Billing and Coding Guidelines

Contractor Name
Wisconsin Physicians Service Insurance Corporation

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Title
Billing and Coding Guidelines for Low Vision Services (OPHTH-026)

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CMS National Coverage
Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations.

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

Title XVIII of the Social Security Act, section 1862 (a) (20). This section explains outpatient occupational therapy services or outpatient physical therapy services furnished as an incident to a physician's professional services.

Code of Federal Regulations 20 ch 111 Pt. 404 Subpt. P, App1 categorization of impairment of special senses and speech.

Code of Federal Regulations 42 CFR § 410.59 (a) (3) (iii), Restriction of "incident to" therapy (PT and OT) services to be provided by qualified PTs and OTs.

CR 2083; PM AB-02-078 (May 29, 2002)

Text: This document is intended for use with the WPS Medicare LCD entitled Low Vision Services, L32007, (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.

Excerpt from CR 2083*,*
Medicare Coverage of Rehabilitation Services for Beneficiaries with Vision Impairment
Medicare beneficiaries who are blind or visually impaired are eligible for physician prescribed rehabilitation services from approved health care professionals on the same basis as beneficiaries with other medical conditions that result in reduced physical functioning.

Excerpt from CMS Publication 100-02, Chapter 15, §*230.5 - Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Non-Physician Practitioners (NPP)*
Incident to a Therapist. There is no coverage for services provided incident to the services of a therapist. Although PTAs and OTAs work under the supervision of a therapist and their services may be billed by the therapist, their services are covered under the benefit for therapy services and not by the benefit for services incident to a physician/NPP. The services furnished by PTAs and OTAs are not incident to the therapist's service

Evaluation and Management CPT Codes for Low Vision Service

Patients referred for a low vision evaluation (LVE) have already had an ophthalmic examination to evaluate *the disease*. The MD or OD performing the LVE evaluates the impairment, not the disease. Thus a low vision evaluation has very different content from an ophthalmic evaluation and ophthalmic codes do not reflect the content of a low vision evaluation. Evaluation and Management Codes (E & M codes) are appropriate for low vision evaluations (LVE), with levels of complexity reflected by the inclusion of specific elements unique to the service.

E & M CODES
New Patient:

Low Complexity, 30 min 99203
Moderate Complexity, 45 min 99204
High Complexity, 60 min 99205

Established Patient (includes any patient seen by any ophthalmologist in your group/dept):

Low Complexity, 15 min 99213

Moderate Complexity, 25 min 99214
High Complexity, 40 min 99215

Prolonged Service (>1.5 hrs) 99354 (56001)

Excerpt from CMS Publication 100-04, Chapter 5, § 20.2
Reporting of Service Units With HCPCS
Counting Minutes for Timed Codes in 15 Minute Units
When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed.
Time intervals for 1 through 8 units are as follows:
Units Number of Minutes
1 unit: = 8 minutes through 22 minutes
2 units: = 23 minutes through 37 minutes
3 units: = 38 minutes through 52 minutes
4 units: = 53 minutes through 67 minutes
5 units: = 68 minutes through 82 minutes
6 units: = 83 minutes through 97 minutes
7 units: = 98 minutes through 112 minutes
8 units: = 113 minutes through 127 minutes
The pattern remains the same for treatment times in excess of 2 hours.
If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes, that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes. See examples 2 and 3 below.
When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of timed units billed. See example 1 below.
If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes. See example 5 below.
The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.
If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.

Fundus Photography and Low Vision Service

Fundus Monitored Perimetry (FMP) is the state-of-the-art technology for precise macular mapping. The scanning laser ophthalmoscope and other FMP technology allows for visualizing of the macula in real time and simultaneously delineating scotomata (blind spots) and locating the fixation point (Preferred Retinal Locus or PRL: the substitute fixation point when the fovea is not functioning). This technology produces fundus photography (CPT 92250) with a precise central field superimposed on it and thus it is appropriately billed as a combination of fundus photography (92250) and visual field examination (92081-92083).

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.