



Corcoran  
Consulting  
Group

A Division of Ardare Corporation

**Medicare Reimbursement  
For  
Optos<sup>®</sup> Retinal Imaging**

*Prepared for*



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# Medicare Reimbursement for Optos® Retinal Imaging

By

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**Objective:** *This report is provided as a general discussion of practice management and reimbursement issues associated with the family of **optomap**® exams. Local variations between carriers may occur which are not described here. Users are strongly encouraged to review official instructions promulgated by the Centers for Medicare and Medicaid and their Medicare administrative contractors; this document is not an official source nor is it a complete guide on all matters pertaining to reimbursement. This discussion is intended to assist the reader to better understand the rules and regulations regarding reimbursement for retinal imaging. However, the responsibility for appropriate usage, adequate documentation, and proper coding are always the physician's.*

*Optos® Ophthalmic Imaging System: **optomap**® Retinal Exam, **optomap**® plus Medical Retinal Exam and **optomap**® fa Angiography Procedure are registered trademarks of Optos, Inc.*

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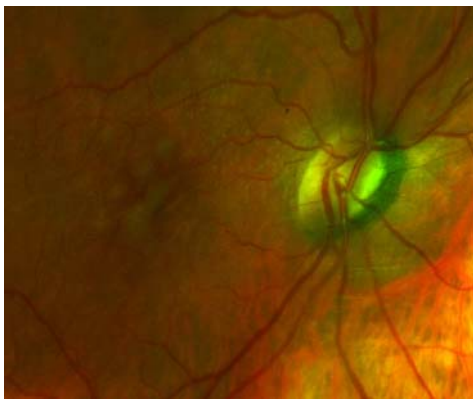
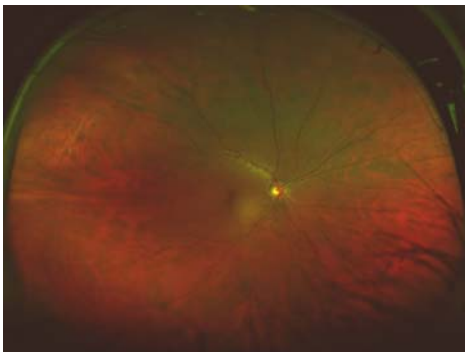
**Disclaimer:** *The reader is reminded that this information can and does change over time, and may be incorrect at any time following publication.*



## INTRODUCTION

It is said that the eyes are the windows of the soul. It should also be said that a look through the window exposes the condition of the human body. So, the observant physician may uncover a variety of systemic diseases, such as diabetes or hypertension, which manifest as retinal pathology and may otherwise be unknown to the patient.

Figure 1 **Fundus Photographs**



In this monograph, we discuss practice management and reimbursement considerations related to three different applications of the Optos<sup>®</sup> Ophthalmic Imaging System: **optomap<sup>®</sup>** Retinal Exam, **optomap<sup>®</sup> plus** Medical Retinal Exam and **optomap<sup>®</sup> fa** Angiography Procedure.

Much of the information in this document is taken from official publications of the Medicare program. The reader is encouraged to check with the local Medicare administrative contractor

(MAC) for additional information and instructions. For other third party payers, we have used the coding concepts contained in CPT and published by the American Medical Association; diagnosis codes are from ICD-9-CM. To obtain reimbursement, the medical record must support the medical necessity for the service(s), so we describe those required elements in detail.

Since economic analyses are a necessary part of any practice management decision, we include Medicare's 2008 payment rates for the procedure as well as estimated utilization rates.

## THE DEVICES

There are three different Optos<sup>®</sup> imaging systems: the P200, P200C, and P200MA. They each produce full color, high resolution images and capture details of nearly the entire retina through a dilated or undilated pupil. These digital images can be enhanced, stored on a computer, transmitted to other physicians or printed. Three different types of retinal imaging are performed by these devices. Please check with Optos to determine which is best for your practice.

Figure 2 **Optos<sup>®</sup> P200MA**



## optomap<sup>®</sup> Retinal Exam

The **optomap<sup>®</sup>** Retinal Exam is a screening tool for early detection of disease or abnormalities in the posterior segment of the eye in the context of preventative medicine and wellness. Optos<sup>®</sup> believes that many indicators of systemic disease and precursors to eye disease often exhibit first in the periphery of the retina. However, routine undilated retinal exams provide only a limited, narrow-field view of the retina (typically up to 45 degrees or about 5% view of the retina). So, these exams can miss diseases or conditions that may be present in the periphery of the retina. An ultra-widefield **optomap<sup>®</sup>** retinal exam provides 200 degrees, or 82% of the retina, at once so the examiner can quickly and easily evaluate the fundus.

## optomap<sup>®</sup> plus Medical Retinal Exam

The **optomap<sup>®</sup> plus** medical retinal exam expands on the basic screening exam, using additional capabilities in the image capture and review process to facilitate the diagnosis and management of previously detected ocular pathology. It is indicated for medically necessary testing.

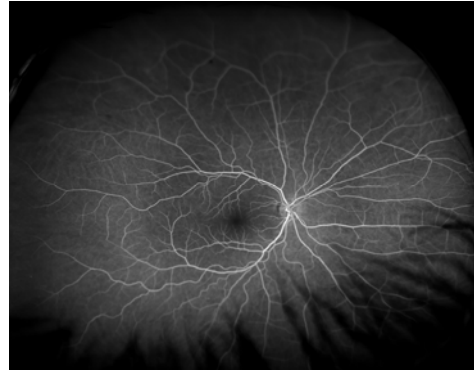
Figure 3 **Age-Related Macular Degeneration**



## optomap<sup>®</sup> fa Angiography Procedure

The **optomap<sup>®</sup> fa** expands on the **optomap<sup>®</sup>** Medical Retinal Exam using ultra high resolution, ultra widefield fluorescein angiography.

Figure 4 **Fluorescein Angiogram**



## Optos<sup>®</sup> V2 Vantage Software

V<sup>2</sup><sup>®</sup> Vantage software's features and capabilities include: ResMax<sup>™</sup> high resolution enhancement for the central pole; targeted ophthalmoscopy view simulating the view of a binocular indirect ophthalmoscope; added image artifact counting; enhanced retinal drawing tools; and the capability to easily export **optomap<sup>®</sup>** images. Collectively, V2 Vantage software gives the physician a tool to facilitate and enhance interpretation of **optomap<sup>®</sup>** images.

## **INDICATIONS FOR USE**

### Screening: **optomap<sup>®</sup>**

Some ophthalmologists and optometrists have standing orders for non-mydratic fundus photography for all patients prior to an eye exam, so the doctor can screen for posterior segment disease as well as educate patients about the back of the eye. Screening is differentiated from other diagnostic testing by several features.

- Screening is part of a wellness program to check for disease that may otherwise go undetected.
- Screening is not required by medical necessity; it's optional.
- The ophthalmologist or optometrist recommends the **optomap<sup>®</sup>** Retinal Exam prior to every complete eye examination.

- The **optomap**<sup>®</sup> Retinal Exam is performed by a technician *before* the patient is seen by the ophthalmologist or optometrist.
- All patients are screened unless they decline.

Significantly, the **optomap**<sup>®</sup> Retinal Exam is not covered by Medicare and most third party payers, so the patient is financially responsible for the service.

#### Fundus Photography: **optomap**<sup>®</sup> *plus*

According to the American Academy of Ophthalmology's (AAO) Preferred Practice Patterns (PPP) for age-related macular degeneration, primary open-angle glaucoma, and diabetic retinopathy, fundus photography provides objective documentation and is the best routine approach to establish a baseline for future comparisons. Fundus photographs facilitate detailed evaluation of the optic nerve head, find landmarks for retinal lesions, assist in determining the size of detachments and are an essential diagnostic tool for evaluating dry age-related macular degeneration. The AAO's PPPs further point out that fundus photography is a more reproducible technique than clinical examination for detecting posterior segment disease.

Diagnostic tests, including fundus photography, are ordered and performed when the information garnered from the eye exam is insufficient to adequately assess the patient's disease. Medicare covers fundus photography as an adjunct to evaluation and management 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 they are not covered, even if disease is identified (CFR 411.15 (a) (1)).

Wheatlands Administrative Services, Inc., formerly the Medicare administrative contractor for Kansas, Nebraska and Northwestern Missouri, and Empire Medicare of New York, now known as National Government Services, issued instructions that the fundus photographs

provide more than mere documentation of a disease or the absence of disease.<sup>1</sup> Their policy stated: "*Fundus photographs are not medically necessary simply to document the existence of a condition. Photographs are medically necessary to establish a baseline to judge later if a disease is progressive...The fundus photography should aid in making a clinical decision.*"

Repeated fundus photography is necessitated by disease progression, the advent of new disease, or planning for surgical treatment (*e.g.*, laser). Otherwise, repeated photographs of the same, unchanged condition are unwarranted.

In general, fundus photography is performed to:

- evaluate abnormalities in the fundus identified during a prior eye exam
- follow the progress of a disease
- plan the treatment for a disease
- assess the therapeutic effect of recent surgery (*e.g.*, photocoagulation)

A variety of disease entities justify testing (Table 1). It is important to note that MACs do not all agree on a common list of diagnoses. Careful review of contractor-specific local coverage determination (LCD) policy is necessary. See the Appendix for a representative policy.

In the case of diabetes, fundus photography may be indicated when there is ocular manifestation of the disease as diabetic retinopathy, but a fundus photograph of an unaffected retina is not considered medically necessary although annual eye exams are considered mandatory for these at risk patients.

Coverage policies for fundus photography vary. The Wisconsin Physicians Service Insurance Corporation (WPS)<sup>2</sup> Medicare policy is representative of many (see Appendix).

<sup>1</sup> LCD 9189, August 2005

<sup>2</sup> WPS is the Medicare administrative contractor for Illinois, Indiana, Michigan and Wisconsin

**Table 1 Common ICD-9 Diagnosis Codes For Fundus Photography**

250.5x	Diabetes with ophthalmic manifestations
360.50	Foreign body, magnetic, intraocular
360.60	Foreign body, intraocular
361.10	Retinoschisis
361.3x	Retinal defects w/o detachment
362.01	Background diabetic retinopathy
362.02	Proliferative diabetic retinopathy
362.10	Background retinopathy
362.11	Hypertensive retinopathy
362.12	Exudative retinopathy
362.17	Retinal microvascular abnormalities
362.18	Retinal vasculitis
362.30	Retinal vascular occlusion
362.33	Partial arterial occlusion
362.50	Macular degeneration
362.51	Nonexudative macular degeneration
362.52	Exudative macular degeneration
362.53	Cystoid macular degeneration
362.63	Lattice degeneration
362.75	Other retinal dystrophies
362.76	RPE dystrophies
362.82	Retinal exudates and deposits
362.84	Retinal ischemia
365.xx	Glaucoma
377.0x	Papilledema
377.1x	Optic atrophy
377.3x	Optic neuritis
377.4x	Disorders of optic nerve
379.34	Posterior dislocation of lens
743.52	Fundus coloboma
743.55	Congenital macular changes
871.x	Open wound of eyeball

NOTE: Listed codes are representative of covered diagnoses but differences in payment policies exist for many contractors. This list is neither exhaustive nor universally accepted. See your contractor bulletins.

### Fluorescein Angiography: **optomap<sup>®</sup> fa**

Fluorescein angiography (FA) is performed to detect abnormalities of retinal blood vessels. Regardless of any treatment, the FA helps determine the extent and location of the pathology, facilitating future determinations of

disease progression, stability, and retreatment. FA often provides insight into the cause of unexplained visual acuity changes secondary to macular nonperfusion or macular edema. An FA is often used to differentiate exudative from non-exudative AMD. Typically, an FA is only done for neovascular AMD, however high-risk non-neovascular AMD with patient symptoms suggesting progression does warrant an FA. The results of the FA help assess progression of the disease, prognosis and treatment modality for the patient. The lesions can change significantly over short time periods, therefore, timely interpretation of the FA is necessary.

Coverage policies for FA vary. The Wisconsin Physicians Service Insurance Corporation (WPS) Medicare policy is representative of many (see Appendix). It states:

#### *Indications and Limitations of Coverage and/or Medical Necessity*

*Medical necessity of fluorescein angiography is established as an adjunct to the diagnosis of chorioretinal vascular abnormalities especially relating to choroid revascularization, non-infective vasculitis, age related macular degeneration, diabetic retinopathy and retinal vascular occlusions. It may also be appropriate in evaluating intraocular tumors, visual loss in systemic disease and optic disc edema. Medical necessity for such angiography would generally be in the context of a changing clinical picture.*

*Fluorescein angiography following treatment, for example, of choroidal revascularization (CNV) is necessary to monitor for recurrence or to detect additional treatable disease. Usually this is performed on the basis of a change in the clinical picture similar to the way it is employed prior to treatment. However, fluorescein angiography may be performed following treatment without clinical change in order to detect occult lesions. This will occur most often in CNV and very rarely in other diseases. It would be unusual to need more than 7 fluoresceins on an eye in a 12-month period.*

**Table 2 Common ICD-9 Diagnosis Codes For Fluorescein Angiography**

115.02	Histoplasma capsulatum retinitis
115.12	Histoplasma duboisii retinitis
135	Sarcoidosis
190.5-190.6	Malignant neoplasm eye
224.5-224.6	Benign neoplasm eye
228.03	Hemangioma of retina
228.09	Hemangioma of other sites
250.50-250.53	Diabetes with ophthalmic manifestations
282.60	Sickle-cell disease, unspecified
282.64	Sickle-cell/Hb-C disease with crisis
282.68	Other sickle-cell disease
340	Multiple sclerosis
360.21	Progressive high (degenerative) myopia
361.10-361.14	Retinoschisis and retinal cysts
361.19	Other retinoschisis and retinal cysts
361.2	Serous retinal detachment
362.01-32.07	Diabetic retinopathy
362.10-362.18	Other background retinopathy and retinal vascular changes
362.30-362.37	Retinal vascular occlusion
362.41-362.43	Separation of retinal layers
362.50-362.57	Macular degeneration (senile), unspecified
362.70-362.77	Hereditary retinal dystrophies
362.81	Retinal hemorrhage
362.83-362.84	Other retinal disorders
363.00-363.01	Focal chorioretinitis and focal retinochoroiditis
363.03-363.08	Focal chorioretinitis and focal retinochoroiditis
363.10-363.15	Disseminated chorioretinitis and disseminated retinochoroiditis
363.20-363.22	Other and unspecified forms of chorioretinitis and retinochoroiditis
363.31	Solar retinopathy
363.41-363.43	Choroidal degeneration
363.55-363.56	Hereditary choroidal dystrophies
363.63	Choroidal rupture
363.71-363.72	Choroidal detachment
368.10-368.13	Subjective visual disturbance
377.21	Drusen of optic disc
377.24	Pseudopapilledema
377.41	Ischemic optic neuropathy
V67.51	Following completed treatment with high-risk medication

NOTE: Listed codes are representative of covered diagnoses but differences in payment policies exist for many contractors. This list is neither exhaustive nor universally accepted. Check your MAC's LCD.

## BILLING ISSUES

### Procedure Codes

Use HCPCS code S9986, *Not medically necessary service (patient is aware that service not medically necessary)*, to report screening services performed with the **optomap**<sup>®</sup> Retinal Exam. Alternately, use 92250-GY to report screening services when the beneficiary asks you to file a claim to obtain a denial.

Use CPT code 92250, *Fundus photography with interpretation and report*, to report fundus photography performed with the **optomap**<sup>®</sup> *plus*. At one time, during the product launch of the **optomap**<sup>®</sup> Ophthalmic Imaging System, a question was raised about reporting this test using CPT code 92135, *scanning computerized ophthalmic diagnostic imaging (SCODI)*. The Optos<sup>®</sup> Panoramic 200 uses a scanning laser ophthalmoscope to capture images of the retina. However, the images are two dimensional, rather than three dimensional and there are no quantitative measurements that typify SCODI using other instruments. Using the coding principle that, “A provider or coder using the CPT coding system first chooses the name and associated code of the procedure or service which most accurately identifies and describes the service(s) performed”, we opined that 92250 was the most appropriate choice to report digital fundus imaging with **optomap**<sup>®</sup> *plus*. Our opinion was corroborated by another ophthalmic coding expert with extensive knowledge of SCODI and fundus photography.

Use CPT code 92235, *Fluorescein angiography (includes multiframe imaging) with interpretation and report*, to report fluorescein angiography performed with the **optomap**<sup>®</sup> *fa*.

All of these services include two aspects: a technical component (*i.e.*, the images) and a professional component (*i.e.*, the interpretation). The use of special software, such as the V2 Vantage software, does not constitute another billable service. Rather, the use of the software

is part of the professional component or interpretation.

Likewise, annotations with a pen on the printed copies of the digital images are properly considered part of the physician's interpretation and not a separate service. Specifically, drawing on a digital image is not extended ophthalmoscopy (92225, 92226).

### Bilateral vs Unilateral

Some diagnostic tests are defined by Medicare as bilateral (billed once for both eyes), while some are defined as unilateral (billed per eye). Other third party payers often disagree with these rules.

While the CPT code descriptions for some ophthalmic procedures do not state "bilateral", Medicare nonetheless defines them as such. Reimbursement is the same whether one eye or both eyes are tested. No additional reimbursement is made for bilateral ophthalmic tests if they are billed with modifier 50 or RT/LT. Fundus photography (92250) is defined as a bilateral test within the Medicare program.

### *Sample Claim for Fundus Photos*

During evaluation of the posterior pole with binocular indirect ophthalmoscopy, several small drusen were noted. Fundus photography was ordered OU to establish the extent of the nonexudative age-related macular degeneration and to permit re-evaluation at a later date. The claim will read as follows:

17 J. Jones, MD		17a				
		17b 123456780				
19						
21 1. 362.51 2.						
24a	24b	24c	24d	24e	24f	24g
mm/dd/yyyy	11		92250	1	xxx.xx	1

Conversely, fluorescein angiography (92235) is an example of a unilateral test. Reimbursement for this code is 200% of the allowable when FA is performed on both eyes. When a unilateral

test is performed on both eyes, some MACs prefer modifier 50 appended to the CPT code, while others prefer a two-line entry with RT and LT.

### *Sample Claims for Fluorescein Angiography*

A 57 y/o patient was diagnosed with proliferative diabetic retinopathy, OD>OS, secondary to uncontrolled Type II diabetes. A fluorescein angiogram was ordered OU. Multiple images were taken of both eyes, beginning with the right side. The claim will read as follows:

17 J. Jones, MD		17a				
		17b 123456780				
19						
21 1. 250.52 2. 362.02						
24a	24b	24c	24d	24e	24f	24g
mm/dd/yyyy	11		92235 RT	1	xxx.xx	1
mm/dd/yyyy	11		92235 LT	1	xxx.xx	1

Note: 92235-50 is an equivalent claim.

It is important to note that Medicare believes this procedure is commonly performed on just one eye. Fluorescein angiography techniques vary depending on the patient's condition, the skill of the photographer, and the flexibility of the equipment. Many studies will concentrate on one eye only. For example:

A 60 y/o male patient was diagnosed with a subretinal net near the macula of his left eye. A fluorescein angiogram was ordered for the left eye, and two reference shots were made on the right eye. The claim will read as follows:

17 J. Jones, MD		17a				
		17b 123456780				
19						
21 1. 362.16 2.						
24a	24b	24c	24d	24e	24f	24g
mm/dd/yyyy	11		92235 LT	1	xxx.xx	1

Note: Reference shots are incidental and not billable.

## Modifiers

The following modifiers may be applicable on claims for fundus photography or fluorescein angiography.

AQ .....	Services provided in a Health Professional Shortage Area (HPSA) ( <i>Medicare modifier only; replaces QB and QU</i> )
AR .....	Services provided in a Physician Scarcity Area (PSA) ( <i>Medicare modifier only</i> )
GA .....	Medicare probably does not cover this service. Advance Beneficiary Notice (ABN) signed ( <i>Medicare modifier only</i> )
GY .....	Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit.
GZ .....	Medicare probably does not cover this service. No ABN on file ( <i>Medicare modifier only</i> )
TC .....	Technical component of a diagnostic test
26 .....	Professional component of a diagnostic test
52 .....	Reduced service ( <i>e.g., only one eye tested</i> ) (FP only)
RT .....	Right Eye (FA only)
LT .....	Left Eye (FA only)

## Advance Beneficiary Notice

An ABN is a written notice a physician, or other provider, gives to a Medicare beneficiary before items or services are furnished when the physician believes that Medicare probably will not pay for some or all of the items or services.

In June, 2002, CMS published an official ABN form (CMS-R-131-G) which was mandated by HIPAA (PM AB-02-114). A revised ABN

(CMS-R-131) became available in March 2008. The revised ABN replaces the existing ABN-G (Form CMS-R-131G) and ABN-L (Form CMS-R-131L). It may also be used in lieu of the NEMB (Form CMS-20007). CMS will allow a transition period from the date of implementation for use of the revised form and instructions. All providers must begin using the revised ABN no later than March 1, 2009. (See Appendix for sample form)

An ABN is required for both assigned and non-assigned claims. Submit your claim with modifier GA appended to the appropriate CPT or HCPCS code.

By signing an ABN, the Medicare beneficiary acknowledges that he or she has been advised that Medicare will probably or certainly not pay, and agrees to be responsible for payment, either personally or through other insurance. Medicaid qualifies as "other insurance" so get an ABN even for dual-eligible patients.

The ABN must be signed before you provide the items or services. Keep the original in your file and provide a copy to the patient. The "Estimated Cost" field, formerly optional, is now required. The patient must *personally* choose from Option 1, 2 or 3. The patient must *sign* and *date* the form; an unsigned form is not valid. Without the Medicare beneficiary's advance acceptance of financial responsibility, you will be required to refund any payment you collected for non-covered services.

You do not need an ABN for services that are statutorily (by law) non-covered by Medicare. Statutorily non-covered services in an eye care practice include refractions, as well as cosmetic surgery and the associated testing. A Notice of Exclusions from Medicare Benefits (NEMB) form notifies the beneficiary that this service is non-covered, and that the patient will be responsible for the charges associated with the procedure. For non-Medicare beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) serves the same purpose (see Appendix

## Practice Management Tips

- Differentiate covered and non-covered testing based on the reason for the fundus photographs or fluorescein angiogram. Use an ABN where Medicare coverage is doubtful or restricted.
- Screening photographs, or photos taken on the basis of standing orders, are always non-covered. Obtain patients' acceptance of financial responsibility for non-covered services in writing (*i.e.*, NEMB or NEHB).
- In general, get a physician's order with appropriate medical rationale before providing the service.
- Document the physician's interpretation of the fundus photographs and/or fluorescein angiogram within a short time of the test, generally within 72 hours. Be sure to address the quality of the photos, the findings and the assessment. Sign the note.
- Watch that repeated fundus photographs are merited due to disease progression.
- Monitor NCCI bundles (*e.g.*, FP with SCODI)
- Check your Local Coverage Determination (LCD) policy for specific guidance in your area. Investigate the policies of other third party payers as well.
- Place a note in the medical record that identifies where digital photos are stored.
- Don't use fundus photographs as a surrogate for a dilated fundus evaluation during a comprehensive eye exam. Non-mydratic images do not substitute for a dilated fundus exam.
- If you use an independent contractor to perform fundus photography or fluorescein angiography - that is, someone who provides all the equipment and is not an employee - then get assistance with the arcane rules associated with purchased diagnostic tests.

for a sample form). By signing a form, the beneficiary accepts financial responsibility.

### Prohibited Code Combinations

The Centers for Medicare and Medicaid Services (CMS) instructs the MACs to treat some concurrent procedures as a "bundle" for payment purposes. This means that no separate payment is made for the test outside of the bundled procedure. In addition, some procedures are considered "mutually exclusive" with others. This means that, when two procedures or tests are performed on the same day on the same patient, only one of the procedures will be paid; generally the one of lesser value. The National Correct Coding Initiative (NCCI) is the regulation that updates these payment rules, usually on a quarterly basis. Some MACs have also published local policies with additional limitations. You may not use an ABN to circumvent the NCCI edits.

Fundus photography (92250) is considered mutually exclusive with scanning computerized ophthalmic diagnostic test (92135). It is also bundled with ICG angiography (92240).

Fluorescein angiography (92230) is bundled with fluorescein angiography (92235).

Since April 2003, minimal eye exams (99211) performed by a medical assistant or technician are bundled with concurrent diagnostic tests. Examinations or consultations by a physician on the same day as a diagnostic test are not bundled.

### Purchased Diagnostic Tests

In some instances, the physician may have access to this instrument but may not own it, or may not employ a skilled technician to operate it. Under the Medicare Physician Fee Schedule, reimbursement for some tests is subdivided into a technical component (*i.e.*, the test itself) and a professional component, which is the physician service associated with the test. In the situation where (a) a physician does not own a specialized diagnostic instrument and/or (b) the physician

doesn't employ a technician to operate the device, different reimbursement issues exist. Note that a written rental agreement or lease arrangement qualifies as "ownership" of the equipment.

If another entity provides either the equipment or the operator, or both, the physician (or the physician's medical group) can charge for the technical component by following these criteria.

- 1) The purchasing physician or group may not "mark up" the "purchase price" of the test.
- 2) The purchaser must perform the interpretation.
- 3) The physician or other supplier that furnished the technical component must be enrolled in the Medicare program. No formal reassignment is necessary.
- 4) The "purchase price" cannot be based on volume, (*i.e.*, "a volume discount").
- 5) The purchaser must accept the lowest of the following as full payment for the test even if assignment is not accepted:
  - a) the Medicare fee schedule amount for the technical component,
  - b) the physician's actual charge, or
  - c) the supplier's net charge to the purchasing physician.

To submit a claim for a purchased diagnostic test, Box 20 of the CMS-1500 claim form must be completed when the diagnostic test is subject to purchase price limitations (*i.e.*, those with a technical component). The purchase price under charges must be shown if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates that "no purchased tests are included on the claim." When "yes" is annotated, item 32 must be completed with the supplier's name, address, zip code and NPI. When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form.

As an alternative arrangement, the ordering physician may claim reimbursement for the professional component alone, and ask the performing physician or supplier to bill for the technical component.

#### Health Professional Shortage Area (HPSA)

Medicare pays a quarterly 10% premium to physicians who provide services in a Health Professional Shortage Area (HPSA). Historically, modifiers QU (urban) and QB (rural) designated services eligible for a HPSA bonus. Modifier AQ replaced these modifiers on January 1, 2006. A distinction between rural and urban HPSAs no longer exists. No modifier is necessary if your zip code is listed as HPSA eligible; the bonus payment will be automatic. Eligible services provided at locations not listed will continue to need the modifier AQ. This premium is pertinent only to professional services, and does not apply to the technical component (TC) of diagnostic tests. Until recently, it was necessary to separate the professional and technical components in order to receive bonuses, but no longer. The carrier will automatically calculate bonus payments on the professional component.

As an illustration, if the fundus photo in the Sample Claim, above, had been performed in a HPSA not receiving automatic bonus payments, then the claim would read as follows:

17 J. Jones, MD		17a				
		17b 123456780				
19						
21 1 362.51						
2						
24a	24b	24c	24d	24e	24f	24g
mm/dd/yyyy	11		92250-AQ	1	xxx.xx	1

#### Physician Scarcity Area (PSA)

The Medicare Modernization Act (MMA) of 2003 created a new Physician Scarcity Area (PSA) bonus program effective January 1, 2005 through December 31, 2007. This program was set to expire but was given an extension through

June 30, 2008 as a result of the Medicare, Medicaid and SCHIP Extension Act of 2007; it was extended again in July, 2008. Physicians providing eligible services in the counties with the lowest 20% ratio of primary care or specialty physicians to Medicare beneficiaries are eligible for the bonus payment. Bonus payments are paid quarterly to providers for professional services. Similar to HPSA, the technical component of diagnostic tests is not eligible for a bonus payment. Bonus payments are based on what Medicare paid for the service and not on the approved amount. The PSA bonus is 5%. Some services may qualify for both HPSA and PSA bonus payments. At this time optometrists are not eligible for the PSA bonus.

Zip codes that will automatically receive bonus payments are listed on the CMS website. Separate zip code lists exist for the Primary Care (ophthalmologists and optometrists) HPSA bonus and Specialty Care (ophthalmologists) PSA bonus. The PSA bonus will be automatic to those zip code areas listed on the CMS web site. If an area is not listed, but eligible based on the CMS PSA county list, add modifier AR to eligible services in order to receive the bonus payment.

### PAYMENT LEVELS

CPT code 92250 is defined as bilateral so reimbursement is for both eyes. The 2008 national Medicare Physician Fee Schedule allowables are shown in Table 3. The amounts are adjusted in each area by local indices.

Table 3 Medicare National Payment Rates for Fundus Photography

<u>Code</u>	<u>PAR</u>	<u>Non-PAR</u>	<u>Limiting Charge *</u>
92250	\$69.32	\$65.85	\$75.73
92250-TC	\$47.99	\$45.59	\$52.43
92250-26	\$21.33	\$20.26	\$23.30

\* Limiting charge for non-participating physicians

Other payers set their own rates, which may differ significantly from the Medicare published fee schedule.

CPT code 92235 is defined as unilateral so reimbursement is per eye. The 2008 national Medicare Physician Fee Schedule allowables are shown in Table 4. The amounts are adjusted in each area by local indices. Again, other payers set their own rates, which may differ significantly from the Medicare published fee schedule.

Table 4 Medicare National Payment Rates for Fluorescein Angiography

<u>Code</u>	<u>PAR</u>	<u>Non-PAR</u>	<u>Limiting Charge *</u>
92235	\$123.02	\$116.87	\$134.40
92235-TC	\$82.65	\$78.52	\$90.29
92235-26	\$40.37	\$38.35	\$44.11

\* Limiting charge for non-participating physicians

### DOCUMENTATION

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)
- a diagnosis (if possible)
- the impact on treatment and prognosis
- the signature of the physician

Figure 5 is a form that may be used for interpreting fundus photography and fluorescein angiography.

Figure 5 Interpretation Report

<b><u>INTERPRETATION REPORT</u></b>	
Name _____	Date _____
<input type="checkbox"/> Fundus Photography	<input type="checkbox"/> OU <input type="checkbox"/> OD <input type="checkbox"/> OS
<input type="checkbox"/> Fluorescein Angiography	<input type="checkbox"/> OU <input type="checkbox"/> OD <input type="checkbox"/> OS
<b>Technician's Comments:</b>	
Performed By: _____	
Reliability: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Patient Cooperation: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
<b>Physician's Interpretation:</b>	
Test Results:	
OD _____	OS _____
Diagnosis _____	
Impact on Treatment/Prognosis: _____	
_____	
Ordering Physician's Signature & Date	

Fundus photography is commonly ordered in conjunction with FA. When both tests are performed, each requires a specific order and separate interpretation in the medical record.

### SUPERVISION

Effective July 1, 2001, Medicare revised its supervision rules for many ophthalmic diagnostic tests. Fundus photography requires *general* supervision. This means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during performance of the test. Under general supervision rules, the training of the non-physician personnel who actually perform the diagnostic test and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician (CFR 410.32 (b)(3)(i)).

The supervision requirement for a fluorescein angiogram is different because an intravenous dye is being introduced, so *direct* supervision is required. 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 at the time of the test.

### UTILIZATION

Medicare utilization rates are published and are shown below. Commercial utilization rates are not readily available. There are no published limitations for repeated testing. In general, these and all diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required. If your utilization rate exceeds the expected norms, you will likely garner attention from Medicare and other payers. Careful attention to documentation of the test and the reasons it was performed are your best defense against reproach in the event of postpayment review.

Medicare utilization rates for claims paid in 2006 show that fundus photography was performed in 6% of all office visits by ophthalmologists. That is, for every 100 exams and consultations performed on Medicare beneficiaries, Medicare paid for this service 6 times. For optometrists, the utilization rate is 9% (Table 5).

For fluorescein angiography, Medicare utilization was 8% of all office visits by ophthalmologists. That is, for every 100 exams and consultations performed on Medicare beneficiaries, Medicare paid for this service 7 times. For optometrists, the utilization rate is below a reportable amount (Table 5). Note that this is per eye rather than per patient.

Table 5 Medicare Utilization Rates\*

Code	Description	MD	OD
92250	Fundus Photography	6%	9%
92235	Fluorescein Angiography	8%	nil

\* Medicare 2006 data

## CONCLUSION

A well known proverb says that a picture is worth a thousand words. This is particularly true for ophthalmologists and optometrists for whom visualization of a problem in the eye can lead to better vision for the patient. Unlike ophthalmoscopy where the examiner must be content with a brief look at the fundus while the patient grudgingly submits to an uncomfortable examination, retinal imaging with **optomap**<sup>®</sup> provides crisp, detailed, close up pictures of the posterior pole as well as the mid and far periphery. It also affords the opportunity for leisurely study of abnormalities, as well as subsequent use as a benchmark for comparison purposes. Retinal images even have utility for people other than the examining physician. For example, the images are helpful: in telemedicine (*i.e.*, screening), during litigation (*e.g.*, malpractice), as part of criminal investigations (*e.g.*, shaken baby), for teaching purposes, and for other caregivers when patients desire a transfer of medical records.

As the usage of digital imaging has grown, along with expanding indications and wider availability of this technology, so also have the reimbursement regulations governing these services. Some applications of fundus photography, particularly as an aid to screening, are not covered by Medicare and most other third party payers. For covered services, chart documentation of the physician's interpretation is crucial; where it is abbreviated or missing reimbursement is jeopardized.

This discussion is meant to assist the reader to better understand the rules and regulations regarding reimbursement for **optomap**<sup>®</sup>, **optomap**<sup>®</sup> *plus* and **optomap**<sup>®</sup> *fa*, however the responsibility for appropriate usage, adequate documentation and proper coding are always the physician's.

## **APPENDIX**



Sample ABN Form

Print your name, address and telephone number. Logo is optional.

Patient Name:

Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items or services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

Table with 3 columns: Items or Services, Reason Medicare May Not Pay, and Estimated Cost. Row 1: Fundus photographs for indications not covered by the local Medicare administrative contractor. Reason: Your Medicare administrative contractor establishes limitations on coverage and payment in its local coverage determination policies. Estimated Cost: \$\$\$\$.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
Ask us any questions you may have after you finish reading.
Choose an option below about whether to receive the optomap plus Medical Retinal Exam listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS:

Check only one box. We cannot choose a box for you.

[ ] OPTION 1. I want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

[ ] OPTION 2. I want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and I cannot appeal if Medicare is not billed.

[ ] OPTION 3. I don't want the items or services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227 / TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:

Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

**Sample NEMB Form**

*(Customize top of form with name, address & phone)*

*(Provide 1 copy to patient, keep original in your files.)*

Patient's Name:

Medicare # (HICN):

---

## **NOTICE OF EXCLUSION FROM MEDICARE BENEFITS**

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.
- When you receive an item or service that is not a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: \$\_\_\_\_\_)

**Medicare will not pay for:**

Screening fundus photos of the posterior segment of the eye.

**Because of the following exclusion from Medicare benefit:**

Medicare policy prohibits payment for screening tests performed as a part of wellness program.

**Medicare will only pay for:**

Medically necessary tests as an adjunct to diagnosing, managing and treating disease. Images taken as baseline documentation of a healthy eye or as preventative medicine to screen for potential disease are not considered medically necessary and therefore excluded by §1862(a)(1) of the Medicare law.

I understand and agree.

---

**Date**

**Signature of patient or person acting on patient's behalf**

---

## Sample NEHB Form

*(Customize top of form with name, address & phone)*

*(Provide 1 copy to patient; keep original in your files.)*

Patient's Name: \_\_\_\_\_

# NOTICE OF EXCLUSION FROM HEALTH PLAN BENEFITS

- Health insurance does **not** pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not insurance benefits and your insurance plan will not pay for them.
- When you receive an item or service that is not a covered benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why your insurance won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: \$\_\_\_\_\_)

### Your health plan will not pay for:

- 1) Screening fundus photos of the posterior segment of the eye.
- 2) Fundus photos for indications that are not covered by your health plan.

### Because it does not meet the definition of any covered benefit:

- 1) Your health plan prohibits payment for screening tests as part of a wellness program.
- 2) Your health plan does not cover fundus photos for every indication, only those that it considers to be medically necessary.

### Your health plan will only pay for:

Medically necessary tests as an adjunct to diagnosing, managing and treating disease. Insurance does not cover images taken as baseline documentation of a healthy eye or as preventative medicine to screen for potential disease.

I understand and agree.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or person acting on patient's

## Sample Medicare Coverage Policy for Fundus Photography

### **Contractor Information**

#### **Contractor Name**

Wisconsin Physicians Service Insurance Corporation

#### **Contractor Number**

05102

#### **Contractor Type**

MAC - Part B

### **LCD Information**

#### **LCD ID Number**

L26712

#### **LCD Title**

Fundus Photography

### **Contractor's Determination Number**

OPHTH-508

### **AMA CPT / ADA CDT Copyright Statement**

CPT codes, descriptions and other data only are copyright 2007 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. Current Dental Terminology, (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. © 2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

## **CMS National Coverage Policy**

Title XVIII of the Social Security Act, Section 1862(a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Title XVIII of the Social Security Act, section 1862(a)(7) excludes  routine physical evaluations.

### **Primary Geographic Jurisdiction**

Iowa

### **Oversight Region**

Region I

### **Original Determination Effective Date**

For services performed on or after 02/01/2008

### **Original Determination Ending Date**

### **Revision Effective Date**

For services performed on or after 03/01/2008

### **Revision Ending Date**

## **Indications and Limitations of Coverage and/or Medical Necessity**

Fundus photography is covered for documentation of effects of treatment when the photography is used for making further treatment decisions.

Fundus photography uses a special camera to photograph structures behind the lens of the eye. This procedure does not include laser scanning of the retina.

In order to document a disease process, plan its treatment, or follow the progress of a disease, fundus photographs may be necessary. Fundus Photography is not covered for routine screening.

Fundus photographs are not medically necessary simply to document the existence of a condition. However, photographs may be medically necessary to establish a baseline to judge later whether a disease is progressive. Examples are as follows:

(1) It does not add to the patient's care to photograph dry age-related maculopathy to document its existence.

(2) Fundus photography may be necessary to establish the extent of retinal edema in moderate non-proliferative diabetic retinopathy. Then, in four to six months the baseline photograph can be compared to the clinical appearance of the current diabetic retinal edema to see if it is progressing to clinically significant diabetic macular edema. This information can then be used to decide whether or not to advise the patient to undergo focal laser photocoagulation.

The intent of these examples is to point out how in the former there is not a therapeutic decision being made, while in the latter there is. The fundus photography should aid in making a clinical decision.

The RVU amount for this service is already based on this procedure being performed as a bilateral procedure. If service is reported with a 50 modifier or with any other indication that it is being billed twice on the same day, payment will be based on the reimbursement rate for a single code.

### **Coverage Topic**

Diagnostic Tests and X-Rays

### **Coding Information**

#### **Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

## Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

## CPT/HCPCS Codes:

92250 FUNDUS PHOTOGRAPHY WITH INTERPRETATION AND REPORT

## ICD-9 Codes that Support Medical Necessity

042 HUMAN IMMUNODEFICIENCY VIRUS (HIV) DISEASE  
078.5 CYTOMEGALOVIRAL DISEASE  
091.51 SYPHILITIC CHORIORETINITIS (SECONDARY)  
094.83 SYPHILITIC DISSEMINATED RETINOCHOROIDITIS  
115.02 HISTOPLASMA CAPSULATUM RETINITIS  
115.92 HISTOPLASMOSIS RETINITIS UNSPECIFIED  
130.0 MENINGOENCEPHALITIS DUE TO TOXOPLASMOSIS  
130.2 CHORIORETINITIS DUE TO TOXOPLASMOSIS  
130.9 TOXOPLASMOSIS UNSPECIFIED  
190.0 MALIGNANT NEOPLASM OF EYEBALL EXCEPT CONJUNCTIVA CORNEA RETINA AND CHOROID  
190.5 MALIGNANT NEOPLASM OF RETINA  
190.6 MALIGNANT NEOPLASM OF CHOROID  
198.4 SECONDARY MALIGNANT NEOPLASM OF OTHER PARTS OF NERVOUS SYSTEM  
224.0 BENIGN NEOPLASM OF EYEBALL EXCEPT CONJUNCTIVA CORNEA RETINA AND CHOROID  
224.5 BENIGN NEOPLASM OF RETINA  
224.6 BENIGN NEOPLASM OF CHOROID  
225.1 BENIGN NEOPLASM OF CRANIAL NERVES

- 228.03 HEMANGIOMA OF RETINA
- 228.09 HEMANGIOMA OF OTHER SITES
- 250.00 - DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR  
250.03 UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES MELLITUS  
WITHOUT MENTION OF COMPLICATION, TYPE I [JUVENILE TYPE],  
UNCONTROLLED
- 250.40 - DIABETES WITH RENAL MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT  
250.43 STATED AS UNCONTROLLED - DIABETES WITH RENAL MANIFESTATIONS, TYPE  
I [JUVENILE TYPE], UNCONTROLLED
- 250.50 - DIABETES WITH OPHTHALMIC MANIFESTATIONS, TYPE II OR UNSPECIFIED  
250.53 TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH OPHTHALMIC  
MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED
- 250.60 - DIABETES WITH NEUROLOGICAL MANIFESTATIONS, TYPE II OR UNSPECIFIED  
250.63 TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH NEUROLOGICAL  
MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED
- 250.70 - DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE II OR  
250.73 UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH  
PERIPHERAL CIRCULATORY DISORDERS, TYPE I [JUVENILE TYPE],  
UNCONTROLLED
- 250.80 - DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE II OR  
250.83 UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH OTHER  
SPECIFIED MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED
- 250.90 - DIABETES WITH UNSPECIFIED COMPLICATION, TYPE II OR UNSPECIFIED TYPE,  
250.93 NOT STATED AS UNCONTROLLED - DIABETES WITH UNSPECIFIED  
COMPLICATION, TYPE I [JUVENILE TYPE], UNCONTROLLED
- 264.7 OTHER OCULAR MANIFESTATIONS OF VITAMIN A DEFICIENCY
- 340 MULTIPLE SCLEROSIS
- 348.2 BENIGN INTRACRANIAL HYPERTENSION
- 360.00 - PURULENT ENDOPHTHALMITIS UNSPECIFIED - VITREOUS ABSCESS  
360.04
- 360.11 - SYMPATHETIC UVEITIS - OTHER ENDOPHTHALMITIS  
360.19
- 360.20 - DEGENERATIVE DISORDER OF GLOBE UNSPECIFIED - OTHER METALLOSIS OF  
360.24 GLOBE
- 360.30 - HYPOTONY OF EYE UNSPECIFIED - HYPOTONY ASSOCIATED WITH OTHER  
360.33 OCULAR DISORDERS

360.43 HEMOPHTHALMOS EXCEPT CURRENT INJURY

360.44 LEUCOCORIA

360.50 - FOREIGN BODY MAGNETIC INTRAOCULAR UNSPECIFIED - INTRAOCULAR  
360.59 FOREIGN BODY MAGNETIC IN OTHER OR MULTIPLE SITES

360.60 - FOREIGN BODY INTRAOCULAR UNSPECIFIED - INTRAOCULAR FOREIGN BODY  
360.69 IN OTHER OR MULTIPLE SITES

361.00 - RETINAL DETACH WITH RETINAL DEFECT UNSPECIFIED - OLD RETINAL DETACH  
361.07 TOTAL OR SUBTOTAL

361.10 - RETINOSCHISIS UNSPECIFIED - OTHER RETINOSCHISIS AND RETINAL CYSTS  
361.19

361.2 SEROUS RETINAL DETACH

361.30 - RETINAL DEFECT UNSPECIFIED - MULTIPLE DEFECTS OF RETINA WITHOUT  
361.33 DETACH

361.81 TRACTION DETACH OF RETINA

361.89 OTHER FORMS OF RETINAL DETACH

361.9 UNSPECIFIED RETINAL DETACH

362.01 - BACKGROUND DIABETIC RETINOPATHY - DIABETIC MACULAR EDEMA  
362.07

362.10 - BACKGROUND RETINOPATHY UNSPECIFIED - RETINAL VASCULITIS  
362.18

362.21 RETROLENTAL FIBROPLASIA

362.29 OTHER NONDIABETIC PROLIFERATIVE RETINOPATHY

362.30 - RETINAL VASCULAR OCCLUSION UNSPECIFIED - VENOUS ENGORGEMENT OF  
362.37 RETINA

362.40 - RETINAL LAYER SEPARATION UNSPECIFIED - HEMORRHAGIC DETACH OF  
362.43 RETINAL PIGMENT EPITHELIUM

362.50 - MACULAR DEGENERATION (SENILE) OF RETINA UNSPECIFIED - DRUSEN  
362.57 (DEGENERATIVE) OF RETINA

362.60 - PERIPHERAL RETINAL DEGENERATION UNSPECIFIED - SECONDARY  
362.66 VITREORETINAL DEGENERATIONS

362.70 - HEREDITARY RETINAL DYSTROPHY UNSPECIFIED - RETINAL DYSTROPHIES  
362.77 PRIMARILY INVOLVING BRUCH'S MEMBRANE

362.81 - RETINAL HEMORRHAGE - OTHER RETINAL DISORDERS  
362.89

362.9 UNSPECIFIED RETINAL DISORDER

363.00 - FOCAL CHORIORETINITIS UNSPECIFIED - FOCAL RETINITIS AND  
363.08 RETINOCHOROIDITIS PERIPHERAL

363.10 - DISSEMINATED CHORIORETINITIS UNSPECIFIED - DISSEMINATED RETINITIS  
363.15 AND RETINOCHOROIDITIS PIGMENT EPITHELIOPATHY

363.20 - CHORIORETINITIS UNSPECIFIED - HARADA'S DISEASE  
363.22

363.30 - CHORIORETINAL SCAR UNSPECIFIED - DISSEMINATED SCARS OF RETINA  
363.35

363.40 - CHOROIDAL DEGENERATION UNSPECIFIED - ANGIOID STREAKS OF CHOROID  
363.43

363.50 - HEREDITARY CHOROIDAL DYSTROPHY OR ATROPHY UNSPECIFIED - OTHER  
363.57 DIFFUSE OR GENERALIZED DYSTROPHY OF CHOROID TOTAL

363.61 - CHOROIDAL HEMORRHAGE UNSPECIFIED - CHOROIDAL RUPTURE  
363.63

363.70 - CHOROIDAL DETACH UNSPECIFIED - HEMORRHAGIC CHOROIDAL DETACH  
363.72

363.8 OTHER DISORDERS OF CHOROID

363.9 UNSPECIFIED DISORDER OF CHOROID

364.24 VOGT-KOYANAGI SYNDROME

365.00 - PREGLAUCOMA UNSPECIFIED - OCULAR HYPERTENSION  
365.04

365.10 - OPEN-ANGLE GLAUCOMA UNSPECIFIED - RESIDUAL STAGE OF OPEN ANGLE  
365.15 GLAUCOMA

365.20 - PRIMARY ANGLE-CLOSURE GLAUCOMA UNSPECIFIED - RESIDUAL STAGE OF  
365.24 ANGLE-CLOSURE GLAUCOMA

365.31 CORTICOSTEROID-INDUCED GLAUCOMA GLAUCOMATOUS STAGE

365.32 CORTICOSTEROID-INDUCED GLAUCOMA RESIDUAL STAGE

365.41 - GLAUCOMA ASSOCIATED WITH CHAMBER ANGLE ANOMALIES - GLAUCOMA  
365.44 ASSOCIATED WITH SYSTEMIC SYNDROMES

365.51 - PHACOLYTIC GLAUCOMA - GLAUCOMA ASSOCIATED WITH OTHER LENS  
365.59 DISORDERS

365.60 - GLAUCOMA ASSOCIATED WITH UNSPECIFIED OCULAR DISORDER - GLAUCOMA

365.65 ASSOCIATED WITH OCULAR TRAUMA  
365.81 - HYPERSECRETION GLAUCOMA - OTHER SPECIFIED GLAUCOMA  
365.89  
365.9 UNSPECIFIED GLAUCOMA  
368.41 SCOTOMA INVOLVING CENTRAL AREA  
368.54 ACHROMATOPSIA  
368.61 CONGENITAL NIGHT BLINDNESS  
377.00 - PAPILLEDEMA UNSPECIFIED - FOSTER-KENNEDY SYNDROME  
377.04  
377.10 - OPTIC ATROPHY UNSPECIFIED - HEREDITARY OPTIC ATROPHY  
377.16  
377.21 - DRUSEN OF OPTIC DISC - PSEUDOPAPILLEDEMA  
377.24  
377.30 - OPTIC NEURITIS UNSPECIFIED - OTHER OPTIC NEURITIS  
377.39  
377.41 - ISCHEMIC OPTIC NEUROPATHY - OTHER DISORDERS OF OPTIC NERVE  
377.49  
379.00 SCLERITIS UNSPECIFIED  
379.07 POSTERIOR SCLERITIS  
379.09 OTHER SCLERITIS  
379.21 - VITREOUS DEGENERATION - OTHER DISORDERS OF VITREOUS  
379.29  
379.60 - INFLAMMATION (INFECTION) OF POSTPROCEDURAL BLEB, UNSPECIFIED -  
379.63 INFLAMMATION (INFECTION) OF POSTPROCEDURAL BLEB, STAGE 3  
710.0 SYSTEMIC LUPUS ERYTHEMATOSUS  
743.51 - VITREOUS ANOMALIES CONGENITAL - OTHER CONGENITAL ANOMALIES OF  
743.59 POSTERIOR SEGMENT  
759.5 TUBEROUS SCLEROSIS  
759.6 OTHER CONGENITAL HAMARTOSES NOT ELSEWHERE CLASSIFIED  
759.82 MARFAN SYNDROME  
771.0 CONGENITAL RUBELLA  
871.5 PENETRATION OF EYEBALL WITH MAGNETIC FOREIGN BODY  
871.6 PENETRATION OF EYEBALL WITH (NONMAGNETIC) FOREIGN BODY

- 950.0 OPTIC NERVE INJURY
- 950.1 INJURY TO OPTIC CHIASM
- V10.84 PERSONAL HISTORY OF MALIGNANT NEOPLASM OF EYE
- V58.42 AFTERCARE FOLLOWING SURGERY FOR NEOPLASM
- V58.43 AFTERCARE FOLLOWING SURGERY FOR INJURY AND TRAUMA
- V58.44 AFTERCARE FOLLOWING ORGAN TRANSPLANT
- V58.63 LONG-TERM (CURRENT) USE OF ANTIPLATELETS/ANTITHROMBOTICS
- V58.64 LONG-TERM (CURRENT) USE OF NONSTEROIDAL ANTI-INFLAMMATORIES
- V58.65 LONG-TERM (CURRENT) USE OF STEROIDS
- V58.66 LONG-TERM (CURRENT) USE OF ASPIRIN
- V58.67 LONG-TERM (CURRENT) USE OF INSULIN
- V58.69 LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
- V58.71 AFTERCARE FOLLOWING SURGERY OF THE SENSE ORGANS NOT ELSEWHERE CLASSIFIED
  
- V58.72 AFTERCARE FOLLOWING SURGERY OF THE NERVOUS SYSTEM NOT ELSEWHERE CLASSIFIED
- V58.77 AFTERCARE FOLLOWING SURGERY OF THE SKIN AND SUBCUTANEOUS TISSUE NOT ELSEWHERE CLASSIFIED
- V58.83 ENCOUNTER FOR THERAPEUTIC DRUG MONITORING
- V67.51 FOLLOW-UP EXAMINATION FOLLOWING COMPLETED TREATMENT WITH HIGH-RISK MEDICATION NOT ELSEWHERE CLASSIFIED

### **Diagnoses that Support Medical Necessity**

### **ICD-9 Codes that DO NOT Support Medical Necessity**

### **ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation**

#### **General Information**

## Documentation Requirements

In order to determine medical necessity, a copy of the clinical records may be requested, which must justify the diagnosis listed on the claim and the reason(s) that fundus photographs and the frequency with which they were repeated were necessary for planning therapy and monitoring the progress of the disease diagnosed.

Documentation must support the medical necessity of this service as outlined in the Indications and Limitations of Coverage and/or Medical Necessity section of this policy.

Documentation in the patient's medical record should include all of the following:

1. A current, pertinent history and physical examination, and progress notes describing and supporting the covered indication
2. Pertinent prior diagnostic testing and completed report(s). This would include, when appropriate, previous fundus photographs.
3. The medical record must be made available to Medicare upon request.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

When requesting a written redetermination (formerly appeal), providers must include all relevant documentation with the request.

## Appendices

### Utilization Guidelines

Fundus Photography will not be covered at a frequency that exceeds what is medically reasonable and necessary.

Fundus photography may be covered as a baseline prior to implantation of a Ganciclovir Vitreal Implant (GIOD) and at 2 week intervals following implantation of the GIOD. Physician discretion should determine whether or not there is an end point beyond which fundus photographs are no longer necessary.

It is expected that these services would be performed as indicated by current

medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

## **Sources of Information and Basis for Decision**

WPS has consolidated the existing LCDs for MAC Jurisdiction 5 according to the instructions provided by CMS so that they are the same throughout the jurisdiction. In the vast majority of cases, one least restrictive LCD was selected as the jurisdictional LCD. In some cases, appropriate revisions, such as combining sections of LCDs that only addressed a portion of a general topic into a single, more complete document, were made to improve the clinical appropriateness of the LCD while keeping with the least restrictive requirement.

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This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in consideration of the active LCDs maintained by the preceding Medicare contractors for Jurisdiction 5.

American Academy of Ophthalmology Primary Open-Angle Glaucoma-Preferred Pattern (revised September 2005)

Duane's Clinical Ophthalmology 2005

American Academy of Ophthalmology Diabetic Retinopathy Preferred Practice Pattern (updated 6/21/2002)

Yanoff, Ophthalmology, 2nd edition (2004)

Braunwald et al, eds. Harrison's Principles of Internal Medicine, 16th edition (2005)

Other carriers' policies

American Academy of Ophthalmology Diabetic Retinopathy Preferred Practice Pattern

**Advisory Committee Meeting Notes**

**Start Date of Comment Period**

**End Date of Comment Period**

**Start Date of Notice Period**

12/15/2007

**Revision History Number**

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**Revision History Explanation**

added Missouri Eastern

**Reason for Change**

Other

**Last Reviewed On Date**

11/01/2007

**Related Documents**

This LCD has no Related Documents.

**LCD Attachments**

Billing and Coding Guidelines (PDF - 9,938 bytes)

## Sample Medicare Policy for Fluorescein Angiography

### Contractor Information

**Contractor Name**

Wisconsin Physicians Service Insurance Corporation

**Contractor Number**

05102

**Contractor Type**

MAC - Part B

### LCD Information

**LCD ID Number**

L26672

**LCD Title**

Fluorescein Angiography

**Contractor's Determination Number**

OPHTH-516

### AMA CPT / ADA CDT Copyright Statement

CPT codes, descriptions and other data only are copyright 2007 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. Current Dental Terminology, (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. © 2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

### CMS National Coverage Policy

Title XVIII of the Social Security Act, Section 1862(a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, Section 1833(e). This section prohibits

Medicare payment for any claim which lacks the necessary information to process the claim.

### **Primary Geographic Jurisdiction**

Iowa

### **Oversight Region**

Region I

### **Original Determination Effective Date**

For services performed on or after 02/01/2008

### **Original Determination Ending Date**

### **Revision Effective Date**

For services performed on or after 03/01/2008

### **Revision Ending Date**

### **Indications and Limitations of Coverage and/or Medical Necessity**

Fluorescein angiography is used in the diagnosis and treatment of a wide range of ocular disorders. Visible fluorescein leaking from damaged vessels makes it particularly useful in the diagnosis of retinal vascular disorders and monitoring treatment of conditions amenable to laser photocoagulation.

The dye is injected intravenously and serial photographs are taken through the dilated pupil. While morphological characteristics alone may be pathognomonic of certain disease states, the timing of dye appearance in the choroid, in the central retinal artery and in the filling (or otherwise) of the quadrants have diagnostic implications.

A trace of Sodium Iodide as a contaminant of the dye may have clinical implications in patients allergic to shellfish.

Medical necessity of fluorescein angiography is established as an adjunct to the diagnosis of chorioretinal vascular abnormalities especially relating to choroid revascularization, non-infective vasculitis, age related macular degeneration, diabetic retinopathy and retinal vascular occlusions. It may also be appropriate in evaluating intraocular tumors, visual loss in systemic disease and optic disc

edema. Medical necessity for such angiography would generally be in the context of a changing clinical picture.

Fluorescein angiography following treatment, for example, of choroidal revascularization (CNV) is necessary to monitor for recurrence or to detect additional treatable disease. Usually this is performed on the basis of a change in the clinical picture similar to the way it is employed prior to treatment. However, fluorescein angiography may be performed following treatment without clinical change in order to detect occult lesions. This will occur most often in CNV and very rarely in other diseases. It would be unusual to need more than 7 fluoresceins on an eye in a 12-month period.

All of the coverage criteria must be met before this service can be reimbursed by Medicare.

Compliance with the provisions in this policy is subject to monitoring by post payment data analysis and subsequent medical review.

### **Coverage Topic**

Diagnostic Tests and X-Rays

### **Coding Information**

#### **Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

#### **CPT/HCPCS Codes**

92235 FLUORESCEIN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERPRETATION AND REPORT

#### **ICD-9 Codes that Support Medical Necessity**

115.02 HISTOPLASMA CAPSULATUM RETINITIS

115.92 HISTOPLASMOSIS RETINITIS UNSPECIFIED

130.2 CHORIORETINITIS DUE TO TOXOPLASMOSIS

135 SARCOIDOSIS

190.5 MALIGNANT NEOPLASM OF RETINA

190.6	MALIGNANT NEOPLASM OF CHOROID
224.5	BENIGN NEOPLASM OF RETINA
224.6	BENIGN NEOPLASM OF CHOROID
228.03	HEMANGIOMA OF RETINA
228.09	HEMANGIOMA OF OTHER SITES
250.50 - 250.53	DIABETES WITH OPHTHALMIC MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH OPHTHALMIC MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED
340	MULTIPLE SCLEROSIS
348.2	BENIGN INTRACRANIAL HYPERTENSION
360.00 - 360.04	PURULENT ENDOPHTHALMITIS UNSPECIFIED - VITREOUS ABSCESS
360.11 - 360.19	SYMPATHETIC UVEITIS - OTHER ENDOPHTHALMITIS
360.20 - 360.29	DEGENERATIVE DISORDER OF GLOBE UNSPECIFIED - OTHER DEGENERATIVE DISORDERS OF GLOBE
360.30 - 360.33	HYPOTONY OF EYE UNSPECIFIED - HYPOTONY ASSOCIATED WITH OTHER OCULAR DISORDERS
361.10 - 361.19	RETINOSCHISIS UNSPECIFIED - OTHER RETINOSCHISIS AND RETINAL CYSTS
361.2	SEROUS RETINAL DETACH
361.81	TRACTION DETACH OF RETINA
362.01 - 362.07	BACKGROUND DIABETIC RETINOPATHY - DIABETIC MACULAR EDEMA
362.11 - 362.18	HYPERTENSIVE RETINOPATHY - RETINAL VASCULITIS
362.29	OTHER NONDIABETIC PROLIFERATIVE RETINOPATHY
362.30 - 362.37	RETINAL VASCULAR OCCLUSION UNSPECIFIED - VENOUS ENGORGEMENT OF RETINA
362.40 - 362.43	RETINAL LAYER SEPARATION UNSPECIFIED - HEMORRHAGIC DETACH OF RETINAL PIGMENT EPITHELIUM
362.50 - 362.57	MACULAR DEGENERATION (SENILE) OF RETINA UNSPECIFIED - DRUSEN (DEGENERATIVE) OF RETINA
362.60 - 362.66	PERIPHERAL RETINAL DEGENERATION UNSPECIFIED - SECONDARY VITREORETINAL DEGENERATIONS
362.70 - 362.77	HEREDITARY RETINAL DYSTROPHY UNSPECIFIED - RETINAL DYSTROPHIES PRIMARILY INVOLVING BRUCH'S MEMBRANE

362.81 - RETINAL HEMORRHAGE - RETINAL ISCHEMIA  
362.84

363.00 - FOCAL CHORIORETINITIS UNSPECIFIED - FOCAL RETINITIS AND  
363.08 RETINOCHOROIDITIS PERIPHERAL

363.10 - DISSEMINATED CHORIORETINITIS UNSPECIFIED - DISSEMINATED  
363.15 RETINITIS AND RETINOCHOROIDITIS PIGMENT EPITHELIOPATHY

363.20 CHORIORETINITIS UNSPECIFIED

363.21 PARS PLANITIS

363.22 HARADA'S DISEASE

363.31 SOLAR RETINOPATHY

363.42 DIFFUSE SECONDARY ATROPHY OF CHOROID

363.43 ANGIOID STREAKS OF CHOROID

363.50 - HEREDITARY CHOROIDAL DYSTROPHY OR ATROPHY UNSPECIFIED - OTHER  
363.57 DIFFUSE OR GENERALIZED DYSTROPHY OF CHOROID TOTAL

363.61 CHOROIDAL HEMORRHAGE UNSPECIFIED

363.62 EXPULSIVE CHOROIDAL HEMORRHAGE

363.63 CHOROIDAL RUPTURE

363.70 CHOROIDAL DETACH UNSPECIFIED

363.71 SEROUS CHOROIDAL DETACH

363.72 HEMORRHAGIC CHOROIDAL DETACH

364.24 VOGT-KOYANAGI SYNDROME

364.42 RUBEOSIS IRIDIS

365.63 GLAUCOMA ASSOCIATED WITH VASCULAR DISORDERS OF EYE

368.10 SUBJECTIVE VISUAL DISTURBANCE UNSPECIFIED

368.14 VISUAL DISTORTIONS OF SHAPE AND SIZE

368.16 PSYCHOPHYSICAL VISUAL DISTURBANCES

368.54 ACHROMATOPSIA

377.00 - PAPILLEDEMA UNSPECIFIED - FOSTER-KENNEDY SYNDROME  
377.04

377.16 HEREDITARY OPTIC ATROPHY

377.21 DRUSEN OF OPTIC DISC

377.22 CRATER-LIKE HOLES OF OPTIC DISC

377.24 PSEUDOPAPILLEDEMA

377.30 OPTIC NEURITIS UNSPECIFIED

377.31	OPTIC PAPILLITIS
377.41	ISCHEMIC OPTIC NEUROPATHY
377.43	OPTIC NERVE HYPOPLASIA
379.07	POSTERIOR SCLERITIS
379.21 - 379.25	VITREOUS DEGENERATION - VITREOUS MEMBRANES AND STRANDS
379.60 - 379.63	INFLAMMATION (INFECTION) OF POSTPROCEDURAL BLEB, UNSPECIFIED - INFLAMMATION (INFECTION) OF POSTPROCEDURAL BLEB, STAGE 3
433.10	OCCLUSION AND STENOSIS OF CAROTID ARTERY WITHOUT CEREBRAL INFARCTION
433.11	OCCLUSION AND STENOSIS OF CAROTID ARTERY WITH CEREBRAL INFARCTION
446.5	GIANT CELL ARTERITIS
V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
V67.51	FOLLOW-UP EXAMINATION FOLLOWING COMPLETED TREATMENT WITH HIGH-RISK MEDICATION NOT ELSEWHERE CLASSIFIED

### **Diagnoses that Support Medical Necessity**

### **ICD-9 Codes that DO NOT Support Medical Necessity**

### **ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation**

### **Diagnoses that DO NOT Support Medical Necessity**

## **General Information**

### **Documentation Requirements**

1. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to Medicare upon request. The fluorescein interpretation report should include the following:

- Preliminary diagnosis
- Description of angiographic findings
- Clinical impression or diagnosis

2. This information should be available and generally submitted on reconsideration only (or with the claim(s) if the services are unusual or if a

rejection is anticipated).

3. Documentation supporting the medical necessity of this item (ICD-9-CM codes) must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary.

## **Appendices**

### **Utilization Guidelines**

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1. Melber N.S., Thomas M.A., et al. "Successful Feeder Vessel Laser Treatment of Recurrent Neovascularization Following Subfoveal Surgery." Arch

Ophthalmology February 1996: 144.

2. George R.K., et al. "Primary Retinal Vasculitis Systemic Association and Diagnostic Evaluation." Ophthalmology March 1996: 103.

3. Arnold C., et al. "Fluorescein Angiography in Non-ischemic Optic Disc Edema." Arch Ophthalmology March 1996: 114.

4. Staurengi G., et al. "Visualization of Neovascular Membranes With Infrared Light Without Dye Injection by Means of a Scanning Laser Ophthalmoscope." Arch Ophthalmology March 1996: 114.

5. "Occult Choroidal Neovascularization Influence on Visual Outcome in Patients with Age-Related Macular Degeneration." Macular Photocoagulation Study Group, et al. 1996.

6. "Laser Photocoagulation of Subfoveal Neovascular Lesions of Age-Related Macular Degeneration Updated Findings From Two Clinical Trials." Macular Photocoagulation Study Group, et al. Arch Ophthalmology September 1996: 111.

7. Jampol L.M. "Hypertension and Visual Outcome in the Macular Photocoagulation Study." Arch Ophthalmology June 1991:109.

8. "Risk Factors for Neovascular Age-Related Macular Degeneration." The Eye Disease Case-Control Study Group. Arch Ophthalmology December 1992: 110.

9. Carrier Medical Director ophthalmologic work group model policy.

10. Macular Photocoagulation Study Group, et al. 1996. "Occult Choroidal Neovascularization Influence on Visual Outcome in Patients with Age-Related Macular Degeneration" Arch Ophthalmology Volume 114 (April).

11. Macular Photocoagulation Study Group, et al.1993. "Laser Photocoagulation of Subfoveal Neovascular Lesions of Age-Related Macular Degeneration Updated Findings From Two Clinical Trials" Arch Ophthalmology Volume 111 (September).

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