

Optometry Coding & Billing Alert

Compliant Coding: Hone Your Optometry Coding Skills With These Eye Code FAQs

The extensive guidelines explaining how to properly use the general service codes, commonly known as the eye codes, will make any optometry coder's head spin.

These answers to frequently asked questions about eye codes will help you set your claims in motion for pleasing payments.

Q: Do I need to report the eye codes with modifier -50 when the service is performed bilaterally?

A: The general ophthalmological services codes, or eye codes, are automatically considered bilateral when reported and should never be used with modifier -50 (Bilateral procedure), says **Marianne F. Wink, RHIT**, compliance analyst and educator for the University of Rochester Medical Center in New York. "Generally where the modifier is needed is for a procedure that identifies one or the other eye only," perhaps with the special ophthalmological procedures, for example. When reporting these codes for a unilateral procedure, or if only one eye is assessed, you must use modifier -52 (Reduced services) to indicate that the full service(s) reported was not fully rendered, Wink says. "This does not affect reimbursement; it is informational" - CPT-4 and local medical review policies do not state that both eyes must be evaluated in order to bill an eye code.

Q: The intermediate-level eye codes' guidelines state, "may include the use of mydriasis for ophthalmoscopy." What is mydriasis and why is it singled out?

A: Mydriasis, a long-continued or excessive dilation of the pupil, is used to facilitate visualization of the ocular media and fundus. It is added in the definition to help distinguish between the intermediate and comprehensive levels of service. The use of mydriasis and examination of the posterior segment is obviously more extensive than an examination of only the anterior segment. But there is no clear rationale explaining why this potential component of an ophthalmoscopy is singled out, except perhaps to clarify that the use of mydriasis to perform an ophthalmoscopy does not classify the ophthalmoscopy as "extensive," Wink says.

Extended ophthalmoscopies, 92225-92226, are reported separately and should not be confused with standard ophthalmoscopies, which are included in the eye codes.

Q: Can "special ophthalmological services" be provided and reported at the same time as the eye codes? Is modifier -25 required on the eye code if the two are performed together?

A: You should definitely and will have to report the special ophthalmological services, 92015-92140, in addition to the eye codes if you use eye codes rather than E/M codes to report office visits. Testing services do not require the use of modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) because they are not considered minor procedures. Minor procedures have a postoperative period of 0 or 10 days and require the -25 modifier to be used on the eye code or E/M service when the definition is met.

So if an established patient presents for a routine comprehensive evaluation of the function of his eye and has an extended ophthalmoscopy, you will need to code 92014 and 92225. But be careful of your local medical review policy and/or payment policy from your carrier. Some carriers have a long-time edit in place not to pay for extended ophthalmoscopy (92225-92226) when billed with 92014. If this is the case in your area, you will either need to bill the

services and end up in the review and appeal process proving medical necessity or select the intermediate-level eye code or E/M code instead of the comprehensive eye code.