Optometry Coding & Billing Alert

Earn Full Pay for Pre-Cataract Surgery Tests With Bulletproof Bilateral Coding

Improperly coding IOL Masters or A-scans can cost you $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.

Could one of these myths be damaging your claims?

Include Bilateral and Unilateral Components in Global Code

Myth: If the optometrist calculates 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 the optometrist calculated the IOL power of both eyes. To understand why, it's helpful to know how Medicare's Physician Fee Schedule 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 **Amanda Kunze, CPC, OCS,** coder and reimbursement specialist for the Eye and Ear Clinic of Wenatchee in Washington. The technical component (the actual performing of the test) is marked with modifier TC, and the professional component (viewing and interpreting the results) is marked with modifier 26, Kunze says.

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

Exception: For both 76519 and 92136, the technical component has a different bilateral status from the professional component, Kunze says. Both 76519-TC and 92136-TC are marked with modifier indicator -2,- which means that the codes are considered inherently bilateral.

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

Code Components Separately if Both Eyes Tested

The professional components (76519-26 and 92136-26) are marked 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 at 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 the optometrist calculates 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 bilateral procedures can be reimbursed. Since the global components of both 76519 and 92136 are marked with bilateral status -2,- Medicare payment policy is to pay the fee schedule amount for only one code if you report it bilaterally, says **Raequell Duran, CPC,** president of Practice Solutions in Santa Barbara, Calif.

Thus, claiming 92136-50 will only yield $86, based on the 2006 fee schedule, unadjusted for geographical location (2.27 RVUs x 37.8975 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 = (1.48 RVUs x 37.8975) = $56.09

92136-26-50 = (0.79 RVUs x 37.8975) x 2 = $59.88

Total: $115.97

Another way: -If the patient comes in and is having the first eye done, we just code the regular A-scan,- Kunze says -- e.g., 76519-RT, if the right eye is being tested. -We would get paid then for the technical component of both eyes and the professional component of the first. When the patient came back in, we would code 76519-26-LT for the second eye and get reimbursed additionally for the second reading.- Again, the reimbursement would total $115.97.

Check This 76519/92136 Bundle

Myth: If the optometrist has to perform both an A-scan and an IOL Master, report both 76519 and 92136.

Reality: The National Correct Coding Initiative (NCCI) thinks otherwise. Codes 76519 and 92136 are in a mutually exclusive bundle, says **Christina Hollis, OCS,** coder and surgery scheduler at Pediatric Ophthalmology Associates in Columbus, Ohio. If you report both codes, Medicare carriers will only pay you for 92136.

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

Look for Fifth Digit on Cataract Dx

Myth: ICD-9 code 366 should be enough to justify medical necessity for 76519 or 92136.

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

Tip: Look for helpful notes in your ICD-9 manual. If a code has a -34th- or -35th- note next to it, look below it for a more detailed code.