Codify
BY AAPC

Optometry Coding & Billing Alert

Do You Know the Secrets of Full Reimbursement for IOL Power Calculations?

Improperly coding IOL Masters or A-scans can cost you almost $30 per patient

Calculating intraocular lens power for patients facing cataract surgery has gotten more precise as A-scan and IOL Master technology has advanced. But to make sure your practice is getting fairly reimbursed each time, you need to understand the bilateral rules for 76519 and 92136.

Include Bilateral and Unilateral Components in Global Code

Myth: If you calculate IOL power in both eyes, you should report 76519 (Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation) or 92136 (Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation) twice (e.g., 76519-RT and 76519-LT, or 76519-50, Bilateral procedure).

Reality: You should not report 76519 or 92136 bilaterally, even if you calculated the IOL power of both eyes. To understand why, you should know how Medicare's Physician Fee Schedule (MPFS) values the procedures.

As it does with many other diagnostic tests, CMS divides the A-scan (76519) and the IOL Master (92136) into two components, says **Judy Seymour, ACS-OH,** coder and biller for Eye Associates of the South in Biloxi, Miss. The fee schedule marks the technical component (actually performing the test) with modifier TC, and the professional component (viewing and interpreting the results) with modifier 26.

For most procedures, the technical and professional components have the same bilateral status -- for example, 92250-TC (Fundus photography with interpretation and report) and 92250-26 are both considered inherently bilateral, marked with modifier indicator "2" on the fee schedule. CMS bases the reimbursement for all components of 92250 on both eyes being tested.

Exception: For both 76519 and 92136, the technical component has a different bilateral status from the professional component, Seymour says. The fee schedule marks both 76519-TC and 92136-TC with modifier indicator "2," which means that Medicare considers the codes inherently bilateral.

The single CPT codes include the work for performing the procedure on both eyes-- you should report 76519-TC or 92136-TC only once, regardless of whether the optometrist tests one or both eyes.

Code Components Separately if Both Eyes Tested

The MPFS marks the professional components (76519-26 and 92136-26) with modifier indicator "3," however, which means that the codes are inherently unilateral. When you report a global code without modifiers, you are telling the insurer that you performed both the technical and professional components of that service.

Why? An optometrist usually performs the technical component of the procedure -- the actual measurement of the eye -- on both eyes on the same day. But he may only perform the professional component -- the IOL power calculation -- on the eye that is going to have surgery. For example, if an optometrist performs an A-scan on both eyes, calculating IOL power in the right eye, he would report 76519-RT. That code and modifier tell Medicare that the optometrist performed both the (bilateral) technical and the (unilateral) professional component.

If you calculate IOL power in both eyes, code the technical and professional components separately. For example, for an IOL Master and power calculation in both eyes, code:

- 92136-TC for the bilateral technical component

- 92136-26-50 for the bilateral professional component.

Append modifier 50 (Bilateral procedure) to show that you bilaterally performed this usually unilateral component.

What's the difference? Medicare rules dictate how it will reimburse bilateral procedures. Since the MPFS marks the global components of both 76519 and 92136 with bilateral status "2," Medicare payment policy is to pay the fee schedule amount for only one code if you report it bilaterally.

Thus, claiming 92136-50 will only yield $82.27, based on the 2008 fee schedule, unadjusted for geographical location (2.16 total transitional relative value units [RVUs] x 38.0870 conversion factor). But reporting IOL measurements in both eyes properly, with 92136-TC and 92136-26-50, should bring in about $30 more:

- 92136-TC = (1.39 RVUs x 38.0870) = $52.94

- 92136-26-50 = (0.77 RVUs x 38.0870) x 2 = $58.65

- Total: $111.59

Check This 76519/92136 Bundle

What if you have to perform both an A-scan and an IOL Master? Should you report both 76519 and 92136?

No, says the Correct Coding Initiative (CCI). Codes 76519 and 92136 are in a mutually exclusive bundle. If you report both codes, Medicare carriers will only pay you for 92136.

Example: You perform the technical portion of an A-scan on the left eye, but dense cataracts prevent you from getting a viable result from the right eye. You perform an IOL Master on the right eye and calculate IOL power for the right eye. You can only report one unit of 92136-RT.

Look for Fifth Digit on Cataract Dx

Although 366.x (Cataract) is a good start, it's not where you should end your ICD-9 quest for 76519 or 92136. Coding rules dictate that you code as specifically as possible.

Because the codes under 366.x extend into five digits, you will need a five-digit code, such as 366.02 (Posterior subcapsular polar cataract), to describe the patient's condition fully.

This is a good tip on all procedures, office visits and special tests, says **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas.

Tip: Look for helpful notes in your ICD-9 manual. If a code has a "4th" or "5th" note next to it, look below it for a more detailed code.

For more information on ICD-9 coding, see "Don't Stop at 4 Digits for Your IOL Master Diagnosis" below