CODING ADVISOR
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THE EFFECT OF BILATERAL RULES ON RETINA CODING

Start with indicators and learn how to report from there.

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Coding bilateral retina procedures can be challenging, especially when it comes to intravitreal injections. Here are a few tips to help you streamline the coding and reimbursement process within your practice.

BILATERAL INDICATORS

Medicare uses status indicators to designate whether a CPT code is eligible to be reported as a bilateral procedure. These indicators are published with the Medicare Physician Fee Schedule (MPFS) and defined by description.

Bilateral surgeries, defined as an indicator of B, Bilateral Surgery Rules (modifier -50), are associated with the following status indicators and their descriptions:

- 0: 150% payment adjustment for bilateral procedures does not apply due to anatomy, or the code descriptor is a unilateral procedure
- 1: 150% payment adjustment for bilateral procedures applies
- 2: 150% payment adjustment for bilateral procedures does not apply, as the code descriptor states the procedure is bilateral and/or paid whether performed unilaterally or bilaterally
- 3: The usual payment adjustment for bilateral procedures does not apply. When reported for both eyes on the same day (modifiers -RT and -LT), 100% payment is issued for each eye
- 9: Concept does not apply

Retina examples with a bilateral indicator of 0 include CPT code 67221, destruction of localized lesion of choroid, photodynamic therapy (PDT), and CPT code 67225, destruction of localized lesion of choroid, PDT, second eye, at single session. When PDT is performed bilaterally, report CPT codes 67221 and 67225 for the bilateral procedure. Modifier -50 is not appropriate in this case.

BECAUSE PAYER POLICIES VARY, YOU MUST INTERNALLY TRACK THE PREFERRED METHOD FOR BILATERAL CLAIM SUBMISSION FOR SURGICAL PROCEDURES.

Most surgical retina procedures, including CPT code 67036, pars plana vitrectomy, and CPT code 67028, intravitreal injection, have an indicator of 1. When performed bilaterally, the payment adjustment is 150%, meaning the first eye is paid at 100% and the second at 50% of the MPFS.

A bilateral indicator of 2 includes CPT code 92134, scanning computerized ophthalmic diagnostic imaging, posterior segment with interpretation and report, unilateral or bilateral, and CPT code 92235, fluorescein angiography, with interpretation and report, unilateral or bilateral. These tests are paid the same, whether performed on one or both eyes. Appending modifier -50 will prompt a claim denial.

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CPT code 76512, ophthalmic ultrasound, diagnostic B-scan, has an indicator of 3 and, when performed bilaterally, should be reported with modifiers -RT and -LT on separate lines. Payment will be 100% for each eye.

BILATERAL CODING

CPT Coding

For bilateral surgical procedures, Medicare Part B requires the CPT code to be submitted with modifier -50 on one line and 1 unit. The fee submitted should be doubled to ensure the 150% payment adjustment is calculated appropriately. For example, a bilateral intravitreal injection is submitted as 67028-50, 1-unit, billed fees doubled. If the MPFS for CPT code 67028 is $114.65, the bilateral procedure payment would be $171.98. Other insurance payers may follow Medicare's rules or require bilateral procedures to be submitted on the claim form with two separate lines, either 67028 and 67028-50 or 67028-RT and 67028-LT.

HCPCS Coding

When reporting bilateral intravitreal injections, the claim submission for the HCPCS code can vary. Most Medicare Administrator Contractors and insurance payers allow the HCPCS code to be billed on one line with the appropriate units doubled. For example, faricimab (Vabysmo, Genentech/Roche) is reported with HCPCS code J2777, with 60 units representing the 6 mg/0.05 mL administered per eye. Report a bilateral procedure on one line as J2777, 120 units. If reporting on two separate lines is required, report as J2777, 60 units, and J2777, 60 units. Only report anatomical modifiers (-RT and -LT) if required by the payer, as incorrect usage may prompt a claim denial.

CHECK TWICE

When reporting bilateral procedures, confirm that the payment received is appropriate per the bilateral indicator. Because payer policies vary, you must internally track the preferred method for bilateral claim submission for procedures and intravitreal injections. Create an internal reference guide, reviewed and updated appropriately, to ensure that your guidance is current and your denials are limited.

Explore the AAO's resources on bilateral procedures on our resource pages, Coding for Injectable Drugs (aao.org/injection) and Retina Practice Management and Coding (aao.org/retinapm). ■

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