

Billing and Coding Guidelines

Contractor Name

Wisconsin Physicians Service Insurance Corporation

Contractor Type

MAC – A

MAC - B

Title

Billing and Coding Guidelines for Optometrist Service (OPHTH-503)

Original Effective Date

01/16/2010

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04/01/2011

Text

This document contains the coding and billing guidelines for WPS Medicare LCD, Optometrist Services (OPHTH-503).

Coverage Topic

Diagnostic Tests and X-Rays; Eye Care-Following Cataract Surgery, Glaucoma Screening, Routine; Eyeglasses and Contact Lenses

Coding Information

1. List the appropriate ICD-9 code that best supports the medical necessity for the service performed. ICD-9code(s) must be present on all Physicians' Service claims and must be coded to the highest level of accuracy and digit level completeness.
2. List the appropriate CPT/HCPCS code that represents the service performed; include any necessary modifiers (e.g. 26, TC)
3. E&M services performed in an Assisted Living Facility or Adult Living Facilities (13) should be reported using CPT codes 99324-99328, 99334-99337.
4. Postoperative Care:
 - a. The date the surgical service was performed should be entered as the date of service on the claim.
 - b. Indicate the postoperative care by adding a 55 modifier to the surgery code.
 - c. Report the date the postoperative care was relinquished and assumed in item 19 of the CMS 1500 claim form, or in the HIPAA approved format equivalent field for electronic claims
5. When reporting CPT code 92499 or 99499 include a description of the service in item 19 of the CMS 1500 claim form or in the HIPAA approved format, equivalent field if filing electronically. When there is insufficient space in item 19 or the electronic equivalent for the full description of the unlisted service and/or there is additional information available for review for any service,

state "DOCUMENTATION AVAILABLE UPON REQUEST" in this field.

6. 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 and the GY modifier (items or services statutorily excluded or does not meet the definition of any Medicare benefit)
7. 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 there is no ABN for he service on file.
8. When applicable, a copy of the therapeutic/expanded licensure certification from the state should be filed with the WPS Provider Enrollment unit.
9. Procedure codes 65771, 92015, 92310, 92340-92342, 92370, 92390, 92391, are listed by Medicare with a status code "N". These services are non-covered by statute. Beneficiaries may be billed for these services. The beneficiary should be notified these services are non-covered and informed of the cost the physician will charge for the service. These services do not need to be billed to Medicare, unless the beneficiary requests they be billed for denial. In this situation the services should be billed in the routine manner and with a GY modifier.
10. Procedure codes 92352-92355, 92358, 92371, are listed by Medicare with a status code "B". These services are bundled in to the cost of preparing the lenses/glasses or physician's evaluation service. The beneficiary may **not** be billed for these services.
11. Procedure codes 92392, 92393, 92395, 92396, are listed by Medicare with a statue code "I". These services are not valid for Medicare. The beneficiary may **not** be billed for these services.
12. Glasses or contact lenses for aphakia should be billed, using the appropriate vision codes (V2020-V2799), to the DMERC.

Denial Summary

The following situations will result in the denial of the initially billed Optometrist Services or in some cases as a result of a postpayment 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 not 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 part.

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

2. Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and eyeglasses.

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

Medicare excludes from coverage certain visual services and products pertaining to the provision of glasses and contact lenses.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to physicians' services (and services incident to a physicians' service) performed in conjunction with an eye disease, or to post-surgical prosthetic lenses used during convalescence from cataract surgery or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease.

Expenses for all refractive procedures are excluded from Medicare coverage.

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' 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.

4. If the required therapeutic/expanded certification is not on file, performance of services requiring that certification by state law and rules would not be covered.
5. Services performance beyond the scope of practice of the provider, are not covered
6. Services excluded from Medicare coverage performed by an Optometrist are not covered, even though an optometrist is authorized by their State law to perform them.
7. Blepharoplasty of the lower lid (CPT codes 15820, 15821) is considered cosmetic and will be denied as non-covered.

Sources

CMS Pub. BP 100-2 15 §30.4; 100.2 16 §90; CMS Pub. CP 100-4 12 §30.6.6, 40.1A, 40.1D, 40.2; 100-4 13 §10; 100-4 23 §10-10.1.7

Notes

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

Other Versions

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04/01/2011

Effective Date/Number/Explanation

04/01/2011: Reformatted. Corrected CPT codes listed in sentence number three (3) under section titled Coding Information. No other changes to this attachment document for OPHTH-503