Corcoran Consulting Group
a subsidiary of MEDICAL CONSULTING GROUP

MEDICARE REIMBURSEMENT FOR CORNEAL TOPOGRAPHY

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1 ***QUESTION:*** What is corneal topography performed with Nidek's Meridia Pro?

ANSWER: Corneal topography (CT) is a non-invasive imaging technique for mapping the surface curvature of the cornea. The Meridia Pro combines premium anterior, fluorescein imaging and videos, and dry-eye options including detailed meibography.

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

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

CT is most frequently used for the diagnosis and management of corneal diseases, disorders, abnormalities, or injuries. Covered diagnoses include irregular astigmatism (H52.21-), keratoconus (H18.6-), and complications of corneal graft (T85.328). Check your local coverage determination (LCDs) for additional indications. The Meridia is also useful in dry eye and contact lens fitting, although these applications are not separately covered.

3 ***QUESTION:*** What CPT code is used to describe CT?

ANSWER: Use CPT code 92025 (*Computerized corneal topography, unilateral or bilateral, with interpretation and report*) to report this service.

4 ***QUESTION:*** What documentation is required in the medical record?

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

A form suitable for documenting the interpretation of external photos and other tests is available on Corcoran's website. It may also be adapted for use within an EMR system.

5 ***QUESTION:*** What does Medicare allow for 92025?

ANSWER: CPT 92025 is defined as "unilateral or bilateral", so reimbursement is for one or both eyes. The 2025 national Medicare Physician Fee Schedule allowable for 92025 is $35. Of this fee schedule amount, $17 is assigned to the technical component and $18 is the value of the professional component (*i.e.,* interpretation). Medicare allowed amounts are adjusted in each area by local wage indices. Other payors set their own rates, which may differ significantly from the Medicare published fee schedule.

92025 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.

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6 ***QUESTION:*** Is CT bundled with other services?

ANSWER: Along with the description of 92025, CPT instructs, *"Do not report 92025 in conjunction with 65710-65771"*. Medicare bundles 92025 with 65730-65770. Medicare also bundles the technician exam, 99211, with the test.

7 ***QUESTION:*** How often may this test be repeated on a patient?

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.

Medicare utilization rates for claims paid in 2022 show that CT was performed at 1.3% of all office visits by ophthalmologists. That is, for every 1,000 exams and consultations performed on Medicare beneficiaries, Medicare paid for this service 13 times. The utilization rate for optometry is 0.4%.

8 ***QUESTION:*** Must the physician be in the office while CT is being performed?

ANSWER: Medicare has no supervision policy published for this diagnostic test. In our opinion, it seems reasonable to use general supervision since most 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 test.

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

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

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 CT (NCD §80.7). 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 a 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.,* H52.22-).

10 ***QUESTION:*** If coverage for CT is unlikely or uncertain, how should we proceed?

ANSWER: Explain why you feel the test is necessary, and that the payor will likely deny the claim. Get a written financial waiver, such as:

- An Advance Beneficiary Notice of Noncoverage (ABN) is used where Part B Medicare coverage is ambiguous or doubtful, and may be useful where a service is never covered.
- 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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