Codify
BY AAPC

Optometry Coding & Billing Alert

Reader Questions: Read This Before Billing Separately for EO

Question: A patient reports flashes and floaters but the optometrist does not find evidence of retinal pathology on routine ophthalmoscopy. Are we justified in billing for extended ophthalmoscopy (EO)?

Kansas Subscriber

Answer: If the ophthalmoscopy is a routine part of a patient's eye exam, do not bill for it separately.

However, complaints of flashers and floaters are always serious and must be evaluated carefully; often, these symptoms will justify extended ophthalmoscopy (92225, Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial).

Use 92225 to report a Goldmann-3 exam (examining the retina with a three-mirror goniolens). Remember to provide your formal interpretation and report of the findings in the patient's medical record.

In many cases in which flashers and floaters are present, extended ophthalmoscopy (EO) combined with a retinal exam shows vitreous degeneration or posterior vitreous detachment (379.21, Vitreous degeneration). If an optometrist does not see anything in the routine ophthalmoscopy, he will probably not do an EO.

In the unlikely event that the optometrist doesn't find any significant problems with the retina after the EO, link 92225 to 379.24 (Disorders of vitreous body; other vitreous opacities). "Vitreous floaters" appears in a note under that code in the ICD-9 manual. If the optometrist does not see floaters, look to the 368.1x series (Subjective visual disturbances).

However: If the optometrist can't see anything more with an EO than he can see with a routine ophthalmoscopy, defending the use of the EO may be difficult. Some experts recommend not billing for an EO unless there is some abnormality of the retina or vitreous to draw in the report.