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Optometry Coding & Billing Alert

Prove Medical Necessity for Pre-Bleph Visual Fields or Risk Nonpayment

Frustrated by denials for 'taped and untaped' VFs? Here's how to get the reimbursement your practice deserves.

To prove that blepharoplasty is medically necessary, you have to perform two sets of visual fields per patient -- but many Medicare carriers will pay only for one set. You may not ever see full reimbursement for your work, but here's how you can code to get most of what you're due.

Before approving blepharoplasty payments, insurers look for proof that the drooping eyelids are interfering with the patient's field of vision -- accomplished by performing visual field (VF) tests (92081-92083).

Optometrists must perform a visual field test with the patient's eyelids taped out of the way (in addition to a standard VF), showing what the postoperative field of vision will be, says **Becky Zellmer, CPC, COTA, MBS, CBCS,** medical billing and coding supervisor for Suby, Von Haden and Associates in Neenah, Wis.

The visual field should demonstrate a minimum of 12 degrees or 30 percent loss of the upper field of vision with upper lid skin and/or upper lid margin, says Zellmer, who led the "Effective Strategies for Blepharoplasty Coding" seminar at The Coding Institute's July conference.

Choose Between These Coding Options

So how can you get more fair reimbursement when you perform two visual field tests?

Scenario: A patient is referred to a plastic surgeon to have part of a droopy eyelid removed because of a decreased field of vision. In order to determine that the droopy eyelid was indeed the cause of the decreased vision, the plastic surgeon asks the optometrist to perform taped and untaped visual field tests.

Key: Optometrists should check with payers about acceptable coding for preblepharoplasty visual fields, advises **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas. "In spite of the fact that all the carriers are supposed to be doing the same thing, this is a prime example that it just isn't happening across the board," he says. "There are many different methods being required out there."

Best way: You should use 92082 (Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination [e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33]) to show the work of drawing two isopters (the graphic representation of the patient's field of vision).

Alternative: Some carriers will reimburse you for both tests because they mandate two VF tests, which requires extra work by the optometrist. In this case, you should append modifier 76 (Repeat procedure or service by same physician) to the second test and report 92082 and 92082-76. You can add comments in Block 19 of the claim form (or the electronic equivalent) to indicate "taped and untaped," notes Zellmer.

Alternative strategy: One insurer, Pennsylvania's Highmark Blue Shield, directs you toward an unlistedprocedure code. "Codes 92081-92083 should be used as appropriate to report 'untaped' automated visual field examinations," says Highmark's policy on "Automated Visual Field Examinations." "Code 92499 [Unlisted ophthalmological service or procedure] should be used to report a 'taped' automated visual field examination."

Smart: Check with your local carrier to make sure these coding scenarios are acceptable.

Exception: Not all carriers require two sets of visual fields. For example, TrailBlazer, the Part B carrier for Delaware, Maryland, Texas, Virginia, and Washington, D.C., published a local coverage determination in September 2004 stating that one untaped set of visual fields "recorded to demonstrate an absolute superior defect to within 15 degrees of fixation" is sufficient.

Seek Out Acceptable Complaints

One thing to watch for is the chief complaint. The patient's chief complaint may be only cosmetic but a cosmetic complaint is not something that will drive a medically necessary procedure, says Gibson. But if the patient complains of problems seeing due to droopy lids, that's another story -- "so here's a great time to think creatively and dig a little deeper in the case history," he suggests. "Remember, patients don't always understand the need for medical necessity or that droopy lids can interfere with their vision."

Example: A patient who notes that she has to hold her head back to see when she drives, or that she has to physically hold her lids up in order to read, is indicating a medical problem, not a cosmetic one. Medicare requires the documentation to be able to evaluate whether the procedure was cosmetic or medical.

Prepare in Advance With an ABN

To keep your office on the safe side, give an advance beneficiary notice to any blepharoplasty cases. Append modifier GA (Waiver of liability statement on file) to any medically necessary claims, and append modifier GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) for any cosmetic claims.

File a cosmetic claim only if the patient insists on it -- for example, if he needs the denial to seek payment from another carrier.