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Medical diagnosis codes used to document NeuroVisual Exam

Abnormality/Staggering Gait- 781.2
Accomodative Insufficiency- 367.55
Anisometropia- 367.31
Astigmatism- 367.2
Anxiety- 300.02
Blurred Vision- 368.8
Dizziness- 780.4
Double Vision- 368.2
Esophoria- 378.41
Esotropia-378.0
Exophoria- 378.42
Exotropia- 378.1
Eye Pain- 379.91
Eye Strain- 368.13
Headache- 784.0
Heterotropia-378.30
Hyperopia- 367.0
Hypertropia-378.31
Hypotropia-378.32
Nausea- 787.02
Neck Pain- 723.1
Photophobia- 368.13
Photosensitive to Sun- 692.72
Photosensitive other than to Sun- 692.82
Superior Oblique Palsy- 378.53
Superior Semicircular Canal Dehiscence Syndrome (SSCD)- 386.8
Vertical Heterophoria- 378.43
Alignment definitions

**Hypertropia** - 378.31
Eyes look vertically upward, one eye on top of the other causing double vision.

**Esotropia** – 378.0
Eyes misaligned horizontally pointing inward causing double vision

**Exotropia** – 378.1
Eyes misaligned horizontally pointing outward causing double vision

**Esophoria** – 378.41
Eyes misalign inward horizontally without double vision

**Exophoria** – 378.42
Eyes misalign outward horizontally without double vision

**Superior Oblique Palsy** - 378.53
4\textsuperscript{th} cranial nerve affecting muscle to one eye, causing an upward drift. Sometimes causes double vision.
**Office Visit coding guidelines**

**99205**

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

**99215**

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

**99204**

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99214
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

99203
Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

99213
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
Procedure coding guidelines

92015
Determination of refractive state

92060
Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)

92065
Orthoptic and/or pleoptic training, with continuing medical direction and evaluation

99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)

99199
Unlisted special service, procedure or report
**Prolonged office visit coding (99354)**

New Exam

*Time (mins) for Exam Codes:*
- \( \geq 90: \) 99205 + 99354 (60 min+30 min)
- 75-89: 99204 + 99354 (45 min+30 min)
- 60-74: 99205 (60 min.)
- 45-59: 99204 (45 min.)

Progress Assessment Established

*Time (mins) for Exam Codes:*
- \( \geq 70: \) 99215 + 99354 (40 min+30 min)
- 55-69: 99214 + 99354 (25 min+30 min)
- 40-54: 99215 (40 min.)
- 25-39: 99214 (25 min.)
**Fundus Photographs and Visual Fields coding guideline**

**92081**
Visual field examination, unilateral or bilateral, ordered with interpretation and report: limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

**92082**
Intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33) Ordered with interpretation and report.

**92083**
Extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degree, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2 or 30/60-2) Ordered with interpretation and report.

**92250**
Fundus photography ordered with interpretation and report. Includes both eyes. Use modifier 52 if only one eye is photographed.

**Fundus Photographs and Visual Fields approved amounts**

**Medicare approved amounts**

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**Blue Cross approved amounts**

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Supercoder.com

**Find Your Way to Foolproof Fundus Photography Reimbursements**

How you handle fundus photography claims today could affect the outcome of your next audit.

Fundus photography, 92250 (Fundus photography with interpretation and report), a highly specialized form of medical imaging, is a common procedure that a technician performs. A fundus camera, which is attached to an ophthalmoscope, is aligned to view the back of the eye. Pictures are then taken of the optic nerve head, vitreous, macula, retina and its blood vessels to document any present pathology.

92250 is in CPT's special ophthalmological services section, which is a compilation of services that practices may report for Medicare in addition to the general ophthalmological services (92002-92014) or E/M services (99201-99499).

Other payers, such as the "Blues," may try to bundle these services. But on the Medicare fee schedule, many of these codes have both a technical component and a professional component and, in CPT, have language that states, "interpretation and report by the physician is an integral part of special ophthalmological services," which sometimes goes unnoticed.

The majority of codes in the special ophthalmological section are for diagnostic tests, i.e., 92083 (Visual field examination, unilateral or bilateral, with interpretation and report; extended examination [e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2]), 92135 (Scanning computerized ophthalmic diagnostic imaging [e.g., scanning laser] with interpretation and report, unilateral), and 92235 (Fluorescein angiography [includes multiframe imaging] with interpretation and report).

**Documenting Your Way to Clean Audits**

Though fundus photographs can be used to diagnose certain eye conditions, they are more often used to document a disease process or a diagnosis the physician has already observed. As a result, many ophthalmologists do not comply with the "interpretation and report" component of
the code. "They also do not document the order for the photo consistently, thereby placing themselves at risk if they are ever audited," says Raequell Duran, president of Practice Solutions, an ophthalmology coding and reimbursement consultancy based in Santa Barbara, Calif.

"Even though the payer rarely knows what the documentation looks like at the time they process [a claim] for payment, if the records are ever reviewed as part of an audit, and interpretations are not documented, then the practice will owe money back to the payer at a minimum," adds Lise Roberts, vice president of Health Care Compliance Strategies, a Jericho, N.Y.-based company that develops interactive compliance training courses. The practice could even be fined for "billing for services not rendered," a [...]
HCFA Form use in NV Optometry; Modifications for Auto patients and Workman's Comp

1. List on HCFA form, all procedures codes first starting with the evaluation code. List all vision codes for lenses and frames second as this is less confusing for the adjuster or insurance company reading your claim.
2. If you are billing an auto claim, fill in box 10 on the HCFA form with A for accident and list the state in which the accident occurred.
3. If you are billing a workers compensation claim or other accident, mark yes in box 10 on the HCFA form.
4. If your patient has a health insurance primary to an auto claim, bill all codes to the health insurance first without marking box 10. When you receive payment/rejection, forward the explanation of benefits along with your HCFA form to the auto/workers comp company marking box 10 at that time.

RECORDS/DOCUMENTATION

1. It is important to send as much detailed documentation as possible with your HCFA form to an auto/workers comp company. You should also be calling auto and workers compensation carriers ahead of the patient’s appointment to verify the claim is open and billable and verify the claim mailing address.
2. Include traumatic brain injury or other head injury in notes. Be specific about which doctor diagnosed the injury and the date of the diagnosis. If possible, obtain a letter or referral from that doctor stating the diagnosis.
3. Make sure the doctor’s signature and date are on records sent.
4. All testing and result numbers should be listed in the patient records.

WEBSITES

ICD9Data.com- Lists - HCPCS Codes and diagnosis codes with definitions
ama-assn.org/ama – lists CPT definitions and fee schedule amounts
BILLING FOR NEUROVISUAL OPTOMETRY TRAINING COURSE
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**Total Charge:** $562.00

**Remaining Due:** $562.00
Information to include when billing an auto/injury claim

1. HCFA Form
2. Primary health insurance explanation of benefits if applicable
3. Patient records
4. Referrals from other doctors
5. Letter or referral stating head injury diagnosis and date of injury
6. VH explanation letter and necessity of payment for frames and lenses letter (for new patients)
7. Explanation letter if a patient has another diagnosis besides VH. This should replace VH explanation letter for new patients.

SEND ALL PACKETS CERTIFIED MAIL FOR BEST RESPONSE AND PAYMENT.
Auto / Workman’s Comp Billing and Collection

1. Visit is billed to the auto or work comp insurance company with all records. A VH explanation packet is included for all new patients. Typically the time frame from the auto or work comp company to respond to our initial billing is 3-6 weeks, but sometimes 8-12 weeks.

2. If the patient has a coordinated auto policy the primary health insurance is billed first. When payment/rejection is received from the primary health insurance, the bill is sent to the auto company with all records and the primary health insurance explanation of benefits.

3. If the auto company sends back a denial for entire bill or part of the bill, a first appeal is prepared by the end of the week and it is put in our accordion file to be worked monthly. The first appeal includes a letter explaining patient’s care and how it relates to auto. Records are resent
   - Accordion file: The accordion file is alphabetized. Patient denials are pulled at the 5 month mark from their last date of service and put into a second accordion file by month. We work these first to avoid sending the account to the attorney. At the 2 month mark from the patient’s last date of service the account goes to the attorney.
   - Worked accounts: When we work the accounts monthly, calls to the adjuster for status of payment are included. Time is spent explaining the need for care on the phone and supervisors are contacted if necessary. Records and bills are often faxed and re-faxed or mailed again. Attorneys are dealt with and case managers are consulted. The requests vary by patient and are often very detailed and time consuming.

4. If a second denial is received, a final appeal is prepared with a letter stating we will pursue a suit with our attorney against the company and treatment is once again outlined with relatedness to the accident. Any records or additional documentation is included.

5. When a second denial is received the patient and or case manager are contacted. An alert is placed on the patient’s account to hold future appointments until claim is resolved. If the patient has an attorney, we call the attorney to see if he is handling medical claims for the patient. The balance is transferred to the patient at this time also so they start receiving monthly statements.
6. If the final appeal is denied, and the patient’s attorney is not handling the claim, we turn it over to our attorney to file suit if balance is over $1,000.00.

7. If the balance is under $1,000.00 then the patient becomes responsible.

8. Three statements are mailed to the patient. If no payment is made, then a letter stating we will turn the account over to collections if no payment is received in 30 days is mailed to the patient.
Financial Forms Given to Patient by Biller or Staff

1. Assign Balance to Patient: With an Attorney
2. Assign Balance to Patient: Insurance Denial
3. Estimate of Insurance Charges
4. Lien Form
5. Upgraded Frame charge form
Assign balance to patient: with attorney

Date

Patient name
Patient address

RE: Outstanding balance of $_______ for account #______

Dear __________

Please find enclosed a copy of the statement showing total outstanding charges in the amount of $_______ along with copies of the Explanations of Benefits from ___________(ins. Co.) showing denials for each date of service in question.

We understand that you have retained the services of an attorney and we have spoken to their office and faxed over copies of our billings to them. We will continue to maintain contact with your attorney’s office.

We have made every attempt to collect on these dates of service from your insurance company with no success. We would like to see the outstanding balance get resolved and paid by the insurance company. However, until that time we had no choice but to transfer the balance to you.

It might be helpful to contact the insurance company and speak with the adjuster. Sometimes the patient can make a difference by doing so. Our records show the following contact information:

Insurance name___________
Adjuster name___________
Adjuster phone#__________

Please contact our office to discuss payment arrangements.

Sincerely
Billing Department

Enclosures
Assign balance to patient: insurance denial

Date

Patient name
Patient address

Dear ________(patient name),

Please find enclosed a copy of the statement showing total outstanding charges in the amount of $_________ along with copies of the Explanations of Benefits from ___________(ins. Co.) showing denials for each date of service in question.

After multiple appeals to get your claims paid, your insurance company is standing firm in denying payment. Therefore, we are assigning this balance to you.

Please contact our office at ____________(phone#) to complete the payment of this claim.

If you have any questions, please do not hesitate to call.

Sincerely
Billing Department

PS - It might be helpful to contact the insurance company and speak with the adjuster. Sometimes the patient can make a difference by doing so. Our records show the following contact information:

Insurance name____________
Adjuster name____________
Adjuster phone#___________
Estimate of Insurance Charges

Please use the information below for an estimate of the treatment plan used for Vertical Heterophoria and Superior Oblique Palsy. Multiple visits and lens modifications may be needed once a treatment plan is established.

Date of Service: ____/____/____
Patient: __________________________
Claim #: __________________________
Date of Injury: ____/____/____

Exam Services Total: $___________

**Breakdown**

Code: ______________$___________
Code: ______________$___________
Code: ______________$___________

**Material Services Total: $___________**

**Breakdown**

Frames: $_______________ / New Purchase / Patient’s own frame
Lenses: $_______________ / Single Vision / Standard Bifocal / Progressive
Prism: $_______________ / Medically Necessary
Crizal Alize: $_______________ / Medically Necessary (Anti – Glare)
Transitions: $_______________ / Medically Necessary (Photophobia)
Polycarbonate: $_______________ / Recommend for patient safety (Impact Resistant)
Therapeutic Clip: $_______________

If you have any further questions please feel free to contact our office. Thank You.

This estimate was prepared by: __________________________ / ___
**Lien Form**

Office Name  
Address  
City, State, Zip Code

Patient Name: ____________________________________________________________

Injury Date: ____________________________

SS#______________________________

Law firm representing patient: ________________________________________________

The above named law firm and patient do hereby agree that in consideration of ______(office name) cooperation in providing medical reports, billings, records and medical legal consultations, no disbursement of client proceeds shall be made to the patient until amounts have been reserved to pay the then existing balance due and owing to ______(office name). Such sum that is reserved shall be paid to ______(office name) without reduction, collection fee or costs of any kind, unless the patient objects to such payment.

In the event of such patient objections, the reserved sum shall be held by the law firm and not disbursed to the patient or to any other person absent agreement of the patient, ______(office name) or a court order.

Patient  
Signature________________________________________Date_____________________

Law firm Representative_____________________________________Date_____________________

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**Vision Specialists Institute**  
BILLING FOR NEUROVISUAL OPTOMETRY  

**NEUROVISUAL OPTOMETRY TRAINING COURSE**
**Upgraded frame charge**

As an auto and or worker’s compensation claim, we would like to let you know that your insurance company will only pay for a standard frame. You are choosing a deluxe frame and will be responsible to pay any difference on this upgraded frame.

The cost of the upgrade is_____________________________________________________

By signing this form you understand that we will bill your insurance for up to $219.00 and you will pay the difference.

Patient Name______________________________________________________________

Patient Signature__________________________________________________________

Date________________________
**DOCTORS NOTES: documenting a Level 5 Exam**

The doctor’s notes can make or break the task of relating the accident to your treatment. Below are some points to include in patient records.

**New Patient:**
1. You want to make sure the doctor’s notes start by stating the type and date of the accident.
2. Detail all symptoms the patient is experiencing after the accident. Talk about the degree of severity of symptoms.
3. Next, state which symptoms were not present prior to the accident or symptoms that were worsened after the accident. (ie: patient may have had occasional headaches prior to the accident that are worse or more often after the accident.)
4. State if the patient has a head injury and note the doctor and specific diagnosis the patient received if possible.
5. If your patient did not wear glasses prior to the accident, note it. It is harder to prove “relatedness” in patients who wore glasses prior to an accident.
6. State a summary of the plan and time frame to be treated.

**Established Patient:**
1. Start by again stating that the patient is being treated for an accident or injury and state the date of the accident.
2. State the symptoms that have improved since the patient’s last visit and use words like- “with the addition of prism”. Use the 0-10 number system to explain the amount of improvement.
3. State any symptoms that have been eliminated with the prescription of prism.
4. Next, list the symptoms the patient is still experiencing and again use the 0-10 numbering system to describe the severity.
5. State a limited summary of the plan and time frame to be treated again.

**Words to avoid in documentation:**
1. Visual symptoms- this makes the insurance company think optical. (ie: near or far sighted.) Instead use the words medical symptoms, or just symptoms.
2. Patient has no symptoms. If the patient’s symptoms have been eliminated after the first visit and a new prescription is not necessary then state that. State what the previous symptoms were and note 100% improvement.
3. Check- up- this leads an insurance company to think the patient is having no problems/symptoms. Instead, use the word follow up or progress assessment, then go on to describe why the patient needed to be seen.
4. Re-check or prescription check. This again makes an insurance company think there are no symptoms relating to the accident. It also makes the insurance company think optical and not medical. Use the word follow up or progress exam.

5. Near sighted or far sighted. Be careful with these and if you must use them, state why the near or far vision was affected and how it relates to the accident.

6. Vision- while VH does affect how the patient sees as far as blurriness, double vision etc., it would be better to use the actual words blurriness or double vision.

7. Avoid statements like: patient is doing well with his vision. Instead talk about specific medical symptoms and improvements relating to accident.

8. Avoid saying the statement, the patient is here for a general exam with no specific visual problems. VH exams are never a “general exam” this implies optical exam.

9. Avoid a statement like this: it has been 3 years since his last eye exam. He is here for a check-up. Even if the patient had a lapse in annual visits, relatedness to the accident must still be noted.

10. Patient is here today to assess visual symptoms relating to his accident on ___________.
    Instead, just state the patient is here to have an evaluation to assess symptoms relating to his accident on __________.
History

1. **Chief complaint (CC):** Need only 1-2 words (e.g. – headache, dizziness)

2. **History of present illness (HPI):** need at least 4 listed below.
   a. Location: where pain or symptom occurs, be specific.
   b. Duration: how long problem, pain or symptom has persisted.
   c. Severity: Description of severity of pain/symptom (e.g. 0-10)
   d. Quality: Description of pain/symptom (e.g. dull, aching)
   e. Timing: When pain/symptom occurs (e.g. worse in am, continuous)
   f. Modifying factors: actions taken to lessen or worsen pain/symptom (e.g. pain relievers, bending)
   g. Context: instances that can be associated with the pain/symptom. (e.g. standing/sitting for long periods)
   h. Association signs and/or symptoms: other problems that occur with primary pain/symptom. (e.g. stress causes headaches)

3. **Review of symptoms (ROS):** need at least 10 listed below. Document all positive and negative responses. The phrase “all other systems negative” can be used if all symptoms were reviewed. ROS can be recorded by staff of patient but documentation must show doctor reviewed it. Notes should include who recorded information. ROS from an earlier encounter does not need to be rerecorded as long as documentation shows doctor reviewed it and updated any new information or changes. New changes or no changes should be noted along with date and location of the earlier ROS.
   a. Constitutional symptoms: (e.g. fever, weight gain, weakness)
   b. Eyes: (e.g. double vision, blurred vision)
   c. Ears, Nose, Mouth, Throat: (e.g. sinuses, difficulty swallowing)
   d. Cardiovascular: (e.g. chest pain)
   e. Respiratory: (e.g. shortness of breath)
   f. Gastrointestinal: (e.g. stomach pain, heartburn)
   g. Genitourinary: (e.g. dysuria, burning, frequency)
   h. Musculoskeletal: (e.g. pain, stiffness, swelling)
   i. Integumentary: (e.g. rashes, pain, lumps)
   j. Neurologic: (e.g. seizures, fainting, headaches, numbness)
   k. Psychiatric: (e.g. sleeping habits, feelings)
   l. Endocrine: (e.g. thyroid problems, thirst, sweating)
   m. Allergic/immunologic: (e.g. allergies, reaction, immune symptoms)

4. **Past, Family and Social History (PFSH):** For new patients, include one item from each of 3 listed below. For established patients, include one item from each of 2 listed below.
PFSH can be recorded by staff of patient but documentation must show doctor reviewed it. Notes should include who recorded information. PFSH from an earlier encounter does not need to be rerecorded as long as documentation shows doctor reviewed it and updated any new information or changes. New changes or no changes should be noted along with date and location of the earlier PFSH

a. Past history-review or prior illnesses, injuries, operations, hospitalizations, medications, etc.
b. Family history-review of medical events in the patient’s family that are hereditary or place patient at risk.
c. Social history-review of habits such as smoking or drug use, living arrangements, occupation, etc.
Exam

Time is normally the least significant factor in determining level of service. The exception to this is in the case where counseling and/or coordination of care dominated the visit (face to face time). If more than 50% of the visit is spent on counseling/coordination of care then time is considered the controlling factor.

Elements of a comprehensive and detailed exam:
Comprehensive exam- 14 elements (new exam)
Detailed exam 9-13 elements (annual and follow-up exams)

1. VA- (visual acuity)
2. Confront- (visual fields by confrontation
3. EOM/CT-
4. Conjunctiva
5. Adnexa/Lacrimal glands
6. Pupils/Irises
7. Cornea
8. Post Seg
9. Lens
10. IOP (interocular pressure)
11. OP Disc
12. Posterior Segment
13. Oriented to Time, Place, Person
14. Assess Mood, Affect, Depression, Anxiety

92060- Sensorimotor Exam:
a. Document doctor’s name that has ordered the sensorimotor exam and the date.
b. Document the findings of the sensorimotor exam.
c. Include location and eye.
d. List a management plan to address the findings.
Medical Decision Making

There are 4 types of complexity:

1. Straightforward
2. Low Complexity
3. Moderate Complexity
4. High Complexity

There are 3 elements to determine complexity:

1. Number of Diagnosis/Management Options
2. Amount and Complexity of data to be reviewed
3. Risk

**Straightforward**
- a. # of diagnosis/management - 0-1
- b. Data reviewed – 0-1
- c. Risk – minimal

**Low**
- a. # of diagnosis/management – 2
- b. Data reviewed – 2
- c. Risk – Low

**Moderate**
- a. # of diagnosis/management – 3
- b. Data reviewed – 3
- c. Risk – moderate

**High**
- a. # of diagnosis/management – 4+
- b. Data reviewed – 4+
- c. Risk - high
## Time

Time is normally the least significant factor in determining level of service. The exception to this is in the case where counseling and/or coordination of care dominated the visit (face to face time). If more than 50% of the visit is spent on counseling/coordination of care then time is considered the controlling factor.

If the doctor chooses to report level of service based on counseling and/or coordination of care, the total length of actual face to face time with physician must be documented.

### Level of Service

Key:

- PF - problem focused
- EPF - expanded problem focused
- D - detailed
- C - comprehensive
- MDM - medical decision making
- SF - straightforward

### New Patient - need 3 of 3

<table>
<thead>
<tr>
<th>Level of service</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>PF</td>
<td>PF</td>
<td>SF</td>
<td>10-15 min</td>
</tr>
<tr>
<td>99202</td>
<td>EPF</td>
<td>EPF</td>
<td>SF</td>
<td>20-30 min</td>
</tr>
<tr>
<td>99203</td>
<td>D</td>
<td>D</td>
<td>Low</td>
<td>30-40 min</td>
</tr>
<tr>
<td>99204</td>
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<td>C</td>
<td>Moderate</td>
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<tr>
<td>99205</td>
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<td>C</td>
<td>High</td>
<td>60-80 min</td>
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<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
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<td>N/A</td>
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<tr>
<td>99213</td>
<td>EPF</td>
<td>EPF</td>
<td>Low</td>
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<tr>
<td>99214</td>
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<td>D</td>
<td>Moderate</td>
<td>25- min</td>
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<tr>
<td>99215</td>
<td>C</td>
<td>C</td>
<td>High</td>
<td>40- min</td>
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Documentation Wording

**Diagnosis – Assessment**

a. Patient is Dx’ed w/ VH:

Analysis of today's History and / or Examination(s) and / or Trial Framing reveals that the patient has vertical heterophoria.

b. VH is caused by ABI:

Analysis of today's History and / or Examination(s) and / or Trial Framing reveals that this patient suffered an ABI (Acquired Brain Injury), which has caused symptom(s) that are being diagnosed as VH (a form of Binocular Vision Dysfunction).

c. Prior VH s x’s worsened by ABI:

Analysis of today's History and / or Examination(s) and / or Trial Framing reveals that the patient has suffered an ABI (Acquired Brain Injury), which has caused a worsening of symptom(s) that they had prior to their ABI, that is being diagnosed as VH (a form of Binocular Vision Dysfunction).

d. Increased risk – car accident:

Due to having VH, this patient is at increased risk for having a car accident.

e. Increased risk of falling:

VH is affecting this patient's balance, placing them at increased risk for falling.

f. VH interferes w/ reading:

This patient's VH interferes with their ability to read.

g. VH interferes w/ school:

This patient's VH interferes with their ability to attend and to perform well at school.

h. VH interferes w/ work:

This patient's VH interferes with their ability to work.
i. VH affects ADL’s:

VH is interfering with this patient's Activities of Daily Living (ADL's).

**Diagnosis – Plan**

a. **Prism Rx’ed to Tx VH**

Prismatic lenses are being prescribed to correct the patient's VH. It is anticipated that this will lead to a reduction of the patient's VH mediated symptoms and risks.

b. **Re-eval 2 wks after new Rx**

The patient requires re-evaluation 2 weeks after receiving their new lenses. This evaluation is needed to assess progress with prismatic lenses, and to assess the need for adjustment to the patient's lens prescription.

c. **DC Home with prism clips**

Trial Framing today reveals significant improvement with prismatic lenses to correct the patient's VH. The patient will be sent home with Prism Clip-ons to ameliorate their VH symptoms.

d. **Change / update to Rx is needed**

Analysis of today's History and / or Examination(s) and / or Trial Framing reveals the need to change / update the current lens prescription - see today's prescription.

e. **No change to current Rx**

Analysis of today's History and / or Examination(s) and / or Trial Framing reveals that there is no need to change the current lens prescription.

f. **ADL’s affected– support needed:**

VH is interfering with this patient's Activities of Daily Living (ADL's) to such an extent that they require support with their ADL's.

g. **No Driving**

Due to the patient's vision condition, they have been advised not to drive.
h. Unable to work:

The patient's VH is so severe they are unable to work.

i. Referred for consultation:

This patient has inadequate resolution of symptoms from the use of prismatic lenses alone. The patient will be referred for further evaluation and care.

j. Refer for Detox:

The patient is taking medications that seem to be interfering with prismatic lens treatment of their VH. They are being referred to an Addiction Medicine specialist to aid the patient in discontinuing the suspect medications.

k. F/U 1 yr

The patient has responded well and requires no further adjustments to their lens prescription at this time. The patient should follow-up in 1 year to assess the need for an adjustment to their lens prescription, sooner if symptoms begin to return.
Sensorimotor Exam - Findings

New Patient – Prism Trial - Improved

Prism testing was done outside of the instrument. The results of the prism trial demonstrate improvement of symptoms with prismatic lenses that correct for visual misalignment.

New Patient – Prism Trial – Not Improved

Prism testing was done outside of the instrument. The results of the prism trial demonstrate no improvement of symptoms with prismatic lens correction of apparent visual misalignment.

Previous Patient – Need Change Prism

Prism testing was done outside of the instrument. The results of the prism trial demonstrate improvement of symptoms with an updated prismatic lens prescription that corrects for visual misalignment.

Previous Patient – no change of prism

Prism testing was done outside of the instrument. The results of the prism trial demonstrate that the current prism prescription requires is effective.

Sensorimotor Exam - Management Plans

Prism will be Rx’ed

Prism will be prescribed.

Prism will not be Rx’ed

Prism will not be prescribed.

Previous Pt – Prism Rx updated

An updated prism prescription will be added to the patient's lens prescription.
Previous Pt – no change to current prism Rx

The current prism prescription requires no change at this time.

Fundus Photography

Fundus photography is performed for one or both eyes to view a complete image of the structure behind the lens of the eye. The photo outlines any areas of concern. This interpretation and report by the doctor determines the need for referral or additional treatment.

Visual Field Examination

Visual Field testing pinpoints areas of visual loss, either unilaterally or bilaterally, by allowing the patient to see images at different points on the field screens. The test results show areas of the field that the patient may see clearly or faintly, thus focusing on areas in the eye that may be of concern. This interpretation and report by the doctor determines the need for referral or additional treatment.

Orthoptic training / Trial Framing

Trial framing is utilized w/ each adjustment to the prismatic lens prescription. These adjustments usually occur w/ in 6 months of the initiation of treatment, and then as needed with updates to the prism prescription. Prism testing was done outside of the instrument. The results of the prism trial demonstrate improvement of symptoms with prismatic lenses that correct for visual misalignment.

Analysis of today's History and / or Examination(s) and / or Trial Framing reveals that there is no need to change the current lens prescription. The patient has responded well and requires no further adjustments to their lens prescription at this time. The patient should follow-up in 1 year to assess the need for an adjustment to their lens prescription, sooner if symptoms begin to return.

Prolonged / Extended Service or Face to Face Time

Face-to-face time was utilized in performing the standard optical exam, as well as performing the prolonged and specialized binocular vision exam that utilizes trial frames to help determine the
correct prismatic spectacle lens prescription in real time. This involves one or more episode of the trial framing process during this visit, each of which is followed by face-to-face reassessment of the patient to determine effectiveness of the prescription. Patient will return for a follow up visit in three months time, or later/sooner if she finds necessary.

**Prism Lenses**

Prismatic lenses are being prescribed to correct the patient's VH/SOP. It is anticipated that this will lead to a reduction of the patient's VH/SOP mediated symptoms and risks. The patient requires re-evaluation 4 weeks after receiving their new lenses. This evaluation is needed to assess progress with prismatic lenses, and to assess the need for adjustment to the patient's lens prescription.

Prism testing was done outside of the instrument. The results of the prism trial demonstrate improvement with an updated prismatic lenses prescription that correct for visual misalignment.

An updated prism prescription will be added to the patient's lens prescription.

The patient is doing well to her current refractive and prismatic correction. She is responding well to her current glasses and requires no change at this time.