

Perils of EHR: Extended Ophthalmoscopy

Not surprisingly, billing for extended ophthalmoscopy has its issues. These tips and guidelines can make the process a bit easier and reduce the chance of an audit.

BY RIVA LEE ASBELL

There is a definite love-hate relationship when it comes to electronic health records (EHRs). One of the problems that most physicians are not aware of is these systems' lack of compliance with Medicare's guidelines for chart documentation. This review explores the requirements and guidelines for Medicare billing of extended ophthalmoscopy—one of the most audited diagnostic tests in ophthalmology.

CPT DEFINITION

Following is the definition of ophthalmoscopy from Current Procedural Terminology (CPT):

Routine ophthalmoscopy is part of general and special ophthalmologic services (ie, eye codes and evaluation and management office visit codes) whenever indicated. It is a nonitemized service and is not reported separately.

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

Note the following guidelines:

- Medical necessity for the service must be established by noting the presence of a symptom or finding in the chart documentation. The usage cannot be routine.
- For reimbursement purposes the code is considered unilateral, meaning you are paid for each side independently. Thus, it is crucial that medical necessity—be it a symptom such as floaters or decreased vision or a pathological finding—also be documented for each side.
- Routine ophthalmoscopic findings or history must be documented in the chart and must support

the physician's decision to proceed to extended ophthalmoscopy.

- A detailed drawing is mandatory. Without it, Medicare will not consider the service for payment.
- The difference between "initial" and "subsequent" is not related in any way to the status of the patient as new or established. Rather, use CPT code 92225 when examining a patient for the specific condition for the first time and CPT code 92226 for subsequent examinations for the same condition. Thus, it is quite possible that an initial service (92225) may be coded more than once for a given patient.
- The interpretation and report (I&R) is mandatory as well, and, again, the service will not be considered for payment without it.

MAC LCD GUIDELINES

Each US state or territory in which Medicare covers residents' health care services is under the jurisdiction of a Medicare administrative contractor (MAC). The states that are included in a given MAC's contract varies from contract to contract. For any given service that is not covered by a national coverage determination (NCD), the MAC can issue its own rules for payment. As a payee of Medicare funds, the physician is responsible for being aware of these regulations and abiding by them. They can be found on your MAC's website, usually under medical policy.

Local coverage determinations (LCDs) that are active should be followed. Those that are retired are not supposed to be used for auditing purposes; however, it is a good idea to be in compliance with them because the auditors will inevitably refer to them internally. If your MAC does not have an LCD, use the one from National Government Services (NGS; Table). The easiest way to access it is to Google NGS Medicare and select

TABLE. SELECTED HIGHLIGHTS FROM NGS MEDICARE'S POLICIES

Document	Subject	Information
LCD L25466	Documentation	- Although routine ophthalmoscopy and biomicroscopy are part of an ophthalmologic examination and are not separately payable, these should still be documented in the patient's medical record. - All findings and a plan of action should be documented in the notes.
LCD L25466	Medical Necessity Issues	- Extended ophthalmoscopy is indicated when the level of examination requires a complete view of the posterior segment of the eye and documentation is greater than that required for general ophthalmoscopy. - An extended ophthalmoscopy may be considered medically reasonable and necessary for the following condition: <i>[Author's Note: an itemized list follows and is omitted here]</i>. - Extended ophthalmoscopy of a fellow eye without signs or symptoms or new abnormalities on general ophthalmoscopic exam will be denied as not medically necessary. Repeated extended ophthalmoscopy at each visit without change in signs, symptoms, or condition may be denied as not medically necessary. - When other ophthalmological tests (eg, fundus photography, fluorescein angiography, ultrasound, optical coherence tomography, etc.) have been performed, extended ophthalmoscopy will be denied as not medically necessary unless there was a reasonable medical expectation that the multiple imaging services might provide additive (nonduplicative) information.
LCD L25466	Instrumentation and Dilation	- Most frequently performed using an indirect lens, although it may be performed using contact lens biomicroscopy. It may require scleral depression and is usually performed with the pupil dilated. - The medical record should document whether the pupil was dilated, and which drug was used.
LCD L25466	Utilization Guidelines	- Patients actively being treated with intravitreal injections of medication for exudative age-related macular degeneration (ICD-9-CM code 362.52) may require up to 12 extended ophthalmoscopies per eye, per year <i>[Author's Note: the injection and extended ophthalmoscopy are bundled under the NCCI and not separately payable if performed on the same day]</i>. - Conditions coded with other ICD-9-CM codes in the range of 360.0 – 365.9, may require up to six (6) extended ophthalmoscopic examinations per eye, per year. - For ICD-9-CM codes 190.0, 190.5, 190.6, 198.89, 224.5, and 224.6, up to four (4) extended ophthalmoscopic examinations may be required per eye, per year. - Other conditions usually require no more than two (2) extended ophthalmoscopic examinations per eye, per year. - Extended ophthalmoscopy is a physician service (examination of the eye) commonly occurring during the global postoperative period of ophthalmic surgery. As a physician service, it is included in the aftercare of the patient and is not separately billable.
Article A44439	Subjects Addressed	Advanced Beneficiary Notice, modifiers, unrelated conditions payment, directions for which codes to use with the different eye codes.

Part B under the link to NGS Medicare.com. Next, click on "Medical Policy and Review" in the top bar, then on Medical Policy Center in the dropdown menu. From here, choose Active LCDs for a geographic area, then click on the selected area, which will take you to a CMS listing of policies. L25466 is on the second page entitled

"Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography)".

AUDITS REVEAL EHR-SPECIFIC PERILS

The Drawing

Much has been written over the years on the

requirements for the drawing originating with the form that accompanied the indirect ophthalmoscope upon purchase. Without the anatomically specific extensive drawing that is mandated by most Medicare MACs, the service simply cannot be billed.

The LCD from NGS Medicare specifies the following:

- A separate sketch for each eye with a minimum diameter of 4 inches to 6 inches. *[Author's note: Other MACs allow a 3-inch diameter. Smaller drawings may not pass an audit.]*
- The use of between four and six colors is preferred; however, noncolored drawings are also acceptable if clearly labeled.
- An extensive scaled drawing must accurately represent normal, abnormal, and common findings such as lattice degeneration, hypertensive vascular changes, proliferative diabetic retinopathy, as well as retinal detachment, holes, tears, or tumors.

EHR Perils and Recommendations

Peril: EHR Drawings

The EHR is good for sketches only—not the detailed information for the drawings required for Medicare. The drawings are difficult to make anatomically specific using this modality, and labeling is not easily performed.

Peril: Cloned Drawings

With the cut-and-paste feature so readily available, some physicians have taken to copying the electronic drawings from encounter to encounter. I have seen this in audits and caution that you cannot bill for the service with cloned material because it will be considered fraud.

Recommendation

If you are adamant about billing for extended ophthalmoscopy and are willing to adhere to all the requirements, then perhaps it is better to use a form and scan the drawing (may include the I&R) into the EHR.

I&R Perils and Recommendations

Peril: Insufficient I&R

This report must contain “the three Cs”: clinical diagnosis, comparative data (if not a new patient), and clinical management. Without this information, the I&R will not be considered complete under audit.

NGS Medicare’s LCD specifically states: “Extended ophthalmoscopy is the detailed examination of the retina and always includes a true drawing of the retina, with interpretation and report... . The examination must be used in the medical decision-making for the patient.”

“The EHR is good for sketches only—not the detailed information for the drawings required by Medicare.”

Recommendation

Create a template with a few lines for the three Cs to be easily filled in with free text. An alternative would be to fill out a form and then scan it into the patient’s medical record.

Because the provider is being paid additional monies for the test, the I&R should be in a separate position and clearly labeled as an I&R in the chart documentation. This is true for all diagnostic tests.

SHOULD I OR SHOULDN’T I?

The reimbursement for each eye—in metropolitan Philadelphia, Pa., for example—is \$28.85 for CPT code 92225 and \$26.62 for CPT code 92226 for the latter part of 2015.

A further consideration is the National Correct Coding Initiative code-edit pairs (bundles), wherein extended ophthalmoscopy is bundled into other services that are performed at the same session on the same day. Examples of this are extended ophthalmoscopy plus intravitreal injections, and extended ophthalmoscopy performed the day of a major procedure. Many MACs will not reimburse for extended ophthalmoscopy performed in the global period of a procedure. The services should not be unbundled, with few exceptions such as a new symptom or finding in the fellow eye.

Many providers have elected to forego performing the extensive drawing and the I&R and thus do not bill for extended ophthalmoscopy because of the time and work involved in following the guidelines and requirements. Each physician practices differently, and that is why it is a personal and individual decision. ■

Riva Lee Asbell is the principal of Riva Lee Asbell Associates, an ophthalmic reimbursement consulting firm located in Fort Lauderdale, Fla. Ms. Asbell may be reached at rivalee@rivaleeasbell.com.



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