LCD Reference Article	Billing and Coding Article

Article - Billing and Coding: Ophthalmic Biometry for Intraocular Lens Power Calculation (A57070)

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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
A57070

Article Title
Billing and Coding: Ophthalmic Biometry for Intraocular Lens Power Calculation

Article Type
Billing and Coding

Original Effective Date
09/26/2019

Revision Effective Date
11/22/2023

Revision Ending Date
N/A

Retirement Date
N/A

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Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Code of Federal Regulations:

42 CFR §410.32 indicates that diagnostic tests may only be ordered by a treating physician (or other treating practitioner acting within the scope of his/her license and Medicare requirements) who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician (or other qualified non-physician provider) who is treating the beneficiary are not reasonable and necessary (see Sec. 411.15(k)(1) of this chapter).

CMS Publications:

CMS Publication 100-02, *Medicare National Coverage Determinations Manual,* Chapter 1, Part 1:

10.1 Use of Visual Tests Prior to and General Anesthesia during Cataract Surgery,

CMS Publication 100-03, *Medicare National Coverage Determinations Manual,* Chapter 1, Part 1:

10.1 Use of Visual Tests Prior to and General Anesthesia during Cataract Surgery

CMS Publication 100-03, *Medicare National Coverage Determinations Manual,* Chapter 30:
220.5 Ultrasound Diagnostic Procedures

Article Guidance

Article Text

This article gives guidance for billing, coding, and other guidelines in relation to local coverage policy L34181-Ophthalmic Biometry for Intraocular Lens Power Calculation.

Ophthalmic biometry using A-scans (76519) and optical coherence biometry (92136) for the same patient should not be billed by the same provider/physician/group during a 12-month period. Claims for either of these services in excess of these parameters will not be considered medically necessary.

The technical portion of either 76519 or 92136 and the respective interpretations for the same patient should not be billed more than once during a 12 month period by the same provider/physician/group unless there is a significant change in vision. Claims in excess of these parameters will not be considered medically necessary.

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.)

For claims submitted to the Part B MAC:

All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim.

Claims for intraocular lens power calculation services are payable under Medicare Part B in the following places of service:

- The global is payable in the office (11) and independent clinic (49) for CPT codes 76519 and 92136.
- The technical component is payable in the office (11); independent clinic (49); federally qualified health center (50); and rural health clinic (72) for CPT codes 76519 and 92136.
- The professional components are payable in the office (11), off campus-outpatient hospital (19), inpatient hospital (21), on campus-outpatient hospital (22), ambulatory surgical center (24) and independent clinic (49) for 76519 and payable in the office (11), off campus-outpatient hospital (19), inpatient hospital (21), on campus-outpatient hospital (22), and independent clinic (49) for 92136.

The National Correct Coding Initiative (NCCI) may include edits for these CPT codes. Currently, NCCI edits for CPT codes 76519 and 92136 are as follows:

- Procedure code 76519 includes services performed for procedure 76516. Separate reimbursement will not be made for 76516 when billed with 76519;
- Payment for 76519 and 92136 for the same patient, same provider, same day will not be made.

Currently, the **Medicare Physician Fee Schedule Database (MPFSDB) bilateral surgery indicator is "2" for the global and technical components** of each method of ophthalmic biometry for intraocular lens power calculation (CPT codes 76519 and 92136). The definition of "2" is as follows:

- 2 = *150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code.*

When the MPFSDB bilateral surgery indicator is "2," the relative value units (RVUs) are based on the

procedure performed on each eye.

- The global service includes the bilateral technical component (76519-TC or 92136-TC) and a unilateral professional service (76519-26 or 92136-26). The anatomic modifier (-RT or -LT) should be used to indicate the eye on which the professional component was performed.
- The technical component should not be billed with the bilateral modifier -50. Payment is based on the lower of the submitted charge or the fee schedule for a single code. No additional payment is made when code 76519-TC or 92136-TC is billed with the bilateral modifier -50.
- If the technical portion of the procedure is only performed on one eye, the -52 modifier for reduced services should be used as well as the appropriate anatomic modifier (-RT or -LT).

Currently, the **Medicare Physician Fee Schedule Database (MPFSDB) bilateral surgery indicator is "3" for the professional components** of each method of ophthalmic biometry for intraocular lens power calculation (CPT codes 76519 and 92136). The definition of "3" is as follows:

- *3= The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side.*

When the MPFSDB bilateral surgery indicator is "3," the RVUs are calculated based on the procedure being performed as a unilateral procedure on each eye. Payment is based on the lower of the submitted charge or 100% of the fee schedule amount for each eye.

- It is not uncommon for an IOL implant to be required for both eyes. When surgery for bilateral cataracts is scheduled several weeks apart, bill the professional component only when the IOL calculation is done within a timeframe that it can be used for the second planned surgery.
- When the scan is performed and the calculation done on the **first** eye, bill the technical portion on one line (76519-TC or 92136-TC) and the professional component on a second line [76519 26-RT (or 26-LT) or 92136 26-RT (or 26-LT)].
    - Alternatively, bill the global code and use modifier -RT or -LT to indicate on which eye the professional component was performed [76519-RT (or -LT) or 92136-RT (or –LT)]. Do not submit modifier -50.
- If the technical and professional components are performed on **both eyes on the same date**, bill the global service on one line and the second professional component on a second line, indicating the anatomic modifier (-LT/-RT) for the second eye.
- One physician may do the technical component and another physician the professional component. Each will need to use the appropriate modifier, e.g., -TC (technical component) or -26 (professional component). The professional component should also have the anatomic modifier (-LT/-RT) appended.

Effective January 1, 2017 the professional component for 76519 and 92136 was changed to a bilateral indicator of 2 and will follow the same rules as outlined above for the global and technical component of these codes.

For claims submitted to the Part A MAC:

Hospital Inpatient Claims:

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-10-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)
- For claims submitted to the Part A MAC: this coverage determination also applies within states outside

the primary geographic jurisdiction with facilities that have nominated CGS Administrators, LLC. to process their claims.

Hospital Outpatient Claims:

- *The hospital should report the full ICD-10-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report an ICD-10-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (Z00.00-Z13.9).*
- *The hospital enters the full ICD-10-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.

Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes: (2 Codes)

CODE	DESCRIPTION
76519	OPHTHALMIC BIOMETRY BY ULTRASOUND ECHOGRAPHY, A-SCAN; WITH INTRAOCULAR LENS POWER CALCULATION
92136	OPHTHALMIC BIOMETRY BY PARTIAL COHERENCE INTERFEROMETRY WITH INTRAOCULAR LENS POWER CALCULATION

CPT/HCPCS Modifiers

N/A

ICD-10-CM Codes that Support Medical Necessity

Group 1 Paragraph:

It is the responsibility of the provider to code to the highest level specified in the ICD-10-CM. The correct use of an ICD-10-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

Group 1: Codes

Group 1 Codes: (240 Codes)

CODE	DESCRIPTION
E08.36	Diabetes mellitus due to underlying condition with diabetic cataract
E09.36	Drug or chemical induced diabetes mellitus with diabetic cataract
E10.36	Type 1 diabetes mellitus with diabetic cataract
E11.36	Type 2 diabetes mellitus with diabetic cataract
E13.36	Other specified diabetes mellitus with diabetic cataract
H25.011 - H25.013	Cortical age-related cataract, right eye - Cortical age-related cataract, bilateral
H25.031 - H25.033	Anterior subcapsular polar age-related cataract, right eye - Anterior subcapsular polar age-related cataract, bilateral
H25.041 - H25.043	Posterior subcapsular polar age-related cataract, right eye - Posterior subcapsular polar age-related cataract, bilateral
H25.091 - H25.093	Other age-related incipient cataract, right eye - Other age-related incipient cataract, bilateral
H25.11 - H25.13	Age-related nuclear cataract, right eye - Age-related nuclear cataract, bilateral
H25.21 - H25.23	Age-related cataract, morgagnian type, right eye - Age-related cataract, morgagnian type, bilateral
H25.811 - H25.813	Combined forms of age-related cataract, right eye - Combined forms of age-related cataract, bilateral
H25.89	Other age-related cataract
H25.9	Unspecified age-related cataract
H26.001 - H26.003	Unspecified infantile and juvenile cataract, right eye - Unspecified infantile and juvenile cataract, bilateral
H26.011 - H26.013	Infantile and juvenile cortical, lamellar, or zonular cataract, right eye - Infantile and juvenile cortical, lamellar, or zonular cataract, bilateral
H26.031 - H26.033	Infantile and juvenile nuclear cataract, right eye - Infantile and juvenile nuclear cataract, bilateral
H26.041 - H26.043	Anterior subcapsular polar infantile and juvenile cataract, right eye - Anterior subcapsular polar infantile and juvenile cataract, bilateral
H26.051 - H26.053	Posterior subcapsular polar infantile and juvenile cataract, right eye - Posterior subcapsular polar infantile and juvenile cataract, bilateral
H26.061 - H26.063	Combined forms of infantile and juvenile cataract, right eye - Combined forms of infantile and juvenile cataract, bilateral
H26.09	Other infantile and juvenile cataract

CODE	DESCRIPTION
H26.101 - H26.103	Unspecified traumatic cataract, right eye - Unspecified traumatic cataract, bilateral
H26.111 - H26.113	Localized traumatic opacities, right eye - Localized traumatic opacities, bilateral
H26.121 - H26.123	Partially resolved traumatic cataract, right eye - Partially resolved traumatic cataract, bilateral
H26.131 - H26.133	Total traumatic cataract, right eye - Total traumatic cataract, bilateral
H26.20	Unspecified complicated cataract
H26.211 - H26.213	Cataract with neovascularization, right eye - Cataract with neovascularization, bilateral
H26.221 - H26.223	Cataract secondary to ocular disorders (degenerative) (inflammatory), right eye - Cataract secondary to ocular disorders (degenerative) (inflammatory), bilateral
H26.231 - H26.233	Glaucomatous flecks (subcapsular), right eye - Glaucomatous flecks (subcapsular), bilateral
H26.31 - H26.33	Drug-induced cataract, right eye - Drug-induced cataract, bilateral
H26.8	Other specified cataract
H26.9	Unspecified cataract
H27.01 - H27.03	Aphakia, right eye - Aphakia, bilateral
H27.10	Unspecified dislocation of lens
H27.111 - H27.113	Subluxation of lens, right eye - Subluxation of lens, bilateral
H27.121 - H27.123	Anterior dislocation of lens, right eye - Anterior dislocation of lens, bilateral
H27.131 - H27.133	Posterior dislocation of lens, right eye - Posterior dislocation of lens, bilateral
H28	Cataract in diseases classified elsewhere
H40.021 - H40.023	Open angle with borderline findings, high risk, right eye - Open angle with borderline findings, high risk, bilateral
H40.061 - H40.063	Primary angle closure without glaucoma damage, right eye - Primary angle closure without glaucoma damage, bilateral
H40.1110	Primary open-angle glaucoma, right eye, stage unspecified
H40.1111	Primary open-angle glaucoma, right eye, mild stage
H40.1112	Primary open-angle glaucoma, right eye, moderate stage
H40.1113	Primary open-angle glaucoma, right eye, severe stage
H40.1114	Primary open-angle glaucoma, right eye, indeterminate stage
H40.1120	Primary open-angle glaucoma, left eye, stage unspecified
H40.1121	Primary open-angle glaucoma, left eye, mild stage
H40.1122	Primary open-angle glaucoma, left eye, moderate stage

CODE	DESCRIPTION
H40.1123	Primary open-angle glaucoma, left eye, severe stage
H40.1124	Primary open-angle glaucoma, left eye, indeterminate stage
H40.1130	Primary open-angle glaucoma, bilateral, stage unspecified
H40.1131	Primary open-angle glaucoma, bilateral, mild stage
H40.1132	Primary open-angle glaucoma, bilateral, moderate stage
H40.1133	Primary open-angle glaucoma, bilateral, severe stage
H40.1134	Primary open-angle glaucoma, bilateral, indeterminate stage
H40.1210 - H40.1214	Low-tension glaucoma, right eye, stage unspecified - Low-tension glaucoma, right eye, indeterminate stage
H40.1220 - H40.1224	Low-tension glaucoma, left eye, stage unspecified - Low-tension glaucoma, left eye, indeterminate stage
H40.1230 - H40.1234	Low-tension glaucoma, bilateral, stage unspecified - Low-tension glaucoma, bilateral, indeterminate stage
H40.1310 - H40.1314	Pigmentary glaucoma, right eye, stage unspecified - Pigmentary glaucoma, right eye, indeterminate stage
H40.1320 - H40.1324	Pigmentary glaucoma, left eye, stage unspecified - Pigmentary glaucoma, left eye, indeterminate stage
H40.1330 - H40.1334	Pigmentary glaucoma, bilateral, stage unspecified - Pigmentary glaucoma, bilateral, indeterminate stage
H40.1410 - H40.1414	Capsular glaucoma with pseudoexfoliation of lens, right eye, stage unspecified - Capsular glaucoma with pseudoexfoliation of lens, right eye, indeterminate stage
H40.1420 - H40.1424	Capsular glaucoma with pseudoexfoliation of lens, left eye, stage unspecified - Capsular glaucoma with pseudoexfoliation of lens, left eye, indeterminate stage
H40.1430 - H40.1434	Capsular glaucoma with pseudoexfoliation of lens, bilateral, stage unspecified - Capsular glaucoma with pseudoexfoliation of lens, bilateral, indeterminate stage
H40.2210 - H40.2214	Chronic angle-closure glaucoma, right eye, stage unspecified - Chronic angle-closure glaucoma, right eye, indeterminate stage
H40.2220 - H40.2224	Chronic angle-closure glaucoma, left eye, stage unspecified - Chronic angle-closure glaucoma, left eye, indeterminate stage
H40.2230 - H40.2234	Chronic angle-closure glaucoma, bilateral, stage unspecified - Chronic angle-closure glaucoma, bilateral, indeterminate stage
H40.2290 - H40.2294	Chronic angle-closure glaucoma, unspecified eye, stage unspecified - Chronic angle-closure glaucoma, unspecified eye, indeterminate stage
H40.31X0 - H40.31X4	Glaucoma secondary to eye trauma, right eye, stage unspecified - Glaucoma secondary to eye trauma, right eye, indeterminate stage
H40.32X0 - H40.32X4	Glaucoma secondary to eye trauma, left eye, stage unspecified - Glaucoma

CODE	DESCRIPTION
	secondary to eye trauma, left eye, indeterminate stage
H40.33X0 - H40.33X4	Glaucoma secondary to eye trauma, bilateral, stage unspecified - Glaucoma secondary to eye trauma, bilateral, indeterminate stage
H40.41X0 - H40.41X4	Glaucoma secondary to eye inflammation, right eye, stage unspecified - Glaucoma secondary to eye inflammation, right eye, indeterminate stage
H40.42X0 - H40.42X4	Glaucoma secondary to eye inflammation, left eye, stage unspecified - Glaucoma secondary to eye inflammation, left eye, indeterminate stage
H40.43X0 - H40.43X4	Glaucoma secondary to eye inflammation, bilateral, stage unspecified - Glaucoma secondary to eye inflammation, bilateral, indeterminate stage
H40.51X0 - H40.51X4	Glaucoma secondary to other eye disorders, right eye, stage unspecified - Glaucoma secondary to other eye disorders, right eye, indeterminate stage
H40.52X0 - H40.52X4	Glaucoma secondary to other eye disorders, left eye, stage unspecified - Glaucoma secondary to other eye disorders, left eye, indeterminate stage
H40.53X0 - H40.53X4	Glaucoma secondary to other eye disorders, bilateral, stage unspecified - Glaucoma secondary to other eye disorders, bilateral, indeterminate stage
H43.821 - H43.823	Vitreomacular adhesion, right eye - Vitreomacular adhesion, bilateral
Q12.0 - Q12.4	Congenital cataract - Spherophakia
Q12.8	Other congenital lens malformations
Q12.9	Congenital lens malformation, unspecified
T85.21XA	Breakdown (mechanical) of intraocular lens, initial encounter
T85.22XA	Displacement of intraocular lens, initial encounter
T85.29XA	Other mechanical complication of intraocular lens, initial encounter
T85.72XA	Infection and inflammatory reaction due to insulin pump, initial encounter
T85.79XA	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter
T86.8421	Corneal transplant infection, right eye
T86.8422	Corneal transplant infection, left eye
T86.8423	Corneal transplant infection, bilateral
Z79.83	Long term (current) use of bisphosphonates
Z79.85	Long-term (current) use of injectable non-insulin antidiabetic drugs
Z96.1	Presence of intraocular lens

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
013x	Hospital Outpatient
071x	Clinic - Rural Health
073x	Clinic - Freestanding
077x	Clinic - Federally Qualified Health Center (FQHC)
085x	Critical Access Hospital
999x	Not Applicable

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
032X	Radiology - Diagnostic - General Classification
033X	Radiology - Therapeutic and/or Chemotherapy Administration - General

CODE	DESCRIPTION
	Classification
034X	Nuclear Medicine - General Classification
035X	CT Scan - General Classification
040X	Other Imaging Services - General Classification
051X	Clinic - General Classification
052X	Freestanding Clinic - General Classification
0761	Specialty Services - Treatment Room
092X	Other Diagnostic Services - General Classification
096X	Professional Fees - General Classification

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
11/22/2023	R10	Revision Effective: 11/22/2023 Revision Explanation: Updated LCD Reference Article section.
05/25/2023	R9	R9 Revision Effective: 05/25/2023 Revision Explanation: Annual review, no changes.
10/01/2022	R8	R8 Revision Effective: 10/01/2022 Revision Explanation: In revision 7 there was a typo for the ICD-10 code that was added to group 1. G71.031 was not added to group 1 but Z79.85 was added to the this group.
10/01/2022	R7	R7

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		Revision Effective: 10/01/2022 Revision Explanation: Annual ICD-10 Update, Added tp Group 1 G71.031
06/02/2022	R6	R6 Revision Effective:06/02/2022 Revision Explanation: Annual review, no changes were made.
05/27/2021	R5	R5 Revision Effective: 5/27/221 Revision Explanation: Annual review, no changes were made.
10/01/2020	R4	R4 Revision Effective: 10/01/2020 Revision Explanation: During annual ICD-10 review code T86.842 was deleted and replaced with T86.8421, T86.8422, and T86.8423.
01/01/2020	R3	R3 Revision Effective: n/a Revision Explanation: Annual review, no changes made.
01/01/2020	R2	R2 Revision Effective:01/01/2020 Revision Explanation: CPT code 92136 is no longer approved to be done in an ASC setting so information for were the professional service could be completed has been updated to reflect this change.
12/05/2019	R1	R1 Revision Effective: 12/05/2019

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		Revision Explanation: Added text concerning billing claims to Part A or Part B, additional information on bilateral indicators, and some utilization information.

Associated Documents

Related Local Coverage Documents

Articles

A52397 - (MCD Archive Site)

LCDs

L34181 - Ophthalmic Biometry for Intraocular Lens Power Calculation

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
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		
11/15/2023	11/22/2023 - N/A	Currently in Effect (This Version)
05/19/2023	05/25/2023 - 11/21/2023	Superseded
10/05/2022	10/01/2022 - 05/24/2023	Superseded
09/20/2022	10/01/2022 - N/A	Superseded

Keywords

N/A