Optometry Coding & Billing Alert

Go Beyond Routine Coding for Extended Ophthalmoscopies

Ensure you know what qualifies as an EO before adding 92225-92226 to another claim

Most eye exams include some form of ophthalmoscopy, but payers often bundle this service into general ophthalmic exam or E/M codes.

So how do you know when the exam warrants an extended ophthalmoscopy (EO) code? You-ll have to rely on detailed documentation to prove medical necessity and capitalize on the more complicated service.

Read on to make sure you-re not missing out on EOs you could rightfully report.

Know When to Take Coding to the Next Level

Any general ophthalmic examination will include a routine ophthalmoscopy, says **Sara Root, CPC,** coder for the Fletcher Allen Health Care department of ophthalmology in Burlington, Vt. But "an extended ophthalmoscopy is a special ophthalmologic service that goes beyond the general eye exam," she says.

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, with interpretation and report; initial; and 92226, - subsequent) for a more detailed examination.

Consider this example: An obese female patient presents with headaches, slightly reduced vision in her right eye, vague complaints of soreness and variable blur. A routine ophthalmoscopy shows elevated discs, so the OD decides to perform EO with a Volk 78 lens. The EO reveals papilledema.

On this claim, report the following:

- 92225 for the EO

- modifier RT (Right side) appended to 92225 to show that you are only billing for the patient's right eye

- 377.00 (Papilledema, unspecified) linked to 92225 to prove medical necessity for the EO.

Remember to Include Detailed EO Documentation

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

While standard documentation will be sufficient for your routine ophthalmoscopy claims, you-ll need more notes to back up your EO claims, says **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas. "EO is a detailed, extra, separate procedure requiring additional documentation with interpretation and report," he says.

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

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," Gibson says. If you have any documentation concerns on your EO claims, check your payer contract or call the payer before filing.

Bill Bilaterally Based on Carrier

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. If there is a problem with both eyes, you can report the service for both eyes, Gibson says. Depending on insurer preference, report bilateral EOs with either:

- 92225-50 (Bilateral procedure) or

- 92225-RT (Right side) and 92225-LT (Left side).

Benefit: "You get paid 100 percent of the allowable amount for each eye, but both eyes have to have something that needs to be evaluated," Gibson says.

Prove it: Don't assume both eyes have the same diagnosis. You must report ICD-9 codes showing medical necessity in each eye you performed EO on. Consult your carriers- local coverage determinations for diagnosis codes that support medical necessity. The range of accepted codes is "pretty wide," says **Katie Stillman,** coding specialist for EYE Q Vision in Fresno, Calif.

Don't Rule Out Other Services

There are many times when you have to shy away from reporting more than one service during an encounter. When both services are medically necessary, however, you can report an extended ophthalmoscopy on the same day as a minor procedure or other service.

CPT classifies extended ophthalmoscopies as special ophthalmologic services. "According to CPT 2008, these special ophthalmologic services may be reported in addition to general ophthalmologic services or E/M codes," Root says.

"Often the extended ophthalmoscopy is what determines if a minor or major procedure is necessary." You can therefore report 92225 and 92226 within the global period of another procedure as well, if the documentation proves medical necessity.

Consider this example from Gibson: An established patient with a history of eye trauma presents after being hit in the eye with a soccer ball. She complains of slightly blurred vision (20/30) and a general soreness around the left eye. A dilated retinal exam shows a whitish area of retinal edema superior to the macular area. The OD documents the area of edema with extended ophthalmoscopy and orders an OTC to further evaluate the macular edema.

In this instance, you should report an EO code. On the claim, include the following:

- 92014 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits) for the general exam

- 92225-LT (Left side) to represent the EO

- 92135-LT (Scanning computerized ophthalmic diagnostic imaging, posterior segment [e.g., scanning laser] with interpretation and report, unilateral) for the OTC

- 362.83 (Retinal edema) linked to 92014, 92225 and 92135 to prove medical necessity for the encounter.

Skip 25: In many cases, you need to append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M or eye service code when

you are reporting a code for a minor procedure performed during the same visit. You do not need modifier 25, however, when reporting 92225-92226 with 99201-99215 or 92002-92014, Root says.