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Optometry Coding & Billing Alert

Look to Modifiers KX, EY for Keys to DME Reimbursement

Keep medical necessity distinct from patient preference in your documentation.

If you're providing refractive lenses for cataract surgery patients, you'll need to unravel your DME MAC's complex coding and billing rules to claim deserved Medicare reimbursement.

The challenge: Optometrists often describe durable medical equipment (DME) coding and billing as one of the most complex duties they perform. Coding for refractive lenses 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, notes **Joyce D. Ardrey, CPC,** who led a seminar on billing for frames, lenses, and contact lenses at The Coding Institute's 2008 Optometry Coding and Reimbursement Conference.

Most DME Medicare Administrative Contractors (DME MACs) specify that your claim for refractive lenses must be linked to one of these ICD-9 codes to prove medical necessity:

• 379.31 -- Aphakia

• 743.35 -- Congenital aphakia

• V43.1 -- Organ or tissue replaced by other means; lens.

Append KX for Doctor-Ordered Extras

The key to 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, explains **David Gibson, OD, FAAO**, a practicing optometrist in Lubbock, Texas. If the patient or the optometrist want more features, a modifier will be necessary on the claim.

The prescribing physician must specifically order the special lens; it cannot be simply 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 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.

In these cases, report 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. "It doesn't need to go on the claim; just have it in the records," according to Gibson.

Additionally, 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 a glass or plastic lens. 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).

Use EY and GA for Patient Preferences

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 them without a specific order from the prescribing physician, says DME MAC Noridian's local coverage decision (LCD) for refractive lenses. If the DME MAC will not cover an item (see box on page 83), append modifier GA (Waiver of liability statement 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.

Watch for POS Errors

Hidden trap: The place of service (POS) code you include on the claim depends on the patient's place of residence, says Ardrey. 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), Ardrey warns. The date of service for the claim is the date the patient receives the DME.

Online resource: Make sure your DME MAC documentation is complete. Noridian offers a documentation checklist on its Web site. Download it at http://www.noridianmedicare.com/dme/coverage.