FORESIGHT
Optometric Documentation & Coding Consultants

Ryan P. Ames, OD, MBA
DrAmes@ForeSightOD.com
888.456.2046

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Over the past couple years I have cut back on providing CE lectures. When I have lectured, the topics have been more related to business and telehealth, not documentation and coding. However, this past weekend I spoke in Boise and one of the lectures I gave was the *3 Hour Documentation & Coding Boot Camp*. What made this unique was that this talk was part of the main lecture series during their annual convention. Oftentimes documentation talks are tucked away in a small room, and the majority of the doctors stay in the main lecture hall to get glaucoma credits. This weekend, I got the ears of every doctor at the conference, and it was great. The doctors who thought they knew it all and likely would not attend a documentation lecture had their eyes opened to basic concepts and were reminded of details they had long forgotten. During breaks, there were great conversations and questions and more than once I heard, "This is blowing my mind." The crazy thing was nothing presented was new and the definitions provided are readily available in CPT, ICD-10, or the 1997 Documentation Guidelines. There is no secret sauce…the main details in this talk have not changed in twenty-two years!

One question that caught me off guard more than once was, "Can you really bill 920x4 with a medical diagnosis? As in, send it to Medicare and get paid!?!" In case you don't know, the answer is YES! This reminded me that we need to continually review topics easily forgotten…or never properly learned.

The confusion has come from vision plans convincing us that the 92000 codes are vision codes and the 99000 codes are medical codes. The truth is that both code sets were designed to be used for medical care. And some payers warped our understanding by identifying the 92000 codes in their system as "routine" care. This is not for what they were intended to be used. They were created because eye care is unique in medicine in how we provide care. Therefore, CPT created a code-set that happened to match what we do in the majority of patient encounters. This does not mean we are forced to use them in all situations. But it does provide us with an option.

Every 99000 and 92000 code has documentation requirements that must be met for use. Below we will review the requirements for both intermediate and comprehensive ophthalmological codes as stated in AMA's Current Procedural Terminology (CPT).

Intermediate Ophthalmological Service (92002/92012)	**Comprehensive Ophthalmological Service (92004/92014)**
• A new or existing problem <u>complicated by a new problem</u> • History • General Medical Observation • External Ocular/Adnexal Examination • Other Diagnostic Procedures as Indicated • Initiation (or continuation) of Diagnostic & Treatment Program	<u>General evaluation of the complete visual system</u> • History • General Medical Observation • External Ocular/Adnexal Examination • Ophthalmological Examination *(with or without mydriasis/cycloplegia)* • Gross Visual Fields • Basic Sensorimotor Examination • Other Diagnostic Procedures as Indicated • Initiation (or continuation) of Diagnostic & Treatment Program

As you can see in the above chart, an ophthalmoscopic evaluation is a required element of 920x4, but dilation is not part of a comprehensive ophthalmological service according to CPT. However, individual payers can have differing definitions of certain services as part of their contract. It would be a good idea to pull your contracts and make sure you are compliant. If a payer is requiring something different from the CPT definitions, it should be clearly laid out in the contract. If you ever find yourself in an audit and the requirements of individual codes come into question, you first need to reference the CPT definition and then your contract with that payer. If the signed contract does not have a different definition than CPT, you would default to CPT's definition.

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As the number of audits increases, it is more important than ever to make sure your documentation is complete. There is no "close enough" when it comes to the requirements of the codes. If just one element is missing, you do not meet the definition of the code and it cannot be used. Performing internal audits throughout the year is a wise practice. If you are not comfortable doing this yourself, there are individuals and companies who would be happy to assist.