Reimbursement FAQs for:

optomap® *plus*/Fundus Photography

1 What is optomap*plus*?

An **opto**map*plus* is a high resolution, ultra-widefield (UWF) 200° digital fundus image acquired with an Optos® retinal imaging device. These UWF fundus photos are used to facilitate assessment and documentation of retinal pathology including lesions in the far periphery.

CPT code 92250 (Fundus photography with interpretation and report) best describes this test. Medicare and other payers define the code as bilateral, so bill only once whether one or both eyes are tested.

2 What are the indications for this test?

Indications for **opto**map*plus* are the same as for traditional fundus photography. For

3 Does Medicare cover fundus photography?

Medicare covers fundus photography if the patient presents with a complaint that leads you to perform this test or as an adjunct to management and treatment of a known disease. If the images are taken as baseline documentation of a healthy eye or as preventative medicine to screen for potential disease, then the test is not covered even if disease is identified. This test is not covered if performed for an indication not cited in the local coverage policy.

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:

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- 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?

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. According to Medicare's National Correct Coding Initiative (NCCI), 92250 is mutually exclusive with OCT/SCODI (scanning computerized ophthalmic diagnostic imaging) of the posterior segment (92133, 92134). It is also bundled with ICG angiography (92240, 92242). Extended ophthalmoscopy (92201, 92202), retinal screening imaging (92227, 92228, and 92229), and a technician exam (99211) are bundled with 92250.

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

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6b If autofluorescence (AF) imaging is also performed, can it be billed separately?

No. CPT 92250 describes fundus imaging including multiple images and multiple imaging modes (ie, color, AF, red-free). It is inappropriate to use another CPT code, such as 92499 (*unlisted ophthalmologic service or procedure*) for other fundus imaging modes when billing 92250.

6c Should optomap*plus* (fundus photo 92250) be billed on the same day as an optomap screening image?

As a rule, when two similar tests are performed on the same day, only one of them is billed – usually the more extensive test.

6d How often may optomap*plus* (fundus photo 92250) be repeated on a patient?

Repeat fundus photography may be necessitated by disease progression, the advent of new disease, or planning for additional treatment (*e.g.*, laser). Repeated photos of the same, unchanged condition are unwarranted. Some MACs have published policies that include frequency guidelines for 92250.

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.

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- 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?

According to Medicare guidelines, this test requires general supervision. *General supervision* means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

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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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