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Optometry Coding & Billing Alert

Back to CPT Basics: Have You Made Your Case for 99214? Read This, Then Decide

Determine whether you're basing your coding on time spent with the patient

Office visit code 99213 may seem like a reliable friend to **optometry coders** . But if you-re relying too heavily on that code, when you could justifiably be coding 99214 or 99215, that friend could be costing you as much as $67 per patient.

Optometrists report 99213 (Office or other outpatient visit for the evaluation and management of an established patient ...) more frequently than they report any other E/M code, and with good reason: In accordance with CMS- documentation guidelines, optometrists don't frequently perform E/M services that warrant higher-level codes. So if your practice reports mostly 99214's and 99215-s, you-d better be prepared to show an auditor the required documentation.

Don't Upcode, but Don't Fall Into 99213 Rut

Many physicians have been conditioned over the years to assume every visit warrants 99213, so even when a physician's documentation supports a level-four visit, he often chooses a level-three established patient service just to be safe.

But if your documentation supports billing 99214, you should report it, says **Betty Carpenter, CCS-P**, coding and compliance manager for a practice in Grand Rapids, Mich.

To report 99214, says **Mary Cremers, CPC**, coder for the Northwest Eye Clinic in Minneapolis, the optometrist must document all of the following:

- a detailed history
- a detailed exam
- medical decision-making of moderate complexity.

According to CPT, an MDM of moderate complexity means that the optometrist must meet or exceed two of the following three components:

- multiple diagnoses or management options
- moderate amount and/or complexity of data to be reviewed
- moderate risk of complications and/or morbidity or mortality.

-That doesn't mean that every visit is going to be a 99213,- says **Heather Corcoran**, coding manager at CGH Billing Services in Louisville, Ky. -In fact, some insurers put up red flags when a practice never bills any other E/M codes. They wonder what type of patient care a practice is providing when they never, ever bill anything higher than that. Or they wonder why every visit warrants a 99213 and none ever justifies a 99212.-

Count All Counseling Minutes

Although optometry coders do encounter the occasional 99214 chart, they rarely report 99215--unless counseling or coordination of care dominates the E/M visit. In those cases, you can select your E/M code based on the amount of time that the optometrist spends with the patient.

According to CPT guidelines, if counseling and/or coordination of care constitutes more than 50 percent of the

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physician/patient encounter, you may use time as -the key controlling factor to qualify for a particular level of E/M services.- CPT stresses, however, that to code by time the physician must clearly document how long the complete examination took and how much time he spent counseling the patient.

Review Time-Based Coding Guidelines

Start here: For most E/M codes, CPT lists the time the physician usually spends rendering the service. For example, for established patient code 99215, CPT states, -Physicians typically spend 40 minutes face-to-face with the patient and/or family.- This is called the -reference time.- If the optometrist documents that he spends a total of 45 minutes with a patient and documents that he spent 25 of those minutes providing counseling, you are justified in skipping 99214 and coding 99215 for the visit.

Use Eye Codes for Annual Exams

When should you use an ophthalmological examination code (92002-92014, Ophthalmological services: medical examination and evaluation -) instead of an E/M code to describe an office visit? It depends on what exactly you-re examining and for what reason, experts say.

If you are strictly evaluating the function of the eye, report an eye code (92002-92014). If, however, you are evaluating a more far-reaching systemic disease process, report the appropriate E/M code (99201-99215).

-If I am doing an annual exam with or without complaints, I am going to use a 920xx code,- says **David Gibson, OD, FAAO**, a practicing optometrist in Lubbock, Texas. -These give me a complete overall view of the status of the ocular health.-

For -visits done strictly to evaluate a specific condition, or for non-visual complaints needing prompt attention,- Gibson uses the E/M codes. -I always use 992xx codes for emergency visits--such as red eye, foreign bodies or sudden pain--or progress-type visits to monitor a condition like glaucoma, or follow-up visits after a foreign-body removal.-

Example 1: A new patient presents complaining of blurred vision. You perform a comprehensive dilated examination, including checking her ocular mobility, screening visual fields and intraocular pressure. Since this is strictly an examination of the eyes- function, use 92004 (Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits).

Example 2: A new patient presents with some symptoms of glaucoma but also complains of a recent onset of headaches. The optometrist takes a comprehensive history, performs a comprehensive eye exam and makes moderately complex medical decisions.

This additional evaluation, with the appropriate documentation, constitutes an E/M service. Code this visit with 99204 (Office or other outpatient visit for the evaluation and management of a new patient -).

-If this were a new patient to my office and I didn't perceive this to be an emergency, I would code a 92004 for the initial evaluation just to establish a record and obtain baseline readings,- Gibson says.

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