

2011 MEDICARE QUICK-REFERENCE

Billing Medicare (DMERC) for Glasses

Payable Diagnosis Codes (all other codes will be denied):

V43.1 (pseudophakia): 1 frame and 2 lenses per operated eye.

379.31 (aphakia): 1 frame and 2 lenses per year or on a reasonable and necessary basis.

743.35 (congenital aphakia): 1 frame and 2 lenses per year or on a reasonable and necessary basis.

Billing for Standard Lenses: For 1 or 2 lenses, bill the correct HCPCS code (V21xx, V22xx, or V23xx) on separate lines for each eye, use modifier RT or LT and the fee for one lens at your usual and customary (U&C) fee.

Note: Modifier 50 cannot be used when billing materials.

Billing for Progressives:

First: Bill for standard lenses (see above).

Then: For 1 or 2 lenses, bill on separate lines for each eye with V2781 and modifier RT or LT. The fee is the difference between your U&C fees for standard lenses and progressives.

Billing for Lens Extras: For 1 or 2 lenses, bill the correct HCPCS code(s) (V27xx) on separate lines for each item and each eye, use modifier RT or LT and the fee for one lens at your U&C fee.

Billing for Frames:

First: Bill for the basic frame using V2020 and Medicare's allowed amount for the fee.

Then: For frame overages (deluxe frame), bill on a separate line using V2025. The fee is the difference between Medicare's allowed amount and your U&C fee for the frame.

Applicable Modifiers: RT, LT, GA, EY and KX (see *Modifiers* for definitions). Detail lines with GA and EY modifiers must be submitted on separate claim forms.

For Glasses After Cataract Surgery: include the surgeon's name (17), NPI (17b), date(s) of surgery (19) and modifier RT and/or LT (24d).

Note: All codes ending in "99" require a description (Ex: V2799). Find a complete list of "V" codes at www.noridianmedicare.com/dme/news/manual/docs/hcpcs_V_codes.pdf.

Require a Referring Physician or Self-Referral by the OD

76514/TC/26	92025	92225	92226
76519/TC/26	92227	92228	92260
92250/TC/26	97535		

Billing Medicare for Co-Management

66821, 66982, 66983, 66984

Use Modifier(s):

55indicates post-op care

RT/LT...indicates operated eye

79indicates second surgery during the post-op period of another surgery

Date of Service: Must be the date of surgery.

Diagnosis Code(s): Must be the pre-surgery diagnosis and must match the diagnosis that the surgeon billed (Example: 366.16). **Note:** Some carriers allow the use of V43.1. Check with your Carrier for specifics.

Procedure Code(s):

Must match the procedure code that the surgeon billed for (Example: 66984).

Item 17 & 17b (CMS 1500):

Include the surgeon's name and NPI.

Item 19 (CMS 1500):

- Care assumed date is usually the day after surgery but is **always** the day after the surgeon releases care.
- Care released date is no more than 90 days after the date of surgery and is **always** after the assumed date.
- Include number of days during co-management.

Example of Item 19 (CMS 1500):

Post-op Care Assumed 1/1/11, Released 4/2/11, 90 days

Bilateral Services (two eyes)

Always use quantity of 1. To report a reduced service (bilateral service performed on one eye only), use a 52 modifier.

76514/TC/26	76516/TC/26	76519/TC
92020	92060/TC/26	92081/TC/26
92082/TC/26	92083/TC/26	92100
92250/TC/26	92283/TC/26	92285/TC/26
92286/TC/26	92025/TC/26	

Unilateral Services (one eye)

Always report an RT or LT modifier or report bilaterally using a 50 modifier and a **quantity of 1**.

65205	65220	65210
68810	68840	65222
67938	68801	

Always report an RT or LT modifier or report bilaterally using a 50 modifier and a **quantity of 2**.

76519/26	92070	92136/26
92225	92226	

Unilateral or Bilateral Services

Always use quantity of 1. Do not use modifiers RT, LT, or 50.

92132	92133	92134
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Foreign Body Removal

65210, 67938, 65220, 65222, 65205

- Payment is per eye.
- Requires RT or LT modifier(s).
- Each eye must be listed on separate lines.
- Use a quantity of 1.
- Global period = 0 days.
- 67938: 10 day global period (includes all related services).
- Use a 25 modifier on the exam if it is separate and identifiable from the foreign body removal.
- Commonly payable diagnosis code(s) (check your Carrier for specifics on payable codes):

65210-930.1	65220-930.0	65222-930.0
67938-930.8	65205-930.1	

Punctal Occlusion by Plug 68761

- Temporary or permanent.
- Payment is per plug.
- Supply of plug is included in the allowed amount.
- Requires E modifier(s).
- Each plug must be listed on separate lines.
- Use a quantity of 1.
- Global period = 10 days.
- Use a 25 modifier on the exam if it is separate and identifiable from the punctal plug.
- Commonly payable diagnosis code: 375.15 (check your Carrier for specifics on payable codes).

National Correct Coding Initiatives Edits

Services that cannot be billed/provided on the same day:

- 92132 (SCODI-Anterior Seg) and 92133 (SCODI-Posterior Seg, Optic Nerve) or 92134 (SCODI-Posterior Seg, Retina).
- 92133 and 92132 or 92134 or 92250 (Fundus Photography).
- 92134 and 92132 or 92133 or 92250.
- 92136 (ophthalmic biometry by partial coherence interferometry) and 76519 (A-scan with intraocular lens calculation).
- 92225 (extended ophthalmoscopy, initial) and 92226 (extended ophthalmoscopy, subsequent).
- 92081 (visual field, limited), 92082 (visual field, intermediate) and 92083 (visual field, extended).

Modifiers

- 24 Unrelated E&M service/same doctor/during post-op.
- 25 Separate, identifiable E&M service/same doctor/same day as procedure. Use to unbundle some services.
- 26 Professional component.
- 50 Indicates both eyes on unilateral codes.
- 52 Reduced service/indicates 1 eye on bilateral codes.
- 55 Post-op care only (use with procedure 66821, 66982, 66983 and 66984).
- 59 Distinct procedural service (use to unbundle some services).
- 79 Unrelated procedure or service/same doctor/during post-op.
- AQ Health professional shortage area (HPSA).
- E1 Left upper.
- E2 Left lower.
- E3 Right upper.
- E4 Right lower.
- EY No physician or other health care provider ordered item or service.
- GA For services/materials not covered by Medicare; patient has signed Advance Beneficiary Notice (ABN).
- GP Services delivered under an outpatient PT plan of care.
- GW Service not related to hospice patient's terminal condition.
- GX States that a voluntary ABN was issued to the patient for rendered services that are excluded from or are not a benefit of the Medicare program.
- GY Item or service is not a Medicare benefit.
- GZ Item or service may not be reasonable and necessary.
- KX Use with certain material codes if physician determines it is medically necessary.
- LT Left eye.
- RT Right eye.
- TC Technical component.

Modifiers Tip (TC & 26): If both the technical component (TC) and the professional component (26) are performed on the same day, omit both modifiers and bill only the procedure on one line. The procedure automatically includes both components.

Epilation 67820

- Payment is per eyelid.
- Requires E modifier(s).
- Each eyelid must be listed on separate lines.
- Use a quantity of 1.
- Global period = 0 days.
- Use a 25 modifier on the exam if it is separate and identifiable from the epilation.
- Commonly payable diagnosis code(s): 374.01 and 374.05 (check your Carrier for specifics on payable codes).