**1. QUESTION:** What is iCam?

**ANSWER:** Optovue’s iCam is a non-contact, non-mydriatic fundus camera that captures 45 degree color fundus images using a 12-bit CCD sensor. The device uses a white LED which is synchronized to flash when the operator presses the capture button on the joystick. iCam received FDA 510(k) Premarket Notification on January 11, 2013.¹

**2. QUESTION:** What documentation is required in the medical record to support this test?

**ANSWER:** 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
- the reliability of the test (e.g., cloudy due to cataract)
- test findings (e.g., microaneurysm)
- comparison with prior tests (if applicable)
- a diagnosis (if possible)
- the impact on treatment and prognosis
- physician’s signature

**3. QUESTION:** What CPT code should we use to describe this test with the iCam?

**ANSWER:** CPT code 92250 (Fundus photography with interpretation and report) best describes this test.

**4. QUESTION:** Does Medicare cover fundus photography?

**ANSWER:** Medicare will reimburse you for fundus photography if the patient presents with a complaint that leads you to perform this test as an adjunct to evaluation and management of a covered indication. 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 generally not covered (even if disease is identified). Also, it is not covered if performed for indication not in the local coverage policy.

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

**ANSWER:** CPT 92250 is defined as bilateral so reimbursement is for both eyes. The 2020 national Medicare Physician Fee Schedule allowable is $45.83. Of this amount, $23.82 is assigned to the technical component and $22.01 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.

---

¹ January 28, 2020

The reimbursement information is provided by Corcoran Consulting Group based on publicly available information from CMS, the AMA, and other sources. The reader is strongly encouraged to review federal and state laws, regulations, code sets, and official instructions promulgated by Medicare and other payers. This document is not an official source nor is it a complete guide on reimbursement. Although we believe this information is accurate at the time of publication, the reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

© 2020 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. CPT is a registered trademark of the American Medical Association.
The reimbursement information is provided by Corcoran Consulting Group based on publicly available information from CMS, the AMA, and other sources. The reader is strongly encouraged to review federal and state laws, regulations, code sets, and official instructions promulgated by Medicare and other payers. This document is not an official source nor is it a complete guide on reimbursement. Although we believe this information is accurate at the time of publication, the reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

© 2020 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. CPT is a registered trademark of the American Medical Association.

January 28, 2020

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

**ANSWER:** Yes. According to Medicare’s National Correct Coding Initiative (NCCI), 92250 is mutually exclusive with SCODI codes 92133 and 92134, and with the new extended ophthalmoscopy codes 92201 and 92202. The remote screening retinal test, 92227, is bundled with 92250, as is the technician exam 99211.

7 **QUESTION:** Must the physician be present 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.

8 **QUESTION:** How often may testing with the iCam be repeated?

**ANSWER:** In general, diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required. Most often, the justification is an indication of progression of a chronic disease.

9 **QUESTION:** What is the frequency of fundus photography in the Medicare program?

**ANSWER:** Medicare utilization rates for claims paid in 2018 show that fundus photography was performed in 9.5% of all office visits by ophthalmologists. That is, for every 100 exams performed on Medicare beneficiaries, Medicare paid for this service about 9 times. For optometrists, the utilization rate is about 15%.

10 **QUESTION:** If coverage of fundus photography is unlikely or uncertain, how should we proceed?

**ANSWER:** Explain to the patient why fundus photography 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 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.