Optometry Coding & Billing Alert

Diagnostics: Could One of These Myths Be Sinking Your EO Claims?

Extended ophthalmology coding has a few sticking points read on to smooth your way to deserved reimbursement.

To many eye coders, extended ophthalmoscopy (EO) can seem baffling. Because most eye exams include some sort of ophthalmoscopy, how do you know when a payer will consider it part of the general ophthalmic exam or E/M code, and when you're allowed to bill for it separately?

Unfortunately, too many optometry coders get hung up on one of the below myths. Don't be one of them read on to see clearly the difference between myth and reality.

Myth: Every ophthalmoscopy, even EO, is included in the general examination.

Reality: Any general ophthalmic examination will include a routine ophthalmoscopy. But an extended ophthalmoscopy is a special ophthalmologic service that goes beyond the general eye exam.

Caution: The general ophthalmic examination codes (92002-92014) already include the routine ophthalmoscopy, so you should not report routine ophthalmoscopy (which can include a slit lamp examination with a Hruby lens or direct ophthalmoscopy for fundus examination) separately with 92002-92014.

When an initial exam uncovers a serious retinal problem, retinal specialists then turn to extended ophthalmoscopy (92225, Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial; and 92226, ... subsequent) for a more detailed examination.

Myth: You should report 92225 only for the first EO a patient ever has, and 92226 for each one after that, regardless of which eye was examined.

Reality: For an initial extended ophthalmoscopy exam, use 92225, and for all subsequent exams on the same eye, use 92226, as the code descriptors indicate.

"It is possible to have charges for an EO done for the first time on one eye and an EO done subsequent to a previous encounter on the other eye," notes **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE,** AHIMA-approved ICD-10 CM/PCS trainer and president of Maggie Mac-Medical Practice Consulting in Clearwater, Fla. "Thus, the coding may look like this: 92225-LT and 92226-RT."

While standard documentation will be sufficient for your routine ophthalmoscopy claims, you'll need more notes to back up your EO claims. EO is a detailed, extra, separate procedure requiring additional documentation with interpretation and report.

The documentation should include the reason the optometrist performed an extended exam as well as the procedure he used.

Also include a drawing of the area on the fundus in question (like the disc). A color drawing, even with just red and blue colored pencils, would be best, but it is not required by every carrier. If you have any documentation concerns on your EO claims, check your payer contract or call the payer before filing. Some payers have specific requirements on the size of the drawing and colors that must be used with a detailed drawing and findings labeled.

Myth: You can never bill EO bilaterally.

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Reality: While you're unable to report most of the other ophthalmic testing codes in the 92xxx series bilaterally, you can report 92225 and 92226 for each eye if there is a medically necessary reason.

EO is a unilateral procedure. Although CPT® doesn't specifically describe the procedure as unilateral in the code descriptor, most insurers follow Medicare's lead. You can find the bilateral surgery indicators in the fee schedule. Check column Z of the database, marked "Bilat Surg." The fee schedule assigns 92020 a bilateral surgery indicator of "3," which means that Medicare has set the relative value units (RVUs) for gonioscopy based on the optometrist performing the procedure unilaterally. If there is a problem with both eyes, you can report the service for both eyes. Depending on insurer preference, report bilateral EOs with either:

- 92225-50 (Bilateral procedure) or
- 92225-RT (Right side) and 92225-LT (Left side).

Prove it: Don't assume both eyes have the same diagnosis.

You must report ICD-10 codes showing medical necessity in each eye you performed EO on. Consult your carriers' local coverage determinations for diagnosis codes that support medical necessity.

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