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Optometry Coding & Billing Alert

Coding Class: 76519 Under the Microscope - Follow CMS Regulations

One of the most commonly reported scan codes is 76519, but before you can calculate your expected reimbursements for this A-scan, you'd better be sure your claim meets CMS' requirements.

Use the answers to these frequently asked questions to clear up any confusion you may have about billing 76519 (Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation).

Question: What kind of documentation do I need when I report claims for 76519?

Diligent, detailed documentation is always a good idea when submitting a claim to an insurance company, but when you are submitting a claim for 76519, it is crucial.

When claims for ophthalmic biometry - CPT codes 76516 and 76519 - are submitted to carriers, you should document the presence of a cataract and the plan for its removal. You should first check in the patient's chart for a written order by the doctor for the A-scan, says **Rita Knapp, CPC**, coding specialist with Whitson Abrams Vision and Laser Centers in Indianapolis.

Medicare covers 76519 only when it's performed in conjunction with cataract surgery, and the documentation must indicate the presence of a cataract if you want to avoid denials or payment postponement, says **Brenda Parker**, CPC, assistant administrator for River Cities Ophthalmology in Fort Madison, Iowa. The documentation may also indicate the need for a secondary implant.

"Generally, we perform the A-scan the same day as the preoperative evaluation, and that is when we bill them," Parker says. If you perform the A-scan the same day as the preoperative evaluation, document that there is an intent to perform cataract surgery, Parker tells coders. As long as the A-scan was ordered when the patient elected to have surgery, you have documented intent, she adds.

Although Parker's instructions sound easy, many charts are missing the doctor's order for the A-scan along with the laboratory tests that are going to be performed, says **Raequell Duran**, president of Practice Solutions in Santa Barbara, Calif. "Not only is the order required to substantiate medical necessity, but the order of testing services contributes to the level of evaluation and management service," she says.

Question: What are the rules for billing 76519 bilaterally?

Billing for bilateral A-scans with intraocular lens (IOL) power calculations is tricky because 76519 has both a professional and a technical component.

When optometrists use A-scans to determine the appropriate pseudophakic power of the IOL, for example, you have to be careful to determine whether you should report 76519 with modifier -26 (Professional component), -TC (Technical component), or by itself.

When you bill for a testing service as a "global" service, Duran says, it includes one technical component (-TC) and one professional component (-26). You can reference these in your Medicare fee schedule. In the case of 76519, the technical component is bilateral, for both eyes, and the professional component is unilateral, for one eye (76519 = 76519-TC-50 + 76519-26). Modifier -50 is for bilateral procedure.

In other words, if you are billing a Medicare carrier, it is imperative that you remember the following guidelines:

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The professional component (-26) claim is considered unilateral for Medicare patients, and the technical component (-TC) claim is considered inherently bilateral, according to Medicare.

Knapp offers the following advice: If you perform a bilateral A-scan, "make sure the second A-scan is always billed to Medicare with modifier -26 .... occasionally, if it is charged out with -LT or -RT or no modifier at all, Medicare will pay the same fee for the second scan as they did for the first, and you will need to refund the difference."

Use This Example as a Guide

Suppose a Medicare patient undergoes an A-scan with IOL calculation, with the cataract surgery planned for the right eye. You code 76519-RT. The first use of 76519 accounts for the technical component of both eyes (which is performed for comparison) and the professional component of the right eye. If and when cataract surgery is performed on the fellow eye, the ophthalmologist typically uses the same ultrasound, compares the patient's visual outcome with the first IOL selection, and selects the IOL power for the fellow eye. "This is when a second service can be billed 76519-26-LT for the interpretation/professional component for the fellow eye," Duran says.

But suppose a doctor thinks that a new technical portion of the service, the A-scan itself, needs to be performed. For example, the optometrist performs an A-scan on a patient's right eye before performing cataract surgery. Fourteen months later, that same optometrist takes a second A-scan on that same patient's left eye prior to cataract surgery in the left eye. Depending on your locality and your Medicare carrier's frequency guidelines, you may or may not be paid without going through the review process, Duran says.

"Some carriers have determined that it is medically necessary to repeat the scan after a year has passed, some carriers do not have a time limit, and one carrier states it's once per lifetime," she says. This does not mean that if you receive a denial you have to perform a write-off of the service, she says, but you will have to prove why it was medically necessary to repeat the testing service in order to be paid. "Something people don't commonly know is that even when you send a claim into review that has been denied with proof of medical necessity, it may not have an effect on your claim."

Duran explains the system: At the first review process, the reviewer's job is to make sure the claim was processed correctly. If the local medical review policy states the service is to be paid only once per year, the denial may be upheld. At the next step, the appeal process, you can request again that the claim be reprocessed for payment based on the information you have provided.

In the event that an A-scan is taken either unilaterally or bilaterally, but the professional component of the service is not performed (i.e., if the cataract surgery is cancelled and the IOL power calculation is not performed), you may need to bill the technical component of an A-scan separately with 76519-TC.

Another example of when to use the -TC modifier with 76519 is if there is a cancellation or indefinite postponement of the surgery by the patient in advance, Knapp says.

Commercial carriers may vary on what billing method they will accept for 76519. Unlike Medicare carriers, some carriers will pay for 76519-RT followed by 76519-LT a few weeks later, without requiring you to use modifier -26, because they consider 76519 inherently unilateral. Don't make the mistake of only billing the professional component of 76519 assuming you have already been reimbursed for the technical component of 76519 for both eyes - check the patient's insurance policy first.

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