Billing and Coding Guidelines

Contractor Name
Wisconsin Physicians Service Insurance Corporation

Title
Billing and Coding Guidelines for Corneal Pachymetry

Original Effective Date
03/18/2010

AMA CPT/ ADA CDT Copyright Statement

Text
This document contains the coding guidelines and reasons for denial of Corneal Pachymetry services. This document should be used in combination with the Corneal Pachymetry OPHTH-025 LCD (L30485).

Coverage Topic
Diagnostic Tests and X-rays

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.

3. Procedure code 76514 is classified a bilateral procedure, 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 reduction to the physician's usual charge.

4. 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.

5. 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

Denial Summary
The following situation will result in the denial of initially billed CP services or in some cases as a result of a postpayment review

Corneal pachymetry will always be denied when it is used in clinical decision-making associated with refractive surgery. Refractive surgery is a statutorily excluded service [Social Security Act 1861(a) (7)-Cosmetic surgery

Title XVIII of the Social Security Act section 1862 (a) (1) (A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

1. Claims submitted without an ICD-9 code that support medical necessity would be denied as not medically necessary.

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

3. CP measurement performed on a routine basis prior to uncomplicated cataract surgery will be denied as not medically necessary

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

1. Screening tests, 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.

1. Physician's services submitted without an ICD-9 code, or not coded to the greatest degree of accuracy and digit level completeness will be denied as unprocessable.

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

Other Versions

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02/01/2010

Revision History/Number/Explanation
04/01/2011: Annual review. Formatting changes. No changes to coverage (one).