



Issue: October 2006

feature

E/M vs. Eye Codes: Choices for 2007 (Part 1)

Stay in compliance while optimizing reimbursement.

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The 2007 Medicare Physician Fee Schedule has some big surprises awaiting you for office visit/consultation coding. An increase in Relative Value Units (RVUs) was given to the Evaluation and Management (E/M) codes, whereas the Eye Codes didn't keep up. To help you make the proper choices — and to keep you on the path of compliance while optimizing reimbursement — *Ophthalmology Management* is providing a three-part series on this important topic.

Part 1, which follows, offers an overview of the E/M requirements. Part 2 of the series will overview the Eye Codes, while Part 3 will provide an algorithm guide for making the most suitable choices.

Figure 1 EVALUATION & MANAGEMENT CODES EYE EXAMINATION	
System/Body Area	Elements of Examination
Constitutional	
Head and Face	
Eyes	<p>Test visual acuity (does not include determinations of refractive error)</p> <ul style="list-style-type: none"> • Gross visual field testing by confrontation • Test ocular motility including primary gaze alignment • Inspection of bulbar and palpebral conjunctiva • Examination of ocular adnexa including lids (e.g., ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular nodes • Examination of pupils, irises including shape, direct and consensual reaction (afferent pupil), size (e.g., anisocoria) and morphology • Slit lamp examination of the corneas including epithelium, stroma, endothelium and tear film • Slit lamp examination of anterior chambers including depth, cells and flare • Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex and nucleus • Measurement of intraocular pressures (except in children and patients with trauma or infectious disease) <p>Ophthalmic examination through dilated pupils (unless contraindicated) of</p> <ul style="list-style-type: none"> • Optic discs including size, C/D ratio, appearance (e.g., atrophy, cupping, tumor

Choosing Correct Codes

Most ophthalmologists prefer using the Eye Codes, believing they are easier to use and more audit-proof. That is not necessarily so. If you use only eye codes, not only are you punishing yourself financially, but you also may be found to be upcoding or downcoding under audit. For example, the intermediate eye code for established patients (CPT code 92012) is not always suitable for coding frequent follow-ups such as follow-up examination for corneal abrasion. (The correct code for healing corneal abrasion often usually is E/M code 99212).

The Center for Medicare and Medicaid Services (CMS) wants you to code correctly — to neither upcode nor downcode. Recently, there has been an increase in Medicare audits triggered by severely homogenous coding. So be forewarned.

Let's first take an in-depth look at the requirements for the E/M codes.

E/M Codes

The new E/M codes were first established in 1994/1995 with the examination requirements for single-organ systems (such as eyes) being presented in 1997. The original document, "Documentation Guidelines for Evaluation and Management Services," jointly issued by the AMA and HCFA (now CMS) may be found at <http://www.cms.hhs.gov/medlearn/emdoc.asp>.

The E/M codes were — and still remain — difficult to learn the first time around, but they have advantages in that they are relatively clear and can be described as "black and white" compared to the Eye Codes, which are somewhat vague and gray. It behooves you to master them. If used properly with a forced entry form for chart documentation, the E/M codes become easy to master. More on the chart examination form later.

	elevation) and nerve fiber layer • Posterior segments including retina and vessels (e.g., exudates and hemorrhages)	The E/M codes are defined by seven components, the first three of which are used in conjunction with each other to determine the code for outpatient office visits/consultations. The first three components — History, Examination and Medical Decision Making — carry levels from one to five, with five being the highest. Some important points for each of the first three components follow.
Ears, Nose, Mouth And Throat		
Neck		History – The First Key Component
Respiratory		The History component is organized with four parts — three of which contain the term "history," thus abetting the confusion.
Cardiovascular		The four parts are: Chief Complaint, History of the Present Illness (HPI), Review of Systems (ROS) and Past History, Family History and Social History (PFSH). To understand it better, think of it as a corporate chart with <i>History — The First Key Component</i> being chairperson of the board and the four components as vice presidents.
Chest (Breasts)		
Gastrointestinal (Abdomen)		
Genitourinary		
Lymphatic		
Musculoskeletal		
Extremities		
Skin		
Neurological/Psychiatric	Brief assessment of mental status including • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety and agitation)	■ Chief Complaint. The chief complaint is the reason for the encounter, and as such may be in the patient's words or the history taker's documentation of the dialogue. This varies significantly from what physicians are taught in medical school, namely, that the chief complaint must be in the patient's own words.
CONTENT AND DOCUMENTATION REQUIREMENTS		Medicare does not cover services performed for annual checkups, routine visits, screenings, refractions or eyeglasses. If your chart note states that the patient's reason for coming into the office is any of the following —"glasses aren't good," "routine checkup," "annual check" or "no real complaints" — then that automatically makes the service noncovered. The patient must pay for the service and the practice may not bill Medicare. If you self-audited last week's charts, would you pass or would you be refunding money to Medicare?
Level of Examination	Perform and Document	
Problem Focused	One to five elements identified by a bullet	
Expanded Problem Focused	At least six elements identified by a bullet	
Detailed	At least nine elements identified by a bullet	
Comprehensive	<i>Perform all</i> elements identified by a bullet; document every element in every box with a shaded border and document at least one element in every box with an unshaded border	■ History of the Present Illness. The HPI is composed of eight elements that I commonly refer to as the brain-killers. They are: location, duration, timing, quality, context, severity, modifying factors, associated signs and symptoms.

The HPI is divided into Brief and Extended. Brief has from one to three elements described and Extended has 4+ elements described. Why is this so important?

For an encounter to qualify as level 4 for the History portion, you must have an extended HPI – four or more elements must be qualitatively described. If you only describe three elements, then the entire encounter drops to a level 2 and for a consultation, for example, you will have lost \$128.39 on a national average (using projected conversion factor of \$35.9647. Even if the conversion factor is raised, the differential in RVUs remains the same).

You must address the eight elements and not repeat the same ones for credit. For example, with a complaint of blurry vision, you cannot count occasional tearing and itching as two elements. They both are examples of associated signs and symptoms.

Here is a bad example turned into a good example.

CC: (Bad) Patient complaining of red right eye with associated pain.

CC: (Good) Patient complaining of pain and redness in the right eye x 1 day. Sudden onset. Very severe. Also has nausea and abdominal pains.

■ **Review of Systems and Past, Family, Social History.** The ROS and PFSH are basically inventories. You are taking an inventory of organ systems in the ROS and of the various pertinent occurrences in PFSH. It's pretty much the same as taking inventory of your house.

The systems are: Constitutional, Eyes, Ears, Nose, Mouth, Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary (skin and/or breast), Neurological, Psychiatric, Endocrine, Hematologic/
Lymphatic and Allergic/Immunologic.

To be in compliance with the proper chart documentation, you must note whether each system has been inventoried and whether or not there were any abnormalities. If there is a problem, then that problem must be described. Chart documentation problems occur when the history taker fails to note "normal" or "abnormal" for each system and only notes the abnormalities. One of the biggest problems I have encountered is when the practice uses a history form that identifies disease entities rather than organ systems. Thyroid and diabetes both belong in endocrine, and cancer is not an organ system at all.

For the PFSH, you must ask the patient one question for each category for that category to be considered inventoried. Both the ROS and PFSH are leveled. To bill the higher-level codes (Levels 4 and 5), you must inventory 10 or more organ systems for the ROS and each of the three categories in the HPI.

Examination – The Second Key Component

The Examination requirements are shown in Figure 1. Each bullet identifies an element that must be performed by the physician if that element is to be counted toward the level of the examination. No substitutions allowed. You cannot take elements from other single-organ systems and count them as eye examination elements. There are 14 elements that are identified by a bullet. At the highest level, all 14 have to be performed.

At the bottom of the chart, you will find the leveling of the examination based on the number of elements performed and documented.

Here are some of the documentation problems I frequently encounter when auditing:

- ▶ confrontation visual fields not addressed. If not done, state the reason
- ▶ primary gaze alignment is not "versions full." You must address the primary gaze measurement
- ▶ no reason given when IOP not measured
- ▶ pupils not dilated and the two elements (optic nerve and posterior segment) still being counted toward the level of the exam — with no explanation why. A medical contraindication is required here
- ▶ neurological/psychiatric elements missing
- ▶ dilating drops not on chart
- ▶ failure to check off normals for each eye, particularly when there is a problem in the other eye
- ▶ failure to describe the abnormality
- ▶ failure to perform all 14 elements by subspecialists who feel they are entitled to bill higher level because of subspecialty training. This is especially true in retina and plastics. In retina cases, you cannot count an extended ophthalmoscopy as the basic elements of optic disc and posterior segment and also as the separate diagnostic test, extended ophthalmoscopy.

Medical Decision Making – The Third Key Component

Medical Decision Making is the most difficult of the three key components in E/M coding to master, mainly because

it is less quantitative than the other two key components — History and Examination. In its simplest form, Medical Decision Making consists of one of four adjectives — straightforward, low, moderate and high. It is rather intuitive. Acute glaucoma is best described as high where as conjunctivitis is best described as low.

These are the four categories of Medical Decision Making: Straightforward, Low Complexity, Moderate Complexity and High Complexity. The complex method used for determining the level of Medical Decision Making is shown in Figure 2 and is based on those used by Medicare as audit guidelines. The selection of the proper category for the encounter you are coding is calculated using Tables A, B and C of Figure 2.

The two tasks that seem the most troublesome for ophthalmologists are defining chronic illnesses and deciding the level of surgery. Let's look at chronic illnesses first:

■ **Chronic Illness selection.** Chronic illnesses should be ones that are being treated by the ophthalmologist, such as glaucoma, cataracts or recurrent corneal erosion. Incidental problems should not be counted just to enhance the level of risk. The level is also influenced by the state of the illness — whether it is stable, improving or worsening. So a +1 nuclear sclerosis is considered minimal risk, but a +3 nuclear sclerosis that is causing difficulties, with the decision made to schedule surgery on that visit, would be moderate risk. A stable glaucoma would be low risk; a glaucoma that is not in control and requires change of medicine would be moderate risk. A patient presenting with acute glaucoma is considered high risk.

■ **Level of Surgery selection.** When either minor or major surgery is selected as the management option, one of four different categories must be chosen: two are for minor and two are for major. They are: Minor Surgery with no identified risk factors; Minor Surgery with identified risk factors; Major Surgery with no identified risk factors; Major Surgery with identified risk factors. The fifth classification is Emergency Major Surgery.

What is meant by "risk factors" is not what a risk management specialist would define as risk factors. The intended meaning is that the likelihood or probability that complications or unfavorable outcomes would occur with that given surgery in that given patient.

This is not to be confused with the fact that there are "risks" inherent in all surgery, but rather the likelihood that this patient has a greater chance than average of not doing well. Thus, a patient with a standard cataract who is scheduled for surgery would fall into the moderate-risk category (elective major surgery with no identified risk factors) whereas a patient who previously lost an eye secondary to an expulsive hemorrhage during cataract surgery, and who also has had glaucoma surgery in the remaining eye complicated by a severe chronic uveitis would be in the high-risk category (elective major surgery with identified risk factors) when that patient is scheduled to have the second eye operated upon.

When selecting the level of risk, think outcomes. What is the chance/likelihood that this patient will or will not have a good result? Keep in mind you are coding for that particular office visit/consultation.

■ **High Risk.** Some ophthalmologists think they never have circumstances defined as high risk whereas others firmly believe that everything they do qualifies as high risk. Obviously, neither is correct. Some clinical examples of high risk that would fit into the "Presenting Problems" category are perforating corneal ulcer and acute glaucoma. All emergency surgery, such as repair of ruptured globe, or a recurrent retinal detachment encroaching on the macula requiring immediate surgery, are examples of circumstances qualifying for the adjective "high".

Forced Entry Chart

The secret of facilitating proper chart documentation is a good forced entry chart. (A useful version of my forced entry chart can easily be downloaded from my Web site www.RivaLeeAsbell.com). When using a chart such as this, all elements of the history and examination must be checked off as being either "negative" or "positive" and "normal" or "abnormal." Do not use squiggly lines. This type of chart is the first step toward electronic medical records — all of which are based on this system. It is easy and fast and enables you to access all levels of coding.

Pearls and Pitfalls

► There is only one Table of Risk, (see page 31) and that is the generic Table of Risk used by all specialties. There is no ophthalmology Table of Risk sanctioned by Medicare. Note that the word "referral" does not appear in the document. You do not receive credit for referring a patient.

- ▶ Note the parenthetical comment "to the examiner" in Table A. This refers to the examiner and not the practice. In a group practice, if a subspecialist is referred a retinal detachment patient for evaluation and treatment, this is considered a new problem to the examiner.
- ▶ When coding encounters for established patients, be sure to use both Table A and Table C.
- ▶ Requesting a consultation is not an activity that can be counted under Amount and Complexity of Data.
- ▶ The audit forms are the basis for audit sheets for Medicare. Use them for your own internal self audits.
- ▶ Chief complaint and HPI technically are to be performed by the physician; any element that is counted in determining the level of the examination must be performed/repeated by the physician.

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Part 2 will appear in the November issue and focus on the usage and requirements of the Eye Codes.

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Figure 2 SUMMARY TABLE MEDICAL DECISION MAKING

Final Result for Level of Medical Decision Making

Draw a line down any column with two or three circles to identify the type of decision making in that column.

Otherwise, draw a line down the column with the second circle from the left.

Table A	Number of Diagnoses or Management Options	≤1 Minimal	2 Limited	3 Multiple	≥4 Extensive
Table B	Amount & Complexity of Data	≤1 Minimal OR Low	2 Limited	3 Multiple	≥4 Extensive
Table C	Highest Risk	Minimal	Low	Moderate	High
Type of Decision Making		Straightforward	Low Complexity	Moderate Complexity	High Complexity

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS TABLE A

A	B x C = D		
Problem(s) Status	Number	Points	Result
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Established problem (to examiner); stable, improved		1	
Established problem (to examiner); worsening		2	
New problem (to examiner); no additional work-up planned	Max = 1	3	
New problem (to examiner); additional work-up planned		4	
		Total	

AMOUNT AND/OR COMPLEXITY OF DATA REVIEWED

TABLE B

Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Review and summarization of old records and/or obtaining history from someone other than patient 2 and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
Total	

TABLE C: TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	<ul style="list-style-type: none"> • One self-limited or minor problem, e.g., cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> • Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echo cardiography • KOH prep 	<ul style="list-style-type: none"> • Rest • Gargles • Elastic bandages • Superficial dressings
Low	<ul style="list-style-type: none"> • Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> • Physiologic tests not under stress, e.g., pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies 	<ul style="list-style-type: none"> • Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	<ul style="list-style-type: none"> • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness 	<ul style="list-style-type: none"> • Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> • Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	<ul style="list-style-type: none"> • One or more chronic illnesses with severe exacerbation, progression, or side 	<ul style="list-style-type: none"> • Cardiovascular imaging studies with contrast with identified risk factors • Cardiac 	<ul style="list-style-type: none"> • Elective major surgery (open, percutaneous or endoscopic) with

<p>effects of treatment</p> <ul style="list-style-type: none">• Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure• An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss	<p>electrophysiological tests with identified risk factors</p> <ul style="list-style-type: none">• Diagnostic Endoscopies• Discography	<p>identified risk factors</p> <ul style="list-style-type: none">• Emergency major surgery (open, percutaneous or endoscopic)• Parenteral controlled substances• Drug therapy requiring intensive monitoring for toxicity• Decision not to resuscitate or to de-escalate care because of poor prognosis
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