

Glaucoma Office Visits

Documenting services for Medicare and Medicaid.

BY HEATHER B. FREELAND

The guiding principle for Medicare is determining whether a medical service billed to the program is medically necessary, medically justified, and medically reasonable. If any one of these qualities is missing, the service will probably be denied as not meeting the criteria for Medicare coverage. Documentation in a patient's chart is the first line of defense for any level of office visit, diagnostic test, or surgical procedure.

PRIMER ON OPHTHALMOLOGICAL OFFICE CODES

Ophthalmologists have an advantage over other specialists when it comes to billing Medicare for office encounters. They have a choice between ophthalmological or eye codes (92002-92014) and evaluation and management (E & M) codes (99201-99215). Most physicians are familiar with the Centers for Medicare & Medicaid Services' (CMS) guidelines for expected docu-

TABLE 1. DOCUMENTATION GUIDE FOR EYE CODES VERSUS E & M CODES: COMPREHENSIVE AND INTERMEDIATE LEVELS OF SERVICE

Comprehensive Services	
Eye codes (92004, 92014)	E & M codes (99204, 99214)
Ocular history, CC	Complete history, CC • Extensive HPI, complete ROS, and complete PFSH
8 to 10 examination elements	All 13 examination elements
Dilation performed	Dilation performed
Treatment program initiated • Only need 1 Dx and 1 mgmt option • Can be Rx for new glasses, diagnostic test, plan surgery, etc.	Medical decision making requires 2 of 3 • 5 to 6 Dx and/or mgmt options • Moderate amount of data • Moderate-to-high risk
Intermediate Services	
Eye Codes (92002, 92012)	E & M Codes (99202, 99213)
Brief ocular history, CC	Expanded problem focused history, CC • Brief HPI and pertinent ROS
3 to 7 examination elements	6 to 8 examination elements
No dilation required	No dilation required
No initiation of treatment program required • Only need 1 Dx	Medical decision making requires • 3 to 4 Dx and/or mgmt options • Limited amount of data • Low risk (requires minimal treatment plan)
Abbreviations: CC, chief complaint; Dx, diagnosis; HPI, history of the present illness; mgmt, management; PFSH, past, family, and social history; ROS, review of systems; Rx, prescription.	

TABLE 2. A COMPARISON OF THE FEES FOR THE NEW PATIENT'S INTERMEDIATE AND COMPREHENSIVE OPHTHALMOLOGICAL CODES AND THE EQUIVALENT E & M OFFICE SERVICES FOR 2010

EYE CODES	E & M OFFICE CODES
92002 - \$70.72 Intermediate	99201 - \$38.97 Problem focused
	99202 - \$67.47 Expanded problem focused
92004 - \$132.41 Comprehensive	99203 - \$92.77 Detailed
	99204 - \$151.53 Moderately complex comprehensive

mentation in the medical chart for each level of E & M service. Ophthalmologists should use the May 1997 guidelines that are available on the CMS' Web site at <http://www.cms.gov/MLNProducts/Downloads/MASTER1.pdf>.

Currently, ophthalmological codes are reimbursed at a higher rate under Medicare than the respective E & M codes. Choosing which code to use depends on the documentation in the chart. For an E & M service, the CMS' E & M guidelines must be followed. For an ophthalmological code, the individual state contractor's local coverage determination, either retired or active, must be followed. There are no national Medicare guidelines for the documentation of ophthalmological codes.

When billing E & M services, it is important to remember that the examining physician must document obtaining the history of the patient's present illness for higher levels of service (levels 3-5) and must perform the required number of elements of the examination in addition to documenting the diagnosis and treatment as a result of the encounter. Technicians cannot perform these E & M requirements, and for those elements to be counted toward the level of service, a technician can only serve as a scribe for the dictating physician. Also, the final outcome of the visit and the reason for the visit have a direct bearing on whether the level being billed is appropriate.

When performing at least one element of the slit-lamp and one element of the fundus examination, it is appropriate to bill an ophthalmological examination rather than an E & M service. Failure to document the performance of both ophthalmological components only leaves the E & M service documented. To bill a

comprehensive eye code, the initiation of a diagnostic or therapeutic plan of treatment must also be documented (Table 1).

NEW PATIENTS

A new patient is defined in Current Procedural Terminology and by the CMS as someone who has not been seen by the physician, either at all or within the last 3 years (and 1 day just to be sure). A new glaucoma patient is usually the result of a referral from his or her primary eye care specialist. With the demise of consultations for Medicare patients, glaucoma specialists now must choose the appropriate office service—E & M or ophthalmological.

Documentation of a new patient's visit should always include the medical reason why he or she was sent to a glaucoma specialist. If the patient does not know why he or she was referred, the visit may only be billed as a routine visit.

As a rule, a glaucoma patient should receive a comprehensive level of service on his or her first visit, one that includes pupillary dilation and diagnostic testing. Unless the patient has multiple medical problems or requires surgery, the level of the E & M visit should not be above a detailed service. The comprehensive new patient ophthalmic examination, on the other hand, requires less documentation and pays more under Medicare (Table 2).

ESTABLISHED PATIENTS

It is easier to document the chief complaints of established glaucoma patients than other types of patients due to the previously diagnosed glaucoma. Since the patient presents to the ophthalmologist for the glaucoma visit, no other chief complaint is required.

When a patient is asked to return for a glaucoma check 3 weeks after a change in glaucoma medications, that follow-up visit can be a simple pressure check or result in a complete examination with pupillary dilation. If the documentation supports only a simple pressure check with no new complaints and no additional plan of treatment, the maximum E & M level warranted is a problem-focused evaluation (code 99212). If a fundus examination is performed, an intermediate ophthalmic examination is warranted.

However, if the new prescribed medication does not perform as expected and the patient requires re-evaluation of the possible available medicines, the level of service escalates. If a change in the medication is required again, the justified level is at least an expanded problem-focused evaluation (code 99213). If a dilated fundus examination was necessary, a comprehensive ophthalmic examination could be warranted. Ordering a different medication is the initiation of a plan of treatment (Table 3).

(Continued on page 64)

(Glaucoma Office Visits, continued from page 59)

TABLE 3. A COMPARISON OF THE FEES FOR THE ESTABLISHED PATIENT'S INTERMEDIATE AND COMPREHENSIVE OPHTHALMOLOGICAL CODES AND THE EQUIVALENT E & M OFFICE SERVICES FOR 2010

EYE CODES	E & M CODES
92012 - \$74.68 Intermediate	99212 - \$38.97 Problem focused
	99213 - \$65.66 Expanded problem focused
92014 - \$108.96 Comprehensive	99214 - \$98.50 Detailed
	99204 - \$132.77 Moderately complex comprehensive

CHIEF COMPLAINTS

The first criterion for a medically necessary office visit under Medicare is that the patient be documented as being seen for a medical complaint, illness, or symptom. The chief complaint is usually a brief statement of the reason the patient made the appointment with the ophthalmologist. It should never just be a general statement that everything is "fine" and there is nothing wrong with the patient's vision.

The reason for a new patient's visit is usually documented as the chief complaint and the reason for the visit. The reason for an established patient's return to the practice is generally found in the plan of the previous visit.

When the patient is happy with his or her vision and adheres to prescribed medical therapy, the chart should indicate the medical condition—glaucoma—that prompted the visit. Then, and only then, is it appropriate to mention everything is "fine." Failure to list a medical reason for the visit will likely result in a denial from the contractor in the event of an audit.

CONCLUSION

An office visit for a glaucoma patient can vary from that of a general ophthalmological patient. It can range from seeing a patient who needs a simple IOP check with visual field testing to a more complex scenario of a patient with elevated IOP who requires laser treatment that day. The simpler the problem, the lower the level of service needed and vice versa. □

Heather B. Freeland is the director of coding and compliance at Rose & Associates in Duncanville, Texas. Rose & Associates is a health care consulting firm specializing in Medicare reimbursement and compliance for the specialty of ophthalmology. Ms. Freeland may be reached at (800) 720-9667; results@roseandassociates.com.

