Pediatric and Binocular Vision Examination and Billing Protocols

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Introduction

The purpose of this manual is to offer Pediatric/Binocular Vision interns a protocol for the core examination procedures for pediatric patients. This manual will also introduce the intern to concepts for billing routine examinations and consultations from referring doctors.

If you have any questions or concerns please contact me.

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The objective of the Binocular Vision/Pediatric Clinic is to provide experience with the diagnosis and management of binocular vision disorders such as amblyopia, suppression, strabismus, accommodative and eye movement disorders, or visual processing problems. The Visual Information Processing assessment is one of the services offered in this clinic that is driven by in-house referrals, as well as referrals from outside doctors. Visual therapy is an important component of the Binocular Vision/Pediatric Clinic. Therapy plans and letters to the referring doctors are crucial to the success of the service, and must be completed. You are expected to correctly and efficiently perform tests to determine the diagnosis during evaluations, as well as perform visual therapy techniques during training sessions with the patient.

More than 10% of children starting school will ultimately suffer from learning problems and underachievement at school. Many of these children, as well as many adults, suffer from vision problems which affect learning. Services offered by local school systems are not always sufficient to address such problems. The Binocular Vision/Pediatric Service will train you to provide care related to vision conditions that may interfere with a child’s ability to learn. In addition to providing comprehensive vision care, you will have the opportunity to screen and test for visual processing problems. Finally, in addition to learning to evaluate a child’s learning skills, you will be taught the importance of proper communication and cooperation between parents, schools, psychologists, therapists, and other health care providers in the care of children with learning problems. It is important for these disciplines to work together to help children gain the most from their educational experience.
# Recommended Eye Examination Frequency for the Pediatric Patient

<table>
<thead>
<tr>
<th>Patient Age</th>
<th>Asymptomatic/risk free</th>
<th>At-risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 24 months</td>
<td>At 6 months of age</td>
<td>At 6 months of age or as recommended</td>
</tr>
<tr>
<td>2-5 Years old</td>
<td>At 3 years of age</td>
<td>At 3 years of age or as recommended</td>
</tr>
<tr>
<td>6 to 18 years</td>
<td>Before first grade and every two years thereafter</td>
<td>Annually or as recommended</td>
</tr>
</tbody>
</table>

From the American Optometric Association, Optometric Clinical Guidelines
Routine Comprehensive Pediatric Eye Examination

The following protocols are based on the patient age, and represent a mixture of recommendations from the American Optometric Association and pediatric/binocular vision faculty. These tests should be considered standard of care and performed in all instances. If a test cannot be performed on a particular patient, the reason it could not be performed should be documented in the chart. While the following protocols specify the standard of care for pediatric examinations at the Indiana University School of Optometry, it is not a limit on the tests you perform. Auxiliary/ancillary tests may be added as needed.

Infant and Toddlers (Birth to 2 years 11 months)

1. Case History
   All of the following are addressed on the pediatric history form. The intern is expected to expand on a patient history as needed.
   a. Identification and description of the chief complaint
   b. Visual history
   c. Medical History (including pre-, peri- and post-natal history and a review of systems)
   d. Developmental history
   e. Family eye and medical histories
   f. Current medical caregivers and reason for being under their care
   g. Documentation of previous eye examinations

2. Visual Acuity
   At least one of the following tests should be performed:
   a. Preferential looking visual acuity testing.
   b. This is the preferred method and should be attempted first using either Teller or Cardiff cards.
   c. Fixation and tracking testing including occlusion preference
   d. Bruckner’s testing

3. Binocular Function and Ocular Motility
   a. Cover Test (Distance and Near)
   b. NPC
   c. Hirschberg corneal reflexes
   d. Versions
   e. Bruckner’s testing

4. Refraction
   a. Dry retinoscopy for accommodative performance
   b. Cycloplegic retinoscopy

5. Visual/Ocular Health Examination
   a. Pupillary response
   b. Examination of the ocular anterior segment and adnexa
   c. Internal examination with C/D ratio specified for each eye. All new patients should have a dilated fundus examination.
Preschool Children (3 years to 5 years, 11 months)

1. Case History
   All of the following are addressed on the pediatric history form. The intern is expected to expand on a patient history as needed.
   a. Identification and description of the chief complaint
   b. Visual history
   c. Medical History (including pre-, peri- and post-natal history and a review of systems)
   d. Developmental history
   e. Family eye and medical histories
   f. Current medical caregivers and reason for being under their care
   g. Documentation of previous eye examinations

2. Visual Acuity
   Measure best corrected visual acuity using one of the following techniques:
   a. Lea Symbols
   b. Lighthouse Symbols
   c. HOTV test
   d. Snellen Acuity

3. Binocular Function and Ocular Motility
   a. Cover Test (Distance and near)
   b. NPC
   c. Stereopsis

4. Accommodation
   a. Amplitude of accommodation
   b. Accommodative facility (if possible)
   c. Monocular Estimation Method

5. Refraction
   a. Static retinoscopy
   b. Cycloplegic retinoscopy/refraction as needed

6. Visual/Ocular Health Examination
   a. Pupillary response
   b. Versions
   c. Gross visual fields
   d. Color Vision Test
   e. Examination of ocular anterior segment and adnexa
   f. Dilated Internal health examination
      All new patients need to be dilated and again once every two years unless otherwise indicated
School Age Children (6 years to 15 years, 11 months)

1. Case History
   All of the following are addressed on the pediatric history form. The intern is expected to expand on a patient history as needed.
   a. Identification and description of the chief complaint
   b. Visual history
   c. Medical History (including pre-, peri- and post-natal history and a review of systems)
   d. Developmental history
   e. Family eye and medical histories
   f. Current medical caregivers and reason for being under their care
   g. Documentation of previous eye examinations

2. Visual Acuity
   a. Best corrected visual acuity should be measured using a Snellen chart.
   b. The intern must document in the chart the reason a patient is unable to respond to the Snellen chart. Furthermore, the intern must obtain an alternate acuity measurement.

3. Binocular Function and Ocular Motility
   a. Cover Test (Distance and near)
   b. Modified Thorton (Horizontal and Vertical)
   c. NPC
   d. Stereopsis

4. Accommodation
   a. Amplitude of accommodation
   b. Accommodative facility
   c. Monocular Estimation Method

5. Refraction
   a. Static retinoscopy
   b. Subjective refraction

6. Visual/Ocular Health Examination
   a. Pupillary response
   b. Versions
   c. Gross visual fields
   d. Color Vision Test
   e. Examination of ocular anterior segment and adnexa
   f. Tonometry
      Contact or non-contact tonometry is standard of care; however, digital palpation is acceptable with a documented explanation.
   g. Dilated Internal health examination
      All new patients need to be dilated and again once every two years unless otherwise indicated.
Billing for Pediatric Examinations

Medicare developed the E/M Codes, these are the same codes used by all other insurance companies including Medicaid. There are specific requirements that need to be met in order to bill appropriately. If we consistently over bill and an audit is performed fines will be levied. If we consistently under bill then the school is not being paid appropriately for its time. The following is designed to assist in coding the examination properly. The information comes from the Medicare/Medicaid Update 2001. I would like to thank Douglas Morrow, OD and Richard Windsor, OD for allowing me to use portions of their manual.

Documentation of E/M Services

Components

a. History
b. Examination Procedures
c. Decision Making

History

To qualify for a certain level of history, each of the three elements needs to be met. A chief complaint must be described at each level

<table>
<thead>
<tr>
<th>Type of History</th>
<th>History of Present Illness</th>
<th>Review of Systems</th>
<th>Past, Family Social History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused (PF)</td>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused (EPF)</td>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed (D)</td>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Comprehensive (C)</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
</tr>
</tbody>
</table>

Guidelines

1. Review of Symptoms and/or Past, Family, Social History obtained during a prior encounter does not need to be re-recorded if there is evidence that it was reviewed and updated.

2. Faculty needs to initial next to the Review of Symptoms on the patient intake form

Definitions of specific components

1. Chief Complaint: A clear concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the patient encounter

2. History of Present Illness: A description of present illness. Brief and extended History of Present Illness are distinguished by the amount of detail. The History of present Illness should include Location, Quality, Severity, Duration, Timing, Context, Associated signs, Modifying factors, Symptoms.

   a. Brief: Consist of one to three elements

   b. Extended: Consist of four elements of the present illness or the status
of at least three chronic or inactive conditions

3. **Review of Symptoms**: The following is a list of systems that are needed to be addressed in the history.

<table>
<thead>
<tr>
<th>Constitutional symptoms</th>
<th>Eyes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ears, Nose, Mouth, Throat</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>Integumentary</td>
<td>Neurological</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Endocrine</td>
</tr>
<tr>
<td>Hematological</td>
<td>Allergic/Immunological</td>
</tr>
</tbody>
</table>

i. **Problem Oriented**: Inquiries about the system directly related to the Chief complaint

ii. **Extended**: Inquiries about the system directly related to the Chief complaint and limited number of additional systems

iii. **Complete**: Inquires about the system directly related to the Chief complaint and at least 10 organ systems must be reviewed

4. **Past Family and or/ Social History**: The components include Past History, Family History and Social History

i. **Pertinent**: Review of the history directly related to the chief complaint at least one area must be reviewed

ii. **Complete**: Review of at least two of the three areas

**Documentation of Examination Procedures**

The following is a listing of the elements that must be documented in order to qualify for the different levels of service

1. Test of visual acuity
2. Gross visual fields
3. Test of ocular motility including primary gaze alignment
4. Inspection of bulbar and palpebral conjunctiva
5. Examination of the ocular adnexa including lids, lacrimal gland, lacrimal drainage, orbits and preauricular lymph nodes
6. Examination of the pupils and irises
7. Slit lamp examination of the corneas
8. Slit lamp examination of the anterior chambers
9. Slit lamp examination of the lenses
10. Measurement of the intraocular pressures
11. Ophthalmoscopy examination through dilated pupils of optic discs, including size, C/D and appearance
12. Posterior segment examination including retina and vessels
13. Orientation of time, place and person
14. Mood and affect

<table>
<thead>
<tr>
<th>Type of examination</th>
<th>Required Examination Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>One to five elements</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>At least six elements</td>
</tr>
<tr>
<td>Detailed</td>
<td>At least nine elements</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Perform all elements</td>
</tr>
</tbody>
</table>

Medical Decision Making

Medical decision making is a vast area of grayness. Below are the components of decision making and suggestion on how to incorporate them for billing purposes.

- Three Components of decision making
  1. The number of diagnoses or management options (how hard is the problem to diagnose?)
  2. The amount and/or complexity of data gathered and in the record (what is the information you need to get?)
  3. The degree of risk of complications and/or morbidity or mortality (what is the risk to the patient?)

- Types of decision making

<table>
<thead>
<tr>
<th>Type of decision</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>There are minimal diagnoses or management options. There is not data or only minimal data to be reviewed. The risks of complications, morbidity or mortality are minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>There are limited diagnoses, management options and data to be reviewed. The risks of complications, morbidity or mortality are low.</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>There are multiple possible diagnoses and management options. The amount of data to be reviewed is moderate. The risks of complications, morbidity and mortality are moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>There are extensive possible diagnoses and management options. The amount of data to be reviewed is extensive. The risks of complications, morbidity and mortality are high</td>
</tr>
</tbody>
</table>
• Decision making table: Must meet two of the three sections

<table>
<thead>
<tr>
<th>Types of decision making</th>
<th>Number of diagnoses or management options</th>
<th>Amount and complexity of data to review</th>
<th>Risk of complications and morbidity or mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

Office Services

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Est. Patient</th>
<th>History</th>
<th>Examination</th>
<th>Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td></td>
<td>Prob. Focus</td>
<td>Prob. Focus</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99202</td>
<td></td>
<td>None</td>
<td>None</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203</td>
<td></td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low complexity</td>
</tr>
<tr>
<td>99204</td>
<td></td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Mod. Complexity</td>
</tr>
<tr>
<td>99205</td>
<td></td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

New Patients must meet all three components above. Established patients must only meet two of the three components.

Optometric Routine Examinations

Routine eye/vision examinations have their own codes which we utilize. Office visits should be coded with these codes when coming in for their annual eye examination.

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Examination</td>
<td>92002</td>
</tr>
<tr>
<td>Comprehensive Examination</td>
<td>92004</td>
</tr>
</tbody>
</table>

The elements of the eye examination are:

1. Anterior Chamber
2. Basic Visual Fields
3. Cornea
4. Eyelids and Adnexa
5. Intraocular pressure
6. Lens
7. Ocular Motility
8. Optic Disc
9. Pupils/Iris
10. Retina
11. Visual Acuities

- An Intermediate examination must consist of seven of the above elements
- A Comprehensive examination must consist of eight or more elements. It does not include a dilated fundus examination, posterior pole needs to be viewed with a direct ophthalmoscope

Use of 92065 code

This code is defined as a sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure). This code is a testing code similar to a visual field code. Therefore, this should be paired with an E/M office visit code when used

Use of Consultation Codes

Consultation codes may be used when a patient is referred from another physician. We may diagnosis and initiate therapy but we cannot take over the care of the patient. We may initiate therapy and then send them back to their doctor for follow-up care. If the physician wants us to manage their patient we should code the appropriate E/M code.

Intermediate 99242  Detailed 99243  Comprehensive 99244

In order to bill using these codes you must have certain documentation

1. Specific written request for the consultation from the requesting physician or a specific reference to the request in the consultant's record. Ideally there should be a request in the patient's chart. If there is no request then the chief complaint should state that the patient's was referred by a specific doctor for a specified reason

2. A letter needs to be written to the referring doctor and a copy of this letter must remain in the patient's chart.

Clinical Examples of Billing Procedures

The following examples should be used as a guide to proper coding. I have chosen common scenarios that are seen clinically on a daily basis.

Example #1

*An established patient with refractive amblyopia treated with atropine penalization comes in for a follow-up visit.*

**History**

You ask how compliant he has been with therapy, if there have been any side effects of the medication, including breathing problems, redness, light sensitivity, flushing of the skin.

**Examination**
The following tests are performed Visual acuities, pupil response (check for compliance), and assessment of fixation.

**Medical Decision Making**

Refractive amblyopia no signs of atropine toxicity, continue current treatment RTC 8 weeks

When an amblyopia patient is coming in for a follow-up and they are patching 99213 should also be used

This should be coded as a Expanded Problem Focus Examination 99213

- **History:** Expanded problem focus
- **Examination:** Problem focus
- **Decision:** Low Complexity

99213 requires

- **History:** Expanded problem focus
- **Examination:** Expanded problem focus
- **Decision:** Low complexity

Since this is an established patient you only need to meet two requirements which are met with the History and Medical Decision.

**Example #2**

*A toddler (established patient) with a chief complaint of red eyes with discharge for two days.*

**History**

Eyes started getting red two days before, no pain, discharge (greenish yellow), no vision complaints recently had a cold, sneezing, congestion, no headache. Not currently under doctor’s care, no medical allergies.

**Examination**

The following tests are performed Visual acuities, pupils, motility, cover test, slit lamp examination, PAN evaluation

**Medical Decision Making**

Bacterial conjunctivitis OU, prescribe Poly trim RTC 1 week

This should be coded as a Expanded Problem Focus Examination 99213

- **History:** Expanded problem focus
- **Examination:** Expanded problem focus
- **Decision:** Low Complexity

99213 requires

- **History:** Expanded problem focus
- **Examination:** Expanded problem focus
- **Decision:** Low complexity

**Example #3**

*The patient from Example #2 returns to the clinic for a one week follow-up.*

**History**
Patient has been using Polytrim as indicated, the redness and discharge have cleared up. No more cold symptoms. No pain.

**Examination**
The following tests are performed Visual acuities, pupils, Slit lamp

**Medical Decision Making**
Resolved bacterial conjunctivitis d/c medication

This should be coded as a Problem Focus Examination 99212

<table>
<thead>
<tr>
<th>History:</th>
<th>Problem Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination:</td>
<td>Problem Focus</td>
</tr>
<tr>
<td>Decision:</td>
<td>Straightforward</td>
</tr>
</tbody>
</table>

99212 requires

<table>
<thead>
<tr>
<th>History:</th>
<th>Problem Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination:</td>
<td>Problem Focus</td>
</tr>
<tr>
<td>Decision:</td>
<td>Straightforward</td>
</tr>
</tbody>
</table>

**Example #4**

*A six-year-old male referred to your office for consultation of possible amblyopia in the right eye. A referral letter has already been sent, and is in the patient’s chart.*

**History**
You ask questions concerning how well the child appears to see out of each eye, ask about strabismus, about previous trauma, illnesses, difficulties with pregnancy or delivery, under a doctor’s care, family history of amblyopia and other major ocular/systemic conditions.

**Examination**
Measure, visual acuities, stereo, accommodation, cover test (in primary and four quadrants), eccentric fixation, correspondence, slit lamp examination, dilated fundus examination, cycloplegic retinoscopy.

**Medical Decision Making**
You diagnosis the patient with strabismic amblyopia secondary to accommodative esotropia. Glasses are prescribed and he is to return in six weeks.

You can code this examination with the following:

- Detailed consultation 99243 and
- Sensorimotor exam 92060

<table>
<thead>
<tr>
<th>History:</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination:</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Decision:</td>
<td>Low Complexity</td>
</tr>
</tbody>
</table>

Secondary test Sensorimotor exam, is an ancillary test like a visual field

It should be coded along with a office visit charge

A 99243 requires

<table>
<thead>
<tr>
<th>History:</th>
<th>Detailed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination:</td>
<td>Detailed</td>
</tr>
</tbody>
</table>
Decision: Low complexity

You should not be using 99244 (comprehensive consultation) because with new patients we need to match all three components and we do not reach the definition for moderate complexity with medical decision making.

You will need to send a report back to the referring doctor and leave a copy in the patient’s chart.

We can have this patient return to the clinic and initiate amblyopia therapy (patching or atropine), but we then need to send him back to the referring doctor for continuation of therapy.

If the referring doctor wants you to take over the management of the patient then you cannot code a consultation visit. You need to code the appropriate level office visit code with the sensorimotor examination.