

# OPTOMETRY CODING & BILLING ALERT

Your essential guide to Coding • Billing • Clean claims • Efficient collections • Compliance • HIPAA

SAMPLE ISSUE

**What's Inside**

You Be the Expert.....42

▶ Epilation of Lashes

Don't Stop at 4 Digits for Your IOL Master

Diagnosis.....43

▶ *To prove medical necessity, you must get specific — or risk denials*

News You Can Use:

Eliminate NEMB Jumble With New ABN.....44

▶ *Update now if you're not already using the revised form for refractions*

Build a Better Business:

Capitation May Be on the Horizon: Get Ready.....46

▶ *Find out whether capitation will help — or harm — your practice*

**Reader Questions**

Modify Eye Codes Just Like E/M Codes.....45

File Secondary Claims to Foster Patient Relations.....45

Don't Charge Insertion by Plug Type.....47

Document Complaint for Glaucoma Follow-Up.....47

Get a Handle on Timely Filing Date Rules.....48

## Do You Know the Secrets of Full Reimbursement for IOL Power Calculations?

▶ ***Improperly coding IOL Masters or A-scans can cost you almost \$30 per patient***

Calculating intraocular lens power for patients facing cataract surgery has gotten more precise as A-scan and IOL Master technology has advanced. But to make sure your practice is getting fairly reimbursed each time, you need to understand the bilateral rules for 76519 and 92136.

### Include Bilateral and Unilateral Components in Global Code

**Myth:** If you calculate IOL power in both eyes, you should report 76519 (*Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation*) or 92136 (*Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation*) twice (e.g., 76519-RT and 76519-LT, or 76519-50, *Bilateral procedure*).

**Reality:** You should not report 76519 or 92136 bilaterally, even if you calculated the IOL power of both eyes. To understand why, you should know how Medicare's Physician Fee Schedule (MPFS) values the procedures.

As it does with many other diagnostic tests, CMS divides the A-scan (76519) and the IOL Master (92136) into two components, says **Judy Seymour, ACS-OH**, coder and biller for Eye Associates of the South in Biloxi, Miss. The fee schedule marks the technical component (actually performing the test) with modifier TC, and the professional component (viewing and interpreting the results) with modifier 26.

For most procedures, the technical and professional components have the same bilateral status — for example, 92250-TC (*Fundus photography with interpretation and report*) and 92250-26 are both considered inherently bilateral, marked with modifier indicator "2" on the fee schedule. CMS bases the reimbursement for all components of 92250 on both eyes being tested.

**Exception:** For both 76519 and 92136, the technical component has a different bilateral status from the professional component, Seymour says. The fee schedule marks both 76519-TC and 92136-TC with modifier indicator "2," which means that Medicare considers the codes inherently bilateral.

The single CPT codes include the work for performing the procedure on both eyes— you should report 76519-TC or 92136-TC only once, regardless of whether the optometrist tests one or both eyes.

## Code Components Separately if Both Eyes Tested

The MPFS marks the professional components (76519-26 and 92136-26) with modifier indicator “3,” however, which means that the codes are inherently unilateral. When you report a global code without modifiers, you are telling the insurer that you performed both the technical and professional components of that service.

**Why?** An optometrist usually performs the technical component of the procedure — the actual measurement of the eye — on both eyes on the same day. But he may only

perform the professional component — the IOL power calculation — on the eye that is going to have surgery. For example, if an optometrist performs an A-scan on both eyes, calculating IOL power in the right eye, he would report 76519-RT. That code and modifier tell Medicare that the optometrist performed both the (bilateral) technical and the (unilateral) professional component.

If you calculate IOL power in both eyes, code the technical and professional components separately. For example, for an IOL Master and power calculation in both eyes, code:

- 92136-TC for the bilateral technical component
- 92136-26-50 for the bilateral professional component.

Append modifier 50 (*Bilateral procedure*) to show that you bilaterally performed this usually unilateral component.

**What’s the difference?** Medicare rules dictate how it will reimburse bilateral procedures. Since the MPFS marks the global components of both 76519 and 92136 with bilateral status “2,” Medicare payment policy is to pay the fee schedule amount for only one code if you report it bilaterally.

Thus, claiming 92136-50 will only yield \$82.27, based on the 2008 fee schedule, unadjusted for geographical location (2.16 total transitional relative value units [RVUs] x 38.0870 conversion factor). But reporting IOL

## You Be the Expert

### Epilation of Lashes

**Question:** *What is the proper way to code for epilation of lashes? We used to bill per lash removed up to a maximum dollar amount, but that does not seem to work now. Which modifiers are best to use?*

New York Subscriber

**Answer:** See page 44. □

### CONTACT INFORMATION

We would love to hear from you. Please send your comments, questions, tips, cases and suggestions for articles related to optometry coding, reimbursement and/or compliance to Jerry Salley at [jerrys@eliresearch.com](mailto:jerrys@eliresearch.com).

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*Optometry Coding & Billing Alert* is published monthly by The Coding Institute, a subsidiary of Eli Research, 2222 Sedwick Road, Durham, NC 27713. © 2008 The Coding Institute. All rights reserved.  
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measurements in both eyes properly, with 92136-TC and 92136-26-50, should bring in about \$30 more:

- 92136-TC = (1.39 RVUs x 38.0870) = \$52.94
- 92136-26-50 = (0.77 RVUs x 38.0870) x 2 = \$58.65
- Total: \$111.59

### Check This 76519/92136 Bundle

What if you have to perform both an A-scan and an IOL Master? Should you report both 76519 and 92136?

No, says the Correct Coding Initiative (CCI). Codes 76519 and 92136 are in a mutually exclusive bundle. If you report both codes, Medicare carriers will only pay you for 92136.

**Example:** You perform the technical portion of an A-scan on the left eye, but dense cataracts prevent you from getting a viable result from the right eye. You perform an IOL Master on the right eye and calculate IOL power for the right eye. You can only report one unit of 92136-RT.

### Look for Fifth Digit on Cataract Dx

Although 366.x (*Cataract*) is a good start, it's not where you should end your ICD-9 quest for 76519 or 92136. Coding rules dictate that you code as specifically as possible.

Because the codes under 366.x extend into five digits, you will need a five-digit code, such as 366.02 (*Posterior subcapsular polar cataract*), to describe the patient's condition fully.

This is a good tip on all procedures, office visits and special tests, says **David Gibson, OD, FAAO**, a practicing optometrist in Lubbock, Texas.

**Tip:** Look for helpful notes in your ICD-9 manual. If a code has a "4th" or "5th" note next to it, look below it for a more detailed code.

For more information on ICD-9 coding, see "Don't Stop at 4 Digits for Your IOL Master Diagnosis" below. □

## Don't Stop at 4 Digits for IOL Master Diagnosis

### ► To prove medical necessity, you must get specific — or risk denials

Medicare covers IOL calculation procedures for patients about to undergo cataract surgery. But just listing 366.x (*Cataract*) as your diagnosis code will likely get your claim rejected.

Below is a list of specific ICD-9 codes that many carriers recognize as demonstrating medical necessity for both 76519 (*Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation*) and 92136 (*Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation*):

- 366.00-366.09 — *Infantile, juvenile and presenile cataract*
- 366.10 — *Senile cataract, unspecified*
- 366.13 — *Anterior subcapsular polar senile cataract*
- 366.14 — *Posterior subcapsular polar senile cataract*
- 366.15 — *Cortical senile cataract*
- 366.16 — *Nuclear sclerosis*
- 366.17 — *Total or mature cataract*
- 366.18 — *Hypermature cataract*
- 366.19 — *Other and combined forms of 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*
- 379.31-379.34 — *Aphakia and other disorders of lens*
- 743.30-743.39 — *Congenital cataract and lens anomalies*
- V43.1 — *Lens replaced by other means.*

**Note:** Always base your ICD-9 coding on the patient's condition, not on whether it will help your claim be paid, experts say. □

## News You Can Use:

# Eliminate NEMB Jumble With New ABN

► **Update now if you're not already using the revised form for refractions**

If your practice is like most optometry offices, every day you perform services, like refractions, that Medicare does not cover. If you've never quite understood when you should provide a patient with an ABN rather than an NEMB for a noncovered service, CMS has just made your life easier.

Medicare has unveiled its new advance beneficiary notice. This new form not only replaces the previous advance beneficiary notice (ABN-G for physician

services) but also incorporates the notice of exclusions from Medicare benefits (NEMB) form. CMS expects this new, combined form to “eliminate any widespread need for the NEMB in voluntary notification situations,” according to the new ABN Form Instructions document.

**The old way:** Previously, you would use an ABN only for procedures that Medicare might not cover. The ABN did not apply to procedures that CMS statutorily excluded from Medicare benefits — that's where the NEMB came in.

**The new way:** Now, CMS will accept the new ABN form for either a “potentially noncovered” service or for a statutorily excluded service. “The revised version of the ABN may also be used to provide voluntary notification of financial liability,” CMS says.

**Get ready for the change now:** Medicare carriers began accepting the new ABN on March 3, but CMS has implemented a six-month transition period. Although you aren't required to submit the new form until Sept. 1, you may find making the change immediately a little easier.

**How to get it:** You can view a sample copy of the revised ABN, as well as CMS' complete instructions for implementing and using the form, on the CMS Web site at [www.cms.hhs.gov/BNI/02\\_ABNGABNL.asp](http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp).

Although the ABN form has changed, many previous ABN “best practices” remain (mostly) the same. Here are four guidelines to follow anytime you use the form.

## 1. Provide the ABN Up-Front

If you discover that Medicare won't pay for a patient's upcoming procedure but the patient still wants you to perform the service, the ABN will inform the patient that he may be responsible for paying the noncovered portion.

ABNs help patients decide whether they want to proceed with a service even though they might have to pay. A signed ABN ensures that the physician will receive payment directly from the patient if Medicare won't pay. Without a valid ABN, you cannot hold a Medicare patient responsible for denied charges, says **Kara Hawes, CPC-A**, with Advanced Professional Billing in Tulsa, Okla.

“The patient has to sign the ABN form at the time of service, otherwise the form is not valid,” Hawes says. “When the claim is denied without an ABN, Medicare will not allow you to be reimbursed for the service or collect money from the patient.”

## You Be the Expert

(Question on page 42)

### Epilation of Lashes

**Answer:** Most carriers only want you to report 67820 (*Correction of trichiasis; epilation, by forceps only*) once per date of service.

Although some carriers have reimbursed for epilation for each eyelash, most do not.

There may be some instances when you would append eyelid modifiers (E1, *Upper left, eyelid*; E2, *Lower left, eyelid*; E3, *Upper right, eyelid*; E4, *Lower right, eyelid*) to 67820, but in most cases you won't.

For the epilation codes, CPT 2008 references the AMA's July 1998 *CPT Assistant*, which says that the intent of 67820 is to report the service per procedure, not per eyelash or per eyelid.

Many Medicare Part B carriers have used that reference to amend or clarify their rules for 67820, so you can no longer report 67820 once for each eyelid you treat.

Medicare has indicated a bilateral status of “1” for 67820. So, when you perform the service bilaterally and report it with modifier 50 (*Bilateral procedure*) or RT (*Right side*) and LT (*Left side*) on separate lines of the claim form, Part B carriers should base payment on 150 percent of the fee schedule amount. □

## 2. Explain the ABN to the Patient

ABNs help the patient understand his options. Once you have completed the ABN and discussed it with the patient, he can: 1) sign the ABN and assume financial responsibility for the service or procedure in question; 2) cancel the service or procedure; or 3) reschedule the procedure or service for a future date when he can afford it, or when Medicare may cover the procedure.

## 3. Give the Patient an Estimate

“Medicare is going to require that the estimated cost be included on the form starting in September. That’s a big change,” says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-OBGYN, CPC-CARDIO**, manager of compliance education for the University of Washington Physicians and Children’s University Medical Group Compliance Program.

## 4. Apply Modifiers to Explain ABN Status

When you expect Medicare to deny all or part of a service, you should append the correct modifier to the service code so Medicare’s explanation of benefits (EOB) will properly outline when the patient has to pay.

“You should use modifier GA (*Waiver of liability statement on file*) when the service provider believes the service is not covered and the office has a signed ABN on file,” says **Dena Rumisek**, practice biller in Grand Rapids, Mich. This might include tests ordered without a payable diagnosis code or ordered more frequently than covered.

Modifier GY (*Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit*) applies when Medicare excludes the service and you’re using the new ABN as you previously would have used the NEMB.

Modifier GZ (*Item or service expected to be denied as not reasonable and necessary*) means that you didn’t issue an ABN when you probably should have, and you cannot bill the patient when Medicare denies the service. □

### Newsletter Question or Comment? Article Suggestion?



If you have a question or comment about what you’ve read here, please contact the editor, Jerry Salley, at [jerrys@eliresearch.com](mailto:jerrys@eliresearch.com).

## READER QUESTIONS

### Modify Eye Codes Just Like E/M Codes

**Question:** *Can we append modifiers 25 or 57 to the eye codes 92002-92014? The descriptions of the modifiers only specify E/M codes — do the eye codes count?*

Arizona Subscriber

**Answer:** Medicare and most other carriers treat the eye codes — 92002 (*Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient*), 92004 (... *comprehensive, new patient, one or more visits*), 92012 (*Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient*) and 92014 (... *comprehensive, established patient, one or more visits*) — the same as E/M codes.

Therefore, if there is a separately identifiable service, you can report it with an eye code and append modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) or 57 (*Decision for surgery*).

Chapter 11 of the *National Correct Coding Policy Manual* for Part B Medicare Carriers makes the comparison official: “When evaluation and management codes are reported, these general ophthalmological service codes ... are not to be reported; the same services would be represented by both series of codes.” That means you can report either an E/M code or an eye code.



### File Secondary Claims to Foster Patient Relations

**Question:** *A patient’s primary insurer is Medicare, and she also has secondary insurance. Medicare has paid its portion, and the explanation of benefits shows patient responsibility as the amount left over. Medicare did not forward to the secondary insurance. Are we responsible for filing the secondary (as the patient believes), or can we bill the patient and have her submit to her secondary?*

Georgia Subscriber

**Answer:** Filing the claim on your patient’s behalf might be in your practice’s best interest. Many statements

*(Continued on page 47)*

## BUILD A BETTER BUSINESS

Streamline your collections system and get your deserved money faster with these tips on completing claim forms and charging for services. *Optometrists*: Clip and give this monthly section to your biller.

### Capitation May Be on the Horizon: Get Ready

#### ► Find out whether capitation will help — or harm — your practice

If you thought you wouldn't have to worry about capitation, you might want to think again.

Capitation was a commonly heard word in the billing world in the 1990s, but it fell out of use several years ago. With Blue Cross and Blue Shield of Massachusetts' new plan to stop paying doctors and hospitals for each patient visit or treatment and instead pay doctors and hospitals a flat sum per patient each year, capitation is in the billing forefront again.

Now's the time to make sure you know the ins and outs. Take a look at this capitation FAQ to learn the capitation basics.

#### Question 1: What is capitation?

Capitation is a payment method in which the payer reimburses the provider a fixed amount per month for every member of the health plan panel to whom they provide some type of service, says **Peter Lucash, MBA, MPH**, a medical practice consultant and trainer in Charleston, S.C., who writes the "Medical Practice Business Blog" at [www.allbusines.com/11417](http://www.allbusines.com/11417) and is the author of *Medical Practice Business Plan Workbook — 2nd Edition*.

The payer reimburses the provider at set intervals throughout the year, as set up in the capitation contract — usually monthly, quarterly, semiannually or annually. Under capitation, the contracted payer reimburses you based on the number of patients covered in the contract (by head) rather than by the number of services your physician provides.

**Example:** You accept Health Plan A, which has 100 members who are assigned to you for optometry services. Based on your contract with Health Plan A, your office gets a check for \$5 per member each month, or \$500 per month. This is known as "per member per month" (PMPM), Lucash says. Some months you see 10 patients from this panel, and sometimes you'll see 60 per month. "You will get the same check, regardless of the services rendered to this group, more or less," Lucash says.

#### Question 2: How do I bill claims under capitation?

Under capitation, you have to track services for the panel and will probably have to submit claims, even though the payer won't pay you on a per-claim basis, Lucash says.

"That said, there may be services that are not covered by the contract and for which you will be paid in addition to the capitation fee," Lucash adds.

**Tip:** Check to see how your billing software deals with capitation claims. "Some software, if set up correctly, will adjust off all of the charges at the time of posting and leave the patient's copay," says **Melinda S. Brown, CMBS**, insurance biller for a primary-care provider in Kennewick, Wash. "However, I had to set up a separate insurance carrier (plan) 'Ins X Capitated' and 'Ins X.' I can control my posting by carrier, so I set up Ins X Capitated to adjust off."

**Best practice:** Be sure to review your explanations of benefits (EOBs) even though you're not getting reimbursement on a claim-by-claim basis. The payer could still inaccurately process your payments.

#### Question 3: Can I still bill the secondary if the primary is capitated?

Yes. Submit claims to secondary insurance even if you have a capitation contract with the primary insurance.

**Best bet:** Include a statement with the claim you send to the secondary payer explaining that the physician receives payment under a capitation contract from the primary insurance company. Make sure the secondary payer understands that just because the EOB from the primary payer shows no payment, that doesn't mean the claim is invalid.

**Caution:** To get paid at secondary, you'll still need the EOB from the primary payer. If the primary payer, which you're capitated with, doesn't automatically provide the EOB, you need to work something out with the payer, or the secondary payer may not pay you. □

that patients receive from their physicians do not include all the information an insurer requires. This may slow down reimbursement if the patient tries to file the secondary claim himself. Secondary carriers will be able to pay the difference faster if they receive a CMS-1500 form.

**First step:** Check your Medicare explanation of benefits. The EOB will show you if the claim is crossing over to the secondary carrier. Then, print out each secondary claim that you're not sure will cross over.

**Next:** After one month, if the secondary carrier hasn't paid the claim, either submit the claim for the patient or call the secondary company and make sure it hasn't already received the claim from Medicare.

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### Don't Change Insertion Code by Plug Type

**Question:** *Our optometrist uses both temporary and permanent punctal plugs. Should I code differently for each type?*

California Subscriber

**Answer:** How you code the plug placement doesn't change based on the type of plug. There are three types of punctal plugs that an optometrist may use: temporary collagen, semipermanent silicone, and intracanalicular plugs.

You should use 68761 (*Closure of the lacrimal punctum; by plug, each*) for punctal plug insertion, regardless of type. For Medicare claims, you should append the E modifiers to the procedural code to explain the plug's location. Use modifier E1 (*Upper left lid*), E2 (*Lower left lid*), E3 (*Upper right lid*) or E4 (*Lower right lid*), depending on where the ophthalmologist placed the punctal plug.

**Alternative:** Most non-Medicare carriers do not recognize the E modifiers. Instead, you can use modifiers RT (*Right side*) and LT (*Left side*).

**Supplies:** Don't expect payment for punctal plug supplies from Medicare — it considers the plugs non-billable. Non-Medicare carriers, however, may pay for the plug supply. Depending on the type of plug, you'll report A4262 (*Temporary, absorbable lacrimal duct implant, each*) or A4263 (*Permanent, long-term, nondissolvable lacrimal duct implant, each*) for some carriers.

Still other carriers may prefer 99070 (*Supplies and materials [except spectacles], provided by the physician over and above those usually included with the office visit or other services rendered [list drugs, trays, supplies, or materials provided]*).

**Tip:** Carriers pay close attention to whether punctal plugs are medically necessary. Your documentation should show that you first tried other treatments, such as eye drops or ointments, and that they failed.

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### Document Complaint for Glaucoma Follow-Up

**Question:** *How should I code an office visit for a wheelchair-bound nursing home patient who comes in for a follow-up for glaucoma?*

Texas Subscriber

**Answer:** Optometrists often have to follow up with glaucoma patients because of medications or postsurgical concerns. Many practices differ in their coding method for follow-up visits, using either E/M or eye codes. Both sets are acceptable. The eye codes (92002-92014) require less documentation, but to bill them you must perform the required exam elements — and you must consider those elements medically necessary for the presenting problem.

When documenting follow-up glaucoma visits, be sure to document a chief complaint even if it is simply "follow-up glaucoma." Even though the patient is from a nursing home, the place of service is always where she is seen — in this case, your office.

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(Continued on next page)

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## Get a Handle on Timely Filing Date Rules

**Question:** What is the best way to handle a claim that is past the timely filing date for the insurance company?

Mississippi Subscriber

**Answer:** Most likely you're going to have to write off the entire claim amount. If you have not yet submitted the claim, you can submit it to the payer, which will deny the claim, and you will have to write it off.

If you submitted it on time and the payer is denying you for timely filing reasons, you must appeal the denial with proof of timely filing (in most cases, payers only accept your electronic confirmation).

The only time you can submit a bill after the timely filing deadline and successfully seek payment is if the patient did not provide you with the proper information before the filing deadline. Then the payment is the patient's responsibility, and you should bill the patient rather than write off the claim amount.

**Good news:** Some billers say that they've successfully appealed timely filing denials when the patient did not provide the information until after the filing limit. You can try appealing the denial, explaining that if the patient had provided you with the correct insurance information, you would have filed the claim within the proper amount of time. You may want to include documentation showing when you first billed the patient and a history of all other statements you sent to the patient.

**Exceptions:** Payers will make an exception to timely filing rules due to things like natural disasters or exceptional circumstances, such as a failed implementation of a new billing system. They may apply a one-time exception. Contact your payer in these circumstances, explain the situation, and request an extension.

— *Answers to You Be the Expert, Reader Questions and Build a Better Business reviewed by David Gibson, OD, FAAO, practicing optometrist in Lubbock, Texas.* □

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