FAQs

optomap® Fluorescein & ICG Angiography

1. Can fluorescein and/or indocyanine green angiography (FA & ICG) be performed with Optos devices?
Yes; the California and Silverstone lines include models with FA and ICG imaging. These devices can quickly and easily produce a series of single-capture, ultra-widefield (200°) FA and/or ICG images.

These high-resolution angiographic images capture the movement of dye through retinal or choroidal vessels across virtually the entire retina and offer clinicians information helpful for diagnosis, management, and determining treatment of retinal and choroidal conditions. Medicare and other payers define the codes as bilateral, so bill only once whether one or both eyes are tested.

There are three CPT codes for these tests:
92235: Fluorescein angiography (FA)
92240: Indocyanine-green angiography (ICG)
92242: FA and ICG performed at the same patient encounter

2. What are the indications for these tests?
FA allows the clinician to evaluate retinal diseases such as diabetic retinopathy, macular edema, vascular occlusive disease, and ARMD.

ICG is performed to assess choroidal circulation and is commonly used in diseases such as SRNVM, serous or hemorrhagic detachment of the RPE, and subretinal hemorrhage.
For a list of the common ICD-10 codes that support these codes see: **Imaging ICD-10 Codes.**

3. Does Medicare cover FA and ICG?
Yes, for covered indications and as part of the overall evaluation and management of disease. For example, FA following treatment of choroidal neovascularization is necessary to monitor for recurrence or to detect additional treatable lesions. Medical necessity for testing usually occurs in the presence of a change in the clinical assessment.
For a list of common ICD-10 codes that support these codes see: **Imaging ICD-10 Codes.**

4. What documentation is required in the medical record to support these claims?
A physician's interpretation and report are required. A brief notation such as "abnormal" does not suffice. In addition to the images or a reference to where they are stored, the medical record should include:

- Order for the test with medical rationale
- Date of the test
- Reliability of the test (e.g., cloudy with cataract)
- Test Findings (e.g., retinal hemorrhages, neovascularization)
- Comparison with prior tests (if applicable)
- A diagnosis (if possible)
- The impact on treatment and prognosis
- Physician's signature and date

5. What is the Medicare payment amount for this test?
For national payment rate and notes on National Correct Coding Initiative (NCCI) edits see: Imaging CPT Codes and Rates.

Please note, this CPT code is subject to Medicare's Multiple Procedure Payment Reduction (MPPR). This reduces the allowable for the technical component of the lesser-valued test when more than one test is performed on the same day.

6. Are there other CPT codes that may not be billed on the same day as this test?
There are some limitations. For information on Medicare rates and National Correct Coding Initiative (NCCI) edits please see: Imaging CPT Codes and Rates.

7. If coverage is unlikely or uncertain, how should we proceed?
Explain to the patient why the test is necessary, and that their insurance provider is likely to deny the claim. Ask the patient to assume financial responsibility for the charge. There are different documentation options; the correct choice depends on the insurance provider.

- For Part B Medicare, an Advance Beneficiary Notice of Noncoverage (ABN) is required for services when coverage is ambiguous, doubtful, or never covered. You may collect your fee from the patient at the time of service or wait for a Medicare denial. If both the patient and Medicare pay, promptly refund the patient or show why Medicare paid in error.
- For Part C Medicare/Medicare Advantage (MA), determination of benefits is required to identify beneficiary financial responsibility prior to performing noncovered services. MA Plans have their own waiver processes and are not permitted to use the Medicare ABN form.
- For commercial insurance beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN.

8. Is the physician's presence required during testing?
Yes. Because an intravenous dye is being introduced, direct supervision is indicated. Direct supervision means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the test but need not be in the room.

As always, health care providers should check local coverage polices before billing.

This information is based on publicly available information from CMS and other sources. The reader is strongly encouraged to review applicable laws, regulations and instructions promulgated by Medicare and other payers. This document is not an official source nor is it a complete guide on reimbursement. We believe this information is accurate at the time of publication; however, this information changes over time, and may be incorrect at any time following publication.

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