

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 92082 or 92083? Choose Wisely With This Expert Strategy

With over \$70 on the line, don't risk submitting the wrong code or inadequate documentation.

Even small ophthalmology practices are likely to have a Humphrey visual field analyzer, yet many ophthalmologists don't know the secrets for securing adequate reimbursement for these services -- and they even go so far as to put themselves at risk for costly audits due to lack of documentation.

Stop Shortchanging Yourself With Intermediate Codes

CPT lists three different visual field examinations -- and the higher the code, the higher the reimbursement.:

- 92081 -- Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, Autoplot, arc perimeter or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
- 92082 -- ... intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
- 92083 -- ... extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2 or 30/60-2).

Pitfall: A common mistake ophthalmologists make is billing 92082 when they could legitimately bill 92083.

The key to choosing the correct VF code is in the code descriptors themselves. For example, if the ophthalmologist plots only two isopters on the Goldmann perimeter, CPT would call that "intermediate," based on its description of 92082. If you plotted three isopters, however, that would be an "extended" examination that would qualify for 92083.

Rule of thumb: An intermediate test is one of the screening tests that you would use if you suspect neurological damage. But ophthalmologists use the threshold exam (92083) when they suspect something that causes a slow, progressive dimming of peripheral vision, like glaucoma. Glaucoma causes a loss of vision like a light bulb slowly becoming dimmer and dimmer, while trauma often causes sudden, complete loss of central or peripheral vision. In screening fields, you are testing whether the retina is "on or off," while in threshold testing you are testing "how dim a light you can perceive."

"The bottom line is to document medical necessity for the level of visual field testing that is ordered," says **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE**, Director, Best Practices-Network Operations at Mount Sinai Hospital in New York City.

Document Now to Stop Headaches Later

When you send in a CMS-1500 form, Medicare only sees the front part of the form. What Medicare doesn't see is what's on the other side of that form, which is your documentation. They assume that your documentation is correct until they do an audit.

If Medicare does an audit and finds that your documentation is not in order, you could find yourself having to pay them back for all the claims they find problems with. That's why it's important to carefully document the medical necessity of the visual field exam in the patient's medical record and the workup findings that were performed and led a physician to suspect a diagnosis, thereby ordering the diagnostic testing, notes Mac.

Following the diagnostic testing, one of the areas ophthalmologists are weak in is the "interpretation and report" portion of several codes, experts say. Code 92083 provides one example: Your record of a visual field states, "Informed patient test for OD showed small area we need to watch; have return in three months." In a postpayment audit, Medicare will not accept this as an adequate interpretation of the test results and complete report to support the billing. Why? "Interpretation and report" requires assessment of both eyes.

Remember: All three visual field codes have a technical and professional component, notes **David Gibson, OD, FAO**, a practicing optometrist in Lubbock, Texas. When you bill 92083, you are telling Medicare you performed both the technical component (indicated by modifier TC) and the professional component (modifier 26). It's best to have a form just for visual fields, in addition to your regular notes.

Overkill? Not at all, stresses Mac. "A formal report is required whenever the professional component of diagnostic services are billed. And in the case of an audit, such a form will be necessary to support the work performed by the physician which constitutes formal documentation of an interpretation and report."