MEDICARE REIMBURSEMENT FOR
SPECULAR MICROSCOPY

1. **QUESTION:** Does Medicare cover endothelial cell count performed with a specular microscope?

   **ANSWER:** Yes, when medically necessary. Medicare has a national coverage determination policy (NCD 80.8) addressing reimbursement for endothelial cell photography (i.e., specular microscopy). The Heidelberg Retina Tomograph also includes the Rostock Cornea Module, which performs specular microscopy.

2. **QUESTION:** What is Medicare’s coverage policy?

   **ANSWER:** Specular microscopy is a covered procedure under Medicare when reasonable and necessary for patients who meet one or more of the following criteria:
   
   1. Have slit lamp evidence of endothelial dystrophy (e.g., corneal guttata, H18.51)
   2. Have slit lamp evidence of corneal edema (H18.1-, H18.2-)
   3. Are about to undergo a secondary intraocular lens implantation (H27.0)
   4. Have had previous intraocular surgery and require cataract surgery (e.g., Z98.83-)
   5. Are about to undergo a surgical procedure associated with a higher risk to corneal endothelium, i.e., phacoemulsification or refractive surgery (subject to some limitations for excluded refractive procedures)
   6. Have evidence of posterior polymorphous dystrophy of the cornea (H18.58) or iridocorneal-endothelium syndrome (H21.26-, H18.51)
   7. Are about to be fitted with extended wear contact lenses after intraocular surgery (H27.0-, Z96.1, Z98.83)

   Some Medicare Administrative Contractors (MACs) have published other covered indications, including visual disturbance (R48.3, H53.8) and congenital aphakia (Q12.3). Check your local policies.

3. **QUESTION:** Are there any limitations on coverage?

   **ANSWER:** Medical coverage policies require that specular microscopy, as with all diagnostic tests, must have specific relevance to the individual patient and be utilized in the management of the patient’s condition. “Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary.”

   In addition, when the only visual problem is cataracts, specular microscopy is considered to be part of the presurgical eye exam and not separately reimbursed. Also, it is not covered if performed in the preoperative evaluation for refractive keratoplasty (e.g., LASIK, PRK).

4. **QUESTION:** Is the physician’s presence required while the test is being performed?

   **ANSWER:** Under Medicare program standards, 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.

5. **QUESTION:** Will specular microscopy be reimbursed if performed on the same day as an eye exam or another diagnostic test?

   **ANSWER:** Yes, subject to the limitations noted above. According to Medicare’s National Correct Coding Initiative (NCCI), separate reimbursement is allowed for specular microscopy when performed in conjunction with exams (except technician exam, 99211) or other tests.

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The reader is strongly encouraged to review federal and state laws, regulations, code sets (including 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.

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6 QUESTION: What documentation is required in the medical record to support claims for specular microscopy?

ANSWER: In addition to the images, 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., poor, due to corneal scarring)
- test findings (e.g., number of cells/mm² morphology)
- comparison with prior tests (if applicable)
- a diagnosis (if possible)
- the impact on treatment and prognosis
- physician’s signature

7 QUESTION: How much does Medicare allow for this test?

ANSWER: Use CPT 92286 (Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis) to describe specular microscopy. This is a bilateral service, so a single payment is made for both eyes. The 2018 national Medicare Physician Fee Schedule allowable is $39.24. Of this amount, $16.56 is assigned to the technical component and $22.68 is the value of the professional component (interpretation). The specific allowable for each geographic area is determined by adjusting the national rate by geographical practice cost indices.

Specular microscopy 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.

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8 QUESTION: How often may specular microscopy be repeated on a patient?

ANSWER: There are no published limitations for repeated testing. Medicare utilization data for 2016 shows that specular microscopy was associated with about 0.4% of all eye exams by optometrists and ophthalmologists, or approximately 4 times per 1,000 eye exams. In general, diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required.

9 QUESTION: If coverage of specular microscopy is unlikely or uncertain, how should we proceed?

ANSWER: Explain to the patient why specular microscopy 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.