Billing and Coding Guidelines

Contractor Name
Wisconsin Physicians Service Insurance Corporation

Title
Ophthalmic Biometry OPHTH-006: Billing and Coding Guidelines

Original Effective Date
07/01/2006

Text
This document contains the coding guidelines for reporting ophthalmic biometry services and reasons for denial of these services. This article should be used in combination with the Ophthalmic Biometry OPHTH-006 LCD.

Coding Information

1. List the appropriate procedure code for the service performed, include any necessary modifiers.

2. List the appropriate ICD-9 code that best supports the medical necessity for the service. ICD-9 code(s) must be present on all Physicians Service claims and must be coded to the highest degree of accuracy and digit level completeness. (See OPHTH-006 Documentation Requirements)

3. Procedure codes 76510 and 76511 global, technical (TC) and professional (26) components are classified as unilateral codes; the Physicians Fee Schedule amount represents payment for one eye. When these procedures are performed on both eyes on the same DOS the services may be reported on a single claim line with a 50 modifier or on two separate claim lines with the RT and LT modifiers. When the procedure is performed on one eye per DOS report the service on a single claim line with the appropriate RT or LT modifier.
4. Procedure codes 76516 the global, technical (TC) and professional (26) components are classified as bilateral procedures where the bilateral adjustment does not apply, the Physicians Fee Schedule amount represents payment for both eyes. The procedure should be reported on a single claim line **without** the 50 or RT/LT modifiers. In the event that the procedure is performed on only one eye per DOS the procedure may be reported with a 52 modifier – (reduced service) and a reduced charge.

5. Procedure code 76519 and 92136 global and technical (TC) components are classified as bilateral procedures where the bilateral adjustment does not apply, the Physician Fee Schedule amount for a global procedure represents payment for the technical components (TC) for both eyes and one professional component (26). The technical component procedures (TC) represent payment for both eyes. These procedures should be reported on a single claim line **without** the 50 or RT/LT modifiers and if applicable one additional line for the opposite professional component (26).

   The professional component (26) is classified as a unilateral procedure; the Physicians Fee Schedule amount represents payment for one eye. When only the professional component (26) procedure is performed on both eyes on the same DOS the service may be reported on a single claim line with the 50 modifier or on two separate claim lines with the RT and LT modifiers. When the procedure is performed on one eye per DOS report the service on a single claim line with the RT or LT modifier.

6. When billing for optical coherence biometry on or after 01/01/2002 use procedure code 92136.

*7. When billing for services, requested by the beneficiary for denial, that are statutorily excluded by Medicare (i.e. screening), report a screening ICD-9 code **(V80.2)** and the GY modifier (items or services statutorily excluded or does not meet the definition of any Medicare benefit). A Notice of Exclusion from Medicare Benefits (NEMB) may be used with services excluded from Medicare benefits. See www.cms.gov/BNI

*8. When billing for services, requested by the beneficiary for denial, that would be considered **not** reasonable and necessary, report an ICD-9 code that best describes the patients condition and the GA modifier (waiver of liability on file) if an ABN signed by the beneficiary is on file or the GZ modifier (items or services expected to be denied as not reasonable) when a signed ABN for this service is not on file.

Coding Table Information
Procedure Codes
76510, 76511, 76516, 76519, 92136

Diagnosis Codes
NA

Other Information
Documentation Requirements
See Ophthalmic Biometry OPHTH-006

Denial Summary
The following situations will result in the denial of the initial A-scan service or in some cases as a result of a post payment review.

1. Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section excludes coverage and payment for items and services that are considered to be medically reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the function of a malformed body area.

   Claims submitted without an ICD-9 code to support medical necessity will be denied as not medically necessary

*2. Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical check-ups and eye examinations and services.

   Screening tests, in the absence of associated signs, symptoms, illness or injury will be denied as non-covered.

3. Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

   Physicians Service submitted without an ICD-9 code, or not coded to the greatest degree of accuracy and digit level completeness will be denied as unprocessable.

4. Ophthalmic Biometry services not meeting the medical criteria in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the OPHTH-006 policy will be denied as not medically necessary

Sources
CMS Pub.100-3 Ch.1 §10.1; CIM 35-44
CMS Pub.100-4 Ch.23 §10-10.1.7; MCM §15021-15021.1F

Notes
An asterisk (*) indicates a revision to that section of the article.

Other Versions

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06/01/2011: Annual review. Reformatted (two)

*02/01/2008, Annual review, added note section below, no changes to reimbursement (three); 07/01/2006, Annual review (two); 01/01/2005, New format, 2005 HCPCS, text review (one)

Notes: *Italicized font* - represents CMS national policy language/wording copied directly from CMS Manuals or CMS Transmittals. Carriers are prohibited from changing national policy language/wording. Providers, through their associations/societies, should contact CMS to request changes to national policy through the Medicare Coverage Policy Process at http://www.cms.gov/center/coverage.asp