Optometry Coding & Billing Alert

Reader Question: One-Two Punch for Ophthalmoscopy Coding

Question: How should I bill for an extended ophthalmoscopy (92225-92226)? Is one code for a new patient and the other for an established patient? Should I bill twice for both eyes?

California Subscriber

Answer: Unless your Medicare carrier has a local medical review policy (LMRP) that says you can bill 92225 (Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial) only one time, these codes refer to "initial" and "subsequent" patients rather than "new" and "established."

The CPT principle behind this language comes from coding for inpatient hospital visits: When a recurrence of a condition requires hospitalization, coders may use the initial hospital visit code again for the new admission.

CPT does not intend for 92225 to be a one-time-only code. You should use 92225 for the initial extended ophthalmoscopy (EO) of new symptoms of a nonchronic condition, such as new flashes and floaters.

Example #1: You see a patient for a complaint of flashes and floaters and perform an initial EO (92225). You find postvitreous detachment and ask the patient to return within six weeks.

At the subsequent visit, you perform an additional EO (92226, ...subsequent). You find that the retina is intact and educate the patient about retinal detachment.

A few weeks later, the patient asks for a new appointment because she sees a spider web and new flashes, and you must perform another EO. Bill this as 92225 because it is a new event.

Example #2: A physician refers a diabetic patient to you for a consultation. The patent has diabetic retinopathy, a chronic condition. At the first appointment, you perform an initial EO (92225).

You ask the patient to return in a year for a dilated examination. In a year, you perform a subsequent EO (92226). You do the same thing the following year, and again bill 92226, and so on.

Codes 92225 and 92226 are unilateral codes in the Medicare program.

If it is medically necessary to perform the procedure in both eyes, and you perform the drawing and report for both eyes, you can choose one of two coding options:

1. 92225-50 (Bilateral procedure) as a single-line bill,
   or
2. 92225-RT (Right side) and 92225-LT (Left side) on two lines.

Rarely, a carrier will want units, so check with your carrier for any unit requirements.

Be sure your documentation of medical necessity supports billing bilaterally.

CPT® 2023 American Medical Association. All rights reserved.

Codify
BY AAPC

CPT® 2023 American Medical Association. All rights reserved.