



CARL ZEISS MEDITEC

2009 REIMBURSEMENT GUIDE ATLAS™



Corneal Topography System

INTRODUCTION

The following guide provides an overview of billing and reimbursement for procedures performed with Carl Zeiss Meditec's ATLAS Corneal Topography System. The information contained in this guide is gathered from various resources and is subject to change.

Carl Zeiss Meditec cannot guarantee success in obtaining third-party insurance payments. It is the responsibility of the provider to determine and submit appropriate codes, charges, and modifiers for the services being rendered. Providers should contact insurers directly for specific information on policies for corneal topography.

QUESTIONS

If you have any questions or concerns regarding this guide, please contact Cheri Ritter, Manager of Practice Development and Ophthalmic Coding Specialist at (858) 716-0697.

COVERAGE

Payers will cover procedures that are considered reasonable and medically necessary. Corneal topography is a well-established procedure that may be used to diagnose and manage several eye conditions. Although Medicare, Medicaid, and most private insurers typically will provide coverage for these services when performed for the appropriate indications, payers may have specific guidelines regarding frequency and patient selection.

CODING AND REIMBURSEMENT

The following table outlines the Current Procedural Terminology¹ (CPT) codes that may be appropriate when performing procedures using the ATLAS™ Corneal Topography System. The payment rates listed below reflect the national unadjusted Medicare Physician Fee Schedule amounts effective January 1, 2009.

CPT Code	Modifier	Description	2009 Medicare Allowable*
92025		Computerized corneal topography, unilateral or bilateral, with interpretation and report	\$31.02
92025	-TC	Technical component	\$13.34
92025	-26	Professional component	\$17.67

* Fees listed are 2009 Medicare National Averages. Check with your local carrier for allowable payments specific to your area.

Modifiers for professional or technical components

The (-26) and (-TC) modifiers are used to identify the professional and technical components of a procedure, respectively. The professional component identifies the physician work associated with the service including the analysis and interpretation of the results. The technical component identifies the equipment and resources necessary to furnishing the procedure.

Generally, if a provider both owns the ATLAS System and performs the procedure, they should report without either modifier, indicating that the global service was performed. The professional and technical component modifiers are typically used in instances where the provider performing corneal topography does not own the resources associated with the service.

¹ All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines, and other material are Copyright 2009 American Medical Association. All rights reserved.

DIAGNOSIS CODES

It is important to include a patient's diagnosis to the greatest level of specificity when seeking reimbursement for computerized corneal topography procedures. The following table is a reference of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes that may be used to support the medical necessity for ATLAS System procedures.

Please note that not all Medicare, Medicaid, and private insurers will cover the conditions outlined in this table. Please check with each insurer to determine which diagnosis codes will be covered when submitting claims for computerized corneal topography procedures.

367.22	Irregular astigmatism
370.07	Mooren's ulcer
370.50 - 370.59	Interstitial keratitis unspecified - other interstitial and deep keratitis
370.8	Other forms of keratitis
371.00 - 371.05	Corneal opacity unspecified - phthisical cornea
371.21 - 371.24	Idiopathic corneal edema - corneal edema due to wearing of contact lenses
371.40	Corneal degeneration unspecified
371.42 - 371.46	Recurrent erosion of cornea - nodular degeneration of cornea
371.48	Peripheral degenerations of cornea
371.49	Other corneal degenerations
371.50 - 371.58	Hereditary corneal dystrophy unspecified - other posterior corneal dystrophies
371.60 - 371.62	Keratoconus unspecified - keratoconus acute hydrops
371.70 - 371.73	Corneal deformity unspecified - corneal staphyloma
372.40 - 372.45	Pterygium unspecified - recurrent pterygium
871.0	Ocular laceration without prolapse of intraocular tissue
871.1	Ocular laceration with prolapse or exposure of intraocular tissue
871.5	Penetration of eyeball with magnetic foreign body
871.6	Penetration of eyeball with (nonmagnetic) foreign body
940.0	Chemical burn of eyelids and periocular area
940.2 - 940.4	Alkaline chemical burn of cornea and conjunctival sac - other burn of cornea and conjunctival sac
996.51	Mechanical complication of prosthetic corneal graft
996.53	Mechanical complication of prosthetic ocular lens prosthesis
998.83	Non-healing surgical wound
V42.5	Cornea replaced by transplant
V43.1	Lens replaced by other means
V45.61	Cataract extraction status
V45.69	Other states following surgery of eye and adnexa

FREQUENTLY ASKED QUESTIONS

Q: What are some of the ICD-9 diagnosis codes that are commonly covered when submitting claims for the procedure?

The ATLAS System has a variety of applications, including management of corneal pathologies, fitting of contact lenses (for patients with irregular astigmatism), and cataract surgery evaluation. Although payers will generally cover corneal topography for these indications, insurers may have their own set of specific guidelines and restriction. Providers should use their own discretion when selecting the appropriate diagnosis codes to report.

Q: I submitted a claim to the patient's insurer, but was denied payment because the procedure is not covered. Is there anything I can do?

If you believe the claim should have been paid, you may request additional consideration and submit an appeal to the insurer. Oftentimes, this will involve a written statement detailing the reason(s) the procedure was considered medically necessary. Insurance companies may have additional guidelines on how providers should appeal a denied claim.

Q; How often can I perform computerized corneal topographies per year on each patient?

Most Medicare carriers have not implemented frequency limitations for corneal topography. Although each payer will have its own coverage guidelines, the procedure will be covered if considered reasonable and medically necessary. We recommend that you contact your patient's insurance company directly to obtain specifics.

Q: When are Advanced Beneficiary Notices (ABN) required?

Medicare requires providers to issue an ABN when a procedure is not expected to be covered due to medical necessity. If you do not believe Medicare will provide coverage for a procedure performed with the ATLAS System (for example, when frequency limitations have been met, or Medicare does not pay for imaging of the patient's condition) you will need to notify the patient prior to the exam that they are financially responsible for the procedure and supply the patient with an ABN.

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