Chapter Overview

The genesis of major federal government involvement with healthcare began with the passage by the US Congress of Title XVIII and Title XIX of the Social Security Act. The original Social Security Act was passed in 1935, a component of the New Deal proposed by President Franklin Roosevelt during the Great Depression. The Social Security Act of 1935 established the principle of federal aid to states for public health and welfare assistance, and provided benefits to retirees and the unemployed. Building upon this Act was Medicare (Title XVIII) and Medicaid (XIX) in 1965, a component of the Great Society by President Lyndon Johnson. Medicare originally provided hospital and medical benefits to individuals who are age 65 and over while Medicaid provided hospital and medical benefits to the poor (indigent). It is imperative that optometrists understand the role that these two very important programs command within their practices. A lack of understanding and knowledge could result in lost revenues, increased staff time and expense for processing and reprocessing claims, and prosecution for fraud and abuse, which could have severe consequences. The doctor is personally responsible for ensuring proper procedures are being followed in his or her practice as once the practitioner signs up to be a provider, they are obligated to know all the rules and guidelines. This chapter will assist the optometrist in understanding the foundations of Medicare and Medicaid.

Objectives

On completion of this chapter, the reader should be able to:

1. Describe the Medicare and Medicaid programs
2. Understand the funding and administration of Medicare and Medicaid
3. Describe optometry historical and current participation in both programs
4. Understand cost containment mechanisms utilized by Medicare
5. Understand the basis for determination of covered services for Medicare and Medicaid

Background

The Medicare and Medicaid programs fall under the jurisdiction of the Centers for Medicare and Medicaid Services (CMS), an agency of the US Department of Health and Human Services. Both of these programs, Medicare and Medicaid, are third party payers of healthcare and as such do not directly provide healthcare services but act as insurance providers. In the case of Medicare, private contractors (typically insurance companies) are hired to administrate the
benefit programs and processes claims. For Medicaid, the state directly administers the program. Optometrists and other physicians provide these services and are then reimbursed by Medicare (contractors) and Medicaid (states).

**Medicare**

Medicare was enacted as Title XVIII of the Social Security Act in 1965, with an effective date of July 1966. The program initially provided benefits only to individuals age 65 and over but was amended in 1972 to include the disabled and patients with end-stage renal disease. Medicare is an entitlement program but is not income based (not means tested). In 2008 there were 45 million Medicare beneficiaries.

**Optometry Participation in Medicare**

With the passage of Medicare in 1965, optometrists were defined as physicians only for the purpose of providing prosthetic lenses for the aphakic patient (post cataract surgery). None of the optometrist’s services provided to patients were reimbursable by Medicare at this time. To amend Medicare (e.g., changing the definition of optometry) requires amending the Medicare Act, which can only be achieved by an Act of the US Congress. In 1981 optometrists obtained the additional right to be classified as a physician for medical related services provided to patients related to the condition of aphakia. While an improvement over the previous definition, this was still very limited in scope. It wasn’t until 1987, twenty two years after the passage of the original Medicare Act that optometrists reached parity with other physicians. Optometrists were now defined as physicians for all covered Medicare services for patients while functioning within their scope of practice as defined by the state law. Optometrists could be reimbursed for all covered services provided by them, just like other physicians, i.e., parity. This longtime struggle was lead by the AOA, the leading advocate, working with the US Congress to remedy this exclusion by pursing these amendments to include OD reimbursement. Additionally, the APHA passed a resolution in support of ODs providing services under Medicare. Even today, the AOA has to continually work with the US Congress to make sure that on-going changes to Medicare and Medicaid are in the patient’s best welfare and do not exclude access to eye care and optometrists.

Medicare originally consisted of two parts, A and B. Part C was added in 1997 and Part D added in 2006. The current four parts are:

- Part A: Hospital Insurance
- Part B: Medical Insurance
- Part C: Medicare Advantage
- Part D: Prescription Drug Plan

Part A is basic hospital insurance for all individuals covered by social security benefits. Services include hospital inpatient care, skilled nursing facility (SNF)
care, home healthcare, and hospice care. The financing of Part A is through mandatory payroll taxes. For an employed individual, the employee contributes 1.45% of salary (no salary cap) with the employer contributing another 1.45%. For the self employed individual the entire amount of 2.9% is contributed by the individual. New optometric graduates need to be cognizant of this tax, for if they work as an independent contractor (as many new graduates do) that this is a self employed position and income will be taxed at the rate of 2.9% (1.45% plus the 1.45%)

Contrary to popular perception, Medicare does not cover all medical expenses. There are deductibles, coinsurance payments, and co-pays. For Part A services, the individual for each benefit period (January to December) in 2009 is responsible for:

Hospital Stay: $1,068 deductible and no coinsurance for days 1-60
   $267 per day for days 61-90
   $534 per day after day 90, limited to 60 days in lifetime
   Thereafter, all cost

SNF Stay: Only eligible after hospital stay
   $0 for the first 20 days
   $133.50 per day for 21-100 days
   All cost, after 100 days

Part B is basic medical insurance which covers physician services, diagnostic tests, medical equipment and supplies when medically necessary. Part B is a voluntary program. The financing of Part B is through premiums paid by beneficiaries and contributions from the general Federal government revenues. The monthly premium is based on the individual's yearly income. The premium in 2009 for beneficiaries range from a low of $96.40 per month for individual with yearly incomes of 85,000 or less ($170,000 if filing joint tax return) to $308.30 per month for individual with yearly income greater than $231,000 (greater than $426,000 if filing joint tax return). The beneficiary is also responsible for a deductible of $135 per year in 2009 and a coinsurance of 20% of the Medicare approved amount for services and materials. For example, if your charge for fundus photos is $100 and Medicare approved amount is $75 for fundus photos then Medicare reimburses 80% of $75 or $60 and the patient is responsible for 20% of $75 or $15. The practice “writes off” the $25, the difference between your fee and the allowed amount. Patients may have Medigap/supplemental insurance to cover the portion not covered by Medicare ($15 in this case). This supplemental insurance may have been purchased by the individual or could have been provider by a former employer.

Part A and Part B are often referred to as traditional Medicare now that Part C, the Medicare Advantage Program is available. Part C is the Medicare Advantage Program which utilizes managed care organizations e.g., Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) to provide services that are normally provided under Part A and Part B. CMS
contracts with these organizations to provide services and process claims of Medicare beneficiaries. The Medicare Advantage organization is usually paid on a capitation basis from CMS, i.e., a fixed dollar amount per member per month. The Medicare Advantage (MA) plan will then contract with providers (including optometrists) to provide the services on a fee for service basis. If the Medicare beneficiary is eligible for Part A and enrolled in Part B then the individual can switch to Part C. Even though the choices of providers maybe restricted, individuals sign up for Part C because the benefits may be better than Part B, e.g., the coverage of routine vision eye care and eyeglasses. The cost paid by the individual varies on the MA plan. Traditional Medicare beneficiaries may join or leave a Medicare Advantage plan once a year, from November 15 to December 31. Unlike traditional Medicare, optometrists may not be considered physicians by all Medicare Advantage plans. This could create problems for optometrists as they may not be able to join the plan and therefore cannot be reimbursed for their services by the plan.

Part D is the optional prescription drug coverage program and can be chosen with either Part B or Part C. Individuals pay premiums of approximately $32 per month (varies with plan selected), $25 yearly deductible, and 25% coinsurance up to annual $2250 spending; 100% of cost between $2,250 and 3,600 in annual drug spending, and only a small copay above the limit of $3,600. This is the so called donut shape coverage, a hole in the middle (100% coinsurance by patient). Some Medicare Advantage plans include Part D coverage.

CMS is currently in the process of awarding new contracts for Medicare Administrative Contractors (MACs) to replace Medicare carriers for Part B and fiscal intermediaries for Part A. These MACs combine the administration of Part A and Part B. CMS believes this will improve service to patients and providers as well as greater administrative efficiency and effectiveness. The first contract was awarded in 2006 and final implementation for the entire country will be early 2010.

COVERED SERVICES IN MEDICARE

Traditional Medicare does not cover routine vision care nor eyeglasses or contact lens. The exception for coverage of eyeglasses and contact lenses is when used for replacement of the crystalline lens of the eye (aphakia or pseudophakia). For the aphake (no intra-ocular lens implant after cataract the coverage) the coverage for eyeglasses and contact lenses is a lifetime benefit whereas for the pseudophake (intra-ocular lens implant) the benefit is only for one pair after the surgery. Additionally, for all services and procedures, medical necessity is required before Medicare will reimburse the provider. Eye examinations are reimbursed if performed for a medical condition, medical sign, or symptom. CMS has developed a system to help providers determine medical necessity for services and procedures. Included in this program is:

National Coverage Determinations (NCDs)
National Coverage Provisions (NCPs)
Local Coverage Determinations (LCDs)

NCDs originate from the Centers for Medicare & Medicaid Services (CMS) and apply to all Medicare jurisdictions (Medicare carriers). The impetus for NCD development can come from different sectors, such as provider groups and beneficiary advocate groups, often working through legislative channels. All NCDs are located on the CMS Website at: http://www.cms.hhs.gov/center/coverage.asp. An example of a NCD affecting eye care is *Ocular Photodynamic Therapy (OPT)*. Components included in this policy (typical of NCDs) are:

- Title
- Effective date of policy
- Description of procedure
- Covered indications
- Non-covered indications
- Billing guidelines

NCPs are developed and published by Medicare carriers in order to provide information and clarification to the medical and beneficiary communities, especially when similar subjects are addressed in various different sources. NCPs are composed of excerpts and quotes from various program manuals, which are collated into a single document. NCPs also apply to all Medicare jurisdictions (Medicare carriers). Direct language from the Centers for Medicare & Medicaid Services (CMS) language is italicized. An example of a NCP affecting optometrist is **Consultations**. Components included in this policy (typical of NCPs) are:

- Title
- Effective date
- Indications and limitations of coverage
- Documentation requirements of consultations
- Examples of consultations
- Coding information

LCDs are contractor (carrier) developed coverage policies, pertaining to services or items not addressed in National Coverage Determinations (NCDs) or program manuals. LCDs contain coding and utilization guidelines as well as
descriptive passages. LCDs sometimes contain some Centers for Medicare & Medicaid Services (CMS) language as well, which is italicized.

LCDs are developed for various reasons, some of which are:

1. To define the appropriate use of new technologies
2. To address services with an abuse history or potential
3. High volume, high dollar services
4. List ICD codes that support medical necessity of procedure

LCDs are subject to the Carrier Advisory Committee (CAC) and public comment period processes. Optometry has representation on each CAC, which is very instrumental in developing LCDs.

All LCDs, both current and those under development, from all contractors in the country are located on the CMS Website at: http://www.cms.hhs.gov/center/coverage.asp. An example of a LCD affecting optometry is Corneal Pachymetry, this example from WPS, the Medicare carrier for Michigan (See Appendix for the complete Corneal Pachymetry LCD)

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<thead>
<tr>
<th>Title</th>
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<tr>
<td>Effective date</td>
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<tr>
<td>Indications and limitations of coverage and/or medical necessity</td>
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<tr>
<td>Utilization guidelines</td>
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<tr>
<td>Billing and coding guidelines</td>
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Providers should avail themselves of the critical information in NCDs, NCPs, and LCDs. Neglecting these policies can have detrimental consequences including loss of revenues and increase staff time to file and refile claims.

In addition to medical necessity, Medicare (and other medical insurers) requires proper medical record documentation, and proper usage of diagnostic codes and procedure codes. HIPAA (Health Insurance Portability and Accountability Act) requires a standard medical code data set, which specifies the usage of ICD-9-CM (diagnostic codes), HCPCS Level I codes (CPT-4 codes), and HCPCS Level II codes (S codes, G codes and materials codes). All of these necessary codes can be found in the Codes for Optometry book, which is published annually by the AOA and is available for purchase from AOA.
MEDICARE AND COST CONTAINMENT

Over the years the cost of the Medicare program has escalated. The federal government has taken action to control this increase cost. For Part A, starting in 1983 Medicare has used Diagnosis Related Groups (DRGs) for payment of hospital care. The hospital is reimbursed a certain amount fee for a certain numbers of days for a particular diagnosis. If the patient is hospitalized for a less number of days allowed, then the hospital comes out ahead financially. On the other hand if the patient stays in longer than the allowed number of days then the hospital losses financially. With this implementation of cost containment, many hospitals closed during the 1980s or merged with other hospitals to remain financially sound.

For Part B, starting in 1992 Medicare used Resource Based Relative Value Scale (RBRVS) for reimbursement. Previously an average of the providers’ usual and customary fees had been used for determination of reimbursements. Under this system, providers could just increase fees to increase reimbursements thus preventing any cost containment. With RBRVS, the provider’s usual and customary fees no longer affect the reimbursements. For each CPT (service or procedure) a unit value is calculated and is based on:

Physician Work
Practice expense
Professional Liability Insurance
Geographical area index

Medicaid

Medicaid was enacted as Title XIX of the Social security Act in 1965 with an effective date of January 1967. Medicaid provides health care for the poor and is administrated by state government under federal guidelines. Medicaid is an entitlement program that is income based (needs based). States are not required to participate in Medicaid but currently all 50 states have Medicaid programs. Currently there are 59 million individuals covered under the Medicaid program.

For Medicaid, each state sets its own guidelines regarding eligibility and services. Many groups of people are covered by Medicaid. Even within these groups, though, certain requirements must be met. These may include age, whether pregnant or not, disabled, blind, or aged; income and resources (like bank accounts, real property, or other items that can be sold for cash); and whether a U.S. citizen or a lawfully admitted immigrant. The rules for counting income and resources vary from state to state and from group to group. There are special rules for those who live in nursing homes and for disabled children living at home. Funding of Medicaid is from both federal and state money, with
the federal government paying approximately 57% and states paying approximately 43% of the cost.

**Federal Guidelines**

While states administrate Medicaid, the federal government requires a number of mandated services. Included in the services are:

- Inpatient hospital services
- Outpatient hospital services
- Laboratory and x-ray services
- Skilled nursing home services
- Physician’s services
- Home health services
- Early and periodic screening, diagnosis, and treatment (EPSDT) for individuals under 21

EPSDT covers screening and early intervention services to promote children’s healthy development, vision, dental and hearing services, scheduling and other administrative services, and care to ameliorate acute and chronic physical and mental health conditions. EPSDT mandates that eligible children receive an eye screening and if necessary a follow-up full exam and treatment services including eye glasses. Optometrists and nurses can perform these screenings. If nurses are performing the screenings, the optometrist should take this opportunity to work with local school districts to educate nurses about what a scientific based vision screening should include to avoid false positives and negatives.

Unlike for Medicare optometrists are not considered physicians for Medicaid. Each state may determine what medical services are covered for optometrists. It should be noted that vision services are not a federal mandated service for and therefore vision services do not have to be covered by Medicaid. In tight budget times, states may cut vision services as a benefit to Medicaid patients. However, Medicaid must cover a follow-up vision examination if a defect is found on the EPSDT screening even if the state does not cover vision services. With so many variations from state to state it is impossible to generalized optometric Medicaid coverage across the country. The provider needs to check the state Medicaid agency for rules and guidelines. In the last few years most states have added managed care options to their Medicaid programs, e.g., Health Maintenance Organizations (HMOs).

**State Children Health Insurance Program (SCHIP)**

SCHIP was enacted as Title XXI of the Social Security Act in 1997. This mostly federal funded program enables states to initiate and expands child health assistance to uninsured low-income children not eligible for Medicaid. There is
variability among the states as to eligibility requirements and services provided. Nevertheless, vision screenings are federally mandated and the state may include vision exams and eye glasses for children. SCHIP may function as an expansion of the state’s Medicaid program or as a separate state program. In Michigan the program is called MIChild and covers vision exams and eye glasses for children under the age of 19.

Case Study

A 68 year retired school teacher, Mr. Paul McCartney, an avid sailor who owns a 36 foot sailboat named Eight Days a Week, presents to your office for an eye exam. He states he has Medicare Part A and Part B coverage as well as Aetna medical insurance provided by the Michigan State Retired Teachers System. Mr. McCartney also states he has vision insurance. Patient says he needs an eye exam and is complaining of headaches.

What protocol do you use in your office to handle the insurance and this patient?

1. Bill vision or medical insurance? Patient states he has three insurances, Medicare, Aetna medical, and vision insurance. The reason the patient presented, i.e., the chief compliant is the deciding factor as to whether you would bill medical or vision. If the compliant is medical then the examination is billable to Medicare (or major medical). This patient’s chief compliant is headaches. Since this is medical then the exam is billable to Medicare. Had the chief compliant been annual checkup, general examination, routine examination, needs new glasses, or check eyeglass prescription then it would have been billable to the vision insurance.

   Practice Management Pearl: The primary diagnosis may not be the deciding factor as to whether you bill medical or vision. In this case myopia and presbyopia are the primary diagnoses, but the secondary diagnosis of headaches is billable to Medicare.

2. Bill Medicare or Aetna medical insurance? Medicare is always primary, i.e., bill first except if the patient is still employed or spouse is employed and has medical insurance provided. Since this individual is retired (and spouse is retired as well) Medicare is primary and Aetna is secondary insurance and possibly will cover any deductible, copays, or coinsurance. In this case Mr. McCartney has only met $50 of his Medicare annual deductible. Your fee for the eye examination (CPT code 92004) is $150; Medicare allowed amount for 92004 is $130. The patient is responsible for any remaining deductible, which is $135 (annual Medicare deductible) minus $50 (amount paid previously on deductible) or $85. The allowed amount is $130 for the examination; therefore the patient owes $95 plus 20% of $35 ($130 - $95) or a total of $102. Medicare would reimburse 80% of $35 or $28. Since this patient has
secondary insurance (Aetna medical) this would roll over to that carrier for payment and Mr. McCartney would not pay out of pocket.

Practice Management Pearl: Some secondary insurances may have a deductible also.

Practice Management Pearl: If the patient does not have secondary insurance, then you should collect the $102 up front, i.e., at the time of the visit.

Practice Management Pearl: If the patient has Medicare and Medicaid, Medicare is always primary and Medicaid is secondary.

3. Patient also needs a new pair of glasses. Billable to Medicare? No, Medicare only covers glasses after cataract surgery; therefore either the patient pays or vision insurance pays if the patient has coverage. In this case Mr. McCartney has vision insurance. Your staff would have to find out what is covered by the plan and what expenses are the responsibilities of the patient.

Practice Management Pearl: For most secondary medical insurance, like Aetna in this case, vision insurance is a “carve out” of the Aetna medical insurance. Your staff needs to call Aetna to find out who is the carrier for the vision component of the coverage.

As this case illustrates the current health care system in the US is complicated. It is hopeful that with new incoming administration, healthcare reform will become a reality.

Study Questions

1. Explain the funding of Part A and Part B of Medicare.
2. Describe the major milestones as optometry achieved parity in Medicare.
3. Explain the eligibility for qualifying for Medicare and Medicaid.
4. Define DRGs and describe how this is a cost containment scheme for Part A of Medicare.
5. Define RBRVS and describe how this is a cost containment scheme for Part B of Medicare.
6. Who issues LCDs and why is it important for your practice.
7. Your fee for pachymetry is $50 and the Medicare allowed amount is $30. If the patient has no insurance other than Medicare how much does the patient pay directly to you for this procedure.
8. Are vision examinations mandated under federal guidelines for Medicaid.
9 Explain how you could be reimbursed for a vision examination by Medicaid even if vision examinations are not covered by your state's Medicaid program.

10 As an independent contractor optometrist you have earnings of $90,000 for the year. The amount of the payroll tax owed for Medicare is $______.

11 Explain the funding of Medicaid.

12 Is Part B of Medicare a mandatory program?

13 Explain the administration of the Medicare and Medicaid programs. How are they similar and how are they different?

Bibliography


Appendix. Decision Process for Reimbursement of Corneal Pachymetry for one Carrier

Contractor Name
Wisconsin Physicians Service (WPS)

Contractor Number
00951, 00952, 00953, 00954

Contractor Type
Carrier

LCD Database ID Number
Wisconsin: L13993
Illinois: L13578
Michigan: L13579
Minnesota: L13580

LCD Version Number

LCD Title
Corneal Pachymetry

Contractor's Determination Number
OPHTH-025

AMA CPT/ ADA CDT Copyright Statement
CPT codes, descriptions and other data only are copyright 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. Current Dental Terminology, (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. © 2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

CMS National Coverage Policy
42CFR410.32 Diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of their licenses and Medicare requirements)* who will use the results in management of the beneficiary’s specific medical problem and diagnostic tests payable under the Physicians Fee Schedule must be furnished under the appropriate level of supervision by a physician.

Primary Geographic Jurisdiction
Wisconsin, Illinois, Michigan, Minnesota

Oversight Region
Region V

CMS Consortium
Midwest

Original Determination Effective Date
09/16/2003
Revision Effective Date
*06/01/2007

Indications and Limitations of Coverage and/or Medical Necessity
Corneal Pachymetry (CP) is a measurement of the thickness of the cornea. The cornea is approximately 540 to 550 microns thick in the center area and 1,000 microns (one millimeter) thick in the periphery. The most common accepted technique for obtaining corneal pachymetric measurement is ultrasound biometry due to its availability, accuracy and cost effectiveness. CP can also be measured by optical low coherence reflectometry.

The evaluation of corneal thickness is a well-established procedure for studying corneal function in a number of medical disease conditions. There must be documented indications in the patients’ medical record to substantiate medical necessity for testing. These disease conditions can be categorized into four groups:

1. Disorders of endothelial cell function
2. Disorders of corneal thickness
3. Corneal transplantation
4. Ocular hypertension (OHT) and glaucoma

The utilization of CP for Group 1, 2, and 3 is for the management of corneal disease and corneal transplant surgery. Payment frequency will be no more the once every six month, bilaterally, as indicated by the medical records.

The utilization of CP in relation to OHT and glaucoma (Group 4) has been documented in recent studies demonstrating that intraocular pressure (IOP) measurements need to be adjusted for abnormally thick or thin corneas. The target IOP is lower for a thin cornea and higher for a thick cornea.

The decision to treat glaucoma or OHT with topical medications, systemic medications, laser surgery or intraocular surgery is made by the treating physician after analyzing:
1. Ocular factors (various ocular parameters e.g. IOP, corneal thickness, optic nerve assessment, visual field results) and
2. General systemic factors including family history, age, anemia, systemic medication, diabetes, other vascular diseases, etc.

CP payment frequency for isolated category 4 criteria would be once in a patients’ lifetime, bilaterally, as documented in the medical record for any individual provider or provider billing group. In patients’ who have had CP based on group 4 indications, have subsequent corneal refractive surgery or transplant surgery, then it would be appropriate to repeat the test if, medically indicated based on the group 4 criteria.

This service is considered a bilateral service and will, therefore, be paid once whether one or both eyes are tested. Reimbursement of this procedure will be comparable to that for 76516 for services performed prior to 01/01/2004.

CP measurement is not considered medically reasonable and necessary when performed prior to routine cataract surgery unless corneal disease is documented.
*For routine glaucoma screening see CMS Pub100-02 Ch. §280.1 and CMS Pub.100-04 Ch.18 §§70-70.3.

**Coverage Topic**
Diagnostic Tests, X-Rays, and Lab Services

**CPT/HCPCS Codes**
76514  Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness) (Eff. 1/1/04)
0025T  Determination of corneal thickness (e.g. pachymetry) with interpretation and report, bilateral. (DC 12/31/03)

**Does the CPT 30% Rule Apply**
No

**ICD-9 Codes that Support Medical Necessity**
Note: ICD-9 codes must be coded to the highest level of specificity.

Disorders of Endothelial Cell Function (Group1)
371.20-371.23, 371.57, 371.58

Disorders of Corneal Thickness (Group 2)
370.00-370.06, 371.03, 371.48, 371.60-371.62, 371.70-371.72

Corneal Transplant (Group 3)
996.51, 996.80

Ocular Hypertension (OHT) and Glaucoma (Group 4)

**Diagnoses that Support Medical Necessity**
Any listed above

**ICD-9 Codes that DO NOT Support Medical Necessity**
Any Not listed above

**Diagnoses that DO NOT Support Medical Necessity**
Any Not listed above

**Documentation Requirements**
1. Physician Services and diagnostic tests must be submitted with an ICD-9 code to support medical necessity and must be coded to the greatest level of accuracy and highest level of digit completeness. This means the precise ICD-9 code that most fully explains the narrative description of the diagnosis contained in the medical record or test interpretation and report including the 4th or 5th digit subclassification for that diagnosis category. The ICD-9 code based on the results of the diagnostic test should be reported as the primary diagnosis. If the diagnostic test results are normal or inconclusive the ICD-9 code representing the sign, symptom, illness or injury prompting the ordering of the test should be reported as the primary diagnosis. In the absence of signs, symptoms, illness or
injury a screening ICD-9 should be reported, and payment will be denied. Ref. CMS Pub.100-04 Ch. 23 §§10.1-10.1.7

2. The patient's medical records should be legible, contain the relevant medical history and physical findings conforming to the criteria stated in the “Indication and Limitations of Coverage and/or Medical Necessity section of this policy. Records must be made available to the Carrier on request.

Utilization Guidelines
The utilization of CP for Group 1, 2, and 3 will be no more the once every six month, bilaterally, as indicated by the medical records.

The utilization of CP Group 4 criteria would be once in patients’ lifetime, bilaterally, as documented in the medical record. In patients’ who have subsequent corneal refractive surgery or transplant surgery, then it would be appropriate to repeat the test if, medically indicated based on the group 4 criteria.

More frequent CP may be approved when submitted with documentation describing the medical circumstance relating to the patient’s condition explaining the need for more frequent services.

Sources of Information and Basis for Decision


Medical Consultant and CAC member input

Other Carriers policy

Advisory Committee Meeting Notes
Meeting Date:
Wisconsin: 05/16/2003
Illinois: 05/28/2003
Michigan: 05/07/2003
Minnesota: 05/08/2003

Start Date of Comment Period
05/29/2003

Medicare and Medicaid  Roger D. Kaman
End Date of Comment Period
07/14/2003

Start Date of Notice Period
(Published) *06/01/2007 (art); 11/01/2005; 09/01/2004; 01/01/2004 Art; 08/01/2003

Revision History Number/Explanation
*06/01/2007 Four (I&L or Med Nec § text rev.); 11/01/2006 Three (Yrl rev); 09/01/2004 Two (LCD);
01/01/2004 One (04 HCPCS UD)

Last Reviewed On

Notes
The “Coding Guidelines” and the “Reasons for Denial” have been removed from this policy. The
information has been placed in a companion article. See Article. **Corneal Pachymetry OPHTH-025: Billing and Coding Guidelines**

An asterisk (*) indicates a revision to that section of the policy.

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director.
Although the final decision rests with the contractor, this policy was developed in cooperation
with advisory groups, which includes representatives from Ophthalmology.

**Does this LCD contain a "Least Costly Alternative" Provision?**
No

Corneal Pachymetry LCD
Reprinted from WPS