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Optometry Coding & Billing Alert

Earn $136 for Corneal Topography With Clean Coding

You can bill the procedure for patients with surgically-induced astigmation

If your office has a corneal topographer, you face a few challenges even after the procedure is completed: finding the right CPT code, then wrestling with your carrier's reimbursement rules.

Your CPT manual won't be much help. CPT has undergone several changes in the new year, but one thing stays the same in 2006. There is still no code for corneal topography even though optometrists have been asking the AMA for one for years.

This means that in 2006, you should still report 92499 (Unlisted ophthalmological service or procedure), says **L. Heath Pridgeon, CCS-P, CPC, ABOC**, certified optician and account representative for A/R Medical Claims Recovery in Tallahassee, Fla. Medicare will only reimburse for corneal topography, also known as corneal mapping or computer assisted video keratography (CAVK) under very strict guidelines.

Make Sure Reason for Test Is Covered

As the name of the procedure suggests, optometrists use corneal topography to generate a topographical map of the surface of the cornea. The corneal topographer projects a series of light rings onto the cornea, which are reflected back into the device. A computer analyzes the reflected light and produces a detailed map of the curvature and other physical features of the cornea.

Optometrists can use the map to measure a patient's astigmatism prior to refractive surgery or as part of a patient's post cataract surgery care. But because Medicare does not cover refractive surgery at all, it will not cover pre-LASIK corneal topography. When performing CAVK for this purpose, have the patient sign an advance beneficiary notice (ABN) explaining that Medicare will not cover the procedure, and inform the patient that he will be responsible for payment.

CAVK can also detect and monitor the progress of corneal disease, such as corneal pterygium or keratoconus. Some optometrists use corneal topography as an alternative method for determining IOL power in cases in which previous LASIK surgery makes it difficult to use an A-scan or IOL Master.

Many providers use corneal topography for more accurate contact lens fitting. In these cases, include corneal topography in your charge for the fitting (for example, 92310, Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia), advises **David Gibson, OD, FAAO**, a practicing optometrist in Lubbock, Texas. -We do topography at no additional charge on contact lens patients,- says Gibson.

Keep CAVK Claims Clean With Box 19

In addition to reporting 92499, make sure that you have -corneal topography- typed into the comments area or Box 19 on your claim form and send a description with the claim, advises Pridgeon.

Many carriers also want you to keep the computerized corneal topography results, along with the examination and photo interpretation, in the patient's record. You must make these records available to the carrier when it requests them.

Another way: For non-Medicare payers, you may try using HCPCS code S0820 (Computerized corneal topography, unilateral) for this procedure, says **Loetta Morales**, insurance specialist at Gorovoy Eye Specialists in Fort Myers, Fla.

Just keep in mind that all payers are not required to recognize HCPCS codes, and there is a plan eventually to phase out the use of HCPCS codes.

Medicare carriers also determine which ICD-9 codes prove the medical necessity for corneal topography, and each carrier may have a different list. In many cases, if the diagnosis is astigmatism, the astigmatism must be caused by prior surgery in order for CAVK to be reimbursable.

Best bet: Check your local carrier's policy for its list approved ICD-9 codes, advises Gibson. Diagnosis codes that many carriers have found to support medical necessity include:

- 367.21--Regular astigmatism (Report V45.61[States following surgery of eye and adnexa; cataract extraction status] or V45.69 [... other states following surgery of eye and adnexa] as secondary code.)

- 367.22--Irregular astigmatism (Report V45.61 or V45.69 as secondary code.)

- 370.00-370.07--Corneal ulcer

- 371.00-371.73--Corneal opacity and other disorders of cornea

- 372.40-372.45--Pterygium*

- 372.52--Pseudopterygium*

- 743.41--Anomalies of corneal size and shape

- 871.0-871.1--Ocular laceration

- 940.2-940.4--Burn confined to eye and adnexa

- 996.51--Mechanical complications of other specified prosthetic device, implant and graft; due to corneal graft

- V42.5--Organ or tissue replaced by transplant; cornea (secondary diagnosis)

- V45.61-V45.69--States following surgery of eye and adnexa (secondary diagnosis)

*Some carriers, such as Noridian, require that a letter documenting medical necessity accompany the claim when CAVK is performed for pterygium or pseudoterygium.

Most carriers consider corneal topography to be inherently unilateral, says Pridgeon. When you perform topography on both eyes, report one unit of 92499 with modifier 50 (Bilateral procedure) appended to tell the carrier you performed the procedure bilaterally. Alternately, you may report the service on two lines, with modifiers LT (Left side) and RT (Right side) appended. Check with your carrier for its preference.

Check Carrier for Comparison Codes

For procedures coded with unlisted codes, some Medicare carriers will compare them with established codes to determine how much they will reimburse. If your carrier has no comparison code, draw its attention to the following examples.

One carrier, Cahaba of Alabama, Georgia and Mississippi, states that they will reimburse the procedure -equivalent to the allowance of CPT code 92135.- Code 92135 (Scanning computerized ophthalmic diagnostic imaging [e.g., scanning laser] with interpretation and report, unilateral) has 1.16 RVUs in Medicare's 2006 fee schedule; multiplying that by the 2006 conversion factor of 36.177 yields $41.96 ($83.92 bilaterally).

Noridian, the Part B carrier for Colorado, North and South Dakota and Wyoming, has stated that they will reimburse corneal topography -at the same level as procedure code 92286, until such time as a specific code is established.- CPT code 92286 (Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count) has 3.76 RVUs in the fee schedule, leading to $136 in reimbursement.