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RETINA IMAGING: HOW TO AVOID DENIALS AND AUDIT RISKS

This article reviews common reasons why retina imaging claims may be denied or audited and documentation best practices to help reduce these risks.

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Retina imaging such as OCT, fluorescein angiography (FA), fundus photography, and diagnostic ultrasound are essential to guide diagnosis, treatment decisions, and long-term monitoring for a wide range of conditions. As the use of imaging has increased, so has payer scrutiny. Retina imaging services are frequently targeted for denials, audits, and recoupment requests. In many cases, the issue is not an incorrect Current Procedural Terminology (CPT) code selection, but the failure to provide adequate documentation.

Repeat testing frequency, multiple imaging studies performed on the same day, standing orders, and missing documentation are common payer concerns. Understanding these risks can help practices strengthen compliance and reduce reimbursement challenges. This article reviews several common denial reasons and audit risks involving retina imaging services and practical strategies to help avoid them.

COMMON REASONS FOR DENIALS

Documentation Does Not Support Medical Necessity

Imaging is reimbursable only when it is reasonable and necessary for diagnosing or managing a patient's condition—not simply because the practice routinely performs the test for a particular condition or visit type. Payers increasingly scrutinize imaging that appears repetitive or protocol driven. This is especially true when testing is performed before the physician evaluates the patient and determines the need for imaging at that encounter. For example, performing OCT at every injection visit without documenting a specific clinical reason may trigger denials or audit scrutiny. Similarly, fundus photography for a patient with stable disease may not support payment if the record does not explain why photography was necessary. Strong documentation for imaging should include:[1]

- A physician order
- The patient's diagnosis, symptoms, or clinical findings
- Whether the condition was new, worsening, or under active monitoring
- Why the imaging modality was selected
- How the findings affected treatment decisions

Practices should identify the payer before services are performed. Although many payers follow National Correct Coding Initiative (NCCI) edits, coverage requirements, payable diagnoses, and frequency limitations may differ between Medicare Administrative Contractors, Medicare Advantage plans, and commercial insurers.

A service payable under one payer's policy may be denied by another if documentation, diagnosis coding, or use requirements are not met. Retina practices should regularly review payer-specific and related coverage articles applicable to ophthalmic imaging services. A list of Medicare requirements for these testing services can be found at aao.org/lcds.

Testing Frequency Is Not Justified

Even when repeat imaging is clinically appropriate, the documentation must explain why testing was necessary at

that visit. Stable disease alone may not justify repeat testing over short intervals, and payer policies have frequency limitations.

Documentation such as "follow-up AMD" or "continue injections" often does not sufficiently explain why imaging was repeated. Stronger documentation connects the test directly to the physician's clinical concern or management decision. Examples of justification for repeat OCT imaging may include:

- Assessing for recurrent intraretinal or subretinal fluid
- Evaluating response to anti-VEGF therapy
- Monitoring progression of diabetic macular edema
- Determining whether treatment intervals can safely be extended

Similarly, FA claims may face scrutiny when angiography is repeated without documentation explaining why prior imaging was insufficient or why additional vascular evaluation was necessary.

Frequency expectations, called *frequency edits,* may differ by payer. Some insurers apply stricter use edits or require additional documentation when imaging studies are repeated frequently. For example, Novitas allows OCT to be performed monthly (ie, every 28 days) with active treatment but only every 2 months when monitoring disease.

Practices should also avoid using templated documentation across multiple visits. Individualized charting better demonstrates clinical decision making and helps support medical necessity during payer review.

Multiple Imaging Studies Appear Duplicative

Retina patients often require multiple imaging studies during the same encounter. However, performing several tests does not automatically mean all services are separately payable. One common denial trigger occurs when documentation does not distinguish the purpose of each imaging modality. Fundus photography (CPT 92250), for example, is frequently denied when billed with OCT because they are bundled together.[2] NCCI bundling edits and payer-specific policies help determine which imaging combinations may be reported together. Although many imaging combinations are allowable under NCCI guidance, payment still depends on whether each test was medically necessary, what the specific payer policy allows, and whether it provided distinct diagnostic information.[3]

Some commercial payers may apply stricter bundling edits than standard NCCI policy. When multiple imaging studies are performed on the same day, the record should clearly establish 1) why each test was ordered, 2) what unique information each study provided, and 3) how each study contributed to patient management. Without this distinction, payers may determine the tests were redundant or unnecessary. In addition, if a payer bundles two imaging services and it is inappropriate to unbundle with modifier -59, practices should ensure the billed test best reflects the imaging study that provided the most clinically relevant information for diagnosis or treatment decisions.

STABLE DISEASE ALONE MAY NOT JUSTIFY REPEAT TESTING OVER SHORT INTERVALS, AND PAYER POLICIES HAVE FREQUENCY LIMITATIONS.

COMMON AUDIT RISKS

Documentation Does Not Support the Test Performed

Again, to avoid triggering an audit, the medical record must adequately support why a specific imaging modality was selected. This is particularly important with diagnostic ultrasound. B-scan ultrasound (CPT 76512) is typically performed when the posterior segment cannot be adequately visualized; thus, simply documenting "B-scan performed" is unlikely to support reimbursement during an audit. Instead, the record should explain why visualization was limited with other imaging modalities, and what clinical question the ultrasound was intended to answer. Examples include:

- Dense vitreous hemorrhage obscuring retinal view
- No posterior view due to mature cataract
- Evaluate for retinal detachment in the setting of vitreous opacity

Similarly, FA documentation should clearly explain why angiography was needed beyond OCT or clinical examination findings—for example, the evaluation of vascular leakage, ischemia, neovascularization, or another specific clinical concern.

In general, the more invasive or resource-intensive the test, the greater the expectation that the documentation clearly supports why it was necessary.

Missing or Insufficient Interpretation and Report

An image alone is not sufficient for reimbursement. The interpretation should document clinically relevant findings, comparison with prior studies when appropriate, and the effect on diagnosis or treatment decisions. Examples of clinically relevant findings may include intraretinal or subretinal fluid, pigment epithelial detachment, vitreomacular traction, retinal nonperfusion, vascular leakage, or

disease progression compared with prior imaging.

Brief statements such as "reviewed," "stable," or "see scan" generally do not meet documentation requirements. Interpretation and report deficiencies are particularly problematic during audits because the imaging may appear clinically appropriate yet still fail to meet billing requirements due to incomplete physician documentation.

No Written Order for Delegated Tests

Another frequent audit deficiency involves the absence of a documented physician order for delegated diagnostic testing. Under the Code of Federal Regulations (42 CFR §410.32), diagnostic tests may only be ordered by the treating physician. Delegated tests performed without an appropriate physician order may be considered not reasonable and necessary and, therefore, nonbillable. When diagnostic testing is delegated to clinical staff, the medical record should contain a clear physician order before the test is performed. The order should include:

- The specific test being ordered
- The eye or site being tested
- When the test is scheduled for
- Documentation supporting medical necessity

Payers also require that delegated orders include a compliant physician signature; unsigned or incomplete orders may not support payment during audit review. However, when the physician does personally perform the test rather than delegating it to staff, the documentation should clearly reflect this, so an outside reviewer is not expecting a separate physician order in the record.

SHOW YOUR WORK

Retina imaging denials and recoupment requests are often preventable. In many cases, the imaging itself was clinically appropriate, but the documentation failed to clearly explain why the test was performed, how it contributed to management, or why multiple studies were needed. Practices can reduce denial and audit risk by implementing consistent documentation workflows. Imaging should support—not replace—clinical decision making, and the medical record should clearly demonstrate that connection. ■

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2. Medicare NCCI Procedure-to-Procedure (PTP) Edits. CMS. Accessed July 23, 2026. tinyurl.com/n3h8scvj
3. Medicare Claims Processing Manual. CMS. Accessed July 23, 2026. www.cms.gov

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