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Optometry Coding & Billing Alert

Follow 3 Tips for Exemplary Extended Ophthalmoscopy Coding

Understanding the difference between EO and routine ophthalmoscopy is the key to avoiding denials

Because optometrists usually perform some form of ophthalmoscopy during any general exam, knowing when it's OK to report extended ophthalmoscopy can be difficult. Hint: It's up to the optometrist to prove that an EO is medically necessary and reimbursable.

Use these expert tips for reporting extended ophthalmoscopies to ensure clear sailing for your 92225-92226 claims.

Tip 1: Distinguish -Extended- From -Routine-

General ophthalmological exams (92002-92014) already include routine ophthalmoscopy, often as part of a screening exam, says **Donita Baker,** education and compliance coordinator for TLC Eyecare and Laser Centers in Jackson, Mich. 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 or an E/M code.

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

A reimbursable EO is one that generates information the optometrist could not have attained through other means (such as a view of the peripheral retina obtained by scleral depression versus indentation), Baker says. Carriers will also reimburse EO when the test generates information that affects or determines the patient's treatment plan.

In general, extended ophthalmoscopies are warranted in cases of serious retinal disorders (e.g., retinal detachment) that constitute medical necessity, and they require detailed documentation. Many glaucoma specialists also perform EO to evaluate the optic nerve.

Do this: Check with your carriers for ICD-9 codes they accept as proving medical necessity for EO. Acceptable codes usually include most codes in the following families: 361.xx (Retinal detachments and defects), 362.xx (Other retinal disorders), 363.xx (Chorioretinal inflammations, scars, and other disorders of choroid) and 365.xx(Glaucoma), says **Raequell Duran, CPC,** president of Practice Solutions in Santa Barbara, Calif. However, most Medicare carriers have specific requirements for reporting the 365.xx range, Duran says.

Tip 2: Don't Fall Into the Modifier 25 Trap

In many cases, you need to append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M or eye code when you are reporting a code for a minor procedure performed during the same visit. However, modifier 25 is not necessary when reporting 92225-92226 with 99201-99215 or 92002-92014 -- and it may even lead to denials.

This was not always the case, says **Maggie M. Mac, CMM, CPC, CMSCS,** consulting manager for Pershing, Yoakley & Associates in Clearwater, Fla. -Several years ago, for a brief time, it was necessary to append modifier 25 to the eye or E/M codes when an EO, or any of the codes from the medicine section of CPT, was performed,- she says.

Although Medicare no longer requires it, -unfortunately, there are still some payers that want this modifier used when an E/M or eye code is reported on the same day as another service,- Mac says.

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The rule of thumb is that you should not append modifier 25 when you are reporting a diagnostic service (70000 series of CPT) or a medicine service (90000 series of CPT) on the same day as an eye code or E/M code, Mac says.

-The office visits have a global period of XXX, as does extended ophthalmoscopy, so they do not have a postoperative package, like a minor procedure does,- Duran says. -Nothing else is included that has to be identified as separate and payable.-

So if an established patient presents for a comprehensive evaluation of the function of his eye and has an extended ophthalmoscopy, you will need to use 92014 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits) and 92225.

Caution: Pay attention to your carriers- local medical review policies or payment policies. Some carriers have long-standing edits in place that prohibit paying for EO and 92014 performed in the same visit. An alternative is to select the intermediate-level eye code or an E/M code instead of the comprehensive eye code.

-Usually, if they-re having the EO, it's because of some kind of medical problem,- says **Tawnya Shanklin,** coder and billing manager at Medical Eye Associates in Waukesha, Wis.

Because many carriers view the eye codes as strictly appropriate for vision-related examinations, Shanklin relies on the E/M codes, which are more closely associated with medical problems.

Part B carrier Group Health also specifies that 92225 is payable with all eye exam codes, but -92226 is payable only with [established-patient codes] 92012 and 92014.- If you report a subsequent EO with 92226, the carrier would not expect to see 92002 or 92004, which are both new-patient codes.

Tip 3: Check Carrier Rules for Billing Bilaterally

Unlike most of the ophthalmic services in the 92002-92499 family, Medicare sees EO as inherently unilateral, and assumes that the procedure includes the examination of one eye only.

When the optometrist performs EO bilaterally, you must prove medical necessity for both eyes. If there is a problem in one eye, don't assume the other eye has the same diagnosis (although it often does). You must report ICD-9 codes showing medical necessity for each eye--although they do not have to be different for each eye, Baker says.

This can be tricky to catch, Duran says, because a responsible optometrist will almost always perform an extended ophthalmoscopy on the fellow eye when one eye is symptomatic.

Make sure your physicians know that to bill the procedure for both eyes, there has to be a -medically necessary- reason -- not a -preventive- reason -- for billing the EO on the fellow eye.

Unfortunately, there are no blanket rules for reportingbilateral procedures. Some carriers 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, such as CIGNA in Idaho, North Carolina and Tennessee, specifically forbid reporting 92225-92226 with modifier 50, and direct you instead to report the procedures on two lines with modifiers LT (Left side) and RT (Right side) appended.

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