

## REIMBURSEMENT GUIDE

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Spectralis®

CODE 92235

Fluorescein Angiography

SPECTRALIS®

The Fusion of Imaging Technologies

# HEIDELBERG ENGINEERING, INC.

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*This document should not be considered a replacement for published Medicare regulations.*

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## Spectralis®

**Spectralis HRA+OCT** dual beam imaging system combines high resolution cross-sectional imaging with a simultaneous reference image and offers all of the imaging modalities listed in the table below. The **Spectralis OCT** and the **Spectralis HRA** models offer the subsets of the imaging modalities shown in the table below.

	HRA+OCT	OCT	HRA
Optical coherence tomography	●	●	
Infrared imaging	●	●	●
Fluorescein angiography	●		●
ICG angiography	●		●
Iris angiography	●		●
External photography	●	●	●
Autofluorescence	●		●
Red-free photography	●		●
Fundus photography	●	●	●

This reimbursement guide addresses specifically the Medicare reimbursement and documentation requirements for billing fluorescein angiography as it relates to the Spectralis. Providers should note that appropriate ICD-9-CM 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 carrier for specific billing and documentation guidelines.

### *Fluorescein Angiography*

#### **CPT Code 92235**

#### **Fluorescein Angiography (includes multiframe imaging) with interpretation and report**

Fluorescein angiography (FA) plays an important role in the diagnosis of and evaluation of many retinal conditions. Because it can precisely delineate

areas of abnormality, it is an essential guide for planning treatment of retinal vascular disease.

After the intravenous injection or oral administration of a contrast solution of sodium fluorescein, ophthalmoscopy using *Spectralis* with a 488 nm wavelength to excite the fluorescein is useful in detecting leaking capillaries (sub-retinal neovascularization). The *Spectralis* makes a record of the study using electronic imaging methods.

## Coverage Guidelines

The medical necessity of fluorescein angiography is established as an adjunct to the diagnosis of chorioretinal vascular abnormalities especially relating to choroid neovascularization, non-infective vasculitis and age related macular degeneration. It may also be appropriate in evaluating intraocular tumors, visual loss in systemic disease, and optic disc edema. The medical necessity for such angiography would generally be in the context of a changing clinical picture.

Fluorescein angiography following treatment, for example, of choroidal neovascularization (CNV) is necessary to monitor for recurrence or to detect additional treatable disease. Usually this is performed on the basis of a change observed in the clinical picture similar to the way it is employed prior to treatment. However, fluorescein angiography may be performed following treatment without clinical change in order to detect occult lesions. This will occur most often in CNV and very rarely in other diseases.

Most Medicare carriers consider fluorescein angiography medically necessary for the following conditions:

- Initial evaluation of a patient with abnormal findings of the fundus/retina on ophthalmoscopy exam and may include any of the following:
  - Choroidal Neovascular Membranes (CNVM)
  - Lesions of the Retinal Pigment Epithelium (RPE)
  - Fibrovascular disciform scar
  - Vitreous hemorrhage (sudden loss of vision)
  - Drusen

o Diabetic Retinopathy

- Evaluation of a patient presenting with symptoms such as sudden central vision loss, blurred vision, distortion, etc., which may suggest that a subretinal neovascularization is present.
- Evaluation of patients with non-proliferative (background) and proliferative diabetic retinopathy with or without macular edema.
- Evaluation of patients with chorioretinitis, chorioretinal scars of choroidal degeneration, dystrophies, hemorrhage and rupture or detachment.
- Evaluation of patients with known retinal or macular disorders.
- Evaluation of patients with ocular tumors, visual loss in systemic disease, and optic disc disease.

Not all Medicare carriers 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.

ICD-9	DIAGNOSIS CODE DESCRIPTION
115.02	Histoplasma capsulatum retinitis
115.92	Histoplasmosis retinitis unspecified
130.2	Chorioretinitis due to toxoplasmosis
135	Sarcoidosis
190.5	Malignant neoplasm of retina
190.6	Malignant neoplasm of choroid
224.5	Benign neoplasm of retina
224.6	Benign neoplasm of choroid
228.03	Hemangioma of retina
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
360.00	Purulent endophthalmitis unspecified
360.01	Acute endophthalmitis
360.02	Panophthalmitis
360.03	Chronic endophthalmitis
360.11 - 360.14	Sympathetic uveitis - ophthalmia nodosa
360.20 - 360.24	Degenerative disorder of globe unspecified - other metallosis of globe
360.55	Foreign body magnetic in posterior wall
360.65	Foreign body in posterior wall of eye
361.2	Serous retinal detach

362.01 - 362.07*	Background diabetic retinopathy - diabetic macular edema
362.10 - 362.18	Background retinopathy unspecified - retinal vasculitis
362.21 - 362.29	Retrolental fibroplasia - other nondiabetic proliferative retinopathy
362.30 - 362.37	Retinal vascular occlusion unspecified - venous engorgement of retina
362.40 - 362.43	Retinal layer separation unspecified - hemorrhagic detach of retinal pigment epithelium
362.51 - 362.57	Nonexudative senile macular degeneration of retina - drusen (degenerative) of retina
362.65	Secondary pigmentary degeneration of retina
362.66	Secondary vitreoretinal degenerations
362.70 - 362.77	Hereditary retinal dystrophy unspecified - retinal dystrophies primarily involving Bruch's membrane
362.81 - 362.85	Retinal hemorrhage - retinal nerve fiber bundle defects
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 - 363.22	Chorioretinitis unspecified - Harada's disease
363.30 - 363.35	Chorioretinal scar unspecified – disseminated scars of retina
363.40 - 363.43	Choroidal degeneration unspecified – angioid streaks of choroid
363.50 - 363.57	Hereditary choroidal dystrophy or atrophy unspecified - other diffuse or generalized dystrophy of choroid total
363.61 - 363.63	Choroidal hemorrhage unspecified - choroidal rupture
363.70 - 363.72	Choroidal detach unspecified - hemorrhagic choroidal detach
364.24	Vogt-Koyanagi syndrome
364.42	Rubeosis iridis
368.11	Sudden visual loss
377.00 - 377.04	Papilledema unspecified - Foster-Kennedy syndrome
377.16	Hereditary optic atrophy
377.21 - 377.24	Drusen of optic disc – pseudopapilledema
377.30 - 377.34	Optic neuritis unspecified - toxic optic neuropathy
377.41 - 377.49	Ischemic optic neuropathy - other disorders of optic nerve
379.07	Posterior scleritis
379.22	Crystalline deposits in vitreous
794.11	Nonspecific abnormal retinal function studies

\* ICD-9-CM code 362.07 requires a dual diagnosis. When using ICD-9-CM code 362.07 (diabetic macular edema) a code for diabetic retinopathy (362.01-362.06) must also be used.

Some Medicare carriers require additional documentation to accompany the claim if billed as a bilateral service and involve the following diagnoses. Again, check with your local Medicare carrier for specific coverage guidelines.

ICD-9	DIAGNOSIS CODE DESCRIPTION
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190.6	Malignant neoplasm of choroid
362.30	Retinal vascular occlusion, unspecified
362.31	Central retinal artery occlusion
362.32	Arterial branch occlusion
362.34	Transient arterial occlusion
362.35	Central retinal vein occlusion
362.36	Venous tributary (branch) occlusion
362.37	Venous engorgement
362.41	Central serous retinopathy
362.42	Serous detachment of retinal pigment epithelium
362.43	Hemorrhagic detachment of retinal pigment epithelium
362.50	Macular degeneration (senile), unspecified
362.51	Nonexudative senile macular degeneration
362.52	Exudative senile macular degeneration
362.53	Cystoid macular degeneration
362.54	Macular cyst, hole, or pseudohole
362.56	Macular puckering
363.10	Disseminated chorioretinitis, unspecified
363.11	Disseminated chorioretinitis, posterior pole
363.12	Disseminated chorioretinitis, peripheral
363.13	Disseminated chorioretinitis, generalized
363.14	Disseminated chorioretinitis, metastatic
363.63	Choroidal rupture
363.70	Choroidal detachment, unspecified
363.71 – 363.72	Serous and hemorrhagic choroidal detachment
377.22	Cater-like holes of optic disc

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

## *Billing Tips*

Fluorescein angiography 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 carriers permit one line item using both the –RT/-LT modifiers with a “2” in the units column.

Most Medicare carriers have determined it would be unusual to need more than 7 fluoresceins on an eye in a 12 month period.

Fundus photography, code 92250, is not bundled with FA under Correct Coding Initiative (CCI) when performed at the same session.

Fluorescein angiography performed for a retinal condition on the same day as an OCT, code 92135, is not subject to the Correct Coding Initiative (CCI) bundling edits and can be billed separately. When fluorescein angiography is performed on both eyes, there must be documented evidence of pathology in both eyes before both eyes can be billed to Medicare.

### *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)
  - If digital or other media, location of 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 fluorescein 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 carriers 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 carrier 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 fluorescein 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.

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

**Health Professional Shortage Area**

Medicare pays a quarterly 10% premium to doctors who provide services in a Health Professional Shortage Area (HPSA) and a 5% premium to doctors in a Physician Scarcity Area (PSA). These premiums 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.

CMS no longer distinguishes between urban and rural HPSA areas. The new –AQ modifier replaces the –QB and –QU modifiers and must be appended on all claims for dates of service January 1, 2006 or after. Payment will be paid automatically based on the zip code provided in Item 32 of the CMS-1500 claim form. When billing HPSA services, Medicare no longer requires the claim to be split-billed on two separate line items using the -26 and -TC modifiers. Bonus payment will be made only on the professional component even when the total component is billed.

## *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 carriers 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 carriers 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 fluorescein angiography using the *Spectralis*. 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 carrier for specific guidelines regarding reimbursement, documentation and coding of fluorescein angiography.

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