Billing FAQs for:

optomap® *retina health check* imaging

1 Is there a CPT code for optomap *retina health check* imaging?

An **opto**map is a nonmydriatic, ultra-widefield (UWF™) fundus image acquired with an Optos® retinal imaging device. A single **opto**map image documents up to 80% of the retina with no face-to-face doctor/patient interaction. **opto**map images have been shown to enhance pathology detection, clinic flow, and patient engagement.[1, 2] For this reason, many eye doctors have added **opto**map *retina health check* imaging to their clinical examination protocol.

Since healthy eye imaging is not generally a covered procedure, a CPT code has not been established for this test.

In certain cases, for example, patients with diabetes, screening for eye disease may be covered. Three CPT codes (92227, 92228, and 92229) are used to describe imaging for this purpose; however, while these images are often reviewed by an eye doctor, they are typically used for imaging in primary care or other non-eyecare setting.

2 How does optomap *retina health check* imaging differ from fundus photography (CPT 92250)?

Healthy eye imaging differs from diagnostic imaging in several ways including:

- It is not generally considered a medical necessity, so it is typically not covered by insurance.
- It is generally conducted prior to or as part of a comprehensive eye examination while diagnostic imaging is done by doctors' orders to evaluate a known condition/pathology.
- It is often used by the doctor as a guide to facilitate a dilated examination.
- Retina health check protocols usually involve imaging for all patients unless the patient declines.

3 Does Medicare cover healthy eye imaging?

No; imaging as preventative screening or as baseline documentation of retinal status is typically not covered by Medicare or most other third-party payers.

4 What documentation should we include in the medical record for this procedure?

Even if the test is not billed to a third party, it is an important part of the patient exam and should be properly documented. Appropriate documentation includes interpretation of the test results, a notation of the findings, and assessment. When results do not identify pathology or abnormality, it is sufficient to note "normal fundus" (V72.0). When pathology is found, more extensive notes are warranted including findings, impression, and/or diagnosis. In addition to the image(s) or a reference to where they are stored, the chart should contain:

- the patient's name and date of the test
- appropriate notes about the findings
- signature of the physician

4b If pathology is discovered on an optomap *retina health check* image, may a claim for reimbursement be submitted?

No; for Medicare and most other third-party payers, screening is a non-covered service regardless of what is found. If pathology is found on an optomap *retina health check* image, the patient may need to return for medically necessary diagnostic tests to evaluate the pathology and determine a course of treatment. A claim for these tests is reasonable provided they are ordered by the doctor and chart documentation is complete and supportive.

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

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5 What is the charge for this test?

Fees for noncovered services are up to the discretion of the practice. For **opto**map *retina health check* imaging fees typically range from $39.00 to $65.00 depending on the complexity of the test (ie, includes or does not include OCT imaging) and local market dynamics.

6 Which office visit codes can be billed with on an optomap *retina health check* exam?

The level of service and corresponding CPT or HCPCS code for are determined by factors including:

- the patient's complaint and reason for the visit
- systemic conditions that necessitate a lengthy medical history
- interval since last eye exam
- extent of the exam and number of elements documented in the medical record

Eye doctors may use either E/M codes (992xx), eye codes (920xx), or HCPCS codes (S062x). Ancillary services such as refraction (92015) or similar tests may also apply.

6b How should we report this test in our billing system?

In most cases no claim will be sent because the patient is paying for a non-covered service and reimbursement is not sought. The patient's statement should describe the test as "**opto**map *retina health check*." HCPCS code S9986 can be used in this situation.

If a patient insists a claim be filed, it is better to report using code 92250-GY* as many payers will not accept S9986. Include a diagnosis code indicative of screening, such as Z13.5 "*Encounter for screening for eye and ear disorders".*

**Modifier GY means an "Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit."*

7 Since insurance does not generally cover this test, do we need financial responsibility documentation from the patient?

It is a good idea to clarify payment/coverage with the patient up front. Start by explaining why the test is important even though it is not covered by their insurance. Many practices have the patient sign an acceptance of financial responsibility form, while some require only a verbal acknowledgment of responsibility.

Citations:

(1) Silva et al, Nonmydriatic Ultrawide Field Retinal Imaging Compared with Dilated Standard 7-Field 35-mm Photography and Retinal Specialist Examination for Evaluation of Diabetic Retinopathy, AJO 2012.

(2) Tornambe, The Impact of Ultra-widefield Retinal Imaging on Practice Efficiency, US Ophthalmic Review 2017.

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