PERILS OF THE EYE CODES

Three common coding dangers can be avoided with a basic understanding of the rules and requirements.

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There are innumerable myths, mysteries, and mistakes involving the interpretation of the eye codes. This column addresses some of the perils a practice may encounter in using this set of codes, which is frequently the only set of codes used in a given claim submission.

DEFINITIONS

Below are the four Current Procedural Terminology (CPT) eye code definitions.[1]

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

Additional requirements are described in the prefatory statements that precede the code descriptors. Below is the narrative description for the intermediate eye codes:

> 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 description for the comprehensive eye codes contains 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.
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> 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.

PERIL NO. 1: HOW TO COMPLY

Did you skim over the definitions above? Please read them again carefully. Your successful defense, if and when audited, will depend on your understanding of these requirements and having supported them with the proper chart documentation. Let us take a closer look.

When compared with evaluation and management (E/M) codes (99xxx), the eye codes (92xxx) might appear to be simpler to use. Not true. There are requirements for both sets of codes, and your electronic health record (EHR) system is based on E/M codes rather than on eye codes.[2]

TABLE 1. MANDATORY AND OPTIONAL COMPONENTS OF THE EYE CODES

	Comprehensive Eye Codes	Intermediate Eye Codes
National mandatory components	• History • General medical observation • External examination • Gross visual fields • Basic sensorimotor evaluation • Ophthalmoscopic examination	• History • General medical observation • External ocular and adnexal examination • Other diagnostic procedures as indicated
Optional components	• Biomicroscopy • Examination with cycloplegia or mydriasis (recommended) • Tonometry	• May include mydriasis for ophthalmoscopy
Miscellaneous components	• Initiation of diagnostic and treatment programs (mandated for new patients)	• Initiation of diagnostic and treatment programs (mandated for new patients)

Medical Necessity

Medical necessity is the crux of the Medicare reimbursement program. The service itself—and the component parts of each code—must be medically necessary. Medicare's foundation is that only medically reasonable and medically necessary services will be covered and paid. Performing a service because it is good medicine does not make it medically necessary, according to Medicare.

There are three main components of an office visit: 1) history, 2) examination, and 3) medical decision-making. Most EHRs are set up to capture information on the history portion according to the 1997 Evaluation and Management Guidelines issued by the American Medical Association and the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services, or CMS).[3] There are subtle and obvious differences between the E/M codes and the eye codes for examination, such as documentation for extraocular muscle balance, and a completely different system for calculating level of service. Medical decision-making is inherent in the eye codes, but it is a complicated calculation in E/M codes.

Table 1 provides a breakdown of the mandatory and optional components of intermediate and comprehensive eye codes.

Issues

One problem with eye codes that must be dealt with involves the differences between the prefatory statements and the code descriptors. Both eye codes for new patients (92004 and 92002) require initiation of diagnostic and/or treatment program. Because one is dealing with a new patient encounter, it is unlikely that a diagnostic and/or treatment program would not be initiated, particularly in a retina practice. It may be more problematic to fulfill this requirement in established patients because the key word is *initiate*, which does not suggest simply having a patient return in 6 months. However, the code descriptors allow for *continuation*, which may save the day.

Whose work counts? An important detail is that the physician must perform every component of the examination that is being counted toward fulfilling the requirements of a given code. Components performed by ancillary personnel cannot be counted unless they are also performed by the physician and are documented accordingly. Another important detail to be aware of is that the E/M codes have quantitative numerical examination requirements, whereas the eye codes have mandated examination element requirements.

The last concern is the overuse of 92004/92014 with modifier 25 in order to enable payment of an office visit with a minor surgery procedure. If all of the required components of the code are not performed by the physician, then the code would be considered invalid when audited.

PERIL NO. 2: THE COST OF IMPROPER CODE USE

A practice may lose significant revenue if only the eye codes are used for new patients. New patients presenting to a retina practice inevitably have some type of pathology that requires diagnostic testing and treatment. With the proper chart documentation in place, the encounter can most often be coded as 99204 (E/M code) rather than 92004 (eye code). The national average differential between the two is $16.13, favoring the E/M code (Table 2). Over time, this difference can add up for any size practice.

Conversely, a practice using E/M code 99213 for follow-up visits with established Medicare patients, rather than the intermediate eye code 92012, may lose significant revenue (national differential $12.56). Note: Virtually any time one uses E/M code 99213, the eye code 92012 could be used instead. This may not pertain to non Medicare insurances.

TABLE 2. 2017 RELATIVE VALUE UNITS AND AVERAGE FEES

2017 Conversion Factor = 35.8887
National Averages

OPHTHAL CODES New Patient	RVU NON FACILITY	NATIONAL AVERAGE	E/M CODES OFFICE VISITS New Patient	RVU NON FACILITY	NATIONAL AVERAGE
92002	2.29	$81.52	99201	1.24	$44.50
92004			99202	2.11	$75.72
			99203	3.05	$109.46
			99204	4.63	$166.16
			99205	5.83	$209.23
EYE CODES Established Patient			E/M CODES OFFICE VISITS Established Patient		
92012	2.41	$86.49	99211	0.57	$20.45
92014	3.49	$125.51	99212	1.23	$44.14
			99213	2.06	$73.93
			99214	3.03	$108.74
			99215	4.08	$146.42

PERIL NO. 3: AUDIT TRIGGERS

Comparative Billing Reports

In 2015, comparative billing reports (www.cbrinfo.net/node/85) were issued by eGlobalTech to ophthalmologists who were considered outliers in three areas. One of those areas that pertained to retina specialists was utilization of the eye codes. CMS-outsourced audits have already begun regarding the use of codes for complex cataract cases (another issue), and I would not be surprised to see audits initiated to target the eye codes as well. A full report on this can be found at bit.ly/asbell515.

Overutilization of Eye Codes

It is my opinion that there were serious miscalculations by CMS and eGlobalTech in determining the eye code utilization issue described above. Regarding use of the comprehensive eye codes for new patients, I would expect the percentage to be at 100% for those retina practices using only the eye codes. However, practices are well advised to be aware that using 92014-25 for every intravitreous injection is overcoding and is probably not valid in most instances. This is based on lack of medical necessity for the constant repetition of mandated elements themselves and nonphysician personnel performing the mandated examination elements.

EHR, History Taking, and Chart Documentation

Not having sufficient documentation in place is the main cause of not succeeding in an audit defense. Auditors generally have little clinical background, and, even with some type of medical training, most often cannot intuit the thinking that went into caring for general ophthalmology patients, let alone those in a complex specialty such as retina. Thus, it is safer to overdocument.

EHR systems themselves cause practices to be noncompliant. Compliance with the 1997 Evaluation and Management Guidelines must be quite specific, and few, if any, EHR systems have achieved that specificity.[3] The biggest obstacle lies in the documentation of the history key component, which is made up of four separate portions: 1) chief complaint (CC); 2) history of the present illness (HPI); 3) review of systems (ROS); and 4) past, family, and social history (PFSH). Note that all EHR systems base their history documentation on these four elements, whereas all eye codes simply require a "history." Thus, if the key component history is properly documented for E/M codes, then it is also properly documented for the eye codes.

Below are some tips for possible modification of one's EHR in order to be in compliance.

- Technicians may perform the CC but not the HPI, so separation of the two categories facilitates having the proper person perform each one. The CC is simply the reason for the encounter. The description of complaints (duration, location, etc.) is part of the HPI.

- The ROS/PFSH intake may be performed by anyone, including the patient. Most EHR systems lack a place for the physician to state that these entries were reviewed, with a signature or initials and a date. Without the review and signature, an auditor would disallow these.
- For follow-up office visits, there can be a statement that the ROS/PFSH were reviewed and that there were no changes since the date of the last comprehensive baseline history.
- The ROS/PFSH is an inventory, and, as such, there must be a place in the EHR for documenting negative or positive findings. Cookie-cutter remarks such as "denies breathing problems" or "denies heart issues" are insufficient. The formatting of the EHR often precludes compliance for this important documentation. Furthermore, if the statement regarding changes is incorporated and filled out, then there is no reason to bring forward the same ROS/PSFH ad infinitum.
- The ROS/PFSH is not what physicians were trained in while in medical school. This is a coding document and, as such, combines present and past systems. For example, if a patient is on insulin, then "endocrine" should be noted as positive. The medication list should correlate with the ROS/PFSH.

Initiation of Diagnostic and Treatment Programs

Initiation includes any of the items listed in the prefatory remarks in CPT and cited earlier in this article. However, a statement such as "continue same meds" ordinarily does not qualify because no initiation is indicated. This criteria is more important for new patients because the code descriptors for established patients (codes 92012 and 92014) also provide for "continuation of diagnostic and treatment program," which is good for defense in an audit of the eye codes.

CONCLUSION

With so many Medicare and CMS regulations to cope with, basic teaching regarding use of the E/M and eye codes has fallen by the wayside. Now is a good time to refresh your knowledge of the rules and make sure new associates have a basic understanding of them. A complete course on office visit coding may be found on my website at www.rivaleeasbell.com/articles.php. ■

1. CPT 2017 Professional Edition. Chicago, IL: American Medical Association; 2017.
2. Asbell RL. Smoothing the road to Medicare audits: EHRs, compliance, and personnel vulnerabilities. *Retina Today*. 2015;10(1):33-39.
3. Centers for Medicare & Medicaid Services. 1997 documentation guidelines for evaluation and management services. www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf. Accessed February 2, 2017.

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