Optometry Coding & Billing Alert

Defeat Ophthalmic Diagnostic Service Denials With Bulletproof Modifier Use

Do you know how Medicare wants you to bill bilateral OCT? The answer could be worth $44

Keeping straight which diagnostic tests you can report per eye -- and which modifiers different carriers prefer for bilateral tests -- can be vexing. Not keeping that information straight, however, can be costly if your claims are denied.

Zero in: A common cause of denials with your insurance carriers, especially Medicare, can be the inappropriate use of modifiers on your diagnostic tests. Leaving off needed modifiers can also cause underpayment on your claims.

On average, Medicare would pay $44.18 for a unilateral optical coherence tomography (OCT), based on 1.16 relative value units (RVUs) times the 2008 conversion factor, 38.0870. A bilateral OCT should therefore bring in about $88.36.

Interpret the Fee Schedule for -Bilateral- Answers

To find out if any CPT code is bilateral or unilateral, check your Medicare fee schedule. You can find the bilateral indicator in column "Z" ("Bilat Surg") of the Physician Fee Schedule spreadsheet.

The bilateral indicator can tell you whether a CPT code is billable per eye or only once for both eyes, says **Raequell Duran, CPC,** president of Practice Solutions in California, who led the "2008 Modifier Essentials" seminar at The Coding Institute's Optometry Coding and Reimbursement Conference in Feb. 2008. It can also tell you whether or not you can append modifier 50 (Bilateral procedure) to a CPT code.

Tip: You can download the fee schedule spreadsheet from the CMS Web site at www.cms.hhs.gov/FeeScheduleGenInfo -- or you can look up information for a single code at www.cms.hhs.gov/PFSLookup or at your carrier's Web site.

Bilateral, Unilateral -- or Both?

The bilateral indicators you-ll find in the Physician Fee Schedule for optometric diagnostic tests are:

Bilateral indicator "2": Medicare assigns indicator "2" to codes that already specify a bilateral procedure, so you do not need to append a modifier to show that you performed any of these on both eyes. Often, such codes will also specify "unilateral or bilateral" in their individual CPT descriptors.

Example: You perform serial tonometry, 92100 (Serial tonometry [separate procedure] with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day), on both of a patient's eyes. Code 92100 has a bilateral status of "2," telling you that the work involved in measuring both corneas is already included. So you should report 92100 only once.

Bilateral indicator "3": You can report codes with indicators of "3" bilaterally using the appropriate modifier(s). Bilateral indicator "3" indicates that the usual bilateral payment adjustment does not apply. For many procedures that you report for both sides on the same day, insurance carriers will pay 150 percent of the unilateral fee. For procedures marked with bilateral indicator "3," however, carriers will base payment on the fee schedule amount for each side -- bringing you 200 percent reimbursement.

Example: You perform OCT on both eyes. Code 92135 (Scanning computerized ophthalmic diagnostic imaging [e.g., scanning laser] with interpretation and report, unilateral) has a bilateral indicator of "3." Bill 92135-50 (or list it twice with modifiers LT and RT appended). The carrier should pay you twice the amount it would have for a unilateral OCT

(either the fee schedule amount or your actual fee, whichever is lower).

Bilateral indicator "9": The concept of bilateral surgery does not apply to codes with this indicator. Therefore, you should never append modifier 50 or modifiers LT/RT in combination to these procedures.

Example: Refraction, 92015 (Determination of refractive state), has a bilateral status of "9" and therefore may never have a 50, RT or LT appended to it on a claim form. Bill it only once.

Bill Lens Fittings Unilaterally

Two other modifier indicators can give you critical clues for accurate coding of optometric procedures:

Bilateral indicator "1": You can append modifier 50 to the code.

Example: You perform epilation with forceps on both eyes to correct trichiasis (67820, Correction of trichiasis; epilation, by forceps only). When you find 67820 in the Physician Fee Schedule database, you-ll notice a "1" in the "Bilat Surg" column, and you can therefore report 67820-50.

Bilateral indicator "0": Modifier 50 is not allowed. In many cases, bilateral billing is inappropriate for these codes because the code descriptors specifically state that they are unilateral. You may report modifiers LT or RT, however, either in combination or singly, to make your claim more specific.

Example: The fitting of one aphakic lens, 92311 (Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye), has a bilateral status of "0" and therefore may never have modifier 50 appended to it on a claim form. To report fitting of aphakic lenses for both eyes, use code 92312 (... corneal lens for aphakia, both eyes).

Use the Right Billing Method for Your Carrier

You usually have two options for reporting unilateral services done bilaterally:

1. Report the service on one single line item, append modifier 50, leave your total units as "1" and double your normal fee.

2. Report each eye on a separate line, appending modifiers LT and -RT. Report one unit each and bill each line at your normal fee.

Last word: "Just pick the way that it is easier to do and see if your carrier accepts it," advises **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas. "You can always appeal it if they reject it, but both methods are technically correct."