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MEDICARE REIMBURSEMENT FOR CORNEAL TOPOGRAPHY

7 QUESTION: Must the physician be present while the CT is being performed?

ANSWER: Medicare has no supervision policy published for CT. In our opinion, it seems reasonable to use general supervision since most other non-invasive ophthalmic tests come under that requirement. 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 CT be repeated?

ANSWER: There are no 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.

Within the Medicare system, in 2015, claims paid for CPT 92025 were associated with 1% of all exams by ophthalmologists. That is, for every 100 exams on Medicare Part B patients, 92025 was paid once. This excludes CT for refractive procedures and non-covered indications. Utilization by optometrists is much lower.

9 QUESTION: Will Medicare cover CT prior to cataract surgery?

ANSWER: Usually not. Claims might be paid by the Medicare Administrative Contractors (MACs) if there is a diagnosis (e.g., irregular astigmatism), in addition to cataract, to support medical necessity. More often, CT prior to cataract surgery is to screen for astigmatism and plan concurrent limbal relaxing incisions or implantation of a toric IOL when pre-existing, regular astigmatism is present. This indication is not covered.

10 QUESTION: What is Medicare’s position on CT and refractive surgery?

ANSWER: Refractive surgery for the purpose of reducing dependence on eyeglasses or contact lenses is not covered by Medicare, nor are the diagnostic tests associated with this surgery, including CT.

11 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.

January 1, 2017

1 Topcon Medical Systems. Aladdin. Link here.
2 Topcon Medical Systems. CA-800 Corneal Topgrapher. Link here.
3 Topcon Medical Systems. KR-1W Wavefront Analyzer. Link here.

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