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Optometry Coding & Billing Alert

Extended Ophthalmoscopy: Routine or Extended? Initial or Subsequent? Find Your EO Answers Here

Tip: Be sure to understand bilateral rules before you file your next claim.

For most optometrists, extended ophthalmoscopy (EO) is an essential part of the toolbox. But as with many common procedures, misconceptions and questions about billing and coding abound. Read on for our experts' answers to some of coders' most frequently asked questions.

Question: When do I code EO, as opposed to a routine ophthalmoscopy?

Answer: Any general ophthalmic examination will include a routine ophthalmoscopy. But an extended ophthalmoscopy is a special ophthalmologic service that goes beyond the general eye exam.

Caution: The general ophthalmic examination CPT® codes (92002-92014) already include the routine ophthalmoscopy, so you should not report routine ophthalmoscopy (which can include a slit lamp examination with a Hruby lens or direct ophthalmoscopy for fundus examination) separately with 92002-92014.

When an initial exam uncovers a serious retinal problem, retinal specialists then turn to extended ophthalmoscopy (92225, Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial; and 92226 (... subsequent) for a more detailed examination.

Question: What's the difference between initial and subsequent EO?

Answer: It has nothing to do with whether the patient is new or established, say experts. Use 92225 to report an EO for a new problem, even if that problem occurs in an established patient. For a subsequent EO to track the same problem, report 92226.

Example: A physician refers a patient to your office for a consultation. The patient has been complaining of floaters. During the first appointment, the optometrist performs an initial EO (92225) and diagnoses the patient with post-vitreous detachment. He asks the patient to return in six weeks, at which point he performs a subsequent EO (92226). The patient returns again in another year for a subsequent EO (92226).

Question: Is EO unilateral or bilateral?

Answer: 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 database, in the column marked "Bilat Surg."

The fee schedule assigns 92225 a bilateral surgery indicator of "3," which means that Medicare has set the relative value units (RVUs) for extended ophthalmoscopy based on the physician performing the procedure unilaterally, says **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE**, AHIMA-approved ICD-10 CM/PCS trainer and president of Maggie Mac-Medical Practice Consulting in Clearwater, Fla.

If there is a problem with both eyes, you can report the service for both eyes. Depending on insurer preference, report bilateral EOs with either:

- 92225-50 (Bilateral procedure) or
- 92225-RT (Right side) and 92225-LT (Left side).

Prove it: Don't assume both eyes have the same diagnosis.

You must report ICD-9 codes showing medical necessity in each eye you performed EO on. "This starts with performance of a general ophthalmoscopy where findings indicate the necessity to perform an extended exam," notes Mac. "It is very important to document the initial findings which support the need to do the detailed extended ophthalmoscopy for each eye. Routine performance of an extended ophthalmoscopy without indications found in the general or routine exam is grounds for denial."

Consult your carriers' local coverage determinations for diagnosis codes that support medical necessity.

Question: What documentation do I need for an EO claim?

Answer: While standard documentation will be sufficient for your routine ophthalmoscopy claims, you'll need more notes to back up your EO claims. EO is a detailed, extra, separate procedure requiring additional documentation with interpretation and report.

The documentation should include the reason the optometrist performed an extended exam as well as the procedure he used, and a plan of action for treatment.

Also include a drawing of the area on the fundus in question (like the disc). A color drawing, even with just red and blue colored pencils, would be best, but it is not required by every carrier. If you have any documentation concerns on your EO claims, check your payer contract or call the payer before filing.