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coding

Understanding the Eye Codes

Part 2 of this series on choosing the best coding options focuses on the Eye Codes.

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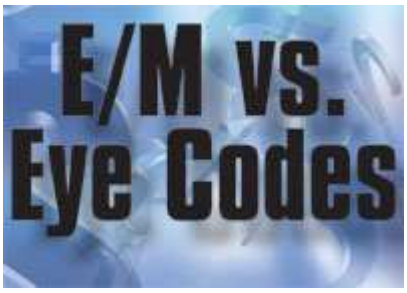

The purpose of this three-part series is to explain the differences between the Evaluation/Management (E/M) codes and the Eye Codes so that practices can choose the codes that keep the practice in compliance while also maximizing reimbursement. Part 1, which appeared in the October issue, explained the requirements and usage of the E/M codes. In Part 2, I will review the definitions, examination requirements and ambiguities involving the Eye Codes, technically referred to in Current Procedural Terminology (CPT) as General Ophthalmological Services. More and more I find that many providers have never really studied these codes — they have just always used them, not even being aware that they are a part of CPT or that there are rules for them.

Definitions and Contradictions

A significant problem with the Eye Codes is that the definitions in the general description of the codes do not correspond with the definitions next to the CPT code numbers, particularly in reference to initiation of diagnostic and treatment programs.

There are four codes: two new patient codes for new intermediate and comprehensive services and two established patient codes for the same services (92002, 92004, 92012, 92014). There are both national and local requirements for these codes — the national requirements being found in CPT and the local requirements being found in your Medicare carrier's Local Coverage Determination (LCD). Most LCDs include the CPT definitions. Be sure you look up your Medicare carrier's policy — many ophthalmologists do not even know there are such things. You are responsible for adhering to them.

The codes as listed in CPT:
New Patient

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

92004 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits

Established Patient

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

92014 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits

In addition, there are narrative descriptions in CPT that many of you are not aware of until you find yourself in an audit situation. These are found at the back of CPT under "special ophthalmological services." The narrative descriptions for the intermediate eye codes are as follows:

"Intermediate ophthalmological services describes an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated; may include the use of mydriasis for ophthalmoscopy."

The narrative descriptions for the comprehensive Eye Codes contain the following excerpted information:

"Comprehensive ophthalmological services describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Intermediate and comprehensive ophthalmological services constitute integrated services in which medical decision-making cannot be separated from the examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, routine ophthalmoscopy, retinoscopy, tonometry or motor evaluation is not applicable.

Initiation of diagnostic and treatment program includes the prescription of medication, and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services.

Special ophthalmological services describes services in which a special evaluation of part of the visual system is made, which goes beyond the services included under general ophthalmological services, or in which special treatment is given. Special ophthalmological services may be reported in addition to the general ophthalmological services or evaluation and management services."

A serious contradiction is that the code descriptors allow use of the established patient codes for follow-up examinations, whereas the narrative description in the beginning contradicts that. In my opinion, because there is an additional statement in the narrative for comprehensive Eye Codes, "It always includes initiation of diagnostic and treatment programs," this should be adhered to when using 92004 and 92014. I think it is acceptable to use 92012 for continuation of medical treatment, such as in glaucoma follow ups.

Examination Requirements

The intermediate eye examination codes require an external ocular and adnexal examination, whereas the comprehensive examination additionally requires gross visual fields, basic sensorimotor evaluation and an ophthalmoscopic examination.

	Comprehensive Eye Codes	Intermediate Eye Codes
National Mandatory Components	History General medical observation External examination Gross visual fields Basic sensorimotor evaluation Ophthamoscopic examination	• History • General medical observation • External ocular and adnexal examination Other diagnostic procedures as indicated
Optional Components	Biomicroscopy Examination with cycloplegia Tonometry	May include mydriasis for ophthalmoscopy
Miscellaneous Components	Initiation of diagnostic and treatment programs	

And, in many states, the Medicare carriers have mandated elements similar, but not identical, to those found in the E/M codes. A typical policy may list 10 elements and states that in order to bill an intermediate service fewer than seven elements should be performed and documented, and more than eight should be performed and documented for a comprehensive examination. The number of elements themselves and the number required for each category vary from carrier to carrier.

Almost all of the LCD policies state that for minimal services use E/M codes. A minimal service is a brief examination, such as follow-up for a corneal abrasion or follow-up for conjunctivitis. The service typically includes one to three elements and should be billed with code 99212.

Dilation requirements vary from Medicare carrier to carrier. Some carriers mandate that the pupils be dilated in order to count the posterior segment elements and others do not.

The table below outlines the various requirements of the Comprehensive and Intermediate Eye Codes:

Medical Necessity

Denials for services based on the lack of medical necessity become more evident when Medicare performs audits in various ophthalmic services and procedures.

Medicare states that all services must be medically necessary and medically reasonable. This broad concept gives Medicare a great deal of leeway in interpreting your coding and chart documentation in their decisions for audit and payment. It is not a matter of what a physician deems "good medicine" or medically appropriate. Rather, the service must be warranted in Medicare's opinion.

When dealing with evaluation/management services or general ophthalmological services, not only does the service itself (office visits, consultations etc.) have to be medically necessary — so do the elements within the service such as confrontation fields and sensorimotor evaluation. As an example, with a patient being followed for glaucoma with automated visual fields, there would be no medical necessity for performing confrontation fields. For a patient with a unilateral choroidal nevus, there would be no medical necessity to perform extended ophthalmoscopy in the other eye.

Initiation of Diagnostic and Treatment Programs

Several years ago, audits of the comprehensive eye codes (92004/92014) began with resultant downcoding of claims based on the lack of initiation of a diagnostic or treatment program. Comprehensive ophthalmology codes (92004, 92014) should meet the mandate of always including initiation of diagnostic and treatment programs that are defined as including "the prescription of medication, and arranging for special diagnostic or treatment services, consultations, laboratory procedures and radiological services." The diagnostic or treatment program does not have to be a reimbursable service; prescribing eyeglasses would count. Ordering of any of the special ophthalmic diagnostic tests such as visual fields or optical coherence tomography (OCT) is considered as initiating a diagnostic program. An order such as "Return PRN" or "Return to Clinic in 1 year" would not be an initiation of a diagnostic or treatment program, nor would "continue same meds".

Coming Next

In the concluding installment of this series, I will review the critical factors involved in deciding to make the choice between E/M and Eye Codes based on compliance and reimbursement optimization. Remember, under audit your best defense is a good chart documentation offense.

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