Codify
BY AAPC

Optometry Coding & Billing Alert

Make A-Scan Coding As Easy As 1-2-3 With These Expert Tips

Caution: Bilateral modifiers may not be appropriate

When you see words such as -ultrasound,- -mode- or -biometry- in your optometrist's documentation, you should automatically start thinking of coding an A-scan. But if you don't know the difference between the two types of scans or which terms apply, you-re bound to select the wrong code and set yourself up for denials.

The slight nuances between code descriptors determine whether a code applies. They also govern the rules for reporting the scan if it's bilateral. -Scans have always been a big problem for us billers,- says Brenda Arendt, CMC, of the Center for Total Eye Care in Westminster, Md.

You have several codes to choose from, including the following diagnostic ultrasound codes:

- 76510--Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter
- 76511--- quantitative A-scan only
- 76512--- B-scan (with or without superimposed non-quantitative A-scan)
- 76513--- anterior segment ultrasound, immersion (water bath) B-scan or high-resolution biomicroscopy
- 76516--Ophthalmic biometry by ultrasound echography, A-scan
- 76519--- with intraocular lens power calculation
- 92136--Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation.

Differentiate A From B

Your first step in determining the coding choice is to break the ultrasound codes down into two categories: A-scans and B-scans.

A-scan technology implies a one-dimensional measurement procedure; B-scan implies a two-dimensional procedure. Your optometrist might use A-scans to differentiate between various intraocular tumors, to measure tumor size, or to differentiate other types of intraocular and orbital pathology.

Don't Fret Over Bilateral Scans

If your optometrist performs an A-scan on each eye, you-ll need to consider appending a bilateral modifier to the correct code.

Select a modifier: Before you decide between modifier 50 (Bilateral procedure), LT (Left side), and RT (Right side) for a given claim, you should consult the Medicare

Physician Fee Schedule.

You-ll see that codes 76510, 76511 and 76513 all have a modifier indicator of -3.- This means that the usual payment adjustment for bilateral procedures does not apply to that code. Therefore, you should report the procedure bilaterally using the appropriate modifier and expect to be paid the full amount for each side.

Code 76516 has a modifier indicator of -2,- which means that the code already specifies a bilateral procedure, so you should not append a modifier to denote a procedure's bilateral nature. Therefore, if the optometrist performs these tests

on both eyes, you should report a single unit of the procedure code, with no modifiers appended. The insurer will make no payment adjustment for a bilateral procedure.

Codes 76519 and 92136 also have a modifier indicator of -2---but it applies only to the technical component (TC) of the service, says **Maggie M. Mac, CMM, CPC, CMSCS**, consulting manager for **Pershing, Yoakley & Associates** in Clearwater, Fla.

However, the professional components (76519-26 and 92136-26) have a modifier indicator of -3,- which means the optometrist's interpretation is unilateral. Therefore, you should code the professional component individually for each eye (76519-26-RT and 76519-26-LT, or 76519-26-50; 92136-26-RT and 92136-26-LT, or 92136-26-50).

Note: Many commercial carriers -still do not recognize modifier 26,- Arendt says. Be sure to ask your carriers which modifiers they prefer and recognize.