CMS Manual System

Pub. 100-02 Medicare Benefit Policy

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

Transmittal 48 | **Date: MARCH 24, 2006**

CHANGE REQUEST 4365

SUBJECT: Glaucoma Screening Services

I. SUMMARY OF CHANGES: Medicare coverage for glaucoma screening for certain beneficiaries considered to be at high-risk is being expanded to cover Hispanic Americans age 65 or over.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2006
IMPLEMENTATION DATE: April 3, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/280/Preventive and Screening Services
R	15/280.1/Glaucoma Screening

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-02	Transmittal: 48	Date: March 24, 2006	Change Request 4365

SUBJECT: Expansion of Glaucoma Screening Services

I. GENERAL INFORMATION

A. Background: On January 1, 2002, CMS implemented regulations at 42 CFR 410.23(a)(2), Conditions for and limitations on coverage of screening for glaucoma, requiring that the term "eligible beneficiary" be defined to include individuals in the following high-risk categories: (1) individuals with diabetes mellitus, (2) individuals with a family history of glaucoma, or (3) African-Americans age 50 and over.

B. Policy: The Physician Fee Schedule for Calendar Year 2006 Final Rule, 70 FR 70270, dated November 21, 2005, expands Medicare coverage of high-risk individuals eligible to receive glaucoma screening services to include Hispanic Americans age 65 and over. This expansion of coverage is effective for services performed on or after January 1, 2006, and revises 42 CFR 410.23(a)(2) accordingly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

<table>
<tr><th rowspan="3">Requirement Number</th><th rowspan="3">Requirements</th><th colspan="9">Responsibility ("X" indicates the columns that apply)</th></tr>
<tr><th rowspan="2">FI</th><th rowspan="2">RHHI</th><th rowspan="2">Carrier</th><th rowspan="2">DMERC</th><th colspan="4">Shared System Maintainers</th><th rowspan="2">Other</th></tr>
<tr><th>FISS</th><th>MCS</th><th>VMS</th><th>CWF</th></tr>
<tr><td>4365.1</td><td>Effective for dates of services on or after January 1, 2006, contractors shall pay claims for glaucoma screening services when performed on Hispanic-Americans age 65 and over.</td><td>X</td><td></td><td>X</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>4365.2</td><td>Contractors shall apply current payment methodologies, rates, and payment policies for glaucoma screening services when these services are performed on Hispanic-Americans age 65 and over.</td><td>X</td><td></td><td>X</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>4365.3</td><td>Contractors shall not search for and adjust claims with dates of service January 1, 2006, and forward, but shall adjust any claims brought to their attention.</td><td>X</td><td></td><td>X</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4365.4	Contractors shall deny claims if coverage criteria at Pub. 100-02, chapter 15, section 280.1, are not met.	X		X						
4365.4.1	Contractors shall deny claims by returning remittance advice claim adjustment reason code 96 (Non-covered charge) and existing remark codes M83 (Service not covered unless the patient is classified as at high-risk) and N129 (This amount represents the dollar amount not eligible due to patient's age).	X		X						
4365.4.2	Contractors shall deny claims not meeting the age-related and/or ethnic-related coverage criteria at Pub 100-02, chapter 15, section 280.1, by returning Medicare Summary Notice 21.21 (This service was denied because Medicare only covers this service under certain circumstances).	X		X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4365.5	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "Medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider	X		X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Bill Larson (coverage), William.Larson@cms.hhs.gov, 410-786-4639, Tom Dorsey (Part B claims processing), Thomas.Dorsey@cms.hhs.gov, 410-786-7434, Bill Ruiz (Part A claims processing), William.ruiz@cms.hhs.gov, 410-786-9283 **Post-Implementation Contact(s):** Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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280 – Preventive and Screening Services

(Rev. 48, Issued: 03-24-06; Effective: 01-01-06; Implementation: 04-03-06)

See section 50.4.4.2 for coverage requirements for PPV, hepatitis B vaccine, and Influenza Virus Vaccine.

See Medicare Claims Processing Manual, Chapter 18, "Preventive and Screening Services," for coverage requirements for the following:

- §40 for screening pelvic examinations,
- §50 for prostate cancer screening test and procedures, and,
- *§70.4 for glaucoma screening.*

280.1 – Glaucoma Screening

(Rev. 48, Issued: 03-24-06; Effective: 01-01-06; Implementation: 04-03-06)

A. Conditions of Coverage

The regulations implementing the Benefits Improvements and Protection Act of 2000, §102, provide for annual coverage for glaucoma screening for beneficiaries in the following high risk categories:

- Individuals with diabetes mellitus;
- Individuals with a family history of glaucoma; or
- African-Americans age 50 and over.

In addition, beginning with dates of service on or after January 1, 2006, 42 CFR 410.23(a)(2), revised, the definition of an eligible beneficiary in a high-risk category is expanded to include:

- *Hispanic-Americans age 65 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:

- A dilated eye examination with an intraocular pressure measurement; and
- 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.

The following HCPCS codes apply for glaucoma screening:

G0117 - Glaucoma screening for high-risk patients furnished by *an optometrist or ophthalmologist*; and

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

The type of service for the above G codes is: TOS Q.

For providers who bill intermediaries, applicable types of bill for screening glaucoma services are 13X, 22X, 23X, 71X, 73X, 75X, and 85X. The following revenue codes should be reported when billing for screening glaucoma services:

- Comprehensive outpatient rehabilitation facilities (CORFs), critical access hospitals (CAHs), skilled nursing facilities (SNFs), 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.

B. Calculating the Frequency

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 the count beginning with the month after the month in which the previous covered screening procedure was performed.

C. Diagnosis Coding Requirements

Providers bill glaucoma screening using screening ("V") code V80.1 (Special Screening for Neurological, Eye, and Ear Diseases, Glaucoma). Claims submitted without a screening diagnosis code may be returned to the provider as unprocessable.

D. Payment Methodology

1. Carriers

Contractors pay for glaucoma screening based on the Medicare physician fee schedule. Deductible and coinsurance apply. Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge (refer to the Medicare Claims Processing Manual, Chapter 12, "Physician/Non-physician Practitioners," for more information about the Medicare limiting charge).

2. Intermediaries

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 the Medicare Claims Processing Manual, Chapter 3, §30.1.1, 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.

E. Special Billing Instructions for RHCs and FQHCs

Screening glaucoma services are considered RHC/FQHC services. RHCs and FQHCs bill the contractor 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, the contractor installs an edit in its system to assure payment is not made for revenue code 770 unless the claim also contains a visit revenue code (520 or 521).