Documentation and Coding 101

A Basic Introduction for Ophthalmic Technicians

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Agenda

1. Goal
   - Quality Patient Care
2. Documentation and Coding Defined
   - Essential tools
   - Diagnosis Codes (ICD-10-CM)
   - Procedures
   - Modifiers
   - Evaluation & Management (E&M) and "Eye Codes"
3. Your Checklist
4. Resources

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 Codes (ICD-10-CM, Procedures and Modifiers

Documentation and Coding Defined: *Essential Tools*

National Coding Manuals

- **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")

Documentation and Coding Defined: *Essential Tools*

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 compliment the national coding manuals

Documentation and Coding Defined: *Diagnosis Codes*

The medical necessity is the documented diagnoses

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"

Documentation and Coding Defined: *Diagnosis Codes*

The use of the ICD-10 coding structure and guidelines are new to the Untied 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 avail to add codes in the future

Documentation and Coding Defined: *Diagnosis Codes*

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-)**

H40.2210 Right eye, stage unspecified
H40.2211 Right eye, mild stage
H40.2212 Right eye, moderate stage
H40.2213 Right eye, severe stage
H40.2214 Right eye, indeterminate stage

H40.2220 Left eye, stage unspecified
H40.2221 Left eye, mild stage
H40.2222 Left eye, moderate stage
H40.2223 Left eye, severe stage
H40.2224 Left eye, indeterminate stage

H40.2230 Bilat eye, stage unspecified
H40.2231 Bilat eye, mild stage
H40.2232 Bilat eye, moderate stage
H40.2233 Bilat eye, severe stage
H40.2234 Bilat eye, indeterminate stage

H40.2290 Unspecified eye, stage unspecified
H40.2291 Unspecified eye, mild stage
H40.2292 Unspecified eye, moderate stage
H40.2293 Unspecified eye, severe stage
H40.2294 Unspecified eye, indeterminate stage

Documentation and Coding Defined: *Diagnosis Codes*

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

H40.231 Intermittent, Right Eye
H40.232 Intermittent, Left Eye
H40.233 Intermittent, Bilateral Eye
H40.239 Intermittent, Unspecified Eye

Documentation and Coding Defined: *Diagnosis Codes*

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

Documentation and Coding Defined: *Diagnosis Codes*

Astigmatism (H52.2-)

H52.2**11** Irregular astigmatism, right eye
H52.2**12** Irregular astigmatism, left eye
H52.2**13** Irregular astigmatism, bilateral
H52.2**19** Irregular astigmatism, unspecified eye

H52.2**21** Regular astigmatism, right eye
H52.2**22** Regular astigmatism, left eye
H52.2**23** Regular astigmatism, bilateral
H52.2**29** Regular astigmatism, unspecified eye

Documentation and Coding Defined: *Procedures*

3 Types of Procedures

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

Documentation and Coding Defined: *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)?

Documentation and Coding Defined: *Procedures and Modifiers*

Example - *Punctual Plug Occlusion - LLL / RLL*

- What question are we asking ourselves?

Documentation and Coding Defined: *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 involve?
  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 involve? *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 preformed 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

Evaluation and Management and "Eye Codes" (Office Visits)

Documentation and Coding Defined: *Scribing*

"The Joint Commission *defines* a medical scribe as an unlicensed individual hired to enter information into the electronic health record (EHR) or chart at the direction of a physician or licensed independent practitioner .." -AHIMA

- Core responsibility is to capture accurate and detailed documentation (handwritten or electronic)
- Timely manner
- Not permitted act independently or function as a clinician

Ask yourself/your organization some key questions

- Do we have and internal policy to interpret the regulations, define roles and responsibilities, provide an acceptable statement, etc
- When the scribe acts as a clinician and documents independent decisions or translations, how will we handle this?

Documentation and Coding Defined: *Scribing*

Multiple Sources

The **Centers for Medicare & Medicaid Services** (CMS) (Transmittal 713, revised May 5, 2017)

American Health Information Management Association (AHIMA) (Journal of AHIMA, "Using Medical Scribes in a Physician Practice," Nov. 2012, pp 64–69).
http://library.ahima.org/doc?oid=106220#.XL39nrB8DVQ

The **Joint Commission** (July 2012, Guidelines for the Use of Scribe)

American Academy of Professional Coders
https://www.aapc.com/blog/32632-medical-scribes-a-compliance-checklist/

Documentation 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 920**02** New Patient
CPT 920**12** Established Patient

Comprehensive

CPT 920**04** New Patient
CPT 920**14** Established Patient

Documentation and Coding Defined: *Eye Codes*

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

*Medicare does ***not*** require the documentation for an *intermediate* eye service to state the initiation of diagnostic and treatment programs, but CPT states in the description that the initiation of diagnostic and treatment programs ***is*** part of the *intermediate* eye codes.

Documentation and Coding Defined: *Eye Codes*

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, conjuctiva, 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/ cycoplegia 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)*

E/M Level of Service (LOS)

3 Key Elements

- History
- Examination
- Medical Decision Making

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)

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

4 Levels of History

- Problem Focused
  Chief Compliant, Brief HPI (1-3)
- Expended Problem Focused
  Chief Compliant, Brief HPI (1-3), Problem Pertinent ROS (1)
- Detailed
  Chief Compliant, Extended HPI ($+ or 3 chronic conditions), Extended ROS (2-9), Pertinent PFSH (1)
- Comprehensive
  Chief Compliant, Extended HPI ($+ or 3 chronic conditions), Complete ROS (10+), Complete PFSH (2-3)

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

Examination
14 Elements

- Gross visual field testing by confrontation
- Test ocular mobility including primary gaze alignment.
- Inspection of bulbar palpebral conjuctivae
- 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 pupil), size (eg:anisocoria), & morphology
- Slit lamp exam of the corneas including epithelium, stroma, endothelium, 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, C/D ratio, appearance (eg. Atrophy, cupping, tumor elevation), and nerve fiber layer
- Posterior segments including retina & vessels (eg exudates and hemorrhages)

NEURO/PSYCH:

- Orientated x3
- Mood & affect

** 1997 Documentation Guidelines **

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

4 Levels of Examination

Problem Focused	1-5 Elements
Expended Problem Focused	6-8 Elements
Detailed	9-12 Elements
Comprehensive	13+ Elements

Documentation and Coding Defined: *Medical Decision Making (MDM)*

3 Components of MDM

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

Documentation and Coding Defined: *Medical Decision Making (MDM)*

Diagnoses / Management Options

Number of Diagnosis & Management Options	Points	Score
Self limiting or Minor Problem (stable, improved or worsening) Max=2	1	
Established Problem-Stable Improved	1	
Establsihed Problem-Worsening	2	
New problem-No Add'l. work Up Planned Max=1	3	
New Problem-Add'l Work-Up Planned (more exam,xray, lab, other tests)	4	

Documentation and Coding Defined: *Medical Decision Making (MDM)*

Amount / Complexity of Data

Amount/Complexity of Data	Points	Score
Ordered and/or reviewed clinical lab	1	
Ordered and/or radiology reviewed.	1	
Discussed tests with performing physician	1	
Order and/or review tests in medicine section. (EEG, EKG, ETC.)	1	
Independent/direct view of image, tracing or specimen.	2	
Decision to obtain old records or history from someone other than patient.	1	
Review and summarize old records and/ or obtain history from someone other than patient.	2	

Documentation and Coding Defined: *Medical Decision Making (MDM)*

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limiting or minor problem, ie. Cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-ray • EKG/EEG • Urinalysis • Ultrasound, ie. Echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limiting or minor problems • One stable chronic illness, e. well controlled hypertension or non-insulin dependentdiabetes, cataract, BPH • Acute, uncomplicated illness or injury, ie. Cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, ie. Pulmonary function test • Non-cardiovascular imaging studies with contrast, ie. barium • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives

Documentation and Coding Defined: *Medical Decision Making (MDM)*

Table of Risk

Level of Risk	Presenting Problem	Diagnostic Procedure (s)	Management Options Selected
Moderate	• One or more chronic illnesses with mil exacerbation. • Two or more stable chronic illnesse • Undignosed new problem with uncertain prognosis, ie. lump in breast, rectal bleeding • Acut illness with systemic symptoms, ie. pyelonephritis, pneumonitis, colits • Acut complicated injury with breif loss of consciousness	• Physiologic tests under stress ie, cardica stress test, MRI for brain tumor • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and not identified risk factors, ie. arteriogram, cardiac catheterization. • Obtained fluid from body cavity, ie. lumbar puncture, thoracentesis, culdocentesis.	• Minor surgery with identified risk factors • Referral for or decision to do elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation

Documentation and Coding Defined: *Medical Decision Making (MDM)*

Table of Risk

Level of Risck	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
High	• One or more chronic illnessed with sever exacerbation, progression, or side effects of treatment • Acute or chronic illness or injuries that may pose a threat to life or bodily function, ie. Multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness eith potential threat to self or others, peritonitis, acute renal faliure • An abrupt change in neurologic status, ie. Seizure, TIA, weakness, or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open percutaneous or endoscopic) • Referral for or decision to perform emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resucitate or to de-escalate care because of poor prognosis

Documentation and Coding Defined: *Medical Decision Making (MDM)*

Medical Decision Making

(2 out of 3 needed)	1	2	3	4
# of Diag & Mgmt Options	Minimal 1	Limited 2	Multiple 3	Extensive 4
Amt & Complexity of Data	Minimal 1	Limited 2	Moderate 3	Extensive 4
Risk of Compl. Morbidity & Mortality	Minimal 1	Low 2	Moderate 3	High 4
Total Score for MDM	Straightforward Complexity	Low Complexity	Moderate Complexity	High Complexity

Documentation and Coding Defined: *TeleHealth Services*

Guidelines are still forming
Billing varies from payer to payer

What types of healthcare providers can bill for telemedicine?
Limitations on the frequency billed per patient (coverage)?
We the codes set up in the system to bill?
What Place of Services (POS) are we to use in certain circumstances (e.g. physicians providing the service from their home/vacation destination)?

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf (section 190, page 181)

Check List and Resources

Things to Ask Yourself and Resources to Tap Into

Your Check List

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!