

Optometry Billing Guide

a. Introduction

The purpose of this billing guide is to provide you with the most current policy and billing information on services rendered by an optometrist.

Doctors of optometry are eligible for payment of all covered Medicare services which are within the scope of the states' optometric license.

A doctor of optometry who is legally authorized to practice optometry by the state in which he performs such function is a "physician" as defined for program purposes.

b. Coverage Requirements

- Reimbursement will be made only for services related to a disease or disorder of the eye.
- Services related to routine eye care for diagnoses such as ametropia, anisometropia, astigmatism, emmetropia, hypertropia, myopia, and refractive error are also not covered.

c. Eye Refraction

An eye refraction is not eligible for payment regardless of the patient's diagnosis. If a refraction is performed by an optometrist, it must be reported using procedure 92015 (determination of refractive state) as a separate line item. Payment for eye refraction is the responsibility of the patient.

Note: Routine physical checkups' eyeglasses, contact lenses and eye examinations for the purpose of prescribing, fitting or changing eyeglasses (e.g., refractions) are not covered.

d. Evaluation and Management Services

The following services are considered to be an integral part of the evaluation and management service; therefore, they are not reimbursed separately.

- Amsler Grid Test, Maddox Test
- Brightness Acuity Test
- Corneal Bandage
- Corneal Sensation
- Exophthalmometry
- General Medical Observation
- Glare Test
- History
- Keratometry
- Laser Inteferometry
- Pachometry
- Potential Acuity Meter (PAM)
- Schirmer's Test
- Slit Lamp
- Tear Film Adequacy
- Transillumination

e. Social Security Act Section 1862 (a) (1) (A)

Until such time as the State of PA determines what the appropriate standards are, defines the term "surgery" and determines which agency within Pennsylvania has the authority to make "scope of practice recommendations" for optometrists, HGSA will apply the principles of the Social Security Act Section 1862 (a) (1) (A), the so called reasonable and necessary, to monitor the claims submitted by optometrists in Pennsylvania.

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f. Splitting Post Operative Care

Specific billing guidelines must be followed when the surgical procedure and the post operative care are split between different physicians not in the same group practice. Both the surgeon and the physician providing the post operative care must keep a copy of the written transfer agreement in the beneficiary’s medical record.

The physicians must agree on the transfer of care during the global period. The modifiers **54** and **55** are to be used to indicate that the surgical care and post operative management services are being rendered by two different physicians.

■ **Modifier 54**

54 - Surgical Care Only: When one physician performs a surgical procedure and another provides postoperative management, surgical services may be identified by adding the modifier **54** to the surgical procedure code.

Services billed with a **54** modifier will be reimbursed at the intraoperative allowance for the surgical procedure. The intraoperative allowance includes the one day preoperative care, the intraoperative service, as well as any in-hospital visits that are performed.

■ **Modifier 55**

55 - Postoperative Management Only: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier **55** to the surgical procedure code.

This modifier is used to identify postoperative, out of hospital medical care associated with a surgical procedure. When billing for postoperative care only, report the original date of surgery as your date of service and the procedure code for the surgical procedure followed by the **55** modifier.

Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service.

f.1 Billing Procedures for Split Post Operative Care

In rare situations where the out of hospital postoperative care is split between physicians, each physician must also indicate the period of his/her responsibility for the patient’s postoperative care by reporting the appropriate range of dates.

In those cases where the post discharge postoperative care is “split” between physicians, the billing for the postoperative care would be as follows:

- Report the date of service using the date of the surgical procedure.
- Report the procedure code for the surgical procedure, followed by modifier 55.
- Report the range of dates that you provided the postoperative care in the procedure description (narrative) field on electronic claims, and block 19 on the HCFA-1500 (12-90) claim form. We do not need each date; only the range of dates.

National Standard Format (NSF)	ANSI X12 Version 30.32	ANSI X12 Version 30.51	HCFA 1500 (12-90) Claim Form
HA0 Record	2-405	2-485	Block 19
Positions 40-320	NTE Segment	NTE Segment	
	Data Element 02	Data Element 02	

g. Bilateral Procedures

Bilateral procedures are procedures performed on both sides of the body during the same session or on the same day. Medicare payment for a bilateral service is based on 150% of the fee schedule amount for a single service. The limiting charge is 115% of that amount.

g.1 Billing Instructions

If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), report the procedure with modifier **50**. Report such procedures as a single line item with a unit of 1.

Note: This differs from the CPT-4 coding guidelines which indicate that bilateral procedures should be billed as two line items.)

It is not appropriate to report the **50** modifier for procedures specifically identified by CPT as 'bilateral' or 'unilateral or bilateral' since the relative value units (RVUs) for these procedures reflect any additional work involved and the bilateral payment rule would not be applicable.

h. Presurgical Cataract Services

For presurgical cataract evaluations, a single scan (A-scan) to determine the appropriate pseudophakic power of the IOL is usually sufficient. For a simple cataract, payment may be allowed for one diagnostic A-scan. However, for those patients with a dense mature cataract, both an A-scan and a B-scan may be paid. Additional tests are considered not reasonable and necessary unless there is an additional diagnosis and the medical need for the test is documented.

If the patient decides not to have the surgery until later, or to have the surgery performed by a physician other than the diagnosing physician, it may be medically appropriate for the operating physician to conduct another examination and perform additional tests. The documentation in the medical records should reflect these circumstances to substantiate the necessity for the additional tests. In these situations, the claim will be referred for medical review.

h.1 Special Billing Instructions for Ophthalmic Biometry by Ultrasound Echography, A-Scan; with intraocular Lens Power Calculation (76519)

■ Technical Component Only

Report 76519-TC. This procedure is typically performed on both eyes on the same day. Do not report modifier **50**.

■ Professional Component Only

Report 76519-26. This will be paid if the physician performs the implant and the test for both eyes on the same day. Report modifier **50**.

■ Technical and Professional Components (Global)

Do not report modifier **50**. Reimbursement includes payment for the technical component performance on both eyes and the professional (IOL calculation) performance on one eye.

If the provider performs an IOL calculation on both eyes and performs the technical component on the same day, report 2 lines of service as follows:

■ 76519-2650

■ 76519-TC

i. Lacrimal Punctum Plug Billing

CPT code 68761 identifies the closure of a single punctum; therefore the relative value units for this procedure are set up for each punctum.

Bilateral payment rules apply to this procedure if performed on both eyes. If one punctum is closed in each eye, report the procedure code with a **50** modifier.

In situations where two puncta are treated in the same eye, multiple surgery rules apply. In this case, report each service as a separate line item, adding the **51** modifier to the second and subsequent procedures.

If multiple puncta are closed in each eye, both bilateral payment and multiple surgery rules apply. For example, if two puncta are closed in each eye, report the closure of the first puncta in each eye with the procedure plus the **50** modifier. The closure of the second puncta in each eye should be reported with both bilateral and multiple surgery modifiers, i.e. the procedure with a **50** and **51** modifier.

Separate payment is allowed for A4263 (permanent, long term, non-dissolvable lacrimal duct implant), when performed in an office setting. These plugs are not subject to either bilateral or multiple surgery reductions and should be reported without modifiers but with an indicator in the number of services field.

Note: Effective for dates of service January 1, 2001 and after, these lacrimal punctum plugs are considered a “bundled” service and may **not** be reimbursed separately.

j. Special Anterior Segment Photography (92286)

Specular endothelial microscopy (also known as endothelial cell photography and corneal endothelial microscopy) is a procedure performed to determine the endothelial count. It is used to predict the success of ocular surgery or other ocular procedures. When performed on patients who meet one or more of the following criteria, specular endothelial microscopy is a covered procedure and should be processed under code 92286.

- Have slit lamp evidence of endothelial dystrophy (cornea guttata) (371.57).
- Have a slit lamp evidence of corneal edema (unilateral or bilateral) (371.20 - 371.24).
- Are about to undergo a secondary intraocular lens implantation.
- Have had previous intraocular surgery and require cataract surgery.
- Are about to undergo a surgical procedure associated with a higher risk to corneal endothelium; i.e., phacoemulsification, or refractive surgery.
- With evidence of posterior polymorphous dystrophy of the cornea (371.58) or iridio-corneal endothelium syndrome.
- Are about to be fitted with extended wear contact lenses after intraocular surgery.

When a pre-surgical examination for cataract surgery is performed and the above criteria are met, if the only visual problem is cataracts, endothelial cell photography is covered as part of the pre-surgical evaluation and not in addition to it.

k. Prosthetics and Orthotics

Claims for prosthetics and orthotics, frames and lenses are processed by the Durable Medical Equipment Regional Carrier (DMERC). The residence of the beneficiary will determine the DMERC to which you must submit the service(s) being billed.

The following are DMERC Carriers by Region:

DMERC Carrier

States in Region

United Health Care
DMERC
PO Box 6800
Wilkes-Barre, PA 18773-6800
(570) 735-9445

Region A: Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, York, Pennsylvania, Rhode Island and Vermont

Administar Federal, Inc.
Assigned Claims: PO Box 7078
Indianapolis, IN 46207-7027
Non Assigned Claims:
PO Box 7031
Indianapolis, IN 46207-7027
(317) 577-5722

Region B: District of Columbia, Illinois, Indiana, Maryland, Michigan, Minnesota, Ohio, Virginia, Wisconsin

Palmetto Government
Benefits Administration
PO Box 100141
Columbia, SC 29202-0141
(803) 691-4300

Region C: Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands

CIGNA
PO Box 690
Nashville, TN 37202
(615) 251-8182

Region D: Alaska, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming
American Samoa, Mariana Islands

I. Correct Coding Combinations

For additional information on Correct Coding, please refer to Appendix C of the **Medicare Part B Reference Manual**.

m. Instructions for Billing for Claims for Screening Glaucoma Services

The Benefits Improvements and Protection Act of 2000, provides annual coverage for glaucoma screening for eligible Medicare beneficiaries, i.e., those with diabetes mellitus; a family history of glaucoma; African-Americans age 50 or over, and certain other individuals found to be at high risk for glaucoma as determined by CMS. Medicare will pay for glaucoma screening examinations when they are furnished by or under the direct supervision of an ophthalmologist or optometrist, performed in an office setting only, and who is legally authorized to perform the services under State law.

Screening for glaucoma is defined to include (1) a dilated eye examination with an intraocular pressure measurement; and (2) a direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination. Payment may be made for a glaucoma screening examination that is performed on an eligible beneficiary after at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed. Coverage applies to services performed on or after January 1, 2002. Reimbursement for screening glaucoma will be made under the Medicare physician fee schedule and deductible/coinsurance applies. A screening glaucoma provided on the same day with any other service that is paid under the MPFSDB will be bundled into the physician service for which payment is made.

Use the following HCPCs codes to bill for glaucoma screenings:

- G0117 Glaucoma screening for high risk patients furnished by a physician
- G0118 Glaucoma screening for high risk patients furnished under the direct supervision of a physician

Diagnosis Code Requirements - Report ICD-9 code V80.1 (Special Screening for Neurological, Eye, and Ear Diseases, Glaucoma) to report glaucoma screening. Claims submitted without a screening diagnosis code will be returned as unprocessable and not afforded Appeal rights.

HGSAdministrators has produced this publication as an informational reference source for providers/suppliers furnishing services/supplies in our Medicare contract jurisdiction. This material is intended to complement and not replace Medicare program requirements as set forth in statute, regulations and manual instructions. It is the responsibility of each provider/supplier submitting claims to HGSA to familiarize themselves with Medicare coverage requirements. HGSA makes efforts to ensure the information contained in this publication is accurate and current. However, because the Medicare program is constantly changing, it is the responsibility of each provider/supplier to remain abreast of the Medicare program requirements.