

Optometry Coding & Billing Alert

Testing: Scan Your 76519 and 92136 Coding for These Destructive Myths

Tip: Knowing the bilateral rules for the technical and professional portions is critical.

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.

Is one of these myths lurking in your claims?

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).

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 (Fundus photography with interpretation and report) and 92250-26 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.

Myth: Bilateral billing is the same whether the optometrist performs just the technical component or the professional component of the test.

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

Myth: Reimbursement rules are the same for the technical and professional component of the codes.

Reality: 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 \$91.27, based on the 2015 fee schedule, unadjusted for geographical location (2.43 RVUs x 35.9335 conversion factor). Reporting IOL measurements in both eyes properly, with 92136-TC and 92136-26-50, however, should bring in about \$30 more:

$$92136-TC = (1.66 \text{ RVUs} \times 35.9335) = \$59.64$$

$$92136-26-50 = (0.88 \text{ RVUs} \times 35.9335) \times 2 = \$63.24$$

Total: \$122.88

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

Reality: You may be tempted to report both, but the Correct Coding Initiative (CCI) 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.

