Four Misunderstood Concepts of the 92000 Comprehensive Exam Code Definition

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There are four key concepts often misunderstood in the CPT (Current Procedural Terminology) definition of the 92000 comprehensive ophthalmologic services (i.e.: 92004 and 92014). A doctor must understand these concepts to properly use these codes. These key concepts are: documenting general medical observation, necessity of a dilated fundus exam, initiation of diagnostic and treatment programs, and what and when to bill.

Concept #1: Documenting general medical observation

The CPT definition for a comprehensive ophthalmologic service states: “The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination.”

One piece of documentation often missing in an eye examination medical record coded for 92004 or 92014 is general medical observation. Observing the patient gives significant insight into the general medical health of the patient being examined. Documenting general medical observation involves written notes about areas such as body features and symmetry, appearance, nutritional state, weight, skin color, frequency and volume of breaths, hair distribution and odors.

Without documentation of general medical observation, 92004 or 92014 cannot be coded or billed. The word “includes” in the definition of 92004 and 92014 means always includes. Documentation supporting the coding and billing of either 92004 or 92014 must include notes about the areas listed in the definition. A primary documentation rule is: if you didn’t write it down, it didn’t happen. To fix this problem, simply add a checklist such as the one in Example 1 to your medical examination form. It is acceptable to record if each area observed is normal. Remember the documentation rule: if you identify a problem, you must further describe it in words or pictures.

Concept #2: Is dilation required?

The CPT definition for a comprehensive ophthalmologic service states: “It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry.”

The words “often includes” in the definition for 92004 and 92014 means may or may not include. According to the definition of 92004 and 92014, the doctor must document an ophthalmoscopic examination; however, a dilated fundus evaluation (DFE) is optional. This stands in direct opposition to the 99000 Evaluation and Management comprehensive examination definition which requires a DFE unless contraindicated.

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Normal General Medical Observation

- Y N Body features and symmetry
- Y N Appearance
- Y N Nutritional state
- Y N Weight
- Y N Skin color
- Y N Frequency and volume of breaths
- Y N Hair distribution
- Y N Odors

Example 1

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Even though coding and billing 92004 and 92014 does not require a DFE, the doctor should still consider a DFE essential unless contraindicated. The gold standard for an eye examination is a DFE. In a malpractice lawsuit where something was missed, one of the first witnesses the prosecutor will put on the stand will be an eye doctor who will be asked “Should the doctor have dilated this patient?” If something was missed, the answer is always, “Yes.”

In a malpractice lawsuit you are not held to the code definition, you are held to the DFE standard. The medico-legal issue of a DFE outweighs every other consideration. To put this in a context, picture yourself in a courtroom trying to complete this answer if you missed something retinal that could have been picked up on a DFE: “Your Honor, the reason I chose not to dilate was ____.” Anything you would put in the blank pales beside what the patient could potentially lose.

It is interesting to note some Medicare carriers such as Palmetto GBA require a DFE for 92004 and 92014. Here’s the relevant quote from the Palmetto GBA website for the definition of 92000 comprehensive exams: “A comprehensive examination consists of eight or more elements, and always includes a fundus examination with the pupils dilated.” Note the “always includes” part of the definition.

Can you do a comprehensive eye exam and not do a DFE and meet the CPT technical definition for 92004 or 92014? The answer is yes. Are you giving the patient the best care and protecting both the patient and yourself by not doing a DFE? No. It appears reasonable to conclude if you want to give the best and safest eye examination in the litigious society in which we live, it does not make sense to do a comprehensive eye evaluation without a DFE.

**Concept #3: Initiation of diagnostic and treatment programs**

The CPT definition for a comprehensive ophthalmologic service states: “It always includes initiation of diagnostic and treatment programs.”

According to the definition, “exam only” with no additional tests ordered or no treatment program prescribed means you cannot code or bill 92004 or 92014. What is the definition of a diagnostic and treatment program? CPT gives us the answer - “Initiation of diagnostic and treatment program includes the prescription of medication, and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services.”

To properly code 92004 and 92014, we need to understand each category of diagnostic and treatment programs.

- In order to meet the definition you must initiate a diagnostic or treatment program involving medicine regulated by legislation requiring a prescription. It is not enough to order over-the-counter medicine for a patient and code 92004 or 92014.
- Ordering special ophthalmological diagnostic services such as gonioscopy, corneal topography, sensorimotor examination, threshold visual field examination or fundus photography meets the code definition. There must be a written order for the special ophthalmological diagnostic service in the primary medical record.
- Ordering special ophthalmological treatment services such as orthoptic and/or pleoptic training, fitting of contact lens for treatment of disease or corneal foreign body removal meets the code definition for 92004 or 92014.
- In this context, a consultation is a request from you to another physician with expertise in a specific medical area beyond your knowledge for advice or council in evaluating or treating a patient for a specific problem. Ordering a consultation meets the code definition.
- (Can one optometrist order a consultation from another optometrist? A strong case can be made that a “general” optometrist sending a patient to a COVD fellow for advice or council in evaluating or treating a patient for specific problem meets the definition of a consultation. Because some state optometry laws do not recognize optometric specialties, a consultation request from one optometrist to another is a gray area. Ask your carrier for clarification in writing.)
- Ordering a laboratory procedure such as a blood evaluation meets the code definition.
- (Does ordering spectacle lenses from the laboratory meet the code definition? Since spectacles are not a covered medical service unless they are being used to treat accommodative esotropia, ask your carrier for clarification in writing.)
- Ordering corneal pachymetry or an A or B ultrasound meets the radiological services portion of the code definition.
When ordering additional diagnostic tests or treatment, place the order in your general medical record. Auditors look for a statement of medical necessity in addition to the medical order for the additional tests or treatment. Put the following statement in your general medical record and fill in the blanks to meet both criteria:

The discovery of ___ during ___ triggered the medical necessity for ordering ___ on ___ (insert where, date and time).

There are two additional requirements for any special ophthalmological services you provide: (A) document the additional tests and results on a separate piece of paper from your general medical exam record and (B) write a report. The simplest report has four sections: (1) changes since last test, (2) reliability of test results, (3) assessment and plan, and (4) signature and date. The report must be clearly identified, so draw a box around your four sections and place the label REPORT at the top.

Concept #4: What and when to bill

The CPT definition for a comprehensive ophthalmologic service states: “The comprehensive services constitute a single service entity but need not be performed at one session.”

It’s 4:00 PM and the patient informs you upon leaving the office they will be driving due west for 2 hours. The patient requests no dilation. The patient agrees to return tomorrow. You choose to do no ophthalmoscopic examination today, instead waiting until tomorrow to complete the examination. In this scenario, you cannot bill a 92004 or 92014 today because you have not completed all the requirements for those codes. Any of the following choices will fix this problem:

1. Complete a non-dilated fundus examination today.
2. Bill a 92000 intermediate examination today (i.e.: 92002 or 92012).
3. Bill the appropriate 99000 Evaluation and Management code today.
4. Wait until tomorrow when the examination is completed and bill 92004 or 92014.

Choice 4, waiting until tomorrow to bill, is an administrative nightmare. Utilize any of the above options except choice 4.

The doctor is responsible for coding. When the code definition for 92004 or 92014 is not met, a different code must be chosen. An intermediate ophthalmological service (92002 or 92012) or an appropriate 99000 Evaluation and Management code can be chosen. Understanding these four concepts of the 92000 comprehensive exam code definition enables the doctor to code and bill appropriately.

References

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