

# **E/M versus Eye Codes – Choices for 2015**

## **Part I - E/M Codes**

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### **INTRODUCTION**

In 2010 the inpatient and outpatient consultation codes were eliminated by Medicare as usable codes although they still appear in the 2015 CPT (Current Procedural Terminology) book). In order to help you navigate through the available codes – and to keep you on the path of compliance while optimizing reimbursement - the following three part series is presented. In Part I an overview of the E/M requirements is presented; in Part II the overview of the Eye Codes given and in Part III an algorithm guide for making “The Choice” is presented.

### **BACKGROUND OF E/M AND EYE CODES**

Most ophthalmologists prefer using 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, but you also may be found to be upcoding or down coding when audited. 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).

CMS (Center for Medicare and Medicaid Services) wants you to code correctly – to neither up code nor down code. There has been an increase of Medicare audits triggered by the various audit agencies and this promises to intensify.

Let’s first take a 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>.

It was – and remains – difficult to learn the first time around, but it has its advantages in that it is very black and white compared to the eye codes which are very 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 in conjunction with each other to determine the code for outpatient office visits that are leveled

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 organized with four component parts – three of which contain the term “history”, thus abetting the confusion. They 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-The First Key Component being Chairperson of the Board and the four components as Vice-presidents – you will understand it better.

**Chief Complaint.** 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 checkup”, “annual check” or “no real complaints” – then that automatically makes the service non covered - one that the patient must pay for and for which 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 8 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 leveled into Brief and Extended, Brief having 1-3 elements described and Extensive having 4+ elements described. Why is this so important?

In order for a new patient encounter to ultimately qualify as an E/M level 4 for the History portion, you must have an extended HPI – 4 or more elements must be qualitatively described. If you only describe 3 elements then the entire encounter drops to a level 2 and for a new patient, for example, you will have lost \$90.93 on a national average .

You must address the 8 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 2 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 x 1 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 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.

In order 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, 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'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!

For the PFSH you must ask one question for each category in order 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.

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 (Fig. 1) 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. It has to be a medical contraindication – not that it's a sunny day!
- Neurological/Psychiatric elements missing
- Dilating drops not on chart
- Failure to check off normal's 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, 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 quantitated than the other two key components - History and Examination. 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 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 given in the sidebar 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 (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.*** The chronic illnesses should be ones that are being treated by the ophthalmologist, such as glaucoma, cataracts, 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 subconjunctival hemorrhage is considered minimal risk; a +3 nuclear sclerosis that is causing difficulties and the decision is 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 minor or major surgery is selected as the management option there are four different types: two for minor and two 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 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 with the fact that there are “risks” inherent in all surgery. This is 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 chances/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 (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 and a version of my chart is presented here for your use (Figure 3). A similar version can be downloaded from my web site [www.RivaLeeAsbell.com](http://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/ 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 and enables you to access all levels of coding.

EMR is essentially the next logical step. Do not set automatic “negative” or “normal” defaults – it becomes quite obvious that this is what has transpired during an audit, 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 Table of Risk 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 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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Figure 1

**EVALUATION & MANAGEMENT CODES  
EYE EXAMINATION**

<b>System/Body Area</b>	<b>Elements of Examination</b>
Constitutional	
Head and Face	
Eyes	<ul style="list-style-type: none"> <li>•Test visual acuity (does not include determinations of refractive error)</li> <li>•Gross visual field testing by confrontation</li> <li>•Test ocular motility including primary gaze alignment</li> <li>•Inspection of bulbar and palpebral conjunctiva</li> <li>•Examination of ocular adnexa including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular nodes</li> <li>•Examination of pupils, irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology</li> <li>•Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film</li> <li>•Slit lamp examination of anterior chambers including depth, cells, and flare</li> <li>•Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus</li> <li>•Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)</li> </ul> <p>Ophthalmic examination through dilated pupils (unless contraindicated) of</p> <ul style="list-style-type: none"> <li>• Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer</li> <li>• Posterior segments including retina and vessels (eg, exudates and hemorrhages)</li> </ul>
Ears, Nose, Mouth And Throat	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	
Extremities	
Skin	
Neurological/ Psychiatric	<p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> <li>•Orientation to time, place, and person</li> <li>•Mood and affect (eg, depression, anxiety, agitation)</li> </ul>

## CONTENT AND DOCUMENTATION REQUIREMENTS

### Level of Examination

Problem Focused  
Expanded Problem Focused  
Detailed  
Comprehensive

### Perform and Document

**One to five** elements identified by a bullet  
**At least six** elements identified by a bullet  
**At least nine** elements identified by a bullet  
Perform all elements identified by a bullet; document every element in every box with a shaded border and document at least 1 element in every box with an unshaded border



Figure 2

## SUMMARY TABLE MEDICAL DECISION MAKING

Final Result for Level of Medical Decision Making

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 2<sup>nd</sup> circle from the left.

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

### 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 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