Optometry Coding & Billing Alert

Extended Ophthalmoscopy: Scope Out EO Coding Guidelines, or Risk $28 Each Time

Know when you can and can't report this procedure separately.

Is that ophthalmoscopy routine or extended? Is it included in the eye exam code, or can you bill for it separately? With approximately $28 at stake for each procedure (based on 0.76 RVUs multiplied by the 35.9335 conversion factor in 2015), CPT® codes 92225 (Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial) and 92226 (... subsequent) appear quite frequently in claims from many optometry practices including yours, most likely.

Both beginning and seasoned coders often find themselves with questions about coding and reimbursement for extended ophthalmoscopy. Read on for our expert answers to a few of them.

Question: Can I code for a comprehensive visit along with EO?

Answer: The critical word is "extended." There is nothing in the CPT® manual which would prevent you from coding 92225 along with an office visit, either an evaluation and management (E/M) service or an eye code. According to CPT, routine ophthalmoscopy is indeed part of general and special ophthalmologic services. But you may be able to report an extended ophthalmoscopy if you have the proper documentation.

Don't Miss: "It is not appropriate to perform an extended ophthalmoscopy unless the preliminary exam indicates a need or it is necessary to re-assess chronic disease," warns **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.

EO includes a drawing of the retina, with interpretation and report. Furthermore, Medicare carriers have designated certain colors to be used in these drawings, but some carriers require more differentiation than others.

"Most will waive the need for different colors if the drawings have detailed labels," Mac says. "The size of the drawing may also be a specific requirement, so be sure to check with your payer for documentation requirements." A patient with glaucoma may also need a separate drawing of the optic nerve, she adds.

Also, be sure to provide the reason (medical necessity) the optometrist performed the EO as well as the procedure he used. "Finally, it is essential to provide a report of the interpretation and findings from the diagnostic test, including one for the optic nerve drawing," Mac says.

Question: Is EO bilateral or unilateral?

Answer: Medicare considers EO inherently unilateral, meaning that one unit of CPT® code 92225 or 92226 represents the work in testing only one eye. In its Physician Fee Schedule, Medicare gives the codes a bilateral indicator of "3," which indicates that if you report the code bilaterally, Medicare will pay the full amount for two procedures. Although CPT® doesn't specifically describe the procedure as unilateral, most payers will follow Medicare's lead.

Caveat: Carriers will not pay double for bilateral EO unless you can justify medical necessity for performing EO on both eyes. If an optometrist has diagnosed a problem in one eye, don't assume the other eye has the same diagnosis although chances are it will. You must report ICD-10 codes showing medical necessity in each eye he performed EO on. The diagnoses don't have to be different for each eye, but they do have to demonstrate medical necessity for the EO.

Strategy: Check with your carrier for ICD-10 codes and clinical criteria they accept as proving medical necessity and

for their rules for reporting bilateral procedures. Some want you to report the procedure on one line with modifier 50 (Bilateral procedure) appended; that would work best if both eyes do in fact have the same diagnosis. Other carriers will direct you to report two units of service with modifiers LT and RT appended to each code to signify the left and right eyes.

Question: Can I only code an initial EO on a new patient who has never had an EO before?

Answer: The "initial" (92225) and "subsequent" (92226) EO codes don't necessarily correspond to new and established patients. CPT does not intend for 92225 to be a one-time-only code you should only use with new patients. Rather, report 92225 for the initial EO associated with new symptoms of a non-chronic condition.

Example: The optometrist sees a new patient complaining of flashes and floaters. He performs an initial EO, finding post-vitreous detachment. He asks the patient to return in six weeks. At that visit, he performs a subsequent EO. A few weeks after that, the patient returns, now complaining of blurred vision. The optometrist performs another EO.

You would code:

- 92225 for the first EO
- 92226 for the subsequent EO performed after six weeks
- 92225 for the third EO, performed when the patient complained of blurred vision.

For the second EO, code 92226 is appropriate because the optometrist is following up on the post-vitreous attachment. When the patient returns with the blurred vision complaint, the optometrist is then investigating a new condition, so report 92225.

On the other hand, payers consider 92226 to be a "physician service" and not a "diagnostic service." If you report this service in the post-op period for a related diagnosis, some payers may not reimburse for it.

If you report the service during the post-op period for an unrelated diagnosis, append modifier 79 (Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period) to the code, and link to the new diagnosis.