

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 Low Vision Services (OPHTH-026)

Original Effective Date:

Revision Effective Date:

Text: This document is intended for use with the WPS Medicare LCD entitled Low Vision Services, LXXXXX, (OPHTH-026).

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.

Excerpt from CMS Publication 100-02, Chapter 15, § 60.1 –

Incident To Physician's Professional Services

Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.

Reasons for Non-Coverage

The provision of conventional refraction aids less than or equal to +3 diopters and the immediate instruction in their use are not covered under the Medicare program, unless related to aphakia or pseudophakia.

Testing included under General Ophthalmological Services may not be billed separately, in addition to evaluation and management services performed on the same date of service.

A patient, who has poor rehabilitative potential, is unable to cooperate in the program or where no goals are definable, will not be covered.

Maintenance, where a patient has reached a steady state in his or her rehabilitation and is seen at intervals to maintain that state, is not covered under the Medicare program.

Not all of those reporting a visual disability have a permanent or uncorrectable visual impairment. One purpose of the policy is to establish eligibility criteria for low vision services. A second goal is to define minimum documentation guidelines which will enable a reviewer to determine if goals are relevant to perceived needs of the patient. In addition the policy seeks bright-line determinants of when goals have been achieved or progress has reached a plateau, and treatment is maintenance, which is non-covered by Medicare begins.

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.

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

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.