INTRODUCTION

One of my first columns for EyeWorld (EyeWorld, March 1998) was entitled “Quantitating the Ophthalmology Codes - The Demise of the 4-code Office”. There has been a lot of interest in these codes again, both by providers and Medicare. Increased audits have been noted. More and more I find that many providers have never really studied these codes - they have just always used them.

THE CODES

There are four codes: two new patient codes for 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 LMRP (local medical review policy) if your carrier has one.. Most LMRP’s include the CPT definitions.

The codes as listed in CPT (Current Procedural Terminology):

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 I am including in this article. So many eye care providers simply have not read these descriptions, are unaware of the requirements, and finally have found themselves in a Medicare audit situation.

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.

EXAMINATION REQUIREMENTS

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

And, in many states, the Medicare carriers have mandated elements similar, but not identical, to those found in the E/M (Evaluation and Management) codes. A typical policy may list 10 elements and state that in order to bill an intermediate service fewer than 7 elements would be performed and documented, and that more than 8 should be performed and documented for a comprehensive examination. The number of elements themselves and the number required for each category varies from carrier to carrier.

All of the policies state that for minimal services use E/M codes. A minimal service is a very brief examination, such as follow up for a corneal abrasion or follow up for conjunctivitis. The service typically includes 1 to 3 elements and should be billed with code 99212.

CONCLUSION

Now that we have laid out the basic requirements, we will explore in Part II audit ramifications, diagnosis idiosyncrasies, and Medicare audit problems.