New E/M Rules for Office Visits, Part 2: How to Document the Retina Exam

On Jan. 1, 2021, new documentation criteria for the office-based evaluation and management (E/M) codes 99202-99215 go into effect with a focus on what's medically relevant. Before the turn of the year, take time to teach your technicians how to properly document patient histories under the new rules.

What is medically relevant? Last month, *EyeNet* provided examples of what should be documented when you are examining cataract, cornea, glaucoma, and pediatric patients. This month, the emphasis is on retina.

Retina Examples

Under the new rules, what elements will Eric P. Brinton, MD, expect his technicians to document? This will depend on the reason for the exam.

Flashes and floaters. If the patient was referred because of flashes and floaters, Dr. Brinton would expect the following information to be recorded in the patient's medical record:

- When did the flashes and floaters begin?
- Right, left, or both eyes?
- Over time, have the flashes and floaters become more intrusive, less intrusive, or stayed the same?
- Recent eye surgery or trauma?
- Is the patient a high myope?
- Does the patient have diabetes?

Wet AMD follow-up. For a one-month follow-up exam on a patient who received an injection in one eye, document the following:

- Has the patient noticed any improvement?
- Were there any problems following the injection, such as eye irritation?
- How committed is the patient about continuing treatment?
- Any issues or changes with the other eye?

(Note: For a checklist of payers' requirements on the day of the injection, whether the exam is billable or not, visit aao.org/retinapm and click on the "Anti-VEGF Drug Treatment" documentation checklist.)

Following the NPDR patient. When patients with nonproliferative diabetic retinopathy (NPDR) are coming in every six to nine months, the exam's documentation should include the following:

- Any changes or worsening in vision?
- Any bleeds in either eye?
- Status of blood sugar/A1c? (If the patient doesn't know, that is a red flag.)

General tips. Dr. Brinton said that training on the new documentation requirements is an opportunity to remind staff about best practices, such as:

- Examination of the eye may lead to other pertinent questions.
- Words of encouragement should be expressed to the patient with any chronic condition.

Dr. Brinton practices at the Retina Associates of Utah in Northern Utah.

What About Nonoffice Exams?

What if you leave your office to examine a patient or if a hospital inpatient is transported to your office for an exam? In those cases, at least for 2021, you must continue to fulfill the E/M criteria that were established in 1997, with your documentation including the following:

- **A chief complaint and a history of the present illness** that includes at least four of the following elements: location, context, modifying factor, duration, timing, quality, and associated signs and symptoms.
- **A review of at least 10 of the following systems** and, for any that are positive, what the patient is currently doing to treat the problem:
  - eyes (e.g., sudden loss or change in vision)
  - constitutional (e.g., fever)
  - ears, nose, mouth, throat (e.g., dry mouth)
  - gastrointestinal (e.g., hepatitis)
  - genitourinary (e.g., bladder or kidney issues)
  - integumentary (e.g., dermatitis)
  - cardiovascular (e.g., high blood pressure)
  - respiratory (e.g., asthma)
  - hematologic/lymphatic (e.g., infection)
  - psychiatric (e.g., mental and/or emotional factors)
  - neurological (e.g., stroke)
  - musculoskeletal (e.g., arthritis)
  - allergic/immunologic (e.g., hay fever)
  - endocrine (e.g., diabetes)
- **Past, family, and social history**

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