Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Need to Differentiate E/M Codes From Eye Codes? Consider These 5 Items

5 questions let you ditch eye codes with confidence.

Frustrated counting E/M codes' HPI, ROS, and exam elements?

Financially, you're better off with eye codes, provided documentation supports choosing this code set rather than E/M services. "Currently, eye codes pay more than E/M codes," pointed out **Raequell Duran, CPC,** in "Eye Code or E/M Code? The Wrong Answer Can Cost You Big" at The Coding Institute's National Coding and Reimbursement Conference.

To focus on the correct code set -- and prevent leaving dollars on the table, spot these differences.

1. Does Documentation Contain HEM?

E/M codes have national coding guidelines that detail the documentation necessary to support a given level of service (such as 99203, Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity ...).

You can choose to use either the 1995 guidelines, which involve a multi-system exam, or the 1997 guidelines, which offer a single-system exam. Your ophthalmologist may have an easier time reaching higher-level exam types and ultimately higher service levels with the 1997 guidelines.

Since a specialist does not usually examine multi-systems, Medicare created the 1997 guidelines to give all providers access to all five levels of visits, Duran explains.

The guidelines describe each service level's national Medicare required amount of history, examination, and medical decision making (HEM). Only medically necessary performed and documented items count toward an area. "Eye codes do not have those [HEM] requirements and are not subject to mandatory auditing," Duran says.

Result: If documentation doesn't contain HEM that supports an E/M service, go with the higher-paying eye codes. For instance, 92004 (Ophthalmological services: medical examination and evaluation, with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits) has about the same amount of physician work as 99203 without any national CMS documentation requirements and pays approximately $32 more. Code 92004 has a national Medicare allowable of $119.87 compared to 99203's unadjusted rate of $87.84.

2. Does the Note Contain Enough History?

When determining a service's history level using a standard audit tool, such as the Marshall tool, count all medically necessary elements of history of present illness (HPI), review of systems (ROS), and past medical, family and/or social history (PFSH). Be sure to look throughout the note from the chief complaint (CC) to the plan/assessment for history.

"The medical decision (assessment/plan) usually will reiterate history elements and may often note items not previously mentioned in the history at the beginning of the visit," points out **Suzan Berman (Hvizdash), CPC, CEMC, CEDC,** senior manager of coding and compliance with the UPMC departments of surgery and anesthesiology in Pittsburgh.

For a given history level, such as problem focused (99201), expanded problem focused (99202) or detailed (99203), documentation must meet or exceed all types ofhistory. If you have various history levels among the HPI, ROS, and PFSH elements, default to the lowest level.

Example: A note contains extended HPI, problem pertinent ROS, and pertinent PFSH, you would have expanded problem focused history. You would need medically necessary extended ROS to move up to detailed history.

3. Does the Exam Fail Carrier's Requirements?

If you don't meet your carrier's definition of "intermediate" or "comprehensive" eye exams, you should report an E/M service code instead of an eye code. No national guidelines from Medicare exist for the eye exam codes, but some local carriers recommend that an intermediate exam (92002, 92012) cover three to seven elements, while a comprehensive exam (92004, 92014) would cover eight or more.

Additionally, either exam may require dilation, but some carriers may require a dilated fundus exam to assign the comprehensive level of eye codes. Check with your local carrier, or state statutes when indicated, for specific guidelines and restrictions. Some local carriers have defined specific elements required to meet the level of service or as necessary to diagnose the patient condition, according to **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE,** consulting manager for Pershing, Yoakley and Associates in Clearwater, Fla.

These elements include:

• exam of eyelids and adnexa -- required for intermediate exam

• ocular mobility required for comprehensive exam

• gross visual fields required for comprehensive exam.

The following additional elements may also be indicated for either level:

• visual acuity

• pupils and iris

• cornea

• anterior chamber

• lens

• intraocular pressure

• retina (vitreous, macula, periphery, and vessels)

• optic disc.

4. Is the Patient's Problem Resolving?

There are, however, encounters that call for reporting an E/M code. "Be careful of using only eye codes if providing comprehensive ophthalmic services that include evaluating resolved or resolving conditions that are very straightforward in nature," Duran cautions.

An E/M code might be the right choice, when documentation describes follow-up of known, straightforward, or resolving problems (99211-99215), consultations (99241-99255), or hospital services (99221-99233).

5. Does the Visit Qualify for Time-Based Billing?

Also, be aware that you can use E/M codes for counseling-based visits. When counseling and/or coordination of care dominates more than half the time spent faceto face with the patient by the physician, coding guidelines allow you to assign the E/M code based on the time indicated in the E/M code's description. Before coding based on time, make sure you follow these principles:

• If you are billing based on time spent, your documented time must equal or exceed the "average" time given to bill that CPT code level per Medicare regulations.

• Billing is based on total time spent (not just the amount of time spent in counseling), stresses **Tessa Bartels, CPC, CEMC,** reimbursement manager at the Medical College of Wisconsin in Milwaukee.

• Your documentation must state:

1) total time spent face to face by the physician

2) amount of the total time spent in counseling/coordination of care (must be more than 50 percent of total time)

3) detailed statement on the content and extent of the counseling.

Example: The ophthalmologist spent 35 minutes with patient, 20 minutes of which was for counseling regarding treatment options for macular degeneration, risks, and benefits, which included injectable drug therapy. The ophthalmologist discussed photodynamic therapy, laser treatment, surgery, and vitamin and mineral supplements. He answered all of the patient's questions and gave her additional literature for at-home reading. The patient will call back with her decision. This would be a 99214. "If your physician spent a total of 40 minutes with the patient, 35 minutes of which was counseling ... then the total time spent would equal a 99215," Bartels explains.