The Ongoing Debate
E/M vs Eye Codes

Corcoran Consulting Group

Financial Disclosure
Mary Pat Johnson is a consultant for Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

Classic Chart Note
- Name
- Date
- Chief Complaint “S”
- History
- Objective Findings “O”
- Assessment “A”
- Plan “P”
- Signature

Before Coding, Consider Coverage

Vision Plan or Medical Plan?
Where do we start this discussion?
- Initial call to the office
- Upon arrival for appointment
- Technician intake
- What is the reason for today’s office visit?

Chief Complaint
- In the patient’s own words
- Identifies the reason for visit
- Along with primary Dx, CC helps determine who is responsible for payment
Chief Complaint for Routine Eye Exam

- "I broke my glasses"
- "I need a new prescription (for glasses)"
- "Routine eye exam"
- "My contact lenses need replacement"
- "I’m here for my annual eye exam"

Chief Complaint for Medical Exam

- CC: Watery eyes Dx: Keratitis sicca
- CC: Diabetic eye exam Dx: IDDM, controlled
- CC: IOP re-check Dx: COAG
- CC: Can’t read fine print Dx: AMD
- CC: Headache Dx: UL ptosis, OU
- CC: Failed DMV test Dx: Cataract

Guidelines for Diagnosis Coding

“During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code.”

Source: Introduction to ICD-9-CM

Diagnosis Code Disconnect

CHIEF COMPLAINT
- "Routine eye exam"
- "Annual check-up"
- "Want to update my glasses"

ASSESSMENT
- Dx: AMD
- Dx: Diabetes w/BDR
- Dx: Cataracts – proceed with cataract surgery

E/M vs. Eye Codes

E/M Codes
- Complicated
- 2+ pages needed
- 5 levels of service
- Wide range
- Universal
- Used 30%

Eye Codes
- Simple definitions
- Easy documentation
- 2 levels of service
- Higher reimbursement
- Not universal
- Used 70%

Comprehensive Eye Exam

92004, 92014 – Required Elements

- History
- General medical observations
- Gross visual fields (confrontation)
- Basic sensorimotor exam
- External adnexa
- Ophthalmoscopy
- Dilation not required (some carriers disagree)
Comprehensive Eye Exam
92004, 92014 – Required Elements

- Elements not specifically mentioned:
  - Measure visual acuity
  - IOP
  - Biomicroscopy
  - Color vision testing
  - Patient orients to person, place, time
  - Most payer policies require a minimum of 8 exam elements so some of these will be needed

Comprehensive Eye Exam
92004, 92014 – Required Elements

- Initiate or continue diagnostic and treatment program (not specifically designated elements)
  - Diagnostic(s):
    - Refraction
    - Perimetry
    - Imaging
    - Lab work
    - X-ray, MRI, CT
    - Schirmer’s tear test
  - Treatment program:
    - Medication
    - Lenses
    - Minor procedure
    - Schedule for major surgery
    - Refer for treatment
    - Counsel on risks

Intermediate Eye Exam
92002, 92012 – Required Elements

- Evaluate complete visual system
- Not medically necessary on every visit
  - (EMR) Auto-completion is controversial, troublesome
  - Typically, 1-2 times per year (no specific limits)

Intermediate Eye Exam
92002, 92012 – Required Elements

- History
- General medical observations
- External ocular adnexa
- Other exam elements as desired or needed

Source: CPT

Intermediate Eye Exam
92002, 92012

- Initiate or continue diagnostic procedures, as indicated, and treatment program

Source: CPT

Intermediate Eye Exam
92002, 92012

- New condition
  - Existing condition with new problem

- New condition:
  - Acute disease
  - Injury
  - New Dx
  - New symptoms

- New problem:
  - Disease progression
  - Added co-morbidity
  - Exacerbation
  - Re-occurrence (episode)
  - Failed tx, substitute tx

Source: CPT
Intermediate Eye Exam
92002, 92012

- Not suitable for every follow-up visit
- More frequent than CEE, but no specific limit

Source: CPT

E/M Key Components

- History
  - HPI – History of Present Illness
  - ROS – Review of Systems
  - PFSH – Personal, Family, Social History
- Examination
- Decision Making
  - Diagnoses – diagnoses and management options
  - Data – tests, additional information
  - Risk – gravity of the disease(s)

Elements of History

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, and/or Social History (PFSH)

Chief Complaint
What is it?

- The chief complaint (CC) is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for a medical encounter, usually stated in the patient’s words
- It is the patient’s primary complaint and might not actually be the most serious medical issue
- The chief complaint has psychological value – it brings the patient to the physician

Source: 1997 E/M Documentation Guidelines (DG)

Chief Complaint
Why is it important?

- The chief complaint (CC) identifies the patient’s motivation for the eye exam
- It determines who is financially responsible
Chief Complaint Documentation

- Physician or staff may take the CC
- Identifies the reason for visit
  - Blurred vision: Symptom
  - Itch, burn, red: Symptom
  - Difficulty seeing signs while driving: Symptom / ADL
  - Uncontrolled DM – R/O DR: Systemic disease
  - 3 month IOP check as directed: Chronic disease

Chief Complaint Controversial Examples

- Blank – no notations
- “Here for complete eye exam”
- “Routine eye exam”
- “Annual check-up”
- “Want to check the health of my eyes”
- “I had cataract surgery and I’ve never seen better”
- “You sent me a postcard”
- “My wife told me to come in”

Chief Complaint It isn’t the HPI

- The chief complaint (CC) does not substitute for the history of present illness (HPI)
- It may contain some of the same language
- “The HPI is a chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present.”

Source: 1997 E/M Documentation Guidelines (DG)

History of Present Illness What does it contain?

- History of Present Illness (HPI)
  - Location
  - Quality
  - Severity
  - Modifying factors
  - Timing
  - Context
  - Duration
  - Associated signs and symptoms

History of Present Illness A good example

- Quality: Blurred vision
- Location: Both eyes
- Severity: Very poor
- Timing: Especially at night
- Context: Cannot drive safely
- Duration: At least 1 month

History of Present Illness What does it contain?

- 4 HPI elements are required for a “comprehensive” E/M code
  - 992x5, 992x4
- Any number of HPI elements suffices for an eye code
  - 920x4, 920x2
History of Present Illness

Who does it?

- The HPI must be performed by the physician in order to be counted for E/M coding
  - Consultations (9924x, 9925x)
  - Office visits (9920x, 9921x)
  - Hospital and nursing home visits (9922x, 9923x, 993xx)

Source: CMS

History of Present Illness

Documentation

- The HPI can be dictated to a scribe
- Use an attestation:
  - Performed by Dr. I. C. Better and dictated to Sue Scribe
- Use scribe in EMR

History of Present Illness

Chart Documentation

CC

HPI

Performed by scribed by

History of Present Illness

Cataract

CC: Cataract ✓
HPI: VA OK

History of Present Illness

Glaucoma

CC: IOP ✓
HPI: POAG

History of Present Illness

Cataract

CC: 6 mo cataract ✓ per Dr. A
HPI: Cataracts OU x 2 years, VA fluctuates for last 6 mos, Glasses no help, worse @ night, Difficulty with reading

History of Present Illness

Glaucoma

CC: 4 mo IOP ✓ per Dr. C
HPI: POAG OU x 2 years, Drops burn and make eyes red, Pt notices some lightheadness immediately after gtts, doesn’t always use the drops as instructed
History of Present Illness

Key Points

• The HPI provides more detail than the CC
• It’s chronological
• For E/M coding, only a physician may take the HPI
• Four (4) HPI elements are required for a “comprehensive” history in E/M coding
• For eye codes, any number of HPI elements suffices
• For eye codes, a staff member may take the HPI
• In recent audits, if HPI not done by provider, physician gets no credit for the history!!

Review of Systems

What is it and why does it matter?

• Helps define the problem, clarify the differential diagnosis or identify needed testing
• Serves as baseline data on other systems that might be affected by any possible management options
• Physician or staff may take the ROS
• Current status of various body systems
• Requires separate documentation
• It is not the patient’s past medical history

Source: CPT E/M Services Guidelines

Review of Systems

Medical Necessity

• The ROS isn’t required on every visit
• Repeat the elements pertinent for the condition

Review of Systems

Medical Necessity

• Limited ROS likely for
  - established patient
  - short interval recheck (3 mo IOP check)
  - problem focused condition (e.g., Allergic conjunctivitis)
• Complete ROS likely
  - New patients
  - Patients planning surgery
  - Emergent patients (e.g., trauma)
  - Patients with contributing systemic disease
  - After an important change in health status
  - Where the prior ROS is not trustworthy

Review of Systems

Why is it important?

• In E/M coding, all of the ROS elements are required for a "comprehensive" history needed for codes
  • 99204, 99205, 99215
• Any number of ROS elements suffices for an eye code
  • 920x4, 920x2

Review of Systems

Conducting the Review

• Consider starting with the symptoms where you expect a pertinent finding

<table>
<thead>
<tr>
<th>Condition</th>
<th>Inquire about</th>
<th>System reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic patients</td>
<td>Recent FBS</td>
<td>endocrine</td>
</tr>
<tr>
<td>Hypertensive pts</td>
<td>Recent BP</td>
<td>cardiovascular</td>
</tr>
<tr>
<td>Patient on crutches</td>
<td>Injury or cause</td>
<td>musculoskeletal</td>
</tr>
<tr>
<td>Pt on O2</td>
<td>Breathing probs</td>
<td>respiratory</td>
</tr>
</tbody>
</table>

• Then complete inventory and ask about remaining systems, as needed
**Review of Systems**

<table>
<thead>
<tr>
<th>System</th>
<th>Do you currently have any of these problems?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td>Poor vision, eye pain, tearing, redness…</td>
</tr>
<tr>
<td>General</td>
<td>Fever, weight loss, weight gain, unusually tired…</td>
</tr>
<tr>
<td>ENT</td>
<td>Stuffy nose, ear ache, cough, dry mouth…</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>High blood pressure, racing pulse…</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Congestion, wheezing, shortness of breath…</td>
</tr>
<tr>
<td>GI</td>
<td>Upset stomach, diarrhea, constipation, hemia, ulcer</td>
</tr>
<tr>
<td>Genital, Kidney</td>
<td>Painful urination, frequent urination, impotence…</td>
</tr>
<tr>
<td>Females only</td>
<td>Are you pregnant? Nursing?</td>
</tr>
</tbody>
</table>

**Review of Systems**

<table>
<thead>
<tr>
<th>System</th>
<th>Do you currently have any of these problems?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscles, Bones</td>
<td>Joint pain, stiffness, swelling, cramps…</td>
</tr>
<tr>
<td>Skin</td>
<td>Pimples, warts, rash, growths…</td>
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<tr>
<td>Neurological</td>
<td>Numbness, headache, seizures, paralysis…</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Anxiety, depression, insomnia…</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Diabetes, hypothyroid</td>
</tr>
<tr>
<td>Blood, Lymph</td>
<td>Bleeding, anemia, cholesterolmia…</td>
</tr>
<tr>
<td>Immunologic</td>
<td>Allergies, sneezing, swelling, redness, hives, lupus</td>
</tr>
</tbody>
</table>

**History**

**Personal**

- Past personal history
  - Allergies
  - Current medications
  - Illnesses, injuries
  - Operations
  - Hospitalizations

Source: CPT E/M Services Guidelines

**Family**

- Family history
  - Parents, siblings, children
  - Health status?
  - Deceased?
  - Hereditary diagnoses?
  - Relevancy to chief complaint, history of present illness

Source: CPT E/M Services Guidelines

**Social**

- Social History – past and current activities
  - Marital status and/or living arrangements
  - Current employment
  - Occupational history
  - Use of tobacco, alcohol, and drugs
  - Educational level
  - Sexual history

Source: CPT E/M Services Guidelines

**Example**

- CC – reason for visit
- HPI – chronological description of present illness
- ROS – signs or symptoms, inventory of organ systems
- PP – meds, allergies, injuries
- F – related hereditary disease
- S – lifestyle issues
- Blurred vision
- Reduced VA, OU, 3 weeks, worse at night, difficulty driving
- Eyes – glaucoma suspect; Constitution – fair health; all other systems negative
- HBP meds, NKA, no prior injury
- Late onset diabetes, parents
- Driver, married, smoker
History
3 of 3 Key Components

- **HPI**: 1-3
- **BRIEF**: 1-3
- **BRIEF PERTINENT**: 1
- **EXTENDED**: 4+
- **EXTENDED COMPLETE**: 10+
- **ROS**: NONE
- **PROBLEM PERTINENT**: 1
- **EXTENDED**: 2-9
- **COMPLETE**: 10+
- **PFSH**: NONE
- **NONE**: PERTINENT
- **1**: COMPLETE
- **2-3**: COMPLETE
- **HX**: PF
- **EPF**: DETAILED
- **COMPREHENSIVE**: COMPLETE

Examination

- **Visual acuity (VA)**
- **Confrontation fields**
- **Ocular motility**
- **Conjunctiva**
- **External adnexa**
- **Iris, Pupils**
- **Cornea**
- **Anterior chamber**
- **Lens**
- **IOP (except contraindicated)**
- **Fundus**
  - Dilation required unless medically contraindicated
  - Disc, C/D, Size, NFL
  - Macula, Vessels, Periphery
- **Systemic Component**
  - Mental status
  - Mood, affect

- **Problem Focused (PF)**
- **Expanded Problem Focused (EPF)**
- **Detailed**
- **Comprehensive**

**Exception: Medically Contraindicated**

Examination

- **2+ Elements**
- **6+ Elements**
- **9+ Elements**
- **11 Elements + mental status**

Exam

- **ELEMENTS** 2+ 6+ 9+ 12
- **EXAM**: PF
- **EPF**: DETAILED
- **COMPREHENSIVE**: COMPLETE
Decision Making

- Diagnoses – number of diagnoses or management options
- Tests – amount of data reviewed including tests and/or medical records
- Risk – severity of disease, triage

Decision Making

Diagnoses *

- Self limited, minor problem
- Established stable problem
- Established worsening problem
- New problem, no additional workup
- New problem, needs additional workup

*Points are cumulative.

Decision Making

Tests *

- Review, order clinical lab tests
- Review, order radiology tests
- Review, order medical tests
- Discuss tests with performing physician
- Independent review of image, tracing, specimen
- Decide to obtain older records or history from someone other than patient
- Review, summarize old records; obtain history from someone other than patient

*Points are cumulative.

Decision Making

Risk

- Minimal
- Low
- Moderate
- High

- 1 Point
- 2 Points
- 3 Points
- 4 Points

Minimal Risk

Presenting problem
- 1 minor problem
- Self limiting

Management Options
- Rest
- Superficial dressing

Source: AAO, 1997 Anatomy of a Code

Low Risk

Presenting problem
- 1 Acute uncomplicated illness or injury
- 1 Stable chronic problem
- 2+ Self limiting problems

Management Options
- OTC meds
- Minor surgery, no identified risk factors
- Occlusion
- Pressure patch

Source: AAO, 1997 Anatomy of a Code
### Moderate Risk

**Presenting problem**
- 1 Unstable chronic illness
- 2+ Acute problems
- 2+ Stable chronic illnesses
- New impression, undefined diagnosis
- Complicated acute injury

**Management Options**
- Prescription RX
- Minor surgery with identified risk factors
- Referral for consideration of elective major surgery
- Decision for elective major surgery

### High Risk

**Presenting problem**
- 1+ Unstable chronic illness
- Severe exacerbation
- Emergency

**Management Options**
- Multiple meds requiring monitoring
- Major surgery w/identified risk factors
- Referral for or decision to perform emergency major surgery

### Decision Making

2 of 3 Key Components

<table>
<thead>
<tr>
<th>DX, MGMT</th>
<th>MIN</th>
<th>LTD</th>
<th>MULTIPLE</th>
<th>EXTENSIVE</th>
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<tr>
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<td>LTD</td>
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<td>MIN</td>
<td>LOW</td>
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<td>DM</td>
<td>STRT</td>
<td>LOW</td>
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<td>HIGH COMPLEXITY</td>
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### New Patient Office Visit

3 of 3 Key Components

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<tr>
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<td>LOW</td>
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### Established Patient Office Visits

2 of 3 Key Components

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### Established Patient Office Visits

2 of 3 Key Components

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Established Patient Office Visits
2 of 3 Key Components

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Extra Credit
Face-to-face Time

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<td>992x1</td>
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<tr>
<td>992x5</td>
<td>60 mins</td>
<td>40 mins</td>
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New Patient Definition

- One who has not received any professional services from the physician or group within the past 3 years
- When on call or covering for another physician, classified as it would have been by the physician who is not available
- No distinction is made in the emergency department

Source: CPT E/M Services Guidelines

Counseling

- Test results, impressions, recommendations
- Prognosis
- Treatment options, risks, and benefits
- Instructions
- Discussion of compliance
- Risk factor reduction
- Patient and family education

Source: CPT E/M Services

Key Components in Coding Exams

- How many conditions are involved?
- How serious is the condition? (vision threatening?)
- Stable or progressing?
- Elements of history and exam documented
- Additional work-up required?
- Nature of treatment plan
- Don’t oversimplify code selection
More help...

For additional assistance or confidential consultation, please contact us at:

(800) 399-6565
or
www.CorcoranCCG.com