Billing and Coding Guidelines

Title
Optical Coherence Tomography (OCT) OPHTH-015: Billing and Coding Guidelines

Effective Date
10/16/2009

AMA CPT/ ADA CDT Copyright Statement

Text
This document contains the coding guidelines for reporting corneal tomography services and reasons for denial of these services. This article should be use in combination with the Optical Coherence Tomography (OCT) OPHTH-015 LCD.

Coverage Topic
Diagnostic Tests, and X-Rays

Coding Information
1. Use CPT code(s) 92133 or 92134 to report OCT, include any necessary modifiers (e.g. 26, TC).

2. *CPT codes 92133 and 92134 are classified as unilateral or bilateral procedures.
   A. *Bill the test on a single line, place 00010 in Item 24G on the CMS 1500 claim form or its equivalent.
   B. *Per CPT guidelines, do not report 92133 and 92134 at the same patient encounter.

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3. List the ICD-9 code that best support the medical necessity for the OTC and describes the patient's condition. ICD-9 code(s) must be present on all Physicians' Service claims and must be coded to the highest level of accuracy and digit level completeness.

4. When billing for services, requested by the beneficiary for denial that are Medicare exclusions (i.e. screening) report a screening ICD-9 **(V80.2)** code and the GY modifier - item or service 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 http://www.cms.hhs.gov/BNI/01_overview.asp#TopOfPage

5. When billing services, requested by the beneficiary for denial, that would be considered not reasonable and necessary report an ICD-9 code that best described the patients condition and the GA modifier if an ABN signed by the beneficiary is on file or the GZ modifier - item or service expected to be denied as not medically necessary when a signed ABN for this service is not on file.

Denial Summary
The following situations will result in the denial of the initial diagnostic services or in some cases as a

result of a postpayment review

Title XVIII of the Social Security Act section 1862(a)(1)(A). This section excludes coverage and payment for items and services that are not considered reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the function of a malformed body member.

1. Services submitted without an ICD-9 code to support medical necessity will be denied as not medical necessity

2. Services billed at excessive frequency will be denied as not medically necessity.

3. Optic disc studies are not to be used as a screening tool for all patients. There must be documented indications from the patient's exam to justify the medical necessity for testing.

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

4. This service performed for screening purposes or in the absence of associated signs, symptoms, illness or injury will be denied as non-covered.

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.

5. Physicians' services submitted without an ICD-9 code or not coded to the highest level of accuracy and digit level completeness will be denied as unprocessable.

Other Versions

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09/01/2009

Effective Date/Number/Explanation
*03/01/2011: Section titled Coding Guidelines, Sentence B, CPT code 92134 inadvertently listed as 92135 (three).

*02/01/2011: Section titled Coding Guidelines, Revised sentence two (2) and deleted sentence three (3) for the purpose of providing correct billing indications for new 2011 CPT codes 92133 and 92134. Effective 01/01/2011 (two);

01/01/2011; Reformatted and deleted CPT code 92135 and added CPT codes 92133 and 92134 per CPT 2011 revisions (one).