Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Make Sure Your Extended Ophthalmoscopy Claims Stand Up to Audits

Review this FAQ and get to know some of the common extended ophthalmoscopy tripping points.

Coding experts agree that extended ophthalmoscopy claims are among the most heavily audited. Most eye exams will include some sort of ophthalmoscopy, but payers are prone to consider them part of the general ophthalmic exam or E/M code.

There are cases, though, where you're justified in reporting EO separately. Our experts provide answers to the following frequently asked questions to make sure you're not missing out on EOs you could rightfully report.

Question 1: When does ophthalmoscopy qualify as "extended"?

Answer: Any general ophthalmic examination will include a routine ophthalmoscopy. But an extended ophthalmoscopy is a special ophthalmologic service that goes beyond the general eye exam.

Caution: The general ophthalmic examination codes (92002-92014) already include the routine ophthalmoscopy, so you should not report routine ophthalmoscopy (which can include a slit lamp examination with a Hruby lens or direct ophthalmoscopy for fundus examination) separately with 92002-92014.

When an initial exam uncovers a serious retinal problem, retinal specialists then turn to extended ophthalmoscopy (92225, Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial; and 92226 ... subsequent) for a more detailed examination.

Consider this example: An obese female patient presents with headaches, slightly reduced vision in her right eye, vague complaints of soreness and variable blur. A routine ophthalmoscopy shows an elevated disc, so the optometrist decides to perform EO with a Volk 78 lens (although the definition of EO does not refer to any particular type of lens, notes **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas). The EO reveals papilledema.

On this claim, report the following:

- 92225 for the EO
- Modifier RT (Right side) appended to 92225 to show that you are only billing for the patient's right eye
- 377.00 (Papilledema, unspecified) linked to 92225 to prove medical necessity for the EO.

Question 2: What documentation do we need?

Answer: For an initial extended ophthalmoscopy exam, use 92225, and for all subsequent exams on the same eye, use 92226, as the code descriptors indicate. "It is possible to have charges for an EO done for the first time on one eye and an EO done subsequent to a previous encounter on the other eye," notes **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE,** AHIMA-approved ICD-10 CM/PCS trainer and president of Maggie Mac-Medical Practice Consulting in Clearwater, Fla. "Thus, the coding may look like this: 92225-LT and 92226-RT."

While standard documentation will be sufficient for your routine ophthalmoscopy claims, you'll need more notes to back up your EO claims. EO is a detailed, extra, separate procedure requiring additional documentation with interpretation and report.

The documentation should include the reason the optometrist performed an extended exam as well as the procedure he

used.

Also include a drawing of the area on the fundus in question (like the disc). A color drawing, even with just red and blue colored pencils, would be best, but it is not required by every carrier. If you have any documentation concerns on your EO claims, check your payer contract or call the payer before filing. Some payers have specific requirements on the size of the drawing and colors that must be used with a detailed drawing and findings labeled.

Question 3: Can we bill bilaterally?

Answer: While you're unable to report most of the other ophthalmic testing codes in the 92xxx series bilaterally, you can report 92225 and 92226 for each eye if there is a medically necessary reason.

EO is a unilateral procedure. Although CPT® doesn't specifically describe the procedure as unilateral in the code descriptor, most insurers follow Medicare's lead. You can find the bilateral surgery indicators in the fee schedule. Check column Z of the database, marked "Bilat Surg." The fee schedule assigns 92020 a bilateral surgery indicator of "3," which means that Medicare has set the relative value units (RVUs) for gonioscopy based on the optometrist performing the procedure unilaterally. If there is a problem with both eyes, you can report the service for both eyes. Depending on insurer preference, report bilateral EOs with either:

- 92225-50 (Bilateral procedure) or
- 92225-RT (Right side) and 92225-LT (Left side).

Prove it: Don't assume both eyes have the same diagnosis.

You must report ICD-9 codes showing medical necessity in each eye you performed EO on. Consult your carriers' local coverage determinations for diagnosis codes that support medical necessity.

Question 4: What other services are reportable?

Answer: There are many times when you have to shy away from reporting more than one service during an encounter. When both services are medically necessary, however, you can report an extended ophthalmoscopy on the same day as a minor procedure or other service.

CPT® classifies extended ophthalmoscopies as special ophthalmologic services. According to CPT® 2010, these special ophthalmologic services may be reported in addition to general ophthalmologic services or E/M codes.

Often the extended ophthalmoscopy is what determines if a minor or major procedure is necessary. You can therefore report 92225 and 92226 within the global period of another procedure as well, if the documentation proves medical necessity.

Consider this example: A new patient presents for a routine eye exam with no significant complaints except a diagnosis of type II diabetes. Her last exam was 18 months ago and she does not recall being told of any ocular complications of her diabetes. The exam reveals dot/blot hemorrhages and exudates in both eyes, but the right eye is worse. The optometrist documents the areas of disease in both eyes and orders an OCT (92134, Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina) of the macula to further evaluate the macula since some of the exudates superior to the macula could be affecting macula integrity.

But wait: Why do an EO in this case instead of fundus photography (92250)? "Medicare and some private carriers will not pay for OCT and fundus photos in the same visit due to (the insanity of) the CCI [Correct Coding Initiative] which prevents so-called duplicate procedures," explains Gibson.

In this instance, you should report the EO codes. On the claim, include the following along with your EO codes:

- 92014 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits) for the general exam

- 92225-LT (Left side) to represent the EO
- 92134 for the OTC
- 362.83 (Retinal edema) linked to 92014, 92225, and 92134 to prove medical necessity for the encounter