Codify
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Optometry Coding & Billing Alert

Fundus Photos: Appending Modifier 50 to 92250? Not So Fast

Snap **up your rightful fundus photo pay with bundling, Dx know-how.**

Adding too many -- or too few -- codes to your fundus photography claim is a guaranteed way to invite denials or delayed payment. Whether you're selecting CPT or ICD-9 codes, you need to take a minute to match your codes to your documentation and your payer's rules.

Show Medical Necessity by Not Overdoing Dx Codes

Reporting a wrong -- or irrelevant -- diagnosis code for fundus photography (92250, Fundus photography with interpretation and report) is a common slip-up. Be sure you link only the appropriate diagnosis with the procedure.

Example: You perform a comprehensive ophthalmological service such as 92004 or 92014, and you find that the patient has cataracts (366.19, Other and combined forms of senile cataract) and macular degeneration (362.50, Macular degeneration [senile], unspecified). You order fundus photos for the macular degeneration and document an interpretation and report. When you report 92250, you should only associate it with 362.50 -- not 362.50 and 366.19, warns **Maggie M. Mac, CPC, CEMC, CHC, CMM,ICCE,** director of Best Practices-Network Operations at Mount Sinai Hospital in New York City.

Pinpoint Diagnosis Before Overriding 92135 Bundle

If you perform fundus photographs with other diagnostic procedures to document a disease process or follow its progress, knowing which of the services -- and diagnoses -- to code can be confusing.

Any carrier that follows Correct Coding Initiative (CCI) edits will consider 92135 (Scanning computerized ophthalmic diagnostic imaging, posterior segment [e.g., scanning laser] with interpretation and report, unilateral) and 92250 to be bundled. They are mutually exclusive, so it would not be appropriate typically to bill for both in the same visit.

CCI marks this bundle with a modifier indicator of "1," meaning you may be able to report them together by appending a modifier to 92250. But payers will want you to have documentation supporting your decision to code both procedures.

Example: You're monitoring a patient who has glaucoma and diabetic retinopathy. You check the glaucoma's progression with a scanning laser test (92135) and take fundus photographs (92250) to track changes in diabetic retinopathy. Be sure youlink a glaucoma diagnosis, such as 365.11 (Primary open-angle glaucoma), to 92135, and a diabetic retinopathy code, such as 362.05 (Moderate nonproliferative diabetic retinopathy), to 92250.

Your documentation must support the medical necessity for each test. In such a situation, you may want to have the patient sign an advance beneficiary notice (ABN) in case the carrier denies the claim.

Use Photo to Track Disease Process, Add 92225

Rules regarding extended ophthalmoscopy (92225, Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial) when performed with fundus photography differ by payer.

CCI doesn't bundle these codes, but payers may argue that the codes represent redundant procedures -- meaning you won't get additional information by performing both rather than just one.

Check your carrier for its local coverage determination (LCD). If the carrier doesn't explicitly prevent you from reporting

the services together, bill both. You shouldn't need to append modifier 59 (Distinct procedural service) to the lesser code for payment.

Helpful: You're most likely to report 92225 and 92250 together when you document a change in the optic disc or retina or a change in the visual fields. The point is that you're taking photographs to establish a baseline so you can see how a disease progresses over time.

Examine Glaucoma Visit for Coding Opportunities

You may perform fundus photography routinely as part of glaucoma evaluations. But if you also measure visual acuity, check intraocular pressure, and perform gonioscopy, pupil dilation and visual field examination, you need to know which codes to report.

Of these typical components of a glaucoma exam, you can code fundus photography, gonioscopy (92020, Gonioscopy [separate procedure]) and visual field examinations (92081- 92083) separately from the E/M or eye examination code. But check with your carrier to be sure the codes don't have specific frequency limitations.

Medicare Doesn't Want to See Modifier 50

Medicare considers code 92250 to be inherently bilateral. Medicare already bases the relative value units (RVUs) for fundus photography on the procedure being performed bilaterally. Therefore, you should not append modifier 50 (Bilateral procedure). If you do, the carrier will most likely ignore it and just pay for one instance of 92250. You can get a head start on preventing these snafus by looking in column Z ("Bilat Surg") in the physician fee schedule to see if Medicare assumes that a procedure is bilateral. For 92250, there is a "2" in column Z, which means the payment adjustment for a bilateral procedure does not apply. A "0" or a "3" in that column would also indicate no bilateral payment,but a "1" would tell you that the procedure is considered unilaterally performed and should be reported with modifier 50 when performed bilaterally, says **Denise Stanton, CPC, CCP-P,** senior coding analyst at Beth Israel Deaconess Medical Center in Boston, Mass. You can expect to see 150 percent payment for that procedure.