Optometry Coding & Billing Alert

DME Reimbursement: Are These Refractive Lens Myths Keeping Payment Out of Your Pocket?

Tip: Keep modifiers KX, EY, GA in your toolbox.

Optometrists across the country agree: Durable medical equipment (DME) coding and billing is one of the most complex parts of practice management. Coding for refractive lenses for post-cataract patients makes it even more complex, with the multitude of options available to patients combined with Medicare's strict coverage guidelines.

Medicare will only pay for refractive lenses for aphakic beneficiaries (patients who are lacking the organic lens of the eye due to surgical removal, e.g., after cataract surgery, or who have congenital absence). Medicare covers one complete pair of glasses or contact lenses after each cataract surgery with insertion of an artificial intraocular lens.

Myth: The right ICD-9 code is all you need for a successful claim.

Reality: The key to DME Medicare Administrative Contractor (DME MAC) reimbursement for refractive lens features is medical necessity, and this involves more than just choosing the right ICD-9 code.

The standard benefit is a flat-top (FT) 25/28 bifocal or trifocal in plastic or glass. If the patient or the doctor want more features, a modifier will be necessary on the claim.

The prescribing physician must specifically order the special lens; it cannot be the patient's preference for one type of lens over another. If a physician specifically orders a particular type of lens or lens treatment, append modifier KX (Specific required documentation on file) to the HCPCS code. This modifier tells Medicare that you have documentation to support the medical necessity of the item you're claiming.

Example: In most cases, Medicare will not pay for polycarbonate or Trivex lenses (V2784). Patients often prefer polycarbonate lenses because they are sturdier and lighter than regular lenses. However, many optometrists prescribe polycarbonate lenses for patients with monocular vision to help protect the remaining eye.

DME contractor National Government Services specified in a lunch-and-learn teleconference on refractive lenses: "The KX modifier is to be appended to code V2784 if the patient has vision in only one eye."

In these cases, report the lens with modifier KX (V2784-KX) and make sure documentation of the patient's condition is on file. For example, a note in the patient's record saying, "best corrected VA OS 20/400" should suffice.

Myth: Medicare will deny UV protection as unnecessary.

Reality: Medicare considers ultraviolet protection (V2755, U-V lens, per lens) reasonable and necessary after a cataract extraction. But you can only claim V2755 if the UV coating is applied to glass or plastic lenses. If UV protection is inherent in the lens material (as with polycarbonate lenses), you cannot report V2755 as an add-on code.

Don't claim both: Carriers will deny claims for V2755 in addition to V2784 as not medically necessary.

Along with V2755 and V2784, Medicare will sometimes pay for the following items if they are medically necessary:

- tints (V2744, V2745)
- anti-reflective coating (V2750)
- oversize lenses (V2780).

"The KX modifier is to be appended to one of the other four specified add-on HCPCS codes listed above when there is a physician order and the comprehensive medical record supports the medical necessity for the item ordered," advises NGS.

Myth: If the physician didn't order it, the patient can't get it.

Reality: What if the prescribing physician did not specifically order an item, but the patient wants it anyway? Append modifier EY (No physician or other licensed healthcare provider order for this item or service) to patient-preference items.

Append modifier EY to V2744, V2745, V2750, V2780, and V2784 if the patient selects these items without a specific order from the prescribing physician, says NGS. If the DME MAC will not cover an item, you are responsible for obtaining a signed Advance Beneficiary Notice of Noncoverage (ABN) from the patient, and appending modifier GA (Waiver of liability statement on file) to the services you submit to the Medicare carrier. Be sure to provide the patient with a copy of the completed ABN and retain the original on file.

You may also need to append modifiers LT (Left side) and RT (Right side). If you're providing the same lens on both sides, bill both on the same line of the claim form, append both LT and RT, and claim two units of service.

Example: Medicare will pay for trifocal lenses (V2300, Sphere, trifocal, plano to plus or minus 4.00d, per lens), but the patient wants anti-reflective coating (V2750) as well. On the claim form, report:

- V2300-RT-LT with two units of service
- V2750-EY-GA-RT-LT with two units of service.

Tip: Most electronic claims can't handle four modifiers. If this is the case, omit EY.

Myth: The place of service is always the office.

Reality: The place of service (POS) code you include on the claim depends on the patient's place of residence. For DME, the POS is the place where the patient uses the equipment. You could report POS code 12 (Home), but never POS code 11 (Office). The date of service for the claim is the date the patient receives the DME. This normally requires that box 32 be completed also to reflect the office address.