



**Ophthalmology
Optometry
Billing
Guide
July 2010**

NHIC, Corp.

Ophthalmology/Optometry Billing Guide

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INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Ophthalmology/Optometry billing information. It is intended to serve as a useful supplement to other manuals published by 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 Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by CMS, are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), *Medicare B Resource* (quarterly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-02, Chapter 15 & 16; Publication 100-03, Chapter 1; and Publication 100-04, Chapter 12 and 32 of the CMS Online Manual System. The CMS Online Manual System provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://cms.hhs.gov/manuals>.

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If you have questions or comments regarding this material, please call the appropriate NHIC Customer Service Center for your state. The telephone numbers are listed at the end of this guide.

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GENERAL INFORMATION

Medicare Part B provides benefits for ophthalmology/optometry services which are medically necessary for the diagnosis or treatment of an illness or injury. The services must be consistent with the physician's scope of practice. Where more than one practitioner furnishes concurrent care, services furnished to a beneficiary by both an ophthalmologist and another physician (including an optometrist) may be recognized for payment if it is determined that each practitioner's services were reasonable and necessary.

Provider Qualifications

Physician/Ophthalmologist

A physician is defined as a doctor of medicine or doctor of osteopathy. The issuance, by a State, of a license to practice medicine constitutes legal authorization. Temporary State licenses also constitute legal authorization to practice medicine. The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice. If State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within those limitations are covered.

Optometrist

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

Opticians

Opticians should contact their local Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for any questions regarding their services.

EYE SERVICES COVERAGE

Some of the following services are covered through a National Coverage Determination (NCD) and are noted as such. For additional information about NCDs, visit the CMS website at <http://www.cms.hhs.gov/center/coverage.asp>.

Blepharoplasty

Blepharoplasty may be defined as any eyelid surgery that improves abnormal function, reconstructs deformities, or enhances appearance. It may be either reconstructive or cosmetic. Blepharoplasty may be considered reconstructive when performed for one of the following conditions that may affect both upper and lower lids:

- Corrects visual impairment
- Repairs anatomical or pathological defects

- Relieves eye symptoms associated with blepharospasm

When blepharoplasty is performed to improve a patient's appearance in the absence of any signs or symptoms or functional abnormalities, the procedure is cosmetic and **not** allowed. When blepharoplasty is performed to correct visual impairment or repair defects caused by trauma, it is considered reconstructive and is allowed.

Procedure Codes

15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

Note: Please view the complete local coverage determination (LCD) for coverage guidelines, medically necessary medical conditions, and frequency limitations on the NHIC Web site.

Capsule Opacification Following Cataract Surgery: Discission and YAG Laser Capsulotomy

Posterior capsule opacification (PCO) is one of the most common problems following cataract surgery. Anterior capsule opacification (ACO) also occurs, but somewhat less commonly. Both conditions represent the anatomic correlate of a secondary cataract (SC). As capsule opacification increases, the patient begins to notice a decrease in vision that can lead to functional impairment. The approach to the management of functional impairment due to SC, whether the result of ACO or PCO, or both, is similar to that of functional impairment due to cataract. Treatment of SC is reserved for those patients who have documented functional impairment that impacts their ability to perform needed and desired activities of daily living.

Discission and Yag laser capsulotomy is reasonable and medically necessary only to remedy a functional impairment due to opacification, to prevent possible intraocular damage from dislocation of the intraocular lens implant, or the need to evaluate and treat posterior segment pathology.

Procedure Code

66820	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g. YAG laser) one or more stages

Note: Please view the complete local coverage determination (LCD) for coverage guidelines, medically necessary medical conditions, and frequency limitations on the NHIC Web site.

Computer Enhanced Perimetry - NCD

Computer enhanced perimetry involves the use of a micro-computer to measure visual sensitivity at preselected locations in the visual field. It is a covered service when used in assessing visual fields in patients with glaucoma or other neuropathologic defects.

Diabetic Retinopathy Services

Coverage is allowed for diagnostic ophthalmological services provided to diabetic patients at risk for retinopathy. Such tests and evaluations are not considered routine screening services as they are ordered to assess the presence or extent of diabetic retinopathy as part of the appropriate management of a patient with diabetes. Payment is permitted for the following services when performed for assessment of diabetic retinopathy:

- Eye examinations,
- Evaluation and management services,
- Ophthalmoscopy,
- Fluorescein angiography,
- Fluorescein angiography
- Indocyanine-green angiography,
- Fundus photography, and
- Ophthalmodynamometry

Note: The appropriate ICD-9-CM code for diabetes should be reported as the primary diagnosis.

Endothelial Cell Photography - NCD

Endothelial cell photography involves the use of a specular microscope to determine the endothelial cell count. It is used by ophthalmologists as a predictor of success of ocular surgery or certain other ocular procedures. Endothelial cell photography is a covered procedure when reasonable and necessary 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 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 or irido-corneal-endothelium syndrome, or
- 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, if the only visual problem is cataracts, 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.

Evoked Response Tests (NCD)

Evoked response tests, including brain stem evoked response and visual evoked response tests are generally accepted as safe and effective diagnostic tools. These tests measure brain responses to repetitive visual, click, or other stimuli. Program payment may be made for these procedures.

Glaucoma Screening

Conditions of Coverage

Medicare provides annual coverage for glaucoma screening for beneficiaries in the following high risk categories:

- Individuals with diabetes mellitus;
- Individuals with a family history of glaucoma; or
- African-Americans age 50 and over;
- Hispanic-Americans age 65 and over, considered to be at high-risk (effective January 1, 2006).

Medicare will pay for glaucoma screening examinations where they are furnished by or under the direct supervision in the office setting of an ophthalmologist or optometrist, who is legally authorized to perform the services under State law.

Screening for glaucoma is defined to include:

- A dilated eye examination with an intraocular pressure measurement; and
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

Frequency

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. To determine the 11 month period, start the count beginning with the month after the month in which the previous covered screening procedure was performed.

Example: If a beneficiary receives a screening on September 15, 2008, begin counting with the next month (October 2008) until 11 full months have elapsed. Payment can be made for a glaucoma screening rendered anytime in September 2009.

Diagnosis

Providers bill glaucoma screening using the screening diagnosis code V80.1 (Special Screening for Neurological, Eye, and Ear Diseases, Glaucoma). Claims submitted without a screening diagnosis code may be returned to the provider as unprocessable.

Procedure Codes

- G0117** Glaucoma screening for high risk patients furnished by an Optometrist or Ophthalmologist;
- G0118** Glaucoma screening for high risk patients furnished under the direct supervision of an Optometrist or Ophthalmologist.

Payment

Payment for glaucoma screening is based on the Medicare physician fee schedule. Deductible and coinsurance apply. Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge.

Note: The above procedures are only paid if there are no other services paid to the provider for the same date of service under the physician's fee schedule. They are bundled into the service for which payment is made.

Hydrophilic Contact Lenses - NCD

Hydrophilic contact lenses are eyeglasses and are **not** covered when used in the treatment of non diseased eyes with spherical ametropia, refractive astigmatism, and/or corneal astigmatism. However, payment may be made under the prosthetic device benefit for hydrophilic contact lenses when prescribed for an aphakic patient. Prosthetic devices are processed by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

Hydrophilic Contact Lens for Corneal Bandage - NCD

Some hydrophilic contact lenses are used as moist corneal bandages for the treatment of acute or chronic corneal pathology, such as bulbous keratopathy, dry eyes, corneal ulcers and erosion, keratitis, corneal edema, descemetocele, corneal ectasis, Mooren's ulcer, anterior corneal dystrophy, neurotrophic keratoconjunctivitis, and for other therapeutic reasons. Payment may be made for a hydrophilic contact lens approved by the Food and Drug Administration (FDA) when used as a supply incident to a physician's service. The lens is **not** paid separately from the physician's payment.

Intraocular Lenses (IOLs) - NCD

An intraocular lens, or pseudophakos, is an artificial lens which may be implanted to replace the natural lens after cataract surgery. Intraocular lens implantation services, as well as the lens itself, may be covered if reasonable and necessary for the individual. Implantation services may include hospital, surgical, and other medical services, including pre-implantation ultrasound (A-scan), eye measurement of one or both eyes.

Note: Intraocular lenses inserted during or subsequent to cataract surgery are payable separately when billed by a physician if payment has not been made to an Ambulatory Surgical Center (ASC). An IOL inserted in an ASC is included in the facility payment. The facility payment includes an allowance for the supply of the lens. When a beneficiary requests insertion of a presbyopia-correcting IOL or an astigmatism-correcting IOL instead of a conventional IOL

following removal of a cataract, special provisions apply. See Presbyopia-Correcting Intraocular Lenses (P-C IOLs) and Astigmatism-Correcting Intraocular Lenses (A-C IOLs).

Intraocular Photography – NCD

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

Iridotomy/Iridectomy by Laser Surgery

Laser iridotomy/iridectomy is used in the treatment of angle-closure glaucoma and for occludible narrow angles. It is often an alternative therapy to surgical peripheral iridectomy. The laser creates an opening in the peripheral iris, improving the outflow of aqueous humor, and relieving actual or potential pupillary block.

Procedure Code

66761 Iridotomy/iridectomy by laser surgery (e.g. for glaucoma) one or more sessions

Keratoplasty - NCD

Keratoplasty that treats specific lesions of the cornea, such as phototherapeutic keratectomy that removes scar tissue from the visual field, deals with an abnormality of the eye and is not cosmetic surgery may be covered. The use of lasers to treat ophthalmic disease constitutes ophthalmologic surgery. Coverage is restricted to practitioners who have completed an approved training program in ophthalmologic surgery.

Keratoplasty-Descemet Stripping

A newer procedure is termed "Descemet's stripping endothelial keratoplasty" or "deep lamellar endothelial keratoplasty." This procedure involves a small incision to allow intraocular placement of endothelium harvested from a donor cornea after the stripping off of diseased corneal endothelium. Microkeratome-based (automated) preparation of the donor endothelium may be used. This technique offers certain clinical advantages while achieving the goal of penetrating keratoplasty in patients with disease largely related to endothelial dysfunction.

The new Descemet's stripping procedure may be adequately coded as 65730, 65750, or 65755 (based on the patient's lens status), until such time as a more specific code is released. Coding with an unlisted procedure code such as 66999 is not incorrect, but will trigger delays for additional documentation requests, processing, review, and determination of reimbursement.

Keratoplasty (Refractive) - NCD

Refractive keratoplasty is surgery to reshape the cornea of the eye to correct vision problems such as myopia (nearsightedness) and hyperopia (farsightedness). Refractive keratoplasty procedures include keratomileusis, in which the front of the cornea is removed, frozen, reshaped, and stitched back on the eye to correct either near or farsightedness; keratophakia, in which a reshaped donor cornea is inserted in the eye to correct farsightedness; and radial keratotomy, in

which spoke-like slits are cut in the cornea to weaken and flatten the normally curved central portion to correct nearsightedness.

The correction of common refractive errors by eyeglasses, contact lenses or other prosthetic devices is specifically excluded from coverage. The use of radial keratotomy and/or keratoplasty for the purpose of refractive error compensation is considered a substitute or alternative to eye glasses or contact lenses which are specifically excluded (except in certain cases in connection with cataract surgery). In addition, many in the medical community consider such procedures cosmetic surgery which is also excluded from coverage. Therefore, radial keratotomy and keratoplasty to treat refractive defects are not covered.

Laser Procedures

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

The determination of coverage for a procedure performed using a laser is made on the basis that the use of lasers to alter, revise, or destroy tissue is a surgical procedure. Therefore, coverage of laser procedures is restricted to practitioners with training in the surgical management of the disease or condition being treated.

Macugen Treatment of Wet Age-Related Macular Degeneration

Macugen®, pegaptanib sodium injection, received approval from the Food and Drug Administration (FDA) December 17, 2004, for the treatment of (wet) age-related macular degeneration only.

Per package insert, the safety and efficacy of Macugen™ therapy administered to both eyes during the same session has not been studied; therefore, NHIC will cover only one intravitreal injection of Macugen® per date of service.

Coding guidelines include the following:

Diagnosis (ICD-9-CM):	362.52	Exudative senile macular degeneration
Procedure Codes:	J2503	Injection, pegaptanib sodium, 0.3mg
	67028	Intravitreal injection of a pharmacologic agent- separate procedure (Use LT and RT Modifiers)

Ocular Photodynamic Therapy (OPT) -NCD

OPT is used in the treatment of ophthalmologic diseases; specifically, for age-related macular degeneration (AMD), a common eye disease among the elderly. OPT involves the infusion of an

intravenous photosensitizing drug called verteporfin followed by exposure to a laser. OPT is **only** covered when used in conjunction with verteporfin.

OPT with verteporfin is approved for:

- Neovascular AMD with **predominately classic** subfoveal choroidal neovascularization (CNV) lesions (where the area of classic CNV occupies $\geq 50\%$ of the area of the entire lesion) at the initial visit as determined by a fluorescein angiogram. (CNV lesions are comprised of classic and/or occult components). Subsequent follow-up visits require a fluorescein angiogram prior to treatment. There are no requirements regarding visual acuity, lesion size, and number of re-treatments when treating predominantly classic lesions.
- Subfoveal occult with **no classic** CNV associated with AMD; and,
- Subfoveal **minimally classic** CNV (where the area of classic CNV occupies $<50\%$ of the area of the entire lesion) associated with AMD.

The subfoveal treatments are considered reasonable and necessary only when:

- The lesions are small (4 disk areas or less in size) at the time of initial treatment or within the 3 months prior to initial treatment; and,
- The lesions have shown evidence of progression within the 3 months prior to initial treatment. Evidence of progression must be documented by deterioration of visual acuity (at least 5 letters on a standard eye examination chart), lesion growth (an increase in at least 1 disk area), or the appearance of blood associated with the lesion.

Procedure Codes

67221 Destruction of localized lesion of choroid (e.g. choroidal neovascularization); photodynamic therapy (includes intravenous infusion)

67225 Destruction of localized lesion of choroid (e.g. choroidal neovascularization); photodynamic therapy, second eye, at single session (list separately in addition to code for primary eye treatment-67221)

Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography)

Extended ophthalmoscopy is the detailed examination of the retina **with drawing**. It is most frequently performed utilizing an indirect lens, although it may be performed using contact lens biomicroscopy. It may use scleral depression. It is performed by the physician, when a more detailed examination (including that of the periphery) is needed following routine ophthalmoscopy. It is usually performed with the pupil dilated and always includes a true drawing of the retina (macula, fundus and periphery) with interpretation and report.

Extended Ophthalmoscopy Documentation Guidelines:

Retinal drawings must be maintained in the patient's record.

- There must be a separate detailed sketch, minimal size of 3-4 inches.
- All items noted must be identified and labeled.
- Drawings in four (4) - six (6) standard colors are preferred. However, non-colored drawings are also acceptable, if clearly labeled.
- Optic nerve abnormalities should be separately drawn.
- An extensive scaled drawing must accurately represent normal, abnormal and common findings such as: lattice degeneration, hypertensive vascular changes, proliferative diabetic retinopathy, as well as retinal detachments, holes, tears or tumors.

Fundus photography involves the use of a retinal camera to photograph the regions of the vitreous, retina, choroid and optic nerve.

Fundus Photography Documentation Guidelines:

A copy of the fundus photographs must be retained in the patient's medical records. An interpretation and report of the test must also be included, in addition to the photographs themselves. The medical record should document whether the pupil was dilated, and which drug was used.

Procedure Codes

- 92225** Ophthalmoscopy, extended, with retinal drawing (e.g. for retinal detachment, melanoma), with interpretation and report; initial
- 92226** Ophthalmoscopy, extended, with retinal drawing (e.g. for retinal detachment, melanoma), with interpretation and report; subsequent
- 92250** Fundus photography with interpretation and report

Note: Please view the complete local coverage determination (LCD) for coverage guidelines, medically necessary medical conditions, and frequency limitations on the NHIC Web site.

Pachymetry

Pachymetry is the ultrasonic measurement of the thickness of the cornea.

Corneal pachymetry is covered when:

- The test is integral to the medical management decision-making of the patient; and
- The patient has **one** of the following conditions:
 - Corneal ectasias, e.g., keratoglobus, pellucid degeneration, and keratoconus;
 - Fuch's endothelial dystrophy or bullous keratopathy;
 - Posterior polymorphous dystrophy;
 - Corneal rejection post-penetrating keratoplasty;
 - Corneal edema;

Elevated intraocular pressure in glaucoma suspect when corneal thickness is unknown;

Worsening of glaucoma when corneal thickness is unknown;

Enlarged cup-disc ratio is equal to or greater than 0.3;

- Preoperatively for patients scheduled for corneal transplant; or
- Postoperatively when the test is performed following corneal transplant.

Procedure Code

76514 Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)

Note: Please view the complete local coverage determination (LCD) for coverage guidelines, medically necessary medical conditions, and frequency limitations on the NHIC Web site.

Phaco-Emulsification Procedure - Cataract Extraction - NCD

In view of recommendations of authoritative sources in the field of ophthalmology, the subject technique is viewed as an accepted procedure for removal of cataracts. Accordingly, program reimbursement may be made for necessary services furnished in connection with cataract extraction utilizing the phaco-emulsification procedure.

Photodynamic Therapy - NCD

Photodynamic therapy is a medical procedure which involves the infusion of a photosensitive (light-activated) drug with a very specific absorption peak. This drug is chemically designed to have a unique affinity for the diseased tissue intended for treatment. Once introduced to the body, the drug accumulates and is retained in diseased tissue to a greater degree than in normal tissue. Infusion is followed by the targeted irradiation of this tissue with a non-thermal laser, calibrated to emit light at a wavelength that corresponds to the drug's absorption peak. The drug then becomes active and locally treats the diseased tissue.

Photosensitive Drugs - NCD

Photosensitive drugs are the light-sensitive agents used in photodynamic therapy. Once introduced into the body, these drugs selectively identify and adhere to diseased tissue. The drugs remain inactive until they are exposed to a specific wavelength of light, by means of a laser, that corresponds to their absorption peak. The activation of a photosensitive drug results in a photochemical reaction which treats the diseased tissue without affecting surrounding normal tissue.

Presbyopia-Correcting Intraocular Lenses (P-C IOLs) and Astigmatism-Correcting Intraocular Lenses (A-C-IOLs)

Presbyopia is a type of age-associated refractive error that results in progressive loss of the focusing power of the lens of the eye, causing difficulty seeing objects at near distance, or close-up. Presbyopia occurs as the natural lens of the eye becomes thicker and less flexible with age. A presbyopia-correcting IOL is indicated for primary implantation in the capsular bag of the eye for

the visual correction of aphakia (absence of the lens of the eye) following cataract extraction that is intended to provide near, intermediate, and distance vision without the need for eyeglasses or contact lenses.

Regular astigmatism is a visual condition where part of an image is blurred due to uneven corneal curvature. A normal cornea has the same curvature at all axes, whereas the curvature of an astigmatic cornea differs in two primary axes, resulting in vision that is distorted at all distances. The astigmatism-correcting IOL is intended to provide what is otherwise achieved by two separate items; an implantable conventional IOL (one that is not astigmatism-correcting) that is covered, and the surgical correction, eyeglasses or contact lenses that are not covered.

For a P-C IOL or A-C IOL inserted in a physician's office:

- A physician shall bill for a conventional IOL, regardless of whether a conventional, P-C IOL, or A-C-IOL is inserted
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a P-C IOL or A-C IOL following removal of a cataract that exceed the physician charges for services and supplies for the insertion and adjustment of a conventional IOL.
- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, service and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of a P-C IOL or A-C IOL that exceed physician charges for services and supplies to examine and monitor a beneficiary following removal of a cataract with insertion of a conventional IOL.

For a P-C IOL or A-C IOL inserted in a hospital:

- A physician may not bill Medicare for a P-C IOL or A-C IOL inserted during a cataract procedure performed in a hospital setting because the payment for the lens is included in the payment made to the facility for the surgical procedure.
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a P-C IOL or A-C IOL following removal of a cataract that exceed the physician charges for services and supplies required for the insertion of a conventional IOL.

Coding and General Billing Requirements:

Physicians must report one of the following Current Procedural Terminology (CPT) codes on the claim:

66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration)

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or phacoemulsification), complex requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic development stage.

- 66983** Intracapsular cataract with insertion of intraocular lens prosthesis (one stage procedure)
- 66984** Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)
- 66985** Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract extraction
- 66986** Exchange of intraocular lens

Physicians shall bill the following CPT codes for evaluation and management services associated with the services following cataract extraction surgery:

- 92002** Ophthalmological services; medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
- 92004** Ophthalmological services; medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
- 92012** Ophthalmological services; medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate established patient
- 92014** Ophthalmological services; medical examination and evaluation with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more services

Additional services:

- Physicians inserting a P-C IOL or A-C IOL in an office setting may bill code V2632 (posterior chamber intraocular lens) for the IOL. Medicare will make payment for the lens based on reasonable cost for a conventional IOL.
- Effective for dates of service on and after January 1, 2006, physicians may also bill the non-covered charges related to the P-C IOL using HCPCS code V2788 (Presbyopia-correcting function of an intraocular lens). Effective for dates of service on and after January 22, 2007 through December 31, 2007, physicians may also bill the non-covered charges related to the A-C IOL using HCPCS V2788.

- Effective for services on and after January 1, 2008, V2788 is no longer valid to report non-covered charges associated with the **A-C IOL**. HCPCS V2787 (Astigmatism correcting function of an intraocular lens) should be used to report non-covered charges for the **A-C IOL** functionality of the inserted intraocular lens. HCPCS code V2788 continues to be billable for the **P-C IOL**.

Notification:

When a beneficiary requests insertion of a P-C IOL or A-C IOL instead of a conventional IOL following removal of a cataract:

- Prior to the procedure to remove a cataractous lens and insert a P-C IOL or A-C IOL, the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the insertion, adjustment, or other subsequent treatments related to the P-C or A-C functionality of the IOL.
- The P-C or A-C functionality of a P-C IOL or A-C IOL does not fall into a Medicare benefit category, and, therefore, is not covered. The physician is not required to provide an Advanced Beneficiary Notice to beneficiaries who request a P-C IOL or A-C IOL. Although not required, we strongly encourage physicians to issue a Notice of Exclusion from Medicare Benefits to beneficiaries in order to clearly identify the non-payable aspects of a P-C IOL or A-C IOL insertion.

Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

SCODI is a non-invasive, non-contact imaging technique. SCODI produces high resolution, cross-sectional tomographic images of ocular structures and is used for the evaluation of anterior segment and posterior segment disease.

Posterior segment SCODI allows for earlier detection of optic nerve and retinal nerve fiber layer pathologic changes before there is visual field loss. When appropriately used in the management of the glaucoma patient or glaucoma suspect, therapy can be initiated before there is irreversible loss of vision. This imaging technology provides the capability to 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. SCODI also permits high resolution assessment of the retinal and choroidal layers, the presence of thickening associated with retinal edema, and of macular thickness measurement. Vitreo-retinal and vitreo-papillary relationships are displayed permitting surgical planning and assessment.

Anterior segment SCODI is used in the evaluation and treatment planning of diseases affecting the cornea, iris, and other anterior chamber structures. The procedure also may be used to provide additional information during the planning and follow-up for corneal, iris, and cataract surgeries.

Procedure Code

- 92135** Scanning computerized ophthalmic diagnostic imaging, posterior segment, (e.g. scanning laser) with interpretation and report, unilateral
- 0187T** Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral

Note: Please view the complete local coverage determination (LCD) for coverage guidelines, medically necessary medical conditions, and frequency limitations on the NHIC Web site.

Scleral Shell - NCD

Scleral shell (or shield) is a term for 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 encompassing the pupil and iris. Where an eye has been rendered sightless and shrunk by inflammatory disease, a scleral shell may, among other things, obviate the need for surgical enucleation and prosthetic implant and act to support the surrounding orbital tissue. In such a case, the device serves essentially as an artificial eye. In this situation, payment may be made for a scleral shell.

Scleral shells are occasionally used in combination with artificial tears in the treatment of “dry eye” of diverse etiology. Tears ordinarily dry at a rapid rate, and are continually replaced by the lacrimal gland. When the lacrimal gland fails, the half-life of artificial tears may be greatly prolonged by the use of the scleral contact lens as a protective barrier against the drying action of the atmosphere. Thus, the difficult and sometimes hazardous process of frequent installation of artificial tears may be avoided. The lens acts in this instance to substitute, in part, for the functioning of the diseased lacrimal gland and would be covered as a prosthetic device in the rare case when it is used in the treatment of “dry eye.” Prosthetic devices are processed by The Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

Verteporfin-NCD

Verteporfin, a benzoporphyrin derivative, is an intravenous lipophilic photosensitive drug with an absorption peak of 690 nm. Verteporfin is only covered when used in conjunction with ocular photodynamic therapy (OPT) when furnished intravenously, incident to a physician’s service. The OPT must be determined to be medically necessary and reasonable for the verteporfin to be allowed.

Procedure Code

- J3396** Injection, Verteporfin, 0.1 mg

Visual Rehabilitative Therapy

Low vision rehabilitative therapy utilizes aids and education to minimize vision-related disability when no restorative process is possible, for example, correction of refractive error, corneal transplantation, or cataract surgery.

The purpose of rehabilitative therapy is to maximize the use of residual vision and provide patients with many practical adaptations for activities of daily living, which can lead to an increased level of functional ability and independence.

A moderate visual impairment is defined as a best-corrected visual acuity of less than 20/60 in the better eye (including 20/70 to 20/160).

Severe visual impairment refers to a best-corrected visual acuity of less than 20/160 (including 20/200 to 20/400); or a visual field diameter of 20 degrees or less (largest field diameter for Goldmann isopter III4e, 1/100 white test object or equivalent) in the better eye.

A patient with vision loss may be eligible for rehabilitation services designed to improve functioning, by therapy, to improve performance of activities of daily living, including self-care and home management skills. Evaluation of the patient's level of functioning in activities of daily living, followed by implementation of a therapeutic plan of care aimed at safer and independent living, is critical.

Vision impairment ranging from low vision to total blindness may result from a primary eye diagnosis, such as macular degeneration, retinitis pigmentosa or glaucoma, or as a condition secondary to another primary diagnosis, such as diabetes mellitus or acquired immune deficiency syndrome (AIDS).

The patient must have a potential for restoration or improvement of lost functions, and must be expected to improve significantly within a reasonable and generally predictable amount of time. Rehabilitation services are not covered if the patient is unable to cooperate in the treatment program or if clear goals are not definable. Most rehabilitation is short-term and intensive. Maintenance therapy services required to maintain a level of functioning are not covered.

Procedure Codes

97110	Therapeutic exercises
97116	Gait training therapy
97532	Cognitive skills development
97533	Sensory integration
97535	Self care management training
97537	Community/work integration

Note: New Hampshire providers only may participate in the Low Vision Rehabilitation Demonstration Project through March 31, 2011. For detailed information, please view the educational article on the NHIC Web site.

Visual Fields Testing

Visual field testing detects defects in the field of vision, testing the function of the retina, optic nerve and optic pathways. Formal visual field tests are generally performed using automated perimetry, i.e., measurement of the ability to see points of light at varying locations on a curved surface. Gross visual field testing (e.g., confrontation testing) is a part of general ophthalmological service and should not be reported separately.

The patient's medical record must contain documentation that fully supports medical necessity. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

- 92081** Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
- 92082** Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
- 92083** Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 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 threshold programs 30-2, 24-2, or 30/60-2)

Note: Please view the complete local coverage determination (LCD) for coverage guidelines, medically necessary medical conditions, and frequency limitations on the NHIC Web site.

Visual Tests Prior to Cataract Surgery-NCD

In most cases, a comprehensive eye examination (ocular history and ocular examination) and a single scan to determine the appropriate pseudophakic power of the intraocular lens are sufficient. In most cases involving a simple cataract, a diagnostic ultrasound A-scan is used. For patients with a dense cataract, an ultrasound B-scan may be used. Accordingly, where the only diagnosis is cataract(s), Medicare does not routinely cover testing other 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 medically justified, a B-scan. Claims for additional tests are denied as not reasonable and necessary **unless** there is an additional diagnosis **and** the medical necessity for the additional tests is fully documented.

Vitrectomy - NCD

Vitrectomy may be considered reasonable and necessary for the following conditions:

- 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 retraction.

OTHER EYE SERVICES

A-Mode Scans

A-scan uses ultrasonography, or echography, to image intraocular anatomy to determine the axial length of the eye (from the cornea to the retina) for calculating the power required for an intraocular lens implant. High-frequency sound waves are introduced into the eye in a straight line by a transducer placed on the eye. As the waves reflect off the eye tissue, they are also picked up by the same transducer, converted to electrical pulses and displayed on screen. The resulting single-dimensional image is composed of vertical spikes that vary according to the tissue density. Report 76516 for ophthalmic measurements by ultrasound echography and 76519 if intraocular power lens calculation is done.

The technical component of the A-mode scan (76516-TC, 76519-TC) includes payment for both eyes since the technical component is typically performed on both eyes at the same time. Therefore, modifier 50 should not be reported with the technical component. If the scan is performed on only one eye, modifier 52 should be reported to indicate reduced services.

The professional component of the A-mode scan (76516-26, 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. Modifier 50 should be used only when the professional component is performed on both eyes at the same time (allowed on 76519-26 only). 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 even if the technical component was performed on one eye. Submit procedure code 76516 or 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 (76516-26 or 76519-26) is performed on both eyes on the same day.

Examples of billing:

Billing for technical component only:

Billing for both eyes:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1.		743 33				3.						
2.						4.						
	24. A. DATE(S) OF SERVICE					B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	
	From MM	DD	YY	To MM	DD			YY	CPT/HCPCS	MODIFIER		
1	03	01	2010	03	01	2010	11		76519	TC		1
2												
3												

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Billing for one eye:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1.		743 33					3.					
2.							4.					
24. A. DATE(S) OF SERVICE												
From		To		B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
1	03	01	2010	03	01	2010	11		76519	TC	52	1
2												
3												

Billing for professional component only:

Billing for both eyes:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1.		743 33					3.					
2.							4.					
24. A. DATE(S) OF SERVICE												
From		To		B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
1	03	01	2010	03	01	2010	11		76519	26	50	1
2												
3												

Billing for one eye:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1.		743 33					3.					
2.							4.					
24. A. DATE(S) OF SERVICE												
From		To		B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
1	03	01	2010	03	01	2010	11		76519	26		1
2												
3												

Billing globally when technical component performed on both or one eye and professional component performed on one eye only:

Billing technical both eyes and professional one eye:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1.		743 33					3.					
2.							4.					
24. A. DATE(S) OF SERVICE												
From		To		B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
1	03	01	2010	03	01	2010	11		76519			1
2												
3												

by 2010

or copy, either electronic

Ophthalmology/Optometry Billing Guide

Billing for technical one eye and professional one eye:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1. 743 33		3. _____										
2. _____		4. _____										
24. A. DATE(S) OF SERVICE												
From To												
MM	DD	YY	MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
1	03	01	2010	03	01	2010	11		76519	52		1
2												
3												

~~Billing for technical component for both or one eye and professional component of both eyes:~~

Billing for technical both eyes:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1. 743 33		3. _____										
2. _____		4. _____										
24. A. DATE(S) OF SERVICE												
From To												
MM	DD	YY	MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
1	03	01	2010	03	01	2010	11		76519	TC		1
2												
3												

Billing for technical one eye:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1. 743 33		3. _____										
2. _____		4. _____										
24. A. DATE(S) OF SERVICE												
From To												
MM	DD	YY	MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
1	03	01	2010	03	01	2010	11		76519	TC 52		1
2												
3												

Ophthalmology/Optometry Billing Guide

Billing for professional both eyes:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)													
1. 743		33		3. _____									
2. _____													
4. _____													
	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
1	03	01	2010	03	01	2010	11		76519	26	50	1	
2													
3													

Assistant at Cataract Surgery

In some states, prior authorization is required for coverage of services of an assistant at cataract surgery. Contact the appropriate Quality Improvement Organization (QIO) to obtain the prior authorization number for the following CPT-4 procedure codes: 66852, 66920, 66930 and 66940 and 66986.

Massachusetts

Mass QIO
245 Winter Street
Waltham, MA 02451-1231
1-781-890-0011

Maine, New Hampshire, Vermont

Northeast Health Care Quality Foundation
15 Old Rollinsford Road, Suite 302
Dover, NH 03820-2830
1-800-772-0151

Rhode Island

Quality Partners of Rhode Island
235 Promenade Street
Suite 500, Box 18
Providence, RI 02908
401-528-3200

The QIO prior authorization number for these procedures must be entered in Item 23 of the CMS-1500 claim form or electronic media claim equivalent.

Eye Examinations and Evaluation and Management Services on the Same Day

An ophthalmologist/optometrist may bill either an Evaluation and Management (E/M) service or an ophthalmologic examination, whichever is most appropriate. Both services cannot be billed on the same day.

Eye Examinations and Refractions

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors are not covered. Expenses for all refractive procedures, whether performed by an ophthalmologist or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage. NHIC will deny vision services reported with ICD-9-CM diagnosis codes 367.0 through 367.9 (disorders of refraction and accommodation) as routine eye exams.

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) or to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease.

Note: NHIC, Corp and CMS are working closely to reduce the claim submission error rate. One of the top errors is billing for procedure code 92015 - the determination of refractive state. Non-covered services are sometimes billed to Medicare for the purpose of a claim denial. The denial is then forwarded to the patient's secondary insurance for payment consideration. Non-covered services such as "determination of refractive state" must be billed with the **GY** modifier. The **GY** modifier indicates the provider is aware the service is non-covered and the patient is financially responsible for the service.

Eyeglasses and Contact Lenses

Payment may be made for no more than one pair of conventional eyeglasses or contact lenses furnished after each cataract surgery with insertion of an intraocular lens. The eyeglasses or contact lenses are covered as prosthetic devices. Prosthetic devices are processed by The Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

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 is 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.

All eye care services related to the investigation of the IOL must be provided by the investigator (i.e., 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, are not covered

during the period the IOL is being investigated, unless the services are not related to the investigation.

Fitting of Spectacles

Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of the spectacles. Payment for fitting of spectacles, CPT codes 92352 through 92355, 92358 and 92371, is bundled into the payment for the spectacles.

Note: Procedure codes 92340, 92341, 92342 and 92370 are noncovered.

General Anesthesia during Cataract Surgery

The use of general anesthesia in cataract surgery may be considered reasonable and necessary if, for particular medical indications, it is the accepted procedure among ophthalmologists in the local community to use general anesthesia. Anesthesia is not paid separately when the ophthalmologist performs both the surgical procedure and the anesthesia.

Lacrimal Punctum Plugs

Payment for HCPCS procedure code A4263 (permanent, long term, non-dissolvable lacrimal duct implant, each) is bundled into the payment for the physician's service, and is not separately payable.

Miscellaneous

Brightness acuity, glare tests, photokeratoscopy, and potential acuity metered tests are included in the payment for the visit. No separate payment may be made for these services.

GLOBAL SURGERY

The "global surgical package" includes all necessary services performed by the physician the day before major surgeries, the day of 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.

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing physician.

Procedure codes with 90 follow-up days are considered major surgeries.
Procedure codes with 0 or 10 follow-up days are considered minor surgeries.

Global days can be found on the CMS website at www.cms.hhs.gov/physicianfeesched/.

Services Included in the Global Surgery Package

- **Preoperative Visits** - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- **Intra-operative Services** - Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- **Complications Following Surgery** - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
- **Postoperative Visits** - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- **Postsurgical Pain Management** - By the surgeon;
- **Supplies** - Except for those identified as exclusions; and
- **Miscellaneous Services** - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Services Not Included in the Global Surgical Package

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Please note that this policy only applies to major surgical procedures. The initial evaluation is always included in the allowance for a minor surgical procedure;
- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record;
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;
- Diagnostic tests and procedures, including diagnostic radiological procedures;
- Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications; (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 prospectively or at the time of the first procedure.)
- Treatment for postoperative complications which requires a return trip to the operating room;
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;
- Splints and casting supplies are payable separately under the reasonable charge payment methodology;
- Immunosuppressive therapy for organ transplants; and

- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

Transfer of Care between Providers

Ordinarily, the global surgery fee schedule allowance includes preoperative evaluation and management services rendered the day of or the day before surgery, the surgical procedure, and the postoperative care services within the defined postoperative period. Postoperative care may be rendered by an ophthalmologist, optometrist, or providers who are licensed to render such services. When a physician transfers the care of a patient to another provider outside their group practice within the global period, it is considered “a transfer of care”. A transfer of care occurs when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance. Each provider must agree and document the transfer of care in the medical record. The agreement must be in the form of a letter or written as a notation in the discharge summary/hospital records or Ambulatory Surgical Center records. The appropriate CPT-4 modifiers must be added to the surgical procedure code:

- 54 Surgical care only
- 55 Postoperative management only
- 79 Unrelated Procedure or Service by the Same Physician during the Postoperative Period

The claim for the surgical care only and the claim for the postoperative care only must identify the same *surgical date of service* and the *same surgical procedure code*. Modifier 54 must be reported with the surgical care only.

Note: If the same physician performs an unrelated procedure during a postoperative period, the procedure should be reported with modifier 79 (unrelated procedure by the same physician during a postoperative period). A new global period begins.

Example:

Billing for 1st Eye

Dr. Jones performs procedure code 66984 on March 1st and cares for the patient through April 29th. Dr. Smith assumes responsibility for the patient on April 30th for the remainder of the global period.

Note: The date that care was either assumed or relinquished by the rendering provider must be entered in Item 19 of the CMS 1500 Claim Form or electronic equivalent. Bill with 1 unit of service.

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Dr. Jones' claim: assumed 03022010 relinquished 04292010

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1.		743 33						3.				
2.								4.				
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		
From	To											
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER				
03	01	2010	03	01	2010	22	66984	54			1	
03	01	2010	03	01	2010	22	66984	55			1	
03	01	2010	03	01	2010	22						

Dr. Smith's claim: assumed 04302010 relinquished care 05302010

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1.		743 33						3.				
2.								4.				
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		
From	To											
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER				
03	01	2010	03	01	2010	22	66984	55			1	

Billing for 2nd Eye

Dr. Jones performs procedure code 66984 on the 2nd eye on May 1st and cares for the patient through June 29th. Dr. Smith assumes responsibility for the patient on June 30th for the remainder of the global period.

Note: The date that care was assumed or relinquished by the rendering provider must be entered in item 19 of the CMS 1500 Claim Form or electronic equivalent. Bill with 1 unit of service.

Dr. Jones' claim: assumed 05022010 relinquished 06292010

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1.		743 33						3.				
2.								4.				
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		
From	To											
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER				
05	01	2010	05	01	2010	22	66984	79 54			1	
05	01	2010	05	01	2010	22	66984	79 55			1	

Ophthalmology/Optometry Billing Guide

Dr. Smith's claim: assumed 06302010 relinquished 07302010

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1. 743 33				3. _____								
2. _____				4. _____								
24. A. DATE(S) OF SERVICE To B. PLACE OF C. D. PROCEDURES, SERVICES, OR SUPPLIES E.												
From To MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER DIAGNOSIS POINTER												
1	05	01	2010	05	01	2010	22		66984	79	55	1
2												
3												

For claims where physicians share postoperative care, the assumed and/or relinquished dates of care must be indicated in Item 19 of the CMS-1500 claim form, or electronic media claim equivalent. Bill with 1 unit of service.

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. 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 for postoperative care for 66983 is 20 percent, and the length of the global period is 90 days.

Example follows:

Fee schedule amount for 66983 = \$550.00

Post-op days 90

Post-op care (20%) = \$110.00

Dr. Jones provided care for the first 60 days. To determine the allowed amount, divide the 60 days by the total number of post op days (90). This equals 66.7%. Multiply the 66.7% by the 20% post-op care amount. Reimbursement would equal \$73.37.

$$60 \text{ days divided by } 90 \text{ days (total post-op)} = 66.7\%$$

$$66.7\% \times \$110.00 \text{ (20\% post-op)} = \$73.37$$

Dr. Smith provided care for the last 30 days. To determine the allowed amount, divide the 30 days by the total number of post-op days (90). This equals 33.3%. Multiply the 33.3% by the 20% post-op care amount. Reimbursement would equal \$36.63

30 days divided by 90 days (total post-op) = 33.3%

33.3% x \$110.00 (20% post-op) = \$36.63

\$73.37 (Dr. Jones)+ \$36.63 (Dr. Smith) = \$110.00 Total post-op care

MODIFIERS

Modifiers 24, 25, and 57: Evaluation and Management (E/M) Services within a Global Surgical Period

Modifier 24 Unrelated E/M Service by the Same Physician during a Postoperative 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 used with an E/M visit. It is not valid when used with surgeries or other types of services. It is not necessary, or appropriate, for modifier 24 to be used with tests done in the postoperative period. When using modifier 24, ensure that the patient's records and ICD-9-CM codes recorded on the claim clearly indicate that the E/M visit is unrelated to the original procedure.

Modifier 25 Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or other Service

Medicare allows payment for an E/M service performed on the same day as a surgical procedure, if all requirements are met. The term surgery or service includes therapeutic injections and wound repairs.

The additional E/M service must be *separately identifiable* from the surgical procedure and require significant effort above and beyond the usual pre- and post-procedure service routinely required for the procedure. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. Medical records should document the E/M service to such an extent that, upon review, the extra effort may be readily identifiable.

Note: The diagnosis may be the *same* for both the E/M and the surgery or procedure.

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 a 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. Do not use modifier 57 with an E/M performed on the same day as minor surgery.

Modifiers 58, 78 and 79: Surgical Codes Only During a Global Surgical Period

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

Modifier 58 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 Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure during the Postoperative Period

Modifier 78 is 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 pre and postoperative care is included in the allowance for the prior surgical procedure.

An "operating room" is defined 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.

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

Modifier 79 is used for unrelated procedures by the same physician (or physician of the same specialty in the same surgical group) during the postoperative period. Unrelated procedures are usually reported using a different ICD-9-CM diagnosis code.

Note: The use of RT and LT modifiers is helpful and should be used with modifier 79, not in place of it.

Modifier 22: Increased Procedural Services

Modifier 22 is used to identify procedures which require individual consideration and should not be subject to the automated claims process. A description of the increased services may be entered in the comments field of electronically billed claims, or submitted as an attachment with paper claims. NHIC may require additional documentation to support the substantial additional work (for example, increased intensity, time, technical difficulty of the procedure, severity of the patient's condition, and physical and mental effort required. Documentation includes, but is not limited to, descriptive statements identifying the increased services, operative reports, pathology reports, progress notes, office notes, etc. If additional information is needed, we will request it.

The submission of a procedure with modifier 22 does not ensure coverage or additional payment. All claims with modifier 22 and appropriate documentation are reviewed by medical review staff to determine whether payment is justified.

Modifier 22 can be used on all procedure codes with a global period of 0, 10, or 90 days when unusual circumstances warrant consideration of payment in excess of the fee schedule allowance.

Modifier 50: Bilateral Procedures

Bilateral services are procedures performed on both sides of the body during the same session. Medicare considers bilateral procedures as one payment amount equal to 150 percent of the Medicare Physician Fee Schedule allowance for items identified as surgical procedures.

Diagnostic tests (x-rays) may sometime be performed bilaterally. If billed with modifier 50, they are paid at the full fee schedule for each side (200%).

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, and these procedures would be considered physician claim submission errors.

Modifier 51: Multiple Procedures

Modifier 51 need not be reported to Medicare. The carrier will add if appropriate.

Modifier 53: Discontinued Procedure

Modifier 53 is used when it is necessary to indicate that a surgical or diagnostic procedure was started but discontinued, due to extenuating circumstances or those that threaten the well being of the patient.

Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

BILLING GUIDELINES

Documentation of the Medical Record

Medical record documentation is required to record pertinent facts, findings, and observations about a patient'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. It also facilitates:

- The ability of providers to evaluate and plan the patient's immediate treatment and monitor his/her health care over time;
- Communication and continuity of care among providers involved in the patient's care;
- Accurate and timely claims review and payment;
- Appropriate utilization review and quality of care evaluations and
- Collection of data that may be useful for research and education.

The general principles of medical record documentation for reporting of medical and surgical services include the following, if applicable to the specific setting/encounter:

- Medical records should be complete and legible;
- Documentation of each patient encounter should include:
 - Reason for encounter and relevant history;
 - Physical examination findings and prior diagnostic test results;
 - Assessment, clinical impression, and diagnosis;
 - Plan for care; and
 - Date and legible identity of observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible for treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and
- CPT and ICD-9-CM codes reported should be supported by documentation in the medical record.

Documentation of Evaluation and Management Services

CMS established medical record documentation guidelines for evaluation and management services in 1995 and 1997. A link to these guidelines is located on the CMS website at: http://www.cms.hhs.gov/mlnproducts/downloads/eval_mgmt_serv_guide.pdf or may be obtained by contacting Customer Service. All evaluation and management services provided to a patient should be documented, regardless of whether the evaluation was performed as an independent service or in conjunction with other services rendered during a patient encounter.

Claim Submission

Complete instructions for completion of the CMS 1500 claim form are provided in the Claim Form CMS 1500 Instructions. Copies of this guide are available through Customer Service or on

the website under Publications.

Note: The same billing guidelines apply to electronic claims. Electronic claims submitted in the HIPAA format are recognized as being more efficient, have faster processing times, and result in faster payment of Medicare claims to providers.

Procedure Coding

The Centers for Medicare & Medicaid Services Common Procedure Coding System (HCPCS) is the coding system used by Medicare B nationwide and consists of two levels of codes and modifiers used by Medicare. Level I contains the American Medical Association's (AMA) CPT codes which are numeric. Level II contains alpha-numeric codes primarily for items and non-physician services not included in CPT. Level II codes are maintained jointly by CMS, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America.

Diagnosis Coding

Report appropriate ICD-9-CM diagnosis codes in item 21 and reference the code number (using 1, 2, 3, or 4) in item 24E of the CMS 1500 claim form or the electronic equivalent. The diagnosis code(s) chosen should accurately describe the patient's illness, disease, signs or symptoms. Codes must be used to their highest level of specificity (e.g. 3, 4 or 5 digits) Follow instructions provided in the ICD-9-CM to avoid return or denial of claims for incorrect or invalid diagnosis coding.

Reference Books

HCPCS, CPT and *ICD-9-CM* may be purchased in local bookstores or by writing to or calling:

Practice Management Information Corporation (PMIC)

4727 Wilshire Boulevard, Ste. 300

Los Angeles, CA 90010

1-800-633-7467

<http://www.pmiconline.com>

American Medical Association

515 N State Street

Chicago, IL 60610-0946

1-800-621-8335

<http://www.ama-assn.org/>

US Government Printing Office

Superintendent of Documents

Washington, DC 20402

1-866-512-1800 <http://www.gpo.gov>

CLAIMS PROCESSING JURISDICTION

The Durable Medical Equipment Medicare Administrative Contractor (DME MAC) is the federal contractor responsible for processing Medicare Part B claims for durable medical equipment, prosthetics, orthotics, and supplies.

NHIC, Corp.

DME MAC

PO Box 9165

Hingham, MA 02043

Customer Service: 1-866-419-9458

Please refer to jurisdictional listing below to determine which carrier to bill.

V2020 - V2025	Frames	DME MAC
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Ophthalmology/Optometry Billing Guide

V2100 - V2513	Lenses	DME MAC
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DME MAC.
V2530 - V2531	Contact Lenses, Scleral	DME MAC
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DME MAC.
V2600 - V2615	Low Vision Aids	DME MAC
V2623 - V2629	Prosthetic Eyes	DME MAC
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Miscellaneous Vision Service	DME MAC
V2781	Progressive Lens	DME MAC
V2782 - V2784	Lenses	DME MAC
V2785	Processing--Corneal Tissue	Local Carrier
V2786	Lenses	DME MAC
V2787 (effective 01-01-08)	Asigmatism- correcting function of intraocular lens	Local Carrier
V2788	Presbyopia-correcting function of an intraocular lens	Local Carrier
V2790	Amniotic Membrane	Local Carrier
V2797	Vision Supply	DME MAC
V2799	Miscellaneous Vision Service	DME MAC

REIMBURSEMENT

Methods of Payment (Assigned vs. Nonassigned)

The **assigned** method of payment indicates the provider rendering services to a Medicare beneficiary agrees to accept the Medicare *allowance* as payment in full and will receive direct payment from NHIC for services billed. Providers agree to accept assignment for all services rendered to Medicare patients.

The **nonassigned** method states the provider will receive payment from the beneficiary and Medicare will reimburse the beneficiary. The provider may not collect from the Medicare beneficiary any amount in excess of the limiting charge for service(s) rendered. The limiting charge is 115% of the nonparticipating fee schedule.

Note: State billing laws affect the amount providers can charge Medicare beneficiaries. In some states, the laws apply only to beneficiaries who meet certain means tests. However, in other states, the provisions apply to all beneficiaries. These laws may limit providers charging no more than the Medicare approved amount on all claims, or on nonassigned claims, to charging no more than a small percentage above the approved amount. If you practice in a state with balance billing laws, you should obtain more precise information from the state agency administering those laws. Currently, Vermont and Massachusetts have balance billing laws.

Reimbursement Rate

The physician fee schedule is reviewed and revised annually by CMS. It is published on the NHIC website at <http://www.medicarenhic.com>

The fee schedule for a physician is 100% of the physician fee schedule or actual charge, whichever is less. The fee schedule amount is then reduced by any applicable deductible and co-insurance.

NATIONAL CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

MEDICALLY UNLIKELY EDITS

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you have concerns regarding specific MUEs, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907

LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) can be found on the CMS website at the following address: <http://cms.hhs.gov/BNI/>

ABN Modifiers

Modifier **GA** should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as reasonable and necessary and they have on file an Advance Beneficiary Notification (ABN) signed by the beneficiary.

Modifier **GY** should be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered, or is not a Medicare benefit.

Modifier **GZ** should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an Advance Beneficiary Notice (ABN) signed by the beneficiary.

LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

http://www.medicarenhic.com/ne_prov/policies.shtml

NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: <http://www.cms.hhs.gov/mcd/search.asp>

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

Ophthalmology/Optometry Billing Guide

If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

New England:

Maureen Akhouzine, Manager
Safeguard Services (SSG)
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@hp.com

A single number to report suspected fraud is the national OIG fraud hot line: **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

RECOVERY AUDIT CONTRACTOR

The Centers for Medicare & Medicaid Services (CMS) has retained Diversied Collection Services (DCS) to carry out the Recovery Audit Contracting (RAC) program for Region A. The RAC program is mandated by Congress aimed at identifying Medicare improper payments. As a RAC, DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of underpayments and the implementation of actions that will prevent future improper payments. For more information please click on <http://www.dcsrac.com/>

TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date.** The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or SSN of the provider to utilize the IVR system.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

Hours of Operation:

8:00 a.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 4:00 p.m.- Friday

866-801-5304

Dedicated Reopening Requests Only

Hours of Operation:

8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m.- Friday

877-757-7781

MAILING ADDRESS DIRECTORY

Initial Claim Submission	P.O. Box 2323
Maine	Hingham, MA 02044
Massachusetts	P.O. Box 1212
New Hampshire	Hingham, MA 02044
Rhode Island	P.O. Box 1717
Vermont	Hingham, MA 02044
P. O. Box 7777	Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104
	Hingham, MA 02044
Written Correspondence	P.O. Box 1000
	Hingham, MA 02044
Medicare Reopenings and Redeterminations	P.O. Box 3535
**See note below	Hingham, MA 02044
Medicare B Refunds	P.O. Box 5912
	New York, NY 10087-5912
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100
	Hingham, MA 02044
Provider Enrollment	P.O. Box 3434
	Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444
	Hingham, MA 02044

** Requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:

www.medicarenhic.com

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.

Provider Service Line: 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

Reconsideration (Second Level of Appeal)

First Coast Service Options Inc.

QIC Part B North Reconsiderations

P.O. Box 45208

Jacksonville, FL 32232-5208

INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

<http://www.cms.hhs.gov/center/coverage.asp>

<http://www.cms.hhs.gov/mcd/indexes.asp>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

Medicare Learning Network

<http://www.cms.hhs.gov/MLNGenInfo/>

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

<http://www.cms.hhs.gov/OpenDoorForums/>

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

<http://www.cms.hhs.gov/CMSForms/>

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)

<http://cms.hhs.gov/BNI/>

American Medical Association

<http://www.ama-assn.org/>

CMS

<http://www.cms.hhs.gov>
<http://www.medicare.gov>

CMS Correct Coding Initiative

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

CMS Physician's Information
Resource for Medicare

<http://www.cms.hhs.gov/center/physician.asp?>

Electronic Prescribing

<http://www.cms.hhs.gov/exincentive/>

Ophthalmology/Optometry Billing Guide

Evaluation and Management Documentation Guidelines

http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Federal Register

<http://www.archives.gov/federal-register>

<http://www.gpoaccess.gov/index.html>

HIPAA

<http://www.cms.hhs.gov/HIPAAGenInfo/>

National Provider Identifier (NPI)

<http://www.cms.hhs.gov/NationalProvIdentStand/>

NPI Registry

<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

Physicians Quality Reporting

<http://www.cms.hhs.gov/pqri/>

Provider Enrollment, Chain, and Ownership System (PECOS)

http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag

Provider Enrollment

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

U.S. Government Printing Office

<http://www.gpoaccess.gov/index.html>

Revision History

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	7/06/2010	Susan Kimball	Ayanna YanceyCato	Release of document on the new NHIC Quality Portal

NHIC, Corp.

**75 Sgt. William Terry Drive
Hingham, MA 02044**

Website:

<http://www.medicarenhic.com>

CMS Websites

<http://www.cms.hhs.gov>

<http://www.medicare.gov>