

REIMBURSEMENT GUIDE

Spectralis®

CODE 92135

Optical Coherence Tomography

SPECTRALIS®

The Fusion of Imaging Technologies

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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 ocular coherence tomography (OCT) 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.

SCODI (OCT)

CPT Code 92135

Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral

Many forms of scanning computerized ophthalmic diagnostic imaging tests currently exist, such as confocal laser scanning ophthalmoscopy, scanning laser

polarimetry, optical coherence tomography, and retinal thickness analysis. Although these techniques differ, their objective is the same.

Optical coherence tomography (OCT) allows for detection of glaucoma damage to the nerve fiber layer or optic nerve of the eye. It is the goal of this diagnostic test to discriminate among patients with normal intraocular pressures (IOP) who have glaucoma, patients with elevated IOP who have glaucoma, and patients with elevated IOP who do not have glaucoma.

OCT is also a valuable tool for the evaluation and treatment of patients with retinal disease, especially certain macular abnormalities. It details the microscopic anatomy of the retina and the vitreoretinal interface. It is useful to measure the effectiveness of therapy, and in determining need for ongoing therapy, or the safety of cessation of that therapy.

The *Spectralis HRA+OCT* and *Spectralis OCT* use optical coherence tomography to produce images of patient's eyes for the evaluation and treatment of retinal disease especially certain macular abnormalities. It details the microscopic anatomy of the retina and the vitreoretinal interface. It is useful to measure the effectiveness of therapy, and in determining need for ongoing therapy, or the safety of cessation of that therapy.

The *Spectralis* uses multiple tomographic images to measure either the optic nerve head or posterior retinal structures to detect glaucomatous damage to the nerve fiber layer of the retina. It also detects non-glaucomatous retinal changes in the microstructure of the posterior retina (eg, macular edema and atrophy associated with degenerative retinal diseases).

Coverage Guidelines

While there are no national coverage criteria for OCT, most Medicare carriers agree on the covered diagnoses for glaucoma patients. There is no consensus regarding the coverage of retinal conditions—some Medicare carriers pay for retina diagnoses, others may not. Physicians are urged to refer to any specific guidelines published by their individual Medicare carrier. If no guidelines exist, the recommendations outlined in this reimbursement guide may be implemented until carrier information is available.

Indications for coverage of OCT as published by some Medicare carriers:

- Diagnose early glaucoma and monitor glaucoma treatment;
- Differentiate causes of other optic nerve disorders when a diagnosis is in doubt;
- Diagnose and manage the patient's condition when visual field results are insufficient; or when reliable visual field testing cannot be performed, due to visual, physical, mental, or age constraints;
- Differentiate when a discrepancy exists between the clinical appearance of the optic nerve and the visual fields;
- Detect further loss of optic nerve or retinal nerve fiber layer changes in the presence of advanced optic nerve damage and advanced visual field loss;
- Diagnose and manage neuro-ophthalmic and retinal diseases which involve changes in the optic nerve and nerve fiber layer, subretinal and intra-retinal changes, and vitreoretinal changes in the macular region; and
- Follow glaucoma suspects with significant risk factors.

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
190.6	Malignant neoplasm of eye, choroid
224.6	Benign neoplasm of choroid
228.03	Hemangioma of retina
361.00-361.04	Retinal detachments
361.05-361.07	Recent detachment, total or subtotal
361.10-361.19	Retinoschisis, unspecified
361.2	Serous retinal detachment
361.30-361.33	Retinal defect, unspecified
361.81	Traction detachment of retina
361.9	Unspecified retinal detachment
362.01-362.29	Retinopathy
362.30-362.37	Retinal vascular occlusion
362.40-362.43	Retinal layer separation
362.50-362.56	Macular degeneration
362.60	Peripheral retinal degeneration, unspecified
362.66-362.85	Retinal disorders
363.00-363.08	Chorioretinal inflammations

363.10-363.15	Disseminated chorioretinitis/retinochoroiditis
363.20-363.22	Chorioretinitis, other
363.30-363.65	Chorioretinal scars
363.40-363.43	Choroidal degenerations
363.62-363.72	Choroidal hemorrhage and rupture
363.70-363.72	Choroidal detachments
364.04	Secondary iridocyclitis, noninfectious
364.22	Glaucomatocyclitic crises
364.53	Pigmentary iris degeneration
364.73	Goniosynechiae
364.74	Pupillary membranes
364.77	Recession of chamber angle
365.00-365.04	Glaucoma suspects
365.10-365.9	Glaucoma
368.40-368.45	Visual field defects
377.00-377.04	Papilledema
377.13	Optical atrophy, retina
377.14	Glaucomatous atrophy (cupping) of optic disc
377.15	Partial optic atrophy
377.21-377.24	Other disorders of optical disc
377.39	Optic neuritis, other
377.41-377.49	Other disorders of optic nerve
377.51-377.54	Disorder of optic chiasm
377.61-377.63	Disorders of other visual pathways
377.9	Unspecified disorder of optic nerve and visual pathways
743.20-743.22	Buphthalmos
743.58	Vascular anomalies

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

Optical coherence tomography 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.

When OCT is performed on the same day as fundus photography, the fundus photos are bundled under the Correct Coding Initiative (CCI) and not billable separately. In addition, most Medicare carriers also do not permit visual fields to be performed on the same day as OCT for the same diagnosis.

Some Medicare carriers now permit up to 8 tests per year for a retina diagnosis. Some carriers only permit 2-4 tests per year for a diagnosis of exudative macular degeneration or diabetic maculopathy. Other carriers still limit code 92135 to 2 tests per year for a retina diagnosis. For those carriers who have not yet included retina diagnoses in their medical policies, any denials should be appealed.

The following utilization guidelines for glaucoma diagnoses have been made available in numerous local coverage determinations published by Medicare.

- Once per year would be appropriate to follow pre-glaucoma patients or those with “mild” damage.
- Patients with “moderate” damage may be followed with OCT or visual fields. One or two tests per year may be appropriate. If both tests—OCT and visual fields—are performed, only one of each test would be necessary.
- In “advanced” damage, Medicare expects to see visual fields rather than OCT performed. More than four visual fields or OCT exams (if the patient is unable to tolerate a visual field) in a year would be rarely necessary.

Most Medicare carriers have also published the following coverage limitations for scanning laser diagnostic tests:

- Mild Damage** – Scanning laser can be used to follow pre-glaucoma patients or those with mild damage.
- Moderate Damage** – Scanning laser and visual fields, done together or separated by a short period of time, are not considered medically necessary. However, alternating use of these tests at the proper time intervals can be considered appropriate, and may increase the sensitivity of detecting glaucomatous damage.
- Advanced Damage** – Most Medicare carriers have indicated that visual fields would be preferred instead of scanning laser. If the patient is physically unable to tolerate a visual field, the medical necessity for performing an OCT would need to be documented in the patient’s chart.

Since the definitions of the amount of glaucomatous damage can vary by each Medicare carrier, physicians are urged to review local coverage determinations for specific requirements. In the absence of carrier guidelines, the American Academy of Ophthalmology's *Preferred Practice Patterns* can be used as guidance.

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 OCT 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 OCT. 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.

Optical Coherence Tomography (OCT) can be performed under “general” supervision and does not require the presence of a physician.

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 OCT 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 OCT.

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 XX**Medicare Coverage
Quick Reference Guide – CPT Code 92135**

State	Carrier Name	Name of Medical Policy*	Glaucoma Coverage	Non-Glaucoma Coverage	Carrier Website Addresses
Alabama	Cahaba	OCT	Yes	Yes	www.cahabagba.com
Alaska	Noridian	SLGT	Yes	Yes	www.noridianmedicare.com
Arizona	Noridian	SLGT	Yes	Yes	www.noridianmedicare.com
Arkansas	Pinnacle	SCODI	Yes	Yes	www.arkmedicare.com
California – No	NHIC	SCODI	**	**	www.medicarenhic.com
California – So	NHIC	SLGT	Yes	Limited	www.medicarenhic.com
Colorado	Noridian	SLGT	Yes	Yes	www.noridianmedicare.com
Connecticut	First Coast	SCODI	Yes	Yes	www.connecticutmedicare.com
DC	TrailBlazer	LCT	Yes	Limited	www.trailblazerhealth.com
Delaware	TrailBlazer	LCT	Yes	Limited	www.trailblazerhealth.com
Florida	First Coast	SCODI	Yes	Yes	www.floridamedicare.com
Georgia	Cahaba	OCT	Yes	Yes	www.cahabagba.com
Hawaii	Noridian	SLGT	Yes	Yes	www.noridianmedicare.com
Idaho	CIGNA	SCODI	Yes	Yes	www.cignamedicare.com
Illinois	WPS	OCT	Yes	Limited	www.wpsic.com/medicare
Indiana	AdminaStar	No Policy	***	***	www.adminastar.com
Iowa	Noridian	SLGT	Yes	Yes	www.noridianmedicare.com
Kansas	Wheatlands	OCT	Yes	Limited	www.kansasmedicare.com
Kentucky	AdminaStar	No Policy	***	***	www.adminastar.com
Louisiana	Pinnacle	SCODI	Yes	Yes	www.lamedicare.com
Maine	NHIC	SCODI	Yes	Yes	www.medicarenhic.com
Maryland	TrailBlazer	LCT	Yes	Limited	www.trailblazerhealth.com
Massachusetts	NHIC	SCODI	Yes	Yes	www.medicarenhic.com
Michigan	WPS	OCT	Yes	Limited	www.wpsic.com/medicare
Minnesota	WPS	OCT	Yes	Limited	www.wpsic.com/medicare
Mississippi	Cahaba	OCT	Yes	Yes	www.cahabagba.com
Missouri – Eastern	Pinnacle	SCODI	Yes	Yes	www.momedicare.com
Missouri – NW	Wheatlands	OCT	Yes	Limited	www.nwmissourimedicare.com
Montana	Noridian	SCODI	Yes	Yes	www.noridianmedicare.com
Nebraska	Wheatlands	OCT	Yes	Limited	www.nebraskamedicare.com
Nevada	Noridian	SLGT	Yes	Yes	www.noridianmedicare.com
New Hampshire	NHIC	SCODI	Yes	Yes	www.medicarenhic.com
New Jersey	Empire	SCODI	Yes	Yes	www.empiremedicare.com
New Mexico	Pinnacle	SCODI	Yes	Yes	www.oknmmedicare.com
New York – Empire	Empire	SCODI	Yes	Yes	www.empiremedicare.com

New York – GHI	GHI	SCODI	Yes	Yes	www.ghimedicare.com
New York – Upstate	Health Now	SCODI	Yes	Yes	www.umd.nycpic.com
North Carolina	CIGNA	SLGT	Yes	Yes	www.cignamedicare.com
North Dakota	Noridian	SLGT	Yes	Yes	www.noridianmedicare.com
Ohio	Palmetto	SLGT	Yes	Limited	www.palmettogba.com
Oklahoma	Pinnacle	SCODI	Yes	Yes	www.oknmmedicare.com
Oregon	Noridian	SLGT	Yes	Yes	www.noridianmedicare.com
Pennsylvania	Highmark	SCODI	Yes	Yes	www.highmarkmedicareservices.com
Rhode Island	Pinnacle	SCODI	Yes	Yes	www.rimedicare.com
South Carolina	Palmetto	SCODI	Yes	Yes	www.palmettogba.com
South Dakota	Noridian	SLGT	Yes	Yes	www.noridianmedicare.com
Tennessee	CIGNA	SLGT	Yes	Yes	www.cignamedicare.com
Texas	TrailBlazer	LCT	Yes	Limited	www.trailblazerhealth.com
Utah	Noridian	SLGT	Yes	Yes	www.noridianmedicare.com
Vermont	NHIC	SCODI	Yes	Yes	www.medicarenhic.com
Virginia	TrailBlazer	LCT	Yes	Limited	www.trailblazerhealth.com
Washington	Noridian	SLGT	Yes	Yes	www.noridianmedicare.com
West Virginia	Palmetto	SLGT	Yes	Limited	www.palmettogba.com
Wisconsin	WPS	OCT	Yes	Limited	www.wpsic.com/medicare
Wyoming	Noridian	SLGT	Yes	Yes	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
- ** No diagnosis codes listed in old policy. Check with your local Medicare carrier for coverage guidelines.
- *** Even though there is no published medical policy, this carrier may cover glaucoma and retina diagnoses. Check with your local Medicare carrier for coverage guidelines.

Abbreviation Legend:

Medicare Carriers	
GHI	Group Health, Inc.
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