1. **QUESTION:** What is the optomap® fa?

   **ANSWER:** The optomap fa, performed with the Optos California or 200Tx, provides an ultra-high resolution, ultra-widefield angiography and color image, up to a 200 degree view of the fundus. A fluorescein dye is injected in a vein and images are captured as the dye passes through the vessels in the back of the eye. The ultra-widefield view offers clinicians enhanced angiographic information to help monitor and diagnose eye conditions and to assist in treatment determinations.

2. **QUESTION:** What are the indications for optomap fa?

   **ANSWER:** Simultaneous evaluation of the peripheral and central retina allows the clinician to evaluate a wide variety of retinal diseases, such as proliferative diabetic retinopathy, macular edema, vascular occlusive disease, age related macular degeneration, ocular tumors, as well as other retinal pathology. Many third party payers publish policies identifying covered indications for testing.

3. **QUESTION:** Will Medicare cover testing with the optomap fa?

   **ANSWER:** Yes, for covered indications and as part of the overall evaluation and management of disease. Medical necessity for fluorescein angiography (FA) frequently occurs following a change in the clinical assessment. For example, FA following treatment of choroidal neovascularization (CNV) is necessary to monitor for recurrence or to detect additional treatable lesions. FA may also be performed following treatment without clinical change in order to detect an occult lesion. Check your local coverage determination (LCD) policy for guidance.

4. **QUESTION:** What CPT code should we use to describe testing with optomap fa?

   **ANSWER:** CPT code 92235, Fluorescein angiography (includes multiframe imaging) with interpretation and report, should be used to report this test.

5. **QUESTION:** What are the documentation requirements for FA?

   **ANSWER:** In addition to a physician’s order for the test, a physician’s interpretation and report are required. A brief notation such as “abnormal” does not suffice. In addition to the images, the medical record should include:
   - order for the test with medical rationale
   - date of the test
   - reliability of the test (e.g., cloudy due to cataract)
   - test findings (e.g., retinal hemorrhages)
   - comparison with prior tests (if applicable)
   - a diagnosis, if possible
   - the impact on treatment and prognosis
   - physician’s signature

6. **QUESTION:** Is the physician’s presence required during testing?

   **ANSWER:** Yes. Because an intravenous dye is being introduced, direct supervision is indicated. Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the test. The physician is not required to be in the room. In 2016, the claim for reimbursement must identify the supervising physician as the billing physician.1,2

March 15, 2016

The reader is strongly encouraged to review federal and state laws, regulations, code sets (including ICD-9 and ICD-10), and official instructions promulgated by Medicare and other payers. This document is not an official source nor is it a complete guide on reimbursement. The reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

© 2016 Corcoran Consulting Group. All rights reserved. No part of this publication may be reproduced or distributed in any form or by any means, or stored in a retrieval system, without the written permission of the publisher.

Corcoran Consulting Group (800) 399-6565 www.corcoranccg.com

Provided Courtesy of Optos, Inc. (800) 854-3039 www.optos.com
**QUESTION:** What is the reimbursement for FA?

**ANSWER:** CPT 92235 is defined as “unilateral”, so reimbursement is per eye. The 2016 national Medicare Physician Fee Schedule amount is $111. Of this amount, $63 is assigned to the technical component, and $48 is the value of the professional component (interpretation). These amounts are adjusted in each area by local indices. Other payers set their own rates, which may differ significantly from the Medicare published fee schedule.

92235 is subject to Medicare’s Medicare’s Multiple Procedure Payment Reduction (MPPR). This reduces the allowable for the technical component of the second or lesser-valued test when more than one test is performed on the same day.

**QUESTION:** May we be reimbursed for both FA and an exam or other diagnostic test on the same day?

**ANSWER:** According to Medicare’s National Correct Coding Initiative (NCCI) edits, separate reimbursement is allowed for FA when performed in conjunction with an exam (except 99211). Most other diagnostic tests, including fundus photography, are also permitted, although fluorescein angiography (92230) is bundled with 92235.

**QUESTION:** How frequently may the test be performed?

**ANSWER:** In general, this and all diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for repeat testing is always required.

A few payers have published policies, although most do not; check your Medicare administrative contractor’s LCD for frequency guidelines.

**ANSWER:** Sometimes an ophthalmologist may feel that this test is merited even though his or her reasons do not comport with Medicare’s payment policy. Explain to the patient why FA is necessary, and that Medicare or other third party payer will likely deny the claim. Ask the patient to assume financial responsibility for the charge. A financial waiver can take several forms, depending on insurance.

- An Advance Beneficiary Notice of Noncoverage (ABN) is required for services where Part B Medicare coverage is ambiguous or doubtful, and may be useful where a service is 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), determination of benefits is required to identify beneficiary financial responsibility prior to performing noncovered services; MA Plans may have their own waiver forms.
- For commercial insurance beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN.

March 15, 2016

---

1 42 CFR 410.26(b)(5). Billing physician as the supervising physician. Accessed 03/15/16.

2 80 FR 70885 CMS-1631-FC. 2016 Medicare Program; revisions to payment policies under the physician fee schedule. Published Nov 16, 2015. Accessed 03/15/16.