Optometry Coding & Billing Alert

Reader Questions: Continue Treatment Program for 92012-92014

Question: The guidelines in the CPT manual state that the intermediate and comprehensive eye codes (92002-92014) always include the "initiation of [a] diagnostic and treatment program." However, the descriptors for the established patient codes say "with initiation or continuation of diagnostic and treatment program." Can we or can't we use the established patient codes for continuation of treatment, with no initiation of new treatment or new complication?

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Answer: You should not continue to use the eye code 92012 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient) - that code describes the evaluation of a new condition or an existing condition complicated with a new problem.

Therefore, you must use an E/M code. If this is a glaucoma patient with no complaint who is back for a VA check and pressure check, report 99212 (Office or other outpatient visit, established patient ...) or 99213 (Office or other outpatient visit, established patient ...). If you do a complete anterior chamber exam, including IOP check, use 99213. Be sure to have documentation for a full anterior exam.

If you do not perform a full anterior exam, you probably do not have enough elements to justify 99213 - report 99212 instead.

What about dilation? It's appropriate to perform a comprehensive exam (92014, ... comprehensive, established patient, one or more visits) annually, even on a stable glaucoma patient. Report 92014 once a year, with 99212 or 99213 checks every four months or so.

Caution: When treating a patient with a chronic condition like glaucoma, doctors tend to center in on that condition. A new problem (other than the glaucoma) may pop up and be overlooked. Pay close attention to the patient's chief complaint and history of his problems.