Article - Billing and Coding: Computerized Corneal Topography (A56816)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
CGS Administrators, LLC	MAC - Part A	15101 - MAC A	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part B	15102 - MAC B	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part A	15201 - MAC A	J - 15	Ohio
CGS Administrators, LLC	MAC - Part B	15202 - MAC B	J - 15	Ohio

Article Information

General Information

Article ID
A56816

Article Title
Billing and Coding: Computerized Corneal Topography

Article Type
Billing and Coding

Original Effective Date
08/08/2019

Revision Effective Date
01/26/2023

Revision Ending Date
N/A

Retirement Date
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

CMS National Coverage Policy

N/A

Article Guidance

Article Text

This article gives guidance for billing, coding, and other guidelines in relation to local coverage policy L34008 Computerized Corneal Topography .

General Guidelines for Claims submitted to Part A or Part B MAC:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare. For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim. A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act. The diagnosis code(s) must best describe the patient's condition for which the service was performed. For diagnostic tests, report the result of the test if known; otherwise the symptoms prompting the performance of the test should be reported.

Advance Beneficiary Notice of Non-coverage (ABN) Modifier Guidelines

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, for complete instructions.

Effective from April 1, 2010, non-covered services should be billed with modifier –GA, -GX, -GY, or –GZ, as appropriate.

The –GA modifier (“Waiver of Liability Statement Issued as Required by Payer Policy”) should be used when physicians, practitioners, or suppliers want to indicate that they anticipate that Medicare will deny a specific service as not reasonable and necessary and they do have an ABN signed by the beneficiary on file. Modifier GA applies only when services will be denied under reasonable and necessary provisions, sections 1862(a)(1), 1862(a)(9), 1879(e), or 1879(g) of the Social Security Act. Effective April 1, 2010, Part A MAC systems will automatically deny services billed with modifier GA. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Part A MAC, occurrence code 32 and the date of the ABN is required.

Modifier GX (“Notice of Liability Issued, Voluntary Under Payer Policy”) should be used when the beneficiary has

signed an ABN, and a denial is anticipated based on provisions other than medical necessity, such as statutory exclusions of coverage or technical issues. An ABN is not required for these denials, but if non-covered services are reported with modifier GX, will automatically be denied services.

The –GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an ABN signed by the beneficiary. If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier. An ABN is not required for these denials, and the limitation of liability does not apply for beneficiaries. Services with modifier GY will automatically deny.

Documentation Requirements

The patient's medical record should include but is not limited to:

- The assessment of the patient by the ordering provider as it relates to the complaint of the patient for that visit,
- Relevant medical history
- Results of pertinent tests/procedures
- Signed and dated office visit record/operative report (Please note that all services ordered or rendered to Medicare beneficiaries must be signed.)
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Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes: (1 Code)

CODE	DESCRIPTION
92025	COMPUTERIZED CORNEAL TOPOGRAPHY, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT

CPT/HCPCS Modifiers

N/A

ICD-10-CM Codes that Support Medical Necessity

Group 1 Paragraph:

ICD-10 codes Z96.1, Z98.41, and Z98.42 must be accompanied by ICD-10 code H52.211, H52.212, or H52.213.

Group 1 Codes: (77 Codes)

CODE	DESCRIPTION
H11.001 - H11.003	Unspecified pterygium of right eye - Unspecified pterygium of eye, bilateral
H11.011 - H11.013	Amyloid pterygium of right eye - Amyloid pterygium of eye, bilateral
H11.021 - H11.023	Central pterygium of right eye - Central pterygium of eye, bilateral
H11.031 - H11.033	Double pterygium of right eye - Double pterygium of eye, bilateral
H11.041 - H11.043	Peripheral pterygium, stationary, right eye - Peripheral pterygium, stationary, bilateral
H11.051 - H11.053	Peripheral pterygium, progressive, right eye - Peripheral pterygium, progressive, bilateral
H11.061 - H11.063	Recurrent pterygium of right eye - Recurrent pterygium of eye, bilateral
H16.051 - H16.053	Mooren's corneal ulcer, right eye - Mooren's corneal ulcer, bilateral
H16.301 - H16.303	Unspecified interstitial keratitis, right eye - Unspecified interstitial keratitis, bilateral
H16.321 - H16.323	Diffuse interstitial keratitis, right eye - Diffuse interstitial keratitis, bilateral
H16.331 - H16.333	Sclerosing keratitis, right eye - Sclerosing keratitis, bilateral
H17.9	Unspecified corneal scar and opacity
H18.11 - H18.13	Bullous keratopathy, right eye - Bullous keratopathy, bilateral
H18.421 - H18.423	Band keratopathy, right eye - Band keratopathy, bilateral
H18.451 - H18.453	Nodular corneal degeneration, right eye - Nodular corneal degeneration, bilateral
H18.591	Other hereditary corneal dystrophies, right eye
H18.592	Other hereditary corneal dystrophies, left eye
H18.593	Other hereditary corneal dystrophies, bilateral
H18.601 - H18.603	Keratoconus, unspecified, right eye - Keratoconus, unspecified, bilateral
H18.611 - H18.613	Keratoconus, stable, right eye - Keratoconus, stable, bilateral
H18.621 - H18.623	Keratoconus, unstable, right eye - Keratoconus, unstable, bilateral
H18.711 - H18.713	Corneal ectasia, right eye - Corneal ectasia, bilateral
H52.211 - H52.213	Irregular astigmatism, right eye - Irregular astigmatism, bilateral
H53.2	Diplopia
T85.21XA	Breakdown (mechanical) of intraocular lens, initial encounter
T85.22XA	Displacement of intraocular lens, initial encounter
T85.318A	Breakdown (mechanical) of other ocular prosthetic devices, implants and grafts, initial encounter

CODE	DESCRIPTION
T85.328A	Displacement of other ocular prosthetic devices, implants and grafts, initial encounter
T86.8401	Corneal transplant rejection, right eye
T86.8402	Corneal transplant rejection, left eye
T86.8403	Corneal transplant rejection, bilateral
T86.8411	Corneal transplant failure, right eye
T86.8412	Corneal transplant failure, left eye
T86.8413	Corneal transplant failure, bilateral
Z94.7	Corneal transplant status
Z96.1	Presence of intraocular lens
Z98.41	Cataract extraction status, right eye
Z98.42	Cataract extraction status, left eye
Z98.83	Filtering (vitreous) bleb after glaucoma surgery status

ICD-10-CM Codes that DO NOT Support Medical Necessity

N/A

ICD-10-PCS Codes

N/A

Additional ICD-10 Information

N/A

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

CODE	DESCRIPTION
011x	Hospital Inpatient (Including Medicare Part A)
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
071x	Clinic - Rural Health

CODE	DESCRIPTION
073x	Clinic - Freestanding
077x	Clinic - Federally Qualified Health Center (FQHC)
085x	Critical Access Hospital

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

CODE	DESCRIPTION
0360	Operating Room Services - General Classification
0409	Other Imaging Services - Other Imaging Services
0450	Emergency Room - General Classification
0510	Clinic - General Classification
0519	Clinic - Other Clinic
0520	Freestanding Clinic - General Classification
0521	Freestanding Clinic - Clinic Visit by Member to RHC/FQHC
0523	Freestanding Clinic - Family Practice Clinic
0529	Freestanding Clinic - Other Freestanding Clinic
0761	Specialty Services - Treatment Room
0920	Other Diagnostic Services - General Classification
0929	Other Diagnostic Services - Other Diagnostic Service
0960	Professional Fees - General Classification
0962	Professional Fees - Ophthalmology

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/26/2023	R6	R5 Revision Effective: 01/26/2023 Revision Explanation: Annual Review, no changes were made.
02/03/2022	R5	R4 Revision Effective: 02/03/2022 Revision Explanation: Annual Review, no changes were made
02/04/2021	R4	R3 Revision Effective: 02/04/2021 Revision Explanation: Annual Review, no changes were made
10/01/2020	R3	R2 Revision Effective:10/01/2020 Revision Explanation: During the annual ICD-10 update codes H18.59, T86.840, and T86.841 were deleted and replaced with codes: H18.591-H18.593, T86.8401-T86.8403, and T86.8411-T86.8413.
09/19/2019	R2	Revision Effective: N/A Revision Explanation: Annual Review, no changes
09/19/2019	R1	R1 Revision Effective: 09/19/2019

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		Revision Explanation: Converted article into new Billing and Coding template no other changes made.

Associated Documents

Related Local Coverage Documents

LCDs

L34008 - Computerized Corneal Topography

Related National Coverage Documents

N/A

Statutory Requirements URLs

N/A

Rules and Regulations URLs

N/A

CMS Manual Explanations URLs

N/A

Other URLs

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
01/20/2023	01/26/2023 - N/A	Currently in Effect (This Version)
01/25/2022	02/03/2022 - 01/25/2023	Superseded
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		

Keywords

N/A