Local Coverage Article:
Billing and Coding: Ophthalmic Biometry for Intraocular Lens Power Calculation (A56549)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
National Government Services, Inc.	MAC - Part A	06101 - MAC A	J - 06	Illinois
National Government Services, Inc.	MAC - Part B	06102 - MAC B	J - 06	Illinois
National Government Services, Inc.	MAC - Part A	06201 - MAC A	J - 06	Minnesota
National Government Services, Inc.	MAC - Part B	06202 - MAC B	J - 06	Minnesota
National Government Services, Inc.	MAC - Part A	06301 - MAC A	J - 06	Wisconsin
National Government Services, Inc.	MAC - Part B	06302 - MAC B	J - 06	Wisconsin
National Government Services, Inc.	A and B and HHH MAC	13101 - MAC A	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13102 - MAC B	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13201 - MAC A	J - K	New York - Entire State
National Government Services, Inc.	A and B and HHH MAC	13202 - MAC B	J - K	New York - Downstate
National Government Services, Inc.	A and B and HHH MAC	13282 - MAC B	J - K	New York - Upstate
National Government Services, Inc.	A and B and HHH MAC	13292 - MAC B	J - K	New York - Queens
National Government Services, Inc.	A and B and HHH MAC	14111 - MAC A	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14112 - MAC B	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14211 - MAC A	J - K	Massachusetts

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
National Government Services, Inc.	A and B and HHH MAC	14212 - MAC B	J - K	Massachusetts
National Government Services, Inc.	A and B and HHH MAC	14311 - MAC A	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14312 - MAC B	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14411 - MAC A	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14412 - MAC B	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14511 - MAC A	J - K	Vermont
National Government Services, Inc.	A and B and HHH MAC	14512 - MAC B	J - K	Vermont

Article Information

General Information

Article ID
A56549

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

Article Type
Billing and Coding

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Original Effective Date
08/01/2019

Revision Effective Date
09/19/2019

Revision Ending Date
N/A

Retirement Date
N/A

CMS National Coverage Policy

N/A

Article Guidance

Article Text:

This article contains coding and other guidelines that complement the Local Coverage Determination (LCD) for Ophthalmic Biometry for Intraocular Lens (IOL) Power Calculation.

Coding Information:

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 diagnoses 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.

Specific coding guidelines:

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 CPT code 76519-TC or 92136 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.

National Coverage Requirements:

Cataract surgery with an intraocular lens (IOL) implant is a high volume Medicare procedure. Along with the surgery, a substantial number of preoperative tests are available to the surgeon. 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. In most cases involving a simple cataract, a diagnostic ultrasound A-scan is used. For patients with a dense cataract, an ultrasound B-scan may be used. (CMS Publication 100-03, *Medicare National Coverage Determinations(NCD)Manual*, Chapter 1, Part 1, Section 10.1)

Accordingly, where the only diagnosis is cataract(s), Medicare does not routinely cover testing other than one comprehensive eye examination (or a combination of a brief/intermediate examination not to exceed the charge of a comprehensive examination) and an A-scan or, if medically justified, a B-scan. Claims for additional tests are denied as not reasonable and necessary unless there is an additional diagnosis and the medical need for the additional tests is fully documented. (CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 1, Section 10.1)

Because cataract surgery is an elective procedure, the patient may decide not to have the surgery until later, or to have the surgery performed by a physician other than the diagnosing physician. In these situations, it may be medically appropriate for the operating physician to conduct another examination. To the extent the additional tests are considered reasonable and necessary by the carrier's medical staff, they are covered. (CMS Publication 100-03, *Medicare National Coverage Determinations(NCD)Manual*, Chapter 1, Part 1, Section 10.1)

Documentation Requirements:

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (Please see "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. This documentation should include at a minimum the patient's name and date of service, the indications for testing, an order for testing, the results of testing, and the IOL power calculation. Documentation must be available to Medicare upon request.

Utilization Guidelines:

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 be considered not 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 be considered not medically necessary.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 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 Codes that Support Medical Necessity

Group 1 Paragraph:

The 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 the attached determination.

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
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	Cortical age-related cataract, right eye
H25.012	Cortical age-related cataract, left eye
H25.013	Cortical age-related cataract, bilateral
H25.031	Anterior subcapsular polar age-related cataract, right eye
H25.032	Anterior subcapsular polar age-related cataract, left eye
H25.033	Anterior subcapsular polar age-related cataract, bilateral
H25.041	Posterior subcapsular polar age-related cataract, right eye
H25.042	Posterior subcapsular polar age-related cataract, left eye
H25.043	Posterior subcapsular polar age-related cataract, bilateral
H25.11	Age-related nuclear cataract, right eye
H25.12	Age-related nuclear cataract, left eye
H25.13	Age-related nuclear cataract, bilateral
H25.21	Age-related cataract, morgagnian type, right eye
H25.22	Age-related cataract, morgagnian type, left eye

ICD-10 CODE	DESCRIPTION
H25.23	Age-related cataract, morgagnian type, bilateral
H25.811	Combined forms of age-related cataract, right eye
H25.812	Combined forms of age-related cataract, left eye
H25.813	Combined forms of age-related cataract, bilateral
H25.89	Other age-related cataract
H25.9	Unspecified age-related cataract
H26.001	Unspecified infantile and juvenile cataract, right eye
H26.002	Unspecified infantile and juvenile cataract, left eye
H26.003	Unspecified infantile and juvenile cataract, bilateral
H26.011	Infantile and juvenile cortical, lamellar, or zonular cataract, right eye
H26.012	Infantile and juvenile cortical, lamellar, or zonular cataract, left eye
H26.013	Infantile and juvenile cortical, lamellar, or zonular cataract, bilateral
H26.031	Infantile and juvenile nuclear cataract, right eye
H26.032	Infantile and juvenile nuclear cataract, left eye
H26.033	Infantile and juvenile nuclear cataract, bilateral
H26.041	Anterior subcapsular polar infantile and juvenile cataract, right eye
H26.042	Anterior subcapsular polar infantile and juvenile cataract, left eye
H26.043	Anterior subcapsular polar infantile and juvenile cataract, bilateral
H26.051	Posterior subcapsular polar infantile and juvenile cataract, right eye
H26.052	Posterior subcapsular polar infantile and juvenile cataract, left eye
H26.053	Posterior subcapsular polar infantile and juvenile cataract, bilateral
H26.061	Combined forms of infantile and juvenile cataract, right eye
H26.062	Combined forms of infantile and juvenile cataract, left eye
H26.063	Combined forms of infantile and juvenile cataract, bilateral
H26.09	Other infantile and juvenile cataract
H26.101	Unspecified traumatic cataract, right eye
H26.102	Unspecified traumatic cataract, left eye
H26.103	Unspecified traumatic cataract, bilateral
H26.111	Localized traumatic opacities, right eye
H26.112	Localized traumatic opacities, left eye
H26.113	Localized traumatic opacities, bilateral
H26.121	Partially resolved traumatic cataract, right eye

ICD-10 CODE	DESCRIPTION
H26.122	Partially resolved traumatic cataract, left eye
H26.123	Partially resolved traumatic cataract, bilateral
H26.131	Total traumatic cataract, right eye
H26.132	Total traumatic cataract, left eye
H26.133	Total traumatic cataract, bilateral
H26.20	Unspecified complicated cataract
H26.211	Cataract with neovascularization, right eye
H26.212	Cataract with neovascularization, left eye
H26.213	Cataract with neovascularization, bilateral
H26.221	Cataract secondary to ocular disorders (degenerative) (inflammatory), right eye
H26.222	Cataract secondary to ocular disorders (degenerative) (inflammatory), left eye
H26.223	Cataract secondary to ocular disorders (degenerative) (inflammatory), bilateral
H26.231	Glaucomatous flecks (subcapsular), right eye
H26.232	Glaucomatous flecks (subcapsular), left eye
H26.233	Glaucomatous flecks (subcapsular), bilateral
H26.31	Drug-induced cataract, right eye
H26.32	Drug-induced cataract, left eye
H26.33	Drug-induced cataract, bilateral
H26.8	Other specified cataract
H26.9	Unspecified cataract
H27.01	Aphakia, right eye
H27.02	Aphakia, left eye
H27.03	Aphakia, bilateral
H27.111	Subluxation of lens, right eye
H27.112	Subluxation of lens, left eye
H27.113	Subluxation of lens, bilateral
H27.121	Anterior dislocation of lens, right eye
H27.122	Anterior dislocation of lens, left eye
H27.123	Anterior dislocation of lens, bilateral
H27.131	Posterior dislocation of lens, right eye
H27.132	Posterior dislocation of lens, left eye
H27.133	Posterior dislocation of lens, bilateral

ICD-10 CODE	DESCRIPTION
H28	Cataract in diseases classified elsewhere
Q12.0	Congenital cataract
Q12.1	Congenital displaced lens
Q12.2	Coloboma of lens
Q12.3	Congenital aphakia
Q12.4	Spherophakia
Q12.8	Other congenital lens malformations
T85.21XA	Breakdown (mechanical) of intraocular lens, initial encounter
T85.21XD	Breakdown (mechanical) of intraocular lens, subsequent encounter
T85.21XS	Breakdown (mechanical) of intraocular lens, sequela
T85.22XA	Displacement of intraocular lens, initial encounter
T85.22XD	Displacement of intraocular lens, subsequent encounter
T85.22XS	Displacement of intraocular lens, sequela
T85.29XA	Other mechanical complication of intraocular lens, initial encounter
T85.29XD	Other mechanical complication of intraocular lens, subsequent encounter
T85.29XS	Other mechanical complication of intraocular lens, sequela

ICD-10 Codes that DO NOT Support Medical Necessity

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 policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

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 policy, 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 policy should be assumed to apply equally to all Revenue Codes.

N/A

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
09/19/2019	R1	This article was converted to the new Billing and Coding Article type. Bill types and Revenue codes have been removed from this article. Guidance on these codes is available in the Bill type and Revenue code sections.

Associated Documents

Related Local Coverage Document(s)

LCD(s)
L33621 - Ophthalmic Biometry for Intraocular Lens Power Calculation

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

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