Program Memorandum Carriers

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

Transmittal B-01-46 **Date: JULY 25, 2001**

CHANGE REQUEST 1717

SUBJECT: Instructions for Billing for Claims for Screening Glaucoma Services

Conditions of Coverage. - The Benefits Improvements and Protection Act of 2000, §102, provides annual coverage for glaucoma screening for eligible Medicare beneficiaries, i.e., those with diabetes mellitus or a family history of glaucoma, and certain other individuals found to be at high risk for glaucoma as determined by CMS through rulemaking later this year. Medicare will pay for glaucoma screening examinations where they are furnished by or under the direct supervision 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.

Claims Submissions Requirements and Applicable HCPCS Codes. - Claims for screening for glaucoma should be submitted on Form HCFA-1500 or electronic equivalent. Claims must be prepared and submitted by physicians and providers in accordance with the general instructions in the Medicare Carriers Manual (MCM), Part 4, §2010, Purpose of Health Insurance Claim Form HCFA-1500. Review and adjudicate claims in accordance with MCM Part 3, §4020, Review of the Health Insurance Claim Form HCFA-1500.

Use the following HCPCS codes to bill for glaucoma screening:

G0117 - Glaucoma screening for high risk patients furnished by a physician

G0118 - Glaucoma screening for high risk patients furnished under the direct supervision of a physician.

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

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 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 glaucoma screening for frequency and valid HCPCS code.

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(s).

Diagnosis Coding Requirements. - 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 (refer to MCM Part 3, §3005 for more information about incomplete or invalid claims).

Payment Methodology. - Pay for glaucoma screening on the basis of 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 MCM Part 3, §7555 for more information about the Medicare limiting charge).

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 Program Memorandum (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 this PM is January 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2003.

If you have any questions, contact your regional office.