservices.com |
| Delaware | Highmark | SCODI | www.highmarkmedicareservices.com |
| Florida | First Coast | SCODI | www.medicarefcso.com |
| Georgia | Cahaba GBA | OCT | www.cahabagba.com |
| Hawaii | Palmetto GBA | SLGT | www.palmettogba.com |
| Idaho | CIGNA | SCODI | www.cignagovernmentservices.com |
| Illinois | WPS | OCT | www.wpsic.com/medicare |
| Indiana | NGS | SCODI | www.ngsmedicare.com |
| Iowa | WPS | OCT | www.wpsic.com/medicare |
| Kansas | WPS | OCT | www.wpsic.com/medicare |
| Kentucky | NGS | SCODI | www.ngsmedicare.com |
| Louisiana | Pinnacle | SCODI | www.lamedicare.com |
| Maine | NHIC | SCODI | www.medicarenhic.com |
| Maryland | Highmark | SCODI | www.highmarkmedicareservices.com |
| Massachusetts | NHIC | SCODI | www.medicarenhic.com |
| Michigan | WPS | OCT | www.wpsic.com/medicare |
| Minnesota | WPS | OCT | www.wpsic.com/medicare |
| Mississippi | Cahaba | OCT | www.cahabagba.com |
| Missouri | WPS | OCT | www.wpsic.com/medicare |
| Montana | Noridian | SLGT | www.noridianmedicare.com |
| Nebraska | WPS | OCT | www.wpsic.com/medicare |
| Nevada | Palmetto GBA | SLGT | www.palmettogba.com |
| New Hampshire | NHIC | SCODI | www.medicarenhic.com |
| New Jersey | Highmark | SCODI | www.highmarkmedicareservices.com |
| New Mexico | TrailBlazer | SLGT | www.trailblazerhealth.com |
| New York | NGS | SCODI | www.ngsmedicare.com |
| North Carolina | CIGNA | SLGT | www.cignagovernmentservices.com |
| North Dakota | Noridian | SLGT | www.noridianmedicare.com |
| Ohio | Palmetto | SLGT | www.palmettogba.com |

| | | | |
|----------------|--------------|-------|--|
| Oklahoma | Trailblazer | SLGT | www.trailblazerhealth.com |
| Oregon | Noridian | SLGT | www.noridianmedicare.com |
| Pennsylvania | Highmark | SCODI | www.highmarkmedicareservices.com |
| Rhode Island | NHIC | SCODI | www.rimedicare.com |
| South Carolina | Palmetto GBA | SCODI | www.palmettogba.com |
| South Dakota | Noridian | SLGT | www.noridianmedicare.com |
| Tennessee | CIGNA | SLGT | www.cignagovernmentservices.com |
| Texas | TrailBlazer | SLGT | www.trailblazerhealth.com |
| Utah | Noridian | SLGT | www.noridianmedicare.com |
| Vermont | NHIC | SCODI | www.medicarenhic.com |
| Virginia | TrailBlazer | LCT | www.trailblazerhealth.com |
| Washington | Noridian | SLGT | www.noridianmedicare.com |
| West Virginia | Palmetto GBA | SLGT | www.palmettogba.com |
| Wisconsin | WPS | OCT | www.wpsic.com/medicare |
| Wyoming | Noridian | SLGT | www.noridianmedicare.com |

* Medical policies refer to the method of testing, not specific equipment. When the name of the policy indicates OCT, the policy includes all manufacturers of scanning ophthalmic diagnostic imaging.

Abbreviation Legend:

| Medicare Carriers | |
|-------------------------------|---|
| NGS | National Government Services |
| NHIC | National Heritage Insurance Company |
| WPS | Wisconsin Physician Service |
| Medicare Policy Titles | |
| LCT | Laser Coherence Tomography |
| OCT | Ocular Coherence Tomography |
| SCODI | Scanning Computerized Ophthalmic Diagnostic Imaging |
| SLGT | Scanning Laser Glaucoma Tests |