**MEDICARE REIMBURSEMENT FOR FUNDUS PHOTOGRAPHY**

**QUESTION:** Does Medicare cover fundus photography using Topcon’s fundus cameras and imaging systems?

**ANSWER:** Ophthalmic imaging is covered by Medicare subject to the limitations in its payment policies; other third party payers generally agree. 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 it is not covered (even if disease is identified). Also, this test is not covered if performed for an indication that is not cited in the local coverage policy. Check your local policies; they vary.

**QUESTION:** What documentation is required in the medical record?

**ANSWER:** In addition to the photos or proof that digital images exist, the chart should contain:
- an order for the test with medical rationale
- the date of the test
- the reliability of the test (e.g., cloudy due to cataract)
- the test findings (e.g., hemorrhage)
- comparison with prior tests (when applicable)
- a diagnosis (if possible)
- the impact on treatment and prognosis
- the signature of the physician

**QUESTION:** What CPT code describes fundus photography?

**ANSWER:** Use CPT code 92250 (Fundus photography with interpretation and report) to report this service.

**QUESTION:** What is the reimbursement for 92250?

**ANSWER:** CPT 92250 is defined as bilateral so reimbursement is for both eyes. The 2017 national Medicare Physician Fee Schedule allowable is $66.75. Of this amount, $44.50 is assigned to the technical component and $22.25 is the value of the professional component (i.e., interpretation). These amounts are adjusted in each area by local wage indices. Other payers set their own rates, which may differ significantly from the Medicare published fee schedule. 92250 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.

**QUESTION:** Is fundus photography bundled with other tests or services?

**ANSWER:** Yes. According to Medicare’s National Correct Coding Initiative (NCCI), 92250 is bundled with ICG (92240) and mutually exclusive with scanning computerized ophthalmic diagnostic imaging of the posterior segment (92133 or 92134).

January 1, 2017

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: Must the physician be present while the test is being performed?

ANSWER: Under Medicare program standards, this test needs only 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. Other payers generally agree.

7. QUESTION: How often may fundus photography be repeated?

ANSWER: There are no nationally published limitations for repeated testing. In general, this and all diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required. Too-frequent testing can garner unwanted attention from Medicare and other third party payers.

8. QUESTION: What is the frequency of fundus photography in the Medicare program?

ANSWER: Medicare utilization rates for claims paid in 2015 show that fundus photography was associated with 9% of all office visits by ophthalmologists. That is, for every 100 exams performed on Medicare beneficiaries, Medicare paid for this service 9 times. For optometrists, the utilization rate is about 14%.

9. QUESTION: May I ever bill the Medicare beneficiary directly for this service?

ANSWER: Sometimes. Explain to the patient why the test 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.

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.

For non-Medicare beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN.

For Part C Medicare (Medicare Advantage), determination of benefits is required to identify beneficiary financial responsibility prior to performing either noncovered or potentially noncovered services; MA Plans may each have their own process and waiver forms. Be sure and check.

10. QUESTION: Is there another separate CPT code for autofluorescence or red-free images?

ANSWER: No. CPT 92250 describes one or more images taken with the fundus camera, with or without filters. It is inappropriate to use another CPT codes such as 92499, Unlisted ophthalmologic service or procedure.

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