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Optometry Coding & Billing Alert

Think E/M Codes and Eye Codes Are Interchangeable? Think Again

Go for accuracy, not RVUs, when coding office visits - a wrong choice could cost you $170

When you're examining and evaluating a patient in your office, you've got some choices to make. You can report an E/M code (99201-99215), or you can choose an eye code (92002-92014). There may be a code in either series that will describe the work you're doing to the satisfaction of most carriers. Picking the right code to report an eye exam depends on what exactly you're examining and for what reason.

As with most coding dilemmas, much of the answer is in your documentation, says **Karen Smith, RHIT**, optometry coding specialist for the VA Outpatient Clinic in Fort Myers, Fla.

Reminder: You can't report one of each. The National Correct Coding Initiative lists eye codes 92002-92014 as "mutually exclusive" of most E/M codes, Smith says, meaning you can't report them together. Both sets of codes describe office visits, and you have to choose either an E/M code or an eye code to report. So how do you decide?

Resist the Temptation of High RVUs

Experts warn: Don't choose based on amount of reimbursement, says **Ginny Norrell, CPC**, coder for Heaton Eye Associates in Tyler, Texas. The general rule for CPT codes is to "pick the code that most clearly describes the service" the optometrist renders, she says. If you are strictly evaluating the function of the eye, report an eye code. If, however, you are evaluating a more far-reaching 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. 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 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.

Report an E/M code from the 9920x (New patient) series, says **David Gibson, OD, FAAO**, a practicing optometrist in Lubbock, Texas. "But remember that the elements of an E/M service are much more defined as to things like case history and difficulty of medical decision-making," he says. "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."

Know How Carriers Define 'Comprehensive'

Your CPT manual has definitions of "intermediate ophthalmological services" and "comprehensive ophthalmological services" - see "Uncover the Best E/M or Eye Code" on page 67. 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, Smith says. "The intermediate level requires a new problem - a new condition, a new complaint, a new management issue," she says. Smith finds the eye codes "a little bit harder to use for

optometrists, because typically their patients are coming in just because they need refractions."

Smart step: Check your carrier's LMRP for specific guidelines, Smith says. For example, HGSA, Medicare's Part B carrier for Pennsylvania, includes 13 elements in its definition of an ophthalmologic examination:

1. Visual acuity (not including refractive error)
2. Gross visual fields (required for comprehensive level)
3. Eyelids and adnexa (required for intermediate level)
4. Ocular mobility (required for comprehensive level)
5. Pupils
6. Iris
7. Conjunctiva
8. Cornea
9. Anterior chamber
10. Lens
11. Intraocular pressure
12. Retina (vitreous, macula, periphery, and vessels)
13. Optic disc.

Use Documentation to Determine Coding

To qualify to report a comprehensive eye code (92004 or 92014) for an HGSA patient, an optometrist must examine and document nine or more of these elements - always including visual fields and ocular mobility. And, an optometrist must examine either the retina or the optic disc to report 92004 or 92014. An intermediate ophthalmological exam (92002 or 92012) includes between three and eight elements.

Texas has a similar policy, Gibson says - although TrailBlazer combines iris and pupil examinations into one element, does not include conjunctiva on its list, and adds "mental status" (noting if the patient is alert to time, day and place).

Reality: No matter how many elements you examine, if there's no documentation to prove you examined them, you should report an E/M code.

"The eye codes are quite specific for the documentation of what the exam consists of, but they hardly address the amount of case history," Gibson says. "E/M codes are dependent on the amount and specificity of the case history, difficulty of the diagnosis, etc., but don't specify exactly which tests are performed."