FORESIGHT
Optometric Documentation & Coding Consultants

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A few weeks ago, our newest 4th year intern started at the office. As I talked with Maggie about patient care, I have also been discussing proper documentation and coding. As you can imagine, I have high expectations! An observation she made was that she had to change her patient tracking sheets to add the code 920x2. She said, "no one ever uses that at the school and you do it a lot." My response, "That's because very few doctors understand coding the way I do." She followed with the logical question, "Why bill 92012 when the visit is medical and could be billed as a 99000?" Read farther to gleam the same wisdom I bestowed upon our future colleague. ☺

As eye care providers, we have the choice to use either the ophthalmological service codes (920x2/920x4) or the E&M codes (992xx). You do not have to only use one set and stick to it. You can bill a glaucoma evaluation as a 9921x in the morning, and then bill another glaucoma evaluation as a 9201x in the afternoon. Depending on what is done during the office visit, it could be advantageous to bounce between the two coding systems. After surveying the fee schedules for the major payers in my area, 99213 pays less than 92012, which pays less than 99214. The exact dollars will differ between insurance companies, but the order was consistent among the 5 payers I checked. Let's use the national average Medicare fee schedule for our comparison and look just at established patient fees.

92012	$89.28
92014	$128.52
99211	$21.96
99212	$44.64
99213	$74.16
99214	$109.44
99215	$147.60

There are always exceptions, but most pathology exams we do will typically fall between a 99212 and 99214. And based on the thousands of audits we have performed, around 85% of these visits will also qualify for either a 920x2 or 920x4. So who cares? Your wallet does!

Let's say a pathology visit earns **99**213. There is a good chance that it may have also earned a **92**012. Now which should you choose? Looking at the fee schedule, the choice is very clear. 92012 reimburses $15.12 more than a 99213! And if a visit would have earned 99212, it would reimburse $44.64 more if you billed 92012! If you ever see a 99212 or a 99213, you need to ask a few simple questions:

1. Is there new problem (not necessary related to the RFV)?
2. Did you do any form of history (pretty low bar)?
3. Did you document any grossly obvious general medical observations?
4. Did you do a slit lamp exam?
5. Did you record a diagnostic and treatment plan?

If you did **all** of these items, then the visit qualifies as a 92012 and you should mostly likely use it instead of 99212 or 99213. Through our audits, I know most optometrist bill more than one 99213 every day. If just two visits per day were alternatively coded as 92012, that would add ~$30 per day to your NET income. Big deal, right? WRONG! $30 per day adds up to $7800 a year in NET income…cash on the barrel…coins in your pocket…FREE MONEY! If the average optometrist is making $120,000 a year, that's like getting paid for an additional 3 weeks of work by just choosing a code in a more strategic way. Is that enough motivation?

In order for any of this to make sense, you must understand how to grade an exam based on the content of the record. Once the exam is over, grade the encounter based on the history, physical exam, and MDM. Once that is done, choose the code that most accurately reflects the content of the record. And if there are two that match…choose the set that is most beneficial to the practice.

If you are interested in seeing where your documentation stands, ForeSight, LLC would be happy to help by performing a friendly audit. Knowing if your documentation is correct and how your exams code-out, puts you in a strong position if audited and also shows you where the opportunities may be.