

Billing and Coding Guidelines

Contractor Name

Wisconsin Physicians Service Insurance Corporation

Title

Billing and Coding Guidelines for Ophthalmic Biometry (OPHTH-006)

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Text

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

Excerpt from CMS Publication 100-03, Medicare National Coverage Determination Manual, Chapter 1, Part 1, Section 10.1

10.1 - Use of Visual Tests Prior to and General Anesthesia During Cataract Surgery Presurgery Evaluations

Cataract surgery with an intraocular lens (IOL) implant is a high volume Medicare procedure. Along with the surgery, a substantial number of preoperative tests are available to the surgeon. In most cases, a comprehensive eye examination (ocular history and ocular examination) and a single scan to determine the appropriate pseudophakic power of the IOL are sufficient. In most cases involving a simple cataract, a diagnostic ultrasound A-scan is used. For patients with a dense cataract, an ultrasound B-scan may be used.

Accordingly, where the only diagnosis is cataract(s), Medicare does not routinely cover testing other than one comprehensive eye examination (or a combination of a brief/intermediate examination not to exceed the charge of a comprehensive examination) and an A-scan or, if medically justified, a B-scan. Claims for additional tests are denied as not reasonable and necessary unless there is an additional diagnosis and the medical need for the additional tests is fully documented.

General Guidelines for claims submitted to Carriers or Intermediaries or Part A or Part B MAC:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-9-CM diagnoses code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

CPT Code 76516:

For procedure code 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.

CPT Codes 76519 and 92136:

Procedure codes 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.

Advance Beneficiary Notification (ABN) Modifier Guidelines:

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, revised 09/05/2008, for complete instructions.

Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ.

The –GA modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a specific service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary or Part A MAC, occurrence code 32 and the date of the ABN is required.

The –GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier.

For claims submitted to the carrier or Part B MAC:

All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim.

Claims for intraocular lens power calculation services are payable under Medicare Part B in the following places of service:

- The technical component is payable in the office (11); independent clinic (49); federally qualified health center (50); and rural health clinic (72) for CPT code 76519.
- the technical component is payable in the office (11); independent clinic (49); federally qualified health center (50); and rural health clinic (72) for CPT code 92136
- The professional component is payable in the office (11), inpatient hospital (21), outpatient hospital (22), ambulatory surgical center (24) and independent clinic (49) for 76519 and 92136.

The National Correct Coding Initiative (NCCI) may include edits for these CPT codes. Currently, NCCI edits for CPT codes 76519 and 92136 are as follows:

- Procedure code 76519 includes services performed for procedure 76516. Separate reimbursement will not be made for 76516 when billed with 76519;
- Payment for 76519 and 92136 for the same patient, same provider, and same day will not be made.

For claims submitted to the fiscal intermediary or Part A MAC:

Hospital Inpatient Claims:

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*

The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67

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. 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.
4. 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.

Other Information

Sources

CMS Pub.100-3 Ch.1 §10.1; CMS Pub.100-4 Ch.23 §10-10.1.7

Revision History Number/Explanation

06/01/2012 - This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.

Notes

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

Italicized font represents language quoted from Centers for Medicare and Medicaid Services (CMS)