

# Local Coverage Determination (LCD): Indocyanine-Green Angiography (L33911)

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## Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09102 - MAC B	J - N	Florida
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09202 - MAC B	J - N	Puerto Rico
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09302 - MAC B	J - N	Virgin Islands
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## LCD Information

### Document Information

LCD ID  
L33911

Original Effective Date  
For services performed on or after 10/01/2015

Original ICD-9 LCD ID  
[L29197](#)

Revision Effective Date  
For services performed on or after 01/01/2017

LCD Title  
Indocyanine-Green Angiography

Revision Ending Date  
N/A

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Retirement Date  
N/A

Notice Period Start Date  
N/A

Notice Period End Date  
N/A

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CMS National Coverage Policy Language quoted from CMS National Coverage Determination (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

N/A

Coverage Guidance

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

Indocyanine – green (ICG) angiography is an infrared-based, dye imaging technique that is effective in the diagnosis and treatment of ill-defined choroidal neovascularization (e.g., associated with age - related macular degeneration). Indocyanine - green dye is injected intravenously into the patient to highlight the vessels in the retina and those of a deeper tissue layer called the choroid. The green dye fluoresces with invisible infrared light and requires a special camera sensitive to these light rays. Photographs are then taken of the retina at intervals as increasing intensity of retinal and choroidal circulation is displayed.

Indocyanine - green (ICG) angiography will be considered to be medically necessary as an adjunct to fluorescein angiography (FA) in the evaluation of the following conditions:

- Serous detachment of retinal pigment epithelium
- Hemorrhagic detachment of retinal pigment epithelium
- Retinal hemorrhage
- Presence of subretinal hemorrhage or hemorrhagic retinal pigment epithelium (RPE). A fluorescein angiography need not be previously done if patient is allergic to fluorescein
- Central serous retinopathy
- Focal and disseminated choroiditis

In the absence of pre-existing chronic disease, clinical signs or symptoms of disease, an ICG angiography is considered screening and is not covered. Also, a bilateral study is not automatically appropriate, or covered, in every case. Therefore, evidence of medical necessity must be documented in the medical record for each eye.

Contraindications to ICG angiography include prior anaphylactic reaction to ICG dye or contrast agents that contain iodide, liver disease, uremia, and pregnancy.

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## **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.

999x Not Applicable

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.

99999 Not Applicable

CPT/HCPCS Codes

**Group 1 Paragraph:** N/A

**Group 1 Codes:**

92240 INDOCYANINE-GREEN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL  
92242 FLUORESCIN ANGIOGRAPHY AND INDOCYANINE-GREEN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) PERFORMED AT THE SAME PATIENT ENCOUNTER WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL

ICD-10 Codes that Support Medical Necessity

**Group 1 Paragraph:** N/A

**Group 1 Codes:**

ICD-10 Codes	Description
A18.53	Tuberculous chorioretinitis
<a href="#">H30.001 - H30.149</a>	Unspecified focal chorioretinal inflammation, right eye - Acute posterior multifocal placoid pigment epitheliopathy, unspecified eye
<a href="#">H30.891 - H30.899</a>	Other chorioretinal inflammations, right eye - Other chorioretinal inflammations, unspecified eye
<a href="#">H30.90 - H30.93</a>	Unspecified chorioretinal inflammation, unspecified eye - Unspecified chorioretinal inflammation, bilateral
<a href="#">H35.60 - H35.63</a>	Retinal hemorrhage, unspecified eye - Retinal hemorrhage, bilateral
<a href="#">H35.711 - H35.739</a>	Central serous chorioretinopathy, right eye - Hemorrhagic detachment of retinal pigment epithelium, unspecified eye

ICD-10 Codes that DO NOT Support Medical Necessity N/A

ICD-10 Additional Information

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## General Information

Associated Information

**Documentation Requirements**

Medical record documentation maintained by the performing physician must indicate the medical necessity of the indocyanine - green angiography. Office records/progress notes must document the complaint, symptomatology, or reason necessitating the test and must include the examination results/findings.

Utilization Guidelines

Following the performance of indocyanine - green angiography, fluorescein angiography can be considered medically necessary and reimbursable when performed on the same eye, within a one month timeframe of the ICG. Both procedures (i.e., ICG, FA) may be allowed on the same day when additional diagnostic information is medically necessary.

Generally, only one ICG is medically necessary prior to and following a course of treatment. Services in excess of this standard of care must be reflected in the patients’ medical records to support the medical necessity of more frequent testing.

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  
FCSO reference LCD number - L29350

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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
01/01/2017	R1	Revision Number: 1 Publication: December 2016 Connection LCR B2017-001  Explanation of Revision: Annual 2017 HCPCS Update. LCD revised to change code descriptors for 92240. In addition, added CPT code 92242 to “CPT/HCPCS Codes” section of the LCD. The effective date of this revision is based on date of service.	<ul style="list-style-type: none"><li>Revisions Due To CPT/HCPCS Code Changes</li></ul>

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Associated Documents

Attachments N/A

Related Local Coverage Documents N/A

Related National Coverage Documents N/A

Public Version(s) Updated on 12/28/2016 with effective dates 01/01/2017 - N/A [Updated on 07/01/2014 with effective dates 10/01/2015 - N/A](#) [Updated on 03/23/2014 with effective dates 10/01/2015 - N/A](#) [Back to Top](#)

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## **Keywords**

N/A Read the [LCD Disclaimer](#) [Back to Top](#)