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E/M vs. Eye Codes: How to Choose?

**This perpetually challenging decision is confounded by recent changes that took effect this year.
Part 1 of 3.**

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When an exam is complete and it's time to account for your services with insurers, ophthalmologists are fortunate to have the somewhat unique opportunity to choose between the E/M codes, common to all physicians, and a set of unique eye codes. It gives practices the chance to finetune the coding to best reflect the care provided, but adds another layer of complexity to an already challenging task.

Most ophthalmologists prefer the eye codes, believing they are easier to use and more audit-proof. Not necessarily so! If you use only eye codes, not only are you punishing yourself financially, you also may be found to be upcoding or downcoding in the event of an 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 (E/M code 99212 is often the correct choice).

CMS wants you to code correctly: to neither upcode nor downcode. There has been an increase of Medicare audits triggered by the various audit agencies, and this promises to intensify.

To help you navigate through the available codes and to keep you on the path of compliance while optimizing reimbursement, we present the following three-part series, updating an earlier set of articles that addressed coding changes made in 2007. We are revising and republishing the series for 2010 in light of the latest changes — the inpatient and outpatient consultation codes were just eliminated by Medicare as usable codes — plus frequent requests from readers for another copy.

Part 1 provides an overview of the E/M requirements; part 2 will give an overview of the eye codes, and in part 3 an algorithm guide for making “The Choice” is presented. Let's first take a look at the requirements for E/M codes.



E/M Basics

Evaluation and management 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 www.cms.hhs.gov/medlearn/emdoc.asp.

The system was — and remains — difficult to learn the first time around, but it has its advantages in that it is very “black and white” when compared to the eye codes, which are more “gray.” It behooves you to master them. If used properly with a forced entry form or electronic medical records for chart documentation, it becomes easy to master. More on the chart examination forms later.

E/M codes are defined by seven components, the first three of which are used collectively to determine the code level for outpatient office visits, ranging from one to five, with five being the highest. These three components are: History, Examination and Medical Decision Making.

History: The First Key Component

The first key component, history, is comprised of four individual parts – three of which contain the term “history,” thus abetting the confusion. The components are: Chief Complaint, History of the Present Illness, ROS (Review of Systems) and PFSH (Past History, Family History and Social History). If you think of it as a corporate chart —with History being chairperson of the board and the four components as vice-presidents — you will understand it better.

- **Chief Complaint (CC).** The chief complaint is the reason for the encounter, and as such may be in the patient's words or may be 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.

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 in today is any of the following — “glasses aren't good,” “routine check-up,” “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?

- **History of the Present Illness (HPI).** 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, and associated signs and symptoms.

The HPI is separated into Brief (one to three elements described) and Extended (four or more elements) levels. Why is this so important?

In order for an encounter to ultimately qualify as an E/M 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, the entire encounter drops to a level 2. For a new patient, for example, you will have lost \$84.07 on a national average (using conversion factor of \$36.0846).

You must address the eight elements without repetition. 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: Patient complaining of red eye with associated pain in the right eye.

CC: Patient complaining of pain and redness in the right eye x1 day. Sudden onset. Very severe. Also has nausea and abdominal pains.

- **Review of Systems (ROS) and Past, Family, Social History (PFSH).** 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 an inventory of your house or business.

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

To be compliant with the proper chart documentation according to the 1997 guidelines (the ones we use in ophthalmology), you must note whether each system has been inventoried and whether or not it is normal or abnormal. If there is a problem, that 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's history form uses disease entities rather than organ systems. Thyroid and diabetes both belong in endocrine and cancer is not an organ system at all, to cite just a few mistakes I've seen.

For the PFSH, you must ask 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 are allowed; you cannot take elements from other single organ systems and count them as eye examination elements.

Figure 1. Evaluation and Management Coding For Eye Examinations	
ELEMENTS OF EXAMINATION:	
<ul style="list-style-type: none"> • Test visual acuity (does not include determination of refractive error). • 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 and irises, including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology. • Slit lamp examination of the corneas, including epithelium, stroma, endothelium and tear film. 	<ul style="list-style-type: none"> • 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). • Ophthalmic examination through dilated pupils (unless contraindicated) of: <ul style="list-style-type: none"> – Optic discs, including size, C/D ratio, appearance (e.g., atrophy, cupping, tumor elevation) and nerve fiber layer. – Posterior segments, including retina and vessels (eg, exudates and hemorrhages).
CONTENT AND DOCUMENTATION REQUIREMENTS:	
<i>Level of Examination</i>	<i>Perform and Document</i>
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.....	Perform all 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

There are 14 elements, each identified by a bullet. At the highest level of examination, all 14 have to be performed. Furthermore, the physician must perform any element that is being counted toward the level of the examination for billing purposes.

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 was not measured.
- Pupils not dilated but the two elements (optic nerve and posterior segment) are still being counted toward the level of the exam — with no explanation why. It has to be a medical contraindication, not “it’s a sunny day”!
- 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 a higher level because of their subspecialty training. This is especially true in retina and oculoplastics. In retina exams, 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. In its simplest form, Medical Decision Making is one of four adjectives: straightforward, low, moderate and high. It’s rather intuitive — acute glaucoma is best described as high whereas conjunctivitis is best described as low.

The complex method used for determining the level of Medical Decision Making is given 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 along with Figure 2.

Figure 2. Determining Medical Decision Making Level					
<i>Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left</i>					
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		Straight-forward	Low Complexity	Moderate Complexity	High Complexity

Table A. Number of Diagnoses or Management Options			
A	B x C = D		
<i>Problem(s) Status</i>	<i>Number</i>	<i>Points</i>	<i>Result</i>
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

Table B. Amount and/or Complexity of Data Reviewed

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 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. 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, eg, cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> • Lab tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, eg, echocardiography • 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, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> • Physiologic tests not under stress, eg, pulmonary function tests • Non-cardiovascular imaging studies with contrast, eg, 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, eg, lump in breast • Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis • Acute complicated injury, eg, head injury with brief loss of consciousness 	<ul style="list-style-type: none"> • Physiologic tests under stress, eg, 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, eg, arteriogram, cardiac catheterization • Obtain fluid from body cavity, eg 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 effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, 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 • Abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss 	<ul style="list-style-type: none"> • Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic Endoscopies with identified risk factors • Discography 	<ul style="list-style-type: none"> • Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • 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

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 — i.e., whether it is stable, improving or worsening. For instance, a +1 nuclear sclerosis is considered minimal risk; a +3 nuclear sclerosis that is causing difficulties and results in a decision at that visit to schedule surgery would be moderate risk. A stable glaucoma patient would be low risk; 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 surgery is selected as the management option, it must be categorized as one of the following four types: 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. A fifth classification is Emergency Major Surgery.

Note that what is meant by “risk factors” in this categorization is not what a risk management agent 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.

Do not to be confused by the fact that there are “risks” inherent in all surgery. Rather, consider 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 in 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 such. 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 (repair of ruptured globe) and 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 is the first step to electronic medical records, all of which are based on this system. It's easy and fast, enabling you to access all levels of coding.

If using an EMR system, do not set automatic “negative” or “normal” defaults. It becomes quite obvious during an audit that this is what has transpired, leading the auditor to question the entire chart documentation and even whether the work was performed.

Pearls and Pitfalls

- There is only one Table of Risk, and that is the generic one to be 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, not the practice. For instance, in a group practice, if a retinal detachment patient is referred to a retinal subspecialist 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. **OM**

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Riva Lee Asbell can be contacted at www.rivaleeasbell.com, where the order form for her new book, *Tips on Ophthalmic Surgical Coding by Subspecialty*, can be found and downloaded under Products/Books.