Code This Chart: Cataract in a New Patient

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Make sure you are using the E&M codes correctly by pulling a few charts and doing a self-audit. To get you started, this example shows you what to look for.

What Did You Document?

A new patient with cataract visited last month. Here's what is in her chart.

History. *Review of Systems (ROS):* 10 systems were reviewed and details provided. All were negative except asthma and high blood pressure. *Past History:* Patient carries an inhaler for asthma. *Family History:* Patient's mother had AMD. *Social History:* Drinks socially. No tobacco use.

Chief Complaint/History of Present Illness (HPI). Decreased vision, right eye worse than left eye. Worsened gradually over the past three months. No longer comfortable driving at night or on sunny days. Reading phone book or other small print impossible.

Examination. *Elements documented:* Visual acuity, ocular adnexa, cornea, lens, extraocular motility, intraocular pressure, anterior chamber, optic nerve discs, gross visual fields, conjunctiva, iris/pupils, retina and vessels through dilated pupil, and orientation and mood.

Testing/Results/Reports. Ordered IOLMaster in both eyes

Diagnoses. Bilateral cataracts.

Plan. Scheduled surgery in right eye. Risk and benefits outlined. Informed consent given. Her son present.

Please note: Not all payers have a visual acuity requirement for cataract surgery. All payers do require documentation of impact on activities of daily living.

Can You Justify the E&M Code?

For this initial visit, the office coded 99204 (level four new patient E&M), 92136–RT (IOLMaster) and 366.15 (cataract senile, cortical).

Does the chart justify code 99204? This code is for when the patient's chart documents a "comprehensive" history, a "comprehensive" exam and medical decision-making of "moderate complexity." (See box. If the history, exam and decision aren't in the same row, use the lowest level of service.)

The history is considered "comprehensive" when the HPI is "extended," the ROS is "complete" and the past, family and social history (PFSH) is "complete." In this case: The HPI is extended because it includes at least four elements. The ROS is complete because at least 10 systems were reviewed. And the PFSH is complete because all three of the past, family and social histories are documented (though for existing patients, only two of those three need to be present for a complete PFSH).

The scope of the exam is determined by comparing your documentation against a list of exam elements, which includes a mental assessment. The scope can range from "problem focused" (if your chart includes one to five elements) to "comprehensive" (13 elements). This chart includes 13 elements from that list.

The complexity of the decision ranges from "straightforward" to "high complexity" and is based on the number of diagnosis and management options, the amount and/or complexity of data and the overall level of risk. In this case, the decision is found to be of "moderate complexity."

This chart justifies the coding.

New Patient Exam: 3 Factors Justify the E&M Code

HISTORY	EXAM	DECISION	E&M CODE
Problem focused	Problem focused	Straightforward	**99201**
Expanded	Expanded	Straightforward	**99202**
Detailed	Detailed	Low Complexity	**99203**
Comprehensive	Comprehensive	Moderate Complexity	**99204**
Comprehensive	Comprehensive	High Complexity	**99205**