Documenting Eye Exams

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Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.

S.O.A.P.

• The standard documentation of an examination uses the S.O.A.P. method:
  – S – Subjective
  – O – Objective
  – A – Assessment
  – P – Plan

Covered Services

• Subjective entry dictates whether the service is covered or not
  – Coverage of eye examination is based on the purpose of the exam, not on the findings
  – Without complaint, exam is not covered even though doctor discovers a pathological condition
  – Must always ask: Why is the patient here today?

Chief Complaints

• The history can be obtained from the patient, caregiver, referring physician. For a new patient ask about:
  – Vision Problems – blurring, clouding, diplopia, distortion, floaters, photopsia, etc.
  – Comfort Problems – itching, burning, aching, scratching, photophobia, etc.
  – Appearance Problems – redness, swelling, discharge, scaling, etc.
  – Another doctor noted – AMD, glaucoma, cataract, etc.

Chief Complaints

• Elaborate on the patient’s primary complaint:
  – Which eye, OS/OD/OU?
  – When was the onset?
  – Is this problem constant or episodic?
  – What makes it better or worse?
  – How severe is the problem?
  – Does the problem prevent you from activities of daily living?
Chief Complaints

- Established Patient - complaint, symptom or previously diagnosed condition
  - Typically found in the Plan entry of the previous visit if this is a scheduled return visit
  - For example:
    - 4 month POAG IOP check and HVF 24-2
    - 6 month diabetes evaluation
    - 1 year cataract check
    - 2 month AMD check and Macular OCT

- Should record patient’s complaint or indicate “no new complaint” or “no changes”
- If this is an “off-cycle” visit, must treat patient as if it were a new encounter
  - Must be an acute complaint to satisfy the medical necessity for the service

Chief Complaints

- The chief complaint also provides the basis for the nature of the History of Present Illness (HPI)
  - This is one of the most significant issues in documenting E&M services
  - The HPI must be obtained by the physician
- Without a chief complaint, exam is considered routine and not billable
- Cataracts, YAGs & Blepharoplasties also require lifestyle impairments

Office Visits

Evaluation and Management Codes vs. Ophthalmic Codes

Components of E&M

- E&M services consist of 7 components
  - History Taking (3)
    - History of Present Illness (HPI)
    - Review of Systems (ROS)
    - Past, Family, and Social History (PFSH)
  - Examination (1)
    - Medical Decision Making (3)
      - Diagnoses and Management Options
      - Data to be Reviewed
      - Risk of Complications
History Taking

<table>
<thead>
<tr>
<th>History of Present Illness Brief (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family and/or Social History (PFSH)</th>
<th>Type of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief (1-3 Elements)</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused (99201, 99212)</td>
</tr>
<tr>
<td>Brief (1-3 Elements)</td>
<td>Problem pertinent (1 System)</td>
<td>N/A</td>
<td>Expanded Problem Focused (99203, 99214)</td>
</tr>
<tr>
<td>Extended (4+ Elements)</td>
<td>Extended (HPI + 2-9 systems)</td>
<td>Pertinent (1 of the 3 P, F, or S)</td>
<td>Detailed (99214)</td>
</tr>
<tr>
<td>Extended (4+ Elements)</td>
<td>Complete (10 or more systems)</td>
<td>Complete (NEW: 1 each of the 3, EST. FROM any 2 of the 3)</td>
<td>Comprehensive (99204, 99205, 99215)</td>
</tr>
</tbody>
</table>

All three components of History Taking must be met or exceeded for each level. If one component is not met, drop to the next lower level.

Medical Decision Making

<table>
<thead>
<tr>
<th>Number of Diagnosis and/or Management Options</th>
<th>Data to be Reviewed</th>
<th>Risk of Complications</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal (Suggest 1-2)</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Straightforward (99201, 99202, 99212)</td>
</tr>
<tr>
<td>Limited (Suggest 3-4)</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity (99203, 99213)</td>
</tr>
<tr>
<td>Multiple (Suggest 5-6)</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity (99204, 99214)</td>
</tr>
<tr>
<td>Extensive (Suggest 7+)</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity (99205, 99215)</td>
</tr>
</tbody>
</table>

Note
2 of the 3 components of Medical Decision Making must be met or exceeded for each level. Drop the lowest component and bill the lowest of the remaining components.

Determining E&M

<table>
<thead>
<tr>
<th>Type of History</th>
<th>Level of Exam</th>
<th>Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
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</tr>
<tr>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

New Patient
The lowest of the three components determines the overall code.

Established patient
2 of the 3 components must meet or exceed the level to determine the code.

Examination

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Ophthalmological Elements</th>
<th>Level of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal (Med. check)</td>
<td>None Required</td>
<td>Minimal 99211</td>
</tr>
<tr>
<td>Self Limiting or Minor</td>
<td>1-5 elements</td>
<td>Problem Focused (99201, 99212)</td>
</tr>
<tr>
<td>Low to Moderate Severity</td>
<td>6-8 elements</td>
<td>Expanded Problem Focused (99202, 99213)</td>
</tr>
<tr>
<td>Moderate Severity</td>
<td>9-12 elements</td>
<td>Detailed (99203, 99214)</td>
</tr>
<tr>
<td>Moderate to High Severity</td>
<td>15 elements</td>
<td>Comprehensive (99204, 99205, 99215)</td>
</tr>
</tbody>
</table>

TABLE OF RISK (Unofficial)

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problems</th>
<th>Diagnosis Tests Included</th>
<th>Management Options Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One or more limited or minor problems (e.g., allergic conjunctivitis, controlled glaucoma)</td>
<td>None for ophthalmology in the CMS supplement.</td>
<td>Review of Systems, site inspection.</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more limited or minor problems, (e.g., glaucomaquatious, diabetic retinopathy).</td>
<td>A-scan or B-scan, Visual field.</td>
<td>Review of Systems, site inspection.</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more limited or minor problems, (e.g., allergic conjunctivitis, controlled glaucoma).</td>
<td>Paracentesis of vitreous for diagnostic study.</td>
<td>Review of Systems, site inspection.</td>
</tr>
<tr>
<td>High</td>
<td>One or more limited or minor problems, (e.g., allergic conjunctivitis, controlled glaucoma).</td>
<td>Minor surgery with no identified risk factors (e.g., episcleritis, papilledema, episcleritis).</td>
<td>Review of Systems, site inspection.</td>
</tr>
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Determining New Patient E&M

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New Patient
The lowest of the three components determines the overall code.

Low Complexity determines the code 99203.
### Determining Established Patient E&M

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<tr>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

Established patient: 2 of the 3 components must meet or exceed the level to determine the code. Type of History and Level of Exam determine the code 99215.

### Intermediate Eye Exam

- **CPT Codes 92002 & 92012**
  - Requirements from CPT are usually found verbatim in Medicare Local Coverage Determinations (LCDs)
    - History
    - General Medical Observation
    - External & Adnexal Exam
    - Other Procedures as Necessary

### Comprehensive Eye Exam

- **CPT Codes 92004 & 92014**
  - Requirements from CPT are usually found verbatim in Medicare Local Coverage Determinations (LCDs)
    - History
    - Evaluation of the complete visual system
    - General Medical Observation
    - External & Adnexal Exam
    - Gross Visual Fields
    - Basic Sensorimotor exam

### Eye Codes vs. E&M Codes

#### INTERMEDIATE EXAM

**Eye Codes**
- Brief Ocular History, CC
- 3-7 Exam Elements
- Including Adnexa
- GMO
- Dilatation Not Required
- No Initiation of Tx Program Required
- Only need 1 Dx

**E&M Codes**
- Expanded Problem Focused History, CC
  - Brief HPI, Pertinent ROS
  - 6-8 Exam Elements
  - Dilatation Not Required
  - Medical Decision
    - Limited DX/NO (3-4)
    - Limited amount of data to be reviewed
    - Low Risk - requires minimal treatment plan

### E&M vs. Eye Codes

<table>
<thead>
<tr>
<th>E&amp;M</th>
<th>Eye Code</th>
<th>E&amp;M Established</th>
<th>Eye Code Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>$43.98</td>
<td>99211</td>
<td>$20.02</td>
</tr>
<tr>
<td>99202</td>
<td>$75.09</td>
<td>99212</td>
<td>$45.98</td>
</tr>
<tr>
<td>99203</td>
<td>$109.06</td>
<td>92002</td>
<td>$81.53</td>
</tr>
<tr>
<td>99204</td>
<td>$165.91</td>
<td>92004</td>
<td>$149.11</td>
</tr>
<tr>
<td>99205</td>
<td>$208.46</td>
<td>99215</td>
<td>$146.24</td>
</tr>
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</table>

2015 CMS Physician Fee Schedule – National Reimbursement
Cloned Documentation

OIG Target

- Inappropriate payments for E&M Services
  - OIG will continue to determine to what extent certain E&M services were inappropriate
    - Will also review multiple E&M services associated with same providers for documentation errors
  - CMS has noticed increase in identical documentation across services

Electronic Health Records (EHR)

- Both a blessing…
  - More efficient
  - Legible
  - Easily accessed remotely
  - Easily transportable
  - Searchable
  - Comparable

- …and a curse
  - Too efficient - Fills in everything
  - Even the nonsense is readable
  - Accessed remotely - by whom?
  - Easily transportable - to whom?
  - Searchable - by whom?
  - Garbage in garbage out

Electronic Health Records (EHR)

- Cloned Documentation
  - Previous visit findings brought forward including typos & misspelling
    - Exam, assessment & plan
  - Pre-populating Fields
    - Load exam with normal findings
  - Causes documentation to look dubious
    - Creates contradictions
    - Was the element actually performed
    - Makes it difficult to code

- Cloned documentation is seen in both paper and electronic charts
  - Has become a major issue for EHR
- According to OIG, cloned documentation does not meet medical necessity requirements for coverage
Patient History

• Chief Complaint (CC) & History of Present Illness (HPI)
  – Prompts to document 4 or more
  – Dropdown lists
  – Adding nonsensical HPI
• Patient CC & HPI most important part of the documentation
  – Determines if the service is covered
  – Creates the foundation for exam extent

History Example #1

• Exudative AMD
  – “Pt. states his vision is good, no flashes of bright lights, no blurred vision on OU, no pain, no floaters”
  – The EHR counted 4 elements for the HPI
    • Location: OU
    • Quality: blurred, good
    • Associated Symptoms: floaters, flashes, pain
    • Context: bright lights

History Example #2

• Exudative AMD
  – “Pt. states no changes in vision OU since last visit. No pain OU. No new floaters or flashes of light OU.”
  – The EHR counted 5 elements for the HPI
    • Location: OU
    • Quality: new
    • Associated Symptoms: floaters, flashes, pain
    • Timing: last visit
    • Modifying Factors: light

Exam Elements

• All 14 exam elements are filled in on every visit
  – Does the reason for the visit justify all the exam?
  – Frequency of codes
• Medicare would likely deem this not medically necessary unless there is a significant change in patient’s complaint or condition

Assessment

• Failure to update the Assessment
  – Diagnoses remain “new” despite previously being diagnosed
  – Diagnoses are all listed despite the reason for the visit in the same order
  – Diagnoses are listed that are no longer valid

Plan

• The exact same plan from visit to visit
  – Regardless of the reason for the visit
• “Canned” Plans that are all inclusive
  – For example
    • Cataract is visually significant & interfering with patient’s visual function [sic], plan lens calculations [sic] & cataract surgery. May need to employ Malyugin ring, Trypan blue, or iris hooks.
Scanned Documents

- Patient Registration Paperwork Incomplete
  - Assignment of Medicare Benefits
    - Signature on file
  - Privacy Notice
    - Missing signatures
    - Patient identity
    - Dates of signatures

Scanned Documents

- Inconsistently filed
  - From patient to patient
  - Within a single patient record
- Smeared or cut-off copies
- Large stacks in one scan
- Missing documents
  - Co-management correspondence
  - Operative notes

Templates

- Templates with information to be filled but left blank
  - Pupil size not documented
    - But are PERRLA
  - Cup to disc ratio not documented
    - All other disc findings pre-printed including the instrument used for examination

In Summary

- History is KEY
  - Determines IF the exam is covered
  - Lays the foundation for the extent of the exam
- Exams should be both E&M & Eye Codes
  - Each has requirements
  - Code is determined at the end of the service
- Eliminate cloned documentation
  - Perform what is necessary today
  - Document what is found today

Questions

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