Optometry Coding & Billing Alert

Open Your Eyes to Code Evaluation Exams Properly

Determine the difference between intermediate and comprehensive

You must know the four distinct characteristics of the eye exam codes to report these services correctly.

CPT divides general ophthalmological services into new and established patient categories, as well as intermediate and comprehensive:

- 92002 -- Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient

- 92004 -- - comprehensive, new patient, one or more visits

- 92012 -- Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

- 92014 -- - comprehensive, established patient, one or more visits.

To report the evaluation of new or exiting conditions that have been complicated by a new diagnostic or management problem, use 92002 for a new patient or 92012 for an established patient.

To report the evaluation of the complete visual system and treatment over the course of one or more visits, use 92004 for a new patient or 92014 for an established patient. Both the E/M codes (99201-99215, Office or other outpatient visit ...) and the general ophthalmological services codes (92002-92014, Ophthalmological services: medical examination and evaluation ...), describe office visits. So how should you decide which to report?

Switch to E/M Codes for Complicated Exams

Don't choose based on the amount of reimbursement. The general rule for CPT codes is to pick the code that most clearly describes the service your optometrist renders. If you are strictly evaluating the function of the eye, report an eye code. If, however, you are 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. You perform a comprehensive examination, including checking her visual acuity, gross visual fields, ocular mobility, retinas and intraocular pressure. Because this is strictly an examination of the eyes- function, use 92004. In this case, the proper treatment may be to continue monitoring the condition without treating.

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 you don'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 the eye codes don't specify.

Along with Medicare or other medical insurance, many of your patients might have supplemental private insurance --

such as AARP Eye Health Services, Clarity Vision, Vision Service Plan, etc., to cover their routine eye exams.

Example 1: A patient presents for what he thinks will be a routine vision exam, but you find cataracts. Should you bill his vision plan or Medicare? Be careful: The wrong answer could get you in hot water with your patient, not to mention CMS.

When you find a medical problem like cataracts or glaucoma while doing a routine eye exam on these patients, you have a dilemma. Should you bill the patient's medical insurance, since you found a medical condition? Should you bill the patient's vision insurance? Or can you even bill both?

The answer depends on the patient's reason for being there, as well as his expectations. Bill based on the patient's chief complaint and history of present illness (HPI). If he has a specific complaint that can be attributed to a non-refractive diagnosis, then it's a medical visit and you should bill the medical insurance.

Example 2: A patient arrives complaining of blurred vision. You find that cataracts are causing the blurriness. Bill the patient's medical insurance with the appropriate eye exam code (92002-92014) and link it to the appropriate cataract code (366.xx).

As a secondary diagnosis, report 368.8 (Other specified visual disturbances [blurred vision NOS]).

If, however, you found no cataracts or any other condition causing the blurred vision, report 368.8 as the primary diagnosis.

Bill Routine Coverage if There's No Complaint

If the patient doesn't have a complaint, the rule still holds: Code according to why the patient is there. If the patient comes in with no specific complaint, but you diagnose a medical problem, report the routine visit as the primary diagnosis and the medical condition as the secondary diagnosis. Bill that visit to the patient's vision carrier.

Coding the exam: In addition to using general ophthalmological services CPT codes 92002-92014, vision plans often look for ICD-9 code V72.0 (Special investigations and examinations; examination of eyes and vision) as the primary diagnosis.

Have Patient Return for Further Tests

When you do find a medical problem during a routine exam, the optometrist may do better to have the patient return on another day for further tests, rather than convert the exam from routine to medical. A patient who discovers that what he thought was going to be a routine screening with a $20 copay may be confused and upset when he sees a bill for a medical eye exam -- even if his out-of-pocket expenses are the same. If there is a follow-up exam later, the medical condition will be the primary diagnosis, and the bill goes to the patient's medical insurance.

Example: A patient with no complaint comes in for the routine eye exam that his vision insurance provides. You discover glaucoma. Bill the patient's vision insurance with S0620 or S0621 and link it to V72.0. As a secondary diagnosis, report the glaucoma code (365.xx).

When the patient returns for further diagnostic tests -- such as 92081-92083 (Visual field examination, unilateral or bilateral, with interpretation and report ...) and 92020 (Gonioscopy [separate procedure]) -- link the codes to the glaucoma diagnosis.

If a patient presents with no complaints, but the optometrist finds something that necessitates performing tests in addition to the routine screening on that day, you may be able to bill both the medical and the visual insurance.

Example: A patient is in for a routine exam and has no complaints. As part of the optometrist's exam, she finds intraocular pressures (IOPs) of 30 mm Hg in both eyes and suspicious cupping. Because of the unusually high IOP, she

performs fundus photography and visual fields immediately but finds no glaucoma.

Because the patient had no complaints, you would need to bill the patient or his vision plan for the initial visit. But you could bill the fundus photos and visual fields as medical, even if your optometrist performs them on the same day.

Bill the eye exam with the appropriate eye code to the patient's vision insurance. Bill the visual fields (92081-92083) and the fundus photos (92250) to the patient's medical insurance.

Link the CPT codes to 365.01 (Borderline glaucoma [glaucoma suspect]; open angle with borderline findings) -- or the appropriate 365.xx code if your optometrist found glaucoma.

Key: You can only bill one insurer for the initial exam (S0620-S0621 or 92002-92014). Billing both companies for the same exam would be double-dipping and might lead to fraud charges.

When to Use Modifier 25

You can report testing services such as 92225 (Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial) along with comprehensive eye exam codes 92004 and 92014 without appending modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

Although a comprehensive eye exam includes routine ophthalmoscopy, it does not generally include extended ophthalmoscopy, so you are free to code for it separately.You might still see denials, however. Some carriers have a long-time edit in place not to pay for extended ophthalmoscopy when billed with 92014.

If this is the case in your area, you will either need to bill the services and end up in the review and appeal process proving medical necessity or select the intermediate-level eye code or E/M code instead of the comprehensive eye code.

Remember: When you append modifier 25, only append it to the eye exam code or E/M code, not to a procedure code like 92225. Use modifier 25 when you perform an unrelated E/M service along with a minor procedure -- one that has 10 or fewer days in the global surgical period as defined by Medicare.