Optometry Coding & Billing Alert

Conquer the Pre-Blepharoplasty Visual Field Coding Conundrum

"

Stop throwing away $20 every time you do two VFs for a carrier that only pays for one

To prove that blepharoplasty is medically necessary, you have to perform two sets of visual fields per patient - but many Medicare carriers will only pay 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.

To prove medical necessity for blepharoplasty, you must show that the drooping eyelids are interfering with the patient's field of vision - accomplished by performing visual field 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 **Beth Welsch**, billing manager for Sigma Eyehealth Centers in Monticello, Iowa.

Most Medicare carriers require that the untaped VF show an absolute superior defect to within 15 degrees of fixation. The taped VF must demonstrate a significant improvement over the untaped VF, sometimes as much as a 30 percent improvement.

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. The optometrist submits a bill to Medicare for two units of 92082 (Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination), but the carrier only pays for one procedure.

Best way: Code one unit of 92083 (... extended examination) at your regular fee for that code, says **Nina Watson, CPC, CMA**, an **optometry coding** consultant in Fayetteville, N.C. Standard coding practices tell you instead of [reporting the two services separately]" just go to the next level of service to cover what it is you're providing for the patient " she says. "The CPT overall rules say that they had rather you submit one package for the service bundling everything into one package versus unbundling and trying to divide it up into individual pieces. Our Medicare carrier here has said that they prefer that we do it that way."

Even though the reimbursement for 92083 is about $20 greater than for 92082 "you still aren't getting paid the full amount for what you're doing " Watson says because the overall charge for two units of 92082 would be more than you would get for 92083.

Even if you perform visual fields on both eyes just report 92083 once agrees **Angela Smith CPC** coder and biller for the Midwest Eye Institute in Indianapolis. Medicare has based the RVUs for that procedure on the work done to test both eyes. If you report it bilaterally Medicare will only pay for it once. The Physician Fee Schedule values 92083 at $50.03 (unadjusted for geographic region).

Alternative strategy: One Part B carrier HGSAdministrators in Pennsylvania directs you toward an unlisted-procedure

code. "Bill for the 'untaped' visual field using the appropriate visual field's code (92081-92083) " reads their LMRP. "In addition report the 'taped' visual field with code 92499 (Unlisted ophthalmological service or procedure) and include on the claim the narrative description 'taped visual field.' "

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

Pitfall: Don't expect your modifiers to get you out of this one. Some coders recommend appending modifier 76 (Repeat procedure by same physician) to the second procedure (for example 92082 and 92082-76) but many carriers reject this method arguing that modifier 76 should be used with surgical procedures. Another option is to append modifier 59 (Distinct procedural service) to the second procedure - but carriers are likely to reject that too since the two sets of visual fields are not truly distinct from each other.

Exception: Not all carriers require two sets of visual fields says **David Gibson OD FAAO** a practicing optometrist in Lubbock Texas. 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. "A chief complaint of 'My eyes look awful they droop so ' will not get the claim paid " says **Charles Wimbish OD** president of Wimbish Consulting Group in Martinsville Va. "But if the patient complains of problems seeing due to droopy lids that's another story."

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 or not the procedure was cosmetic or medical " Gibson says. "CMS does not want to pay for cosmetic procedures any more than they want to pay for a routine eye exam."

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.

Only file a cosmetic claim if the patient insists on it Wimbish says - for example if he needs the denial to seek payment from another carrier.

With any visual field testing your documentation must cover your interpretation and report. You do not need to submit the results of the visual fields or the external photography with your claim but you should keep them on file Gibson says because Medicare is watching the code for abuse.

Note: See the November 2004 issue of Optometry Coding and Billing Alert for more information on visual field reporting along with a report template.

"