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Optometry Coding & Billing Alert

Testing: Don't Let Unanswered IOL Power Calculation Questions Cloud Your Reimbursement

Read on for our expert answers to these 76519 and 92136 head-scratchers.

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 how to properly report CPT® codes 76519 and 92136. Below are some questions even experienced coders find themselves asking when facing pre-cataract test claims.

Question: How do we report tests done in both eyes?

Answer: One common myth is that 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).

Reality: You should not report 76519 or 92136 with modifier 50 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. The technical component (the actual performing of the test) is denoted with modifier TC, and the professional component (viewing and interpreting the results) is denoted with modifier 26.

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, denoted with modifier indicator "2" on the fee schedule. The reimbursement for all components of 92250 is based on both eyes being tested.

Question: What if the optometrist only performs the professional component on one eye?

Answer: For both 76519 and 92136, the technical component has a different bilateral status from the professional component. You can find the bilateral surgery indicators in the fee schedule. Both 76519-TC and 92136-TC are denoted with modifier indicator "2," which means that the technical component of the codes is considered inherently bilateral.

The work of performing the test on both eyes is included when reporting the CPT® codes you should report 76519-TC or 92136-TC only once, whether the optometrist tests one or both eyes.

The professional components (76519-26 and 92136-26) are denoted with modifier indicator "3," however, which means that the professional component of the codes are inherently unilateral. When you report a global code, without modifiers, you are telling the insurer that you performed the technical component of both eyes and the professional component of one eye for that service. Therefore, you may be leaving money on the table for performance of the professional component on the other eye.

Why? An optometrist usually performs the technical component of the procedure the actual measurement of the eye on both eyes at the same time 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 the (bilateral) technical component and the (unilateral) professional component of the right eye.

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.

Alternatively, some payers require you to report these services as follows:

- 92136-26-RT and 92136-26-LT

Question: What's the difference in reimbursement?

Answer: Medicare rules dictate how bilateral procedures can be reimbursed. Since the global components of both 76519 and 92136 are denoted with bilateral status "2," Medicare payment policy is to pay the fee schedule amount for only one code if you report it globally without the appropriate use of modifiers or using only modifier 50.

However: For bilateral status "3," the carrier should pay you twice the amount it would have for the diagnostic test performed unilaterally, says **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE**, AHIMA-approved ICD-10 CM/PCS trainer and president of Maggie Mac-Medical Practice Consulting in Clearwater, Fla. either the fee schedule amount or your actual fee, whichever is lower.

Thus, claiming 92136-50 will only yield $90.63, based on the 2014 fee schedule, unadjusted for geographical location (2.53 RVUs x 35.8228 conversion factor). Reporting IOL measurements in both eyes properly, with 92136-TC and 92136-26-50, however, should bring in about $30 more:

92136-TC = (1.64 RVUs x 35.8228) = $58.75
92136-26-50 = (0.89 RVUs x 35.8228) x 2 = $63.76
Total: $122.51

Question: What if the optometrist has to perform both an A-scan and IOL Master?

Answer: You may be tempted to report both, but the National Correct Coding Initiative (NCCI) indicates otherwise. CPT® codes 76519 and 92136 are in a mutually exclusive bundle. If you report both codes, Medicare carriers will only reimburse 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 should only report 92136-TC and 92136-26-50.

Do not report the failed 76519 scan and the 92136 scan together. Some payers may have alternative instructions for reporting the A-scan and/or IOL Master when the physician finds it necessary to perform both on the same day. Check with your local payer guidelines for specific guidance.

Question: What diagnosis code justifies this procedure?

Answer: 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 nonsenile cataract), to describe the patient's condition fully.

Tip: Look for helpful notes in your ICD-9 manual. If a code has a "checkmark 4th" or "checkmark 5th" note next to it, look above or below it for a more detailed code or specific instructions on adding the additional digits.

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