

Glaucoma Screening

Overview

Glaucoma represents a family of diseases commonly associated with optic nerve damage and visual field changes (a narrowing of the eyes' usual scope of vision). It is the second leading cause of irreversible blindness in the United States.¹ Of the various forms of glaucoma (such as congenital, angle-closure, and secondary), open-angle glaucoma is the most common. It is estimated that over 4 million Americans have glaucoma but only half of those know they have it.²

Glaucoma occurs when increased fluid pressure in the eye presses against the optic nerve, causing damage. The damage to optic nerve fibers can cause blind spots to develop. These blind spots usually go undetected until the optic nerve is significantly damaged. If the entire optic nerve is destroyed, blindness results. Since glaucoma progresses with little or no warning signs or symptoms, and vision loss from glaucoma is irreversible, it is very important that people at high risk for the disease receive an annual screening. Studies have shown that the early detection and treatment of glaucoma, before it causes major vision loss, is the best way to control the disease.

Medicare coverage of glaucoma screenings was implemented with the Benefits Improvement and Protection Act of 2000 (BIPA). This coverage took effect on January 1, 2002.

The glaucoma screening covered by Medicare includes:

- ▶ A dilated eye examination with an intraocular pressure (IOP) measurement

AND

- ▶ A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination

Increased IOP is common with glaucoma. In the past, it was thought that an increased IOP measurement indicated glaucoma; however, an IOP measurement using non-contact tonometry (more commonly known as the "air puff test") alone was commonly used to diagnose glaucoma. Health care professionals now know that glaucoma can be present with or without increased IOP, which makes the examination of the eye and optic nerve (along with the IOP measurement) a critical part of the glaucoma screening.

Risk Factors

While anyone can develop glaucoma, certain groups of people are at higher risk for the disease. Risk factors that may increase an individual's chances of developing glaucoma include age, race, family history, and medical history.

¹ The Glaucoma Research Foundation. 2008. Some Statistics About Glaucoma [online]. San Francisco, CA: The Glaucoma Research Foundation, April 2008 [cited 24 November 2008]. Available from the World Wide Web: (http://www.glaucoma.org/learn/glaucoma_facts.php).

² Ibid

Coverage Information

Medicare provides coverage of an annual glaucoma screening (i.e., at least 11 months have passed following the month in which the last Medicare-covered glaucoma screening examination was performed) for beneficiaries in at least one of the following high risk groups:

- ▶ Individuals with diabetes mellitus,
- ▶ Individuals with a family history of glaucoma,
- ▶ African-Americans age 50 and over, and
- ▶ Hispanic-Americans age 65 and over.

Because of the prevalence of glaucoma in these groups, it is of special importance that all eligible Medicare beneficiaries be encouraged to get regular glaucoma screenings.

Medicare will pay for glaucoma screening examinations, in the office setting, when they are furnished by or under the direct supervision of an optometrist or ophthalmologist legally authorized to perform services under State law.

Coverage of the glaucoma screening service is provided as a Medicare Part B benefit. Both deductible and coinsurance apply.

NOTE: Medicare does not provide coverage for routine eye refractions.

Documentation

Medical record documentation must support that the beneficiary is a member of one of the high risk groups previously discussed. The documentation must also support that the appropriate screening (i.e., either a dilated eye examination with an IOP measurement and a direct ophthalmoscopic examination OR a slit-lamp biomicroscopic examination) was performed.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1 to report glaucoma screening services:

Table 1 – HCPCS Codes for Glaucoma Screening Services

HCPCS Code	Code Descriptor
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

Diagnosis Requirements

The beneficiary must be a member of one of the high risk groups mentioned to receive a Medicare-covered glaucoma screening. Medicare providers bill for glaucoma screening using the screening (“V”) diagnosis code of V80.1 (Special Screening for Neurological, Eye, and Ear Disease, Glaucoma). For further guidance, contact your Medicare Contractor.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS G code G0117 or G0118 and the corresponding diagnosis V code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, the Medicare provider must report the appropriate HCPCS code G0117 or G0118, the appropriate revenue codes, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for glaucoma screening services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 2:

Table 2 – Facility Types, Types of Bills, and Revenue Codes for Glaucoma Screening Services

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	Hospital outpatient departments are not required to report revenue code 0770; claims must be billed using any valid/appropriate revenue code.
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0770
SNF Outpatient	23X	0770
Rural Health Clinic (RHC)	71X	Use bill type 71X and RHC revenue code 052X to report the related visit. FIs/AB MACs will only pay for the visit, 052X.
Federally Qualified Health Center (FQHC)	73X	Use bill type 73X and FQHC revenue code 052X to report the related visit.
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	0770
Critical Access Hospital (CAH)*	85X	0770

***NOTE:** Method I – All technical components are paid using standard institutional billing practices.

Method II – Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X.

NOTE: Effective April 1, 2005, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will no longer have to report additional line items when billing for preventive and screening services on TOBs 71X and 73X. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC/FQHC services must be reported on the revenue code line for the encounter, 052X, or 0900. RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520.

Reimbursement Information

General Information

Medicare Part B pays 80 percent of the Medicare-approved amount for the glaucoma screening (deductible and coinsurance or copayment apply).

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare bases reimbursement for glaucoma screening on the Medicare Physician Fee Schedule (MPFS). Claims from physicians or other providers where assignment was not accepted are subject to the Medicare limiting charge. In some situations, glaucoma screening codes are bundled with Evaluation and Management (E/M) codes. Additional information can be found at the National Correct Coding Initiative Edits website at <http://www.cms.hhs.gov/NationalCorrectCodInitEd> on the CMS website.

Additional information about MPFS can be found at <http://www.cms.hhs.gov/PhysicianFeeSched> on the CMS website.

Additional information about OPFS can be found at <http://www.cms.hhs.gov/HospitalOutpatientPPS> on the CMS website.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for glaucoma screening is dependent upon the type of facility. For providers billing Outpatient Prospective Payment System (OPPS) claims, HCPCS code G0118 is bundled with HCPCS code G0117 if they are both billed on the same day. Additional information can be found at the National Correct Coding Initiative Edits Hospital OPPS website at <http://www.cms.hhs.gov/HospitalOutpatientPPS> on the CMS website. These codes are not bundled for other providers billing FIs/AB MACs. The following table lists the type of payment that facilities receive for glaucoma screening:

Table 3 – Types of Payments Received by Facilities for Glaucoma Screening Services

If the Facility Is a...	Then Payment is Based On...
Comprehensive Outpatient Rehabilitation Facility (CORF)	Medicare Physician Fee Schedule (MPFS)
Critical Access Hospital (CAH) Method II	101% of reasonable cost plus 115% of the MPFS for the professional component
CAH Method I	101% of reasonable cost
Federally Qualified Health Center (FQHC)	All-inclusive rate for the glaucoma screening based on the visit furnished to the patient
Hospital Inpatient Part B	Outpatient Prospective Payment System (OPPS)
Hospital Outpatient Department	OPPS
Rural Health Clinic (RHC)	All-inclusive rate for the glaucoma screening based on the visit furnished to the patient
Skilled Nursing Facility (SNF) Inpatient Part B	MPFS
SNF Outpatient Services	MPFS

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of glaucoma screening services:

- ▶ The beneficiary received covered glaucoma screening services during the past year.
- ▶ The beneficiary is not a member of one of the high risk groups.
- ▶ Claims submitted without a screening diagnosis code may be returned to the provider as unprocessable.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at <http://www.wpc-edi.com/Codes> on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit <http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip> on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Glaucoma Screening

Resource Materials

Beneficiary Notices Initiative Website

<http://www.cms.hhs.gov/BNI>

Carrier/AB MAC and FI/AB MAC Contact Information

<http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>

Electronic Claim Submission Information

http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Form CMS-1450 Information

http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information

http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

The Glaucoma Foundation Website

<http://www.glaucomafoundation.org>

Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 280.1

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 70

<http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf>

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information, including information about OPPS.

<http://www.cms.hhs.gov/center/provider.asp>

Medicare Learning Network (MLN)

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo> on the CMS website.

Medicare Physician Fee Schedule Information

<http://www.cms.hhs.gov/PhysicianFeeSched>

Medicare Preventive Services General Information

<http://www.cms.hhs.gov/PrevntionGenInfo>

The Medline Plus Health Information Website

<http://www.nlm.nih.gov/medlineplus>

MLN Preventive Services Educational Resource Website

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Correct Coding Initiative Edits Website

<http://www.cms.hhs.gov/NationalCorrectCodInitEd>

Beneficiary-related resources can be found in Reference F of this Guide.

National Eye Institute

Website provides links to Medicare benefits resources that can be ordered by health care professionals for distribution at health fairs, clinics, meal sites, senior centers, and other community locations.

<http://www.nei.nih.gov/medicare>

Outpatient Prospective Payment System

<http://www.cms.hhs.gov/HospitalOutpatientPPS>

Physician Information Resource for Medicare Website

This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.

<http://www.cms.hhs.gov/center/physician.asp>

Prevent Blindness America Website

<http://www.preventblindness.org>

Remittance Advice Information

http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services

This website provides the USPSTF written recommendations.

<http://www.ahrq.gov/clinic/cps3dix.htm>

Washington Publishing Company (WPC) Code Lists

WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.

<http://www.wpc-edi.com/Codes>

Beneficiary-related resources can be found in Reference F of this Guide.