Optometry Coding & Billing Alert

E/M or Eye Code? Choose Wisely With These Documentation Tips

Use the 99200 codes for patients with specific problems -- but make sure your documentation backs them up

Optometrists can use their own set of codes for ophthalmic evaluations instead of the evaluation and management codes, but the codes are not interchangeable. Each one describes an optometrist's services in a slightly different way.

Both sets of codes -- the E/M codes (99201-99215, Office or other outpatient visit ...) and, in the "Medicine" section of CPT, the general ophthalmological services codes (92002-92014, Ophthalmological services; medical examination and evaluation ...) -- describe office visits.

"Optometry and ophthalmology are the only specialties to have their own set of codes to use for exams," says **David Gibson, OD, FAAO**, a practicing optometrist in Lubbock, Texas. "Everyone else has to use the E/M codes."

Problematic: There is no set rule regarding when to use the E/M codes or the "Medicine" section codes, says **Jeffrey Restuccio, CPC, CPC-H,** principal of Ritecode.com, who led the "Coding and Reimbursement for Ophthalmological Procedures" seminar at the Coding Institute's 2008 Optometry Coding & Reimbursement Conference. So how do you decide which one to report?

Switch to E/M Codes for Complicated Exams

Experts warn: Don't choose based on amount of reimbursement. The general rule for CPT codes is to pick the one that most clearly describes the service the optometrist renders. If he is strictly evaluating the function of the eye, report an eye code. If, however, he is evaluating the eye as related to a systemic disease process, report the appropriate E/M code.

Example 1: A new patient presents complaining of blurred vision. The optometrist performs a comprehensive examination, including checking her visual acuity, gross visual fields, ocular mobility, retinas, and intraocular pressure. Since this is an examination of the eyes' function, use 92004.

Example 2: A patient with chronic blepharitis comes in due to a recent foreign-body sensation. During the case history, the patient mentions a recurring headache. The patient had an unremarkable comprehensive exam four months ago, and the optometrist doesn't think it's necessary to do another dilated exam. A slit lamp exam reveals a lash rubbing the cornea on the painful eye. Refraction indicates a significant increase in hyperopia, which may explain the patient's headache.

You can report an E/M code -- as long as you meet the higher standard of documentation for the E/M codes. Be sure to document the date of onset, frequency and duration of symptoms, level of discomfort, whether the condition is improving, and other details defined in the E/M codes that are not specified in the eye codes.

Watch for: Your carriers may have their own guidelines for the eye codes. "BCBS of Texas wants us to bill the 92000 codes for those patients they cover for routine care," explains Gibson. "So, a 92004 billed with myopia (367.1) is paid as routine, but 92004 billed with glaucoma (365.15) is paid as medical care."

Note: For more information on routine and medical care, see "End 'Medical vs. Vision' Insurance Confusion" in Optometry Coding & Billing Alert, Vol. 6, No. 5, page 34.

Check Carriers for 'Comprehensive' Definition

Your CPT manual has definitions of "intermediate ophthalmological services" and "comprehensive ophthalmological services." Be careful, however: Individual carriers have refined those definitions even further.

If you don't meet your carrier's definition of "intermediate" or "comprehensive" eye exams, you should report an E/M service code instead of an eye code. CPT defines an intermediate ophthalmological service level (92002 for a new patient, 92012 for an established patient) as an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, says Restuccio.

CPT dictates that a comprehensive exam (92004 for a new patient, 92014 for an established patient) describes a general evaluation of the complete visual system, notes **Maggie M. Mac, CMM, CPC, CMSCS,** consulting manager for Pershing, Yoakley and Associates in Clearwater, Fla.

Key: Both levels of service include a history, general medical observation, and initiation of diagnostic and treatment programs as indicated. "The part referring to the initiation of diagnostic and treatment programs is very confusing and varies by state," notes Gibson. For example, "the Missouri optometry auditor looks for that exactly as worded, but in Texas, we don't have to 'treat' to be able to use 92004 or 92014. 'Monitoring' a condition is considered treatment for the purpose of the 92000 codes in Texas because sometimes that is the appropriate treatment."

Some local carriers have defined the following elements as required to meet the level of service or as necessary to diagnose the patient condition, says Mac:

• Exam of eyelids and adnexa -- required for intermediate exam

• ocular mobility -- required for comprehensive exam

• gross visual fields -- required for comprehensive exam.

The following additional elements may also be indicated for either level:

• Visual acuity

• pupils and iris

• cornea

• anterior chamber

• lens

• intraocular pressure

• retina (vitreous, macula, periphery and vessels

• optic disc.

No national guidelines exist for the eye exam codes, Restuccio points out, but some local carriers recommend that an intermediate exam (92002, 92012) cover 3-7 elements which includes the required element, while a comprehensive exam (92004, 92014) would cover eight or more, which includes the required elements.

Additionally, either exam may require dilation, but some carriers may require a dilated fundus exam to assign the comprehensive level of eye codes. Check with your local carrier for specific guidelines and restrictions.

Modify Eye Codes Just Like E/M Codes

Medicare and most other carriers treat the eye codes the same as E/M codes. Therefore, if there is a separately identifiable service, you can report it with an eye code and append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) or 57 (Decision for surgery).

Codify
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