

REIMBURSEMENT GUIDE

SPECTRALIS

CODE 92287

Iris Fluorescein 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 iris fluorescein angiography (Iris FA) 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.

External Ocular Photos

CPT Code 92287

Special anterior segment photography with interpretation and report; with fluorescein angiography

Special anterior segment photography with fluorescein angiography is used for detection of abnormalities of blood vessels in the iris. The angiography begins when a small amount of fluorescein dye is injected into the arm. The dye is transported to the eye through the blood vessels. As the dye traverses the vessels in the iris, it is stimulated with light of a specific wavelength and the fluorescence of the dye is captured. This test most often is used to delineate fine neovascularization of tumors in the anterior segment.

Coverage Guidelines

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
190.0	Malignant neoplasm of eyeball except conjunctiva cornea retina and choroid
250.50 - 250.53	Diabetes with ophthalmic manifestations, type ii or unspecified type, not stated as uncontrolled - diabetes with ophthalmic manifestations, type 1 [juvenile type], uncontrolled
364.00 - 364.8	Acute and subacute iridocyclitis unspecified - other disorders of iris and ciliary body
365.41 - 365.44	Glaucoma associated with chamber angle anomalies - glaucoma associated with systemic syndromes
365.52	Pseudoexfoliation glaucoma
365.63	Glaucoma associated with vascular disorders of eye
365.64	Glaucoma associated with tumors or cysts
365.82	Glaucoma with increased episcleral venous pressure
743.00 - 743.06	Clinical anophthalmos unspecified – cryptophthalmos
743.10 - 743.12	Microphthalmos unspecified - microphthalmos associated with other anomalies of eye and adnexa
743.20 - 743.22	Buphthalmos unspecified - buphthalmos associated with other ocular anomalies
743.30 - 743.39	Congenital cataract unspecified - other congenital cataract and lens anomalies
743.41 - 743.48	Congenital anomalies of corneal size and shape - multiple and combined congenital anomalies of anterior segment

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

Special anterior segment photography with fluorescein angiography (Iris FA) is considered by Medicare to be a bilateral service. Medicare reimbursement includes payment for both eyes. Some commercial payers may consider this service to be unilateral and may require it to be reported on separate detail lines with the –RT and –LT modifier.

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

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:

Preliminary Diagnosis: _____

Test Results: _____

Disposition: _____

Provider Signature: _____

Date: _____

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 special anterior segment photography with fluorescein angiography (Iris FA) 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

In some instances, a physician may not own or lease the equipment needed to perform the special anterior segment photography with fluorescein angiography (Iris FA). 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.

Special anterior segment photography with fluorescein angiography (eg. Iris FA) is classified as a professional, or physician, service only and is not assigned a level of supervision. As such, an Iris FA must be performed “incident to” a physician’s service requiring the physician to be in the clinic when the test is 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 Iris FA 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 Iris FA.

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