Unveiling the Secrets of Eye Examination Codes – Maximizing Reimbursement

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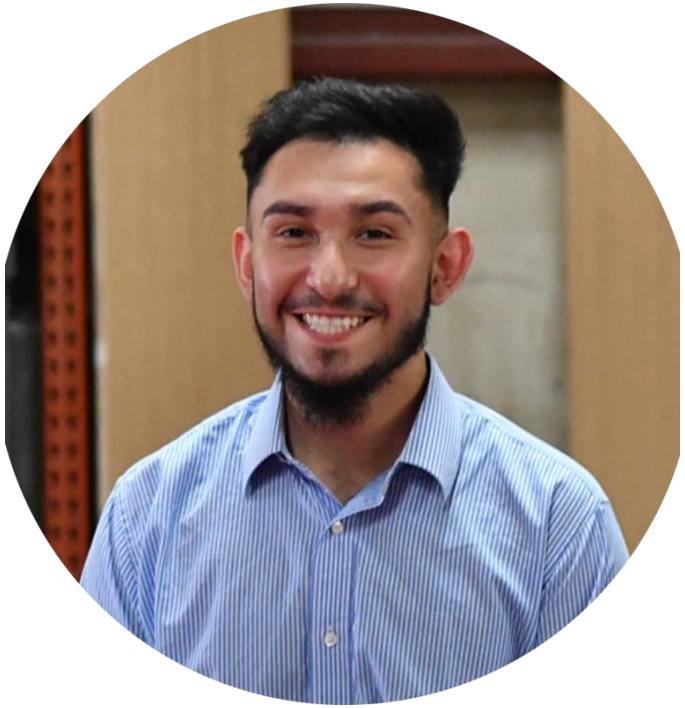

AMA CPT Disclaimer

This material is intended to provide information on coding and billing based on the instructor's experience and training. The instructor disclaims any responsibility for errors, omissions, misuse, or misinterpretation. This handout serves as an educational guide and should not be regarded as a legal or consulting opinion

Objective

- Understand the differences and appropriate use of both family code sets: Evaluation and Management (99202-99215) and Ophthalmology-specific (92002-92014).
- Apply current documentation guidelines to ensure compliance and support accurate coding.
- Identify strategies for maximizing reimbursement through proper code selection.

E/M or Eye Visit Code?

Ophthalmologists have two office-based exam code families to choose from, and the key is understanding when to apply each one based on specific conditions.

Evaluation and Management (99202-99215) and Ophthalmology-specific (92002-92014).

Documentation Guidelines

Evaluation and Management

- Medically relevant history and exam, determine level of E/M from medical decision making or total physician time

Eye Visit Codes

- Meet history, exam elements and initiation of diagnostic and treatment program

Elements of Evaluation and Management

- Number and Complexity of Problems Addressed at the Encounter
- Amount and/or Complexity of Data to be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management

CPT E/M | Level of Medical Decision-Making Table

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Time

Total time on the date of the encounter

Includes physician or other QHP

- Face-to-face and non-face to face time
- Time spent by clinical staff is not includes

Time Considerations for E/M code selection

Includes time spent on the following tasks:

Preparing	Preparing for the patient encounter (reviewing test results)
Conducting	Conducting necessary examinations and evaluations
Reviewing	Reviewing patient history (if obtained separately)
Providing	Providing counseling and education to the patient, family, caregiver
Ordering	Ordering medication, tests, or procedures
Documenting	Documenting clinical information in the EHR or other records
Coordinating	Coordinating care and consulting with other healthcare providers

Case studies

Evaluation & management in Ophthalmology

E/M Case Study

A patient with a known glaucoma comes in for a follow-up to check the intraocular pressure and review test results. Stable glaucoma - the ophthalmologist adjusts the medication dosage and discusses ongoing management.

MDM: 1 Stable Chronic Illness + Prescription drug management

99213 (Established Patient Visit)

E/M Case Study

1. A patient with diabetic retinopathy visits for a routine follow-up. The ophthalmologist performs a detailed exam, including a review of the patient's current medications and blood sugar control, and identifies new retinal changes that require laser treatment (major surgery), taking approximately 35 minutes.

MDM: 1 Chronic Illness with progression + Decision regarding elective major surgery without identified patient or procedure risk factors

Exceeded 35 min

99214 (Established Patient Visit)

E/M Case Study

A new 7-year-old patient presents after failing a vision screening at school, with a chief complaint of blurry vision. A comprehensive eye examination, including a manifest refraction, is conducted. The patient is diagnosed with myopia in both eyes and is prescribed contact lenses.

MDM: Minor problem + minimal risk of morbidity from additional testing and treatment

CPT 99202 (New patient visit)

Eye Codes

92002:

Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient

92012:

Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

92004:

Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

92014:

Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits

Initiation of Diagnostic and Treatment Program

Includes, but is not limited to:

- ❑ Prescription of medication, glasses, or contact lenses
- ❑ Arranging for special ophthalmological diagnostic or treatment services
- ❑ Consultations
- ❑ Laboratory procedures
- ❑ Radiological Services
- ❑ Recommendation or decision for or scheduling or performance of a major or minor procedure
- ❑ Scheduling necessary follow-up of a medical problem
- ❑ Other

Need 1 or more from the list to meet the definition

Elements of Intermediate Exam Codes (92002 -92012)

History

- ❑ Chief compliant
- ❑ History
- ❑ General medical observation

Examination

Three or more, but less than 12 elements of the exam medically necessary to perform

- Visual acuity
- Gross or confrontation visual fields
- Extraocular motility
- Conjunctiva
- Ocular adnexa
- Pupil and iris
- Cornea
- Anterior chamber
- Lens
- Intraocular pressure
- Optic nerve disc
- Retina and vessels

Elements of Comprehensive Exam Codes (92004 - 92014)

History

- ❑ Chief compliant
- ❑ History
- ❑ General medical observation

Examination

All 12 elements of the exam medically necessary to perform unless unable due to age of patient or trauma

- Visual acuity
- Gross or confrontation visual fields
- Extraocular motility
- Conjunctiva
- Ocular adnexa
- Pupil and iris
- Cornea
- Anterior chamber
- Lens
- Intraocular pressure
- Optic nerve disc
- Retina and vessels

- ❑ **Dilation**: As medically necessary. If not dilated, document why.

The medical record should indicate the reason why it was not done. Without documentation of dilation (or an explanation of its omission), the visit may not meet the criteria for coding as a comprehensive exam.

Common Abbreviations | Ophthalmology

- OD – Right eye
- OS – Left eye
- OU – Both eyes
- IOP – Intraocular pressure
- VA- Visual Acuity
- VF – Visual field
- EOM – Extraocular movement
- AC – Anterior chamber
- K – Cornea
- MF – Manifest Refraction
- RX – Prescription for glasses

Compliance, accuracy, and clarity in patient records

Maintaining a standardized list of abbreviations for clinical documentation is essential for several reasons, especially for compliance, accuracy, and clarity in patient records. Here’s why it's so important:

By adopting and regularly updating an approved abbreviation list, a practice can improve the accuracy, safety, and efficiency of its clinical documentation while adhering to essential compliance standards.

Documentation of the Biomicroscope

Slit lamp examination (Biomicroscope) – A microscope that looks at the structures of both the front and inside of the eye.

Slit lamp Exam		
OD (RT)		OS (LT)
Right lower lid edema	Lids	Left lower lid cyst
Right upper lid Madarosis	Lashes	Trichiasis
Tendinitis	Adnexa	Periorbital edema
Pterygium	Conjunctiva	Concretions
Anterior scleritis	Sclera	Nodular Episcleritis
Pannus	Cornea	Photokeratitis
Hyphemia	Anterior chamber	Hypopyon
Rubeosis Iridis	Iris	Iris Nevus
Aphakia	Lens	Nuclear Cataract

Documentation of the Ophthalmoscopy

Fundus Exam (ophthalmoscopy) – test that allows you to see the back of your eye

Fundus Exam		
OD (RT)		OS (LT)
Optic Nerve temporal pallor	Disc	Thinning
Benign choroidal nevus	Choroid	Choroidal neovascularization
Subretinal fluid	Retina	Retinal tear
Macular hole	Macula	Edema
Hypertensive Retinopathy	Vessels	Artery occlusion
Lattice degeneration	Peripheral	Exudates
Vitreous detachment	Vitreous	Floaters

Case studies

Intermediate & comprehensive exams

Eye examination case study

Patient Presentation: A 55-year-old established patient with a history of dry eye presents for evaluation due to recent complaints of eye discomfort and mild blurred vision.

Exam Elements:

- Visual acuity testing
- Gross or confrontation visual fields
- Evaluation of the conjunctiva and cornea
- Assessment of intraocular pressure
- Brief review of ocular history and general medical observation
- Initiation of a diagnostic and treatment plan, including new artificial tear prescription and recommendations for environmental adjustments.

CPT Code: **92012** - Intermediate ophthalmological service for an established patient.

CPT Guidelines:

- **92012** is used when three or more elements of the eye exam are performed and medically necessary, and a diagnostic or treatment plan is initiated or continued.
- This level of service is appropriate for an established patient with specific complaints that require targeted assessment but not a full comprehensive exam.

Eye examination case study

Patient Presentation: A 70-year-old new patient with diabetes presents for an annual diabetic eye exam, reporting no current visual symptoms.

Exam Elements:

- Visual acuity testing
- Gross or confrontation visual fields
- Extraocular motility assessment
- Evaluation of conjunctiva, cornea, anterior chamber, and lens
- Fundus examination with dilated ophthalmoscopy to assess retina and optic nerve
- Intraocular pressure measurement
- Detailed review of ocular and systemic health history
- Discussion of findings, initiation of monitoring plan, and scheduling of follow-up exams to monitor potential diabetic retinopathy progression.

CPT Code: **92004** - Comprehensive ophthalmological service for a new patient, 1 or more visits.

CPT Guidelines:

- **92004** applies to a new patient when all elements of the comprehensive eye exam are performed, unless omitted for a specific reason (e.g., dilation contraindicated).
- This code requires documentation of a complete eye exam, including dilation (or documentation explaining if it’s not performed), and initiation of a diagnostic or treatment program.

Eye examination case study

Patient Presentation: 60-year-old new patient with a history of hypertension who presents for an initial eye examination, reporting occasional blurred vision and mild headaches.

Exam Elements:

- Visual acuity testing
- Gross or confrontation visual fields
- Extraocular motility assessment
- Evaluation of conjunctiva, cornea, anterior chamber, and lens
- Fundus examination without dilated ophthalmoscopy to examine the optic nerve & retina as much as possible
- Measurement of intraocular pressure
- Detailed review of ocular, family, and systemic health history
- Documentation of findings, initiation of a diagnostic plan to monitor intraocular pressure, and scheduling of periodic follow-ups due to glaucoma risk.

CPT Code: **92002** - Intermediate ophthalmological service for a new patient, 1 or more visits.

CPT Guidelines:

- **92004** requires a new patient exam with all 12 exam elements medically necessary, or documentation for any omissions (such as contraindicated dilation).

9 Scenarios When You Should Not Submit an Eye Visit Code

- ICD-10 code is not a covered diagnosis
- POS is not the office
- Frequency exceeded
- E/M required for medical diagnoses
- Subject to down coding based on diagnosis
- Commercial plan still recognized consult codes
- Telemedicine
- Prolonged services
- Payer allowable
- Bonus: Visit qualifies for complexity code, G2211

2024 National Average MPFS * Mar 9 – Dec 31, 2024

New Patient

E/M	Office	RVU
99202	$72.23	2.17
99203	$111.51	3.35
99204	$167.10	5.02
99205	$220.36	6.62

Eye	Office	RVU
92002	$84.55	2.54
92004	$148.46	4.46

Established

E/M	Office	RVU
99212	$56.59	1.70
99213	$90.87	2.73
99214	$128.16	3.85
99215	$180.42	5.42

E/M	Office	RVU
92012	$88.88	2.67
92014	$125.49	3.77

E/M vs Eye Visit Codes

1. New patient: medically relevant history, comprehensive exam, **low** MDM

E/M	
99203	$111.51
Eye	
92004	$148.46

2. New patient: medically relevant history, comprehensive exam, **moderate** MDM

E/M	
99204	$167.10
Eye	
92004	$148.46

3. Est patient: medically relevant history, comprehensive exam, **low** MDM

E/M	
99213	$90.87
Eye	
92014	$125.49

4. Est patient: medically relevant history, problem-focused exam, **moderate** MDM

E/M	
99214	$128.16
Eye	
92012	$88.88

Case Study

A patient with a known glaucoma comes in for a follow-up to check the intraocular pressure and review test results. Patient was dilated & a comprehensive exam was performed. Stable glaucoma - the ophthalmologist adjusts the medication dosage and discusses ongoing management.

Exam Elements:

- Visual acuity testing
- Gross or confrontation visual fields
- Extraocular motility assessment
- Evaluation of conjunctiva, cornea, anterior chamber, and lens
- Fundus examination with dilated ophthalmoscopy to assess retina and optic nerve
- Intraocular pressure measurement
- Detailed review of ocular and systemic health history
- Discussion of findings, initiation of monitoring plan, and scheduling of follow-up exams to monitor the intraocular pressure.

99213: Level 3 MDM | $90.87

92014: Comprehensive Exam | $125.49

Case Study

a 65-year-old established patient with a history of diabetic retinopathy presents for a follow-up examination. The patient reports mild vision changes in one eye and recent fluctuations in blood sugar levels, both of which could impact their ocular health. Given these concerns, the provider decides to perform a comprehensive examination to assess any potential diabetic progression.

- **Exam Elements** documented for this visit include:
- Visual acuity testing,
- Gross visual field assessment,
- Extraocular motility evaluation,
- Examination of the conjunctiva, cornea, anterior chamber, and lens,
- A dilated fundus exam to assess the retina, optic nerve, and vascular structures,
- Measurement of intraocular pressure,
- A thorough review of the patient's ocular and systemic health history, especially related to diabetes,
- Discussion of findings and initiation of a treatment plan.

Additionally, due to the diabetic progression, the provider prescribes a medication to help control the underlying condition and prevent further ocular complications.

92014: Comprehensive Exam | $125.49

99214: Level 4 | 148.46

Separately Billable Diagnostic and Exam Components

- Tonometry
- Fundus Photography
- Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)
- Visual Field Testing
- Refraction
- External Ocular Photography
- Corneal Topography
- Sensorimotor Exam
- Ultrasonography
- Gonioscopy

ICD-10-CM codes in ophthalmology

Diabetes Mellitus with Ophthalmic Manifestations (E08-E13)	Disorders of the Eyelid, Lacrimal System, and Orbit (H00-H05)	Disorders of the Conjunctiva (H10-H11)	Disorders of the Sclera, Cornea, Iris, and Ciliary Body (H15-H22)	Disorders of the Lens (H25-H28)	Disorders of the Choroid and Retina (H30-H36)
Glaucoma (H40-H42)	Disorders of the Vitreous Body and Globe (H43-H44)	Disorders of the Optic Nerve and Visual Pathways (H46-H47)	Disorders of Ocular Muscles, Binocular Movement, Accommodation, and Refraction (H49-H52)	Visual Disturbances and Blindness (H53-H54)	Other Disorders of Eye and Adnexa (H55-H57)
	Intraoperative and Postprocedural Complications (H59)	Q Codes - Congenital Malformations Related to the Eye and Adnexa (Q00-Q99	Injury and Trauma-Related Codes (S00-S09, T15-T19)	Z Codes - Factors Influencing Health Status and Contact with Health Services	

Reduce risk of Denial

Some policies do not cover unspecified eye conditions or diagnoses.

Review records to ensure that coding reflects the highest level of detail.

Identify and clarify any unspecified eye diagnoses before submitting the claim.

- Consult with the provider as needed.

Understand visit modifiers

- Modifier 24 | Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

- Modifier 25 | Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

- Modifier 57 | Decision for Surgery, major procedure

Modifiers 25

- Modifier 25 should be used when a significant and separately identifiable exam is conducted on the same day as a minor ophthalmic procedure. Proper documentation is essential, as these instances often come under intense scrutiny from insurance payers and are common targets for audits and Office of Inspector General (OIG) investigations.

Common misconceptions

Modifier 25 should only be used if the exam addresses issues unrelated to the scheduled procedure. If the exam is primarily for the condition being treated in the procedure, modifier 25 is inappropriate.

Correct Use of Modifier 25

- **Scenario:** A patient comes in for an evaluation of dry eye symptoms. During the visit, the ophthalmologist diagnoses the patient with dry eye and performs punctal plug insertion to treat it. While discussing the dry eye issue, the patient also complains of new symptoms of floaters in their vision. The ophthalmologist performs an additional examination to evaluate the floaters.
- **Application:** In this case, modifier 25 is appropriate because the evaluation and management (E/M) service for the floaters is **separate and distinct** from the service related to the dry eye and punctal plug insertion. Both the floaters and dry eye required separate evaluation and management.
- **Claim:** You would bill the E/M code for the exam (e.g., 99213) with modifier 25, along with the procedure code for the punctal plug insertion (e.g., 68761).

Incorrect Use of Modifier 25: Routine Exam During Minor Procedure

- **Scenario:** A patient comes in for a routine post-operative check-up following cataract surgery. During the visit, the ophthalmologist performs a routine exam and notes the surgical site healing as expected. The patient does not report any new symptoms or issues.
- **Application:** Modifier 25 **should not** be used in this situation. The routine post-op check is part of the global surgical package for the cataract surgery, and there is no separate, significant E/M service provided.
- **Claim:** Billing for an E/M service with modifier 25 in this scenario is improper because there is no separate issue that justifies its use.

Incorrect Use of Modifier 25: Routine Exam During Minor Procedure

- **Scenario:** A patient is seen for routine follow-up on their stable age-related macular degeneration (AMD). The ophthalmologist performs an exam and injects an anti-VEGF medication to manage the condition. The patient does not have any new complaints or symptoms.
- **Application:** In this case, modifier 25 **should not** be used. The evaluation is part of the standard treatment for AMD, and there was no significant and separately identifiable E/M service performed beyond the usual pre-procedure evaluation.
- **Claim:** You should bill only for the injection procedure (e.g., 67028) and the medication (e.g., J2778), without using modifier 25 for the office visit.

Frequently Asked Questions

- What if an intermediate/comprehensive visit is missing the required elements?
- If a patient sees a general ophthalmologist & is referred to a retina specialist, is the patient considered new?
- Can I use ICD-10 codes for laterality (right, left, both) when coding eye conditions?
- Can I bill an Eye code along with an OCT or fundus photo?

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Thank you!

Unveiling the Secrets of Eye Examination Codes – Maximizing Reimbursement

Post Webinar Quiz Questions