Codify
BY AAPC

Optometry Coding & Billing Alert

Reader Question: 92226 Requires Proof EO Is Actually Extended

Question: I just got a denial on 92226. I think I might be using this code incorrectly. Can you explain what it's for and when I can code it?

Missouri Subscriber

Answer: Your optometrist likely performs some form of ophthalmoscopy during any general exam. But you should use 92225 (Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial) and 92226 (... subsequent) to report the service only when the provider does an extended ophthalmoscopy (EO).

Key: Your provider is responsible for documenting the encounter and proving that an EO is medically necessary and reimbursable. A reimbursable EO is one that generates information the optometrist could not have attained through other means (such as a view of the peripheral retina obtained by scleral depression versus indentation), experts say. Carriers will also reimburse EO when the test generates information that affects or determines the patient's treatment plan.

Example: A physician refers a patient to your office for a consultation. The patient has been complaining of floaters. During the first appointment, the optometrist performs an initial EO (92225) and diagnoses the patient with postvitreous detachment. He asks the patient to return in six weeks, at which point he performs a subsequent EO (92226). The patient returns again in another year for a subsequent EO (92226).

Bilateral options: Medicare reimburses both 92225 and 92226 unilaterally, which means that if the optometrist performs EO on both eyes, including the drawing and report, and proves medical necessity, 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), depending on carrier preference, to indicate the bilateral performance of the procedure.

Watch for: Occasionally, you may have to append modifier 79 (Unrelated procedure or service by the same physician during the postoperative period) to 92226 because carriers don't consider this code "diagnostic" if the provider performs the service during a post-op period for an unrelated diagnosis. Check with your carrier for specific documentation requirements for EO because some may specify size of drawing, use of primary colors, and labeling of drawing details.