Optometry Coding & Billing Alert

Part I: Get to the Basics on Diagnostic Test Coding

From refractions to EO, read on for a refresher of the general rules and guidelines for ophthalmic tests.

More than half of all eye exams and consultations on Medicare beneficiaries are accompanied by an ophthalmic test such as refraction, gonioscopy or A-scan biometry, says **Becky Shimanek, CPC,** coding manager for Aviacode, who led a seminar on "Ophthalmic Diagnostic Tests" at the recent CodingCon 2015 conference.

"Overall, the single most frequent ophthalmic test, without regard to the source of payment, is refraction (CPT® code 92015)," she says. "The most frequently reimbursed test ... is scanning computerized ophthalmic diagnostic imaging (SCODI, CPT® code 92135), which continues to increase among Medicare patients."

What's included in a visit code?

According to Shimanek, services that are commonly included in an office visit include:

- Snellen acuity
- Lensometry
- Amsler grid
- Maddox test
- Tonometry
- Ophthalmoscopy
- Retinoscopy
- Corneal sensation
- Confrontation visual fields
- Ishihara plates
- Exophthalmometry
- Keratometry
- Glare test
- Potential acuity meter (PAM)
- Brightness acuity test (BAT)
- Schirmer's tear test
- Laser interferometry
- Phacometry

These services usually cannot be coded separately from an E/M code or an eye code from the 92002-92014 series, Shimanek says.

What documentation is required in the medical record?

First of all, the record must include any photos, scans, or other hard copies as proof that the test or tests were performed, Shimanek says. In addition, the documentation should contain:

- An order for the test with medical rationale
- The date of the test
- The reliability of the test (e.g., patient cooperation)
- The test findings
- A diagnosis, if possible
- The impact on treatment and prognosis

- Signature of the physician.

Why might your claim be denied?

There are several errors that can torpedo your claim, says Shimanek. Some of the most common include:

1. Testing being done for non-covered indications or lacking medical necessity.
2. Not following insurance frequency guidelines. Rules vary by local carriers, Shimanek warns, so be sure to seek guidance from your local carriers.
3. Inappropriate bundling of services. Always check the Correct Coding Initiative (CCI) edits to make sure that Medicare (and carriers that follow Medicare rules) will allow two codes to be reported separately.
4. The use of invalid or inappropriate modifiers.
5. Incomplete reports, especially if the CPT® descriptor of the diagnostic test includes the phrase "with interpretation and report." See the list above for items to include in the documentation.

What are the levels of supervision for different diagnostic tests?

Check the Medicare Physician Fee Schedule Database for the supervision indicators that describe what Medicare requires for each specific test (look for the column labeled "Physician Supervision of Diagnostic Procedures").

General supervision: Supervision indicator 1 indicates "general supervision," which means that the test "can be performed under the general supervision of a physician," according to Medicare. The physician maintains overall direction and control of the procedure but his presence is not required. In other words, the physician must order the diagnostic test but does not need to be in the office when the technician performs the test. He must, however, be available by telephone.

According to Shimanek, diagnostic tests that fall under general supervision rules include:

- Perimetry
- Fundus photography
- External ocular photography
- Scanning computerized ophthalmic diagnostic imaging
- Extended color vision testing
- Dark adaptation exam
- Visual evoked potential (VEP) done by certified tech
- A-scan biometry
- Specular endothelial microscopy and cell count
- Pachymetry.

Direct supervision: Supervision indicator 2 indicates "direct supervision." The physician must be present in the office suite and immediately available to furnish assistance and direction. The physician does not have to be in the room where the test is being performed, however. Tests requiring direct supervision include, according to Shimanek:

- Fluorescein angiography
- ICG angiography
- A-scans (for tumors)
- Immersion B-scan, high-resolution biomicroscopy
- Contact B-scan
- Visual evoked potential (VEP) done by non-certified tech
- Electro-oculography (EOG)
- Electroretinography (ERG).

Personal supervision: Supervision indicator 3 indicates personal supervision the physician must be in attendance in the room during the procedure. Among the ophthalmology codes, only 92265 (Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report) now requires personal supervision, says Shimanek.

Note: Check Optometry Coding and Billing Alert's next issue for Part II, which will address the coding rules and guidelines for specific diagnostic tests.