The Eye Codes - Revisited  
Part II  
Riva Lee Asbell  
Philadelphia, PA

INTRODUCTION

As we saw in Part I, the requirements of the eye codes vary from carrier to carrier, but have the same national requirements as listed in the CPT (Current Procedural Terminology). Most eye care professionals believe that the eye codes are easier to use - a concept that is accurate in only some respects.

MEDICAL NECESSITY

The term “medical necessity” has been bandied about extensively without good comprehension of what Medicare really means. It is an obscure concept, even for Medicare, but one that surfaces constantly.

Medicare states that all services must be medically necessary and medically reasonable - and this broad concept gives them a lot of leeway in interpreting your coding, chart documentation, and their decisions for audit and payment. It is not a matter of what a physician deems is “good medicine” or medically appropriate. Rather, the service must be warranted in Medicare’s opinion.

Denials for services made on the basis of the lack of medical necessity are being used more and more when Medicare performs audits in various ophthalmic services and procedures.

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, in a patient being followed for glaucoma with automated visual fields, there would be no medical necessity for performing confrontation fields. In 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 resulting 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; refraction would count. Ordering of all of the special ophthalmic diagnostic tests such as visual fields, extended ophthalmoscopy etc. is considered an initiating a treatment program. An order such as “Return PRN” or “Return to Clinic in one year” would not be an initiation of a diagnostic or treatment program.

LOCAL MEDICAL REVIEW POLICIES (LMRP’s)/CHART DOCUMENTATION/DIAGNOSES

Many of the carriers have a LMRP (By December 2005 all LMRP’s will be converted into LCD’s – Local Coverage Decisions) in place for the eye codes. It is essential that each provider visits the web site of his/her carrier and reviews that policy, if one exists. Then be sure to adapt your chart documentation to incorporate all the requirements. It is now five years since forced entry forms were first described and all practices should have incorporated them.

Most of the local policies have incorporated acceptable diagnoses. A new twist is given in the policy promulgated by HGSA Administrators (the Pennsylvania carrier) whereby given diagnoses are linked to the level of examination. If you bill a comprehensive visit with a diagnosis on the intermediate visit list, the claim will be denied.

The Wisconsin carrier for the state of Wisconsin has prohibited billing extended ophthalmoscopy with the higher level E/M (Evaluation and Management) codes and the comprehensive eye codes. With the reduced reimbursement for extended ophthalmoscopy this year, those billing practices should be carefully reviewed.
AUDITS

In my column July, 2001 column (EyeWorld, July 2001) I wrote:

In your CPT (Current Procedural Terminology) manual there are extensive definitions for the Ophthalmological Services also commonly referred to as the Eye Codes or Ophthalmology Codes. Many practitioners have not paid particular attention to the definitions in the CPT, let alone adhere to their individual carriers’ policies. Beware! Audits of eye codes are starting to surface. The definitions in CPT admittedly are broken and not well crafted, but they are there and are incorporated into almost all local carrier policies. Audits are being conducted based on them. Carriers (Wisconsin Physicians Service Insurance Company and Kansas Medicare among the most prominent) have put out notices of increased audits for the eye codes.

Here are some key points to remember: Make sure you have medical necessity for performing all the individual elements that you are using for the level you choose to bill.

• Technicians frequently forget to do confrontation fields, and to a lesser extent, basic sensorimotor examination. The physician needs to fill those in if the comprehensive codes are to be billed (92004/92014).

• Carriers have screens for the frequency of the comprehensive eye codes. Usually, more than two services per year will be denied or downcoded.

• The new audits focus on the phrase “It always includes initiation of diagnostic and treatment programs.” This has been interpreted by at least one carrier to mean that if you do not initiate a diagnosis or treatment program, even if it is a nonbillable (to Medicare) service, such as a refraction, then under audit the comprehensive eye code will be downcoded to 92002, 92012 or a lower level E/M code.

CONCLUSION

In conclusion, more than ever it is virtually impossible to be in compliance with Medicare policy by only using the four ophthalmology codes. As well, caution is urged when using the ophthalmology codes to be sure those codes are the appropriate ones. If and when they are not, use the E/M codes.
I urge you to pay meticulous attention to your chart documentation and level of coding for all services as well as learning to differentiate when to use the eye codes and when to use the E/M codes. Your best defense is a good chart documentation offense!

Note: On June 18, 2002 I am doing an audio-web conference for the American Society of Ophthalmic Administrators on “E/M versus Eye Codes - The Choice?!?”*. Visit www.asoa.org and click onto information for the Distance Learning Series to sign up.

*This product is available for purchase – see Products.

CPT codes copyright 2001 American Medical Association
©2002 Riva Lee Asbell
EyeWorld July 2002
Reviewed March 2005