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Optometry Coding & Billing Alert

Diagnostic Tests: 92225-92226 Coding: Get to Know These Guidelines for Extended Ophthalmoscopy

With $27 on the line each time, staying on top of carrier rules is critical.

Many optometry coders aren't clear on when it's appropriate to report 92225 (Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial) or 92226 (...subsequent). The procedure pays about $27 each time, so mistakes can add up. Read on to see if one of the following EO myths could be taking money out of your practice's pockets.

EO Is Not Always Included in Eye Exam

Routine ophthalmoscopy is included in a comprehensive eye exam (92004 and 92014), but according to the National Correct Coding Initiative, extended ophthalmoscopy isn't. CPT® codes 92225 and 92226 are not bundled into 92004 or 92014, as of the latest set of NCCI coding edits.

You might still see denials, however. Some carriers have a longtime edit in place not to pay for extended ophthalmoscopy when billed with 92014. If this is the case in your area, you will either need to bill the services and end up in the review and appeal process proving medical necessity.

What about specialists? The rules are the same regardless of specialty, says **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE,** president of Maggie Mac-Medical Practice Consulting in Clearwater, Fla. "I've seen some practices who routinely perform an extended ophthalmoscopy and when questioned as to why this was being done, the response was 'We are retinal specialists.' A physician's medical specialty does not allow this diagnostic test to be performed routinely," she says. "Per the guidelines, a routine ophthalmoscopy is not separately billable and considered part of the eye exam."

Bilateral EO Requires Documentation

Despite what some coders may assume, carriers will not automatically pay twice the fee schedule amount for one eye if you report EO bilaterally.

Reality: Carriers will not pay double for bilateral EO unless you can justify medical necessity for performing EO on both eyes. If you've diagnosed a problem in one eye, don't assume the other eye has the same diagnosis although chances are it will. You must report ICD-9 codes showing medical necessity in each eye you performed EO on. The diagnoses don't have to be different for each eye, but they do have to demonstrate medical necessity for the EO.

Check with your carrier for ICD-9 codes they accept as proving medical necessity -- and for their rules for reporting bilateral procedures. Some want you to report the procedure on one line with modifier 50 (Bilateral procedure) appended; that would work best if both eyes do in fact have the same diagnosis. Other carriers will direct you to report two units of service with modifiers LT and RT appended to each code to signify the left and right eyes.

Don't miss: "The physician must document findings from the routine ophthalmoscopy that indicate a need to perform an extended ophthalmoscopy," says Mac. "The medical necessity must be clearly stated." Follow-up EOs must also have documented evidence to support medical necessary, such as new symptoms or a necessary re-evaluation to check chronic disease or other medical need, she says.

EO is a unilateral procedure. Although CPT® doesn't specifically describe the procedure as unilateral in the code descriptor, most insurers follow Medicare's lead. You can find the bilateral surgery indicators in the fee schedule.

Watch for: If the optometrist is only examining one eye, be sure your documentation and coding reflect that. Consider this example: An obese female patient presents with headaches, slightly reduced vision in her right eye, vague complaints of soreness and variable blur. A routine ophthalmoscopy shows an elevated disc, so the optometrist decides to perform EO with a Volk 78 lens (although the definition of EO does not refer to any particular type of lens. The EO reveals papilledema.

On this claim, report the following:

92225 for the EO

Modifier RT (Right side) appended to 92225 to show that you are only billing for the patient's right eye

377.00 (Papilledema, unspecified) linked to 92225 to prove medical necessity for the EO.

Check Carrier Rules for Retinal Drawings

You do not have to submit a retinal drawing with the claim, say experts. The drawing stays in the file, where it is available upon request to the carrier. But make sure you know your carrier's guidelines for the drawings. Most carriers insist that the drawing must reflect the individual patient's anatomy, be anatomically correct, and portray any pathology present.

"The drawings must be detailed and labeled with findings to notate abnormalities and normal areas," says Mac. "This is essential with documentation requirements."

The drawing must be either three-dimensional or color-coded. If the drawing is color-coded, 4-6 "standard colors" must be used. Not all carriers specify a minimum size for the drawing; those that do prefer a drawing of 3-4 inches in diameter or larger. Most optometrists who perform extended ophthalmoscopies are already trained in the most detailed ways of color-coding retinal drawings.