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MEDICARE REIMBURSEMENT FOR OCT OF THE POSTERIOR SEGMENT

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1 ***QUESTION:*** Does Medicare cover OCT of the posterior segment with ZEISS CIRRUS OCT systems?

ANSWER: Yes. Computerized ophthalmic diagnostic imaging (*e.g.,* OCT) of the posterior segment is covered by Medicare subject to the limitations in their local coverage payment policies; other third-party payors generally agree. Medicare covers OCT 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 to screen for potential disease, it is not covered (even if disease is identified).[1] Check your policies.

2 ***QUESTION:*** What CPT codes describe OCT of the posterior segment?

ANSWER: There are three CPT codes to describe OCT of the posterior segment.

92133 *Computerized ophthalmic diagnostic imaging (eg, OCT) posterior segment, with interpretation and report, unilateral or bilateral; optic nerve*

92134 *Computerized ophthalmic diagnostic imaging (eg, OCT), posterior segment, with interpretation and report, unilateral or bilateral; retina*

92137 *Computerized ophthalmic diagnostic imaging (eg, OCT), posterior segment, with interpretation and report, unilateral or bilateral; retina, including OCT angiography*

3 ***QUESTION:*** What are the Medicare covered indications for OCT of the posterior segment?

ANSWER: There are numerous eligible diagnoses including: macular degeneration, glaucoma and other posterior segment diseases. Payor policies vary significantly.

4 ***QUESTION:*** What documentation is required in the medical record to support a claim for these tests?

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:

- An order for the test with medical rationale
- The date of the test
- The reliability of the test
- The test findings (*e.g.,* thinning, thickening, separation of layers)
- Comparison with a prior OCT test(s)
- A diagnosis (if possible)
- The impact on treatment and prognosis
- The signature of the physician

Document the location of the images if they are stored separately from the medical record.

5 ***QUESTION:*** Is the physician's presence required while OCT is being performed?

ANSWER: No. Under Medicare program standards, OCT only needs 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 test.

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[1] An exception is monitoring for ophthalmic pathology in patients on long-term therapy with high-risk medications, such as hydroxychloroquine.

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QUESTION: How much does Medicare allow for these tests?

ANSWER: The 2025 national Medicare Physician Fee Schedule allowable amounts are:

Code	Technical Component	Professional Component	Global
92133	$14	$16	$30
92134	$14	$17	$31
92137	$23	$34	$57

The amounts apply whether one or both eyes are tested. Values are adjusted in each area by local wage indices. Other payors set their own rates, which may differ significantly from Medicare.

OCT 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.

7

QUESTION: What payment restrictions or bundles exist between OCT and other ophthalmic services?

ANSWER: CPT instructs that 92133, 92134, and 92137 are mutually exclusive with each other.

Medicare's National Correct Coding Initiative (NCCI) treats fundus photography (92250) as mutually exclusive with OCT. The E/M service 99211 is bundled with these tests.

Several Medicare Administrative Contractors (MACs) have published policies that impose other restrictions when performing OCT with B-scan (76512) and extended ophthalmoscopy (92201, 92202). Check your payor policies.

8

QUESTION: How often may OCT of the posterior segment be repeated?

ANSWER: 92133 is generally allowed once per year for glaucomatous patients. 92134 is allowed monthly in patients undergoing active intravitreal drug treatment. Clear documentation of the reason for testing is always required.

CMS utilization rates for claims paid in 2018 show that 92133 was associated with 10% of all ophthalmology office visits. That is, for every 100 exams for Medicare beneficiaries, Medicare paid for this service 10 times. For 92134, utilization was 31%. For optometry, the utilization was about 8% each. There are no utilization information or published policies on the new code, 92137.

9

QUESTION: If coverage of OCT is unlikely or uncertain, how should we proceed?

ANSWER: Explain why the test is necessary, and that Medicare or other third-party payor will likely deny the claim. Ask the patient to assume financial responsibility for the charge., as follows.

- 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 forms and processes.
- For commercial insurance beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN.

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