E/M versus Eye Codes – Choices for 2018

Part II The Ophthalmology (Eye) Codes

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INTRODUCTION

In this installment of the series, the Eye Codes are reviewed and their definitions, examination requirements and ambiguities are explored. The Eye Codes are technically referred to in CPT as General Ophthalmological Services. Most practices have never really studied these codes - they have just always used them, not being aware that they are a part of CPT or that there are rules for them.

DEFINITIONS AND CONTRADICTIONS

There are four codes: two *new patient* codes for new 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 (Current Procedural Terminology) and the local requirements being found in your Medicare contractor's LCD (Local Coverage Determination). Most LCD's include the CPT definitions. Be sure you see if your Medicare Administrative Carrier (MAC) has a policy – most have been retired but practices would do well to know what the requirements were.

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

The narrative descriptions in CPT are found under Special Ophthalmological Services. They 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."

A significant problem is that the definitions in the general description of the eye codes do not correspond with the code descriptors found next to the CPT code numbers.

In both set of codes for ***established*** patients the code descriptor allows for "initiation or continuation of diagnostic and treatment programs".

However, in the narrative for the comprehensive codes there is a statement that the code "... always includes initiation of diagnostic and treatment programs". In my experience this should be adhered to when using 92004 and 92014 because under audit the code will be disallowed or downcoded if that does not occur.

It is acceptable to use 92012 for continuation of medical treatment, such as in glaucoma follow-ups.

Examination Requirements

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

And, in many states, the Medicare contractors had mandated elements similar, but not identical, to those found in the E/M (Evaluation and Management) codes. A typical policy may have listed 10 elements and stated 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 varied from carrier to carrier.

Most all of the LCD policies stated 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. I recommend following this practice.

Dilation requirements differ for each Medicare contractor wherein some carriers mandate that the pupils be dilated in order to count the posterior segment elements and others do not.

The chart below outlines these requirements:

	Comprehensive Eye Codes	Intermediate Eye Codes
National Mandatory Components	• History • General Medical Observation • External examination • Gross Visual Fields • Basic Sensorimotor Evaluation • Ophthamoscopic examination	• History • General Medical Observation • External ocular and adnexal examination • Other diagnostic procedures as indicated
Optional Components	• Biomicroscopy • Examination with cycloplegia • Tonometry	• May include mydriasis for ophthalmoscopy
Miscellaneous Components	• Initiation of diagnostic and treatment programs	

Medical Necessity

When Medicare performs audits of various ophthalmic services and procedures, denials for services are most often based on the lack of medical necessity.

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.

When dealing with evaluation/management services or general ophthalmological services, not only does the service itself (both E/M and Eye Code office visits) 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.

Initiation of Diagnostic and Treatment Programs

Several years ago audits of the comprehensive eye codes (92004/92014) were conducted with resultant 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; prescribing eyeglasses would count. Ordering of any of the special ophthalmic diagnostic tests, such as visual fields or OCT, is considered an initiating a diagnostic 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, nor would "continue same meds".

CONCLUSION

In Part III we will review how to make the choice between E/M versus Eye codes based on compliance and reimbursement optimization and, remember, under audit your best defense is a good chart documentation offense!

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