Billing and Coding Guidelines

Contractor Name
Wisconsin Physicians Service Insurance Corporation

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

Title
Billing and Coding Guidelines for Computerized Corneal Topography (OPHTH-014)

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07/16/2012

Text
This document contains the coding guidelines for reporting corneal topography services and reasons for denial of these services. The Billing and Coding Guidelines for Computerized Corneal Topography should be use in combination with the Computerized Corneal Topography OPHTH-014 LCD.

Billing/Coding Instructions

***Specific Coding Guidelines for This Policy:**
Do not report CPT code 92025 when computerized corneal topography is performed in conjunction with keratoplasty procedures described by CPT codes 65710, 65730, 65750, 65755, 65756, 65757 and 65770. Computerized corneal topography is considered to be integral to the postoperative management of these keratoplasty procedures. (AMA, CPT Changes 2007 – *An Insider's View).*

CPT codes 65760, 65765, 65767 and 65771 are status "N" on the Medicare Physician Fee Schedule. Corneal topography will be non-covered if performed pre – or post-operatively in relation to a Medicare non-covered procedure, i.e., radial keratotomy.

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

1. List the ICD-9 code that best support the medical necessity for the corneal topography 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.

2. 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.

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

4. Per the CMS Medicare Physicians Fee Schedule Data Base, there is a bilateral indicator for CPT code 92025 of "2". This means that this service may only be billed once per day. Do not use the -50 modifier or bill with the quantity of 2

5. Corneal topography performed pre-or post-operatively in relation to a Medicare non-covered procedure, e.g., radial keratomy, Lasik, prk, or clear lens extraction, will be denied as not medically necessary. Corneal topography performed pre-operative to cataracts surgery, when there is no documented evidence that the patient has irregular astigmatism, will be denied as not medically necessary

6. An eye examination may be reported on the same day as corneal topography if it is medically necessary. (Simple Keratometry is included in the eye examination.)

7. When corneal topography is performed prior to cataract surgery due to irregular corneal curvature, ICD-9-CM code 367.22 must be reported in addition to the cataract ICD-9-CM code

8. When corneal topography is performed for irregular astigmatism as a result of corneal disease or trauma ICD-9-CM code 367.22 must be reported in addition to the corneal disease/ trauma ICD-9-CM code

9. 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.

10. When billing for services, that would be expected to be denied as **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 and necessary) when a signed ABN for this service is not on file.

For claims submitted to the carrier 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 day.

- Claims for computerized corneal topography services are payable under Medicare Part B in the following places of service:

- For the global service - office (11), nursing facility (32 - for Medicare patient not in a Part A stay).

- For the technical component (modifier TC) - office (11), nursing facility (32 - for Medicare patient not in a Part A stay), federally qualified health center (50), and rural health clinic (72).

- For the professional component (modifier 26) - office (11), inpatient hospital (21), outpatient hospital (22), skilled nursing facility for patients in a part A stay (31), nursing facility (32 - for Medicare patient not in a Part A stay).

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.*

For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.

Denial Summary
The following situations will result in the denial of initially billed corneal topography 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 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. Corneal topography performed pre-or post-operatively in relation to a Medicare non-covered procedure, e.g., radial keratomy will be denied as not medically necessary. Corneal topography performed pre-operative to cataracts surgery when there is no documented evidence that the patient has irregular astigmatism will be denied as not medically necessary.

2. Corneal topography performed prior to Keratoplasty surgery, performed for refractive purposes only (this would include: Keratomileusis, Keratophakia for farsightedness and radial Keratotomy), will be denied as not medically necessary. Federal law prohibits payment for refractive keratoplasty. (CMS Pub.100-3 §80.7). Services performed in preparation for a non-covered service are also not covered. When corneal topography is being performed prior to a refractive Keratoplasty, the patient should be asked to sign a waiver of liability statement

Advances Beneficiary Notice (ABN). The beneficiary should also be informed of the performing physician charges prior to the performance of the service.
However, services performed after hospital discharge of these non-covered procedures that are necessary due to surgical complications, but unrelated to refraction, may be covered services. Individual consideration would be given in this circumstance and documentation must accompany the submitted claim.

3. Corneal Topography is a covered service only if the results will assist in defining further treatment. It is not covered for routine follow-up scans.

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

5. When billing for excessive services, such as reporting the scanning of one eye per date of service, is found to be performed on a routine, customary and habitual basis for all patients, these services 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. Services 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.

2.. 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.

3. The use of a 50 modifier, an RT and LT modifier (same DOS) or a quantity of "2" in the days/units field to indicate bilateral performance of this test is invalid for services on or after 01/01/2007 and will result in the denial of the services as unprocessable.

Sources
CMS Pub.100-3 §80.7.1
CMS Pub.100-4 Ch.23 §10-10.1.7

Other Versions

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11/01/2010

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.

07/01/2011: For the purpose of clarity, added section entitled Specific Coding Guidelines for This Policy. Removed incorrect information, statement number one (1), paragraphs a and b, found in the section For claims submitted to the carrier Part B MAC**,** instructions for use of Item 19 of the CMS 1500 form. Addition of revised instructions for the section entitled For claims submitted to the carrier Part B MAC Coding instructions for CPT codes 65710, 65730, 65750, 65755, 65756, 65757 and 65770 effective from DOS 12/16/2010 and thereafter (one).

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

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