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Optometry Coding & Billing Alert

Make the Mo$t of Your Claims for Fundus Photography

At the very least, you want to avoid fraud charges. At most, you want to get every penny your practice deserves. You can do both by learning Medicare's and private carriers' specific policies regarding billing for fundus photography (FP).

Fundus photography, 92250 (Fundus photography with interpretation and report), is a common procedure that a technician performs using a fundus camera attached to an ophthalmoscope, which is aligned to view the back of the eye. Pictures are then taken of the optic nerve head, vitreous, macula, retina and its blood vessels to document any present pathology.

Locate the Correct Code

You can find 92250 in the CPT special ophthalmological services section, which is a compilation of services that practices may report for Medicare and some other insurance companies in addition to the general ophthalmological services (92002-92014) or E/M services (99201-99499).

The majority of codes in the special ophthalmological section are for diagnostic tests, e.g., 92083 (Visual field examination, unilateral or bilateral, with interpretation and report; extended examination [e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2]), 92135 (Scanning computerized ophthalmic diagnostic imaging [e.g., scanning laser] with interpretation and report, unilateral), and 92235 (Fluorescein angiography [includes multiframe imaging] with interpretation and report).

Check Whether Carriers Consider FP Unilateral or Bilateral

When billing for a procedure performed on both eyes, the coder must know whether the payer considers the code unilateral or bilateral. If the code is unilateral, the coder must bill it twice, or the practice will lose revenue unnecessarily. If the code is bilateral, bill it only once, or the practice may be found guilty of fraud, especially if the practice has a pattern of billing bilateral codes twice.

In reality, the optometrist would perform a visual field test on just one eye when the patient has only one eye or is sighted in only one eye. For example, when performing visual field testing on a patient who has had an enucleation, bill 92081, 92082 or 92083 - just as you would for a patient with both eyes.

CPT states that the service is "unilateral or bilateral," but some coders append modifier -52 (Reduced services) to the visual field code when the procedure is done on one eye only. Many commercial payers, however, may consider fundus photography to be unilateral. If your commercial payer says 92250 is unilateral, list the code twice and append modifier -50 (Bilateral procedure) to the second line item, if performed bilaterally, for an extra fee.

Use FP to Diagnose and Document

Though optometrists use fundus photographs to diagnose certain eye conditions, they more often use them to document a disease process or a diagnosis the OD has already observed. As a result, many optometrists do not comply with the interpretation-and-report component of the code.

Optometrists use fundus photography to document what the optometrist has seen upon his or her physical examination of the patient, says **Lise Roberts**, vice president of Health Care Compliance Strategies, a coding, reimbursement and compliance consulting company based in Jericho, N.Y.

"The optometrist orders fundus photography so that at a later time a subsequent photograph can be taken and used as a comparison to the initial photograph. This assists the optometrist in judging any progression in the disease process that may have taken place between examinations."

However, fundal photography is not merely a glorified ophthalmoscope. "The value of fundus photography is for longitudinal analysis of the progress of a disease and should not be performed unless the patient has a disease that warrants it," Roberts says. "Otherwise, it is not generally medically necessary to do more than one a year. The frequency has to be medically justifiable."

As always, when a code such as fundus photography specifies that an interpretation and report is included, you must document the report for each eye in the chart, indicating that the optometrist interpreted the photograph or other testing service for each eye. If the report is the same for each eye, write it once and indicate that it applies to both eyes.

Understand Fluorescein Angiography's Role

Fluorescein angiography is another diagnostic test, but optometrists use it to document the status or progression of the disease process and as a diagnostic tool to reveal the functioning of the vasculature of the eye (such as leakage that cannot be seen on direct examination), Roberts says.

Coding for fundus photography and fluorescein angiography (FA) tends to be confusing to coders because the optometrist's documentation usually doesn't separate them clearly as individual procedures.

You may also find the eye modifiers, -RT and -LT, useful when billing commercial carriers. "We bill the fluorescein angiography with the -RT or the -LT modifier," says **Brenda Arendt** of the Center for Total Eye Care in Westminster, Md., "and if we do the photos the same day, we bill that, and then we bill the office visit with the -25 modifier (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service)."

You Must Show Medical Necessity

The main reasons for denial of these two procedures are lack of supporting documentation and the absence of medical necessity. Documentation for both FA and fundus photography should include the optometrist's initials and dated photographs - this is in case of an audit. In addition, the optometrist must document an interpretation for both the fundus photography and the FA.

Most optometrists already do this for the FA, but many neglect to do it for fundus photography because it seems redundant to them.

Coders often make the mistake of disregarding the crucial element of interpretation and report because fundus photographs are frequently considered documentative, not diagnostic.

Coders should also be aware that Medicare and most other payers consider fundus photography a "bilateral code." When a service is considered "bilateral," the payment for the service has been valued for both eyes. Therefore, the bilateral modifier, -50, does not apply when photos are taken of both eyes.

Coders often mistakenly apply the bilateral code to fundus photographs when taken in conjunction with fluorescein angiographs because fluorescein angiography is considered a unilateral procedure.

Be Specific About 'Technical' and 'Professional'

Proper use of modifiers representing the technical component (taking the photograph) and the professional component (physician interpretation of the results) in 92250 is critical to report the procedure correctly.

One way to bill fundus photography and other diagnostic tests is to bill the technical component (92250-TC) and the professional component (92250-26) separately. If you report 92250 without any modifier, you indicate to the carrier that

the optometrist completed both the technical and professional components of the service.

Because the optometrist does not always complete the interpretation-and-report segment of the service immediately, you will often need to separately report the components of 92250. You can then report the technical component when the photos are taken or the technical part of the service is performed: 92250-TC.

Later, you can report the professional component when the interpretation-and-report segment has been documented in the medical record: 92250-26. Remember that if you perform only the interpretation and do not take the photographs, you should code only for the professional component, not the technical component. That situation may occur when two providers perform separate parts of the service.

An optometrist who is referring a patient to a sub-specialist will often include a copy of a testing service that has already been performed to assist the subspecialist in evaluating and treating the patient. In this case, the sub-specialist should not report his or her review of the test, even if the optometrist documented an interpretation of the test within that visit. The review of the test in that example would count toward the level of medical decision-making performed as part of the E/M service.

Tip: Check Fee Schedule for Bilateral Codes

Medicare considers most CPT codes in the ophthalmology section unilateral, but some are bilateral.

Check the Medicare Physician Fee Schedule Database to determine a code's "bilateral indicator." A bilateral indicator of "0" means the 150 percent payment adjustment does not apply and the code covers payment for one eye only. If surgery is performed on both eyes, you must bill the unilateral code twice. Most Medicare carriers allow you to append modifier -50 (Bilateral procedure) to the code on a single line item. If the status is bilateral, the fee is the same whether the procedure is performed on one eye or both.

The American Academy of Ophthalmology's Web site (www.aao.org) is the best resource for determining the bilateral status of any code, but if you aren't an AAO member, you can go to the CMS Web site and perform a search for the database at http://www.cms.gov/physicians/mpfsapp/default.asp.