Try This for Medicare Fraud
(Well, At Least Abuse)
Part III

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Introduction

There are so many problems with billing for diagnostic tests that it comes as no surprise that more and more audit investigations are focusing on them and serious monies are being recouped by Medicare.

Unilateral versus Bilateral Tests/Modifier -52

All special ophthalmologic diagnostic tests have indicators that specify if the test is to be paid for each side or is to be paid once for both sides. For purposes of this article, let's define unilateral test as one that is reimbursed for each side and a bilateral test as one that is reimbursed one fee for both sides. Examples of unilateral tests are extended ophthalmoscopy, scanning computerized ophthalmic diagnostic imaging, and fluorescein angiography whereas examples of bilateral tests are fundus photography, gonioscopy, and visual fields.

***Modifier 52*.** If you perform any of the bilateral tests on just one eye you must append the modifier -52 (reduced services). Failure to do so would be considered fraudulent billing. Practices have billed all of these services with the RT and LT (right and left) modifiers and been paid for each side. Then comes the knock on the door from the audit arm of your local carrier. Just because you are paid for something from Medicare does not mean it is correct - they just pay the claims and then come back later to recoup. Meanwhile, you have performed a fraudulent/abusive billing error.

Also, many practices often just examine one eye. The value of each code is based on examination of both eyes, so if you do this you should append modifier -52 to the service code.

Interpretation and Report - The Three C's

The CPT (Current Procedural Terminology) phrase "with interpretation and report" is included in the description of most ophthalmic diagnostic tests. The origin of the requirement, the Medicare Carriers' Manual, is full of

interpretation and report references but is markedly lacking in what the actual requirements are.

However, without an interpretation and report surely you will be refunding money to Medicare under audit. Remember The Three C's (EyeWorld, March 2004).

***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. 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 hemorrhage has resolved, visual field loss 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 visual field, this fundus photo. You must address how this test is going to coordinate with 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.

Diagnostic tests have a professional component and a technical component. The professional component is the interpretation and report. Without this, you may find yourself paying back the monies allotted for this portion of the reimbursement. The technical component provides reimbursement for ownership and maintenance of the equipment as well as various overhead expenses such as technician salaries.

Visual Field Examinations

There are three descriptions in CPT for visual field services:

92081 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

92082 intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)

92083 extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30°, 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)

(Gross visual field testing (eg, confrontation testing) is a part of general ophthalmological services and is not reported separately)

Of particular significance is that "unilateral or bilateral" is in the description. I have been questioned as to why payment was denied when the provider billed for each side. The test is deemed bilateral by Medicare and carries that indicator. This test is only to be billed once whether you do one eye or both eyes. Providers have paid upward of $1,000,000 for double billing (ie, the right eye and left eye separately).

Medicare does not pay for routine examinations or screening eye examinations. Some practices routinely do a screening visual field on each new patient. Some glaucoma specialists insist a visual field be performed on each new patient before the patient is examined. This would be considered a screening examination since there is no prior examination and no order for the test, so - this service is not a billable to Medicare.

Another area that is often misused is in determining the level of service to be billed for visual fields performed prior to blepharoplasty or ptosis surgery. Codes 92081 or 92082 are acceptable, but not 92083. Every once in a while you come across a carrier that will pay for two sets - one with the eyelids taped and one with them in their usual position. Carrier instructions state to use modifier -76 on the second set of visual fields.

Extended Ophthalmoscopy

Extended ophthalmoscopies remain 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:

92225 Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report; initial
92226 subsequent

Technically, code 92225 is used for the initial testing encounter for a disease entity and subsequent follow-up extended ophthalmoscopies would be coded 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 again. 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 require scleral depression. The biggest problem occurs when the drawings are no more than sketches and then the service fails to be allowed under audit.

Glaucoma diagnoses are listed in most of the policies, but a word of caution is warranted here. A sketch the size of a thumbnail that allegedly shows slope et cetera would not probably pass a Medicare audit for extended ophthalmoscopy.

Be sure to remember that there must be medical necessity for each side since this is a unilateral test - it is paid for each side. For example, extended ophthalmoscopy performed for follow-up of a choroidal nevus would only be warranted for the involved side, even though it is good medicine to examine both eyes.

Conclusion

Medicare defines the difference between fraud and abuse as being one of intent, with fraud being perpetuated when there is intent to deceive. There is a lot of bad reimbursement advice out there, most of it coming from your colleagues, most of it gathered around coffee breaks at medical

meetings. Just because a practice is billing and getting paid for a service does not mean that it is correct. I hear the refrain all the time "But, we got paid!" Sure you did, but then comes the knock on the door. For the most part, the difference between Medicare and other insurers is that Medicare pays you for almost any reasonable clean claim - and then takes the money back - even years later. Other insurers may initially give you a hard time, but most often do not request refunds, although I have noticed a definite increase in non Medicare auditing of practices. It pays to know the rules!

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