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 Visual Fields (OPHTH-054)

Effective Date
04/15/2011

Coding Guidelines:

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 diagnosis 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.

Advance Beneficiary Notice of Noncoverage (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, for complete instructions.

Effective from April 1, 2010, non-covered services should be billed with modifier –GA, -GX, -GY, or –GZ, as appropriate.

CPT services 92081, 92082 and 92083 are considered bilateral. Use modifier RT or LT only when one eye is being examined.

Taped and untaped visual field testing is considered one unit of service for MUE (medically unlikely edits) purposes. MUEs are established by a separate CMS contractor, not WPS Medicare.

If the claim contains a separate charge for gross visual fields, it will be denied as an incidental service.

If the service is performed in a hospital inpatient or outpatient setting, the modifier -26 should be used to indicate the professional component.

V82.9 (Special screening tests for other conditions, unspecified conditions) should be used in the absence

of any signs or symptoms to indicate screening.

For claims submitted to the carrier or Part B MAC:

Claims for Visual Fields Testing services are payable under Medicare Part B in the following places of service:

The global services (technical plus professional) may be billed in the following places of service:

- Office (11), nursing facility (32) and independent clinic (49).

The technical component may be billed in the following places of service:

- Office (11), nursing facility (32), independent clinic (49), federally qualified health center (50) and rural health clinic (72).

The professional component may be billed at the following places of service:

- Office (11), inpatient hospital (21), outpatient hospital (22), emergency room (23), skilled nursing facility (31), nursing facility (32), independent clinic (49) and comprehensive outpatient rehabilitation facility (62).

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

<u>Hospital Inpatient Claims:</u>

- 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.)

<u>Hospital Outpatient Claims:</u>

- *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.

Revision History and Explanation

Italicized font – represents CMS national policy language/wording copied directly from CMS Manuals or CMS Transmittals. Contractors are prohibited from changing national policy language/wording. Providers, through their associations/societies, should contact CMS to request changes to national policy through the Medicare Coverage Policy Process at http://www.cms.hhs.gov/center/coverage.asp

An asterisk (*) indicates the most current revision.