Part B Insider (Multispecialty) Coding Alert

READER QUESTION: Differentiate Glaucoma Patient Coding Rules Based on Whether SNF Is Involved

If the patient comes to your practice from a skilled nursing facility, consolidated billing rules might apply.

Question: How should I code an office visit for a wheelchairbound nursing home patient who presented to our practice for a follow-up for glaucoma?

Answer: Physicians often have to follow up with glaucoma patients because of medications or postsurgical concerns. Many practices differ in their coding method for follow-up visits, using either E/M codes or eye codes. Both sets are acceptable as long as they accurately depict the service. The decision usually depends on the physician's preference.

Some practices choose the eye codes because they require less documentation. However, the ophthalmologist must perform the required exam elements, and he must consider those elements medically necessary for the patient's presenting problem, to bill the appropriate eye code level.

In documenting follow-up glaucoma visits, be sure always to document a chief complaint even if it is simply "follow-up glaucoma."

Hidden trap: Billing can be complicated if the nursing home resident is a skilled nursing facility (SNF) patient. In that case, the nursing home is receiving a monthly payment from the Medicare program and is responsible for thepayment for all the services the patient requires. The SNF, however, may deny payment, claiming they did not know your ophthalmologist was going to see their patient.

Disaster averted: Calling the nursing home before the ophthalmologist sees the patient to make sure the patient is not at SNF level-- and that you can bill Medicare -- will save you time and money in the future.

Note that even though the patient is from a nursing home, the place of service is always where she is seen -- in this case, she was seen in your office.

CPT® 2023 American Medical Association. All rights reserved.