Codify
BY AAPC

Optometry Coding & Billing Alert

Office Visits: 99201 or 92002? Don't Assume E/M and Eye Codes Are Interchangeable

Look to your documentation, and your local carrier's policies, to determine the best code for each situation.

As an optometrist, much of your time is most likely spent examining and evaluating patients in your office. And, unlike practitioners in other specialties, eye care professionals have two sets of codes to choose from for office visits. You can report an E/M code (99201-99215), or you can choose an eye code (92002-92014).

So, one of the most common -- and most vexing -- dilemmas for optometrists is: Which code to choose? As with most coding dilemmas, much of the answer is in your documentation.

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, 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. The general rule for CPT® codes is to pick the code that most clearly describes the service the optometrist renders,. 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, advises **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." 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. The intermediate level requires a new problem, such as a new condition, a new complaint, or a new management issue.

Smart step: Check your carrier's local coverage determination (LCD) for specific guidelines. For example, Medicare

carrier TrailBlazer's LCD includes ten procedures that may be included in an intermediate eye exam and should not be reported separately:

- Laser interferometry
- Potential acuity meter
- Keratometry
- Exophthalmometry
- Transillumination
- Corneal sensation
- Tear film adequacy
- Schirmer's test
- Slit lamp
- General medical observation.

Use Documentation to Determine Coding

To qualify to report a comprehensive eye code (92004 or 92014) for a TrailBlazer patient, an optometrist must document a service which includes:

- History
- General medical observation
- External and conjunctival inspection
- Ophthalmoscopic examination
- Gross visual fields
- Basic sensorimotor examination.

The comprehensive service also "often includes, as indicated, biomicroscopy examination with cycloplegia or mydriasis and tonometry." And codes 92004 and 92014 always include "a fundus examination through a dilated pupil, except when medically contraindicated, and initiation of diagnostic and treatment programs," according to TrailBlazer.

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."