# E/M versus Eye Codes – Choices for 2019
# Part III ©


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**E/M or EYE CODES?**

Since ophthalmology is the only specialty privileged to have the option of choosing between the two sets of codes for outpatient services (E/M and Eye Codes), for each encounter you must make a decision– which is the best code to use. This should be based on three factors: compliance, medical necessity and financial optimization.

As we are nearing the end of the decision making process, some distinguishing factors should be apparent. Eye codes are vague – there are no sharp divisions between history, examination and medical decision making. Rather, they are all lumped together whereas the E/M codes are quite specific. I have found the E/M codes are easier to defend under audit.

Eye code examination requirements may vary from the different Medicare contractors. You must have medical necessity for the service itself as well as each examination element you are performing. You cannot decide "I always bill 92014" twice a year. There must be medical necessity for the level of service in both sets of codes. The four elements of comprehensive eye code examination and two elements of intermediate eye code examination are set by CPT dictate. You have no choice. Thus, there must be medical necessity for each element. In E/M codes you have a choice of elements – it is a quantitative requirement. Any of the elements fulfill the numerical requirement as long as there is medical necessity.

Compliance, in Medicare terms, means adhering to CMS's regulations and making sure that your chart documentation supports the code and level of service that you have chosen. Medicare wants you to neither overcode nor undercode. Audits are conducted for both mistakes.

The following factors should guide you in making the final decision: compliance, local and national policies and, finally, financial optimization. There really is no problem in selecting a code that also is remuneratively rewarding.

***Code Selection.***

For 2019 it has become imperative that you pay close attention to your coding. For many practitioners, especially the subspecialists who were dependent on the remuneration from the Consultation Codes, there has been a reduction in revenue.

There are certain subspecialties, like oculoplastics, wherein the physicians forewent the dilated fundoscopy examination on new patients/consultation. It is time to revisit and recalculate that. Without funduscopy the most you can bill would be an E/M level 3 new patient ($109.76) whereas with a dilated fundus examination you can bill a level 4 new patient ($166.86).

*Figure 1* is a chart showing the main codes available for coding office encounters in a nonfacility setting for 2019.

In reality you probably will only be using 5 or so of the codes in every day practice. Let's see how the algorithm works.

**New Patients**

***Review Part I and Part II of this series before continuing!***

At the end of the day, when you finish examining the patient and your chart documentation is filled out properly, ask yourself "What is my adjective in E/M codes?" If your answer is Low you are at E/M level 3; if your answer is Moderate you are at E/M level 4, and if your answer is High you are at E/M level 5.

***New Patients.*** If your level is 4 or higher then you should probably being using E/M codes. If your level is 3 or lower you probably should be using Eye Codes unless you fail to initiate a diagnostic and treatment program at the comprehensive eye code level. Then you will have to drop to 99203.

Let's look at an example. A patient is examined with complaints of difficulty seeing out of the right eye etc. A comprehensive history is taken and a comprehensive examination is performed. It is determined that the patient has open angle glaucoma and dry macular degeneration. The adjective is moderate – so you would use CPT code 99204.

The next patient comes in with similar complaints, but has only an early cataract and receives a new prescription for glasses and to return in 6 months. The adjective would be low – so the level is 3. A comprehensive eye code (92004) is the better choice financially over the appropriate E/M code (99203).

**Return office visits**

***92012 versus 99213.*** For return office visits for conditions requiring more frequent visits the choice is often between CPT codes 99213 and 92012. An error was made in the RVU calculation in 1998, and the erroneous calculation has been pretty much maintained. This has resulted in significantly higher reimbursement for code 92012 - $14.42 in 2019 on a national average. Given the choice, the eye code pays better than the E/M code and can be pretty much used in most instances.

***92014 versus 99214.*** Code 92014 basically should be used when coding for comprehensive eye examinations and not for follow-up visits for serious disease.

Use 92014 for your follow-ups where medical necessity dictates a comprehensive examination – such as a return in one year for cataract follow-up. The code is not intended to be used for frequent follow-up visits for serious pathological conditions.

Use 99214 when following serious diseases as long as your medical decision making is moderate and you have the medical necessity to perform nine of the elements. This code has been a target of OIG investigations and you should be confident of your coding skills and chart documentation when using it.

***99212.*** Most Medicare local coverage determinations for the eye codes mandate(d) that for minimal services code 99212 be used – not 99213 or 92012. Quick checkups for conjunctivitis or healing corneal abrasions would fall into this category.

As a final note I would like you to review the definition of a new patient. The CPT and Medicare's definition of a new patient is one who has not received any professional services from the physician or another physician of the same *specialty* who belongs to the *same group practice* in a *face-to-face encounter in three years*. The definition of new patient incorporating "face-to-face" was revised several years ago. In 2014 Medicare audits began using the NPI (National Provider Identifier) number as the identifying number to check if the patient had ever been examined by the given provider within the past three years.

In many established practices that three plus years goes by rather quickly and you are losing about 30 percent of potential reimbursement for the visit by not coding the encounter as new. I see this all the time when auditing.

For example, if you had been renewing glaucoma medication in patient confined to a skilled nursing facility but not actually had examined the patient in a face-to-face encounter for three years, then if that patient, if seen in the office, it would be a new patient.

In conclusion, I hope that this series has provided you with a logical methodology for solving the dilemma when faced with choosing between E/M and Eye Codes. You should be mixing your use of the codes to maintain compliance while optimizing reimbursement at the same time. Good Luck!

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