Chart Documentation for Pediatric Ophthalmology Examinations

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Coding for pediatric ophthalmology cases is often daunting and confusing. This is due to numerous factors, the most important being the age range of patients who are examined—from newborns to youngsters. In each age group the physician and orthoptist (my introductory career in ophthalmology) are challenged by exactly what can be performed due to cooperation, other disabilities, and the overall condition of the patient.

Chart documentation for pediatric examinations is every bit as important as that in adults, even though the payer frequently is not Medicare. Many third-party payers are unsure of themselves, particularly with the eye codes, and it behooves you to document as you would for Medicare, indicating when something was not performed why it was not. An example would be confrontation visual fields. In very young children this may not be possible to obtain; then a notation should be made "not done due to inability to comprehend test," "not done due to poor cooperation," or some similar notation. If your practice is audited, these various components of chart documentation will be evaluated and noted if performed or not.

Tables 1 and **2** describe the examination requirements for the E/M (evaluation and management codes) and the eye codes (ophthalmology codes) respectively.

Chart documentation alternatives

Comments on what ordinarily can be documented follows.

Vision. Usually it is possible to have some notation, such as "fixes and follows or responds to light," even at a very early age. Even in retinopathy of prematurity (ROP) examinations, some sort of notation is usually possible.

Confrontation visual fields. It is not possible to conduct a true confrontation field in very young patients, so when this occurs, state the reason. Examples would be: "Unable," "Poor Cooperation/Comprehension," "Too Young."

Ocular motility. For E/M coding, if you cannot measure primary gaze alignment, note Hirshberg findings as a minimum. Also try to add versions. For the eye codes, I would do the same. Sensory tests should also be added. For additional coding of CPT code 92060 (sensorimotor examination with multiple measurements of ocular deviation [e.g., restrictive or paretic muscle with diplopia] with interpretation and report) you should have measured the cardinal fields using the prism and cover technique. Do not bill when only estimating restriction. Be sure to add some sensory testing results as well.

Conjunctiva. This is easily examined and documented in all age groups.

Ocular adnexa including eyelids, etc. This usually can be examined and documented in all age groups.

Pupils/irides. This is usually easily documented in most patients. You may want to add check-off boxes for "PERRLA," "No APD," "Paradoxical," or add them to your EMR drop-down menus.

Slit lamp examination. Under E/M coding, the following elements require slit lamp examination: **cornea, anterior chamber, lens.** If you are using a pen light instead of slit lamp in very young children or under special circumstances, be sure to note that. Most insurers will accept the notation as having been performed.

Intraocular pressure. As suggested with confrontation visual field documentation, documentation of the inability to perform measurement of intraocular pressure as well as the technique used, should be noted. Examples: "Unable," "Digital," "Schiotz," "Applanation," "Tonopen," "Pneumo."

Dilated fundus examination of optic disc and posterior segment. The E/M guidelines and many Medicare local coverage determinations require dilated examinations or those elements cannot be counted. If there is a medical reason why the patient is not being dilated that should be documented (for example, "previous allergic reaction," "suspected neurologic problem," etc.). Many insurers will allow a higher-level examination without dilation for pediatric patients if the reason is given; otherwise dilation should be performed.

Miscellaneous tips

History. Pediatric histories frequently include information pertaining to family history. It may be difficult to fulfill all the elements of an E/M history without including pertinent negatives.

Level of coding. Some time ago the American Association for Pediatric Ophthalmology and Strabismus surveyed its members. A surprisingly large number of practitioners were coding initial encounters as E/M level 5. I suggest you review the Medicare Table of Risk as well as the E/M guidelines and ascertain that your case falls into that category – most do not.

Amblyopia checkups. I am often asked what level to code for amblyopia checkups when only a vision and perhaps primary gaze alignment are performed along with giving further instructions on therapy. For these quick checkups, in my opinion, E/M code 99212 is most appropriate. AE

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Table 1. Evaluation and Management (E/M) Codes
Eye Examination

System/Body Area	Elements of Examination
Eyes	•☐ Test visual acuity (does not include determinations of refractive error) •☐ Gross visual field testing by confrontation •☐ Test ocular motility including primary gaze alignment •☐ Inspection of bulbar and palpebral conjunctiva •☐ Examination of ocular adnexa including lids (e.g., ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits, and preauricular nodes •☐ Examination of pupils, irises, including shape, direct and consensual reaction (afferent pupil), size (e.g., anisocoria) and morphology •☐ Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film •☐ Slit lamp examination of anterior chambers including depth, cells, and flare •☐ Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus •☐ Measurement of intraocular pressures (except in children and patients with trauma or infectious disease) Ophthalmic examination through dilated pupils (unless contraindicated) of •☐ Optic discs including size, C/D ratio, appearance (e.g., atrophy, cupping, tumor elevation) and nerve fiber layer •☐ Posterior segments including retina and vessels (e.g., exudates and hemorrhages)
Neurological/ Psychiatric	Brief assessment of mental status including •☐ Orientation to time, place, and person •☐ Mood and affect (e.g., depression, anxiety, agitation)

Table 2. Eye Codes (Ophthalmology)
Eye Examination

Intermediate Examination	CPT Codes 92002, 92012
	•☐ External ocular and adnexal examination
Comprehensive Examination	**CPT Codes 92004, 92014**
	•☐ External ocular (and adnexal)* examination •☐ Ophthalmoscopic examination •☐ Gross visual fields •☐ Basic sensorimotor examination *Not in description for comprehensive but is recommended —RLA