Corcoran Consulting Group
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MEDICARE REIMBURSEMENT FOR CORNEAL TOMOGRAPHY

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1 ***QUESTION:*** What is corneal tomography performed with Heidelberg Engineering's ANTERION®?

ANSWER: Corneal tomography is a non-invasive imaging technique for mapping the anterior and posterior curvature of the cornea with optical coherence tomography (OCT).

2 ***QUESTION:*** What diagnoses are typically covered and support a claim?

ANSWER: Corneal tomography is most frequently used for the diagnosis and management of corneal diseases, disorders, abnormalities, injuries, or is related to transplants. Check your local coverage determination policies for additional indications.

Medicare covers diagnostic tests that are medically necessary according to their guidelines. Medicare does not cover routine eye exams or tests, such as those for refractive error, including regular astigmatism.

3 ***QUESTION:*** What documentation is required in the medical record to support claims for corneal tomography?

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 (if compromised)
- test findings (*e.g.*, map and images of cornea)
- comparison with prior tests (if applicable)
- a diagnosis (if possible)
- the impact on treatment and prognosis
- physician's signature

4 ***QUESTION:*** What CPT code is used to describe this test?

ANSWER: Use CPT code 92132 (*Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral*) to report this service.

5 ***QUESTION:*** What is the reimbursement for 92132?

ANSWER: CPT 92132 is defined as "unilateral or bilateral" so reimbursement is usually for both eyes. The 2024 national Medicare Physician Fee Schedule allowable is $31. Of this amount, $15 is assigned to the technical component and $16 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.

Corneal tomography 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.

6 ***QUESTION:*** Will Medicare cover corneal tomography prior to cataract surgery?

ANSWER: Claims are reimbursed by Medicare Administrative Contractors (MACs) if there is a covered diagnosis, in addition to cataract, supporting medical necessity. More often, testing with corneal tomography prior to cataract surgery is associated with planning for concurrent corneal relaxing incisions or implantation of a toric IOL and is not covered.

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7 ***QUESTION:*** Must the physician be in the office while corneal tomography is being performed?

ANSWER: Under Medicare program standards, these tests require 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 this test 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.

In 2021, CMS utilization of CPT 92132 was 0.1%. That is, for every 1,000 exams on Medicare patients, 92132 was paid about 1 time. Utilization for optometrists is similar. There is no utilization data on noncovered tests associated with refractive procedures or for non-Medicare payers.

9 ***QUESTION:*** Is corneal tomography bundled with other services?

ANSWER: Medicare bundles 92132 with 76513 (*ultrasonic biomicroscopy*). Medicare also bundles a technician exam, 99211, with the test.

10 ***QUESTION:*** What is Medicare's position on corneal tomography 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 associated diagnostic tests, including corneal tomography. The patient is financially responsible for the service, either as a discrete charge or as part of the refractive surgery package. Inform the patient of their financial responsibility. If the Medicare beneficiary requests that a claim be filed, append modifier GY to the CPT code to indicate an excluded service; be sure to link the charge to the refractive diagnosis (*i.e.,* ICD-10 H52.22-).

11 ***QUESTION:*** If coverage is unlikely or uncertain, how should we proceed?

ANSWER: Explain to the patient why you feel 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, 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 commercial insurance 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 noncovered services; MA Plans have their own waiver forms and processes.

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