MEDICAL CODING in NEURO-OPHTHALMOLOGY

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Disclaimer: This document is not meant to be used as an official or legal coding guideline. This is an educational tool, and has not been created by a professional coder. Coding guidelines change constantly. Discuss your coding and billing practices with your facility's specialist.

Medical documentation and subsequent claim submission determines the reimbursement value of medical services provided. Knowledge of how to properly document and code is required for each patient encounter or service to be compensated by Medicare, Medicaid, and/or commercial payers.

Outpatient CPT (current procedural terminology) coding has some clearly defined rules, but there is also an element of subjectivity. This subjectivity can produce confusion about the coding documentation requirements, which frustrates many physicians as they try to learn the rules.

Here we will attempt to outline some basic concepts related to coding with the neuro-ophthalmologist in mind.

There is no particular element of a neuro-ophthalmology evaluation which changes coding guidelines compared to any other type of patient. The same rules apply to a neuro-ophthalmology patient as a general neurology patient or a general ophthalmology patient in terms of criteria which must be satisfied to determine a code. That being said, the complexity of many neuro-ophthalmology patients reaches a greater level, which may lead to a higher code, although the coding criteria must still be correctly documented. Furthermore, Eye visit codes (92XXX) can be used instead of Evaluation and Management (99XXX) codes.

Despite the myriad rules described below regarding coding a patient encounter, an overarching concept of 'medical necessity' is meant to drive the level of the code. This is another cause of frustration at the concept of coding. There are guidelines to determine a level of code, but the physician is still asked to determine if the code meets the medical necessity of the patient. Medicare defines medical necessity as "Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet *accepted standards of medicine*." The problem is that there is no specific reference for what constitutes an *accepted standard of medicine*.

More specifically, Medicare states that "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a [current procedural terminology] code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed."[1]

[1] Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual. Selection of Level of Evaluation and Management Service. Use of CPT Codes (§30.6.1.A). http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf.

Any code must still have the proper documentation to have it accepted and reimbursed. Thus, we will next describe the specific guidelines to create a level of service code:

New Patient and Consult Codes

New patient and consult codes require the same level of service criteria (except if coding by time). Medicare and Medicaid no longer allow for the use of consult codes. Some private insurance providers may also not accept consult codes. A consult must satisfy several elements. 1) A referring physician must have documented that they are consulting the physician regarding a specific problem. For example, a family doctor referring a patient to an ophthalmologist because the patient is due for an eye exam is not a consult. 2) The physician must document who the consulting physician is and provide an answer for the consult, as well as send documentation of this back to the consulting physician.

Corresponding new patient and consultation codes are:

99201, 99241: Do not require the presence of a physician and we will not review in detail.
99202, 99242
99203, 99243
99204, 99244
99205, 99245

General Coding Guidelines

CPT codes are based on three elements:

1) History
2) Physical exam
3) Medical decision making

These three elements determine the appropriate code and thus the value of the service. New and consult codes are based on the one LOWEST level of the three elements. For example, a new or consult patient with comprehensive history and comprehensive exam, but with a low level of complexity medical decision making would only get a code of 99203/99243.

History:

The coding level for history is based on several factors, including history of the present illness (HPI), review of systems (ROS), and past, family and social history (PFSH). The HPI can be extended or brief: The extended HPI requires four of the following: Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, & Associated Signs and Symptoms. A brief HPI only requires 1-2 of these HPI elements.

Comprehensive history: requires a chief complaint, an extended HPI, 10 ROS, and one element from each of the past medical history, family history, and social history

Detailed history: requires a chief complaint, an extended HPI, 2-9 ROS, and at least one pertinent element of either the past medical, family, or social history.

Expanded problem focused history: requires a chief complaint, a brief HPI, and one ROS. No PFSH are needed.

Problem focused history: Only a chief complaint and brief HPI are needed.

Physical exam:

The coding level for a physical exam is based on the following guidelines:

Comprehensive exam: Either two bullets from nine organ systems, or all criteria (12 elements) for a specific organ system (this can be either neurology or ophthalmology) plus the mental assessment. There is no particular neuro-ophthalmology exam. The level of exam does not increase if you perform both a complete neurologic and eye exam. Similarly, even if you perform non-listed neuro-ophthalmology aspects of an exam (e.g. ice-rest test), you must still fulfill all the required bullets in a particular organ segment in order to reach a particular level of coding.

Detailed exam: Either 2 bullets from 6 organ systems, or 12 total bullets from two or more organ systems (only 9 required for an eye exam in this case, as an exception).

Expanded problem focused exam: At least 6 bullets from any organ system.

Problem focused exam: 1-5 bullets from 1 or more organ systems.

The following are the elements (bullets) for the Eye Organ System:

1. Visual acuity
        Does not include the determination of refractive error
2. Gross or confrontation visual fields

Must be performed in the lane to count; automated perimetry does not substitute as an element of the exam

3. Extraocular motility

Includes alignment and primary gaze

4. Conjunctiva

Bulbar and palpebral

5. Ocular adnexa

Lids, lacrimal gland, lacrimal drainage, orbits and preauricular nodes

6. Pupil and iris

Size, shape, direct and consensual reactions and morphology

7. Cornea — slit-lamp exam

Tear film, epithelium, stroma and endothelium

8. Anterior chamber — slit-lamp exam

Depth, cells and flare

9. Lens

Clarity, anterior capsule, posterior capsule, cortex and nucleus

10. Intraocular pressure
11. Optic nerve/discs

Cup-to-disc ratio, appearance and nerve fiber layer

12. Posterior segments including retina and vessels

For the comprehensive exam, the following two elements must also be included:

1. Orientation to time, place, and person.
2. Mood and affect.

The following are the elements (bullets) for the neurologic exam:

1. Measurement of 3 vital signs
2. General appearance of the patient
3. Ophthalmoscopic exam of the optic discs and posterior segments
4. Gait and station
5. Muscle strength in the upper and lower extremities
6. Muscle tone in the upper and lower extremities with notation of atrophy or abnormal movements.
7. Orientation to time, person, place
8. Recent and remote memory
9. Attention span and concentration
10. Language
11. Fund of knowledge
12. CN 2-12 individually noted
13. Sensation
14. Deep tendon reflexes in the upper and lower extremities
15. Coordination

For the comprehensive neurologic exam, two of three cardiovascular elements must also be included:
    1) Examination of carotid arteries
    2) Auscultation of heart with notation of abnormal sounds and murmurs
    3) Examination of peripheral vascular system by observation

Medical Decision Making:

Medical decision making complexity is determined by a combination of two of three elements:
1) Problem points
2) Data points
3) Level of complexity

To determine the complexity level of medical decision making, 2 of 3 of the above elements are used. It is not required to satisfy all 3 of the elements for either a new/ consult or a follow up patient.

High complexity: High risk, 4 problem points, 4 data points.
Moderate complexity: Moderate risk, 3 problem points, 3 data points
Low complexity: Low risk, 2 problem points, 2 data points
Straightforward complexity: Minimal risk, 1 problem point, 1 data point.

Therefore, you must understand how to define risk, and know how to determine number of problem points and data points.

A) Problem points:
1 point: Self-limited or minor (max 2).
1 point: Established problem (to examiner), stable or improving.
2 points: Established problem (to examiner), worsening.
3 points: New problem (to examiner), with no additional work-up planned (max 1).
4 points: New problem (to examiner), with additional work-up planned.

B) Data points
1 point: Reviewed or ordered lab tests.
1 point: Reviewed or ordered radiology tests.
1 point: Reviewed or ordered medicine tests (EKG, ECHO, etc).
1 point: Discussed test with performing physician.
2 points: Independent review of images (must give interpretation.
1 point: Decision to obtain old records.
2 points: Review and summation of old records and/or obtaining Hx from someone other than the pt and/or discussion of case with another health care provider.

C) Risk: Guided by examples

High risk:
        One or more chronic illness with severe exacerbation or progression
        Abrupt change in neurologic status
        Acute or chronic illness or injuries which pose a threat to life or bodily function
        Drug therapy requiring intensive monitoring for toxicity

Moderate risk:
        Undiagnosed new problem with uncertain prognosis
        Two or more stable chronic illnesses
        Chronic illness with mild exacerbation, progression, or side effects of treatment
        Acute illness with systemic symptoms.
        Order LP
        Prescription Drug management

Low risk:
        Two or more minor problems
        One stable chronic illness
        Acute uncomplicated injury
        Over the counter drugs
        PT or OT order

Minimal risk:
        One minor problem
        Ordering Labs
        Ordering EEG/EKG/CXR
        Recommending rest as treatment

With all these elements combined, the CPT code can now be determined:

For new and consult patients, ALL three elements below must be satisfied. For any other combination besides those listed below, the LOWEST of the three elements provides the code. For example, a patient with a comprehensive history and exam, but only a low complexity MDM, would receive a 99203/99243

99205/99245:
1) Comprehensive History
2) Comprehensive Exam
3) High Complexity Medical Decision-Making

99204/9944:
1) Comprehensive History

2) Comprehensive Exam
3) Moderate Complexity Medical Decision-Making

99203/99243:
1) Detailed History
2) Detailed Exam
3) Low Complexity Medical Decision-Making

99202/99242:
1) Expanded Problem Focused History
2) Expanded Problem Focused Exam
3) Straightforward Medical Decision-Making

For a follow-up patient, ONLY 2 of the three elements are required for a code. For example, a patient with a high complexity MDM and comprehensive exam, but only a detailed history would still qualify for 99215, since 2 of the 3 elements satisfy a 99215. Note that this is less stringent than a new or consult code, where ALL 3 of the criteria are required.

99215:
1) Comprehensive History
2) Comprehensive Exam
3) High Complexity Medical Decision-Making

99214:
1) Detailed History
2) Detailed Exam
3) Moderate Complexity Medical Decision-Making

99213:
1) Expanded Problem Focused History
2) Expanded Problem Focused Exam
3) Low Complexity Medical Decision-Making

99212:
1) Problem Focused History
2) Problem Focused Exam
3) Straightforward Medical Decision-Making

Below is a summary of the requirements for new and established patients and consultations:

New Patients & Consultations

CODE	99201 *99241	99202 *99242	99203 *99243	99204 *99244	99205 *99245
HX	PF	EPF	DETAIL	COMP	COMP
EXAM	PF	EPF	DETAIL	COMP	COMP
DM	STRT FWD	STRT FWD	LOW	MOD	HIGH

*Consultation codes cannot be used for Medicare and Medicaid

Established Patients

CODE	99211	99212	99213	99214	99215
HX	N/A	PF	EPF	DETAIL	COMP
EXAM	N/A	PF	EPF	DETAIL	COMP
DM	N/A	STRT FWD	LOW	MOD	HIGH

Abbreviations: HX: History; DM: Decision making, PF: Problem focused; EPF: Expanded problem focused; DETAIL: Detailed. STRT FWD: Straight forward; MOD: Moderate.

Theoretically, medical decision making is supposed to drive the comprehensiveness of the history and physical (in other words, someone with a low complexity problem would be not necessarily need a comprehensive history and exam). Of course, in some cases, there is no way to know whose problem is complex or not complex until we are done with the history and physical, so this rule of thumb is not always useful. However, when a patient comes back for a low complexity return visit such as a second follow-up for a recovered diabetic CN6 palsy, where you are not reviewing any further data, the patient only has one prior problem, and is currently asymptomatic, there is little reason to perform a comprehensive physical and history, or to bill a code of 99215. That being said, again there are no hard and fast rules except the guideline of medical necessity described above to define the recommended level of service for any particular case.

Addendum Topic: Coding by Time

Despite all the rules above, it is possible to code a visit without any of this documentation, by coding based on time.   This seems to be much easier, but there are still regulations if you do code based on time. First of all, there are no specific documentation required for HPI, PE, or medical decision making. You do, however, have to document the amount of time spent face to face time with the patient (not spent on reviewing records, making phone calls, etc), and at least 50% of that time must be spent on 'counseling or coordination of care'. You need to document the nature of this counseling and coordination of care.   The 'spirit' of time-based codes suggests that they are not meant to be the primary codes used by neuro-ophthalmologists for most patients. They are meant to be used for patients with chronic disease (ie hypertension, diabetes) whose primary reason for the physician visit was education and counseling (ie smoking cessation).   However, a neuro-ophthalmologist may find this code more appropriate if for example a patient with stable myasthenia gravis wants to see you to discuss questions he has regarding the diagnosis, and you spend 25 minutes, though you did not examine him or perform any change in medical care.

Here are the minimum time-based outpatient conversion codes:

New Patient:
99201: 10 minutes
99202: 20 minutes
99203: 30 minutes
99204: 45 minutes
99205: 60 minutes

Consult code:
99241: 15 minutes
99242: 30 minutes
99243: 40 minutes
99244: 60 minutes
99245: 80 minutes

Established patients:
99211: 5 minutes
99212: 10 minutes
99213: 15 minutes
99214: 25 minutes
99215: 35 minutes

Addendum Topic: Eye Codes

Eye codes are another option for coding. These also include different coding options:

92002 (new patient) and 92012 (established patient) intermediate
    Evaluation of new or existing ocular conditions including:
1. History, chief complaint, PMH, medications and allergies
2. General medical ROS
3. Examination of external eye and adnexa

92004 (new patient) and 92014 (established patient) comprehensive
    Evaluation of compete visual system including:
1. History, chief complaint, PMH, medications and allergies
2. General medical ROS
3. Gross visual fields
4. All 12 elements of the exam,
5. Ophthalmoscopy (may require dilation) If you do not dilate best to document why. Every audit looks for dilation when auditing a comprehensive Eye visit code.

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Addendum Topic: Special Testing

Fundus photo, visual field, and OCT interpretation, and the sensorimotor exam, are other elements of the exam which may allow additional coding and reimbursement. Similarly, certain criteria need to be met to correctly code these procedures.

Sensorimotor Exam (92060): This refers to a quantitative sensorimotor exam, which is separate and in addition to the basic sensorimotor exam (e.g. orthophoric in primary position) in the comprehensive eye exam. The sensorimotor exam requires recording ocular alignment measurements in more than one field of gaze (eg distance and near, left and right gaze). In addition, a test of sensory function must be included. This can be the Worth 4-dot test, Maddox rod testing, or stereovision testing.

The sensorimotor exam must be attached as a code to only certain diagnosis. For example, you cannot get reimbursed if you link the sensorimotor exam code to the diagnosis of 'headache'. Examples of diagnosis which allow this procedure code include esophoria, exophoria, and hypertropia.

Fundus photos, visual fields, and OCT interpretation can all be coded. Fundus photos and OCT cannot both be billed if performed on the same date of service. Similar to the sensorimotor exam, only certain diagnoses are acceptable to reimburse for these procedures. They are too numerous to list here, but your billing specialist can provide you with a list. Macular and RNFL OCTs have separate diagnostic allowances.

To get reimbursed, a report interpretation is needed. Three categories should be included in the report:

a. Clinical findings
b. Comparative data/change in condition
c. Clinical management (what is being done regarding the patient's care in regards to this test result).

Document that you have ordered these tests and why within your note, as it helps prove medical necessity for the test if you are audited.

Conclusion:
Rules of coding are on one hand very regulated and specific, and on the other hand quite subjective and arguable. In general, the physician is expected to have a general knowledge of coding rules, and understand how to code appropriately. The neuro-ophthalmologist has challenges in that patients are often more complex, but that does not necessarily guarantee a higher code. This is why understanding the coding process is the best way to correctly code and maintain security in your practice.