

Optometry Coding & Billing Alert

Fundus Photos: Check These Fundus FAQs to Keep Your Coding Straight

Do you know what to do if the optometrist only tests unilaterally?

It's a sign of the times: Fundus photographs have entered the smartphone era, as recent reports from the American Academy of Ophthalmology have stated that fundus photos displayed on an iPhone are of better quality than those displayed on a 19-inch monitor.

No matter how you take them, your optometry practice probably sees a fair share of fundus photos. And with just one CPT® code to describe fundus photography, 92250 (Fundus photography with interpretation and report), you'd think your task as a coder would be pretty simple.

But veteran coders know that that even the simplest tasks have hidden complexities, from diagnosis coding to bilateral rules. Read on for common questions and expert answers on proper coding and billing for this common diagnostic tool.

Q: When is fundus photography used?

A: CPT® code 92250 describes the taking of fundus photographs — that is, photographs of the posterior segment of the inner aspect of the eye — to document alterations in the optic nerve head, retinal vessels and retinal epithelium. It can be used to document baseline retinal findings and track disease progression.

According to the Preferred Practice Patterns (PPP) of the American Academy of Ophthalmology, fundus photography is useful in documenting disease progression and response to treatment for diseases such as diabetic retinopathy, primary open-angle glaucoma, and age-related macular degeneration. Optometrists often use fundus photographs to establish a baseline to measure against future images, says **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.

Q: When is it covered?

There is no single national coverage policy for ophthalmologic applications of fundus photography. However, some Medicare contractors — such as Cigna and Palmetto GBA — have published Local Coverage Determinations (LCDs) listing various patient diagnoses that may justify coverage.

Key: If there is no LCD for fundus photography, Medicare will cover the procedure according to the medical necessity of an individual case, say experts. In the patient's record, be sure to document the patient's condition, medical history, the reason for the service, and a copy of the test results as evidence to help back up medical necessity.

Common ICD-9 diagnostic codes that may help prove medical necessity include:

- 250.5x — Diabetes with ophthalmic manifestations
- 360.50 — Foreign body, magnetic, intraocular
- 360.60 — Foreign body, intraocular
- 361.10 — Retinoschisis
- 361.3x — Retinal defects w/o detachment
- 362.01 — Background diabetic retinopathy
- 362.02 — Proliferative diabetic retinopathy
- 362.10 — Background retinopathy
- 362.11 — Hypertensive retinopathy

- 362.12 ☐ Exudative retinopathy
- 362.17 ☐ Other intraretinal microvascular abnormalities
- 362.18 ☐ Retinal vasculitis
- 362.30 ☐ Retinal vascular occlusion, unspecified
- 362.33 ☐ Partial retinal arterial occlusion
- 362.50 ☐ Macular degeneration (senile) of retina, unspecified
- 362.51 ☐ Nonexudative senile macular degeneration of retina
- 362.52 ☐ Exudative senile macular degeneration of retina
- 362.53 ☐ Cystoid macular degeneration of retina
- 362.63 ☐ Lattice degeneration of retina
- 362.75 ☐ Other dystrophies primarily involving the sensory retina
- 362.76 ☐ RPE dystrophies
- 362.82 ☐ Retinal exudates and deposits
- 362.84 ☐ Retinal ischemia
- 365.xx ☐ Glaucoma
- 377.0x ☐ Papilledema
- 377.1x ☐ Optic atrophy
- 377.3x ☐ Optic neuritis
- 377.4x ☐ Disorders of optic nerve
- 379.34 ☐ Posterior dislocation of lens
- 743.52 ☐ Fundus coloboma
- 743.55 ☐ Congenital macular changes
- 871.x ☐ Open wound of eyeball.

Careful: Individual Medicare contractors may have their own lists of covered diagnoses. Be sure to check your local carrier's LCD.

Q: Is it bilateral or unilateral?

A: Medicare considers 92250 to be inherently bilateral. In other words, it bases its reimbursement ☐ in 2014, \$79.17, based on 2.21 relative value units (RVUs) multiplied by the 35.8228 conversion factor ☐ on the procedure being performed on both eyes. Therefore, there is no need to append modifier 50 (Bilateral procedure) to 92250 if the optometrist performs it on both eyes.

Don't miss: If the optometrist only photographs one eye, modifier 52 (Reduced services) may be your best bet, say experts. You can then append modifier LT (Left eye) or RT (Right eye) to specify which eye was photographed, although those modifiers are informational and do not affect reimbursement.

Palmetto GBA's LCD adds the following advice for reporting 92250 unilaterally:

- It is not necessary to submit documentation supporting the use of CPT modifier 52 for fundus photography. Palmetto GBA will assume the photography was performed on only one eye.
- Documentation reflecting the reason the service was reduced should be retained in the patient's medical record.

Q: What is it bundled with?

A: Often, an optometrist will perform 92250s with other diagnostic procedures to document a disease process or follow its progress. Any carrier that follows Correct Coding Initiative (CCI) edits will consider 92133 (Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve) and 92134 (...retina) to be mutually exclusive with 92250. 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 92133 or 92134. But payers will want you to have documentation supporting your decision to code both procedures.

Example: The optometrist is monitoring a patient who has glaucoma and diabetic retinopathy. He checks the glaucoma's progression with a scanning laser test (92134) and takes fundus photographs (92250) to track changes in diabetic retinopathy. Be sure you link a glaucoma diagnosis, such as 365.11 (Primary open-angle glaucoma), to 92134, 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.

CCI also bundles 92250 with 92240 (Indocyanine-green angiography (includes multiframe imaging) with interpretation and report). This bundle is also marked with modifier indicator "1." Code 92250 is bundled into 92240, as 92240 is seen as the more extensive procedure.

Additionally, CPT® code 92227 (Remote imaging for detection of retinal disease [e.g., retinopathy in a patient with diabetes] with analysis and report under physician supervision, unilateral or bilateral) is bundled into 92250. Code 92227 describes remote imaging procedures, in which images of the retina are taken with a wide-angle lens and transmitted to a retinal specialist elsewhere.

The code was introduced in CPT® 2011. Instructions in the manual forbid coders from reporting 92227 with 92250 and also forbid reporting 92227 with eye exam codes 92002-92014 (Ophthalmological services...), 92133-92134, or 92228 (Remote imaging for monitoring and management of active retinal disease [e.g., diabetic retinopathy] with physician review, interpretation and report, unilateral or bilateral).