Billing and Coding Guidelines

Contractor Name
Wisconsin Physicians Service (WPS)

Contractor Number
00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302,
05402, 52280

Title
Billing and Coding Guidelines for Fluorescein or Indocyanine Green Angiography (OPHTH-016)

Effective Date
10/16/2010

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07/16/2012

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Article Text
This document contains the billing and coding guidelines for reporting angiography of the retina/choroid with fluorescein or indocyanine green services and reasons for denial of these services. This document should be use in combination with the Angiography-Retinal/Choroidal with Fluorescein or Indocyanine Green OPHTH-016 LCD (L30727).

Coding Guidelines

1. Report the appropriate CPT code for the study performed and include any appropriate modifiers (e.g. TC, 26, RT, LT)

2. List the ICD-9 code that best support the medical necessity for the study and describes the patient's condition. The ICD-9 should be coded to the greatest level of accuracy and digit level completeness.

3. Consult the Correct Coding list for services that are considered included in these services.

4. These services are considered unilateral, when performed on both eyes on the same date of service, report on 2 services lines with the RT and LT modifiers or on 1 service line with the 50 modifier. When performed on one eye report the appropriate CPT code with the appropriate RT or LT modifier.

5. When billing for services, requested by the beneficiary for denial, that are statutorily excluded by Medicare (i.e. screening), report a screening diagnosis **(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 http://www.cms.gov/bni/

6. 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 patient's condition and the GA modifier 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 the services is not on file.

Reasons for Denial
The following situations will result in the denial of the initial diagnostic services or in some cases as a result of a post payment review.
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 to support medical necessity will be denied as not medically necessary.

2. Excessive services and/or when both studies are found to be performed on a routine, customary and habitual basis for all patients 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

3. Screening tests, in the absences of associated signs, symptoms or complaints 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.

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

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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.