Optometry Coding & Billing Alert

Myth Buster: Reporting Extended Ophthalmoscopy Bilaterally? Read This First

Learn the truth behind these common EO misconceptions and earn $23 per procedure

It's a common procedure, performed thousands of times each year in optometry offices - but coding and billing for extended ophthalmoscopy is hardly straightforward. Misconceptions about EO can be costly: The procedure pays about $23 each time (based on unadjusted RVUs), so mistakes can add up. Read on to see if one of the following EO myths could be taking money out of your practice's pockets.

Many optometrists aren't clear on when it's appropriate to report 92225(Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial) or 92226 (...subsequent).

Myth #1: EO is inherently unilateral; carriers will pay twice the fee schedule amount for one eye if you report EO bilaterally.

Reality: Carriers will not pay double for bilateral EO unless you can justify medical necessity for performing EO on both eyes. If you've diagnosed a problem in one eye, don't assume the other eye has the same diagnosis - although chances are it will, says **David Gibson, OD, FAAO**, a practicing optometrist in Lubbock, Texas. You must report ICD-9 codes showing medical necessity in each eye you performed EO on. The diagnoses don't have to be different for each eye, but they do have to demonstrate medical necessity for the EO.

Check with your carrier for ICD-9 codes they accept as proving medical necessity - and for their rules for reporting bilateral procedures. Some want you to report the procedure on one line with modifier -50 (Bilateral procedure) appended; that would work best if both eyes do in fact have the same diagnosis. Other carriers will direct you to report two units of service with modifiers -LT and -RT appended to each code to signify the left and right eyes, says **Tawnya Shanklin**, billing manager at Medical Eye Associates in Waukesha, Wis.

Myth #2: You can't report EO on the same day as a comprehensive eye exam.

Reality: Routine ophthalmoscopy is included in a comprehensive eye exam (92004 and 92014), Shanklin says, but according to the National Correct Coding Initiative, EOisn't. CPT codes 92225 and 92226 are not bundled into 92004 or 92014, as of the latest set of NCCI coding edits.

You might still see denials, however. Some carriers have a long-time edit in place not to pay for extended ophthalmoscopy when billed with 92014. If this is the case in your area, you will either need to bill the services and end up in the review and appeal process proving medical necessity or select the intermediate-level eye code or E/M code instead of the comprehensive eye code.

"Usually, if they're having the EO, it's because of some kind of medical problem," Shanklin says. Since many carriers view the eye codes as strictly appropriate for vision-related examinations, Shanklin relies on the E/M codes, which are more associated with medical problems.

Myth #3: You must submit the retinal drawings with the EO claim.

Reality: The drawing stays in the file, where it is available upon request to the carrier, says **Deb Zipay, CPC**, revenue cycle coordinator for the UMPC Eye Center at the University of Pittsburgh Medical Center. But make sure you know your carrier's guidelines for the drawings, she says. Most carriers insist that the drawing "must reflect the individual patient's

anatomy, be anatomically correct, and portray any pathology present."

The drawing must be either three-dimensional or color-coded. If the drawing is color-coded, 4-6 "standard colors" must be used. Not all carriers specify a minimum size for the drawing; those that do prefer a drawing of 3-4 inches in diameter or larger. Most optometrists who perform extended ophthalmoscopies are already trained in the most detailed ways of color-coding retinal drawings.

Myth #4: Only the first EO ever done on a patient can be reported with 92225; any others after that one must be reported with 92226.

Reality: Just because a patient has had an initial extended ophthalmoscopy does not necessarily mean that all EOs performed after the initial 92225 are "subsequent" and require 92226.

Example: A patient presents seeing flashes, and an initial EO reveals posterior vitreous detachment. Eight weeks later the patient returns for an additional EO - billable with 92226 - that reveals no worsening of the condition. But two weeks later the same patient returns, this time complaining of floaters and flashes. Code the third EO 92225 because the patient is complaining of a new problem, Zipay says.

Exception: If a patient with diabetic retinopathy presents for a consultation, you perform an initial EO (92225), and the patient returns annually for additional EO checkups, you should code all of the subsequent extended ophthalmoscopies with 92226, Zipay says.

If you perform EO during the postoperative period of a surgical procedure, carriers may include it in the global package and not pay for it separately, unless you have documented evidence that you performed the EO for a reason unrelated to the condition for which the patient had surgery. In those cases, code the postoperative EO with modifier -79 (Unrelated procedure or service by the same physician during the postoperative period) appended, in addition to the site modifiers, -RT and -LT.

Myth #5: A diagnosis of diabetes or hypertension is enough to establish medical necessity for EO.

Reality: Those diagnoses are not within the scope of optometry. As an optometrist, you may establish the presence of a diagnosis of diabetes in the case history and document the fact that certain signs of the disease are present, but you will not make the diagnosis of diabetes.

To prove medical necessity for EO, you have to code the ocular manifestations of those diseases, e.g., retinal hemorrhage (362.81) or hypertensive retinopathy (362.11). "Diabetes alone doesn't necessitate doing 92225, so the presence of the hemorrhage or retinopathy is needed," Gibson says.