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BY AAPC

Part B Insider (Multispecialty) Coding Alert

Eye Coding Primer: Know These 3 Quick FAQs to Envision Eye Procedure Payment

Hint: Foreign body removal may be best reported with an E/M code, depending on the circumstances.

If you've ever coded a chart for an eye procedure before, you know that these services can be a challenge--not only do you have to determine whether to use a standard E/M code versus an ophthalmic exam code, but you'll need to get the lowdown on differentiating similar diagnoses from one another. Check out this quick primer for information on how to code these services.

1. Consider Primary Reason for Visit

If the primary diagnosis for a patient's visit is a routine check-up, and the ophthalmologist finds a condition such as blepharitis or conjunctivitis as a secondary finding, the practice should still code for a routine visit.

Example: A new patient comes in for a routine eye exam. The ophthalmologist performs a comprehensive exam and discovers tear film insufficiency. Report 92004 (Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits), and link it to V72.0 (Examination of eyes and vision). As a secondary diagnosis, report the dry eye with 375.15 (Tear film insufficiency, unspecified). If the primary reason for a new or subsequent visit is medical, then the office crosswalks to the minor evaluation and management (E/M) codes -- 99201-99215 -- leaving the 92000 codes behind. The E/M codes require specific levels of history, examination, and medical decision making. The 920xx codes do not have those requirements, she explains.

Important: This means that you may need to focus on taking a more complete history to support submitting codes in the 99201-99215 range. You must also document the extent of your examination and the complexity of your medical decision making.

Example: A patient with chronic blepharitis (373.00, Blepharitis, unspecified) comes in due to a recent foreign body sensation. During the history intake, the patient mentions a recurring headache (784.0, 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 (930.0, Corneal foreign body). Refraction indicates a significant increase in hyperopia (367.0, Hypermetropia), which may explain the headache.

You can report an E/M code -- as long as you meet the documentation guidelines 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 with the E/M codes that are not as specific with the eye codes. Many carriers will look for an E/M code if there is a medical diagnosis.

Keep in mind that an ophthalmologist may report either the eye codes (92002-92014) or the E/M codes (99201- 99215) for any encounter as they see appropriate. There are no hard and fast rules and only strong suggestions to report the eye codes vs. E/M codes, experts say.

2. Nail Down Whether to Report Foreign Body Removal Versus E/M

Primary care physicians and eye specialists frequently see patients who complain about feeling something in their eye, blocking vision. It's up to you to determine how to code these situations, which can be tricky.

Example: A 75-year-old established patient with cataracts in her right eye reports to our doctor with a swollen and red

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right eye. The primary care physician performs an expanded problem focused history and expanded problem focused exam, and discovers "dust particles" clogging the patient's eyelid and conjunctiva. Using a few saline eye drops, the physician removes the particles, bandages the patient's eye, and sends her home. Should you report a foreign body removal (FBR) for this encounter?

Answer: This is more likely an E/M service, though you might want to investigate more thoroughly before deciding. If the encounter is an E/M, report 99213 (Office or other outpatient visit...) for the E/M with 930.1 (Foreign body on external eye; foreign body in conjunctival sac) appended to represent the patient's injury and 366.10 (Senile cataract, unspecified) appended to represent her cataracts.

Rationale: Even though the patient technically had an FB in her eye, the work your doctor did really does not qualify the encounter for an FBR. Coders report either 65205 (Removal of foreign body, external eye; conjunctival superficial) or 65210 (... conjunctival embedded [includes concretions], subconjunctival, or scleral nonperforating) for conjunctival FBRs, depending on the location and penetration of the wound. During these encounters, the provider often uses a burr, needle, tweezers, or some other tool to remove the FBs.

Best bet: Check with your payer to see if it will accept 65205 for the amount of work your physician performed in this instance. Saline irrigation is considered an FBR technique, but it typically takes more than just a few drops to wash the eye out.

3. Break Down Your Coding for Best PC-IOL Payments

After cataract surgery, an ophthalmologist inserts a Crystalens intraocular lens to correct a Medicare patient's presbyopia. Can you code for the physician's services and supplies? The answer is yes -- with these exceptions. Presbyopia-correcting (P-C) IOLs address the eye's inability to focus on near objects. Medicare typically covers the insertion of a conventional, clear IOL to replace the cataract-stricken lens that the ophthalmologist removes, but Medicare has ruled that cataract patients who request a P-C IOL, such as the Crystalens or AcrySof RESTOR lenses, can have them - if they are willing to pay the extra cost.

The problem: Medicare only partially covers P-C IOLs. Although it does consider a conventional IOL medically necessary after cataract surgery, there is "no benefit category" for the presbyopia correction itself.

"A single presbyopia-correcting IOL essentially provides what is otherwise achieved by two separate items: an implantable conventional IOL (one that is not presbyopiacorrecting), and eyeglasses or contact lenses," states CMS Ruling 05-01, released in May 2005. Medicare does cover one pair of eyeglasses or contact lenses for each patient following cataract surgery, but, "although presbyopia-correcting IOLs may serve the same function as eyeglasses or contact lenses furnished following cataract surgery, IOLs are neither eyeglasses nor contact lenses. Therefore, the presbyopia-correcting functionality of an IOL does not fall into the benefit category and is not covered."

Although Medicare has no immediate plans to establish new codes for the presbyopia-correcting (non-covered) portion of the P-C IOL, coding for the portion that Medicare does cover is fairly straightforward: Code for "a conventional IOL, regardless of whether a conventional or presbyopia-correcting IOL is inserted," directs an Aug. 5, 2005, CMS change request, "Instructions for Implementation of CMS Ruling 05-01: Presbyopia- Correcting Intraocular Lens."

For a cataract surgery with a P-C IOL insertion, report either 66982 or 66983 (Extracapsular cataract removal with insertion of intraocular lens prosthesis...) to Medicare.

Note: To read the original ruling, go online to www.cms.gov/Rulings/downloads/CMSR0501.pdf. For the Medicare transmittal with additional coding guidance, visit www.cms.gov/Transmittals/downloads/R636CP.pdf.

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