NHIC
National Heritage Insurance Company

An EDS Company
A HCFA Contracted Medicare Carrier

Medicare Part B

Eye Services Billing Guide

This bulletin must be shared with all health care practitioners and managerial members of the provider/supplier staff. Additional no-cost copies are available on our web site at:
www.medicarenhic.com

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HCFA
Health Care Financing Administration

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Medicare Directory

Telephone Inquiries: (877) 591-1587

Please call Medicare Customer Service if you have any questions. Using a touch-tone phone and our Automated Response Unit (ARU), you have access to a wide range of Medicare information including:

- Claim Status
- Check write information
- Verification of your Electronic Media Claims (EMC) transmission
- Medicare updates or seminar information
- Duplicate Medicare Summary Notice (MSN)
- Publication requests

Customer service representatives are available Monday through Friday from 7:45 a.m. to 4:00 p.m. to answer questions concerning policy or guidelines or to request an appointment with an Education & Training Specialist. Our ARU offers extended hours of 6:00 a.m. to 10:00 p.m. Monday through Friday, and 6:00 a.m. to 6:00 p.m. on Saturday and Sunday.

Telephone Review: (877) 591-1587

You may call for a telephone review of claims where additional documentation is *not* required.

Website: http://www.medicarenhic.com Publications are available on our website.

Written Correspondence and Paper Claims

Assigned Claims	P.O. Box 2804 Chico, CA 95927-2804
All Other Claims	Medicare Claims Chico, CA 95976
Provider Enrollment Medicare Certification Unit	P.O. Box 602 Marysville, CA 95901-0602
Correspondence Medical Necessity Appeals	P.O. Box 2800 Chico, CA 95927-0001
Correspondence (All Other Appeals)	Medicare Claims Review Chico, CA 95976-0001

Walk-In Appointments:

Please note we do encourage you to schedule appointments. However, walk-ins can be accommodated between 8:00 a.m. and 4:30 p.m. at our Medicare offices located at 620 J St. Marysville, CA or 402 Otterson Drive Chico, CA 95928

Durable Medical Equipment (DME): (615) 251-8182

The DME Regional Carrier for California is CIGNA Medicare. Please contact them directly for information.

Introduction

A primary responsibility of Medicare is to provide high-quality, accessible, and cost-effective billing information to the Medicare community.

This billing guide is intended to serve as a useful supplement to other manuals published by National Heritage Insurance Company (NHIC), and not a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from Health Care Financing Administration (HCFA).

It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. National Heritage Insurance Company makes every effort to ensure the information contained in this guide is accurate and current. The edition date appears on each page. However, because the Medicare program is constantly changing, it is the responsibility of each provider or practitioner to keep abreast of the Medicare program requirements.

For more detailed information about the Medicare program, please refer to the *Medicare Part B Basic Billing Guide*, *October-November 2000* edition. For continuing updates to Medicare policies and billing guidelines, refer to the regularly published editions of the *Medicare B Resource*.

This information is also available to view or download at any time at our Web site, www.medicarenhic.com.

If you have any questions about foot care billing, contact the Physician/Supplier Help Line at (877) 591-1587. If you have suggestions about how this guide can be improved, write to:

Educational Outreach
Ophthalmology and Optometry
Billing Guide Comments
P. O. Box 272610
Chico, California 95927-2610

Basic Coverage Guidelines

Medicare covers only services and functions which physicians have been legally authorized to perform under Federal and State laws for the State in which they are performed. The performance of services and functions must be consistent with the physician's scope of practice.

Medicare covers items or services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.

By submitting a properly completed HCFA-1500 claim form or an electronically submitted claim form, the practitioner certifies that the services or items billed were provided and were medically reasonable and necessary for the diagnosis listed.

Ophthalmology Coverage

Medicare reimbursement will be made for services related to a disease or disorder of the eye. This includes:

- Physician services (and services incident to a physician's service) performed in conjunction with an eye disease (e.g., glaucoma or cataracts)
- Postsurgical prosthetic lenses used during convalescence from eye surgery where the lens of the eye was removed
- Permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. A prosthetic lens is a replacement for an internal body organ (i.e., the lens of the eye).

Services related to routine eye care for diagnoses, such as ametropia, anisometropia, astigmatism, emmetropia, hypertropia, myopia, and refractive error, are not covered. Eyeglasses or contact lenses and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors are not covered under the Medicare program.

Optometry Coverage

A doctor of optometry is considered a physician with respect to all services. The optometrist is authorized to perform under State law or regulation. The services must be medically reasonable and necessary for the diagnosis or treatment of illness or injury, and they must meet all applicable coverage requirements to be covered under Medicare. Optometrists can do the following:

- Perform case history, external examination, ophthalmoscopy, biomicroscopy, tonometry, visual fields, ocular motility, binocular function, and evaluation for contact lenses.
- Remove superficial foreign bodies from the eyelid and conjunctive.
- Use absorbable punctal plugs for diagnosis.
- Remove foreign bodies from the cornea.
- Treat peripheral corneal ulcers in emergency situations.
- Perform epilation of the eyelid by forceps only (procedure 67820)

If the optometrist is certified to use therapeutic pharmaceutical agents, he may perform the following procedures:

- Use all diagnostic drugs including mydriatics, cycloplegics, and anesthetics.
- Use agents for the reversal of mydriasis.
- Use topical meiotics for diagnostic purposes.
- Use topical lubricants.
- Use topical nonsteroidal antiallergy agents.
- Use topical antibiotic agents.
- Use the entire drug class of oral tetracyclines for treatment of blepharitis.
- Use oral and topical nonprescription drugs.
- Order laboratory tests, including smears, cultures, and sensitivities.
- Prescribe therapeutic contact lenses.

The above services are provided "incident to" the physicians' services. Payment for "incident to" services are included in the allowance for the visit or exam and will not be allowed separately.

The following codes are payable to an optometrist:

65205	76511	92002	92225
65220	76519	92004	92283
65222		92012-92014	92499
65430		92020	
67820		92060-92065	
67938		92081-92140	
68761		92213-92215	

Basic Covered and Noncovered Eye Services

Blepharoplasty/Pstosis Surgery

To be covered by Medicare, blepharoplasty and pstosis surgery must sufficiently document the medical reason and necessity for the procedures. Blepharoplasty and pstosis surgeries that are performed for cosmetic reasons are not covered by Medicare.

Documentation must be submitted with the Medicare claim and must include, at minimum, a demonstration of a visual field examination, and a full-head/face photograph and a close-up photograph. The patient's name and Medicare Health Insurance Claim (HIC) number must be printed on the back of both photographs.
See the complete Local Medical Review Policy in this manual.

Precataract Surgery Visual Tests

When the patient's only diagnosis is cataract, Medicare does not cover testing for more than one comprehensive eye examination (or a combination of a brief/intermediate examination not to exceed the charge of a comprehensive examination) and an A-scan or, if justified, a B-scan. Claims for additional tests are denied as not reasonable and necessary, unless there is an additional diagnosis, and the medical need for the additional tests is fully documented.

In most cases, a comprehensive eye examination, i.e., ocular history and ocular examination, along with a single scan to determine the appropriate pseudophakic power of the intraocular lens are sufficient. In cases involving a single cataract, a diagnostic ultrasound A-scan is used. For patients with a dense cataract, an ultrasound B-scan may be used.

A-Scans

The appropriate procedure for an A-mode scan performed to determine the intraocular lens (IOL) calculation prior to surgery is 76519, *Ophthalmic biometry by ultrasound echography, A-mode scan; with intraocular lens power calculation*.

The technical component of the A-mode scan (76519 TC) includes payment for both eyes, since the technical component is typically performed on both eyes at the same time. Therefore, do not report modifier 50 with the technical component. If the scan is performed on only one eye, report modifier 52 to indicate reduced services. The professional component of the A-mode scan (76519 26) includes payment for only one eye, since it is uncommon for an IOL implant to be required for both eyes at the same time. You should only use modifier 50 when the professional component is performed on both eyes at the same time.

If billing for the global procedure of an A-mode scan, it is not necessary to break down charges for the technical and professional components. Submit procedure code 76519 with one unit of service. Add modifier 52 if the technical component was performed on only one eye.

Providers performing the global procedure should only split the procedure into component parts when the professional component (76519 26) is performed on both eyes the same day. Should the patient put off cataract surgery, or the patient dies before surgery, an A-scan reported under HCPCS/*CPT* codes 76516 or 76519 is covered only if the claim documents the reason surgery was not performed.

Assistant at Cataract Surgery

Assistant at surgery for the following *CPT* procedure codes require the Peer Review Organization's prior approval: 66852, 66920, 66930, 66940, and 66986.

General Anesthesia During Cataract Surgery

The use of general anesthesia in cataract surgery may be considered reasonable and necessary if it is the accepted procedure among ophthalmologists in the local community to use general anesthesia for particular, medical indications.

Cataract Extraction (Phaco-Emulsification)

This technique is an accepted procedure for the removal of cataracts. Medicare payment may be made for medically necessary services provided in conjunction with cataract extraction using the phaco-emulsification procedure.

Corneal Tissue Services

Procurement for Keratoplasty Procedures

Acquirement of corneal tissue is not included in the fee schedule for keratoplasty procedures. In addition, the cost of processing, preserving, and moving corneal tissue is not included in the ambulatory surgery center (ASC) group 7 payment amount for HCPCS/*CPT* 65710, 65730, 65750, and 65755.

Therefore, corneal tissue acquisition costs, indicated with HCPCS code V2785, are payable separately to either the surgeon, or the ASC when one of the keratoplasty procedures noted above are performed in an ASC. Claims for V3896 must be billed to the Durable Medical Equipment Regional Carrier (DMERC), CIGNA.

Routine Corneal Tissue Testing

Payment for regular corneal tissue testing is included as part of the allowable tissue acquisition costs under HCPCS code V2785, billed to the DMERC, CIGNA. Separate charges for testing are not allowed.

Endothelial Cell Photography

Endothelial Cell Photography is used to determine the endothelial cell count. The cell count information helps determine the success of ocular surgery or other ocular procedures. Reimbursement of this procedure includes both eyes. Medicare covers endothelial cell photography (HCPCS/CPT codes 92286-92287) for patients who meet one or more of the following criteria:

- Have slit lamp evidence of endothelial dystrophy (cornea guttata)
- Have slit lamp evidence of corneal edema (unilateral or bilateral)
- Are about to undergo a secondary intraocular lens implantation
- Have had a previous intraocular surgery and now require cataract surgery
- Are about to undergo a surgical procedure associated with a higher risk to corneal endothelium; i.e., phaco-emulsification, or refractive surgery
- With evidence of posterior polymorphous dystrophy of the cornea or iridocorneal-endothelium syndrome
- Are about to be fitted with extended wear contact lenses after intraocular surgery

When a presurgical examination for cataract surgery is performed, and the conditions of this section are met, and if the only visual problem is cataracts, then endothelial cell photography is covered as part of the "presurgical comprehensive eye examination" or combination brief/intermediate examination provided prior to cataract surgery, and not in addition to it.

Fitting of Spectacles

Payment for the fitting, repair, and adjustment of prosthetic devices, including spectacles, is made as part of the payment for the prosthesis. Payment for these services is not allowed under the physician fee schedule. CPT codes 92358, 92371, and 92352-92355 have been given a "B" status code, indicating that these are bundled services.

Hydrophilic Contact Lens

Hydrophilic contact lenses are eyeglasses within the meaning of the exclusion in section 1862 a (7) of the law, and they are not covered when used in the treatment of the non-diseased eyes with spherical ametropia, refractive astigmatism, or corneal astigmatism. If prescribed for an aphakic patient, payment may be made under the prosthetic device benefit for hydrophilic contact lenses.

Intraocular Lens (IOL)

A pseudophakos, or intraocular lens, is an artificial lens which may be implanted to replace a human lens after cataract surgery. Intraocular lens implantation services, as well as the lens itself, may be covered if they are reasonable and necessary for the individual. Implantation services may include hospital, surgical, and other medical services, including pre-implantation ultrasound measurement (A-scan) of one or both eyes. The Food and Drug Administration (FDA) classifies IOLs into the following four categories, any of which may be covered:

- Anterior chamber angle-fixation lenses
- Iris fixation lenses
- Irido-capsular fixation lenses
- Posterior chamber lenses

Medicare does not cover IOLs currently in core study, or the modified core study investigation groups. FDA-Monitored Studies of Intraocular Lenses (IOLs)—Special coverage rules apply to situations in which an ophthalmologist is involved in a study monitored by the Food and Drug Administration (FDA) for the safety and efficacy of an investigational IOL. The investigation process for IOLs is unique in that there is a core period and an adjunct period. The core study is a traditional, well-controlled clinical investigation with full record keeping and reporting requirements. The adjunct study is essentially an extended distribution phase for lenses in which only limited safety data are compiled. Depending on the lens being evaluated, the adjunct study may be an extension of the core study, or it may be the only type of investigation to which the lens may be subject.

The FDA has taken the position that during the entire investigation period, including the core and adjunct periods, all eye care services related to the investigation of the IOL must be provided by the investigator. The implanting ophthalmologist or another practitioner (including a doctor of optometry) who provides services at the direction or under the supervision of the investigator and who has an agreement with the investigator that information on the patient is given to the investigator so that he or she may report on the patient to the IOL manufacturer.

Eye care services furnished by anyone other than the investigator (or a practitioner who assists the investigator, as described in the preceding paragraph) are not covered during the period the IOL is being investigated, unless the services are not related to the investigation. To assure that this policy is properly applied, inform all ophthalmologists in your service area that, when they are involved in an FDA-monitored study of an IOL, they must annotate their initial and subsequent claims for each beneficiary who is implanted with the investigational lens with the modifier "LS" to the procedure code. This is the HCFA Common Procedure Coding System (HCPCS) two-digit modifier for an FDA-monitored IOL implant. Include this modifier in your HCPCS system.

Instruct the ophthalmologist to provide the names of any other practitioners who will be assisting in the study, and inform the other practitioners to use the LS modifier on their claims. Investigate claims from any other practitioner for conformity with this instruction before making payment.

FDA is currently phasing out the adjunct period of the IOL investigation process. However, until such time as an IOL is approved for general marketing, it is considered investigational.
Medicare covers only IOLs fully approved for marketing by the FDA or those lenses awaiting FDA approval in the FDA adjunct study group.

Payment for IOLs Furnished in Ambulatory Surgical Centers (ASCs)

Effective for services furnished on or after March 12, 1990, payment for IOLs inserted during or subsequent to cataract surgery in a Medicare certified ASC is included with the payment for facility services that are rendered in connection with the covered surgery. Section 5243.3 explains payment procedures for ASC facility services and the IOL allowance.

Limitation on Coverage of Conventional Lenses

Make payment for no more than one pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery with insertion of an IOL.

Intraocular Photography

Intraocular photography is covered when used for the diagnosis of such conditions as macular degeneration, retinal neoplasms, choroid disturbances, and diabetic retinopathy. It may also be used to identify glaucoma, multiple sclerosis, and other central nervous system abnormalities.

Lacrimal Punctum

Lacrimal punctum "plug" surgery is payable per plug, i.e., silicon or collagen, at a maximum of two plugs per eye. Supply of the plugs is included in the allowance for this surgical procedure.

Punctum plug surgery is allowed at 100 percent of the fee schedule allowance for each plug. When reporting punctum surgery, report the number of plugs performed in the "days/units" field (block 24G) of your HCFA 1500 claim form.

According to global surgical definition, lacrimal punctum surgery includes suture removal within the postoperative period. Note: Suture removal is not generally considered appropriate until at least six months after surgery.

Laser Procedures

Medicare recognizes the use of lasers for medical indications. Procedures performed with lasers are sometimes used in place of more conventional techniques. In the absence of a specific non-coverage instruction where a laser has been approved for marketing by the FDA, carrier discretion may be used to determine whether a procedure performed with a laser is reasonable and necessary and therefore covered.

Mucous Membrane Tests

Ophthalmic mucous membrane tests (HCPCS/CPT 95060) are not covered.

Prosthetic Lenses

The term "internal body organ" includes the lens of an eye. Prostheses replacing the lens of an eye include post-surgical lenses customarily used during convalescence from eye surgery in which the lens of the eye was removed. In addition, permanent lenses are also covered when required by an individual lacking the organic lens of the eye because of surgical removal or congenital absence.
The following prosthetic lenses or combinations of prosthetic lenses are covered when they are found to be medically necessary and reasonable to restore the vision provided by the crystalline lens of the eye:

- Prosthetic bifocal lenses in frames
- Prosthetic lenses in frames for far vision or near vision
- Prosthetic contact lense(s) prescribed for far vision (including cases of binocular and monocular aphakia), includes payment for all contact or framed lenses which can be worn simultaneously, or when the far vision contacts are removed

Medicare can pay for supplies that are necessary for the effective use of a prosthetic device (e.g., the batteries needed to operate an artificial larynx). Adjustment of prosthetic devices required by wear or by a change in the patient's condition is covered when ordered by a physician. To the extent applicable, follow the provisions relating to the repair and replacement of durable medical equipment in §2100.4 for the repair and replacement of prosthetic devices. (See §2306.D in regard to payment for devices replaced under a warranty.) Regardless of the date that the original eye wear was furnished (i.e., whether before, on, or after January 1, 1991), do not pay for replacement of conventional eyeglasses or contact lenses covered under subsection B.3.

Necessary supplies, adjustments, repairs, and replacements are covered even when the device had been in use before the user enrolled in Part B of the program, so long as the device continues to be medically required.

Do not make payment for cataract sunglasses obtained in addition to the regular (untinted) prosthetic lenses, since the sunglasses duplicate the restoration of vision function performed by the regular prosthetic lenses.

Routine Services

Medicare does not cover these routine services: physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting or changing eyeglasses; eye refractions; hearing aids and examinations for hearing aids, and immunizations.

The routine physical checkup exclusion applies to (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies. (If the claim is for a diagnostic test or examination performed solely for the purpose of establishing a claim under title IV of Public Law 91-173 (Black Lung Benefits), advise the claimant to contact his or her Social Security office regarding the filing of a claim for reimbursement under that program.)

The exclusions apply to eyeglasses or contact lenses and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to physician services (and services incident to a physician's service) performed in conjunction with an eye disease (e.g., glaucoma or cataracts). The exclusions also do not apply to post-surgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, nor do they apply to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. Such prosthetic lens is a replacement for an internal body organ (the lens of the eye). (See _2130.)

The coverage of services rendered by an ophthalmologist is dependent on the purpose of the examination rather than the ultimate diagnosis of the patient's condition. When a beneficiary goes to an ophthalmologist with a complaint or symptoms of an eye disease or injury, the ophthalmologist's services (except for eye refractions) are covered, regardless of the fact that only eyeglasses were prescribed. However, when a beneficiary goes to his or her ophthalmologist for an eye examination with no specific complaint, the expenses for the examination are not covered, even if the doctor discovered a pathologic condition as a result of that examination.

In the absence of evidence to the contrary, you may carrier may assume that an eye examination performed by an ophthalmologist on the basis of a complaint by the beneficiary or symptoms of an eye disease was not for the purpose of prescribing, fitting, or changing eyeglasses.

Expenses for all refractive procedures, whether performed by an ophthalmologist (or any other physician) or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage. (See §§4125 and 5217 for claims review and reimbursement instructions concerning refractive services.)

With the exception of vaccinations for pneumococcal pneumonia, hepatitis B, and influenza, which are specifically covered under the law, vaccinations or inoculations are generally excluded as immunizations unless they are directly related to the treatment of an injury or direct exposure such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin, or immune globulin.

Scanning Laser Glaucoma Tests (SLGT)

Procedure	Description
92135	Scanning computerized ophthalmic diagnostic imaging (e.g. scanning laser) with interpretation and report, unilateral, a.k.a. Confocal laser scanning ophthalmoscopy (topography) or scanning laser polarimetry (nerve fiber analyzer)

Confocal laser scanning topography uses videographic digitized images to make quantitative topographic measurements of the optic nerve head and surrounding retina. Scanning laser polarimetry measures change in the linear polarization of light (retardation). It uses a polarimeter, an optical device, to measure linear polarization change and scanning laser ophthalmoscope together to measure the thickness of the nerve fiber layer of the retina.

Although these techniques are different, their objective is the same. It allows for early detection of glaucoma damage to the nerve fiber layer or optic nerve of the eye and to follow patients with glaucoma for signs of progression. Scanning laser glaucoma tests discriminate among patients with normal intraocular pressures who have glaucoma, patients with elevated intraocular pressure who have glaucoma, and patients with elevated intraocular pressure who do not have glaucoma.

Medicare covers scanning laser glaucoma tests (SLGTs) when medically necessary and reasonable to diagnose early glaucoma; monitor glaucoma treatment; and differentiate causes of other optic nerve disorders when a diagnosis is in doubt. Medicare will allow SLGT when visual field results are insufficient to properly diagnose and manage the patient's condition. Suggested guidelines for the use of scanning laser glaucoma tests follow.

- Once per year would be appropriate to follow **glaucoma suspect patients or those with "mild glaucomatous damage,"** characterized by any or all of the following:
  - Intraocular pressure >22mmHg as measured by applanation
  - Symmetric or vertically elongated cup enlargement, neural rim intact, cup to disc ratio >0.4
  - Focal optic disc notch
  - Optic disc hemorrhage or history of optic disc hemorrhage
  - Nasal step or small paracentral or arcuate scotoma
  - Mild constriction of visual field isopters

- Patients with **"moderate glaucomatous damage"** may be followed with medically necessary SLGT or visual fields. When SLGT is used, patients typically receive one test each per year. Moderate glaucomatous damage is characterized by any or all of the following:
  - Enlarged optic cup with neural rim remaining but sloped or pale, cup to disc ratio >0.5, but <0.9
  - Definite focal notch with thinning of the neural rim
  - Definite glaucomatous visual field defect, e.g., arcuate or paracentral scotoma, nasal step, pencil wedge, or constriction of isopters

- In **"advanced glaucomatous damage,"** when the nerve fiber layer has been extensively damaged, visual fields will likely detect changes and would be preferred over SLGT. SLGT would **rarely** be beneficial and is not indicated unless reasonable and necessary visual field testing cannot be reliably performed. Advanced glaucomatous damage is characterized by any or all of the following:
  - Severe generalized constriction of isopters (i.e., Goldmann 14e <10 degrees of fixation)
  - Absolute visual field defects within 10 degrees of fixation
  - Severe generalized reduction of retinal sensitivity
  - Loss of central visual acuity, with temporal island remaining
  - Diffuse enlargement of optic nerve cup, with cup to disc ratio >0.8
  - Wipe-out of all or a portion of the neural retinal rim

The primary diagnosis for SLGT listed on the claim form must support that the service is reasonable and necessary for the diagnosis or treatment of illness or injury. The diagnosis must be present for the procedure to be paid. Documentation must show that the service was reasonable and medically necessary for that diagnosis. Medical records need not be submitted with the claim; however, they must be furnished to Medicare upon request.

If a scanning laser glaucoma test is performed, it will affect the medical necessity for other services used to evaluate glaucoma. You must describe and document the medical necessity for procedures such as fundus photography or extended ophthalmoscopy clearly and legibly in the patient's record.

SLGT is not medically necessary for those patients who do not meet the criteria above; however it may be performed for screening purposes. SLGT, performed as screening, is not a benefit of the Medicare program (not covered). Use one of the following *ICD-9-CM* codes for the line item diagnosis if you need to submit a Medicare claim in order to receive a denial as a non-covered service:

ICD-9-CM	**Description**
V70.0	Routine general medical examination at a health care facility
V80.1	Special screening for neurological, eye, and ear diseases; glaucoma
V80.2	Special screening for neurological, eye, and ear diseases; other eye conditions

Scleral Shell

The term scleral shell, or shield, includes different types of hard, scleral contact lenses. A scleral shell fits over the entire exposed surface of the eye, as opposed to a corneal contact lens, which covers only the central, non-white area surrounding the pupil and iris. If an eye has been rendered sightless and shrunken by inflammatory disease, a scleral shell may prevent the need for surgical enucleation and prosthetic implant, as well as support the surrounding orbital tissue. In such a case, the device basically serves as an artificial eye. In this instance, payment may be made for a scleral shell under §1861 s (8) of the law.

Scleral shells are occasionally used in combination with artificial tears in the treatment of dry eye of diverse etiology. The scleral contact lens acts as a protective barrier against the drying action of the atmosphere and substitutes partially for the functioning of the diseased lacrimal gland. In this case, the scleral shell would be covered as a prosthetic device in the rare case it is used in the treatment of dry eye.

Sunglasses

Non-corrective sunglasses neither diagnose or treat an illness or injury, nor do they replace a missing or nonfunctioning body part. Items such as non-corrective sunglasses that do not contribute meaningfully to the diagnosis or treatment of an illness, or injury, or the functioning or replacement of a malformed or missing body member are not covered. Physicians and suppliers should note that this is direct, statutory exclusion; it is not a "medical necessity" denial.

Payment can be made for prosthetic lenses (lenses which replace the lens of an eye for an aphakic patient) which have ultraviolet absorbing or reflecting properties, in lieu of payment for untinted prosthetic lenses. Payment cannot be made for prosthetic lens "sunglasses" in addition to untinted prothetic lenses, as sunglasses duplicate the restoration of vision performed by regular prosthetic lenses.

Vitrectomy

Both simple and complex vitrectomy is covered for:

- Vitreous loss incident to cataract surgery
- Vitreous opacities due to vitreous hemorrhage or other causes
- Retinal detachments secondary to vitreous strands
- Proliferative retinopathy and vitreous refraction

Note: Posterior vitrectomy (HCPCS/*CPT* code 67005 is included with cataract surgical procedure.

Ocular Photodynamic Therapy

AMA CPT 2001 includes a revised code 67220 and a new code 67221. HCFA has created four new HCPCS codes, G0184, G0185, G0186, and G0187.

CPT 67220 *Destruction of localized lesion of choroid (eg. choroidal neovascularization); photocogulation (eg. laser), one or more sessions* may have been used to report retinal services performed by occular photodynamic therapy (OPT), transpupillary thermotherapy (TTT), feeder vessel technique (FVT), and destruction of macular drusen by photocoagulation (DMDP). Effective with the date of publication of the March 2001 Medicare B Resource article, NHIC no longer accepts 67220 or 67299 for TTT, FVT, or DMDP. [67220 has not been accepted for OPT since July 1, 2000.] Instead, report these services with the more specific CPT or HCPCS code listed below. A "session" is defined as the primary service and any additional services supplied within the global period. The global period for 67220 is 90 days.

CPT CODE 67221 *Destruction of localized lesion of choroid (eg. choroidal neovascularization); photocogulation (eg. laser), one or more sessions, photodynamic therapy (includes intravenous infusion)* (A.K.A. occular photodynamic therapy —OPT) may be billed and is covered. The required dye for this service, Visudyne, J3490 (*unclassified drugs*) [C1203 *injection, Visudyne (verteporfin)* for outpatient PPS] may be separately billed and is paid in addition to the laser service. An IV infusion service, CPT code 90780: *IV infusion*

for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour is included in 67221 and, if separately billed for this service will be denied as bundled into 67221. The global period for 67221 service is the day of service. No longer report 67299 for OPT. The 90 days minimum period between OPT services for the same eye remains unchanged.

G0184 *Destruction of localized lesion of choroid (for example, neovascularization); occular photodynamic therapy (includes intravenous infusion), other eye.* G0184 may be billed and is covered for the second eye for OPT when done at the same time as a subsequent OPT treatment of the first eye. Only a single dose of Visudyne is covered for both eyes done at the same setting. Do not report G0184 or 67299 for a second subsequent session of the same eye: report 67221. An IV infusion service (90780*: IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour)* is included in G0184 and, if separately billed for this service will be denied as bundled into G0184. The global period for G0184 is the day of service.

G0185 *Destruction of localized lesion of choroid (for example, choroidal neovasculaization); transpupillary thermotherapy (one or more sessions).* G0185 is a HCPCS code created for 2001. This code was created to recognize that the work value of the service may be different from that reported under CPT code 67220. The presence of the code is not an indication the service is covered. At this time, NHIC does not cover this service because it is experimental. Patients may not be billed for this service unless an advanced beneficiary notice (ABN) is properly completed in advance of the service. Neither 67220 nor 67299 may be reported for this service.

G0186 *Destruction of localized lesion of choroid (for example, choroidal neovascularization); photocoagulation, feeder vessel technique, (one or more sessions).* At this time, NHIC does not cover this service because it is experimental. Patients may not be billed for this service unless an advanced beneficiary notice (ABN) is properly completed in advance of the service. Neither 67220 nor 67299 may be reported for this service.

G0187 ***Destruction of macular drusen, photocoagulation (one or more sessions).*** G0187 is not covered and will be denied because it is experimental and/or not medically necessary. The benefit of treating drusen for prevention of visual loss associated with age-related macular degeneration has not been established. Patients may not be billed for this service unless an advanced beneficiary notice (ABN) is properly completed in advance of the service. Neither 67220 nor 67299 may be reported for this service.

Patients may obtain coverage for some of these services that remain experimental by Medicare by enrolling in qualified clinical trials. For information about Medicare coverage of the support services of qualified clinical trails, see Medicare Resource, January 2001. NHIC will reconsider these non-coverage decisions upon receipt of sufficient scientific articles that support coverage and review with specialty consultants though the Carrier Advisory Committee process.

Treatment of Trichiasis

Triciasis is the condition in which inversion of eyelashes rub on the cornea, causing a continual irritation. Epilation, electrolysis, or a surgical procedure in which the underlying entropion is corrected may treat this complication. The following CPT codes are appropriate to use when extraction of the lashes is the treatment of choice.

67820	Correction of trichiasis; epilation, by forceps only.
67825	Correction of trichiasis; epilation by other than forceps (e.g., by electrosurgery, cryo therapy, laser surgery).

Please note, these codes are intended to be billed per eye. Do not use the above codes to bill per eyelid or per eyelash.

Medicare Medical Necessity Defined

Medicare will only cover items and services which are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

To be considered medically necessary, items and services must have been established as safe and effective. The items and services must be:

- Consistent with the symptoms or diagnosis of the illness or injury under treatment
- Necessary and consistent with generally accepted professional medical standards (in other words, not still experimental or investigational)
- Not furnished primarily for the convenience of the patient, the attending physician, or other physician or supplier
- Furnished at the most appropriate level which can be provided safely and effectively to the patient

Submission of a properly completed HCFA-1500 claim form, or an electronically submitted claim, indicates that the physician or supplier certifies that the services or items billed were provided and were medically reasonable and necessary. As recipients of federal funds, Part 424 of Title 42, Code of Federal Regulations (CFR) requires that the health care provider furnish Medicare carriers "sufficient information to determine whether payment is due and the amount of payment."

When test results and a physician or practitioner's services are described in a clear, accurate, and legible manner, we can validate the following Medicare requirements:

- The billed services have been rendered
- The services were appropriate for the patient's condition
- The services meet reasonable standards for medical care

Complete records contain all pertinent and essential information related to the patient's medical status. Each entry must be able to "stand alone." In other words, it must support the fact that the level of service billed was rendered. When the level of service reported on a claim is not reasonable and necessary (in other words, when it is determined that a less expensive level of service would have met the patient's medical need, or when a less expensive level of service was actually furnished), reimbursement must be based on the reasonable charge for the less expensive level of service. Remember, any overpayment that results from a misbilled code, on an assigned claim, can be recouped from the physician or supplier.

The *CPT* and *ICD-9-CM* codes reported on the health insurance claim form or the electronically submitted form should be supported by the documentation in the medical record. To determine appropriate codes to use to report medical services rendered to Medicare beneficiaries, physicians should refer to their current *CPT* and HCPCS coding manuals.

The person documenting the medical records should always be identifiable, and the documentation should be authenticated and dated. In some instances, especially during inpatient hospitalization, a sample of the physician's signature may be requested. This is to help ensure that the requested physician or supplier's records are correctly distinguished. Using non-standardized medical abbreviations is not acceptable.

Please note that the primary purpose of medical documentation is to ensure that patient treatment is recorded for quality of care and continuity of treatment. Reimbursement and legal issues are secondary. From a reimbursement standpoint, documentation should substantiate the level of service billed.

Experimental and Investigational Items and Services

Federal Medicare law specifically excludes from coverage items and services which are not medically reasonable and necessary for the diagnosis or treatment of illness or injury. If a treatment or procedure is neither specifically covered, nor excluded, in Medicare law or guidelines, carriers must make a coverage determination. This determination is based upon the treatment or procedure's general acceptance by the professional medical community as an effective and proven treatment for the condition for which it is being used. Medicare will make payment only when a service is accepted as effective and proven.

Evaluation and Management Services

Determining the appropriate level of services is important for any Evaluation and Management (E&M) service. Providers are reminded to review the Documentation Guidelines for Evaluation and Management Services in Medicare Bulletin 97-6 for requirements on coding the proper level of service. These guidelines are the criteria used to review medical records for E&M services billed to the Medicare program.

Documentation contained in the medical record must support the level of service billed to Medicare in all cases. Medicare will downcode and/or recoup payment for any paid service when the medical record is reviewed, and the documentation does not support the service that was billed.

New Patient Visits and Consultations

A new patient visit may be billed if the patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

Consultations are defined as referrals to a specialist who is being asked to render an opinion only. A report of the opinion is generally sent to the referring physician. Consultations may be billed when the patient's care has not been transferred.

The Global Surgical Fee

The "global surgical fee" includes all necessary services performed by the physician the day before (for major surgeries), the day of (for major and minor surgeries), during, and after a surgical procedure. Medicare payment for a given surgical procedure includes applicable preoperative, intraoperative, complications, and postoperative care.

Procedure codes with 90 follow-up days are considered major surgeries. Procedure codes with zero or ten follow-up days are considered minor surgeries. Please call the Physician/Supplier Help line at (877) 591-1587, if you are uncertain whether a surgical procedure has zero, ten, or 90 follow-up days.
There are seven components that are included in the global surgical fee:

1. Preoperative visits: Preoperative visits are defined as services provided the day before a major surgery and the day of the surgery for minor surgeries. (MCM Section 4821)
2. Intraoperative services: Services that are normally a usual and necessary part of a surgical procedure.
3. Complications following surgery: All additional medical or surgical services required of the surgeon because of complications, which do not require a return trip to the operating room. (The definition of operating room is a place of service specifically equipped and staffed for the sole purpose of performing procedures. It does not include a patient's room, a minor treatment room, a recovery room or an intensive care unit.)
4. Postoperative visits: Follow-up visits within the global period of surgery.
5. Postsurgical pain management - by the surgeon.
6. Supplies.
7. Miscellaneous services: Items such as dressing changes; local incisional care; removal of cutaneous sutures, staples, exposed K wires, tubes, drains, intraoperative casts, and splints.

The global period for major surgeries includes the day immediately before the day of surgery, the day of surgery, and the 90-day postoperative period beginning the day after surgery. Services furnished prior to surgery or after surgery on the same day are considered part of the preoperative or postoperative periods, respectively. Separate bills should not generally be submitted for these services since the surgical payment includes these services.

Services Not Included

1. The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Use the proper procedure code followed by **modifier 57**.
2. The services of **other physicians**, except where the surgeon and the other physician(s) agree on the transfer of care such as when different physicians in a group practice participate in the care of the patient.
3. Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications from the surgery.
4. Postoperative complications that require a **return trip** to the operating room. An operating room, for this purpose, is defined in Medicare regulations as:

   > A place of service specifically equipped and staffed for the sole purpose of performing surgical procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit unless the patient's condition was so critical there would be insufficient time for transportation to an operating room.
5. Treatment for an underlying condition or an added course of treatment that is not part of the normal recovery from surgery.
6. Diagnostic tests and procedures, including diagnostic radiological procedures.
7. Clearly distinctive surgical procedures during the postoperative period that are not repeat operations or treatment of complications. (In this case, follow the CPT code with modifier 79. A new postoperative period

begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made at the time of the first procedure. If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately. [See "Staged or Extensive Related Procedure (Modifier 58)"]

8. When a less extensive procedure fails, and a more extensive procedure is required. The second procedure is payable separately;
9. Limited supplies for certain services in a physician's office (e.g., routine surgical tray). Also casting supplies, splints, and surgical dressings. See Appendix C for a list of procedures that allow for a separate surgical tray charge.
10. Immunosuppressive therapy for organ transplants (use modifier 24 for any visits).
11. Critical care services (procedure codes 99291 and 99292) unrelated to the surgery (e.g., a seriously injured or burned patient is critically ill and requires constant attendance by the physician). (Use modifier 24 or 25 as appropriate)
12. Limited supplies for certain services in a physician's office (e.g., routine surgical tray). Also casting supplies, splints, and surgical dressings. See Appendix C for a list of procedures that allow for a separate surgical tray charge.
13. Immunosuppressive therapy for organ transplants (use modifier 24 for any visits).
14. Critical care services (procedure codes 99291 and 99292) unrelated to the surgery (e.g., a seriously injured or burned patient is critically ill and requires constant attendance by the physician). (Use modifier 24 or 25 as appropriate)

Modifiers Affecting Payment within Global Period

Modifiers 24, 25, and 57 (for E&M Codes Only)

Modifier 24: Unrelated Evaluation and Management Service by the Same Physician During a Post-operative Period

An E&M service coded with modifier 24 indicates a visit in the postoperative period that is unrelated to the original procedure (surgery). This modifier is only to be coded with an E&M visit; it is not valid when coded with surgeries or other types of services. It is not necessary, or appropriate, for modifier 24 to be coded with tests done in the postoperative period.

In most cases, diagnosis codes that apply to the E&M service or eye examination are different from the diagnosis codes that were indicated on the original procedure. However, in rare circumstances, the diagnoses are the same, but the services are unrelated; if so, document this information with the claim, either in the narrative field of electronic claims or on an 8 1/2" x11" attachment for paper claims

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When coding modifier 24, ensure that the patient's records clearly indicate that the E&M visit is unrelated to the original procedure.

Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service

An E&M examination coded with modifier 25 indicates a visit on the same day that is a significant, separately identifiable service above and beyond an original condition, procedure, or service. This modifier is only to be coded with E&M examinations; it is not valid when coded with surgeries or other types of services.

In most cases, diagnosis codes that apply to the E&M examination are different from the diagnosis codes that were indicated on the original procedure service. However, in rare circumstances, the diagnoses are the same, but the services are unrelated; if so, document this information with the claim, either in the narrative field of electronic claims, or on an 8 1/2" x 11" attachment for paper claims.

MCM section 4821 states: "Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with a head trauma. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status."

MCM section 4822 states: "The physician may need to indicate that on the day of a procedure or service that is identified with a CPT code was performed, the patients condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier 25 to the appropriate level of service."

Modifier 57: Decision for Major Surgery

An E&M examination coded with modifier 57 indicates a visit that resulted in the initial decision to perform the major surgery. Surgeries that have a 90-day follow-up period are considered major surgeries. When coding modifier 57, ensure that the patient's records clearly indicate when the initial decision to perform the surgery was made.
Note: An E&M examination that resulted in an initial decision to perform a minor surgery is not separately payable.

Modifiers 24, 25, and 57 Billing Scenarios

Scenario #1: Major surgery and related E&M examination same day, decision for surgery previously made.

Coding instructions: E&M examination is not separately payable. Do not code modifier 24, 25, or 57 on the E&M examination.

Scenario #2: Major surgery and related E&M examination same day, initial decision for surgery made that day.

Coding instructions: E&M examination with decision for surgery visit is payable on the same day as a major surgery. Code modifier 57 with the E&M examination. Document when the initial decision for surgery was made in the patient's records.

Scenario #3: Minor surgery and related E&M examination, regardless of when initial decision for surgery was made.

Coding instructions: An E&M examination is not separately payable when performed on the same day as a minor surgery, regardless of when the decision for the surgery was made. Do not code modifier 24, 25, or 57 on the E&M examination.

Scenario #4: Major or minor surgery and unrelated, separately identifiable E&M examination on the same day

Coding instructions: An E&M examination on same day as a major or minor surgery is payable when it is clearly unrelated to the surgery. Code modifier 25 with the E&M examination. Document this fully in the patient's medical records.

Modifiers 58, 78 and 79 (Used with Surgical Codes Only)

Modifier 58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

Can be used when a second surgery is done in the postoperative period of another surgery when the subsequent procedure:

- Was planned prospectively (or "staged") at the time of the original procedure; or
- Was more extensive than the original procedure; or
- Was for therapy following a diagnostic surgical procedure.

The full global surgical allowance is made for both surgical procedures.

Modifier 78: Return to the Operating Room for a Related Procedure During the Postoperative Period

Used for a return trip to the operating room for a related surgical procedure during the postoperative period of a previous major surgery. The allowance will be reduced, since postoperative care is included in the allowance for the prior surgical procedure. Modifier 78 is not to be confused with modifier 58 (see above). Call the Physician/ Supplier Help line at (877) 591-1587 for payment reduction amount.

Modifier 79: Unrelated Procedure or Service by the Same Physician During the Postoperative Period

Used for unrelated procedures by the same physician (or physician of the same specialty in the same surgical group) during the postoperative period. Documentation, such as a different ICD-9-CM diagnosis code, will usually be sufficient.

Note: The use of RT and LT modifiers is helpful, but either one should be used in addition to modifier 79, not in place of it.

Modifiers 50 and 51

Modifier 50: Bilateral Procedures

Bilateral surgeries are procedures performed on both sides of the body during the same operative session. Medicare considers bilateral procedures as one payment amount equal to 150 percent (or in some cases 200 percent) of the Medicare Fee Schedule allowance.

Note: CPT procedures identified with the terms "bilateral" or "unilateral or bilateral" should not be billed with modifier 50; modifier 50 will not result in an increased payment for these procedures.

For surgeries:

- Bill the appropriate five-digit procedure code describing the procedure that is being billed bilaterally and add modifier 50. Payment will usually be at 150 percent of the total allowance for the procedure had it been performed unilaterally.

For foot X-rays, which can be performed either unilaterally or bilaterally, a physician can either:

- Bill the procedure code with the modifier 50 and enter "010" in the days/units field (or electronic equivalent) OR;
- Bill the procedure code without modifier 50 and enter "020" in the days/units field (or electronic equivalent).
- Payment for either of the above options will be 200 percent of the normal fee schedule.

Modifier 51: Multiple Procedures

When the same provider performs on the same day or at the same session multiple procedures other than E&M services, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by adding the modifier 51 to the additional procedure or service code(s).

Surgeries are ranked in descending order by the Medicare Fee Schedule amount. Payment is based on the lower of the billed amount, OR:

- 100 percent of the fee schedule amount for the highest value procedure; and
- 50 percent of the fee schedule amount for the second through the fifth procedures.
- If more than five procedures are billed, we will suspend the sixth and subsequent procedures for manual review, and payment will be made, if appropriate, on a "by report" basis.

Note for non-assigned claims: To avoid exceeding your Limiting Charge, reduce your billed amount for second and subsequent procedures accordingly.

Caution: If you accidentally use the 51 modifier on the primary procedure and reduce your billed amount unnecessarily, incorrect payment may result as Medicare will pay the lower of the billed amount or the allowed amount. Be careful to list the highest value procedure as the primary procedure.

"Multiple Bilateral Procedures"

Rank the surgeries in descending order (by Medicare allowed amount, adjusting for bilateral payment first), and then apply the multiple surgery reductions.

Transfer of Care - Ophthalmologists and Optometrist

Ordinarily, the global surgery fee schedule allowance includes preoperative evaluation and management services rendered the of or the day before surgery, the surgical procedure, and postoperative care services within a defined period. Postoperative care may be rendered by either an ophthalmologist or an optometrist. Where physicians agree on the transfer of care during the global period, the appropriate *CPT* modifiers must be added to the surgical procedure code:

Modifier	Description
52	Reduced services
54	Surgical care only
55	Postoperative management only

The claim for the surgical care only and the claim for postoperative care only, must contain the same date of service and the same surgical procedure code with the services distinguished by the appropriate modifier. Modifier 52 must be reported in addition to modifier 55 when more than one physician assumes responsibility for postoperative care.

Example:
Dr. Jones performs procedure code 66983 on March 1 and cares for the patient through April 29. Dr. Smith assumes responsibility for the patient on April 30 for the remainder of the global period.

Dr. Jones' claim will show:		Dr. Smith's claim will indicate:	
03/01/96	66983 54	03/01/96	66983 55 52
03/01/96	66983 55 52		

Box 19: 03/01/99 to 04/29/99 04/30/99 to 05/29/99
For claims where physicians share postoperative care, the assumed or relinquished dates of care must be indicated in block 19 of the HCFA-1500 claim form or on the electronic claim field equivalent. Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary's medical record.

When a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he or she has provided at least one service. Once the physician has seen the patient, that physician may bill for the period beginning with the date on which he or she assumes care of the patient.

When more than one physician bills for the postoperative care, the postoperative percentage is apportioned based on the number of days each physician was responsible for the patient's care. Based on the example above, reimbursement for the postoperative care is apportioned as follows:

- The percentage of the total RVUs for postoperative care for 66983 is 20 percent, and the length of the global period is 90 days.
- Dr. Jones provided care for the first 60 days. Reimbursement is 13.3 percent of the total fee schedule amount (66.7 percent of 20 percent).
- Dr. Smith is reimbursed 6.7 percent of the total fee schedule amount (33.3 percent of 20 percent).

Note: If an unrelated procedure is performed by the same physician during a postoperative period, the procedure should be reported with modifier 79 – an unrelated procedure by the same physician during a postoperative period. A new global period begins. In transfer of care situations, modifiers 52, 54, and 55 must be reported, as appropriate and as necessary, in addition to modifier 79.

ICD-9-CM Diagnostic Codes

For Medicare purposes, Health Care Financing Administration approves one single diagnostic coding system, the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). This coding system can be used for any setting in which medical services are rendered. The use of diagnostic coding is required for all Medicare claims submitted by physicians. The ICD-9-CM books are updated each year, effective October 1, with a grace period until January 1. Changes to the codes must be made by this date, or the service will be rejected.

To obtain the official version of the ICD-9-CM, Volumes 1 and 2, contact:

US Government Printing Office
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

ICD-9-CM coding books are also available from other publishing companies and technical book stores.

ICD-9-CM Volumes 1 & 2

The coding of a medical condition requires the use of Volume 1 - Tabular List and Volume 2 - Alphabetic Index. The index lists each main term and follows it with a code number. An ICD-9-CM diagnostic code is valid when it accurately reflects the highest degree of specificity within a range of codes.

Selecting a Code

Coding is a three-step process:

1. Review the medical record and identify terms included in the diagnostic statement.
2. Look up the disease, signs, symptoms and/or conditions in Volume 2, Diseases Alphabetic Index, and locate the corresponding code.

Example:

Upper respiratory - *see* condition

Go to ➡
Infection, infected, infective
respiratory 519.8
upper (acute) (infectious) NEC 465.9
mul.tiple sites NEC 465.8

3. Look up the corresponding code in Volume 1, Diseases and Tabular List, and choose the most specific code that accurately describes the patient's condition.

Example:

465 Acute upper respiratory infections of multiple or unspecified sites
Excludes: upper respiratory infection due to:
influenza (487.1)
Streptococcus (034.0)
465.0 Acute laryngopharyngitis
465.8 Other multiple sites
Multiple URI
465.9 Unspecified site
Acute URI NOS
Upper respiratory infection (acute)

:

Coding To The Highest Level of Specificity

Codes are to be used at their highest level of specificity.

Review the ICD-9-CM coding book carefully when making your determination of the highest level of specificity. There are various ways of listing the codes which can make choosing the highest level a challenge.

A. Assign a three-digit code only if there are no fourth or fifth digit codes within that code category. There are less than 100 valid three digit ICD-9 CM diagnostic codes. All other codes must contain a fourth or fifth digit to be coded to the highest level of specificity.

Examples of valid three digit codes:

193 Malignant neoplasm of thyroid gland
311 Depressive disorder, not elsewhere classified
585 Chronic renal failure

B. Assign a fourth-digit code only if there are no fifth-digit subclassification codes within that code category.

Examples of four digit codes:

280 Iron deficiency anemias
- **280.0 Secondary to blood loss (chronic)**
- **280.1 Secondary to inadequate dietary iron intake**
- **280.8 Other specified iron deficiency anemias**
- **280.9 Iron deficiency anemia, unspecified**

C. Assign a fifth-digit when the coding calls for it. **Do not add a fifth digit unless a code is specifically indicated as having one.** The fifth digit classifications can be listed in a number of ways:

Example 1:

088 Other arthropod-borne diseases
- **088.0 Bartone Ilosis**
- **088.8 Other specified arthropod-borne disease**
  - **088.81 Lyme Disease**
  - **088.82 Babesiosis**
  - **088.89 Other**

In the above example, 088.0 is a valid four-digit code. However, 088.8 is invalid since there is a higher level of specificity.

Example 2:

250 Diabetes Mellitus

The following fifth-digit subclassification is for use with category 250:

- **0 type II (non-insulin dependent type)...**
- **1 type I (insulin dependent type)...**
- **2 type II (non-insulin dependent type)...uncontrolled**
- **3 type I (insulin dependent type)...uncontrolled**

- ● **250.0 Diabetes mellitus without mention of complications**
- ● **250.1 Diabetes with ketoacidosis**
- ● **250.2 Diabetes with hyperosmolarity**
- ● **250.3 Diabetes with other coma**
- ● **250.4 Diabetes with renal manifestations**
- ● **250.5 Diabetes with ophthalmic manifestations**

In the above example, a fifth digit (0 to 3) must be added to the four digit code to make it the highest level of specificity. The circled "5" (●) indicates the need for the 5th digit.

Example 3A:

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE (710-739)

The following fifth-digit subclassification is for use with categories 711-712, 715-716, 718-719, and 730:

- 0 site unspecified
- 1 shoulder region
- 2 upper arm
- 3 forearm
- 4 hand
- 5 pelvic region and thigh
- 6 lower leg
- 7 ankle and foot
- 8 other specified sites
- 9 multiple sites

Be careful in coding claims with broad ranges, such as above. Even within the ranges indicated, there may be some fifth digit codes which are not valid within that range. The valid codes are generally indicated under the subclassification (the fourth digit code).

Example 3B:

718.0 Articular cartilage disorder
[0-5, 7-9]

In this example, the fifth digit "6" for lower leg is ***not*** valid.

Failure to include the highest degree of specificity will result in rejected claims, delayed payment or denials. Rejected claims must be rebilled with the corrections made. They are not subject to the Appeal process.

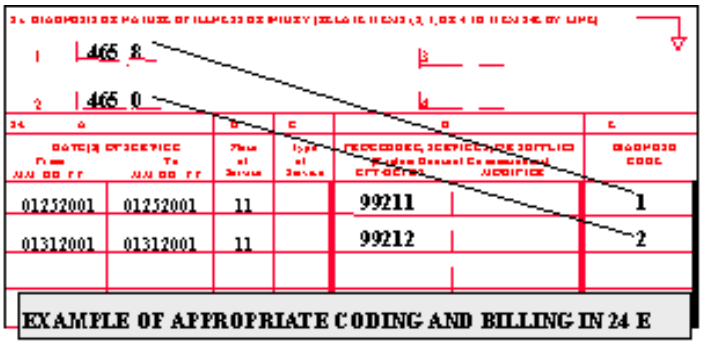
Coding Requirements

The physician can assist the staff by documenting diagnoses and symptoms in more detail. When preparing claims for submission, use a maximum of four valid ICD-9-CM diagnosis codes. Code to the highest level of specificity and code consistent with the age and sex of the beneficiary. Only reference one diagnosis indicator per line of service (see item 24E).

Line 1 - procedure code 99211 is only reference to Block 21 #1 ICD-9-CM code.

Line 2 - procedure code 99212 is only reference to Block 21 #2 ICD-9-CM code.

Note : **Only one diagnosis indicator per line item of service is referenced.**



Correct Coding Initiative

Background

The goal of the Correct Coding Initiative is to identify and eliminate the incorrect coding of services. The new coding combinations identified by AdminaStar Federal were implemented January 1, 1996 by Medicare Part B carriers. Quarterly updates have been made since then, effective the first of each quarter.

To administer these changes the Medicare carrier has installed "edits" into the automated claims processing system. These edits primarily focus on comparing the Current Procedural Terminology (CPT) codes for those situations where outdated codes are being used; the CPT definitions may have been misunderstood or misinterpreted; mutually exclusive procedures have been coded together; or simply mistakes have been made in coding.

Coding Based On Standards of Medical/Surgical Practice

In order for this system to be effective, it is necessary that the procedure code accurately describe what actually transpired during the patient encounter. Because many physician activities are so integral to a procedure, it is impractical and unnecessary to list every event, common to all procedures of a similar nature, as part of the narrative description for a code. Many of these common activities are assumed to be ***included*** as acceptable medical/surgical practice, and while they could be performed separately, they should not be considered as such when a code description includes those activities. Accordingly, all services integral to accomplishing a procedure are bundled into that procedure.

In the case of individual services, there are numerous specific services or items that may typically be involved in order to accomplish a comprehensive procedure. Generally, performance of these services represents the standard of practice for a more comprehensive procedure and the services are therefore bundled together.

Principles of General Coding

The principle of the policy to include all necessary services into the comprehensive procedure is the same as those that apply to the list of generic services listed above. Specifically, these principles include:

- The service represents the standard of care in accomplishing the overall procedure.
- The service is necessary to successfully accomplish the comprehensive procedure; failure to perform the service may compromise the success of the procedure.
- The service does not represent a separately identifiable procedure unrelated to the comprehensive procedure planned.

Medical/Surgical Review

As a result of the variety of surgical, diagnostic and therapeutic nonsurgical procedures commonly performed in medical practice, the extent of the CPT manual has grown.

The need of precise definitions for the various combinations of services is necessary for providers to use correct CPT coding for billing to third party payers.

In general, most services have pre-procedure and post-procedure work associated with them when performed at a single patient encounter. The pre-procedure and post-procedure work is relatively fixed regardless of the number of services actually performed at that session. Additionally, the nature of the pre-procedure and post-procedure work is reasonably consistent across the spectrum of procedures.

In keeping with the policy that the work typically associated with a standard surgical or medical service is included in the CPT manual code description of the service, these general guidelines were developed:

- When the physician performing the primary service provides anesthesia, the anesthesia services are included in the primary procedure (***HCFA Global Surgery Policy).*** If it is medically necessary for a separate provider (anesthesiologist/anesthetist) to provide the anesthesia services (e.g. monitored anesthesia care*),* **a separate service may be billed.**
- When, in the course of a procedure, samples of blood are obtained for analysis (e.g. electrolyte determination, blood gas determination), **a separate service for sample procurement cannot be billed.** The laboratory service for the determination represents a significant, separately identifiable service and **may be separately billed**.
- When an excision and removal is performed ("-ectomy" code), the approach generally involves incision and opening of the organ ("-otomy" code.) The incision and opening of the organ or lesion ***cannot*** be separately billed when the primary service is the removal of the organ or lesion.

CPT Procedure Code Definition

The format of the CPT manual includes descriptions of procedures that are not listed in their entirety for all procedures. The partial description is indented under the main entry, and includes what a semicolon on the main entry always precedes. The main entry then encompasses the portion of the description preceding the semicolon, which applies to and is a part of all indented entries, which follow with their codes.

Example:

70120	Radiologic examination, mastoids; **less than three views per side**
70130	complete, minimum of three views per side

The common portion of the description is "radiologic examination, mastoids" and this description is considered a part of both codes. The distinguishing part of each of these codes is that which follows the semicolon.

In addition, a code description may define a correct coding relationship where one code is a part of another based on the language used in the descriptor. Some examples of this type of correct coding by code definition are:

1. ***"Partial" and "complete" CPT codes are billed***. The partial procedure is bundled into the ***complete*** procedure.
2. "***Partial" and "total" CPT codes are billed.*** The partial procedure is bundled into the ***total*** procedure.
3. "***Unilateral" and "bilateral" CPT codes are billed***. The unilateral procedure is bundled into the bilateral procedure.
4. ***"Single" and "multiple" CPT codes are billed***. The single procedure is bundled into the ***multiple*** procedure.

Coding Services Supplemental To A Principal Procedure (Add-On Codes)

The CPT coding system identifies certain codes which are to be submitted in addition to other codes. Generally, these are identified with the statement "***list separately in addition to code for primary procedure***." The basis for these CPT codes is to enable providers to separately identify a service that is performed in certain situations as an additional service.

Incidental services that are necessary to accomplish the primary procedure (e.g. lysis of adhesions in the course of an open cholecystectomy) are not separately billed.

Supplemental codes frequently specify codes or ranges of codes with which they are to be used. It would be inappropriate to use these with codes other than those specified. When CPT codes are not identified as supplemental codes, they are not to be billed. Those supplemental codes that are part of a more comprehensive procedure but do not describe a separately identifiable service are not appropriate.

CPT Coding Manual Instruction/Guidelines

Each of the six major sections of the CPT manual and several of the major subsections include guidelines. These directions are not all inclusive of, nor limited to, definitions of terms, modifiers, unlisted procedures or services, or written reports, details about reporting separate, multiple or starred procedures and qualifying circumstances. These instructions appear in various places and are found at the beginning of each major section, at the beginning of subsections, and before or after a series of codes or individual codes.

Separate Procedures

The narrative for many CPT codes includes a statement that the procedure represents a "separate procedure." The inclusion of this statement indicates that the procedure, while it can be performed separately, is generally included in a more comprehensive procedure and the service is not to be billed when a related, more comprehensive, service is performed.

Most Extensive Procedures

When procedures are performed together that are basically the same or performed on the same site but are qualified by an increased level of complexity, the less extensive procedure is bundled into the more extensive procedure. In the following situations, the procedure viewed as the most complex would be billed:

1. ***"Simple" and "complex" CPT codes billed;*** the simple procedure is bundled into the ***complex*** procedure.
2. ***"Limited" and "complete" CPT codes billed***; the limited procedure is bundled into the ***complete*** procedure.
3. ***"Superficial" and "deep" CPT codes billed***; the superficial procedure is bundled into the ***deep*** procedure.
4. ***"External" and "internal" CPT codes billed***; the external procedure is bundled into the ***internal*** procedure.

Not Otherwise Classified (NOC) Codes

The codes listed after each section and/or subsection which end in "99" (or a single "9" in a few cases) are used to report a service that is not described in any code listed elsewhere in the CPT manual. Because of advances in technology or physician expertise with new procedures, a code may not be assigned to a procedure when the procedure is first introduced as accepted treatment.

Every effort should be made to find the appropriate code to describe a service and frequent use of the NOC codes is not appropriate. Accurate assignment of the codes to these procedures would occur after the documentation has been reviewed (whenever codes ending in "99" are used, additional documentation must be submitted). The NOC codes are not included in the CCI policy because of the multiple procedures that can be assigned to these codes.

Mutually Exclusive Procedures

There are numerous procedure codes that cannot be billed together because they are mutually exclusive of each other. Mutually exclusive codes are those codes that cannot reasonably be done in the same session.

Example:

13100	Repair, complex trunk; 1.1 cm to 2.5 cm
13101	2.6 cm to 7.5 cm

If multiple wounds of the trunk are repaired in the same repair classification, coding is based on the sum of the length of the repairs. The complex repair cannot be measured and billed in the range of 1.1 centimeters to 2.5 centimeters **and** 2.6 centimeters to 7.5 centimeters. The **total** length of the repair would determine the proper code assignment.

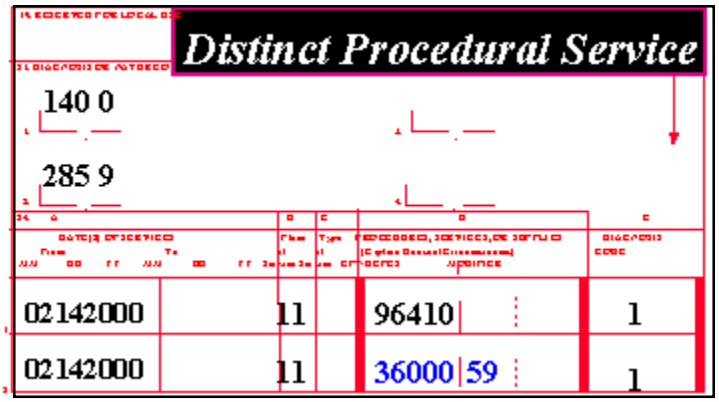
Modifiers

In order to expand information provided by CPT codes, a number of modifiers have been created by the American Medical Association (AMA) and HCFA. Modifiers give physicians a mechanism by which they may indicate that a service or procedure has been altered by some circumstance, but is still described in the code definition. Like CPT codes, it is essential to understand the specific meaning of the modifier before using it. A modifier (-59) has been created expressly for the purpose of identifying those services that would otherwise be bundled. However, the following modifiers will also exclude procedures from bundling and should be considered for use before using modifier -59:

E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
LT	Procedure on left side of body
RT	Procedure on right side of body
25	Separate & identifiable services
59	Distinct procedural service
78	Return to operating room
79	Unrelated procedure

Modifier -59 applies to those procedures that are included in the Correct Coding Initiative (CCI) listing and should only be used for those services that qualify for separate reimbursement.

***-59* Distinct procedural service:**



Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier -59. Only if no more descriptive modifier is available, and the use of modifier -59 best explains the circumstances, should modifier -59 be used.

Note: The CCI listing consists of two sections, bundled edits (CCI) and mutually exclusive edits (MEX). Both sections identify a column II code which may not be reimbursed on the same day as the code listed in column I, *unless the column II code qualifies under the exception rules.*

Column I	***Column II***
96410	*36000*
96410	*36410*
96410	*90780*
96410	*90781*
96410	*99185*

If the column II code qualifies as an exception, *and no more descriptive modifier is available (i.e., LT, RT, etc.),* both codes may be reported. The column II code must be submitted in conjunction with modifier -59. *The modifier is always used on the code that would otherwise be "bundled".*

Certain code combinations will always be subjected to CCI editing regardless of the modifier billed. These combinations are generally those for which other Medicare policy already applies, such as radiation therapy, multiple E/M codes per day, and anesthesia guidelines.

Post-payment auditing of these modifiers will be performed periodically to determine the appropriateness of their usage.

Correct Coding Policy Manual

To order the National Correct Coding Policy Manual used by Part B Medicare Carriers, please call National Technical Information Services (NTIS) sales desk:

- ***To receive ordering information by mail,*** *call* (800)553-6847.
- ***To order subscription service, call*** (703) 605-6060 or (800) 363-2068 for ordering options.
- ***To order a single copy***, call (703) 605-6000.
- ***Ordering and product information*** is also available via World Wide Web at **www.ntis.gov/cci.**

The entire CCI manual can be ordered in paper or CD-ROM version. You also have the option of requesting individual chapters or the full manual (updated quarterly). Below are the available individual chapters:

CHAPTER	DESCRIPTION	ORDER #
2	Anesthesia Services (00000-09999)	SUB-9902 INQ
3	Surgery: Integumentary System (10000-19999)	SUB-9903 INQ
4	Musculoskeletal System (20000-29999)	SUB-9904 INQ
5	Surgery: Respiratory, Cardiovascular, Hemic, Lymphatic System (30000-39999)	SUB-9905 INQ
6	Surgery: Digestive System (40000-49999)	SUB-9906 INQ
7	Surgery: Urinary, Male & Female Genital, Maternity Care, and Delivery System (50000-59999)	SUB-9907 INQ
8	Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, Auditory System (60000-69999)	SUB-9908 INQ
9	Radiology Services (70000-79999)	SUB-9909 INQ
10	Pathology & Laboratory Services (80000-89999)	SUB-9910 INQ
11	Medicine, Evaluation and Management Services (90000-99999)	SUB-9911 INQ

Problems or disagreements with code combinations should be submitted in writing to AdminaStar Federal. The most effective means of obtaining changes is to work through your national medical associations. They may submit comments with substantiating information to:

The Correct Coding Initiative
AdminaStar Federal
P.O. Box 50469
Indianapolis, IN 46250-0469

Documentation of Services

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high-quality care.

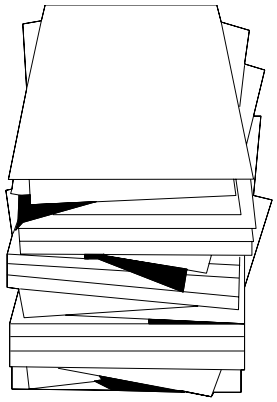
An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care supplied, if necessary.

The following documentation guidelines were developed jointly by the American Medical Association (AMA) and the Health Care Financing Administration (HCFA).

What Does Medicare Want?

Medicare requires documentation that services billed are consistent with the services provided. Medicare may request information to validate:

- the site of service
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services supplied, and/or
- that services supplied have been accurately reported



General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E&M) services, the nature and amount of physician work and documentation varies by type of service, place of service, and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E&M services.

- The medical record should be complete and legible and include the patient name and date of each service
- The documentation of each patient encounter should include:
  - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test result
  - Assessment, clinical impression or diagnosis
  - Plan for care
  - Legible identity of the provider of service
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
- Past and present diagnoses should be accessible to the treating and/or consulting physician
- Appropriate health risk factors should be identified.
- The patient's progress, response to treatment, changes in treatment, and revision of diagnosis should be documented.
- The *CPT* and *ICD-9-CM* codes reported on the HCFA-1500 claim form or electronically submitted claim form should be supported by the documentation in the medical record.

A Few Words About Fraud and Abuse

NHIC will continue to review individual podiatrists, podiatric services, and patterns of care using a variety of innovative methods including data analysis from multiple sources, chart review, random audits, facility queries, patient reports, national, regional, and local historical data, and clinical severity profiling. These efforts will be coordinated with the help of podiatric consultants and medical doctors specializing in foot care and complications of systemic disease. NHIC will continue to cross-check these codes with records from the attending physician and continue a detailed focused review of all incongruent files.

Routine foot care requested by nursing homes for beneficiaries is a routine grooming service, and therefore, it may not be billed as an additional service to Part B Medicare.
The information submitted with a claim must be substantiated by information found in the patient's medical record. For example, the medical record of the attending medical doctor should contain the specific significant systemic condition listed on the claim used to substantiate payment for routine foot care. Any information used for documentation purposes is subject to carrier verification to ensure that the information adequately justifies the coverage for foot care services.

False documentation of a systemic condition to justify payment for noncovered foot care services is abusive and may be fraudulent. Foot care services disguised as another type of service to justify payment for noncovered routine foot care is fraudulent. Payment for such services will be recovered and may be referred to law enforcement for further action.

Limitation of Liability

"Limitation of Liability" is a term used by Medicare in accordance with the provisions of Section 1879 of the Social Security Act. In most cases, as a physician or supplier you may collect charges from patients for services that are completely denied as not covered by Medicare (general program exclusions). An exception applies, however, when the item or service is found to be "not medically reasonable and necessary" according to the Social Security Act (SSA), Section 1862(a)(1), and the patient was not given advance notice of the likelihood of Medicare's denial. If payment is denied on the grounds that the service was unnecessary, the Medicare patient's liability is limited, and he or she is protected from having to pay for the service, because he or she could not have been expected to know at the time that Medicare would not pay.

Whenever you provide a Medicare patient with services that you know or believe Medicare will determine to be medically unnecessary, and thus will not pay for, you are required to notify the patient in writing before performing the service about the reasons you expect Medicare's denial. If such written notice is not given, and your patient did not know that Medicare would not pay, your patient cannot be held liable to pay. However, if your patient did sign a clear, written agreement (see requirements that follow) to pay for the service anyway, your patient will be held liable for payment. Your patient will also be held liable if he or she received a denial in the past for the same or similar service.

The requirement to advise the patient applies both to services which you render, and services which you order or refer, such as laboratory tests and other diagnostic tests done at a remote site.
If Medicare denies a service as unnecessary under SSA Section 1862 (a)(1), you will not be held liable if it can be demonstrated that you, the provider of care, did not know that Medicare would deny the service. According to the Health Care Financing Administration, "A physician/supplier is considered to have knowledge that payment will not be made under Medicare for items or services in a particular claim where the following evidence is established regarding the physician/supplier.

- General notice to the medical community regarding exclusion of certain items or services; for example, colon irrigation, acupuncture.
- General notice to the medical community that services exceeding certain frequencies would be denied or subject to additional review; for example, vitamin Bl2 injections, or nursing home visits more frequent than once a month.
- Written notice to the particular physician or supplier that a type of service or item would be excluded in all or certain circumstances."

Therefore, if prior to the commencement of this service, it is published in a Medicare bulletin that coverage is excluded or restricted in some circumstances, yet, remains a benefit under the Medicare program for other conditions, we will assume that you knew that Medicare would deny the service and you will be held liable. However, if you find that you are not liable, and we determine that the patient is not liable either, then Medicare will make a payment on the claim after making this determination. However, this payment will serve as notice to both you and your patient that future services of this type will be the responsibility of the patient and they will be held liable for payment.

The purpose of the advance notice allows your patient to decide whether or not to receive the service and to agree to pay for the full billed amount personally if Medicare denies the service. Since your patient must be fully informed of his or her options, as well as the need to understand the circumstances of the denial, you must give the patient the reason(s) for the belief that Medicare is likely to deny payment.

The reason(s) given must be specific to the service(s) under consideration; a routine notice or a notice which does no more than state that denial is possible is not acceptable.

Here are some examples of acceptable statements of reasons that Medicare is likely to deny payment:

- Medicare does not usually pay for this many visits or treatments.
- Medicare usually pays for only one nursing home visit per month.
- Medicare does not usually pay for this service because it is a treatment that is yet to be proven effective.
- Medicare does not pay for this office visit unless it was needed because of an emergency.
- Medicare usually does not pay for like services by more than one doctor during the same time period.
- Medicare usually does not pay for this many services within this period of time.
- Medicare usually does not pay for more than one visit per day.
- Medicare usually does not pay for such an extensive procedure.
- Medicare does not pay for like services by more than one doctor of the same specialty.
- Medicare usually does not pay for this equipment.
- Medicare usually does not pay for this lab test.

Statements such as "I never know if Medicare will deny payment" and similar generalizations are not acceptable for advance notice purposes.

Following is an example of language which will satisfy the advance notice requirements.

Physician or Supplier Notice to Beneficiary

Medicare will only pay for services that it determines to be "reasonable and necessary" under SSA Section 1862(a)(1). If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for (specify particular service[s]) for the following reasons: (give reason[s] for your belief).
IN ADDITION TO THE WRITTEN NOTICE, THE AGREEMENT TO PAY IS AN INTEGRAL PART OF THE ADVANCE NOTICE AND IS REQUIRED BEFORE THE PHYSICIAN/SUPPLIER MAY COLLECT PAYMENT.

Beneficiary Agreement
I have been notified by my physician that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed_____
(Beneficiary's Signature) (Date Signed)

You may use the above wording as a guide for your own forms used in your office. Once the patient has been informed of his or her options, understands the reason for the denial, and has signed the agreement, you will need to keep a copy of the notice on file. We recommend you provide a copy for your patient as well.

Note: If an appeal is made to a service which Medicare denies as unnecessary, we will first review the facts in the case. If the claim or service should have been paid, we will make payment at that time. If not, we will proceed to see if either party is liable. The one who files the appeal may present additional evidence or reasons why he or she believes Medicare should have paid for this claim or service. However, any such appeal must be made within six months of the date the claim or service was denied.

Requesting an Appeal

Any clear expression in writing by a party to an initial determination, which indicates, in effect, that he/she is dissatisfied with such determination by the carrier and wants to appeal the matter further constitutes a request for review.

To ensure a complete review of all items and services with which you are concerned, written appeals should include:

- A cover letter explaining precisely which item(s) need to be reviewed, why you feel the item(s) in question were incorrectly processed, and the action(s) you want us to take in satisfying your concern(s). It will help to have the cover letter include your provider number, provider name and beneficiary Health Insurance Claim Number
- An identification of the claim(s) in question, inclusion of copies of Medicare Remittance notices with the affected claim(s) highlighted is best.
- Any documents you feel are necessary to our review, for example, an operative report, and which have not already been submitted with the claim(s)

Medical Necessity Appeals

Send appeals on issues of medical reasonableness and necessity to:

Medical Necessity Appeals
P.O. Box 2800
Chico, CA 95927-2800

Appeals on Other Issues

Appeals on all other issues should be sent to:

Medicare Beneficiary Services
Chico, CA 95976

When an appeal determination does not reverse the original determination, we will mail an answer to the claimant. If an assignee initiated the request for review, a copy of the determination will not be sent to the beneficiary unless waiver of liability is at issue. If we make additional payment to the assignee, we send an informational copy of the adjustment EOMB to the beneficiary. If the appeal determination reverses the initial determination, we do not send a written determination; a Medicare Remittance Notice is sent instead. If the reversal results in a payment, a check is included with the Remittance Notice.

Our review determination letters also describe the right to request a hearing if the claimant is not satisfied with the review determination and the amount in controversy is $100 or more. A review determination is the final determination unless a hearing is requested or the determination is revised in accord with Medicare guidelines.

Telephone Appeals

Physicians and most suppliers may request claim review by telephone for certain conditions (see below). Telephone review is available to all physicians, and all types of suppliers except physical therapy, Chiropractors and ambulance services. To request a review via telephone, call the Help Line at (877) 591-1587 and have the following information ready:

- Your business name, and carrier-issued nine-digit provider identification number (PIN).
- The information necessary to identify the claim(s) you want to appeal.
- The information you believe is necessary for us to correctly process the claim(s).

Note: To ensure equitable use of telephone resources, no more than two beneficiaries services may be appealed during a single telephone call.

For a claim to be eligible for a telephone review, the missing information must be of a kind that can be supplied over the telephone. When the missing information is of a kind that must be furnished in writing for example, test results, invoices, operative reports, etc. The appeal must be made in writing. Appeals that can be handled on the phone are:

- Dates of service.
- Diagnosis (when either the beneficiary or the health care provider has the correct code).
- Information missing on the original claim that is now provided, such as place of service, rendering provider.
- Correction of the procedure code.
- Reissue of staledated or voided checks that are still on current history.
- Claims from nonparticipating providers that were erroneously denied as nonassigned by the system.
- Assigned claims that incorrectly denied as a duplicate of a denied nonassigned claim.
- Claims that were denied for nonassignment and the health care provider wants to accept assignment.

Note: For the most part, this information is also the kind that can be added to a claim for resubmission and reprocessing (see above). You should, therefore, appeal a claim by telephone only if you believe it:

- Was denied due to lack of information.
- Does not fit the criteria given in the Resubmitting Claims section.

Time limits for filing an appeal

Federal law establishes a time limit for filing an appeal of a carrier claim determination. The current time limit, counted from the date of the claim determination (in other words, the issuance of a remittance notice) is six months plus five days for mailing. The resubmission of a previously denied claim for the sole purpose of extending the time limit an appeal may be filed is not appropriate. All appeals are based on the date of the original claim determination.

Hearings

A hearing gives a dissatisfied beneficiary or physician/supplier an opportunity to present reasons for their dissatisfaction with a claim decision, and to possibly receive a new determination based on the record developed at the hearing. Hearing decisions apply only to the claims included in that hearing. The hearing officer's decision is not a precedent setting decision and does not affect subsequent hearing decisions or alter payment determinations on other claims.

Authority of the Hearing Officer

The authority is limited to the extent that the Hearing Officer (HO) must comply with all provisions of Title XVIII of the Social Security Act and regulations issued thereunder, HCFA rulings, general instructions and other guides. The HO may not overrule the provisions of the law or interpret them in a way different than HCFA does when he/she disagrees with their intent.

There are three types of Hearings:

In-Person: The claimant and/or representative is afforded the opportunity to present both oral testimony and written evidence supporting the claim at a mutually agreeable time and place with a hearing officer.

Telephone: The claimant and/or representative is afforded the opportunity to present both oral testimony and written evidence supporting the claim. The only difference between an in-person and telephone hearing is that the claimant and/or representative is not required to appear.

On-The-Record: The claimant submits written evidence which supports the claim at the time of the hearing request. On-The-Record hearings are identical to in-person and telephone hearings except that oral testimony is not presented.

At the discretion of the hearings department an on-the-record hearing can be conducted prior to performing a telephone or in-person hearing or if the request for hearing does not specify the type of hearing preferred. A party who is dissatisfied with the results of that hearing will be afforded the opportunity for an in-person or telephone hearing.

How to qualify for a Hearing

A Medicare Hearing must meet the following criteria:

- A completed appeal/claim review by National Heritage Insurance Company (NHIC), within 6 months of the initial claims processing determination.
- The request for hearing must be made within 6 months of the appeal/review determination.
- The amount in controversy must be $100.00 or more. The amount in controversy is calculated by taking the total amount billed minus any Medicare payments multiplied by 80%.The total amount can be accumulated over the six month period to reach the $100.00 minimum.
- The request for hearing must be in writing. It must be signed by the requesting party or that party's legal representative.

It must clearly state that a hearing is being requested and the dissatisfaction with the carriers review determination, or with the timeliness in which the request for payment was acted upon and a desire to appeal the matter further.

The request should include a clear and completely legible copy of the Medicare Remittance Notice for the initial claim determination and the determination from the claim review issued by the carrier **or**
a letter that includes the patient's Medicare identification (HIC) number(s), dates of service, procedure codes and claims that are to be included in the hearing.

Requests for hearings on claims processed and reviewed by *this* carrier must be sent to:

Medicare Part B Fair Hearings
P.O. Box 2811
Chico, CA 95927-2811.

What is a legal representative?

You must be a legal party to the hearing. If you are not a legal party to the hearing you must submit a signed appointment of representative form (HCFA form 1696U4). This form is available by calling the Medicare Provider Help Line at (877) 591-1587. The form must be signed by the beneficiary or the physician naming you, (the person who signed the hearing request) as the legal representative.

On assigned claims, the physician/supplier and the beneficiary or beneficiary's legal representative (with completed 1696U4 form) are considered a legal party to a hearing.

On nonassigned claims, the beneficiary is a legal party to the hearing. The beneficiary can appointed the physician/supplier as their legal representative for the claim(s) in question (with completed 1696U4 form). The physician/supplier is a legal party to a hearing when the services have been denied as not medically necessary and the physician/supplier has been found liable for the services that were denied.

Supporting documentation

Whenever a request for a hearing is made, any supporting documentation that will substantiate a favorable decision should be included with the request for hearing. Supporting documentation may include but is not limited to, operative reports, office or progress notes, procedural reports, plan of treatment, or specific documentation that has been included in Medicare publications and any other documentation that will substantiate a favorable decision.

Dissatisfaction with hearing decision

If, after the decision is rendered, less than $500 remains in controversy, the Hearing Officer's decision is final and binding. If the amount in controversy is $500 or more, a dissatisfied party has the right to a hearing by an Administrative Law Judge (ALJ).

Local Medical Review Policies

Medicare doesn't have national policy to cover many issues, and thus, places the responsibility for medical policy development on the local carriers. HCFA also provides carriers with a protocol regarding the development of LMRP. It is primarily a program integrity tool aimed at reducing abuse of Medicare funds. HCFA mandates that each carrier compare themselves to the nation in all services billed and review codes that are at least two times the nation. Based on this analysis, Focused Medical Review performs data analysis and claims review to determine why certain carriers stand out amongst other carriers. LMRPs are then written to provide guidelines for providers and claims processors to follow. These LMRPs are developed in consultation with the medical community via the carrier advisory committee and specialty consultants.

In some instances, HCFA contacts its carriers with a "fraud alert" for a particular code and indicates that each carrier must write a LMRP to protect against fraudulent billing in their region. The proposed policy is presented to the Carrier Advisory Committee (CAC). The members of the CAC have 45 days to comment on the policy with the solicited input from specialty societies and physicians. NHIC reviews comments received in the 45-day comment period, and we then determine if the policy should be modified prior to developing the final version of the policy. The final LMRP is published in the *Medicare Bulletin* and becomes effective 30 days after the date of publication. Providers need to refer to the specific bulletin article for billing information.

Generally, there are two types of LMRP: frequency (parameters) and medical necessity (specified *ICD-9-CM* codes). MCM section 7502.1 describes parameters as "the level, often a utilization threshold, below which the carrier does not perform medical review." For example, we may have an audit set up to deny more than 10 particular services in a one-month period. If a provider bills that service nine times within a month, he is still within the parameters. If a provider bills the service 15 times in one month, he is exceeding the parameters, and he will be subject to LMRP. Parameters information cannot be released to providers.

Appendix

Blepharoplasty

This policy is effective for claims submitted on or after March 21, 1997.

Procedure Code(s)	Description
15822-15823	Blepharoplasty, upper eyelid
67901-67908	Repair of blepharoptosis (Tarso levator resection or advancement, exter nal approach)

The goal of functional or reconstructive surgery is to restore normalcy to a structure that has been altered by trauma, infection, inflammation, degeneration, neoplasia, or developmental errors. The following are terms used to described conditions which may require blepharoplasty:

- Dermatochalasis—Excessive skin is usually the result of the aging process with loss of elasticity.
- Blepharochalasis—Excessive skin is usually associated with the disease process of chronic blepharoedema, which physically stretches the skin.
- Blepharoptosis—Drooping of the upper eyelid that relates to the position of the eyelid margin with respect to the eyeball and visual axis.
- Pseudoptosis— "False ptosis." The eyelid margin is usually in an appropriate position with respect to the eyeball and visual axis. However, the amount of excessive skin is so great as to overhang the eyelid margin and create its own ptosis.

Indications and Limitations of Coverage

- Blepharoplasty procedures and repair of blepharoptosis will be considered covered when performed as functional/reconstructive surgery to correct:
- Visual impairment with near or far vision due to dermatochalasis, blepharochalasis, or blepharoptosis.
- Symptomatic redundant skin weighing down upper lashes.
- Chronic symptomatic dermatitis of pretarsal skin caused by redundant upper lid skin.
- Prosthesis difficulties in an anophthalmia socket.

Reasons for Non-coverage

- Medicare does not pay for correction for cosmetic reasons.
- The correction of deformities resulting from previous cosmetic surgery, unless such deformity is causing exposure or other ocular damage is not a benefit of Medicare.
- Lower eyelid blepharoplasty to treat lower eyelid ptosis is covered only when surgery is needed to prevent ocular exposure and globe damage.

Coding

- You must choose the most specific *ICD-9-CM* code and bill it to its highest level of specificity.
- You should report procedure codes 15822-15823 and 67901-67908 with modifier 50 when performed as bilateral procedures.
- You should report procedure codes 15822-15823 and 67901-67908 with either the LT or RT modifiers when the procedures are not performed bilaterally.
- Procedure code 15822 is bundled into procedure code 15823. Procedure codes 15822 and 15823 are bundled into procedure code 67904. You may not report bundled codes separately, and providers may not bill the beneficiary for them.

Place(s) of service:
Procedure codes 67901-67908 may be performed in the following place(s) of service:
- Inpatient hospital (21)
- Outpatient hospital (22)
- Ambulatory Surgical Center (24)

Procedure codes15822-15823 may be performed in the following place(s) of service:
- Inpatient hospital (21)
- Outpatient hospital (22)

Note: Medicare policy does not prohibit payment to a physician who performs a blepharoplasty in the ASC. However, to avoid payment denials of the ASC facility fee, physicians should not perform blepharoplasties in an ASC.

Multiple Surgery Guidelines:
Procedure codes 15822-15823 and 67901-67908 are subject to the multiple surgery guidelines if more than one surgical procedure is performed during the same operative session.

Covered *ICD-9-CM*	**Description**
374.30-374.34	Ptosis of eyelid
374.87	Dermatochalasis (upper lids only)
743.61	Congenital ptosis
V52.2	Fitting and adjustment of artificial eye

Coverage Criteria
- Documented patient complaints which justify functional surgery and are commonly found in patients with ptosis, pseudoptosis, or dermatochalasis include: interference with vision or visual field; difficulty reading due to upper eyelid drooping; looking through the eyelashes or seeing the upper eyelid skin, or chronic blepharitis.
- You must include photographs or visual fields examination in order to justify the need for the procedure.
- Photographs should demonstrate one or more of the following:
- The upper eyelid margin approaches to within 2.5mm (1/4 of the diameter of the visible iris) of the corneal light reflex.
- The upper eyelid skin rests on the eyelashes.
- The upper eyelid indicates the presence of dermatitis.
- The upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmia socket.
- Visual fields recorded to demonstrate a minimum 12-degree or 30 percent loss of upper field of vision with upper lid skin and/or upper lid margin in response and elevated (by taping of the lid) to demonstrate potential correction by the proposed procedure or procedures.

Documentation Requirements

The diagnostic *ICD-9-CM* code that indicates the necessity for the procedure must be supplied. Documentation supporting medical necessity, beyond *ICD-9-CMs*, need not be submitted with the claim. However, the following medical necessity documentation must be kept in the patient's file, and it must remain available upon the request of the carrier for possible post-payment review.

- History and physical
- Operative report
- Visual fields—Visual fields must be recorded using either a Goldmann Perimeter (III 4 E test object) or a programmable automated perimeter (equivalent to a screening field with a single intensity strategy using a 10db stimulus) to test a superior (vertical) extent of 50-60 degrees above fixation with targets presented at a minimum four-degree vertical separation starting at 24 degrees above fixation while using no wider than a ten-degree horizontal separation. Each eye should be tested with the upper eyelid at rest, and the procedure should be repeated with the lid elevated to demonstrate an expected "surgical" improvement meeting or exceeding the criteria.
- Photographs and prints (not slides), must be frontal, canthus-to-canthus with the head perpendicular to the plane of the camera (not tilted) to demonstrate a skin rash, or to demonstrate the position of the true lid margin or the pseudo-lid margin. The photos must be of sufficient clarity to show a light reflex on the cornea. If the redundant skin coexists with true lid ptosis, additional photos must be taken with the upper lid skin retracted to show the actual position of the true lid margin (needed if both 15822-15823 is required and planned in addition to 67901-67908). Oblique photos are only needed to demonstrate redundant skin on the upper eyelashes when this is the only indication for surgery.
- If both a blepharoplasty and a ptosis repair are planned, both must be individually documented. This may require two sets of photographs showing the effect of drooping of redundant skin (and its correction by taping) and the actual presence of blepharoptosis.

Tangent screen testing is not an acceptable method to document the medical necessity for these surgeries.

Other Comments

Test must be performed by an ophthalmologist or optometrist when the operating surgeon is not an ophthalmologist.

Sources of Information

Input from other carriers, Carrier Medical Director, opthalmology clinical workgroup, ophthalmology consultants, and the American Association of Ophthalmology. This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. This policy was developed in consultation with the medical community via the Carrier Advisory Committee (CAC), which includes representatives from many different state specialty societies including the California Association of Ophthalmology.

Covered *ICD-9-CM*	Description
366.00–366.09	Infantile, juvenile, and presenile cataract
366.10–366.19	Senile cataract
366.20–366.23	Traumatic cataract
366.30–366.34	Cataract secondary to ocular disorders
366.41–366.46	Cataract associated with other disorders
366.50–366.53	After cataract
366.8	Other cataract
366.9	Unspecified cataract
743.30–743.39	Congenital cataract and lens anomalies

Cataract Removal

Effective for claims submitted on or after March 21, 1997.

Procedure Code(s)	Description
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (irrigation and aspiration or phacoemulsification)

Indications and Limitations of Coverage

- Medicare covers only intraocular lenses approved for marketing by the FDA.
- Intraocular lens implantation services, as well as the lens itself, may be covered if reasonable and necessary for the individual.

Reasons for Non-coverage

All *ICD-9-CM* codes not listed as covered.

Coding

- The most specific *ICD-9-CM* code must be chosen and billed to the highest level of specificity.
- ·When the surgeon submits a claim for this procedure and does not assume the postoperative care, code 66984 with the modifier 54 should be submitted. The attending physician who assumes the postoperative care should submit a claim for his or her services by using code 66984, followed by modifier 55.

Documentation Requirements

The diagnostic *ICD-9-CM* code that indicates the necessity for the procedure must be supplied. Documentation supporting medical necessity, beyond *ICD-9-CMs*, need not be submitted with the claim. However, medical necessity documentation must be kept in the patient's file, and it must remain available upon the request of the carrier for possible post-payment review.

The documentation regarding medical necessity must indicate that the beneficiary's visual impairment interfered with day-to-day, routine activities. Acceptable reasons include, but are not limited to, glare-induced visual disability; monocular diplopia or polyopia; aneisokonia, anisometropia, and the inability to obtain an unrestricted DMV license because of visual impairment from a cataract. The medical record must also contain sufficient clinical

information to exclude other ocular pathology as a principal cause for the beneficiary's reduced vision.

Sources of Information

Input was received from other carriers, specialty societies, and CAC members. This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. This policy was developed in consultation with the medical community via the CAC, which includes representatives from many different state specialty societies, including the California Association of Ophthalmology.

Covered Diagnoses

ICD-9-CM	**Description**
010.90	Primary TB NOS-unspecified
042	Acquired Immunodeficiency Virus infection
172.1	Malignant neoplasm of eyelid
190.0	Malignant neoplasm of eyeball
190.1	Malignant neoplasm orbit
190.8	Malignant neoplasm of contiguous or overlapping sites of eye whose point of origin cannot be determined
191.0	Malignant neoplasm cerebrum
224.5	Benign neoplasm retina
224.6	Benign neoplasm choroid
225.0	Benign neoplasm brain
227.3	Benign neoplasm pituitary
250.50	Diabetic eye manifestations Type II
250.51	Diabetic eye manifestations Type I
250.62	Diabetes with neurologic manifestations, adult uncontrolled
340	Multiple sclerosis
346.10	Common migraine, without mention of intractable migraine
346.20	Variants of migraine, without mention of intractable migraine
346.80	Other forms of migraine without mention of intractable migraine
360.21	Progressive myopia
361.00–361.07	Retinal detachment with retinal defect
361.10–361.19	Retinoschisis and retinal cysts
62.70	Hereditary retinal dystrophy
363.20	Chorioretinitis
*365.00–365.9	Glaucoma
368.10	Subjective visual disturbance, unspecified
368.15	Visual distortions

Visual Field Examination, Unilateral or Bilateral

Effective for claims submitted on or after March 21, 1997.

Procedure Code(s)	Description
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent).
92082	Intermediate examination (e.g., at least two isopters on Goldmann perimeter, or semi-quantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083	Extended examination (e.g., Goldmann visual fields with at least three isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32, or 42, Humphrey visual field analyzer full thresh old programs 30-2, 24-2 or 30/60-2)

Indications and Limitations of Coverage

- 92081, 92082, and 92083 are considered to be bilateral.
- Special ophthalmological services are payable for conditions not directly related to the eyethat may cause changes to the eye and would therefore require treatment. These conditions are listed in the covered *ICD-9-CM* codes listed below.
- Routine eye examinations performed for the purpose of prescribing, fitting, or changing eye glasses, or check-ups for routine diagnoses will be denied.
- Visual field examinations are sometimes performed more frequently than is normal for most patients. More than one practitioner may perform similar examinations on a beneficiary within a short time period. It is reasonable that prior test results be requested and reviewed before additional, non-urgent tests are ordered.

ICD-9 –CM	Description
362.71–362.77	Hereditary retinal dystrophies
368.16	Psychophysical visual disturbances
239.7	Endocrine glands and other parts of nervous system
348.2	Benign intracranial hypertension
368.40–368.46	Visual field defects
368.60	Night blindness
368.8	Other specified visual disturbances
369.4	Legal blindness as defined in the USA
369.9	Unspecified visual loss
374.30–374.34	Ptosis of eyelid
374.87	Dermatochalasis
377.01	Papilledema associated with increased intracranial pressure
377.10	Optic atrophy, unspecified
377.11	Primary optic atrophy
377.14	Cupping of optic disc

377.15	Partial optic atrophy
377.21	Drusen of optic disc
377.30	Optic neuritis, unspecified
377.34	Toxic optic neuropathy
377.41	Ischemic optic neuropathy
377.49	Other disorders of the optic nerve
379.91	Pain in or around eye
433.11	Carotid artery occlusion with cerebral infarction
434.10	Cerebral embolism without mention of cerebral infarction
435.0	Basilar artery syndrome
435.1	Vertebral artery syndrome
435.8	Other specified transient cerebral ischemia
435.9	Unspecified transient cerebral ischemia
436	Acute, ill-defined, cerebrovascular disease
437.0	Cerebral atherosclerosis
437.1	Other generalized ischemic cerebrovascular disease
446.5	Giant cell arteritis
710.0	Systemic lupus erythematosus
710.9	Unspecified diffuse connective tissue disease
714.0	Rheumatoid arthritis
743.56	Other congenital retinal changes
995.2	Unspecified adverse effect of drug, medicinal and biological substance
V58.69	Long-term (current) use of other medications (high-risk medications)
V67.51	Follow-up examination; following completed treatment with high-risk medications, not elsewhere classified
E931.3	Quinoline and hydroxyquinoline derivatives
E931.4	Antimalarials and drugs acting on other blood protozoa

***Please note:** Some truncated (and therefore unprocessable) codes fall within this range. Consult your *ICD-9-CM* coding manual for specific, highest-level codes.

Reasons for Non-coverage

Routine diagnoses that fall into the *ICD-9-CM* code ranges 367.0-367.21, 367.31, 367.4, and 367.9 are considered nonpathological disorders of refraction and presbyopia and are not Medicare covered services. Color vision and night vision deficiencies (368.5-368.61, 368.63, 368.69) are not covered. Nonspecific diagnoses of blurred vision (368.8) and unspecified visual disturbances (368.9) are not covered.

Coding

- Gross visual field testing is part of the visit and is not coded separately.
- The most specific *ICD-9-CM* code must be chosen and billed to the fourth or fifth digit.

More than two (2) intermediate or extended visual field examinations (*CPT* codes 92082 or 92083) per beneficiary are sometimes medically necessary and reasonable within a 12- month period. If you believe a third or subsequent test is medically necessary:

For Paper Claims: Please state the reason for visual field testing frequency in block 19 of the HCFA-1500 claim form, or attach a brief narrative to the claim.

For EDI Claims: Please state the reason for visual field testing frequency in the comment field. Contact your software vendor for further instructions as required.

Documentation Requirements
The diagnostic *ICD-9-CM* code that indicates the necessity for the procedure must be supplied.

Other Comments
- Visual field testing (92081-92083) performed to ascertain medical necessity of surgical corrections of eyelid ptosis must meet the following criteria:
- Test must be performed by an ophthalmologist or optometrist when the operating surgeon is not an ophthalmologist. Test must be performed using tangent screen, Goldmann perimetry, computerized automated perimeter or comparable apparatus.
- Interpretation must show the visual field is limited to 20 degrees or less superiorly per eye or limited to 10 to 15 degrees laterally per eye to allow for the surgical correction or ptosis.
- Claims may be subject to review by the medical staff to determine medical necessity.

Sources of Information
Input was received from other carriers, specialty societies, and Carrier Advisory Committee members. This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. This policy was developed in consultation with the medical community, via the Carrier Advisory Committee, which includes representatives from the California Association of Ophthalmology and the American College of Physicians.

This policy does not reflect the sole opinion of the carrier or the Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from all specialty groups.

Serial Tonometry

Effective for claims submitted on or after 10/01/98.

Procedure	Description
92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure

Serial tonometry describes multiple determinations of intraocular pressure over a few hours on one day. It is used during the course of medical treatment of acute elevations of intraocular pressure, e.g., acute angle-closure glaucoma. It may also be used to assess diurnal variations of intraocular pressure when glaucoma is suspected, as long as symptoms or signs justify this use.

Indications and Limitations of Coverage and/or Medical Necessity:

- This is a covered service only if performed serially, and not as a onetime measurement, which would be included in the general ophthalmological service.
- A onetime measurement of intraocular pressure is included in a general ophthalmological service, and it is not separately payable.

Diagnosis Codes That Support Medical Necessity:

ICD-9-CMs	Associated Diagnoses
365.00	Borderline glaucoma, pre-glaucoma, unspecified
365.01	Borderline glaucoma, open-angle with borderline findings
365.02	Borderline glaucoma, anatomical narrow angle
365.04	Borderline glaucoma, ocular hypertension
365.10	Open-angle glaucoma, unspecified
365.11	Primary open-angle glaucoma
365.12	Low tension glaucoma
365.13	Pigmentary glaucoma
365.14	Glaucoma of childhood
365.15	Residual stage of open-angle glaucoma
365.20	Primary angle-closure glaucoma, unspecified
365.21	Intermittant angle-closure glaucoma
365.22	Acute angle-closure glaucoma
365.23	Chronic angle-closure glaucoma
365.31	Corticosteroid-induced glaucoma, glaucomatous stage
365.51	Phacolytic glaucoma
365.52	Pseudoexfoliation glaucoma
365.62	Glaucoma associated with ocular inflammations
365.63	Glaucoma associated with vascular disorders
365.64	Glaucoma associated with tumors or cysts
365.65	Glaucoma associated with ocular trauma

Reasons for Denial

- When services are not medically necessary and reasonable
- When performed as a screening process
- Measurements of intraocular pressure by one or more methods during the course of an evaluation and management service are included in the allowance for the E&M code, and are not separately billable as 92100.
- Confirmatory measurement of a particular finding with the same or different tonometers, or with different personnel, does not constitute serial tonometry.
- Bilateral tonometry is not serial tonometry.

Non-covered *ICD-9-CM* Codes: Any diagnosis codes other than those listed in "*ICD-9-CM* Codes That Support Medical Necessity" section will be denied for lack of medical necessity.

Sources of Information
- Other carriers' local medical review policies
- Specialty medical consultants
- Carrier Medical Director

Coding Guidelines
- One unit of service should be reported regardless of whether one or both eyes are tested.
- For medically necessary serial tonometry, only one service will be allowed on a given date of service.
- The appropriate *ICD-9-CM* diagnosis must be linked to the appropriate procedure code. Failure to do so will result in denial in processing the claim. *ICD-9-CM* codes must be used at their highest level of specificity.
- Serial tonometry may not be billed in addition to a same day provocative test for glaucoma (*CPT* code 92140).

Documentation Requirements
Documentation supporting medical necessity, beyond *ICD-9-CMs*, need not be submitted with the claim. However, the medical record must fully document the medical necessity for use of 92100 (i.e. urgent treatment of acute elevation of intraocular pressure, diagnostic diurnal curve determination), and be available upon the request of the carrier.

Indocyanide Green Retinal Angiography

Procedure	Description
92240	Indocyanine Green (ICG) Angiography (includes multiframe imaging) with i interpretation and report

Indocyanine Green (ICG) Angiography is effective when used in the diagnosis and treatment of ill-defined choroidal neovascularization (e.g., associated with age-related macular degeneration). It is used as an adjunct to fluorescein angiography.

Definition of terms:
- Indocyanine green angiography; a diagnostic study where indocyanine green dye is injected intravenously. Photographs are taken of the retina at intervals as increasing intensity of retinal and choroidal circulation is displayed.
- Macula: The portion of the retina that sees tiny detail. The macula is responsible for sight in the center of the field of vision.
- Age-related macular degeneration: Degenerative disease that causes atrophy of the macula. The deterioration may be a process of aging, hereditary, or caused by an arteriosclerotic process.
- Choroidal neovascularization (CNV): choroidal capillary proliferation through a break in the outer aspect of Bruch's membrane.

Indications and Limitations of Coverage:

- Retinal neovascularization
- Serous detachment of retinal pigment epithelium
- Hemorrhagic detachment of retinal pigment epithelium
- Retinal hemorrhage
- Utilized to evaluate abnormalities of the posterior fundus.

Covered Diagnosis Codes

ICD-9 CM	Description
250.50*	Diabetes with ophthalmic manifestation (must have additional diagnosis- see ICD-9-CM 256.5)
250.51*	Diabetes with ophthalmic manifestation, type I not stated as uncontrolled
250.52*	Diabetes with ophthalmic manifestation, type II or unspecified type, uncontrolled
250.53*	Diabetes with ophthalmic manifestation, type I, uncontrolled
362.16	Choroidal neovascularization or subretinal neovascularization
362.42	Serous detachment of retinal pigment epithelium (RPE)
362.43	Hemorrhagic detachment of RPE
362.52	Exudative (wet) macular degeneration
362.81	Retinal hemorrhage, subretinal only
363.61	Choroidal hemorrhage, unspecified
363.62	Expulsive choroidal hemorrhage
363.63	Choroidal rupture
362.72	Hemorrhagic choroidal detachment

***Note:** When these codes (250.50-250.53) are billed, the claim must document an additional diagnosis code.

Non-covered Diagnosis Codes:

ICD-9-CM	Description
362.01	Background diabetic retinopathy
362.10	Background retinopathy, unspecified

Coding Guidelines:

- Report indocyanine green angiography with procedure code 92240.
- When the procedure is performed on both eyes, report the LT and RT modifiers. This procedure is considered to be unilateral.
- An office visit may be reported separately on the same day as the indocynine green angiography.

Note: Medicare will consider the performance of fluorscein angiography to be medically unnecessary if performed within one month of indocyanine green angiography.

- This procedure is considered to be diagnostic in nature and should be coded as such.
- Report this procedure in the following place of service:
  —(11) Physician's office

Sources of Information:
Opthalmology department University of California School of Medicine

Documentation Requirements:
Documentation in the patient's medical record should indicate one of the following:
- Evidence of ill-defined subretinal neovascular membrane or suspicious membrane on previous fluorescein angiography.
- Retinal Pigment Epithelium (RPE) does not show subretinal neovascular membrane on current fluorscein angiography.
- Presence of subretinal hemorrhage or hemorrhagic retinal pigment epithelium (RPE). A fluorescein angiography need not to be previously done.

Note: The physician's documentation must support the frequency and medical necessity of this procedure.

This policy does not represent the sole opinion of the Carrier Medical Director. This policy was developed in consultation with the medical community via the CAC, which includes representatives from the California Association of Opthalmology.

Botulinum Toxin Type A

Effective for claims on or after 12/15/98 .

Procedure	Description
J0585	Botulinum toxin type A, per unit

Botulinum Toxin Type A injections are used to treat various focal muscle spastic disorders and excessive muscle contractions such as dystonias, spasms, twitches, etc. They produce a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. The resulting chemical-denervation of muscle produces local paresis or paralysis and allows individual muscles to be weakened selectively. It has the advantage of being a potent neuromuscular blocking agent with good selectivity, duration of action, with the smallest antigenicity, and fewest side effects.

Botulinum toxin type A can be billed in conjuction with following injection procedure (s):

Procedure	Description
31513	Laryngoscopy, indirect (separate procedure); with vocal cord injection
31570	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic
31571	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope
64612	Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles enervated by facial nerve (eg, for blepharospasm, hemifacial spasm)

64613	Destruction by neurolytic agent (chemodenervation of muscle endplate); cervical spinal muscles (eg, for spasmodic torticollis)
64640	Destruction by neurolytic agent; other peripheral nerve or branch
67345	Chemodenervation of extraocular muscle

Indications and Limitations of Coverage

- Before consideration of coverage may be made, establish that the patient(s) has been unresponsive to conventional methods of treatments such as medication, physical therapy and other appropriate methods used to control and/or treat spastic conditions. However, treatment with botulinum toxin type A may be the least invasive and most effective choice for certain conditions, i.e., strabismus or blepharospasm.
- Coverage of botulinum toxin type A (Botox) for certain spastic conditions (eg, cerebral palsy, stroke, head trauma, spinal cord injuries, and multiple sclerosis), will be limited to those conditions listed in the section of this policy entitled, "ICD-9-CM Codes That Support Medical Necessity." All other uses in the treatment of other types of spasm, including smooth muscle types, will be considered as investigational and, therefore, non-covered by Medicare.
- Botulinum toxin type A can be used to reduce spasticity or excessive muscular contractions to relieve pain; to assist in posturing and walking; to improve range of motion; to permit better physical therapy; to reduce severe spasm in order to facilitate perineal hygiene.
- Botox injections can be used to treat limb spasticity. Botox injections techniques vary, including the number of injections made into each site or muscle, the dosage, and the combinations of muscles injected. Dosage varies from 1-25 units per small muscle (e.g., eye), to 50-200 units for medium to larger muscle groups (e.g., deltoid, biceps, quadriceps, hamstrings, etc.). Note that Americans use mouse units for Botox administration. Europeans use nannograms for a non-Botox medication (Desport). These are not equivalent measures. Dosage varies by age and degree of spasticity. Some recommend no more than 2-4 units/kgm body weight. Generally, a total of 300-400 units may be injected in up to six to eight sites per affected limb. In select cases where toxicity is not a prime consideration, some physicians use even higher doses (600-700 units in more injection sites). Treatment failure, following two successive injections using maximum dose for the size of the muscle, should preclude continued reimbursement. Failure to achieve the desired response using maximum dose should result in discontinuation of Botox therapy. A treatment trial may be repeated in one year as appropriate.
- An examination which reveals site tenderness or pain is usually adequate to determine injection site(s). EMG guidance is generally not necessary (except for extraocular muscle injection) although it may be medically necessary and reasonable in certain documented cases.
- Botox may be covered for the treatment of achalasia. Two-thirds respond within six months and effectiveness lasts on an average of a little over one year for an initial treatment, although shorter and longer durations have been reported. There is some question whether it is as good as or better than conventional therapy, pneumatic dilation or myotomy. Its use should not be endorsed for all patients but it can be considered individually in patients who have one or more of the following:
  - have failed conventional therapy;
  - are at high risk of complications of pneumatic dilation or surgical myotomy;
  - have failed a prior myotomy or dilation
  - have had a previous dilation induced perforation
  - have an epiphrenic diverticulum or hiatal hernia both of which increase the risk of dilation-induced perforation.

- *Some patients may fail a first injection and respond to a second. Further therapy should be questioned if two treatments in a row fail. Therapy can be repeated later in those who fail after an initial response.*

The usual dosage is about 20 units injected into each of four quadrants of the lower esophageal sphincter region for a total of 80 units.

- Due to the uncommonness of organic writer's cramp, Medicare would expect few patients to be treated for this condition.
- There may be patients who require electromyography in order to determine the proper injection site(s). The electromyography procedure codes specified in the HCPCS section of this policy may be covered if such testing is required to determine the proper injection site.
- In cases where satisfactory results have not been obtained, coverage for continued treatment, or for its resumption at a later date, may be considered with compelling clinical evidence of medical necessity.
- Medicare will allow payment for one injection per each functional muscle group (eg, elbow flexors or elbow extensors) regardless of the number of injections made into each group or the number of muscles that compose it.

Covered Diagnosis Codes

ICD-9 CM	Description
333.6	Idiopathic torsion dystonia
333.7	Symptomatic torsion dystonia
333.81	Blepharospasm
333.82	Orofacial dyskinesia
333.83	Spasmodic torticollis
333.84	Organic writers' cramp
333.89	Fragments of torsion dystonia, other
334.1	Hereditary spastic paraplegia
340	Multiple sclerosis
341	Neuromyelitis optica
341.1	Schilder's disease
341.8	Other demyelinating diseases of central nervous system
341.9	Demyelinating disease of central nervous system, unspecified
342.11	Spastic hemiplegia, affecting dominant side
342.12	Spastic hemiplegia, affecting non-dominant side
343.0 - 343.4, 343.8 - 343.9	Infantile cerebral palsy
351.8	Other facial nerve disorders
378.00 - 378.03	Esotropia
378.10 - 378.18	Exotropia
378.20 - 378.24	Intermittent heterotropia
378.30 - 378.35	Other and unspecified heterotropia
378.40 - 378.45	Heterophoria
378.50 - 378.56	Paralytic strabismus
378.60 - 378.63	Mechanical strabismus
378.71 - 378.73	Other specified strabismus
378.81 - 378.87	Other disorders of binocular eye movements

378.9	Unspecified disorder of eye movements
478.75	Laryngeal spasm
530	Achalasia and cardiospasm
723.5	Torticollis, unspecified
728.85	Spasm of muscle

Reasons for Denial

- Anal spasm, irritable colon, biliary dyskinesia or any treatment of other spastic conditions not listed as covered in this policy are considered to be cosmetic, investigational, (including the treatment of smooth muscle spasm), not safe and effective, and are not accepted as the standard of practice within the medical community.
- Services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- Routine physical examinations (screening).
- The patient's medical record must justify that the diagnosis information submitted on the claim accurately reflects the patient's condition and the medical necessity for service. A subsequent determination that the medical record is lacking such justification will result in a retroactive denial under Section 1862(a)(1)(A) of the Social Security Act.

Non Covered Diagnosis

ICD-9 CM	Description
374.34	Blepharochalasis

Coding Guidelines:
1.When billing for injections of botulinum toxin type A for covered conditions or diagnoses; the following guidelines should be used. Failure to report the procedure according to these guidelines may result in denial of the administration procedure

Procedure Description

31513	Laryngoscopy, indirect, (separate procedure), diagnostic with vocal cord injection
31570	Laryngoscopy, direct with injection into vocal cord, therapeutic
31571	Laryngoscopy, direct, with injection into vocal cords, therapeutic, with operating microscope

The above procedures are covered with the following indications:

ICD9CM	Description
478.75	Spastic Dysphonia

Procedure	Description
61612	Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles enervated by facial nerve (eg. For blepharospasm, hemifacial spasm)

The above procedure is covered with the following indications:

ICD9CM	Description
333.81	Blepharospasm
333.82	Oral mandibular dystonia
351.8	Hemifacial spasm nerve

Procedure	Description
64613	Destruction by neurolytic agent (chemodenervation of muscle endplate); cervical spinal muscles (eg. For spasmodic torticollis)

The above procedure is covered with the following indications:

ICD9CM	Description
333.83	Spasmodic torticollis
723.5	Torticollis, unspecified

Procedure	Description
64640	Destruction by neurolytic agent (chemodenervation of muscle endplate); cervical spinal muscles (eg. For spasmodic torticollis)

The above procedure is covered with the following indications:

ICD9CM	Description
333.6	Idiopathic torsion dystonia
333.7	Symptomatic torsion dystonia
333.84	Organic writers cramp
333.89	Other torsion dystonia
334.1	Hereditary spastic paraplegia
340	Multiple sclerosis
*341.0-341.9	Other deyelinating diseases of central nervous system
342.11	Spastic hemiplegia affecting dominant side
342.12	Spastic hemiplegia affecting non-dominant side
*343.0-343.4	Infantile cerebral palsy
343.8	Other specified infantile cerebra; palsy
343.9	Infantile cerebral palsy, unspecified
728.85	Spasm of muscle

The most reasonable and necessary endoscopic procedure to meet the beneficiary's medical need and allow Botox administration is payable for the following condition;

ICD9CM	**Description**
530	Achalasia and cardiospasm

*This code range contains truncated & therefore unprocessable codes (see "ICD-9-CM Codes That Support Medical Necessity").

To bill medically necessary electromyography guidance, report the appropriate CPT code for the procedure performed. (Only one EMG per injection site may be reported.) Needle electromyography (95869), limited study of a specific muscle group (must specify), should be used if only individual muscle groups are being tested.

Procedure	**Description**
92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report
95860	Needle electromyography, one extremity with or without related paraspinal areas
95861	Needle electromyography, two extremities with or without related paraspinal
95869	Needle electromyography; thoracic paraspinal muscles

2. Botulinum toxin type A is supplied in vials and each contains 100 units. If less than 100 units is given during a single treatment session and the remainder is not used for another patient, bill a total of 100 units in the days/ units field (Item 24G) of the 1500 claim form.

Example:

100 Units Billed Line 1: Days/Units Field = 1000 (100 units)

200 Units Billed Line 1: Days/Units Field = 2000 (200 units)

If 100 or more units are billed during a single treatment session per patient, round up to the nearest 100 units serum, but only if the remainder was not used.

EMC billers should contact their software vendors for correct field placement of units of service.

In each case, botulinum toxin type A is coded as J0585.

3. Due to the short life of the botulinum toxin, Medicare will reimburse the unused portion of this drug, but only when the vial is not split between patients. However, documentation must show in the patient's record the exact dosage of the drug given and the exact amount of the discarded portion of the drug.

4. Scheduling of more than one patient is encouraged to prevent waste of botulinum toxin type A. If a vial is split between two patients, the billing in these instances must be for the exact amount of botulinum toxin type A used for each individual patient using J0585. If there is any toxin unused after injecting multiple patients, the remainder can be appropriately billed as waste on the claim of the last patient injected. Medicare would not expect

to see billing for the full fee amount for botulinum toxin type A on each beneficiary when the vial is split between two or more patients.

Documentation Requirements:
Documentation in the medical record should include the following elements:

- support for the medical necessity of the botulinum toxin type A injection;
- a covered diagnosis;
- a statement that traditional methods of treatments have been tried and proven unsuccessful;
- dosage and frequency of the injections;
- support for the medical necessity of any electromyography procedures;
- support of the clinical effectiveness of the injections;
- specify the site(s) injected.

The use of Botox for the diagnosis of achalasia (530.0) will be limited to those patients who have specific contraindications to dilatation or myotomy and will be reviewed on an individual basis. Submissions of the achalasia ICD-9-CM code must have documentation attached or be placed on the "extra narrative" area for electronic claims.

This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from the neurology, gastroenterology, and ophthalmology specialty communities.

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an EDS company

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National Heritage Insurance Company is the Part B Medicare carrier serving all of California If you have comments about this guide or would like to make suggestions, please write to: Educational Outreach, 620 J Street, Marysville, CA 95901. All comments are appreciated. Copies of this manual are available on our website at **www.medicarenhic.com** under the California Physicians and Suppliers, Publications section.

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