INTRODUCTION

Coding and billing for diagnostic testing is a major part of ophthalmic practices in general, but more so in some of the subspecialties such as glaucoma and retina. Many physicians are not sufficiently aware of Medicare’s regulations that guide the reimbursement of these tests and are frequently surprised when monies must be paid back under audit. We will try to outline these for you so you can improve your documentation and pass these audits.

Medicare billing for diagnostic tests is often fraught with technicalities that must be mastered in order to optimize reimbursement while maintaining legitimacy and compliance. The descriptions of most diagnostic tests used in ophthalmology are found in the Medicine section of CPT (Current Procedural Terminology) under the section entitled “Special Ophthalmological Services”. A few others, such as ophthalmic ultrasound (radiology section) and Doppler studies (cerebrovascular arterial studies) are found elsewhere in the Medicine section. The area of commonality is that all these tests have both a professional and technical component, the exception being those tests considered solely a physician service such as gonioscopy and extended ophthalmoscopy.

CHARACTERISTICS OF DIAGNOSTIC TESTS (Table1)

Professional/Technical Components. The global fee for diagnostic tests has two components: the professional portion and the technical portion. CMS (Centers for Medicare and Medicaid Services) has indicated that there are three types of services that have both a professional and technical component: (1) diagnostic and therapeutic radiology services; (2) certain diagnostic tests that involve a physician’s interpretation; (3) physician pathology services.

For diagnostic services, the physician’s professional service is separable from the technical component of the test. This means that the professional diagnostic service is not so integrally related to the performance of the test so as to make separation a practical impossibility. This portion is based on the RVU’s (relative value units) determined by three factors- work RVU, practice expense RVU, malpractice RVU - in much the same fashion as the RVU’s for office visit/consultation codes. However, the practice expense portion for the professional component is based on direct costs such as supplies, equipment, and clinical staff whereas the technical component is based totally on indirect costs of practice expense such as overhead, administrative staff and general expenses encountered in running an office.

The technical component is often misunderstood. In practical terms one may bill for the technical component of a service if one owns the equipment and employs the technician who performs the test. Technical component reflects reimbursement for the staff and equipment costs incurred by the physician, not by a third party such as a hospital or ambulatory surgery center.

Modifier -26 is used to indicate the professional component of a service whereas modifier -TC is used to indicate the technical component. For any given service the
global fee is indicated by just using the procedure code. The professional component +
the technical component = global service or fee.

An example would be CPT code 92235, Fluorescein Angiography. If the
physician owns the equipment and performs the test or employs the person who performs
the examination then the service would be billed as 92235. However, if someone else
owns the equipment and the physician was just giving the professional interpretation,
then the service would be billed 92235-26. On the other hand, if no professional
interpretation were rendered and the patient were sent in just to have the test performed,
then the service should be billed 92235-TC. In this case the right and left side modifiers
would have to be added (RT, LT).

There are certain “diagnostic tests”, such as extended ophthalmoscopy and
gonioscopy, that actually are professional services and do not have a professional and
technical component.

**Interpretation and Report Requirements.** (see Table 2) Most of the special
ophthalmological services have the requirement “with interpretation and report” in the
CPT description of the service.

The presence of a written report in the chart documentation is of paramount
importance when one is audited. I highly recommend that a separate form be used that
leaves an audit trail indicating there is an interpretation and report. This is a particular
problem with digital imaging where, in many instances, the images are reviewed without
the chart, and the physician neglects to provide a written interpretation and report.

What is actually meant by interpretation and report and what has to be performed
to fulfill this requirement? The answer is not well defined in Medicare publications and
not at all in CPT; however, here are some general guidelines gleaned from various
sources.

The Medicare Carriers Manual (§15023) specifies that an interpretation and
report should address the findings, relevant clinical issues, and comparative data (when
available). There must be a written report that becomes part of the patient’s medical
record and this should be as complete as possible.

When teaching how to comply with this requirement I usually like to describe
what must be incorporated into the interpretation and report as The Three C’s.

**Clinical Findings.** The interpretation and report should succinctly summarize
your clinical findings. It does not have to be lengthy - just the pertinent findings. It
should not be scribbled within the body of the examination where it looks like part of the
examination. It should not be scribbled on the back of the test. Auditors will miss it and
you will be challenged.

**Comparative Data.** Medicare always likes to know if something is better, worse
or just the same as before. And this is true for interpretation and report requirements. If
a vitreous hemorrhage has resolved, choroidal neovascularization has progressed, or a
lesion size has changed - then these findings need to be noted.

**Clinical Management.** Documenting the effect of the diagnostic test on your
clinical management is the area that is almost always lacking in the interpretation and
report. Medicare wants to know why they are paying you extra for this test - this
extended ophthalmoscopy, this fluorescein angiography, this fundus photo. You must address how this is going to help you or affect your clinical management. Are you going to change/increase/stop medications? Are you going to recommend surgery? Are you suggesting further diagnostic testing? The answers to these pertinent questions need to be part of your written report.

In retina practices one of the most common errors is not have a separate interpretation and report for each test performed, for example – for both fluorescein angiography and fundus photos.

**Unilateral versus Bilateral Tests.** Many physicians are not aware that certain diagnostic tests are billable for each side and payable at 100 percent of the allowable reimbursement for each side. When applicable, remember that there must be medical necessity for performing the test on each side. The following services commonly used in the retina practice may be billed for each side and paid for at 100 percent of the allowable for each side:

- 76510 Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter
- 76511 quantitative A-scan only
- 76512 B-scan (with or without superimposed nonquantitative A-scan)
- 76513 anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy
- 76529 Ophthalmic ultrasound - foreign body localization
- 92135 Scanning computerized ophthalmic diagnostic imaging
- 92225 Extended ophthalmoscopy, initial
- 92226 subsequent
- 92230 Fluorescein angioscopy
- 92235 Fluorescein angiography
- 92240 Indocyanine - green angiography

For the remainder of the special diagnostic tests, the test is billed one time and includes testing of both eyes or sides.

The determination of the unilateralty of bilaterality of a given test is given in Medicare’s Physician Fee Schedule Data Base.

Keep in mind - if a test is determined to be bilateral, such as fundus photography, and you only perform the test on one eye you must append modifier -52 to the claim to indicate a reduced service was performed. When the value of the test was calculated, it was based on the work et cetera being performed on both eyes.

**Medical Necessity.** There are many intertwining issues between medical necessity and diagnostic tests.

**Unilateral versus Bilateral.** In Medicare terminology (defined by the Medicare Physician Fee Schedule Data Base - MPFSDB) a unilateral test with an indicator of 3 is paid at 100% of the allowable for each side. There should be medical necessity for each test and a correlating diagnosis. This does not necessarily correspond to good medicine. An example: a patient presents with symptoms of flashes and floaters in the right eye. There is only medical necessity for performing extended ophthalmoscopy in the right
eye, even though prudence and good medicine would dictate bilateral testing. If there are no symptoms attributable to the fellow eye then do not bill for the exam for that side.

*Medical Necessity.* There must be medical necessity for the test itself. In the absence of appropriate indications, such as extended ophthalmoscopy, the test becomes ineligible for payment.

*Diagnosis.* Lastly, there must be an appropriate diagnostic reason (and diagnosis) for which a test is ordered. For example, some SCODI (Scanning Computerized Diagnostic Imaging) policies (this code includes OCT) do not incorporate retina diagnoses, in which case you must code for the test using the unlisted code for diagnostic tests 92499.

**MISCELLANEOUS ISSUES**

*Extended Ophthalmoscopy.* Extended ophthalmoscopy remains the most heavily audited codes of all the special ophthalmologic diagnostic tests. I often receive the following question: “What is the difference between codes 92225 and 92226? Should each follow up extended ophthalmoscopy be billed as 92226 even if the patient has not been seen for a while?”

CPT describes the codes as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92225</td>
<td>Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report; initial</td>
</tr>
<tr>
<td>92226</td>
<td>subsequent</td>
</tr>
</tbody>
</table>

Technically, CPT code 92225 is used for the initial encounter for a disease entity and subsequent follow-up extended ophthalmoscopies would be billed as 92226. However, if the patient had not been examined for a while and presented with new symptoms suggesting a different pathological entity, one could use 92225 again. Similarly, if the physician were asked to do a re-consultation for a different problem, 92225 could be used. In practice - particularly since this is so heavily audited, most ophthalmologists use 92226 for all subsequent extended ophthalmoscopies.

Many carriers have Local Coverage Determinations for these services along with coding guidelines. The average requirements are that the drawing must be anatomically specific to the patient, should have a diameter of three to four inches, and some carriers require colours. Other carriers specifically require scleral depression be used, so that needs to be documented and not just assumed. The biggest problem is that if the drawings are no more than sketches and they will fail to be allowed under audit.

**National Correct Coding Initiative.** The bundles continue to present an ever present and constantly changing source of irritation in retina coding. One must be vigilant to check for changes each calendar quarter when the newest version becomes effective (January 1st, April 1st, July 1st, and October 1st of each year). Code edit pairs (as the bundles are officially known) can be broken by appending modifier -59 to the second code pair. Be sure you and your billing personnel have a good medical reason to do this - and that it is not automatically done because you don’t like a bundle. In the September issue of Retinal Physician we will have a surgical coding workshop and examples will be shown. Inappropriate unbundling of code edit pairs continues to be of interest to the Office of the Inspector General.
Interpretation and Report for Each Test. Each test that you bill must have an order documented in the chart as well as an interpretation and report as described above. If you perform, bill and are paid for both fluorescein angiography and fundus photos, then you must have a separate interpretation and report for each test.

And, once again, don’t forget - you must have an audit trail in your chart when you are using digital imaging. I have consistently found that under audit that there is no audit trail and often no interpretation and report. Under audit, monies have been paid back to various insurers because of this.

OCT. Some carriers have incorporated retina diagnoses into their SCODI policies (CPT code 92135) whereas others have not. You will not be paid unless the diagnosis is listed in the policy. If it is not you must use the unlisted CPT code for diagnostic tests - 92499.

Evaluation & Management Codes and Extended Ophthalmoscopy. Most retina specialists use consultation codes for initial encounters, and correctly so. However, consultation codes are E/M codes and all requirements for the level of the code must be met. One cannot perform less than the 14 elements of the single organ system requirements for eyes and bill a level 4 code. Extended ophthalmoscopy is an additional test and cannot be counted twice - once for the exam and once for the extended ophthalmoscopy.

Further, check to see if the carrier you are working with has regulations or prohibiting the billing of higher level E/M codes or Ophthalmology Codes with extended ophthalmoscopy.

CONCLUSION

When dealing with Medicare always remember that getting paid for a given service doesn’t mean anymore than that - you were paid. Under audit, you may find yourself paying back a lot of money unless the guidelines and regulations are followed. Good Luck!

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<table>
<thead>
<tr>
<th>Diagnostic Test CPT Description</th>
<th>Unilateral (1) Bilateral (2)</th>
<th>Interpretation/Report Required</th>
<th>Level of Supervision</th>
<th>LCD/Coding Guidelines usually found</th>
</tr>
</thead>
<tbody>
<tr>
<td>92020 Gonioscopy</td>
<td>2</td>
<td>No</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>92135 Scanning computerized ophthalmic diagnostic imaging</td>
<td>1</td>
<td>Yes</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>92225 Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial</td>
<td>1</td>
<td>Yes</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>92226 Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent</td>
<td>1</td>
<td>Yes</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>92230 Fluorescein angioscopy with interpretation and report</td>
<td>1</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>92235 Fluorescein angiography (includes multiframe imaging) with interpretation and report</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>92240 Indocyanine-green angiography (includes multiframe imaging) with interpretation and report</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>92250 Fundus photography with interpretation and report</td>
<td>2</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>76512 Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
</tbody>
</table>

**GENERAL SUPERVISION(1)** means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

**DIRECT SUPERVISION(2)** in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

**PERSONAL SUPERVISION (3)** means a physician must be in attendance in the room during the performance of the procedure.
<table>
<thead>
<tr>
<th>Ultrasound</th>
<th>Special OPH Services</th>
<th>Ophthalmoscopy</th>
<th>Other S/S</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Scan (76511)</td>
<td>Gonio (92020)</td>
<td>Extended, initial (92225)</td>
<td>OEMG (92265)</td>
</tr>
<tr>
<td>A Scan (76516)</td>
<td>Sensorimotor (92060)</td>
<td>Extended, subseq (92226)</td>
<td>EOG (92270)</td>
</tr>
<tr>
<td>A Scan (76519)</td>
<td>Orthoptic/Pleoptic (92065)</td>
<td>Fluor angiography (92230)</td>
<td>ERG (92275)</td>
</tr>
<tr>
<td>w/ IOL</td>
<td>Visual Field limited (92081)</td>
<td>Fluor angiography (92235)</td>
<td>Color (92283)</td>
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<tr>
<td>B Scan (76512)</td>
<td>Visual Field intermed (92082)</td>
<td>ICG (92240)</td>
<td>Dark ad (92284)</td>
</tr>
<tr>
<td>B Scan (76513)</td>
<td>Visual Field extended (92083)</td>
<td>Fundus photo (92250)</td>
<td>Ext Phot(92285)</td>
</tr>
<tr>
<td>FB Loc (76529)</td>
<td>Serial Tonometry (92100)</td>
<td>Ophthalmodyn (92260)</td>
<td>Endo (92286)</td>
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<tr>
<td>Ultra Pachy</td>
<td>Tonography (92120)</td>
<td></td>
<td>Ant Segment</td>
</tr>
<tr>
<td></td>
<td>SCODI/OCT (92135)</td>
<td></td>
<td>photo w/ fluor</td>
</tr>
<tr>
<td></td>
<td>Ophthalmic biometry (92136)</td>
<td></td>
<td>angio (92287)</td>
</tr>
</tbody>
</table>

**INTERPRETATION AND REPORT:**

**Clinical Findings:**

**Comparative Data:** □ Worse □ Stable □ Not Applicable

**Clinical Management:**

Signature of Physician ___________________ Date __________