Codify
BY AAPC

Optometry Coding & Billing Alert

Reader Question: 92225-92226: Apply Initial EO Code to New Condition

Question: I'm confused about the extended ophthalmoscopy codes. Is 92225 for a new patient and 92226 for an established patient? Should I bill twice for both eyes?

California Subscriber

Answer: The extended ophthalmoscopy (EO) codes, 92225 (Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial) and 92226 (... subsequent), don't correspond to new and established patients. CPT® does not intend for 92225 to be a one-time-only code, only to be used with new patients. Rather, report 92225 for the initial EO associated with new symptoms of a nonchronic condition for each eye.

Example 1: The optometrist sees a patient complaining of flashes and floaters in the right eye. He performs an initial EO (92225-RT), finding post vitreous detachment. He asks the patient to return in six weeks. At that visit, he performs a subsequent EO (92226-RT). A few weeks after that, the patient returns, now complaining of flashes and floaters in the left eye. Since this is a different eye and an initial EO was not performed, report 92225-LT.

Example 2: A physician refers a diabetic patient to your office for a consultation. The patient has diabetic retinopathy, a chronic condition. At the first appointment, the optometrist performs an initial EO (92225-50). He asks the patient to return in a year for a dilated exam, at which point he performs a subsequent EO (92226-50). He returns again in another year for another subsequent EO (92226-50).

Medicare reimburses both 92225 and 92226 unilaterally, which means that if the optometrist performs EO on both eyes, including the drawing and report, you can report the codes bilaterally and receive twice the payment you would have gotten for one procedure. Append modifier 50 (Bilateral procedure) or modifiers LT (Left side) and RT (Right side) to indicate the bilateral performance of the procedure.

Medicare may also have very specific policies about the requirements for these drawings. In most cases, you should have documented drawings that are 3-4 inches, using 4-6 standard colors with findings that are labeled. In addition, if a patient has glaucoma, the record should have a separate drawing with the optic nerve detailed.

Crucial: Before an optometrist performs an extended ophthalmoscopy, the medical record must support documentation of having performed a general ophthalmoscopy with findings that are indicative of medical necessity to perform the extended test. A general ophthalmoscopy is included in the eye examination and not separately billable. However, reporting an extended ophthalmoscopy without the general exam and subsequent need to perform the extended exam would likely trigger a denial or recoupment of monies following an audit.

Watch for: Occasionally, it may be necessary to append modifier 79 (Unrelated procedure or service by the same physician during the postoperative period) to 92226, as this code is not considered "diagnostic," if performed during a post-op period for an unrelated diagnosis.

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