Your scheduled 4:00 pm established patient came into the office for a medical eye examination asks if the dilation can be skipped today because after leaving the office they need to drive for an hour due west into the setting sun. The examining doctor, Dr. Eyeperson, agrees that driving into the sun for an hour with dilated pupils would be uncomfortable. Dr. Eyeperson met all the requirements for a comprehensive ophthalmologic eye examination except the dilated fundus examination element. Today, Dr. Eyeperson bills a major medical third party a comprehensive ophthalmologic examination (CPT 92014) for the patient just seen and schedules the dilated fundus examination in one week. Dr. Eyeperson does not perform an internal today since it will be completed in one week.

Do you see any problems with Dr. Eyeperson’s coding and billing of this patient?

Since most optometrists use the 92000 codes more than the 99000 codes for eye examinations, it is important to know the rules for the codes being used. The major components included in the definition of a 92000 comprehensive ophthalmologic examination are: a case history, 10 examination elements, and initiation of a diagnostic and treatment plan as indicated.

With the exception of diabetes and a very limited number of people who meet the qualifications for G codes for glaucoma; Medicare and major medical third parties do not pay for routine, annual, yearly or screening eye examinations. This means the history must include a medical reason for the visit. These can be eye related medical signs, medical symptoms or ongoing care for a medical condition.

There are ten physical examination elements of an ophthalmologic examination and all must be done to code and bill a comprehensive level of examination (CPT 92204 or 92014). The 10 physical elements to examine are:

1. Basic Visual Fields
2. Eyelids and Adnexa
3. Ocular Mobility
4. Pupils/Iris
5. Cornea
6. Anterior Chamber
7. Lens
8. Intraocular Pressure
9. Retina (Vitreous, Macula, Periphery, and Vessels)
10. Optic Disc

Included in the definition of the ophthalmologic comprehensive examination is: “Comprehensive ophthalmologic services describe a level of service in which a general evaluation of the complete visual system is made. This service constitutes a single service entity, but all services do not need to be performed at one session.” You can start the examination on one date, then finish it on another date, however, you cannot bill until the examination is completed. The date of service is the date when all services are completed and documented, not the date of the start of the examination.

For the example given above, the highest level 92000 code Dr. Eyeperson could use on the day of the examination is an intermediate ophthalmologic examination (CPT 92012). There are only two ways to bill the example in this article as a comprehensive ophthalmologic examination (CPT 92014); complete the fundus examination today or wait until the return visit to bill the examination. As you know, however, waiting until the return visit to bill the examination would be an administrative nightmare.

Dr. Eyeperson did not meet the requirements for the examination billed. By not completing the dilated fundus examination but still billing for a comprehensive ophthalmologic examination, Dr. Eyeperson is committing fraud – billing for a higher level code than was actually done. If Dr. Eyeperson does this repeatedly, it is possible this doctor can be charged with both fraud and abuse.

The initiation of a diagnostic and treatment plan as indicated is also a necessity for a comprehensive examination. This must be clearly documented in the patient record. The most straightforward way to meet this requirement is to number your diagnoses and have an associated treatment plan for each. (Remember the number one diagnosis is the reason for the examination and not the final diagnosis which may be different.)

It is not enough to believe you are a good doctor trying to follow the rules. You must follow the rules.