

How to Take an Ophthalmic History

The primary purpose of the history is to gather pertinent information that will help the physician diagnose and treat the patient.

History Taking and Coding

The history or, more accurately, the depth of the history also plays a key role in coding. Coding refers to a determination of the level of the patient's exam (Table 1-1). The three key components for determining the level of service for each patient visit are history, examination, and medical decision making. Other minor items that come into play are counseling, coordination of care, nature of presenting problem, time, and medical necessity. ¹

The higher the level of service (as determined by the codes), the higher the billing rate. For example, a complete eye exam on a new patient is of a different level than a pressure check on a returning glaucoma patient with no other problems. There is also a difference if the returning glaucoma patient needs only a pressure check or if, while there, he or she also states that his or her vision has been blurry. In the first case, the code is for a simple, uncomplicated (ie, "problem focused") exam. In the second case, the patient needs more, starting with a more complete history of present illness and perhaps a review of certain systems. That will probably be followed by lensometry,