Optometry Coding & Billing Alert

Split the Bill for Full Payment For OD's SNF Visits

Part B may not cover the full service - are you responsible for the rest?

Optometrists often spend a lot of time providing care to patients in nursing homes - which means spending a lot of time unraveling complicated consolidated billing rules. Our expert advice will help you sniff out full reimbursement for nursing home visits.

Billing is complicated for patients in skilled nursing facility (SNF) care, but not all nursing facilities are SNFs. An SNF may not even be an entire facility; some facilities have SNF beds and non-SNF beds, says **Gilda Edelstein**, practice administrator for Medical Eye Care Associates in Norwood, Mass. An SNF patient is covered under Medicare Part A, as opposed to Part B, which covers most outpatient services.

First step: Call the facility and make sure you know whether the patient is in SNF care. If he is not, then you may bill your Part B carrier for all the services you provide, Edelstein says. But if he is an SNF patient, you are about to enter the world of consolidated billing.

Problem: Medicare Part A is paying the nursing facility for all of the patient's care. Therefore, Medicare Part A considers the SNF financially responsible for all the care the patient receives - which includes the care you provide. Whether you visit the SNF or the SNF patient visits your office, if the patient is in a covered Part A stay, the SNF rules apply and the facility is liable for the payment, says **Erin Shabareck**, billing manager at the Florida Vision Institute in Stuart. Most of the services that patient receives are consolidated into the SNF's billing.

Exceptions: Medicare has made things a little more complex by excluding physicians' services and the professional components of certain diagnostic services from the consolidated billing requirement. Medicare sees these as outside the SNF bundle, and says "they remain separately billable to Part B when furnished to an SNF resident by an outside supplier."

Exclude These Services From Consolidated Billing

CMS excludes all of the E/M codes 99201-99350 and eye exam codes (92002-92014) as physician services. Other excluded codes that optometrists often report are:

1. 65205-65222 - Removal of foreign body
2. 67820 - Correction of trichiasis; epilation, by forceps only
3. 92002-92014 - Ophthalmological services: medical examination and evaluation
4. 92020 - Gonioscopy (separate procedure)
5. 92070 - Fitting of contact lens for treatment of disease, including supply of lens
6. 92100 - Serial tonometry
7. 92120 - Tonography with interpretation and report
8. 92130 - Tonography with water provocation

9. 92140 - Provocative tests for glaucoma, with interpretation and report, without tonography
10. 92225-92226 - Ophthalmoscopy
11. 92311-92317 - Prescription of optical and physical characteristics of and fitting of contact lens.

Send the TC Bill to the SNF

For diagnostic tests that have both a professional component and a technical component, Medicare wants you to split the bill, Edelstein says.

The SNF is responsible for the technical component, while you can report the professional component to your Part B carrier with modifier 26 (Professional component) appended to the CPT code for the service.

To get paid for the technical component, submit a bill to the SNF with modifier TC (Technical component) appended to the code.

Example: Using a handheld fundus camera, you take fundus photographs of an SNF patient. Submit a claim to your Medicare Part B carrier for the professional component of the fundus photography, using CPT code 92250-26 (Fundus photography with interpretation and report; professional component). Submit a claim to the SNF with 92250-TC (... technical component).

Downside: "Good luck," Edelstein says. The SNFs she works with can be reluctant to pay for the technical components of tests. "Half of them don't even know the rules and regulations," she says. "We don't even bother sending [a bill]. It's not worth our time and effort."

Note: See "Steer Clear of SNF Billing Snafus by Taking 4 Steps" on page 53 for advice on getting cooperation from nursing facilities.

The professional components of these diagnostic optometric tests are not subject to SNF consolidated billing. Bill the Part B carrier for the professional component, and bill the SNF for the technical component, for the following procedures:

12. 76510-76514 - Ophthalmic ultrasound, diagnostic
13. 76516-76519 - Ophthalmic biometry by ultrasound echography, A-scan
14. 76529 - Ophthalmic ultrasonic foreign body localization
15. 92060 - Sensorimotor examination
16. 92065 - Orthoptic/pleoptic training
17. 92081-92083 - Visual field examination
18. 92135 - Scanning computerized ophthalmic diagnostic imaging
19. 92136 - Ophthalmic biometry by partial coherence interferometry with IOL power calculation
20. 92250 - Fundus photography
21. 92283 - Color vision examination

22. 92284 - Dark adaptation examination

23. 92285 - External ocular photography

24. 92286 - Special anterior segment photography.

Don't miss: Medicare "requires that bills for these particular excluded services, when furnished to SNF residents, must contain the SNF's Medicare provider number." You must also provide the correct place of service code (31) if you visit the patient in the SNF. Prior to seeing the patient, there must be a written request for your services in the patient's medical record.

Note: For a complete list of codes exempt from consolidated billing, visit http://www.cms.hhs.gov/medlearn/snfcode.asp?link=2005.