Ophthalmology Services

Billing Information Sheet

Insured Services, Medical Services Branch

	OVERVIEW
	The **Physician Payment Schedule** outlines the criteria for billing each service code and the applicable assessment rules. Before submitting a claim for service, please make sure that you read the DESCRIPTOR of the service code you are billing for, and are familiar with the different GENERAL ASSESSMENT RULES in the schedule. This billing information sheet is specific to the Section of Ophthalmology with examples and tips on how to submit claims correctly in order to avoid unnecessary rejections that cause **delay in payment**. Claims that fail for manual assessment by a Claims Analyst can take approximately 2-3 payment runs before it gets processed. Any specific billing questions can be directed to **Physician Claim Inquiries at 306-787-3454.**
1.	**BILLING FOR PROCEDURES**
	• All 'procedures' – whether surgical or diagnostic have a "classification". • You can find the classification in the payment schedule on the right hand side of the service code beside the fee. • Unless otherwise indicated in the service code descriptor or by exception, standard assessment rules apply. • Ideally, your billing software should already be applying these assessment rules for you.
	CLASSIFICATION TYPES
	"0" – a 0-day procedure means there is 0 (or no) postoperative period (example: 756S) "10" – a 10-day procedure means there is a 10-day postoperative period (example: 61S) "42" – a 42-day procedure means there is a 42-day postoperative period (example: 135S) "D" – this indicates the procedure is considered "diagnostic" (example: 32S)
	If none of these indicators are listed for a service code, it means that the procedure is considered to be "unclassified" (example: 897L – Tray service)
	Typically, service codes listed as "each", "add", or "per" will be paid at 100% no matter how it is classified (example: 182S), unless otherwise indicated or by exception.

	ASSESSMENT RULES
a.	Please reference **ASSESSMENT RULES** section under the heading **Procedures**. Use the **MULTIPLE SERVICES – GENERAL ASSESSMENT RULES** table to figure out what rule(s) to apply when submitting a claim for multiple services.
b.	The assessment rules apply to the same physician (or another physician in the same specialty and clinic) unless otherwise indicated within the rule.
c.	**"0" OR "10" DAY PROCEDURE** **RULE 1 & 2:** **With a Visit (including Hospital Care) on the same day:** Whichever is the greater fee: ✓ Visit will be submitted at listed fee and procedure will be submitted at 75% **OR** ✓ The procedure alone at 100% Examples: • **7S** submit at listed fee (*visit service*) **756S** submit at 75% of listed fee (*0 day procedure*) • **7S** don't submit (*visit service*) **755S** submit at 100% of listed fee (*0 day procedure*) **Rationale**: 7S listed fee and 755S at 75% is less than the 755S at 100% **Without a Visit on the same day:** ✓ Procedure will be submitted at 100% Example: • **756S** submit at 100% of listed fee (*0 day procedure*)
d.	**VISIT WITH MULTIPLE "0" OR "10" DAY PROCEDURES** **RULE 2 & 8:** Whichever is the greater fee: ✓ Visit will be submitted at listed fee and all procedures at 75% Or ✓ Highest procedure will be submitted at 100% and lower procedure(s) will be submitted at 75% Plus: ✓ Additional 'add' code at listed fee ✓ Unclassified service at listed fee (for ex. 897L)

	Example: • 7S submit at listed fee (*visit service*) 91S submit at 75% of listed fee (*0 day procedure)* 72S submit at 75% of listed fee (*10 day procedure)* 897L submit at listed fee (*Tray service*) **Please note:** 91S is eligible for payment with 899L (*Minor tray service)*. However, MSB will only pay one (1) tray service per patient contact.
e.	**MULTIPLE SERVICES ON THE SAME DAY** Example 1: **RULE 3:** • August 1 – 9S submit at listed fee (*Consultation*) August 8 – 7S do not submit (*Visit*) 135S submit at 100% of listed fee (*42 day procedure*) Example 2: **RULE 3 & 8:** • August 1 – 9S submit at listed fee (*Consultation*) August 8 – 7S do not submit (*Visit*) 160S submit at 100% of listed fee (*42 day procedure*) 520S (*42 day procedure add to 160S*) 135S submit at 75% of listed fee (*42 day procedure*) 135S (*42 day procedure add to 135S*) Example 3: **RULE 3, 5, 6 & 8:** • 9S submit at listed fee (Consultation) 170S submit at 100% of listed fee (*42 day procedure*) 181S submit at listed fee (*42 day procedure add to 170S*) 670S submit at 75% of listed fee (*Diagnostic*) 664S submit at 75% of listed fee (*Diagnostic*) 32S submit at 75% of listed fee (*Diagnostic*) 580S submit at 75% of listed fee (*Diagnostic*)
f.	**DIAGNOSTIC PROCEDURES POST – PROCEDURE** Example: **RULE 1 & 7:** • August 1 – 135S (*42 day procedure)* August 3 – 7S submit at listed fee (*Visit*) 32S submit at 75% of listed fee (*Diagnostic*) August 10 – 7S submit at listed fee (*Visit*) 32S submit at 75% of listed fee (*Diagnostic*) **Please note:** 32S greater than 42 days post-procedure can be submitted at 100% of listed fee.

g.	Do not submit a claim for hospital care the two days prior to a "10" or "42" day procedure. Your claim for hospital care will be rejected with explanatory code **KO**.
h.	Do not submit a claim(s) for hospital care or in hospital visits if the patient is admitted after surgery for a "10" or "42" day procedure. Your claim for hospital care or hospital visits will be rejected with explanatory code **KQ**. **Visits after the discharge of the patient may be billed.**
3.	**"BASE" AND "ADD" SERVICE CODES**
	In order for an "add" code to be eligible for payment, it must be submitted with the required "base" code in the **same claim (same claim number)**. **Do not submit an "add" service code on a separate claim (different claim numbers) as the "base" code, even if both are submitted in the same payment run.** *It may be necessary to contact your software vendor to assist you with entering your claims correctly in your system.* **Correct Submission:** Patient A: Claim No. 10001 7S, follow-up assessment **34S, visual field screening** **651S, add to 34S** Patient B: Claim No. 10002 9S, Consultation 32S, Tension -- measured with a tonometer – bilateral **170S, Retinal tear -- complete treatment by diathermy, cryosurgery or laser** **181S, Laser Technical Components – add to 170S** Claim No. 10003 664S, Indirect ophthalmoscopy 653S, Fundus or Slit Lamp Photography, tech. 652S, Fundus or Slit Lamp Photography, prof. 582S, Optical Coherence Tomography (OCT), tech. 581S, Optical Coherence Tomography (OCT), prof. 580S, Corneal pachymetry **Incorrect Submission:** Patient A: Claim No. 10001 **651S, add to 34S** Claim No. 10002 7S, follow-up assessment **34S, visual field screening**

	Patient B: Claim No. 10003 664S, Indirect ophthalmoscopy 653S, Fundus or Slit Lamp Photography, tech. 652S, Fundus or Slit Lamp Photography, prof. 582S, Optical Coherence Tomography (OCT), tech. 581S, Optical Coherence Tomography (OCT), prof. 580S, Corneal pachymetry **181S, Laser Technical Components – add to 170S** Claim No. 10004 **170S, Retinal tear -- complete treatment by diathermy, cryosurgery or laser** 009S, Consultation 032S, Tension -- measured with a tonometer – bilateral
4.	**PROCEDURES DONE ON BOTH EYES**
	<u>756S</u> Intravitreal injection of drugs • Submit in two (2) separate lines with appropriate comments. For example: Claim No. 10001 Line 1 – 756S submit at 100% listed fee "right eye" Line 2 – 756S submit at 75% listed fee "left eye" **<u>180S</u> Laser trabeculoplasty -- per eye -- bill units** • Submit in one (1) line with 2 units. Comments are not required. • Do not submit in two (2) separate lines even with comments. **<u>181S</u> Laser Technical Components, per eye (unilateral) – laser owned and maintained by physician, bill 2 units for bilateral -- add to 170S, 174S, 175S, 176S, 177S, 178S, 180S, 182S, 186S,187S, 189S, 285S, 286S, 493S, 494S, 495S, 496S, 497S** • Submit in one (1) line with 2 units. Comments are not required. • Do not submit in two (2) separate lines even with comments. • Only billable with the above listed codes. **<u>579S</u> Screening visual fields (FDT or Similar)** • This is a BILATERAL code • Do not submit one (1) for each eye. **Please note:** This is only payable with 34S and limited to one (1) per visit. **<u>651S</u> Automated perimetry/specular microscopy/topography** • This is a BILATERAL code • Do not submit one (1) for each eye. **Please note:** This is only payable with 34S, 35S, 36S, 650S, 671S and limited to one (1) per visit.

5.	**16W BIOMETRY - UNILATERAL**
	• Second eye not billable if done for comparison purposes. • If billing 16W x 2 on the same day, please submit with an appropriate comment (i.e. "not for comparison purposes"). • Second 16W billed without an appropriate comment will be rejected with explanatory code **BA.**
6.	**TECHNICAL COMPONENTS**
	For billing of **technical components** see "**Definitions**" (19) and "**Services Supervised by a Physician**" in the Physician Payment Schedule. • Technical components with location of service **2**, **3**, **9**, **B**, **C**, **K** and **M** will be rejected.
7.	**CLAIMS REJECTED OR RECOVERED WITH CW EXPLANATORY CODE**
	As per the Physician Payment Schedule **CW** descriptor, please submit claims rejected or recovered with explanatory code **CW** to WCB (Workers Compensation Board). If WCB end up denying the claim, then you can resubmit to MSB. To avoid payment delays when resubmitting, it is **IMPORTANT** that the exact comment "**Not WCB**" must appear followed by the **date submitted to** and the **date rejected by** WCB in the comment record of the online claim submission. There is a maximum of 77 characters including spaces per line of service. The MSB claims system is able to read the comment and properly adjudicate the claim. For example, "**Not WCB** – January 1, 2018 – August 1, 2018".