

EYE CARE 101 Q & A NOVEMBER 2006

1. *When a physician who is not a member of the same group as the surgeon provides the post-operative care can they bill for the post-operative care before the end of the global period?*

In this situation, the post-op can be billed after the initial post-op visit has occurred. You do not need to wait until the 90-day post-op period expires. For further details please refer to Section III 3, "Physicians Who Furnish Part of a Global Surgical Package," in National Coverage Provision (NCP) GSURG-001, "Surgery." You may access this policy using the following link:
<http://www.wpsmedicare.com/policies/wisconsin/qsurg001.pdf>
2. *Does WPS Medicare delay payment until after the global period has ended?*

WPS Medicare does not delay the post-op care payment. We will only make one all inclusive payment no matter the number of visits during the 90 day period. Also see: http://www.wpsmedicare.com/providerfaq/surgery_faq.shtml
3. *Where can I find more information on commonly used modifiers?*

Please refer to our *Common Medicare Modifiers* book at the following link:
http://www.wpsmedicare.com/provider/pdfs/med_modifiers.pdf
4. *Why does Medicare not cover refractions?*

Medicare does not cover refractions because they are statutorily excluded from coverage by the Social Security Act (SSA). See SSA section 1862 (a)(7): (a) Notwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services—(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section [1861\(s\)\(8\)](#)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefore, or immunizations (except as otherwise allowed under section [1861\(s\)\(10\)](#) and subparagraph (B), (F), (G), (H), or (K) of paragraph (1)).
5. *Should you use a GY or GA modifier or no modifier at all when reporting procedure code 92015?*


You may use the GY modifier to bypass the processing system and automatically generate a denial, or bill without a modifier, which will also generate a denial. Since refractions are non-covered, it would not be appropriate for you to obtain a waiver of liability and apply the GA modifier to 92015.

For further information on these and other modifiers please refer to our *Common Medicare Modifiers* book at the following Website address:
http://www.wpsmedicare.com/provider/pdfs/med_modifiers.pdf
6. *Can you charge the patient for a refraction after cataract surgery?*

As a statutorily excluded service, a refraction is never covered by Medicare so it is not considered part of the post-operative care and can be charged to the patient.

7. *Should we have the patient sign an ABN for glasses after cataract surgery?*
Please refer to your Durable Medical Equipment Medicare Administrative Contractor (DME MAC, formerly known as DMERC) for information on billing glasses. The DME MAC for Region B (including Michigan, Minnesota, Illinois and Wisconsin) is AdminaStar Federal.
8. *When choosing a fee schedule to download, what is the difference between localities?*
The fee schedule amounts may be different based on the geographic locality. This is because Medicare makes higher payments to providers who practice in areas where business costs are higher. Currently, Illinois and Michigan have different localities based on zip codes.
9. *How do we know what areas are included in a certain locality?*
A listing of areas included in each locality is available at the following Website address:
http://www.wpsmedicare.com/provider/fee_localities.shtml
9. *Where can I access the National Correct Coding Initiative (NCCI) edits?*
The NCCI edits are available on the Centers for Medicare and Medicaid Services (CMS) Website at the address listed below.
<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage>
10. *When does the 9 indicator (modifier not applicable) apply in column F of the NCCI edits?*
It applies to code pairs which were bundled due to an NCCI edit but have since been deleted from that edit, and therefore, the use of a modifier is no longer applicable or necessary.
11. *Are codes 92250 and 92135 bundled together?*
Yes, these codes are bundled, but both may be payable with a valid modifier if the services are separately identifiable.
12. *Do I need modifier 59 on one of these codes (92250 or 92135) if they are done on the same day of service?*
For appropriate use of the 59 modifier, please refer to pages 18-19 of the *Common Medicare Modifiers* book available at the following Website address:
http://www.wpsmedicare.com/provider/pdfs/med_modifiers.pdf
13. *Can we bill the technical component for both 76519 and 92136 on the same date of service?*
According to the NCCI edits, these codes are considered to be “mutually exclusive,” and a modifier will not override the edit causing these specific codes to bundle. They cannot be billed at the same time.
14. *How do you know when to use an E&M code vs. an Ophthalmology code?*
This is at your discretion. You may use the code that is most advantageous to you provided that all the requirements are met.

15. *How do you suggest submitting documentation when submitting claims electronically?*

Please use the [HIPAA crosswalk](#)  154KB and refer to the Item 19 information. This is a free-format narrative field in most systems, and it lets you type in up to 80 characters of information for each claim, plus an additional 80 characters for each line of service.

If you have more than that to communicate to us, merely write in, "Additional documentation available upon request," and we will hold the claim while we write to you and ask for the documentation.

Please note, we will only ask for additional documentation if we cannot process the claim without it. Also, if a claim is waiting for the return of documentation, the processing timeframe could be delayed by as much as 45 days.

16. *Where can I find examples of Ophthalmology documentation errors?*

Examples of documentation errors are accessible in the Comprehensive Error Rate Testing (CERT) report by clicking on the link listed below. Ophthalmology errors are listed on page 24 and Optometry errors on page 43.

http://www.wpsmedicare.com/provider/pdfs/cert_errors.pdf

17. *We put the date and time at the beginning of a visit, but does the doctor have to put the end time for the visit next to his signature?*

Providers are not required to document the duration of a visit unless the duration of a visit is the primary factor used to determine the level of service billed. This would apply when more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care.

For further details please refer to Section B 4 of National Coverage Provision PHYS-001, "General Coverage for Physician Services." You can access this policy at the following Website address:

<http://www.wpsmedicare.com/policies/wisconsin/phys001.pdf>

18. *Does the Not Otherwise Classified (NOC) procedure code 92499 still apply for corneal topography, since it now has its own CPT code?*

Effective January 1, 2007, the NOC code will no longer apply to corneal topography. The Coding Guidelines in the Local Coverage Decision (LCD) OPHTH-014, "Computerized Corneal Topography," Companion Article will be revised to reflect this and will be published in the Communiqué.

19. *Is there a frequency time frame for billing the comprehensive exam code 92014?*

There is no published frequency limitation for procedure code 92014, so Medicare will cover this procedure as often as it can be shown to be medically necessary based on the patient's medical records.

20. *When billing for a Topography or Pachymetry or Optical Coherence Tomography (OCT), do you need to specify it a RT or is this a bilateral code?*

Some of the procedure codes involved are considered unilateral and others bilateral. Guidance on how to bill the procedures can be found by referring to the Billing and Coding Guidelines linked to the policies in question.

For Optical Coherence Tomography (OCT), please refer to OPHTH-015: Billing and Coding Guidelines at the following Website address:

http://www.wpsmedicare.com/policies/wisconsin/opth015_billing.pdf

For Computerized Corneal Topography, please refer to OPHTH-014: Billing and Coding Guidelines at the following Website address:

http://www.wpsmedicare.com/policies/wisconsin/opth014_billing.pdf

For Corneal Pachymetry, please refer to OPHTH-025: Billing and Coding Guidelines at the following Website address:

http://www.wpsmedicare.com/policies/wisconsin/opth025_billing.pdf

21. *The American Medical Association (AMA) Current Procedural Terminology Information Services (CPTIS) states that CPT code 92250 for Fundus Photography can be reported as bilateral with modifier 50. Per the BILT SURG column on the fee schedule there is a 2, does this mean this code is to be reported without the modifier 50?*
A 50 modifier should not be used when billing this procedure to Medicare. An indicator of 2 in the BILT SURG column indicates that "150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure."
22. *Where can we find information on your Website for the new Medicare crossovers?*
Information about the new Medicare crossovers can be found at the following Website address:
<http://www.wpsmedicare.com/xover/xoverhome.shtml>
23. *Please clarify the visual field policy. Claims are denying by local HMO Medicare replacement policies as not meeting Medicare guidelines because it does not fall within the range of diagnosis for the rehabilitation services. We perform visual fields as diagnostic tests.*
WPS Medicare does not have a policy for visual fields. If you are having difficulty with another payer you will need to contact them directly.
24. *Which part of the Corneal Pachymetry policy was revised on 11/1/06?*
The policy underwent a yearly review and the format of the Companion Article was revised. Revisions to a policy are denoted by an asterisk next to the section(s) most recently updated.
25. *Besides calling the facility, is there a website to find out if a nursing home is a skilled nursing home?*
Unfortunately, we are not aware of any such Website.
26. *Should we bill the technical component to the Skilled Nursing Facility (SNF) for any special testing done in our office or only certain tests?*
For a listing of the procedure codes where the technical component should be billed to the SNF and the professional component to Medicare when the patient is in a covered Medicare Part A stay, please refer to File 2 on the Website listed below. Please be sure to select the file for the date of service in question and also to read any updates listed on this page.

http://www.cms.hhs.gov/SNFConsolidatedBilling/02m_2006Update.asp#TopOfPage

27. *Since the Skilled Nursing Facility (SNF) doesn't have the equipment to do our tests, why would those tests be part of the Consolidated Billing (CB) rules?*
Consolidated Billing came into effect through the Balance Budget Act of 1997. One of the provisions of the act was that the technical components of most tests would be included in the Part A comprehensive per diem payment to the Skilled Nursing Facility when the Medicare patient is in a covered Part A stay. This, in turn dictated that an outside entity furnishing the technical component would have to look to the SNF, rather than to Part B, for payment.
For more information regarding Skilled Nursing Facility Consolidated Billing please refer to the following link on the Centers for Medicare and Medicaid Services (CMS) Website.
<http://www.cms.hhs.gov/SNFConsolidatedBilling/>

28. *Will more Eye Care classes be offered?*
No decision has been made at this time pertaining to offering any future Eye Care classes (Basic or Advanced). Please check the Education Schedule on our Website at the address listed below for a list of educational opportunities.
http://www.wpsmedicare.com/provider/proved_seminar.shtml

29. *If a patient comes in to see our optometrist for a routine eye exam, can they send the patient to an ophthalmologist in practice for a cataract consult?*
The patient can be referred to an ophthalmologist by an optometrist for a cataract consultation as long as all the consultation requirements are met

For further information regarding consultations please refer to National Coverage Provision PHYS-006, "Consultations," by clicking on the following Website link:
<http://www.wpsmedicare.com/policies/wisconsin/phys006.pdf>

30. *Does a consultation request need to be documented on a separate request form or in the patient chart note to support billing consultation?*
Yes, a consultation request must be documented in the patient's medical records. Medicare does not specify a particular format so either a consultation request form or chart note would be acceptable.

For further information regarding consultations please refer to National Coverage Provision PHYS-006, "Consultations," by clicking on the following Website link:
<http://www.wpsmedicare.com/policies/wisconsin/phys006.pdf>

31. *Will Medicare reimburse for an eye exam, lenses, and/or frames after cataract surgery?*
If an eye exam is provided during the global period following cataract surgery, it would not be separately reimbursable by Medicare. Post operative care is included in the payment for the surgical code.
For more information please refer to the general surgery guidelines in the NCP GSURG-001, "Surgery," Section II A.

For questions regarding lenses and/or frames please refer to your Durable Medical Equipment Medicare Administrative Contractor (DME MAC, formerly

known as DMERC) for information on billing glasses. The DME MAC for Region B (including Michigan, Minnesota, Illinois and Wisconsin) is AdminaStar Federal.

32. *Does Medicare allow a PRN, standing order or a signed protocol for nursing home patients?*

Medicare does not allow the use of PRNs, standing orders or a signed protocol. WPS Medicare will not cover any service or procedure that is performed on a resident of a skilled nursing facility or nursing facility, unless one of the following criteria is met;

1. The resident's attending physician evaluates the resident and authorizes the order for the service or procedure, or for the referral of the resident to another provider specialty or;
2. A named physician, whose attendance is requested by the resident or the resident's interested family member, legal guardian, or power of attorney for health care, evaluates the resident and authorizes the order for the service or procedure. The attending physician must be notified of any change in the resident's physical, mental or psychosocial status, or of the need to alter the resident's treatment significantly.

For further details please refer to the Indications and Limitations of Coverage and/or Medical Necessity in LCD PHYS-068, "Coverage of Services and Procedures in Nursing Facilities," by clicking on the following Website link:
<http://www.wpsmedicare.com/policies/wisconsin/phys068.pdf>

33. *If we see a patient and use a follow up 92014 exam and also do a test such as 92250 or 76514, do I need two diagnostic codes?*

It may not be necessary for the patient to have two separate diagnoses for both procedures (92014 and 92250 or 76514) to be paid when performed during the same visit, as long as the diagnosis code listed demonstrates medical necessity for both services billed.

For details of Medicare coverage of procedure code 76514 please refer to LCD OPHTH-025, "Corneal Pachymetry," at the following Website address:
<http://www.wpsmedicare.com/policies/wisconsin/opth025.pdf>

For details of Medicare coverage of procedure code 92014 and 92250 please refer to LCD OPHTH-003, "Optometrist Services," at the following Website address:
<http://www.wpsmedicare.com/policies/wisconsin/opth003.pdf>