

# GETTING A HANDLE ON CODING

## I. SELECTING AN E/M CODE

Four things that determine which level of service to bill.

- A. Extent of History Taking
- B. Extent of Examination
- C. Complexity of Medical Decision Making
- D. Determine which Procedure Code

## II. DOCUMENTATION OF HISTORY

You must have a complete medical history on each patient. This should be completed on the first visit and updated on each visit afterward. On visits after the initial visit on the exam form it should reference the date of the full history taken and noted any changes or no changes at this time and the doctor must initial.

### A. New/Established Patient

- 1) New
  - a) Never been to your office
  - b) It has been at least 3 years and 1 day since last visit
  - c) Bill new patient procedure code
- 2) Established
  - a) if the patient has been to your office in the last three years
  - b) Bill est. patient procedure code

### B. Chief Complaint (CC)

- 1) A fragment of a sentence of why the patient is in your office.
- 2) Examples of Chief Complaint (CC): blurry vision, decrease in visual acuity, eyes itch, eyes watering, eye pain

### C. History of Present Illness (HPI)

- 1) Describe in detail each component of the patient's chief complaint.
- 2) Example of History of Present Illness (HPI):
  - Location.....R, L, both eyes, upper lids, lower lids, etc
  - Quality.....Characteristics or attributes of the condition
  - Severity.....Mild, Moderate, Severe
  - Duration.....Length of time that the condition has been present
  - Timing.....Getting worse, getting better
  - Context.....The context in which the present illness occurs (i.e., "in the morning", when I bend over", "only at night", etc.)
  - Modifiers.....Conditions that affect the present illness (i.e., Tylenol, ice pack, rewetting drops, etc.)
  - Symptoms....Any other symptoms related to this illness

### D. Family History

- 1) This needs to be completed on every patient.

### E. Past History

- 1) This needs to be completed on the first visit to office and reviewed for changes on each visit.

#### F. Social History

- 1) Use of tobacco products
- 2) Illegal drugs or alcohol
- 3) Exposure to sexually transmitted diseases
- 4) Occupational exposure to chemicals
- 5) Most offices do not like to ask these kinds of questions but the insurance companies require these answered for patients over 13 yrs of age.

#### G. Review of Systems

- 1) There are 14 Systems of the Body and Optometry is required to get 11 out of 14 of the Systems.
- 2) Make sure you have a good checklist.

#### H. Time

- 1) It is irrelevant with coding.
- 2) It doesn't matter what amount of time you spend with patients you get paid or prosecuted by three things: History-Examination-Medical Decision.

### III. LEVELS OF HISTORY

There are four levels of history. When working with a new patient 1/3 of payment is for history and on an established it is 1/2 of payment. Tip: Do a comprehensive history on all patients then you know you have it.

1. Problem Focused History (PFH)  
Chief Complaint/1-3 HPI (History of Present Illness)
2. Expanded Problem Focused History (EPF)  
Chief Complaint/1-3 HPI/Ocular ROS
3. Detailed History (DH)  
Chief Complaint/4 HPI/Ocular ROS/ROS-2/1 of 3 Past, Family, or Social History
4. Comprehensive History (CH)  
Chief Complaint/4 HPI/Ocular ROS/ROS-10/3 of 3 Past, Family and Social History (New Patient) or 2 of 3 (Established Patient)

### IV. EYE EXAM DOCUMENTATION

There are 14 elements of the eye. They are listed below:

1. Test visual acuity (does not include determination of refractive error)
2. Gross visual fields testing by confrontation
3. Test ocular motility including primary gaze alignment
4. Inspection of bulbar and palpebral conjunctivae
5. Examination of ocular adnexae including lids (e.g. ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes
6. Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size and morphology
7. Slit lamp examination of the corneas including epithelium, and tear film

8. Slit lamp examination of the anterior chambers including depth, cells, and flare
9. Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus
10. Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)
11. Ophthalmoscopic examination of optic nerves including size, C/C ratio, appearance (e.g., atrophy, cupping, tumor elevation) and nerve fiber layer
12. Ophthalmoscopic examination of posterior segments including retina and vessels (e.g. exudates and hemorrhages)
13. Neurological-Orientation to time/place/person
14. Psychiatric-Mood and affect-depression/anxiety/agitation

## **V. LEVELS OF EYE EXAM**

There are four levels of examination and they are as follows:

1. Problem Focused Exam (PFE)  
Limited Exam/1-5 Elements
2. Expanded Problem Focused Exam (EPF)  
Limited Exam/At least 6 Elements
3. Detailed Exam (DE)  
Extended Exam/At least 9 Elements
4. Comprehensive Exam (CE)  
Complete Single System Exam/All 14 Elements

## **VI. LEVELS OF DECISION MAKING**

There are four levels of decision making and they are as follows:

1. Straightforward (SF)  
#DX/RX Options-Minimal/Risk-Minimal  
No brain power
2. Low Complexity (LC)  
#DX/RX Options-Limited/Data-Limited/Risk-Low  
This is Auto-Pilot-not a whole lot of effort-98% of the time
3. Moderate Complexity (MC)  
#DX/RX Options-Multiple/Data-Moderate/Risk-Moderate  
Start a treatment-Change a treatment-Decision for surgery-Outside consult or referral
4. High Complexity (HC)  
#DX/RX Options-Extensive/Data-Extensive/Risk-High  
Wheels of the bus are coming off at 70 MPH.  
Threatens loss of eye sight  
Threatens body crash-send out to MD

## **VII. E/M CODING-OFFICE VISITS**

Always remember on a new patient you must meet 3 out of 3 of the requirements and on a established patient you only have to meet 2 out of 3 of the requirements.

- A. New Patient (3 of 3)
  - 99201-PFH/PFE/SDM
  - 99202-EFH/DFE/SDM
  - 99203-DH/DE/LDM
  - 99204-CH/CE/MDM
  - 99205-CD/CE/HDM
- B. Established Patient (2of 3)
  - 99211-Minimal/5
  - 99212-PFH/PFE/SDM
  - 99213-EFH/EFE/LDM
  - 99214-DH/DE/MDM
  - 99215-CH/CE/HDM

### **VIII. EYE EXAM CODES**

There are two levels of eye exam codes. They are as follows:

- A. 92004/92014 Comprehensive Eye Exam
  - 1) 8 or more elements of the eye documented
  - 2) Need not be performed at one session
  - 3) Includes history, medical observation, external & ophthalmoscopic, gross visual fields, & sensorimotor
  - 4) Often includes biomicroscopy, examination with cycloplegia or mydriasis and tonometry
  - 5) Doesn't have to include dilation but in the past you had to do a dilation to bill this code
  - 6) Always includes initiation of diagnosis and treatment programs  
Includes the prescription of medication, and arranging for special ophthalmological diagnostic testing or treatment services, consultations, laboratory procedures and radiological services. Not including over the counter treatments.
- B. 92002/92012 Intermediate Eye Exam
  - 1) 7 or less elements of the eye documented
  - 2) Evaluation of a new or existing condition
  - 3) Complicated with a new diagnostic or management problem, not necessarily relating to the primary diagnosis
  - 4) Includes history, medical observation, external & adnexa, & other diagnostic procedures as indicated
  - 5) May include use of mydriasis for ophthalmoscopy
- C. 92015 Refraction

- 1) Billed in addition to 99XXX/92XXX
- 2) Non-covered service on most insurances
- 3) Charge only for "RX-able" refractions
- 4) Do not forget to charge for the final refraction when changing spectacles in a post-operative cataract patient

D. S0620/S0621 Routine Comprehensive Eye Exam including Refraction

- 1) The only code for routine/refractive eye exam
- 2) Can be used for private pay patients exams
- 3) Billed at a different fee than a medical exam