

Optometry Coding & Billing Alert

Office Visits: Here's How to Make the E/M vs. Eye Codes Choice Simple

You've got two options for coding office visits – here's how to decide what code to use when.

For some it's a blessing, and for some a curse. While most medical specialties can only use the evaluation and management (E/M) codes in CPT® to report office visits, ophthalmologists and optometrists have another option. Codes 92002-92014 (Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program...) are the only codes in CPT® that specifically describe office visits for one specialty.

How does a coder know which code set to use in which scenario?

Eye Codes for the Eyes, E/M Codes for Everything

The general rule for CPT® codes is to pick the code that most clearly describes the service the ophthalmologist renders. If he is strictly evaluating the function of the eye or doing a "routine" eye exam, report an eye code.

"The American Academy of Ophthalmology (AAO) has stated in the past that the E/M codes should be used for patients presenting with chronic conditions, new problems, injuries, etc." notes **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE**, AHIMA-approved ICD-10 CM/PCS trainer and president of Maggie Mac-Medical Practice Consulting in Clearwater, Fla. "The eye codes are advised to be used for routine vision exams for prescriptive eyewear/contact lenses. But the AAO also stated that the choice is made by the physician, as either codes may be used for billing."

Watch for: Some payers will not pay for general routine vision exams unless covered under the insured's policy and only the eye codes can be submitted once annually, Mac warns. So, for some patients, submitting the eye codes for problem visits more than once per year may pose a problem for payment. Payers may simply have policies in place that direct physicians on which codes may be used – E/M or eye codes – dependent upon the reason for the visit.

Scenario 1: A new patient presents complaining difficulty reading traffic signs. The ophthalmologist 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, report CPT® code 92004 (Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient 1 or more visits). "The diagnosis will drive whether or not the payer will pay a claim based on policy benefits," Mac says.

E/M Codes for Systemic Disease Processes

If, however, the ophthalmologist is evaluating a more far-reaching systemic disease process, report the appropriate E/M code.

Scenario 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 documentation requirements for HEM (history, exam, and medical decision-making) for the level of E/M service.

Be sure to document the date of onset, frequency and duration of symptoms, level of discomfort, and whether the condition is improving ☐ whether you use E/M or eye codes. "The reason for the visit needs to be documented and supported regardless of E/M or eye codes used," Mac explains. "The details are obtained for both visits dependent upon the patient's reason for presentation, and all details are important to support medical necessity, plan of treatment, and diagnosis. Therefore, onset, frequency and duration, etc. are just as necessary to obtain for E/M codes as they are for the eye codes.

Make Sure Documentation Is Solid

While many practitioners prefer using the eye codes, documentation requirements must be present for both the eye codes and the E/M codes to support the reason for presentation and any details needed to describe the reason. An appropriate eye exam will follow based on the patient intake information followed by treatment plan and diagnosis. The exam elements must be medically necessary based on the presenting problem. For more complex problems with co-morbidities, it may be more appropriate to code an E/M service.

E/M codes have national coding guidelines that detail the documentation necessary to support a given level of service (such as 99203, Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity ...).

The guidelines describe each service level's national Medicare required amount of history, examination, and medical decision making (HEM). Only medically necessary performed and documented items count toward an area. Eye codes do not have those HEM requirements and are not subject to mandatory auditing.

Bottom line: "Using the most appropriate code ☐ E/M or eye code ☐ is the most important reason to determine whether to report an E/M or eye code to describe medically necessary physician work documented in the medical record," Mac says. "If you determine that the work performed is supported by the eye code 92004 and also supports the E/M code 99203, you may report the code that results in a higher rate of payment. Keep in mind that private payers may have internal guidelines for reporting the eye codes versus the E/M codes that must be followed."

Result: For instance, 92004 pays approximately \$40 more than 99203. Code 92004 has a national Medicare allowable of \$149.84 compared to 99203's unadjusted rate of \$109.60.