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Optometry Coding & Billing Alert

A-Scans: Modify 76511, 76516, 76519 Correctly for Proper Reimbursement

LT, RT, and TC modifiers are key, experts say.

A-scans are some of the most common procedures performed in optometry offices, but coding them can present you with some uncommon problems.

According to CPT®, A-scans 76511, 76516, and 76519 are the shortened names for A-mode scans, "one-dimensional ultrasonic measurement procedures." Optometrists use 76511 (Ophthalmic ultrasound, diagnostic; quantitative A-scan only) to diagnose eye-related complications such as eye tumors, hemorrhages, retinal detachment, etc.

Physicians use 76516 (Ophthalmic biometry by ultrasound echography, A-scan) to measure the axial length of the eye in preparation for cataract surgery. And 76519 (Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation) is used to determine the intraocular lens calculation prior to cataract surgery only.

Look for Unilateral A-Scans

Not all A-scans are bilateral: Each A-scan code has separate requirements when billed bilaterally. For example, 76511 is considered unilateral, requiring the use of modifiers LT/RT/50 (Left side/Right side/Bilateral procedure) or the units value of "2."

But 76516 is considered inherently bilateral, so you shouldn't append modifier 50 to it.

Beware: Some carriers consider only the technical component bilateral. Some carriers (including Medicare) have determined the technical component of one of the A-scan codes to be bilateral, and the professional component to be unilateral.

Some non-Medicare carriers, on the other hand, want you to bill by line and don't typically divide the professional and technical components, so you must determine which carrier you are coding for and what its policy is for billing A-scans.

Master 76519 for Medicare

Medicare's payment policy for 76519 is notoriously confusing. First, an optometrist performs this procedure before cataract surgery for reimbursement. When you submit claims for ophthalmic biometry CPT® codes 76516 and 76519 to carriers, you should document the presence of a cataract and the plan for removing it. Make sure there is a written order by the provider in the patient's chart for the A-scan.

Clearly convey to the carrier, especially if the carrier is Medicare, which only covers 76519 when it is performed in conjunction with cataract surgery, that the A-scan was performed with the intention of performing cataract surgery.

Billing myth: Code 76519 must be billed the date the surgical procedure (typically 66984, Extracapsular cataract removal ...) is performed, and if the surgery doesn't take place, the test isn't billable. In the early 1990s, some carriers did want the billing date for the A-scan to be the same date as the cataract procedure; this is no longer true.

If the surgical procedure is not performed, the test is still billable based on medical necessity (diagnosis coding of a cataract).

Bisect Technical and Professional Components

Second, you must split up the technical and professional components for 76519. Medicare breaks down 76519 into technical and professional components. The technical portion, represented by modifier TC (Technical component), is the actual measuring.

Special equipment takes two measurements the axial length of the eye and the shape of the cornea and turns them into a calculation for the power of the intraocular lens implant. The professional component, represented by modifier 26, is for the provider's interpretation and selection of correct lens type and power for the lens implant.

Medicare considers the ultrasound itself (the technical component) bilateral, so you should only report it once, even when it is performed on both eyes in a single surgical session.

The professional component (or interpretation), on the other hand, is "unilateral" and you should report it for each eye when it is performed bilaterally. So, if the surgeon is considering surgery on both eyes, you would bill 76519-RT and 76519-LT-26, says **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas. Some Medicare carriers limit 76519-TC to once per year.

Combat Carrier Discrepancies With Knowledge

Carriers often question medical necessity. Your local carrier determines how often it will reimburse for 76519, both the technical and professional component and this payment frequency may differ from the above example. Keep in mind that when a carrier makes a frequency of-payment decision, they have based "frequency" on how often they think the service should be medically necessary.

If you have a circumstance that differs from the "norm," you can go through the appeals process, prove medical necessity, and request payment.

Carriers' policies can differ greatly. One strategy is to set up a meeting with all of your carriers to review how they want A-scans billed in order to clear up inconsistencies among carriers.

Verify Supervision for Ophthalmic Ultrasound

Remember: Codes 76511-TC, 76512-TC, 76513-TC (Ophthalmic ultrasound, diagnostic ...), and 76519-TC all require direct provider supervision, which means the ordering physician, or a physician member of the group practice, must be present in the office suite and he must be available to offer guidance and direction if needed during the service.

Direct supervision means the optometrist must be in the suite of offices, just not necessarily in the room where the procedure is being rendered.