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Optometry Coding & Billing Alert

Preventive Services Mythbuster: Bust These Glaucoma Screening Myths to Secure Medicare Pay

Hint: Medicare may not view a year the same way your calendar does.

Your optometry practice is likely to report glaucoma screenings so frequently that you no longer feel the need to look up the rules on how to bill the services to Medicare. However, the screening regulations are so vast and the rules change so frequently that you may be falling victim to one of the common myths in this category.

Case in point: Just this past May, the government filed suit against a Texas eye care practice that was alleged to have reported all of its tonometry services as glaucoma screenings to Medicare. The doctor was accused of submitting false claims to the government and, if found guilty, faces possible paybacks or jail time.

To ensure that your glaucoma screening claims don't face the same fate, check out the following commonly-held glaucoma screening myths, along with the realities straight from NGS Medicare, which shared the correct way to bill for these services during its Aug. 24 webinar, "Medicare Preventive Services: Glaucoma Screening Services and Preventive Services Resources." Keep in mind that this advice applies to Medicare patients, but private payers may have different rules and regulations.

Myth 1: You Need Symptoms to Qualify for Glaucoma Screening

Although you may think patients only qualify for glaucoma services if they have symptoms, not all patients must actually be symptomatic for Medicare to reimburse you for their screening services. In reality, certain groups are at higher risk for developing glaucoma, with risk factors being age, race, family history and medical history, said NGS's **Arlene Dunphy, CPC**, during the webinar.

"CMS has determined that the evidence backs that a screening for glaucoma is reasonable and necessary for the early detection or prevention of the illness or disability and is appropriate for certain Medicare beneficiaries or individuals," Dunphy said.

Effective Jan. 1, 2002, certain eligible beneficiaries with no complaints or prior history are covered for the screening if they meet any of the following conditions, Dunphy said: Patients have diabetes mellitus, a family history of glaucoma, they're African-Americans age 50 and older, or Hispanic-Americans age 65 and over.

Screening components must include both a dilated eye exam with intraocular pressure measurements and either a direct ophthalmoscopic examination or a slit-lamp bio microscopic examination, she added.

Myth 2: Direct Supervision Involves Being in the Same City

To qualify for the glaucoma screening, the services must be furnished by an optometrist or an ophthalmologist, or furnished under the direct supervision of an ophthalmologist or optometrist, Dunphy said. "Direct supervision means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure."

Bottom line: If the doctor is out to lunch, on vacation, out sick, or otherwise not available in the office suite, you cannot

report a service as if it was furnished under the doctor's direct supervision.

Myth 3: You Should Report Two HCPCS Codes for Glaucoma Screenings

Make sure you're using the appropriate code depending on who performs the screening, either G0117 (Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist) if the doctor does the screening or G0118 (Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist) if it's under the direct supervision of the doctor.

Unfortunately, some coders see these codes and assume that they should list both codes on their claims. However, this constitutes incorrect coding. "You obviously aren't able to report both it's either one or the other, depending on who's rendering the service," Dunphy said.

As for your diagnosis code, you'll report the ICD-10 code Z13.5 (Encounter for screening for eye and ear disorders) for asymptomatic patients who are getting screened for glaucoma.

Myth 4: One Year Always Equals 365 Days

Although coders recognize that glaucoma screenings are an annual benefit, that doesn't necessarily mean you have to wait exactly 365 days from one screening to the next.

"Once the beneficiary has received a covered glaucoma screening procedure, the beneficiary may receive another procedure after 11 full months have passed, as long as the beneficiary is not diagnosed with glaucoma," Dunphy said. "To determine the 11-month period, start counting the following months in which the last covered glaucoma screening was performed. If the patient got the screening in July, the count would start in August, and the patient would be allowed to have another screening in July."

Myth 5: Patients Needn't Pay Anything

Under the Affordable Care Act, you may have gotten accustomed to offering preventive services without having to collect a deductible and coinsurance, but that's unfortunately not the case for this particular preventive visit.

"For these services, which is unusual for preventive services usually they are waived but this service does have deductible and coinsurance apply even though they're preventive services," Dunphy said.

Myth 6: Tack on E/M Codes

If you assume you should report an E/M visit along with your glaucoma screening codes, Medicare has a different idea.

"Always go to the National Correct Coding Initiative to see what you can report along with a preventive service, such as whether an E/M can be billed with it," said NGS's **Michele Poulos** during the webinar.

Once you download the NCCI edits, you'll see that G0117 and G0118 are always bundled into E/M services and are not separately payable. No modifier can separate the bundles. Therefore, if you do perform a separate and distinct E/M visit with the glaucoma screening, you'll report the E/M but not the glaucoma screening that would be bundled into your payment for the E/M.

Myth 7: Documentation of Symptoms Is Enough

Even if you've followed the six steps above to the letter, you may still face a denial for your screening services, unfortunately. Common denial reasons would be if the minimum time has not elapsed since the performance of the last

procedure (11 full months haven't passed) or the beneficiary does not meet the coverage guidelines of being high-risk.

As with all Medicare services, make sure you document the appropriate information, including documentation that the beneficiary falls into one of the high risk categories, and that appropriate screening was performed (pressure measurement, dilation, etc). "And of course a legible signature of the person performing the service, with their credentials," Dunphy said.