Documentation Do’s and Don’ts
In The Retina Practice
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Financial Disclosure
- Advisory Boards
  - Allergan
  - Genentech
  - Regeneron
- Speaker Bureaus
  - Allergan
  - Genentech
  - Regeneron

Documentation Dos and Don’ts
If it’s not written down it wasn’t done
Documentation Dos and Don’ts

- Illegible documentation
- Missing documentation
- Abbreviations
  - Maintain comprehensive list of abbreviations
  - Send with coding audits

Agenda

- Paper vs. EMR
- Exams
- Diagnostic Tests
- Surgeries
- Modifiers
- ICD-10

Paper vs. EMR

- Paper
  - Non EMR offices
  - Not always enough documentation
- EMR
  - Retina specific documentation
  - Too much documentation
Paper Challenges

- Weak or no Chief Complaint
- Limited History of Present Illness (HPI)
- Missing exam elements
- Weak or missing test interpretations
- Physician signature

EMR Challenges

- Too much documentation
- Billing higher level exams
- Contradictory or erroneous entries
- Missing test interpretations
- Missing procedure notes
- Physician not reviewing final chart
- Electronic signature
- Log-in and Log-out practices

Auto Populating

- Copy and paste
- Pull forward
- More efficient use of time?
  - Same Chief Complaint for multiple visits
  - Same diagnosis
  - Same impression and plan
Exams

- Evaluation and Management (E/M) Codes
  - Amount of documentation

E/M Coding

- History
  - HPI – History of Present Illness
    - 4 elements
  - ROS – Review of Systems
    - 10 systems
  - PFSH – Past Family and/or Social History
    - 2-3 history areas
- Examination
  - 12 exam elements

Medical Decision Making (MDM)

- Medical Decision Making
  - Diagnoses – number of diagnosis
  - Tests – amount of data reviewed
  - Risk – severity of disease

Source: 1997 Evaluation and Management (E/M) Guidelines
Example

- 99204 New Patient Level 4 E/M Code
  - Comprehensive history
  - Comprehensive examination
  - Moderate Level of Medical Decision Making
  - Management of multiple diagnosis with associated risk
  - Elective major surgery
  - Macula off retinal detachment
  - ERM

1997 Evaluation and Management Guidelines

Example

- 99205 New Patient Level 5 E/M Code
  - Comprehensive history
  - Comprehensive examination
  - High level of Medical Decision Making
  - Emergent major surgery
  - Macula on retinal detachment
  - Endophthalmitis
  - Same or next day surgery
  - Evolution in treatment timing

Example

- 99214 Established Patient Level 4 E/M Code
  - 2 of 3 requirement
  - 4 History of Present Illness
  - 9 Exam elements
  - Moderate level of Medical Decision Making

Source: CPT Manual
E/M vs. Eye Codes

- Eye Codes
  - Specific required elements
  - Increased utilization of 92014

Comprehensive Eye Codes

What are the four (4) required exam elements of a comprehensive eye code?

- 92004 = New Patient
- 92014 = Established Patient

Source: CPT Manual

Examination

- Visual acuity (VA)
- Confrontation fields
- Ocular motility
- Conjunctiva
- External adnexa
- Iris, pupils
- Cornea
- Anterior chamber
- Lens
- IOP
- Fundus
- Mental status
- 12th element only
Comprehensive Eye Codes

- Documentation
- History
- General medical observations
- Evaluate complete visual system
- Initiation or continuation of a diagnostic and treatment program

Example

- 92004 New Patient Comprehensive Eye Code
  - History of Present Illness = 3
  - Incomplete Review of Systems = Less than 10
  - 11 Exam Elements
  - Medical Decision Making of Low Complexity
    - Single stable diagnosis
    - Stable dry AMD
    - Stable PVD

Source: CPT Manual

Example

- 92014 Established Patient Comprehensive Eye Code
  - Driven by utilization
  - Compared to other ophthalmologists
  - Not just retina
  - Expected utilization
  - 1 encounter every 6 months to 12 months
  - AMD
  - PDR

Source: CPT Manual
Intermediate Eye Codes

What is the only required exam element of an intermediate eye code?

- 92002 = New Patient
- 92012 = Established Patient

Examination

- Visual acuity (VA)
- Confrontation fields
- Ocular motility
- Conjunctiva
- External adnexa
- Iris, pupils
- Cornea
- Anterior chamber
- Lens
- IOP
- Fundus
- Mental status
- 12th element only

Intermediate Eye Codes

- Documentation
  - History
  - General medical observations
  - Other exam elements as needed
- New condition
- Existing condition with new problem
- Change in management
Example

- 92012 Established Patient Intermediate Eye Code
  - New problem
  - Change in management
  - Add medication
  - Intravitreal injections
  - Treatments
    - Lasers
    - Schedule surgery

Source: CPT Manual

Diagnostic Tests

- Physician's order
- Ancillary Staff
- Reliability of test
- Patient cooperation
- Findings
- Assessment
- Impact on treatment
- Physician's signature

Unilateral Testing

- 9222x Extended ophthalmoscopy
- 92235 Fluorescein angiography
- 92240 ICG angiography
- 76512 B-Scan
Unilateral and/or Bilateral Testing

- 92250 Fundus photography
- 92020 Gonioscopy
- 92134 Scanning computerized ophthalmic diagnostic imaging (OCT)

Extended Ophthalmoscopy

Testing During Global Period

- Not included in the global surgery package
- Diagnostic tests
- Medically necessary service?
- Increased scrutiny

Source: Medicare Claims Processing Manual, Chapter 12, §40.18
Minor vs. Major Surgery

- Minor procedure
  - Post-operative period of 0 or 10 days
- Major Procedure
  - Post-operative period of 90 days

Source: Medicare Claims Processing Manual, Chapter 12, §40.1E

Edits

- National Correct Coding Initiative (NCCI)
  - Bundles
  - Mutually exclusive
  - Quarterly publication

Common Edits

- OCT and Fundus photography
- Effective July 1, 2013
  - Extended ophthalmoscopy and procedures
    - New and established patients
  - Officially bundled injections and office visits
  - Global bundle vs. published edit
Minor Procedure

Included in surgery package
• Same day exam usually bundled
• Includes supplies
• Significant Evaluation and Management Service
  • Append exam with modifier 25

Source: Medicare Claims Processing Manual, Chapter 12, §40.1C

Modifier 25

“Significant Evaluation and Management Service on the Day of a Procedure”

It is used to report a significantly, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed.

Source: Medicare Claims Processing Manual, Chapter 12, § 40.2.A8

Modifier 25

NCCI also highlighted payment policy when using the modifier -25. For minor surgical procedures (global period of 000 or 010 days), an E&M service is separately reportable on the same day as the procedure only if significant and separately identifiable. An E&M service should not be reported solely for the decision to perform the minor surgical procedure. A significant and separately identifiable E&M service is indicated with modifier -25. If the patient is only examined to determine the need for an injection in the eye scheduled for treatment, then a visit should not be billed.

ASRS Member Alert: NCCI UPDATE - CMS to Resume Bundling Global Surgical Codes with Eye Visit Codes
Major Surgery

• Included in global surgery package:
  • 90-days postop care related to surgery
  • Pre-operative care by surgeon
    • (1 day before, or day of surgery)
  • Intra-operative services and supplies
  • Care for complications (except in O.R.)
  • Incidental services and supplies

Source: Medicare Claims Processing Manual, Chapter 12, §40.1A

Major Surgery

• Reimbursed during global surgery period
  • Diagnostic tests
  • Care by another doctor (i.e., not in group)
  • Exam to identify need for surgery (-57)
  • Unrelated care (e.g., fellow eye) (-24, -79)
  • Complications involving re-operations (-78)
  • Staged, more extensive, and post diagnostic procedures (-58)

Source: Medicare Claims Processing Manual, Chapter 12, §40.1B

Modifier 24

*Unrelated Evaluation and Management Service by Same Physician During Postoperative Period*

e.g., Hemorrhage in other eye
E/M or eye code

92012 24 Intermediate Eye Code

Source: Medicare Claims Processing Manual, Chapter 12, §40.2A7
Modifier 57

*Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery*

e.g., Mac On RD OD

99204 57 Level 4 NP E/M Service
or
99205 57 Level 5 NP E/M Service
67108 RT  Vitrectomy RD Repair

Source: Medicare Claims Processing Manual, Chapter 12, §40.244

Modifier 58

*Staged or related surgical procedures done during the postoperative period of the first procedure*

- Planned prospectively
- More extensive
- Post Diagnostic

67110 RT  Pneumatic Retinopexy
67108 58RT  Vitrectomy RD Repair

Source: Medicare Claims Processing Manual, Chapter 12, §40.246

Modifier 58

*Staged or related surgical procedures done during the postoperative period of the first procedure*

- Resets post operative period
- 100% reimbursement
## Modifier 78

ReturnTrips totheOperating Room During the Postoperative Period

\[i.e., \text{complication of 1st surgery}\]

- 67040 RT Vitrectomy Endo Laser
- 67036 78RT Recurrent VH

Source: Medicare Claims Processing Manual, Chapter 12, §40.2A5

## Modifier 79

Unrelated Procedures or Visits During the Postoperative Period

\[\text{e.g., Different eye, different diagnosis}\]

- 67210 RT Focal Laser Right Eye
- 67210 79LT Focal Laser Left Eye
- 67228 79RT PRP Laser Right Eye
- 67228 79LT PRP Laser Left Eye

Source: Medicare Claims Processing Manual, Chapter 12, §40.2A7
Modifier 79

Unrelated Procedures or Visits During the Postoperative Period

• Unrelated to previous surgery
• New post operative period
• 100% reimbursement

ICD-10

ICD-10

• Medical
  • Higher specificity
• Coding
  • Billing
• Political
  • Adoption has been delayed multiple times
  • Recent delay due to Act of Congress
  • Tied to Sustainable Growth Rate (SGR) patch
  • New implementation date October 1, 2015
**Code Expansion**

- ICD - 9
  - 3 to 5 digits
- ICD - 10
  - 3 to 7 digits
  - 14,000 to 68,000 codes
  - Higher specificity
  - More documentation

**Code Structure Variability**

- Laterality
  - Right eye vs. Left eye
  - No laterality
  - Combination codes
  - Diabetes Mellitus
    - No laterality

-W22.02XD Walked into lamppost, subsequent encounter

**Code Structure Variability**

- Age-Related Macular Degeneration (AMD)
  - No laterality
  - Nonexudative AMD
    - ICD - 9 = 362.51
    - ICD - 10 = H35.31
  - Exudative AMD
    - ICD - 9 = 362.52
    - ICD - 10 = H35.32
Code Structure Variability

- Retinal detachment right eye
- Laterality
  - Single break – H33.011
  - Multiple breaks – H33.021
  - Giant tear – H33.031
  - Retinal dialysis – H33.041
  - Total – H33.051
- 4 ICD-10 codes per RD type

Code Structure Variability

- Diabetes Mellitus
  - No laterality
  - Severity
  - Combination codes
    - Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
      - ICD-10 = E11.321

Code Structure Variability

- Diabetes Mellitus
  - No laterality
  - Combination codes
    - Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema
      - ICD-10 = E11.351
Summary

- Documentation drives medical necessity
- Code based on documentation
- Stay tuned to recent audit trends
- Monitor utilization of specific codes
- Conduct focused reviews of documentation
- Conduct periodic comprehensive reviews
- GET READY FOR ICD-10!

Thank You!