Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-01-132 **Date: NOVEMBER 2, 2001**

CHANGE REQUEST 1914

SUBJECT: Screening Glaucoma Services

This Program Memorandum (PM) supplements PM A-01-105, CR 1783, and requires standard systems to make appropriate system changes effective April 1, 2002.

Conditions of Coverage -- The regulations implementing the Benefits Improvement and Protection Act of 2000, §102, provides annual coverage for glaucoma screening for Medicare beneficiaries with diabetes mellitus, or a family history of glaucoma, or African-Americans age 50 and over. Medicare will pay for glaucoma screening examinations where they are furnished by or under the direct supervision in the office setting of an ophthalmologist or optometrist who is legally authorized to perform the services under State law.

Screening for glaucoma is defined to include: (1) a dilated eye examination with an intraocular pressure measurement; and (2) a direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination. Payment may be made for a glaucoma screening examination that is performed on an eligible beneficiary after at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed. Coverage applies to glaucoma screening examination services performed on eligible beneficiaries on or after January 1, 2002.

Claim Submission Requirements -- Claims for screening for glaucoma should be submitted on Form HCFA-1450 or electronic equivalent. Claims must be prepared in accordance with the general bill review instructions in §3604 of the Medicare Intermediary Manual, Part 3.

Applicable Bill Types -- The applicable bill types for screening glaucoma services are 13X, 22X, 23X, 71X, 73X, 75X, and 85X. (See below instructions for rural health clinics (RHCs) and Federally qualified health centers (FQHCs).)

HCPCS Coding -- The following HCPCS codes should be reported when billing for screening glaucoma services:

G0117 -- Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist.

G0118 -- Glaucoma screening for high risk patients furnished under the direct supervision of an optometrist or ophthalmologist.

Revenue Coding -- The following revenue codes should be reported when billing for screening glaucoma services:

Comprehensive outpatient rehabilitation facilities (CORFs), critical access hospitals (CAHs), and skilled nursing facilities (SNFs) and independent and provider-based RHCs and free standing and provider-based FQHCs bill for this service under revenue code 770. CAHs electing the optional method of payment for outpatient services report this service under revenue codes 96X, 97X, or 98X.

Hospital outpatient departments bill for this service under any valid/appropriate revenue code. They are not required to report revenue code 770.

Diagnosis Coding -- Providers report glaucoma screening using screening ("V") code V80.1 (special screening for neurological, eye, and ear diseases, glaucoma). Claims submitted without this screening diagnosis code should be returned to the provider as unprocessable.

Payment Methodology -- Payment is made for the facility expense as follows:

- Independent and provider-based RHC/free standing and provider-based FQHC -- payment is made under the all inclusive rate for the screening glaucoma service based on the visit furnished to the RHC/FQHC patient;
- CAH -- payment is made on a reasonable cost basis unless the CAH has elected the optional method of payment for outpatient services in which case, procedures outlined in §3610.22 of the Part A Intermediary Manual should be followed;
- CORF -- payment is made under the Medicare physician fee schedule;
- Hospital outpatient department -- payment is made under outpatient prospective payment system (OPPS);
- Hospital inpatient Part B -- payment is made under OPPS;
- SNF outpatient -- payment is made under the Medicare physician fee schedule (MPFS); and
- SNF inpatient Part B -- payment is made under MPFS.

Deductible and coinsurance apply.

Special Billing Instructions for RHCs and FQHCs

Screening glaucoma services are considered RHC/FQHC services. RHCs and FQHCs bill you under bill type 71X or 73X along with revenue code 770 and HCPCS codes G0117 or G0118 and RHC/FQHC revenue code 520 or 521 to report the related visit. Reporting of revenue code 770 and HCPCS codes G0117 and G0118 in addition to revenue code 520 or 521 is required for this service in order for CWF to perform frequency editing.

Payment should not be made for a screening glaucoma service unless the claim also contains a visit code for the service. Therefore, install an edit in your system to assure payment is not made for revenue code 770 unless the claim also contains a visit revenue code (520 or 521).

Determining the 11 Month Period -- Once a beneficiary has received a covered glaucoma screening procedure, the beneficiary may receive another procedure after 11 full months have passed. To determine the 11-month period, start your count beginning with the month after the month in which the previous covered screening procedure was performed.

Common Working File (CWF) Edits -- Beginning January 1, 2002, CWF edits will be implemented for dates of service January 1, 2002, and later. CWF will edit for glaucoma screening performed more frequently then allowed.

Claims Editing -- Nationwide claims processing edits for pre or post payment review of claim(s) for glaucoma screening are not required at this time. Monitor claims to assure that they are paid only for covered individuals and perform medical review as appropriate. You may develop local medical review policy and edits for such claims.

Remittance Advice Notices -- Use appropriate remittance advice(s) when denying payment for glaucoma screening. Use the following messages where applicable:

> If the services were furnished before January 1, 2002, use existing ANSI X12-835 claim adjustment reason code 26 "Expenses incurred prior to coverage" at the line level.
>
> If the claim for glaucoma screening is being denied because the minimum time period has not elapsed since the performance of the same Medicare covered procedure, use existing ANSI X12-835 claim adjustment reason code 119 "Benefit maximum for this time period has been reached" at the line level.

Medicare Summary Notice (MSN) and Explanation of Medicare Benefits (EOMB) Messages-- Use the following MSN and EOMB messages where appropriate:

If a claim for a screening for glaucoma is being denied because the service was performed prior to January 1, 2002, use the new (May 2001) MSN or EOMB message:

> "This service is not covered prior to January 1, 2002." (MSN Message 16.54, EOMB Message 20.3)

The Spanish version of the MSN or EOMB messages should read:

> "Este servicio no está cubierto antes del 1 de enero de 2002."

If a claim for screening for glaucoma is being denied because the minimum time period has not elapsed since the performance of the same Medicare covered procedure, use MSN or EOMB message:

> "Service is being denied because it has not been [12/24/48] months since your last [test/procedure] of this kind." (MSN Message 18.14, EOMB Message 18.23)

The Spanish version of this MSN or EOMB message should read:

> "Este servicio está siendo denegado ya que no han transcurrido [12, 24, 48] meses desde el último [examen/procedimiento] de esta clase."

Provider Notification -- Notify providers of these changes through your regularly scheduled bulletins, newsletters, and on your website. This PM is not effective until January 1, 2002, a reminder should be included in the last bulletin published for the year 2001.

The *effective date* for this PM is January 1, 2002.

The *implementation date* for intermediary editing for this PM is April 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2003.

If you have any questions, contact your regional office.