Compliance Department

OPHTHALMOLOGY SERVICES

11/2010

Ophthalmology Services

Comprehensive Ophthalmological Service describes a general evaluation of the complete visual system.

New Patient (92004)	Established Patient (92014)

Comp. Ophthalmological Service includes:

- History;
- General medical observation;
- External & ophthalmoscopic exams;
- Gross visual fields; and
- Basic sensorimotor exam

It often includes, as indicated

- Biomicroscopy;
- Exam with cycloplegia or mydriasis; and Tonometry

It always includes initiation or continuation of diagnostic and treatment programs.

Ophthalmology Services

Intermediate Ophthalmological Service describes an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis.

New Patient (92002)	Established Patient (92012)

Intermediate Ophthalmological Service includes

- History;
- General medical observation;
- External ocular & adnexal exams; and
- Other diagnostic procedures as indicated.

  It may include the use of mydriasis for ophthalmoscopy.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

3

ICD-9CM Coding

The CPT code or service is the driving force behind reimbursement. However, the ICD-9 diagnosis code must support the CPT code in order to be reimbursed.

The system of diagnosis codes used is the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9 CM).

The primary diagnosis must support or justify the physician's service. For instance, the inpatient consultant's primary diagnosis would be the reason for the consult and not necessarily the admitting diagnosis.

ICD-9CM Coding
(continued)

The <u>highest level of specificity</u> should be given when establishing a diagnosis. For instance, glaucoma has many subclassifications, such as borderline, open-angle, primary angle-closure, etc. The claim should be as clean as possible. Therefore, try to avoid unspecified diagnoses and codes.

The <u>highest level of certainty</u> should be given when establishing a diagnosis. "Suspected" or "Rule Out" diagnoses cannot be coded. If the physician is working only with signs and symptoms and has not yet formed a diagnosis, then the sign, symptom, or laboratory abnormality should be selected.

Document all conditions that coexist at the time of the visit that require or affect patient care, treatment or management. Conditions that were previously treated and no longer exist should not be coded.

Resources

- UCLA Compliance Office

    - Marti Arvin, Chief Compliance Officer (310) 794-6763

- Confidential Hotline **1-800 296-7188**

- UCLA Compliance Website http://www.mednet.ucla.edu/compliance/.