

Optometry Coding & Billing Alert

Diagnostics: 92250 Survival Guide: Keep These Tips in Your Fundus Photo Toolbox

Don't miss legitimate opportunities in glaucoma visits.

Fundus photography is a critical tool in your optometrist's toolbox for diagnosing and tracking ocular disease. But there are many pitfalls between the performance of a 92250 service and a paid claim. Read on to discover how our experts advise coding and billing for fundus photography.

1. Show Medical Necessity by Not Overdoing Dx Codes

Reporting a wrong -- or irrelevant -- diagnosis code for fundus photography (92250, Fundus photography with interpretation and report) is a common slip-up. Be sure you link only the appropriate diagnosis with the procedure.

Example: The optometrist performs a comprehensive ophthalmological service such as 92004 or 92014, and finds that the patient has cataracts (366.19, Other and combined forms of senile cataract) and macular degeneration (362.50, Macular degeneration [senile] of retina unspecified). He orders fundus photos for the macular degeneration and documents an interpretation and report. When you report 92250, you should only associate it with 362.50 -- but not both 362.50 and 366.19, experts say.

2. Pinpoint Diagnosis Before Overriding 92133 Bundle

If the optometrist performs fundus photographs with other diagnostic procedures to document a disease process or follow its progress, knowing which of the services -- and diagnoses -- to code can be confusing.

Any carrier that follows Correct Coding Initiative (CCI) edits will consider 92133 (Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve) and 92250 to be bundled. They are mutually exclusive, so it would not be appropriate typically to bill for both in the same visit.

CCI marks this bundle with a modifier indicator of "1," meaning you may be able to report them together by appending a modifier to 92133. But payers will want you to have documentation supporting your decision to code both procedures that meet the guidelines to allow unbundling as defined by the CCI edits, says **Maggie Mac, CPC, CEMC, CHC, CMM, ICCE**, President of Maggie Mac-Medical Practice Consulting in Clearwater, Fla., and Brooklyn, N.Y.

Example: The optometrist is monitoring a patient who has glaucoma and diabetic retinopathy. He checks the glaucoma's progression with a scanning laser test (92133) and takes fundus photographs (92250) to track changes in diabetic retinopathy. Be sure you link a glaucoma diagnosis, such as 365.11 (Primary open-angle glaucoma), to 92133, and a diabetic retinopathy code, such as 362.05 (Moderate nonproliferative diabetic retinopathy), to 92250.

Your documentation must support the medical necessity for each test. In such a situation, you may want to have the patient sign an advance beneficiary notice of non-coverage (ABN) in case the carrier denies the claim.

3. Use Photo to Track Disease Process, Add 92225

Rules regarding extended ophthalmoscopy (92225, Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial) when performed with fundus photography differ by payer.

CCI doesn't bundle these codes, but payers may argue that the codes represent redundant procedures -- meaning you

won't get additional information by performing both rather than just one.

Check your carrier for its local coverage determination (LCD). If the carrier doesn't explicitly prevent you from reporting the services together, bill both. You should not need to append modifier 59 (Distinct procedural service) to the lesser code for payment.

Helpful: You're most likely to report 92225 (or 92226 if a subsequent drawing) and 92250 together when the ophthalmologist documents a change in the optic disc or retina or a change in the visual fields. The ophthalmologist is taking photographs to establish a baseline so you can see how a disease progresses over time.

4. Examine Glaucoma Visit for Coding Opportunities

An optometrist may perform fundus photography routinely as part of glaucoma evaluations. But if he also measures visual acuity, checks intraocular pressure, and performs gonioscopy, pupil dilation and visual field examination, you need to know which codes to report.

Of these typical components of a glaucoma exam, you can code fundus photography (92250), gonioscopy (92020, Gonioscopy [separate procedure]) and visual field examinations (92081-92083) separately from the E/M or eye examination code. But check with your carrier to be sure the codes don't have specific frequency limitations.

5. Medicare Doesn't Want to See Modifier 50

Medicare considers code 92250 to be inherently bilateral. Medicare already bases the relative value units (RVUs) for fundus photography on the procedure being performed bilaterally. Therefore, you should not append modifier 50 (Bilateral procedure). If you do, the carrier will most likely ignore it and pay for one instance of 92250.

You can get a head start on preventing these snafus by looking in column Z ("Bilat Surg") in the physician fee schedule database to see if Medicare denotes that a procedure is bilateral. For 92250, there is a "2" in column Z, which means the payment adjustment for a bilateral procedure does not apply. A "0" in that column would also indicate no bilateral payment, but a "1" would tell you that the procedure is considered unilaterally performed and should be reported with modifier 50 when performed bilaterally. You can expect to see 150 percent payment for that procedure. An indicator of "3" means that the procedure is considered unilateral and payment is considered at 100 percent for each eye if performed bilaterally, says Mac.