Optometry Coding & Billing Alert

You Be the Expert: Low-Risk Glaucoma Screenings

Question: Our office sometimes performs glaucoma screenings for patients who don't meet Medicare's definition of "high risk." How should we code to be reimbursed for this service?

Nevada Subscriber

Answer: You should have the patient sign an advance beneficiary notice (ABN) and submit a claim of G0117-GA (Glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist; Waiver of liability statement issued as required by payer policy, individual case). Medicare will then deny the claim and send an EOB to the patient, explaining that he is not considered at high risk for glaucoma.

Medicare covers glaucoma screenings for high-risk patients, but the doctor isn't sure the patient will meet Medicare's description of "high risk."

When your office performs a service ⬜ even a noncovered procedure like certain glaucoma screenings ⬜ you deserve payment for it. If you don't want to get caught absorbing the cost of services that a patient requests or the optometrist recommends, and you know Medicare will not reimburse for a given service, you'd better use modifier GA and reach for an advance beneficiary notice.

Properly used, the modifier/ABN combination allows you to collect payment for the optometrist's effort directly from the patient.

The proper time to have the patient sign an ABN is before the optometrist performs the service or procedure that you don't think the patient's carrier will reimburse. In some circumstances, you may not know for certain if Medicare will cover the service. When in doubt, protect yourself and request that the patient sign an ABN.

Rule: After you've secured a signed ABN from a Medicare patient, you must inform Medicare that you have this information by appending modifier GA (Waiver of liability statement issued as required by payer policy, individual case) to the appropriate CPT® code on the CMS-1500 form.

When Medicare sees the GA modifier and does deny payment for the service, it will send an explanation of benefits to the patient confirming that he is responsible for payment. If you fail to append the modifier, Medicare may not inform the patient of his responsibility.