Goal

Excellence in patient care is why we are here, it is why we do what we do (and love it)

The documentation of services provided and thus reported is the most important patient care data we use within the United States and across the global!

Documentation and Coding Defined:

Essential Tools

- Diagnosis
  Internal Classification of Diseases 10th Edition (ICD-10-CM)
- Procedures and Office Visits
  Current Professional Terminology (CPT)
- Drugs, Supplies
  Health Care Common Procedure Coding System (HCPCS)
  (pronounced “hick-picks”)

Resources

- Federal
  Center for Medicare and Medicaid Services (CMS)
- State (local)
  National Governmental Services (NGS) is our Medicare Administrator Carrier (MAC)
- American Academy of …
  Ophthalmology, Optometry, Professional Coders, etc.

These resources complement the national coding manuals.
Documentation and Coding Defined: Diagnosis Codes

The medical necessity is the documented diagnoses that supports why the service(s) was performed. Diagnoses officially known as International Classification of Diseases, Tenth Edition, Clinical Modification. Commonly called “ICD-10” or “ICD-10-CM”.

The use of the ICD-10 coding structure and guidelines are new to the United States of America as of Oct 1st 2015. New to accommodate:
- specificity and code categories expanded
- guidelines have changed to meet conditions today
- room is available to add codes in the future

Be as specific as possible in the documentation so that the most accurate ICD-10 code can be captured and thus reported.

Let’s look at a few examples …

Documentation and Coding Defined: Diagnosis Codes

**Chronic Angle-Closure Glaucoma (H40.22-)**

- Right eye, stage unspecified: H40.221
- Right eye, mild stage: H40.222
- Right eye, moderate stage: H40.223
- Right eye, severe stage: H40.224
- Right eye, indeterminate stage: H40.225
- Left eye, stage unspecified: H40.226
- Left eye, mild stage: H40.227
- Left eye, moderate stage: H40.228
- Left eye, severe stage: H40.229
- Left eye, indeterminate stage: H40.230
- Bilateral eye, stage unspecified: H40.231
- Bilateral eye, mild stage: H40.232
- Bilateral eye, moderate stage: H40.233
- Bilateral eye, severe stage: H40.234
- Bilateral eye, indeterminate stage: H40.235
- Unspecified eye, stage unspecified: H40.239
- Unspecified eye, mild stage: H40.240
- Unspecified eye, moderate stage: H40.241
- Unspecified eye, severe stage: H40.242
- Unspecified eye, indeterminate stage: H40.243

Let’s look at Myopia and Astigmatism for example …

Documentation and Coding Defined: Diagnosis Codes

**Intermittent Angle-Closure Glaucoma (H40.23-)**

- Right eye: H40.231
- Left eye: H40.232
- Bilateral eye: H40.233
- Unspecified eye: H40.239

Disorders of Refractive and Accommodation (H52.-)

Let’s look at Myopia and Astigmatism for example …
Documentation and Coding Defined: 
**Diagnosis Codes**

**Myopia (H52.1-)**

H52.10 Myopia, unspecified  
H52.11 Myopia, right eye  
H52.12 Myopia, left eye  
H52.13 Myopia, bilateral

**Astigmatism (H52.2-)**

H52.21 Irregular astigmatism, right eye  
H52.22 Irregular astigmatism, left eye  
H52.23 Irregular astigmatism, bilateral  
H52.29 Irregular astigmatism, unspecified eye  
H52.211 Regular astigmatism, right eye  
H52.222 Regular astigmatism, left eye  
H52.223 Regular astigmatism, bilateral  
H52.229 Regular astigmatism, unspecified eye

Documentation and Coding Defined: 
**Procedures**

3 Types of Procedures

> Diagnostic  
> Minor (10 day global period)  
> Major (90 day global period)

**Procedures and Modifiers**

When coding for procedure, ask yourself:

> What area or site is involved
> Is the procedure bilateral / multiple
> Are any surgical services done today related/unrelated (aka is there a global period involved; 10 or 90 days)?

**Example - Punctual Plug Occlusion - LLL / RLL**

> What question are we asking ourselves?

**Procedures and Modifiers**

**Example - Punctual Plug Occlusion - LLL / RLL**

> Is the procedure bilateral / multiple?  
  Yes (50 modifier for bilateral/multiple)
> What area or site is involved?  
  *Left lower lid and the right lower lid (E2 and E4 modifier for anatomical site)*
> Correct coding would then be  
  *CPT 68761-E2 and CPT 68761-50-E4*

Please check with your organization to ensure modifiers adhere to internal Policies & Procedures.
Documentation and Coding Defined:
Procedures and Modifiers

Example - PRP OS Today, S/P PRP OD 7 days ago

➢ What question are we asking ourselves?

Documentation and Coding Defined:
Procedures and Modifiers

Example - PRP OS Today, S/P PRP OD 7 days ago

➢ What question are we asking ourselves?

Is the procedure bilateral / multiple? No
What area or site is involved? Left eye
Are any surgical services done today related/unrelated? Yes, unrelated to the right eye, presented today with new complaints OS, evaluation and management was performed and documented supporting the decision for PRP OS same day

Please check with your organization to ensure modifiers adhere to internal Policies & Procedures.

Documentation and Coding Defined:
Procedures and Modifiers

Example - PRP OS Today, S/P PRP OD 7 days ago

➢ Correct coding would then be

CPT 92014/99214-57 (office visit to determine need to procedure)
CPT 67228-79 (unrelated to RT eye) –LT (anatomical site)

Please check with your organization to ensure modifiers adhere to internal Policies & Procedures.

Documentation and Coding Defined:
Procedures and Modifiers

Example - PRP OS Today, S/P PRP OD 7 days ago

Documentation and Coding Defined:
Procedures and Modifiers

Example - PRP OS Today, S/P PRP OD 7 days ago

Automation and Coding Defined:
Eye Codes

Eye codes require less detailed elements in the documentation than the Evaluation and Management (E&M) codes

Let’s Start with the Eye Codes ….

Documentation and Coding Defined:
Eye Codes

Official Names
General Ophthalmologic Services;
Intermediate
General Ophthalmologic Services;
Comprehensive
Documentation and Coding Defined: 
Eye Codes

Code Set

Intermediate
CPT 92002 New Patient
CPT 92012 Established Patient

Comprehensive
CPT 92004 New Patient
CPT 92014 Established Patient

Documentation and Coding Defined: 
Evaluation and Management (E&M)

E/M Level of Service (LOS)

3 Key Elements
- History
- Examination
- Medical Decision Making

Documentation and Coding Defined: 
Evaluation and Management (E&M)

Intermediate
HISTORY:
General history (Chief Complaint recommended)

EXAM:
1. Eval of new or existing condition complicated w/ new Dx or management problem (not nec. relating to the prim dx)
2. General medical observation
3. External ocular & adnexal exam
4. Other diagnostic procedures as indicated
5. May include the use of mydriasis for ophthalmoscopy

MEDICAL DECISION MAKING:
* Initiation of diagnostic and treatment programs
Intermediate ophthalmological services constitute integrated services in which medical decision making cannot be separated from the examining techniques used

Documentation and Coding Defined: 
Evaluation and Management (E&M)

Comprehensive
HISTORY:
General history (Chief Complaint recommended)

EXAM:
1. General medical observation
2. External (eye & adnexal, which may include but is not limited to the following; eyelids, lashes, eyebrows, alignment of eye, motility of the eye, conjunctiva, cornea, & iris) and ophthalmoscopic (ocular media, the retina, and optic nerve) exam
3. Gross visual fields
4. Basic sensorimotor exam
5. As medically indicated: Biomicroscopy, exam w/ cycloplegia or mydriasis & tonometry

MEDICAL DECISION MAKING:
Describe a general evaluation of the complete visual system. Includes initiation of diagnostic and treatment programs (the prescription of medication(s), and arranging for special ophthalmological diagnostic or treatment services, consultations, lab procedures, and radiological services). Comprehensive ophthalmological services constitute services in which medical decision making cannot be separated from the examining techniques used

Documentation and Coding Defined: 
Evaluation and Management (E&M)

Code Set

New Patient
CPT 99201 - 99205

Established Patient
CPT 99211 - 99215

Documentation and Coding Defined: 
Evaluation and Management (E&M)

4 History Components
- Chief Compliant (CC)
- History of Present Illness (HPI)
  Elements Include: Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Signs/Symptoms
- Review of Systems (ROS)
  Elements Include: Constitutional, Eyes, ENT-CV, Respiratory, GI, GU, M/S, Integument, Neuro, Psych, Endocrine, Heme/Lymph, Allergic/Immun
- Past Medical, Family, Social History (PFSH)
4 Levels of History

- **Problem Focused**
  - Chief Compliant, Brief HPI (1-3)

- **Expanded Problem Focused**
  - Chief Compliant, Brief HPI (1-3), Problem Pertinent ROS (1)

- **Detailed**
  - Chief Compliant, Extended HPI ($\geq$ 3 chronic conditions), Extended ROS (2-9), Pertinent PFSH (1)

- **Comprehensive**
  - Chief Compliant, Extended HPI ($\geq$ 3 chronic conditions), Complete ROS (10-), Complete PFPSH (2-3)

4 Levels of Examination

- **Problem Focused**
  - 1-5 Elements

- **Expanded Problem Focused**
  - 6-8 Elements

- **Detailed**
  - 9-12 Elements

- **Comprehensive**
  - 13+ Elements

Diagnoses / Management Options

<table>
<thead>
<tr>
<th>Number of Diagnosis &amp; Management Options</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self limiting or Minor Problem (stable, improved or worsening)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Established Problem-Stable Improved</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Established Problem-Worsening</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>New problem-No Add'l work Up Planned</td>
<td>Max=1</td>
<td>3</td>
</tr>
<tr>
<td>New Problem-Add’l Work-Up Planned (more exam,xray, lab, other tests)</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Examination

- Gross visual field testing by confrontation
- Test ocular mobility including primary gaze alignment
- Inspection of bulbar palpbral conjunctvae
- Exam of ocular adnexae including lids, lacrimal glands, lacrimal drainage, orbits, & preauricular lymph nodes
- Exam of pupils and irises including shape, direct & consensual reaction (afferent pupill), size (ag.anisocoria), & morphology
- Slit lamp exam of the corneas including epithelium,stroma, tear film
- Slit lamp exam of the anterior chambers including depth, cells, & flare
- Slit lamp exam of the lenses including clarity, anterior & posterior capsule, cortex, & nucleus
- Measurement of IOP (except in children & patients with trauma or infectious disease)
- Ophthalmoscopic exam through dilated pupils (unless contraindicated) of optic discs including size, G/O ratio, appearance (eg. Atrophy, cupping, tumor elevation), and nerve fiber layer
- Posterior segments including retina & vessels (eg.exudates and hemorrhages)

* 1997 Documentation Guidelines *

Diagnoses / Management Options

1. **Number of Diagnosis & Management Options**
   - Points
   - Score
   - Self limiting or Minor Problem (stable, improved or worsening)
   - Established Problem-Stable Improved
   - Established Problem-Worsening
   - New problem-No Add'l work Up Planned
   - New Problem-Add’l Work-Up Planned (more exam,xray, lab, other tests)

Medical Decision Making (MDM)

3 Components of MDM

- **Diagnoses / Management Options**
- **Amount / Complexity of Data**
- **Risk (complication / morbidity)**

Amount / Complexity of Data

<table>
<thead>
<tr>
<th>Amount/Complexity of Data</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordered and/or reviewed clinical lab</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ordered and/or radiology reviewed</td>
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<td>1</td>
</tr>
<tr>
<td>Discuss tests with performing physician</td>
<td>Max=1</td>
<td>2</td>
</tr>
<tr>
<td>Other and/or review tests in medicine section (EEG, EKG, ETC)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Independent/Direct view of image, tracing or specimen</td>
<td>Max=1</td>
<td>2</td>
</tr>
<tr>
<td>Decision to obtain old records or history from someone other than patient</td>
<td>Max=1</td>
<td>2</td>
</tr>
<tr>
<td>Review and summarize old records and/or obtain history from someone other than patient</td>
<td>Max=1</td>
<td>2</td>
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</table>
**Documentation and Coding Defined:**

**Medical Decision Making (MDM)**

**Table of Risk**

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s)/Order(s)</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
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<td></td>
<td></td>
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<tr>
<td>Limited</td>
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<td>Multiple</td>
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<tr>
<td>Extensive</td>
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</table>

**Check List and Resources**

Things to Ask Yourself and Resources to Tap Into

1. Is your documentation as specific as possible each and every time?
2. Is your documentation accurate, relevant and complete (copy/paste, template) and signed?
3. Is your documentation timely?

If a procedure:
- Did you document the anatomical site involved in the care provided today?
- Did you document the surgical status of the other eye if applicable (is there a global period involved with today’s care?)
## Your Resources

1. Your Colleagues
2. The Electronic Health Record you document in
3. American Academy of Ophthalmology
4. Ophthalmic Med Technology Program
5. Coder within your organization
6. Internal documentation and coding polices

... and as always, keep your eye out for more!