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Optometry Coding & Billing Alert

Bilateral Billing: Make the Most of Modifier 50 for Bulletproof Bilateral Claims

Hint: Check code descriptions for clues that a procedure can be billed as unilateral.

Don't let tricky prefixes stand in the way of maximum deserved reimbursement for your practice. Read on to learn when you can expect double payment for a service and how to ethically make the most of modifiers.

Dispel Prefix Confusion

The most common mistake new optometry coders make is tripping over the unilateralbilateral conundrum. Here is the breakdown:

Unilateral means there is a 100 percent allowance per eye. In effect, two unilateral procedures results in a payment equal to 200 percent of the fee.

Bilateral means there is a 100 percent allowance for both eyes. In other words, you can only bill for a bilateral service one time per visit. "Billing the service automatically implies that while you performed the service or test on both eyes, you are only allowed to bill one unit," explains **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas.

Bottom line: Pay special attention when reporting procedures performed on both eyes to avoid missing out on a double reimbursement. Often, but not always, the code description will give you a clue that the procedure can be billed as unilateral.

The following are unilateral procedures that generally fall under an optometrist's scope of practice:

- 92070 -- Fitting of contact lens for treatment of disease, including supply of lens
- 92136-26 -- Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation; Professional component
- 92225 -- Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report; initial
- 92226 --... subsequent.

Know Which Modifier Fits the Bill

Even though a code may be inherently unilateral, you should include the proper modifiers to document that the doctor performed the service on both eyes.

Example: If you are reporting 92225, append modifier 50 (Bilateral procedure) with a unit of 1 to bill for two eyes.

Follow this rule: To use modifier 50, you must use the same diagnosis code for both eyes.

If the diagnosis code is different, use RT/LT modifiers instead.

If you scan both eyes, you must have a diagnosis in both eyes, say experts.

Example: If the ICD-9 codes you're reporting for each eye are different, report 92225-RT (Right side) on line 1 of the claim form and 92225-LT (Left side) on line 2.

When coding a bilateral procedure, remember that in almost every case you would report only one unit and refrain from

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appending a modifier. For example, the following procedures are almost always bilateral:

- 92250 -- Fundus photography with interpretation and report
- 92083 -- Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degree, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or30/60-2).

Exception: If you've been coding long enough, you know that special circumstances may arise. For example, if the doctor is performing 92250 on a patient with one blind eye, you would append modifier 52 (Reduced services) to represent the lower level of service associated with this typically bilateral code.

Last word: When in doubt, reference the "Bilateral Surgery" column in Medicare's physician fee schedule to see if Medicare assumes that a procedure is bilateral, suggests Conrad. For 92250, you will find a "2" in that column, meaning you will only receive reimbursement for this procedure once per allowable period. Likewise, a "0" or a "3" in the column also indicates absence of bilateral payment. On the other hand, a "1" in the "Bilateral Surgery" column means you're free to append modifier 50 when appropriate to earn a double payment.

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