Documentation & Coding Boot Camp

Ryan P. Ames, OD, MBA

1

An Intro to Coding Resources

Ryan P. Ames, OD, MBA

2

Disclosures

NOTHING TO SEE HERE

3

Proper Documentation & Coding is Important

- Accurately represent of what was done
- Required by law
- Shortens reimbursement time
- Improves office revenue

4

92002	$83.38
92004	$146.20
92012	$86.75
92014	$122.71

99201	DELETED
99202	$ 69.54
99203	$ 107.01
99204	$ 160.15
99205	$ 211.45
99211	$ 21.83
99212	$ 53.87
99213	$ 87.48
99214	$ 124.32
99215	$ 173.50

5

How much does it really matter?

Number of Exams per Day	Number of Miscoded Exams	Difference in Revenue per Day	Yearly NET Income
16	2	$60	$15,600
24	4	$120	$31,200

6

Common Pitfalls

Providers choose codes believed to be more acceptable to payers

- Payers want low level codes?
- Payers want OMDs and ODs to use only 92000 code series?
- Payers want doctors to choose care for each patient based on what the payers will pay?

7

Know the Rules

Providers (ODs & MDs) have neglected to learn the rules	• Doctor assigns coding to a staff without training them or providing resources. • Assume the payer's reps know the rules and will apply them to the claims fairly
Knowing the rules is the only alternative!	• If all providers knew the rules, the payers would have to abide by them…Life would be much simpler!

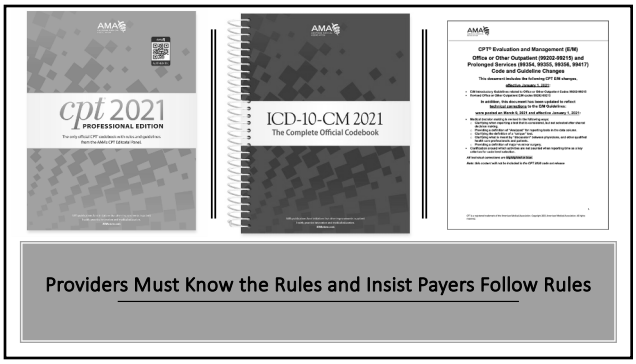
8

Doctors and Key Staff Need Resources

Every office needs **current** copies of the three main references (CPT, ICD, 1997 Documentation Guidelines)

All key staff should have reference materials available and should attend seminars and webinars each year

9



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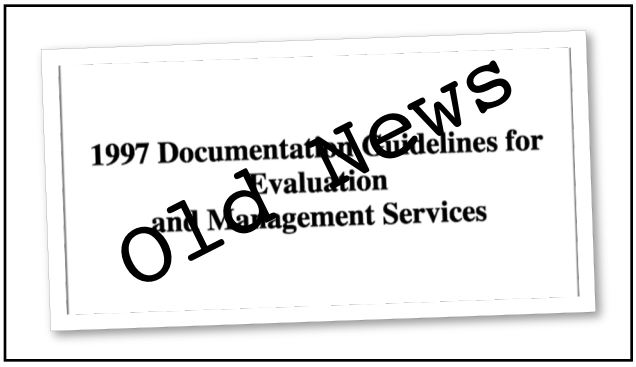

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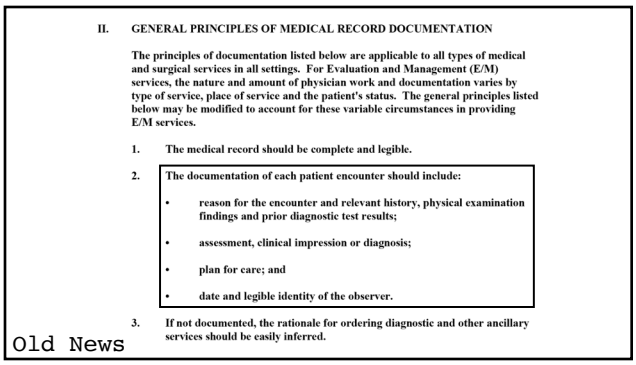

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:
   - reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   - assessment, clinical impression or diagnosis;
   - plan for care; and
   - date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

Old News

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Eye Examination

System/Body Area	Elements of Examination
Constitutional	
Head and Face	
Eyes	• 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 conjunctivae • Examination of ocular adnexae including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph 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 • Slit lamp examination of the 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) Ophthalmoscopic examination through dilated pupils (unless contraindicated) of • Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer • Posterior segments including retina and vessels (eg, exudates and hemorrhages)

Old News

13

Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Old News

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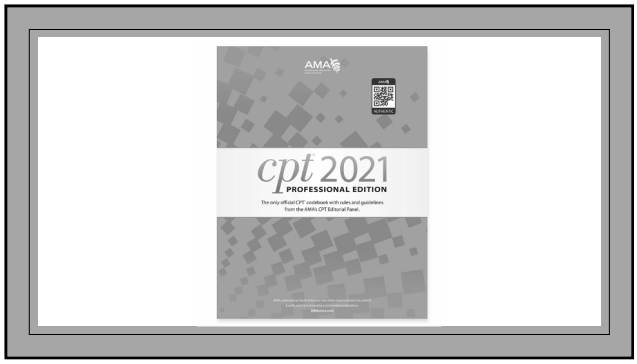
Content and Documentation Requirements

Level of Exam	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	**Perform all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Old News

15



16

What is CPT?

- Developed, updated, maintained and copyrighted but the AMA.
- First published in 1966.
- Standardized descriptions and five-character, alphanumeric codes
- Updated yearly with new codes, revised codes, removed codes.

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CPT® codes fall into 3 categories

- Category I codes describe a procedure or service identified with a five-digit CPT® code and descriptor nomenclature
- Category II codes are supplemental tracking alphanumeric codes that can be used for performance measurement. The use of these codes is usually optional
- Category III codes are temporary codes for emerging technology, services, and procedures. Used to help identify emerging technology and its efficacy, utilization, and outcome.
- Modifiers are sometimes appended to these codes to report special circumstances.

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Category I Codes

- Examples
  - Ophthalmic Codes (Eye Exam)
    - 920x2 & 920x4
  - E&M Codes (Level Codes)
    - 992xx (ie. 99214)
  - Special Ophthalmic Services
    - 92015 (Refraction)
    - 92250 (Fundus Photography)
    - 92132,-33,-34 (OCT)
    - 92081,-2,-3 (Visual Fields)

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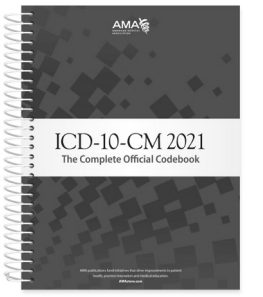
Comprehensive ophthalmological services describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Intermediate and comprehensive ophthalmological services constitute integrated services in which medical decision making cannot be separated from the examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, routine ophthalmoscopy, retinoscopy, tonometry, or motor evaluation is not applicable.

92250 Fundus photography with interpretation and report

CPT Assistant Feb 97:6, Apr 99:10, Feb 11:6, Oct 12:9

20



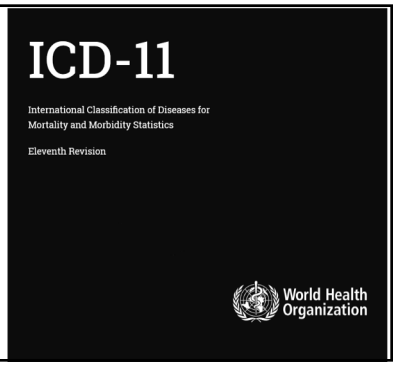
21

International Classification of Disease

- Classify diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease
- Current Version ICD-10
  - Endorsed by the WHO in 1990!
  - Widespread uses globally in 1994

22

ICD-11 was presented at the World Health Assembly in May 2019 for adoption by Member States, and will become official on January 1, 2022.



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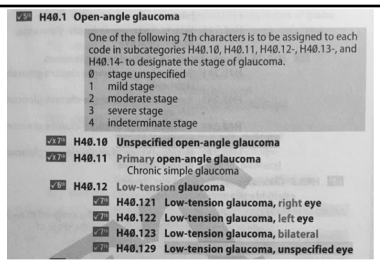
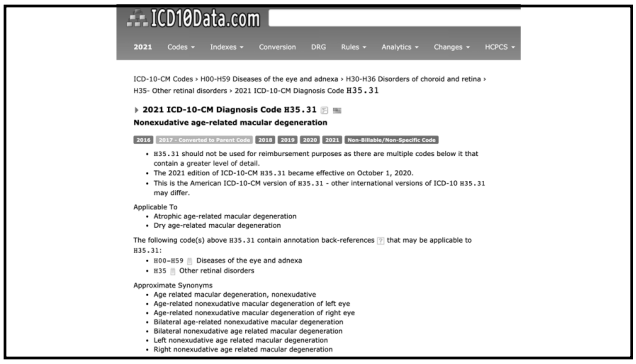
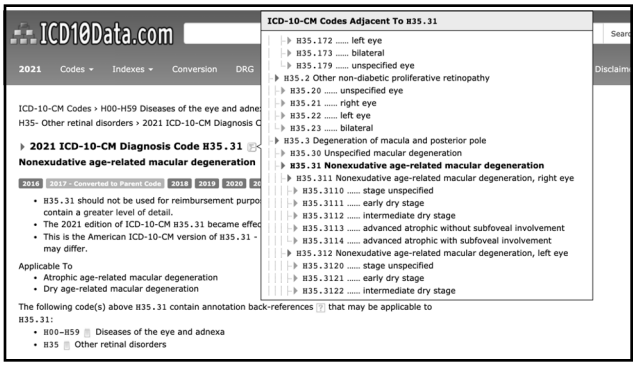


H40.121**1** Low-tension glaucoma right eye, mild stage

24


ICD10Data.com
2021 Codes Indexes Conversion DRG Rules Analytics Changes HCPCS
ICD-10-CM Codes › H00-H59 Diseases of the eye and adnexa › H30-H36 Disorders of choroid and retina ›
H35- Other retinal disorders › 2021 ICD-10-CM Diagnosis Code H35.31
2021 ICD-10-CM Diagnosis Code H35.31
Nonexudative age-related macular degeneration
2016 2017 - Converted to Parent Code 2018 2019 2020 2021 Non-Billable/Non-Specific Code
H35.31 should not be used for reimbursement purposes as there are multiple codes below it that contain a greater level of detail.
The 2021 edition of ICD-10-CM H35.31 became effective on October 1, 2020.
This is the American ICD-10-CM version of H35.31 - other international versions of ICD-10 H35.31 may differ.
Applicable To
Atrophic age-related macular degeneration
Dry age-related macular degeneration
The following code(s) above H35.31 contain annotation back-references that may be applicable to H35.31:
H00-H59 Diseases of the eye and adnexa
H35 Other retinal disorders
Approximate Synonyms
Age related macular degeneration, nonexudative
Age-related nonexudative macular degeneration of left eye
Age-related nonexudative macular degeneration of right eye
Bilateral age-related nonexudative macular degeneration
Bilateral nonexudative age related macular degeneration
Left nonexudative age related macular degeneration
Right nonexudative age related macular degeneration

25


ICD10Data.com
2021 Codes Indexes Conversion DRG
ICD-10-CM Codes › H00-H59 Diseases of the eye and adnexa
H35- Other retinal disorders › 2021 ICD-10-CM Diagnosis C
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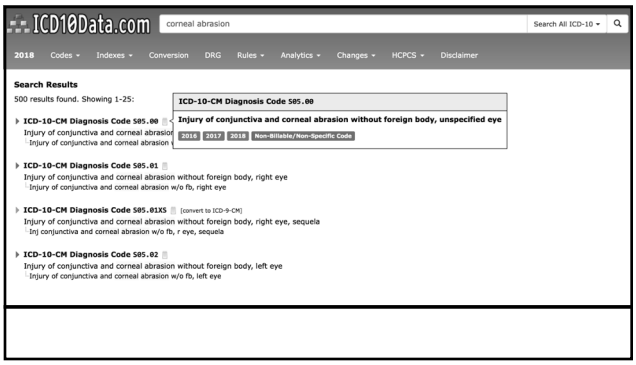
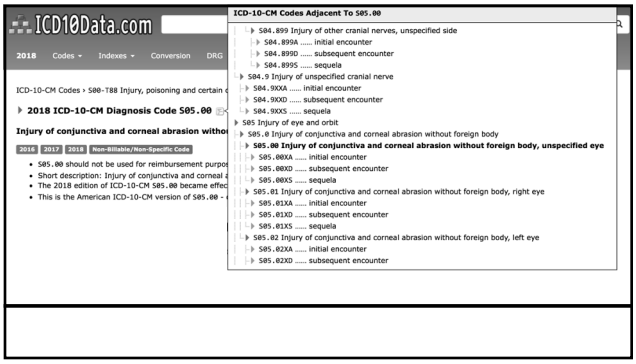
may differ.
Applicable To
Atrophic age-related macular degeneration
Dry age-related macular degeneration
The following code(s) above H35.31 contain annotation back-references that may be applicable to H35.31:
H00-H59 Diseases of the eye and adnexa
H35 Other retinal disorders
ICD-10-CM Codes Adjacent To H35.31
H35.172 ..... left eye
H35.173 ..... bilateral
H35.179 ..... unspecified eye
H35.2 Other non-diabetic proliferative retinopathy
H35.20 ..... unspecified eye
H35.21 ..... right eye
H35.22 ..... left eye
H35.23 ..... bilateral
H35.3 Degeneration of macula and posterior pole
H35.30 Unspecified macular degeneration
H35.31 Nonexudative age-related macular degeneration
H35.311 Nonexudative age-related macular degeneration, right eye
H35.3110 ..... stage unspecified
H35.3111 ..... early dry stage
H35.3112 ..... intermediate dry stage
H35.3113 ..... advanced atrophic without subfoveal involvement
H35.3114 ..... advanced atrophic with subfoveal involvement
H35.312 Nonexudative age-related macular degeneration, left eye
H35.3120 ..... stage unspecified
H35.3121 ..... early dry stage
H35.3122 ..... intermediate dry stage

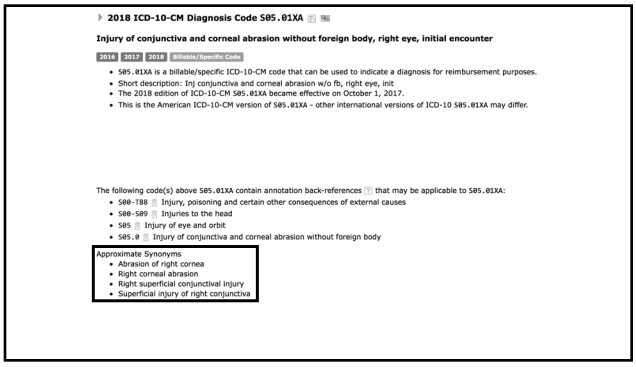
26


ICD10Data.com
corneal abrasion
Search All ICD-10
2018 Codes Indexes Conversion DRG Rules Analytics Changes HCPCS Disclaimer
Search Results
500 results found. Showing 1-25:
ICD-10-CM Diagnosis Code S05.00
Injury of conjunctiva and corneal abrasio
Injury of conjunctiva and corneal abrasion
ICD-10-CM Diagnosis Code S05.01
Injury of conjunctiva and corneal abrasion without foreign body, right eye
Injury of conjunctiva and corneal abrasion w/o fb, right eye
ICD-10-CM Diagnosis Code S05.01XS [convert to ICD-9-CM]
Injury of conjunctiva and corneal abrasion without foreign body, right eye, sequela
Inj conjunctiva and corneal abrasion w/o fb, r eye, sequela
ICD-10-CM Diagnosis Code S05.02
Injury of conjunctiva and corneal abrasion without foreign body, left eye
Injury of conjunctiva and corneal abrasion w/o fb, left eye
ICD-10-CM Diagnosis Code S05.00
Injury of conjunctiva and corneal abrasion without foreign body, unspecified eye
2016 2017 2018 Non-Billable/Non-Specific Code

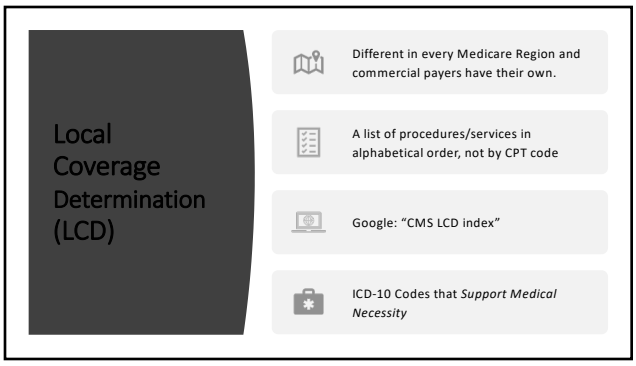
27


ICD10Data.com
2018 Codes Indexes Conversion DRG
ICD-10-CM Codes › S00-T88 Injury, poisoning and certain
2018 ICD-10-CM Diagnosis Code S05.00
Injury of conjunctiva and corneal abrasion witho
2016 2017 2018 Non-Billable/Non-Specific Code
S05.00 should not be used for reimbursement purpo
Short description: Injury of conjunctiva and corneal
The 2018 edition of ICD-10-CM S05.00 became effec
This is the American ICD-10-CM version of S05.00 -
ICD-10-CM Codes Adjacent To S05.00
S04.899 Injury of other cranial nerves, unspecified side
S04.899A ..... initial encounter
S04.899D ..... subsequent encounter
S04.899S ..... sequela
S04.9 Injury of unspecified cranial nerve
S04.9XXA ..... initial encounter
S04.9XXD ..... subsequent encounter
S04.9XXS ..... sequela
S05 Injury of eye and orbit
S05.0 Injury of conjunctiva and corneal abrasion without foreign body
S05.00 Injury of conjunctiva and corneal abrasion without foreign body, unspecified eye
S05.00XA ..... initial encounter
S05.00XD ..... subsequent encounter
S05.00XS ..... sequela
S05.01 Injury of conjunctiva and corneal abrasion without foreign body, right eye
S05.01XA ..... initial encounter
S05.01XD ..... subsequent encounter
S05.01XS ..... sequela
S05.02 Injury of conjunctiva and corneal abrasion without foreign body, left eye
S05.02XA ..... initial encounter
S05.02XD ..... subsequent encounter

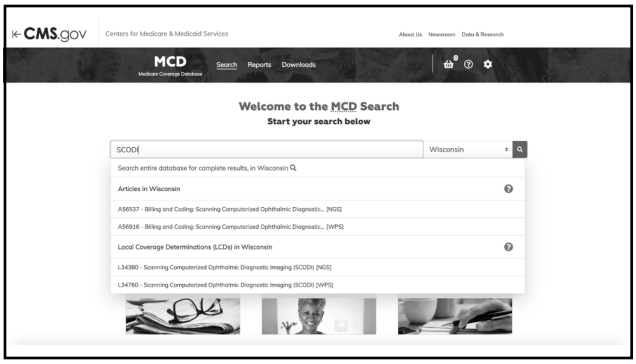
28


2018 ICD-10-CM Diagnosis Code S05.01XA
Injury of conjunctiva and corneal abrasion without foreign body, right eye, initial encounter
2016 2017 2018 Billable/Specific Code
S05.01XA is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.
Short description: Inj conjunctiva and corneal abrasion w/o fb, right eye, init
The 2018 edition of ICD-10-CM S05.01XA became effective on October 1, 2017.
This is the American ICD-10-CM version of S05.01XA - other international versions of ICD-10 S05.01XA may differ.
The following code(s) above S05.01XA contain annotation back-references that may be applicable to S05.01XA:
S00-T88 Injury, poisoning and certain other consequences of external causes
S00-S09 Injuries to the head
S05 Injury of eye and orbit
S05.0 Injury of conjunctiva and corneal abrasion without foreign body
Approximate Synonyms
Abrasion of right cornea
Right corneal abrasion
Right superficial conjunctival injury
Superficial injury of right conjunctiva

29


Local Coverage Determination (LCD)
Different in every Medicare Region and commercial payers have their own.
A list of procedures/services in alphabetical order, not by CPT code
Google: “CMS LCD index”
ICD-10 Codes that *Support Medical Necessity*

30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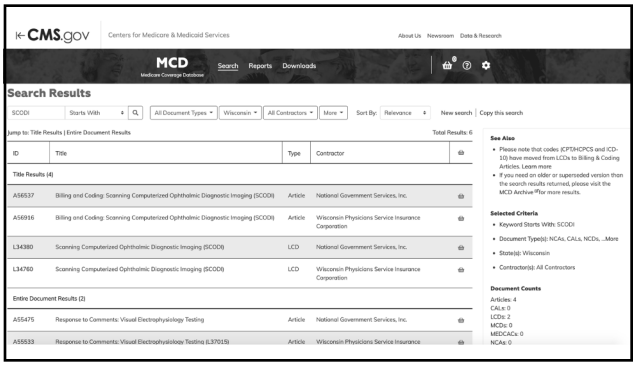
Welcome to the MCD Search
Start your search below
SCODI
Wisconsin
Search entire database for complete results, in Wisconsin
Articles in Wisconsin
A56537 - Billing and Coding: Scanning Computerized Ophthalmic Diagnostic... [NGS]
A56916 - Billing and Coding: Scanning Computerized Ophthalmic Diagnostic... [WPS]
Local Coverage Determinations (LCDs) in Wisconsin
L34380 - Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) [NGS]
L34760 - Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) [WPS]

31


CMS.gov
Centers for Medicare & Medicaid Services
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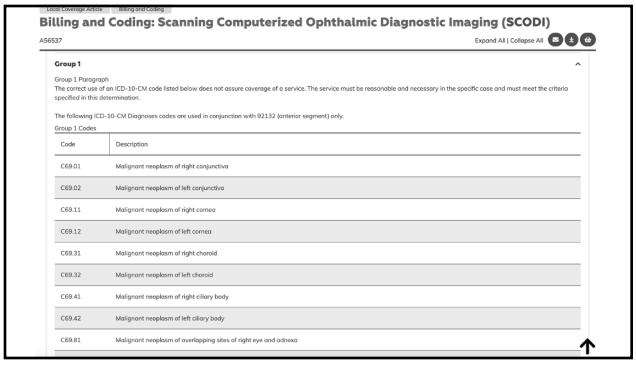
MCD
Medicare Coverage Database
Search Reports Downloads
Search Results
SCODI
Starts With
All Document Types
Wisconsin
All Contractors
More
Sort By: Relevance
New search
Copy this search
Jump to: Title Results | Entire Document Results
Total Results: 6
ID
Title
Type
Contractor
Title Results (4)
A56537 Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) Article National Government Services, Inc.
A56916 Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) Article Wisconsin Physicians Service Insurance Corporation
L34380 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) LCD National Government Services, Inc.
L34760 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) LCD Wisconsin Physicians Service Insurance Corporation
Entire Document Results (2)
A55475 Response to Comments: Visual Electrophysiology Testing Article National Government Services, Inc.
A55533 Response to Comments: Visual Electrophysiology Testing (L37015) Article Wisconsin Physicians Service Insurance
See Also
Please note that codes (CPT®/HCPCS and ICD-10) have moved from LCDs to Billing & Coding Articles. Learn more
If you need an older or superseded version than the search results returned, please visit the MCD Archive® for more results.
Selected Criteria
Keyword Starts With: SCODI
Document Type(s): NCAs, CALs, NCDs, ...More
State(s): Wisconsin
Contractor(s): All Contractors
Document Counts
Articles: 4
CALs: 0
LCDs: 2
MCDs: 0
MEDCACs: 0
NCAs: 0

32


Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)
A56537
Expand All | Collapse All
Group 1
Group 1 Paragraph
The correct use of an ICD-10-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.
The following ICD-10-CM Diagnoses codes are used in conjunction with 92132 (anterior segment) only.
Group 1 Codes
Code
Description
C69.01 Malignant neoplasm of right conjunctiva
C69.02 Malignant neoplasm of left conjunctiva
C69.11 Malignant neoplasm of right cornea
C69.12 Malignant neoplasm of left cornea
C69.31 Malignant neoplasm of right choroid
C69.32 Malignant neoplasm of left choroid
C69.41 Malignant neoplasm of right ciliary body
C69.42 Malignant neoplasm of left ciliary body
C69.81 Malignant neoplasm of overlapping sites of right eye and adnexa

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Pitfalls Common in Eye Care Medical Records

After review thousands of charts…Doctors use just a handful of codes available to eye doctors in CPT

- Staff and doctors tend to stick to ‘familiar’ and/or ‘safe’ codes
- Coding tends to be very conservative; often averaging one or more levels below what the content of the chart earns

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Care Must Be Based On Patient’s Needs, Not Coverage!

- Doctors should carefully interview patient to determine why the patient is here today
- Case history and examination should be customized to meet the patient’s needs
- Record should show all that was done and the results
- Bill should be created using codes based upon the content of the medical record
- Any consideration of payer’s requirements should come last…Not first!

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A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**____________ below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**____________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**____________ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

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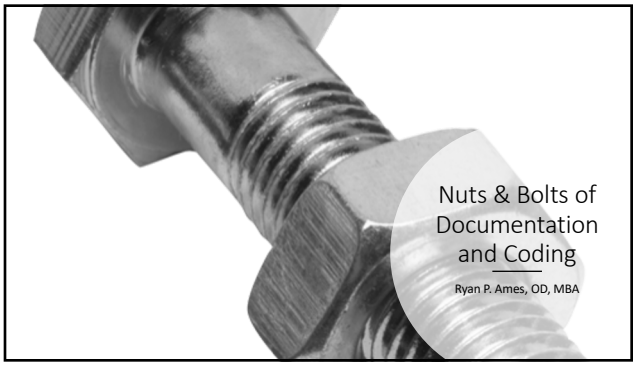
Hierarchy of Care

- Why is the patient here?
- Case Hx & Exam to meet the needs of the patient and the doctor.
- Accurately document the exam.
- Code the exam based on the documentation.

37



38

Doctor and Staff's Role in Documentation

Doctor is responsible for everything in the record, even if some material is recorded by staff

- Signature signifies the doctor has reviewed all the content and is accepting responsibility for the content

Staff is responsible for recording based on doctor's instructions

- Doctor may require staff to initial all entries they make to aid in any review of the content later; internally or externally
- **This does not reduce the doctor's liability**

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In Coding, There is No Place to Hide

- OD's and OMD's use more 92000 codes than 99000 codes to report their services
- Most eye doctors do not know the definitions for the 92000 codes and use them out of habit

40

No Place to Hide

All eye care visits can be coded as one of the 99000 series services

Only ~80% can alternatively be coded as a 92000 series service

Fortunately, many auditors/reviewers don't know the rules so doctors and staff who ***do*** know them and use them correctly can do well in audits!

41

A Peek At Charts

- Be sure to indicate "negatives"
  - No vertical lines or long circles to indicate a series of negatives
- Careful documentation during acute care
- Medicare: Each record must have signature of responsible person…(digital signatures are fine)

  "Legible identity of the observer"

42

More Comments On Charts

- Patient's health history form (review of systems) should permit patient to indicate positive or negative for **each** organ system
- Alternative is to indicate only positives, with statement at end,

"All other systems are normal," dated and initialed by the patient

  - Without such a statement, grading would be only on the systems that had positives.
  - If it is not documented, it was not done!

43

General Ophthalmologic Services 92002, 92012 & 92004, 92014

- Intermediate and comprehensive ophthalmological services are unique to eye care.
- CPT definitions for these services are more general in nature.
- They closely match what we do everyday

44

Choosing A 92000 Code

As with all services, must use these codes only when the documentation matches the definitions in CPT

Most visits can be reported using either 99000 or 92000 codes

- *Note: Approximately 20% of the eye doctors' charts we review are missing at least one requirement for the intermediate or comprehensive ophthalmological services and* ***must be coded as a 99000 visit.***

45

General Ophthalmological Services

- General Ophthalmological Service codes, as all other CPT codes, are designed to report **medical** eye care visits
- May also be used to report **routine** eye care
- Refraction is a separate service (92015) and is not included in any other code, unless required by contract with payer

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Intermediate Ophthalmological Services 92002/92012

- Note: Current Procedural Terminology(© American Medical Association) is the ***only*** accepted source of definitions for these services.
- "***Intermediate ophthalmological services*** describes an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history[1], general medical observation[2], external ocular and adnexal examination[3] and other diagnostic procedures[4] as indicated; may include the use of mydriasis for ophthalmoscopy…with initiation (or continuation) of diagnostic and treatment program[5]."

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Requirements of: Intermediate Ophthalmological Service

Payers develop their own interpretations of these definitions, but the elements that are clearly included in the CPT definition are:

1. A new or existing condition
   - complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis
2. History
3. General medical observation
4. External ocular/adnexal examination
5. Other diagnostic procedures as indicated
6. Initiation (or continuation) of a diagnostic and treatment program

48

Required Elements for: Intermediate Ophthalmological Service

- If one (or more) of these elements is missing, the visit **cannot** be coded as intermediate ophthalmological service.

49

Comprehensive Ophthalmological Service 92004/92014

- "***Comprehensive ophthalmological*** *services* describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, *gross visual fields and basic sensorimotor examination.* It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs."

50

Requirements of: Comprehensive Ophthalmological Service

1. History
2. General medical observation
3. External examination
4. Ophthalmoscopic examination ("with or without cycloplegia or mydriasis")
5. Gross visual fields
6. Basic sensorimotor examination (EOMs)
7. Initiation of diagnostic and treatment program

51

Initiation of Dx/Tx Program Is a Critical Component of Medical Record

- Likely target of reviewers/auditors of eye care records
- Visit will be rejected or changed to 99000 code if record for ophthalmological service is without initiation of diagnostic/treatment program
  - No detailed nationally accepted, detailed definition, so…
  - ***Every office must have its own definition of what's included in initiation (continuation) of diagnostic and treatment program and stick to it.***

52

Your Definition of Initiation of Dx/Tx Program…

- Probably will include 15-20 items
  - Diagnoses pertinent to today's visit
  - RTO
    - For recheck
    - For additional tests
    - For treatment
  - Rx meds
  - Rx specs
- Rx CLs
- Refer for Dx/Tx
- Recommended OTC meds
- Lid hygiene, lid scrubs, etc.
- Ergonomic adjustments at work or home
- Adjustments in school environment
- Refer to another doctor or clinic for Dx/Tx
- Etc.

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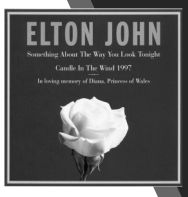

1997 Documentation Guidelines (DGs) Written in 1997…24 Years Ago!

- Created to standardize and "simplify" medical record documentation
- DGs put more detail into CPT definitions for 99000 series codes to make the choices of codes more objective, repeatable, dependable
  - Objective means fewer arguments with auditors
  - Fewer arguments with auditors is a good thing!
- Most ODs and key staff have never read them!

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For 99000 Codes, CPT Rules Come First, Then the Documentation Guidelines

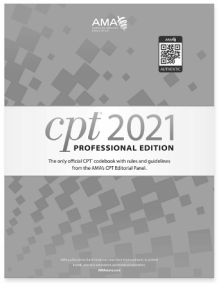
For new patients, CPT requires that record qualifies on **all three** key components	For established patients, CPT requires that record qualifies on **two of three** components
• History • Physical examination • Medical decision making	• History and/or • Physical examination and/or • Medical decision making

Old News

55

CPT Definition: "New Patient"

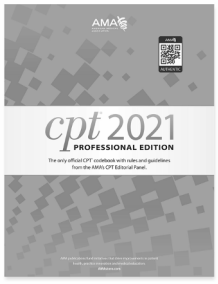
- CPT, "A new patient is one who ***has not*** received any professional services from the physician or another physician of the ***exact same specialty and subspecialty*** who belongs to the same group practice, within the past three years."



56

CPT Definition: "Established Patient"

- CPT, "An established patient is one who ***has*** received professional services from the physician or another physician of the ***exact same specialty and subspecialty*** who belongs to the same group practice, within the past three years."



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CPT Evaluation and Management (E/M)
Effective as of January 1, 2021

- First substantive change since 1997
- **Elimination** of code determination based on *history*, *physical exam*, and *medical decision making*.
- Focus on Medical Decision Making for code selection
- Change to Time based code selection

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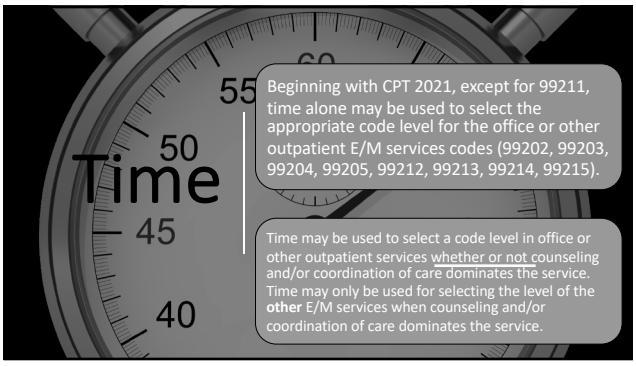
https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

59



Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215).

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

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Time

Total time on the date of the encounter (office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215]): For coding purposes, time for these services is the total time on the date of the encounter.

Includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter

Includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff).

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Time Includes

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/ family/caregiver
- care coordination (not separately reported)

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Time Does NOT Include

The performance of other services that are reported separately

(i.e. interpretation of special testing, performing other procedures)

Travel

Teaching that is general and not limited to discussion that is required for the management of a specific patient

63

Code	Time	Code	Time
99201	DELETED	99211	No time frame – physician presence not required
99202	15-29 minutes	99212	10-19 minutes
99203	30-44 minutes	99213	20-29 minutes
99204	45-59 minutes	99214	30-39 minutes
99205	60-74 minutes	99215	40-54 minutes

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Services Reported Separately

Any specifically identifiable procedure or service (i.e., identified with a specific CPT code) performed on the date of E/M services may be reported separately.

Modifier -25: added to the E/M service

65

History and/or Exam

- Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of office or other outpatient codes.

66

History and/or Exam

- The extent of history and physical examination is not an element in selection of the level of office or other outpatient codes.

67

Number and Complexity of Problems Addressed at the Encounter

- Multiple new or established conditions may be addressed at the same time.
- Each symptom is not necessarily a unique condition
- Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed.
- Final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.*

68

Number and Complexity of Problems Addressed at the Encounter*

- *Therefore, presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid.

69

Code	Level of MDM (Based on 2 out of 3 elements of MDM)	Elements of Medical Decision Making		
		Number of Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the total complexity of the combination and is listed once below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment

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99204 99214	**Moderate**	**Moderate** • **1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;** **or** • **2 or more stable chronic illnesses;** **or** • **1 undiagnosed new problem with uncertain prognosis;** **or** • **1 acute illness with systemic symptoms;** **or** • **1 acute complicated injury**	**Moderate** **(Must meet the requirements of at least 1 out of 3 categories)** **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** o **Review of prior external note(s) from each unique source*;** o **Review of the result(s) of each unique test*;** o **Ordering of each unique test*;** o **Assessment requiring an independent historian(s)** **or** **Category 2: Independent interpretation of tests** • **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** **or** **Category 3: Discussion of management or test interpretation** • **Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)**	**Moderate risk of morbidity from additional diagnostic testing or treatment** **Examples only:** • **Prescription drug management** • **Decision regarding minor surgery with identified patient or procedure risk factors** • **Decision regarding elective major Surgery without identified patient or procedure risk factors** • **Diagnosis or treatment significantly limited by social determinants of health**

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99205 99215	High	**High** **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following**: Review of prior external note(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test*; Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** **or** **Category 3: Discussion of management or test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* Drug therapy requiring intensive monitoring for toxicity Decision regarding elective major surgery with identified patient or procedure risk factors Decision regarding emergency major surgery Decision regarding hospitalization Decision not to resuscitate or to de- escalate care because of poor prognosis

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Prolonged Service: CPT

99417 Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient **Evaluation and Management** services)

- Use 99417 in conjunction with 99205, 99215
- Do not report 99417 for any time unit less than 15 minutes

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Prolonged Service: CMS

G2212 Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT® codes 99205, 99215 for office or other outpatient evaluation and management services)

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Codes	Time range	CPT: times to add on 99417	CMS: times to add on G2212
99205	60-74 min.	**75**-89 min.	**89**-103 min.
99215	40-54 min.	**55**-69 min.	**69**-83 min.

75

The *Reason for Visit* or *Chief Complaint* Runs the Show!

- A record without a clear reason for the visit will be rejected and the doctor will be paid nothing
- The reason for visit determines who pays the bill…the patient, the medical insurer, or the vision plan
- *"The chief complaint is a concise statement describing the symptoms, problems, conditions, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words."* - CPT
- Think of the CC as the "Reason for Visit"

Eg. Day 1: Patient report of symptoms
CC: "Red, irritated, right eye, past 2 days."
Day 3: **Doctor recommended return**
CC: "Patient returned at doctor's request for recheck of OD keratitis "

76

History of Present Illness

- *" The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptoms or from the previous encounter to the present." - CPT*
- Possible elements of HPI include:

Location	**Timing**
Quality	**Context**
Severity	**Modifying Factors**
Duration	**Associated Signs & Symptoms**

Brief HPI: 1-3 elements
Extended HPI: ≥4 elements
Note: When grading the HPI, use only elements that are recorded by the physician…Not by the patient or by physician's staff

OD 1 week

77

Review of Systems (ROS)

- *"A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced." -CPT*
- 14 Systems:

Constitutional Symptoms (fever, weight loss)	**Musculoskeletal**
Eyes	**Integument**
Ears, Nose, Mouth, Throat	**Neurological**
Cardiovascular	**Psychiatric**
Respiratory	**Endocrine**
GI	**Hematological/Lymphatic**
GU	**Allergic/Immunologic**

78

Past, Family, and/or Social History

- **Past** Hx: the patient's past experiences with illness, operations, injuries, and treatments; general and eye related
- **Family** Hx: a review of medical events in the patient's family, including disease which may be hereditary or place the patient at risk
- **Social** Hx: an age appropriate review of the past & current activities
  - **Pertinent:** review directly related to HPI (1 item)
  - **Complete:** review of 2 (established patient) or all 3 items (new patient)

Old News

79

Grading the History

Level of History	HPI	ROS	PFSH
Problem Focused	Brief (1-3)	None	None
Expanded Problem Focused	Brief (1-3)	Problem Pertinent (1 system)	None
Detailed	Extended (4+)	Extended (2-9 systems)	Pertinent (1)
Comprehensive	Extended (4+)	Complete (10+)	Complete (2-3)

History Required for Visit Codes

New Patient Codes
- 99201
- 99202: EPF
- 99203: Detailed
- 99204: Comprehensive
- 99205: Comprehensive

Established Patient Codes
- 99211: *Supervised Visit*
- 99212: PF
- 99213: EPF
- 99214: Detailed
- 99215: Comprehensive

Old News

80

Physical Examinations grading for 99000 Codes in Eye Care

Eye Care
- Visual acuity
- Gross visual fields
- Ocular adnexa
- Pupils and irises
- Motilities/versions
- Cornea
- Anterior chamber
- Crystalline Lenses
- Bulbar and palpebral conjunctiva
- Intraocular pressures
- Dilated ophthalmoscopy, discs
- Dilated ophthalmoscopy, posterior segments
- **Brief assessment of mental status**
  - Orientation to time/place person and
  - Mood and affect

Note: Each exam includes what the patient needs, no more no less… Grading is done after the record is completed!

Old News

81

Grading Physical Exam

- The grade for the examination is determined by simply totaling the number of 'gradable' elements included in the medical record for the day.

Level of Physical Examination	*Number of elements*
Problem Focused	1-5 ophthalmic
Expanded Problem Focused	6-8 ophthalmic
Detailed	9+ ophthalmic and/or psychiatric
Comprehensive	All ophthalmic, both psychiatric

- Note: The requirements for the comprehensive physical examinations for eye visits graded as 99000 series are totally different than the CPT requirements for the comprehensive ophthalmological services (92004/92014)!

82

Grading Medical Decision Making

Complexity of Medical Decision Making	Number of Dx and Management Options and
Straightforward	Minimal/Minimal
Low	Limited/Low
Moderate	Multiple/Moderate
High	Extensive/High

- Complexity of decision making is based on the lower grade of "number of diagnoses and management options" and the "level of risk
- Note: "Amount and complexity of data" is not used in this formula because determination of the level is very subjective, varying widely among providers and insurers' auditors. Keeping the process simple ensures repeatability and accuracy in choosing codes.

83

Grading Medical Decision Making

- Decision making is graded by first determining the number of diagnoses AND management options and the level of risk

Diagnoses/Management options	Total number of Dx and management options pertinent to pt *
Minimal	
Limited	
Multiple	4-5
Extensive	6+

Note: The DGs are not specific as to how many diagnoses and management options equate to each level, minimal through extensive. The numbers provided here are a reflection of the presenter's opinion.

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Grading Medical Decision Making

- *Level of risk is based on a chart provided in the Documentation Guidelines*

Level of Risk Involved in Diagnosing/Treating/Managing this Case	Examples of Each Level of Risk
Minimal	One self limited/minor problem
Low	Two or more self limiting, or stable chronic illness, one acute illness/injury, or minor surgical injury with risks
Moderate	One chronic illness with mild complications, two stable chronic illnesses, an undiagnosed new problem, acute illness with systemic symptoms, acute complicated injury
High	One or more chronic illness with severe complications, acute or chronic illnesses or injuries posing a threat to life, an abrupt change in neurological status

85

Subconjunctival Hemorrhage = Est. Level 4!?!

- 64 y/o WF, Last exam with you 18 month ago
- History

Detailed History

- RFV: Blood red eye
- **Extended** HPI: OD, slightly dry, onset yesterday, associated with blowing nose, tried Visine…it didn't work.
- **Complete** PFSH: No prior ocular hx, no FHx of ocular disease
- **Extended** ROS: Negative eyes, negative cardiovascular
- Physical Exam
- **Detailed** VA's, IOP, EOM's, pupils, cornea, ant. chamber, lens, bulbar & palpebral conj, orientation/mood & affect

Detailed Hx + Detailed Physical Exam = 99214

86

Macula-off RD = Level 3!?!

- 64 y/o WF, Last exam with you 18 month ago
- History

Exp. PF History

- RFV: Curtain over right eye
- **Extended** HPI: OD, vision blocked, onset yesterday, happened after shower, tried Visine…it didn't work.
- **Complete** PFSH: No prior ocular hx, no FHx of ocular disease
- ROS: Negative eyes
- Physical Exam

Prob. Focused

- **Prob. Pert.** VA's, VF, IOP, pupils, dilated posterior segment (large RD)
- MDM

Low Complexity

- **Limited** Dx = RD Plan = referral to retinal specialist
- **Moderate** Undiagnosed new problem

87

Macula-off RD =
Est. Level 3!?!

- Expanded Problem Focused History
- + Problem Focused Physical Exam
- + Low Complexity MDM
- 99213

88

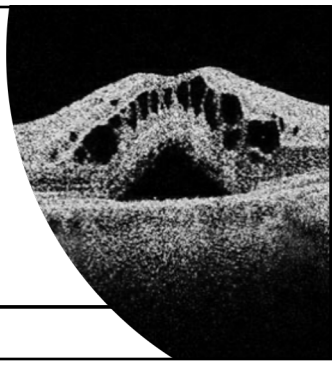
92000 Codes

Ophthalmological Services

89

Interpretation & Report

- Most special ophthalmological services require 'interpretation and report'
- Can be on a separate document, but it best to be on the day's medical record; better than a staple!
- Include the "Four R's"
  - **R**eason - Why you did the test
  - **R**eliability - If the result are useful
  - **R**esults - What you found
  - **R**ecommendation - What you'll do about it



90

Interpretation and Report

Test: HVF 24-2

Reason: POAG progression monitoring

Reliability: Reliable

Results: Stable superior arcuate scotoma, OS

Recommendations:

Continue Trav Z 1gt qhs OU, Repeat 24-2 1 yr

91

Interpretation and Report

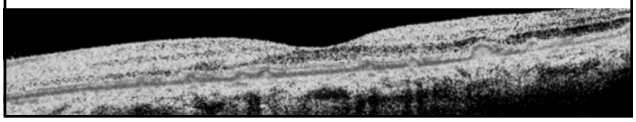
Test: Macular OCT

Reason: Non-Exudative AMD monitoring

Reliability: Reliable scan

Results: Mild RPE disruption with multiple drusen, no neo/fluid

Recommendations: Repeat in 6 mo with DFE. Cont AREDS



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Modifiers for Special Testing

Separating the Technical and Professional Components

- TC: Technical component
  - Applied to CPT procedure code by office performing testing only
- 26: Professional component
  - Applied to CPT code by office performing interpretation & report
- Example of billing for retinal OCT professional component:
- 92134-26

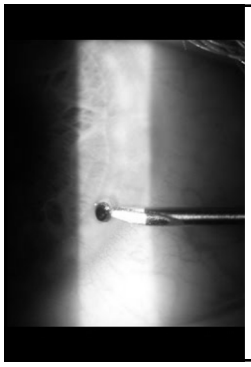
93

Billing for Special Testing

Which of the following require an interpretation and report?

a) 92250: Fundus photography **with interpretation & report**
b) 92020: Gonioscopy
c) 92133: Scanning computerized ophthalmic diagnosis imaging, posterior segment, **with interpretation & report**
d) 76514**:** corneal pachymetry, unilateral or bilateral
e) All of the above
f) None of the above

94



Surgical Procedures

- Include an office visit.
- Typically not billed on the same day as an office.
- Can be billed if the office visit is completely unrelated to the surgery
  - i.e. Pt presents for a glaucoma follow up but happens to require an right eye FB removal the same day.
  - Add modifier -25 to the office visit
    - 92012-25 with glaucoma code
    - 65222-**RT** with FB code
  - **Modifier 25** - *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*

95

Surgical Notes

- Describe the Medical Condition
- Describe Previous Treatment Attempted
- Document Informed Consent
- Describe the Procedure
- Outcome Statement
- Discharge Instructions

96

Surgical Notes

- Two metallic FB embedded in the superior temporal peripheral cornea of the Rt eye
- Explained procedures and risks to pt. Pt consented to Tx of FB.
- Topical tetracaine instilled. FB removed with 27G needle in Slit lamp.
- 1 gt topical ofloxacine instilled post procedure.
- Pt tolerated well and both FB completely removed.
- Post operative care instruction. 1gt topical ofloxacine rxed. RTC in 2 days.

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Questions?

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