Corcoran Consulting Group

A Division of Ardare Corporation

Reimbursement for Diagnostic Tests with the Carl Zeiss Meditec IOLMaster

Prepared for

ZEISS

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Reimbursement for Diagnostic Tests with the Carl Zeiss Meditec IOLMaster

by

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Objective: *This report is provided as a general discussion of billing and documentation for diagnostic tests performed with the Carl Zeiss Meditec IOLMaster and is for informational purposes only. Variations in coverage and payment policies among Medicare Administrative Contractors (MACs) may occur which are not described here. Other non-Medicare payers may promulgate policies that differ from those of Medicare and its contractors. The user is strongly encouraged to review federal and state laws, regulations, code sets (including ICD-10), and official instructions of the Centers for Medicare & Medicaid Services (CMS), the MACs, and other third party payers.*

Notice: *All fee schedule amounts noted in this document are the national Medicare allowed amounts. Actual fee schedule amounts and payments vary by locality.*

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Acknowledgement: *This paper was underwritten by a grant from Carl Zeiss Meditec as an aid to customers and other interested parties. Carl Zeiss Meditec is not the author of, and therefore not responsible for, the content of the reimbursement and billing information provided herein. For further information about their products, contact the company at www.zeiss.com/med.*

INTRODUCTION

This monograph describes reimbursement for diagnostic tests performed with Carl Zeiss Meditec's IOLMaster optical biometry systems, either alone or as part of another service.

Much of the information in this document is taken from official publications of the Medicare program. The reader is encouraged to check with the local Medicare Administrative Contractor (MAC) for additional information and instructions. In the case of other third party payers, we have used the coding concepts contained in Current Procedural Terminology (CPT) and published by the American Medical Association (AMA); diagnosis codes are from the International Classification of Diseases (ICD), ICD-10-CM (10^{th} edition). Documentation of a diagnostic test, and the medical rationale for it, are key to reimbursement so we describe the required elements in detail.

Since economic analyses are a necessary part of any capital budgeting decision, we incorporated Medicare's payment rates for the procedures as well as utilization rates.

THE INSTRUMENTS

The Carl Zeiss Meditec IOLMaster optical biometry systems (Models 500 and 700) are multipurpose diagnostic instruments for evaluating the anterior segment using optical coherence biometry, corneal curvature, and other imaging.[1] The IOLMaster instruments can perform multiple tests depending on the patient's and provider's needs. These tests include:

- Optical coherence biometry
- Anterior chamber depth
- Keratometry
- White-to-white measurement
- IOL calculation, including post-refractive corneal surgery, phakic IOL, and multiple surgeon customization of IOL constants
- Database of more than 200 IOL models are available via the User Group for Laser Interference Biometry (ULIB) [2]
- Optional Reference Image for "markerless" toric IOL alignment to upload to the ZEISS CALLISTO computer-assisted surgery system.

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[1] Carl Zeiss Meditec. IOLMaster Product Information. Link here for IOLMaster 500 and Link here for IOLMaster 700. Accessed 07/06/17.

[2] Haigis W. User Group for Laser Interference Biometry. ULIB Support for the Zeiss IOLMaster. Link here. Accessed 07/06/17.

The IOLMaster 700 performs all of the above, along with some additional features and testing:

- Uses swept source OCT technology for a full-length OCT image showing some anatomical details such as natural lens thickness, tilt, or decentration, and fixation check of the fovea.
- Corneal thickness

All of these tests potentially supplement the eye care professional's evaluation and management of the cornea, cataracts, and planning for anterior segment surgery. The IOLMaster models all provide the above measurements without direct contact with the cornea, thereby minimizing possible compression errors related to ultrasound.

When measurement differences "between eyes" are noted, the instrument alerts the user to ensure these differences can be verified before use on IOL calculations. Additionally, when the IOL powers between the 2 eyes differ, the instrument likewise alerts the user.

Figure 1 **IMAGE of ZEISS Model 500 (L) and Model 700 (R)**

Images Courtesy of ZEISS

The data available and method of presentation are shown in Table 1.

Table 1 **IOLMaster Features by Diagnostic Test**

Test Type	**Data and Imaging Capability**	
	Model 500	Model 700
Optical Coherence Biometry (Axial length)	14 mm to 38 mm	
IOL Calculation	• Multiple IOL formulae, including post-refractive and toric IOL calculators • IOL list can be updated and optimized using the User Group for Laser Interference Biometry (ULIB) website downloads • Can also calculate desired powers for Phakic anterior and posterior chamber intraocular lenses • Exportable database	
White to White Measurement (WTW)	Range 8 – 16 mm	
Anterior Chamber Depth (ACD)	1.5 mm – 6.5 mm	0.7 mm – 8 mm
Central Corneal Thickness (CCT)	-	0.2 mm – 1.2 mm
Lens Thickness (LT)	-	1 mm – 10 mm (Phakic) 0.13 mm – 2.5 mm (Pseudophakic)
Corneal Radii (Curvature)	5 mm – 10 mm	5 mm – 11 mm

Figures 3A-3E show the OCB/OCT image generated by IOLMaster for axial length, a fixation check screen showing the measurement summary and white-to-white, as well as others showing corneal thickness/anterior chamber depth/lens thickness measurements for a variety of patient ages, a sample IOL calculation printout, and the IOLMaster in use (all images courtesy of ZEISS).

Figure 3A **Optical Coherence Biometry (Axial Length) with Signal-to-Noise (SNR)**

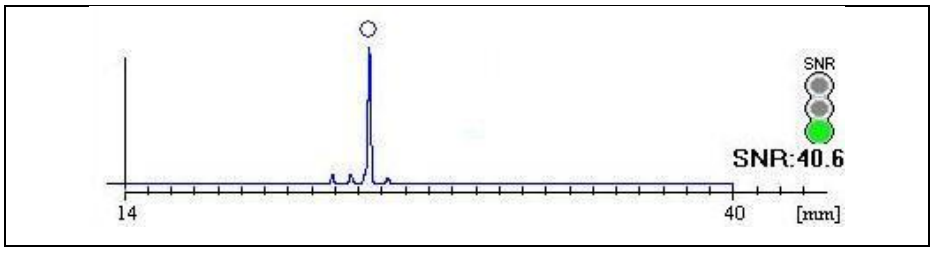

Figure 3B **OCT Image (IOLMaster 700) Fixation Check Screen Showing Measurement Summary including White-to-White (WTW)**

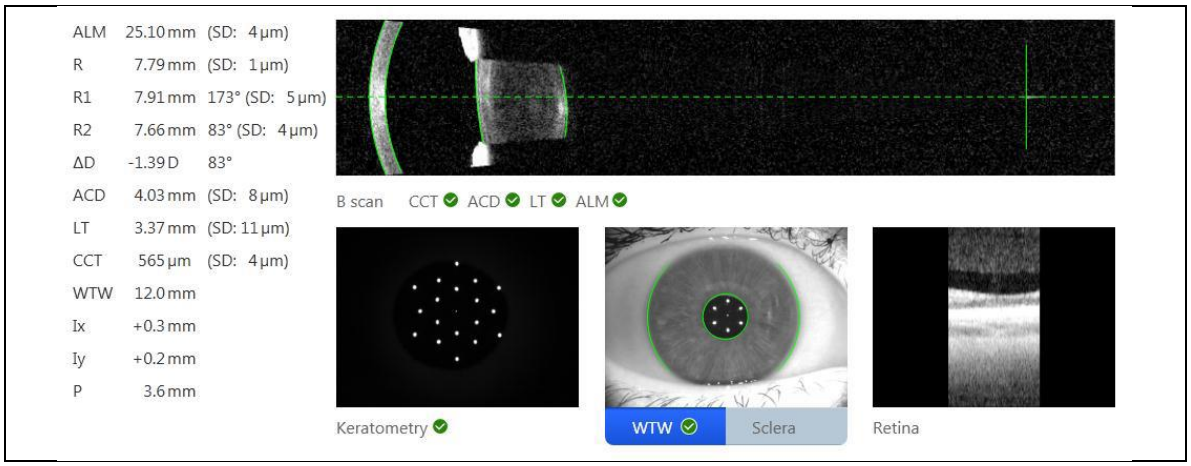

Figure 3C **OCT Image (IOLMaster 700) Anterior Segment Measurement (CCT, ACD, LT)**

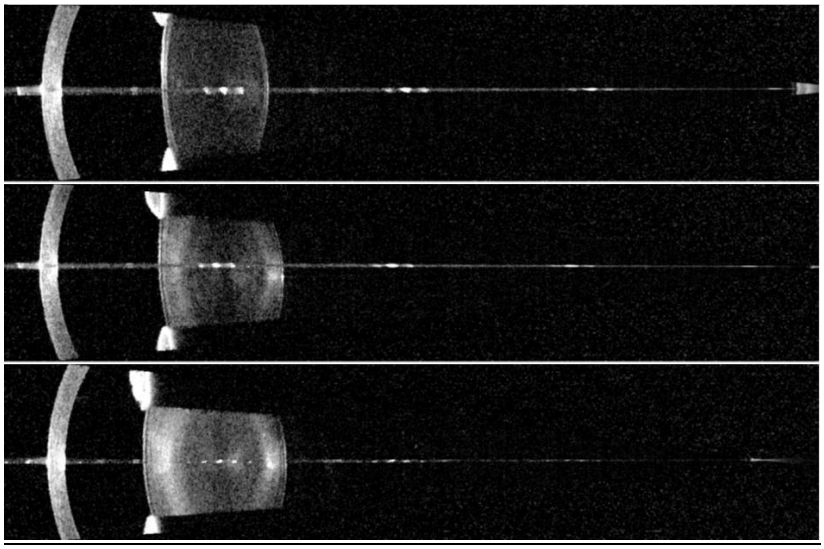

Figure 3D **OCT Image (IOLMaster 700) Sample IOL Master Calculation Screen on Tablet Device**

Figure 3E **IOLMaster 700**

INDICATIONS

Axial length measurement and IOL calculation with the IOLMaster is indicated when cataract surgery with implantation of an intraocular lens is planned. It is also indicated for a secondary implant for an aphakic patient, and when an IOL implant is planned for a patient with congenital aphakia, and may be indicated for some situations related to IOL exchanges. Table 2 contains a listing of common diagnosis codes.

Table 2 **Diagnosis Codes for Optical Coherence Biometry** [3]

ICD-10	Description
H26.-	Other (non-senile) cataract
H26.2-	Complicated cataract
H26.3-	Drug-induced cataract *
H26.8	Other specified cataract
H25.9	Senile cataract, unspecified
H25.89	Other age-related cataract
H25.03-	Anterior subcapsular polar age-related cataract
H25.04-	Posterior subcapsular polar age-related cataract
H25.01-	Cortical age-related cataract
H25.1-	Age-related nuclear cataract (Nuclear sclerosis)
H25.81-	Combined forms of age-related cataract
H25.2-	Age-related cataract, morgagnian (hypermature)
E10.36-, E11.36-	Diabetes with Diabetic cataracts (E10 = type 1, E11 = type 2)
H27.0-	Aphakia and dislocation of lens
Q12.-	Congenital cataract and congenital aphakia
T85.2-	Mechanical complication due to ocular lens prosthesis

White-to-white measurement, although automated on the IOLMaster, can be adjusted manually to allow for refinements when measurement difficulties are encountered (*e.g.*, pterygium and other limbal/corneal conditions). It is integral to the performance of IOL calculation with 92136 and is not separately billable.

[3] Listed codes are representative of covered diagnoses but differences in payment policies exist for many carriers. The ICD-10 codes shown may contain laterality and other issues; the ending "dash" means a longer code is required and contains greater specificity. This list is neither exhaustive nor universally accepted. See your carrier bulletins. The * means that another code might be required due to ICD-10 coding instructions.

Anterior chamber depth and lens thickness are part of the calculations for some IOL formulae; they are incidental to the IOL calculation and are not separately billable.

An important feature of the IOLMaster is that the corneal radii (curvature) measurement is "telecentric" according to ZEISS and will be able to get an accurate reading even if the device-to-eye distance varies.[4] It is like keratometry and thus is incidental to the IOL calculation; it is not separately billable.

DOCUMENTATION

The Medicare guidelines for interpretation of diagnostic tests are discussed in the Medicare Claims Process Manual (MCPM) Chapter 13 §100, Interpretation of Diagnostic Tests.[5]

For any diagnostic test to be covered by Medicare or other insurance, it must meet the following criteria.

- An order for the test, with medical rationale
- The date of the test
- Reliability of the test
- Biometry measurements
- Documentation of the selection of the desired IOL power
- Physician's signature and date

For IOLMaster, the interpretation might read as follows.

- Physician's order – OCB for axial length due to worsening cataract requiring surgery
- June 15, 2017
- Technician: Alex Smith, COA
- Good patient cooperation
- IOL power and model selected and ordered (marked on IOL Calculation printout)
- Proceed with Cataract Surgery/IOL implantation
- *Signed: I. C. Better, M.D.*

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[4] Carl Zeiss Meditec. Distance-independent keratometry. Link here. Accessed 08/05/17.

[5] Medicare Claims Process Manual (MCPM), Chapter 13, §100. Interpretation of Diagnostic Tests. Link here. Accessed 07/06/17.

Within an electronic medical record, we often find a designated spot to record the physician's IOL calculation.

Timing

Ideally, the interpretation of a test follows immediately after the technical component is finished. In practice, there may be a delay; however, the delay should not be lengthy or affect patient care. Since the physician need not be present during the performance of the test, the interpretation might take place the next day. If a weekend intervenes, there may be two days' delay. In any case, the IOL calculation must occur sufficiently in advance of surgery to ensure the selected IOL is available.

Payment Considerations

In the Medicare Physician Fee Schedule, different payment rates are established for the professional and technical components of a diagnostic test where there is discrete reimbursement for an "interpretation and report". Respectively, modifiers 26 and TC are used to make the distinction between the professional and technical portions of the test. As a practical matter, this segregation permits a technician or medical assistant to perform the technical component, with appropriate supervision; however, only the physician can interpret test results. When modifiers TC and 26 are not appended to a CPT code, then the payer understands that reimbursement is sought for both the technical and professional components together in a single payment.

As noted above, interpretation of OCB includes marking the IOL power and model by the surgeon signing and dating the IOL calculation form and filing the results in the medical record (paper or electronic).

SUPERVISION

Medicare's supervision rules for many ophthalmic diagnostic tests have been stable since July 1, 2001. At this time, no supervision policy has been established for 92136, so we looked at A-scan biometry (76519) for guidance. Under the Medicare program standards, *general supervision* is required and, in our opinion, is also appropriate for OCB. This means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during performance of the test.

Under general supervision rules, the training of the non-physician personnel who actually perform the diagnostic test and the maintenance of the necessary equipment and supplies

are the continuing responsibility of the physician.[6] This means the procedure is furnished under the physician's overall direction and control, but the physician's presence in the office is not required during performance of the test.

BILLING ISSUES

CPT Codes

CPT 92136 is defined as: "*Optical biometry by partial coherence interferometry with intraocular lens calculation.*" Optical coherence biometry (OCB) is an alternative to A-scan ultrasound prior to cataract surgery. It uses partially coherent light to determine the axial length of the eye and these numbers, when combined with corneal curvature, are used to determine IOL power before cataract surgery with IOL implantation.

Other measurements that may be performed with one or both models of IOLMaster do not have defined CPT codes and are not separately billable (see Table 1).

OCB would not be billed on the same day as an A-scan (CPT 76519). Longstanding National Coverage Determination (NCD) §10.1 notes that only a single measurement of axial length is generally allowed before cataract surgery,[7] and notes:

> " *… In most cases, a comprehensive eye examination (ocular history and ocular examination) and a single scan to determine the appropriate pseudophakic power of the IOL are sufficient …*"

National Government Services, Inc. (NGS), the Medicare Administrative Contractor (MAC) for Illinois and other Midwestern states, states the following in local coverage determination (LCD) for Optical Biometry for Intraocular Lens Power Calculation.[8]

> "*Prior to cataract surgery on the second, contralateral eye, allowance for the power calculation can be made. However, allowance for the technical component of the A-scan or OCB CPT code cannot be made since this bilateral procedure was performed and reimbursed at the time of the first surgery.*
>
> *The technical component of the scan will generally provide valid information for twelve months. A repeat scan in less than twelve months*

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6 42 CFR 410.32 (b)(3)(i). Definition of general supervision. Link here. Accessed 07/06/17.

7 CMS. NCD 10.1. Use of Visual Tests Prior to and General Anesthesia during Cataract Surgery. Eff. 08/31/1992. Link here. Accessed 07/06/17.

8 National Government Services, Inc. LCD L33621. Ophthalmic Biometry for Intraocular Lens Power Calculation. Rev. Eff. 10/01/2015. Link here. Accessed 07/06/17.

> *would not be covered without documentation of significant change in vision (unless required because a second unaffiliated surgeon performed the second cataract extraction.) … If ophthalmic biometry is performed and later the surgery is canceled, it is reasonable to allow a repeat scan if significant time, e.g., greater than one (1) year, has elapsed when surgery is rescheduled.*
>
> *Ophthalmic biometry for lens power calculation should not be performed unless a decision to remove the cataract has been made by the patient and surgeon.*"

CGS Administrators, the MAC for Kentucky and other states, has the same language as above.[9] First Coast Service Options, Inc. (FCSO), the MAC for Florida, does not reference a time frame in their published policy on OCB[10] but otherwise agrees with them. FCSO, in their Coding Guidelines[11] document which supplements their LCD, also notes the following in agreement with NCD §10.1.

> "*It is not considered medically reasonable or necessary to perform both an A-scan and OCB. Therefore, procedure code 76519 will not be paid in addition to OCB.*"

The swept-source OCT functions of the IOLMaster are valuable but incidental since they are used in alignment of the axial length measurements and are not separately reimbursable.

Modifiers

The following modifiers may be applicable on claims for tests performed with either model of IOLMaster.

26 …….	Professional component of a diagnostic test
52 ……..	Reduced services (unilateral measurement of bilateral test)
AQ …….……	Services provided in a HPSA (*Medicare modifier only; replaces QB and QU*)

[9] CGS Administrators, LLC. LCD L34181. Ophthalmic Biometry for Intraocular Lens Power Calculation. Rev. Eff. 10/01/2016. Link here. Accessed 08/10/17.

[10] First Coast Service Options, Inc. LCD L33927. Optical Coherence Biometry. Eff. Date 10/01/2015. Link here. Accessed 08/10/17.

[11] First Coast Service Options, Inc. Coding Guidelines to LCD L33927. Optical Coherence Biometry. Link here. Accessed 08/10/17.

GA …….....	Waiver of liability statement issued as required by payer policy (signed ABN on file)
GX …….	Notice of liability issued, voluntary under payer policy (signed ABN on file)
GY …….……	Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit
GZ ……..…	Medicare probably does not cover this service. No ABN on file (*Medicare modifier only*)
RT or LT ……...	Right or left eye
TC …….……	Technical component of a diagnostic test

Coding

Ocular coherence biometry with IOL calculation may be billed using a *global code* (92136) without modifiers or with modifiers RT or LT as appropriate. The regulation incorporates a novel definition of the global service that is unique in Medicare, although other payers may elect to follow it. Reimbursement for that code will compensate for the *bilateral* performance of the technical component and *unilateral* performance of the interpretation or professional component. If the physician subsequently interprets the measurement of the second eye for contralateral cataract surgery, only the professional service for the second eye is billable at that time.[12]

Example:

A 75 y/o male is examined and cataract surgery is planned OD. Both eyes are measured using the IOLMaster and the proper power is selected for the right eye only. The claim will read as follows.

92136-RT	OCB w/ IOL calculation

Alternately, some MACs ask for a breakdown as follows.

92136-TC	OCB technical component
92136-26RT	OCB interpretation, right eye

[12] On February 20, 2004, CMS announced a change to the status of CPT 92136. With that change, the professional component (modifier 26) is unilateral. That means you bill 92136 in the same manner as 76519 (A-scan). This change was effective for claims processed on or after April 1, 2004, but retroactive to dates of service beginning January 1, 2004. The Medicare Physician Fee Schedule continues to define the technical portion of the service as bilateral, while the professional component is unilateral.

This is financially equivalent to the global service (92136) without modifiers TC and 26.

Two months later, this patient is re-examined and scheduled for cataract surgery OS. The earlier biometry measurement in the chart is used to calculate the proper power for the IOL for his left eye. The claim will read as follows.

92136-26LT OCB interpretation, left eye

Note that some Medicare contractors have instructed providers to submit claims for this test without modifiers RT or LT. Check your MAC's policy. For some non-Medicare payers, the global fee is paid once on each eye, prior to each surgery, although some have adopted Medicare's payment rules.

Sample Claim

You have been following a 72 y/o female patient over a number of years for cataracts OU; the vision has not adversely affected her activities of daily living until recently. She has noticed a dramatic decrease in vision in the right eye over the past few months, even with her glasses; the acuity in the left eye remains at an acceptable level for now. Refraction shows no improvement, and her functional complaints are well-documented and related to both reading and driving. She is interested in cataract surgery and, after discussion, it is decided to schedule the right eye in the near future. Today, using IOLMaster, you order and obtain OCB. You properly select the IOL power and model for this eye. In addition to the exam (shown as 9xxxx), the claim will read as shown.

17 REFERRING/ORDERING PROVIDER	17a.		
DK J Emdy MD	17b.	NPI	1234567890
19 ADDITIONAL CLAIM INFORMATION			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ICD Ind. 0			
A. H25.11 B. C. D.			

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. POS	C. EMG	D. PROCEDURES, SVCS CPT/HCPCS	MODIFIER	E. DX POINTER	F. $ CHARGES	G. UNITS	H. EPSDT	I. ID QUAL.	J. RENDERING PROVIDER I.D.
mm dd yyyy		11		9xxxx		A	xxx xx	1		NPI	1234567890
mm dd yyyy		11		92136	RT	A	xxx xx	1		NPI	1234567890

Multiple Procedure Payment Reduction

Medicare has implemented a payment reduction when multiple tests are performed at the

same encounter. Known as the Multiple Procedure Payment Reduction (MPPR),[13] it is effective for dates of service beginning January 1, 2013. This payment policy reduces the *technical component* of the second and any subsequent ophthalmic diagnostic tests by 20% when more than one eligible diagnostic test is performed at one patient encounter on the same day by the same physician or group. The list of tests[14] includes ultrasounds, imaging, and visual fields. Tests not on the list are not subject to the MPPR reduction. All the codes discussed in this monograph are subject to MPPR.

MPPR Example

A patient returns for her 6 month cataract and glaucoma check; an OCT of the optic nerve head was ordered at the last visit for performance today. During the exam today, you note that the cataract has worsened significantly and is now ready for surgery; the patient agrees. Optical coherence biometry is ordered and performed today. Both tests are properly interpreted. In 2017, Medicare payment for these two tests when done in the office would be as follows.

Test	Professional	Technical (showing reduction)	Total Payment
92136 Optical Coherence Biometry with IOL calc.	$59.22	$31.94 (No reduction)	$91.16
92133 OCT, Optic Nerve Head	$22.97	$15.07 less $3.02 (20%) = $12.05	$35.02

2017 National Medicare Physician Fee Schedule, PAR allowable

The payment reduction is taken only on the lesser of the two *technical* portions – which is the OCT in this example. Note that the professional portions of each of the respective tests are unaffected and paid in full.

Financial Waivers

An Advance Beneficiary Notice of Non-Coverage (ABN, CMS-R-131)[15] is a written notice a health care provider gives to a Medicare beneficiary when the provider believes that Medicare will not pay for items or services. It applies to both assigned and non-assigned claims. By signing an ABN, the Medicare beneficiary acknowledges that he or

[13] CMS. Medicare Learning Network, MLN Matters MM7848, Eff. January 1, 2013. Link here. Accessed 08/02/17.

[14] CMS Transmittal 1149, dated November 6, 2012, identifies the specific tests by CPT code that are subject to the MPPR. The Medicare Physician Fee Schedule multiple procedure indicator also identifies these codes each year (multiple procedure indicator 7). Link here. Accessed 08/10/17.

[15] Advance Beneficiary Notice of Noncoverage. Link here. Accessed 08/10/17.

she has been advised that Medicare will not pay and agrees to be responsible for payment, either personally or through another insurance plan. For an ABN to have any utility, it must be signed before providing the item or service.

The format of an ABN cannot be modified to any significant degree. You must add your name, address and telephone to the header. You may add your logo and other information if you wish. The "Items or Services," "Reason Medicare May Not Pay," and "Estimated Cost" boxes are customizable so you can add pre-printed lists of common items and services or denial reasons. Anything you add in the boxes must be high contrast ink on a pale background. Blue or black ink on white paper is preferred. You may not make any other alterations to the form. It must be one page, single-sided, although an addendum is allowed.

The patient must *sign* and *date* the form; an unsigned or undated form is not valid. Once the patient has signed the completed form, he or she must receive a legible copy. The same guidelines apply to the copy as to the original: blue or black ink on white paper is preferred; a photocopy is fine. You keep the original in your files.

You must complete your portion of the form before asking the beneficiary to sign. Fill in the beneficiary's name and identification number (but not HIC number) at the top of the form. Complete the "Items or Services" box, describing what you propose to provide. Use simple language the beneficiary can understand. You may add CPT or HCPCS codes, but codes alone are not sufficient without a description. Complete the "Reason Medicare May Not Pay" box with the reason(s) you expect a denial. The reason(s) must be specific to the particular patient; general statements such as "medically unnecessary" are not acceptable. The "Estimated Cost" field is required.

The beneficiary must *personally* choose from Option 1, 2 or 3.

- ☐ Option 1 *I want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but* ***I can appeal to Medicare*** *by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.*
- ☐ Option 2 *I want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and* ***I cannot appeal if Medicare is not billed.***
- ☐ Option 3 *I don't want the items or services listed above. I understand with this choice I am* ***not*** *responsible for payment, and* ***I cannot appeal to see if Medicare would pay.***

If the beneficiary chooses Option 1, you must file a claim and append an appropriate modifier to the reported item(s) or service(s). Option 2 applies to situations where Medicare is precluded from paying for the item or service and the beneficiary does not dispute the point; you are not required to file a claim. If the beneficiary chooses Option 3, there is no claim to file or charge to make; the service is not provided because the patient declines.

You do not need an ABN for items or services that are statutorily (*i.e.,* by law) non-covered by Medicare. Statutorily non-covered services in an eye care practice include refractions and cosmetic procedures such as refractive surgery. Instructions, published on September 5, 2008,[16] allow the use of an ABN *voluntarily* for items excluded from Medicare coverage. At your discretion, you may choose to notify a beneficiary that these services are never covered using the ABN. Written notification is strongly recommended to avoid confrontations with beneficiaries about payment.

In CMS Transmittal R1921CP,[17] effective April 1, 2010, two modifiers were updated to distinguish between *voluntary* and *required* use of liability notices.

- Modifier GA is now defined as "Waiver of Liability Statement Issued as Required by Payer Policy". It applies when you believe Medicare will consider a service not medically necessary in a particular situation. Ask the patient to sign an ABN and submit your claim with modifier GA, allowing the payer to decide if the service is covered.
- Modifier GX is defined as "Notice of Liability Issued, Voluntary Under Payer Policy". It applies when a service is always noncovered; it addresses the fact that most beneficiaries will elect Option 1 in the hope that Medicare might pay, despite your assurances to the contrary. Therefore, if the patient selects Option 1, append modifiers GX and GY to that claim to obtain a denial.
- Modifier GY is defined as "Item or service statutorily excluded or does not meet the definition of any Medicare benefit".

Note that Medicare Advantage plans (Medicare Part C) are prohibited from using the regular Medicare ABN form but may still require prior financial notice. In many cases, they are required to provide a coverage or non-coverage determination in advance. Check plan websites for appropriate instructions.

For non-Medicare beneficiaries, some of the principles outlined above are just as applicable. While the concept of waiver of liability may not be present, or at least not as

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[16] CMS. Medicare Learning Network, MLN Matters MM6136. Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage. Link here. Accessed 08/02/17.

[17] CMS. Transmittal R1921CP. Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs). February 19, 2010. Link here. Accessed 08/02/17.

vigorously, it is still prudent to ensure that patients appreciate the distinction between covered and non-covered services, and accept financial responsibility for the latter.

Prohibited Code Combinations

In 1996, CMS developed the National Correct Coding Initiative (NCCI)[18] to control improper coding leading to inappropriate payments in Part B claims.[19] NCCI consists of a series of edits to analyze codes reported on claims for reimbursement. They ensure the most comprehensive groups of codes are billed rather than the component parts; this is the concept informally known as "bundles". Additionally, the edits check for mutually exclusive code pairs – procedures that are medically incompatible – so just one of the pair may be reimbursed. New edits are published quarterly by the National Technical Information Service (NTIS). Some carriers have also published local policies with additional limitations. Of note, you may not use an ABN to circumvent the NCCI edits.

A bundle means that just one service will be reimbursed when both are performed on the same day. Current NCCI edits for 92136 include A-scan ultrasound biometry with IOL calculation (76519) and the technician exam (99211).

Purchased Diagnostic Tests / Anti-Markup Rule

If you order and bill for a test and either the technical component or the professional interpretation is performed by another physician, you may be prohibited from marking up the test (*i.e.*, receiving payment from Medicare in excess of the amount you paid to the physician who performed the technical component or professional interpretation) unless the physician who performs the test "shares a practice" with you.[20] However, if the performing physician meets the Medicare criteria for "sharing a practice" with you, the prohibition would not apply for that diagnostic test. The prohibition against marking up the test is referred to as the Medicare Anti-Markup Rule and was formerly known as the Purchased Diagnostic Test Rule.

If the Medicare Anti-Markup Rule applies because the performing physician is not deemed to share a practice with the billing physician, the payment to the billing physician (less the applicable deductibles and coinsurance paid by the beneficiary or on behalf of

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[18] Centers for Medicare & Medicaid Services. National Correct Coding Initiative Edits. Link here. Access 08/07/17.

[19] Medicare Claims Processing Manual, Chapter 23, §20.9. Correct Coding Initiative. Link here. Accessed 08/07/17.

[20] CMS. Medicare Learning Network, MLN Matters MM6371, July 1, 2009. Link here. Accessed 08/07/17.

the beneficiary) for the technical component or the professional component of the diagnostic test may not exceed the lowest of the following amounts:

- The performing supplier's net charge to the billing physician or other supplier;
- The billing physician or other supplier's actual charge; or
- The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

For further information about the Medicare Anti-Markup Rule and the "sharing a practice" criteria, please refer to CMS instructions.[21]

Health Professional Shortage Area (HPSA)

Medicare pays a quarterly 10% premium to physicians who provide services in a Health Professional Shortage Area (HPSA). Historically, modifiers QU (urban) and QB (rural) designated services eligible for a HPSA bonus. Modifier AQ replaced these modifiers on January 1, 2006; the distinction between rural and urban HPSAs no longer exists. No modifier is necessary if your zip code is listed as HPSA eligible. The bonus payment will be automatic. Eligible services provided at locations not listed will continue to need the modifier AQ.

This premium is pertinent only to professional services, and does not apply to the technical component (TC) of diagnostic tests. Until recently, it was necessary to separate the professional and technical components in order to receive bonuses, but no longer. The carrier will automatically calculate bonus payments on the professional component.

As an illustration, if the test in Sample Claim 1, above, had been performed in a HPSA not receiving automatic bonus payments, then the claim would be billed as 92136-AQ.

UTILIZATION

Commercial utilization rates are not readily available for these services, but CMS publishes utilization data. The most current data available comes from Medicare fee-for-service claims adjudicated in 2016.

In the Medicare program, 92136 was paid nearly 1.45 million times, or 6.6 per 100 exams performed by ophthalmologists. Claims for 92136 among optometrists were rare.

[21] Medicare Claims Processing Manual, Chapter 1, Section 30.2.9. Link here. Accessed 08/10/17.

If your utilization rate significantly exceeds expected norms, as would be the case in a cataract-focused practice, you will likely garner (unwanted) attention from Medicare and other payers. Careful attention to documentation and the reasons tests were performed are your best defense against reproach in the event of postpayment review. Having original or electronic copies of other documents (such as ABNs) available is also important if there are questions about whether patients were informed of possible noncoverage.

PAYMENT RATES

National Medicare payment rate in 2017 for code 92136 is shown below, including the technical component (TC), the professional component (PC) and the global total. Note that actual payment amounts vary geographically according to local wage indices. MPPS reductions apply when multiple tests are performed on the same day.

Table 5 **Medicare National Allowable Rates**

Code	PAR	Non-PAR	Limiting Charge [22]
92136	$91.16	$86.60	$99.59
92136-TC	$59.22	$56.26	$64.69
92136-26	$31.94	$30.34	$34.90

CONCLUSION

The ZEISS IOLMaster (Models 500 and 700) provides surgeons with a versatile tool to perform corneal curvature, axial length measurement, and IOL calculation before cataract surgery. Discrete reimbursement for medically necessary testing is available for optical coherence biometry (OCB). Anterior chamber depth, corneal curvature measurement, and lens thickness are incidental to the OCB and are not separately billable.

[22] Participating physicians (PAR) agree to accept Medicare allowed amounts on all covered services as their maximum payment from all sources. This is known as "accepting assignment". Non-participating physicians (Non-PAR) may accept assignment on a case-by-case basis, but are also limited in the amount they may charge the patient if they do not accept assignment. For additional discussion, see information published by CMS for patients here. Accessed 08/10/17.

If the proposed cataract surgery is non-covered, usually because the patient does not meet coverage criteria, then the associated OCB would not be covered either. Where a test is not covered, a financial waiver, such as an ABN, is necessary to ensure that the patient accepts financial responsibility. See additional claims processing tips below.

This discussion is meant to assist the reader to better understand the rules and regulations regarding reimbursement for these procedures, however the responsibility for appropriate usage, adequate documentation and proper coding are always the physician's.

Practice Management Tips

- Document the physician's interpretation of the diagnostic test within a short time, preferably within 24 - 72 hours. Be sure to address the quality of the test, the findings, and the assessment (IOL calculation). Sign and date the note.
- Place a note in the medical record that identifies where digital images are electronically stored.
- Monitor NCCI edits.
- Reimbursement for this test is subject to Medicare's MPPR rules. When performed with other tests on the same day, payment may be reduced.
- If you use an independent contractor to perform diagnostic tests - that is, someone who provides all the equipment and technician and is not an employee, then get assistance with the arcane instructions associated with Medicare's anti-markup rules.