Take the Chart Coding Challenge: E&M or Eye Visit Code? What Level?

It is the challenge that ophthalmologists and their staff face each day: Should the exam be submitted using an Evaluation and Management (E&M) code or an Eye visit code? And what level of exam does the documentation support? Test your knowledge with two scenarios.

Exam 1: Commercial Payer With a Vision Plan

A new patient presented with complaints of blurry vision in both eyes. The 43-year-old man said that this came on gradually over the previous three days, and it was affecting both distance and near vision.

Review of systems. Ten body systems reviewed. All normal.

Past history. Not taking any medications. Has worn glasses since he was 7 years old. No family history issues. Drinks socially.

Vision exam. A refraction showed that there was a small change from the prescription of the glasses that he was wearing. All 12 elements of the exam were performed through dilated pupils. IOP was 35 mm Hg in both eyes. Gonioscopy revealed that his angles were open. Cup-to-disc ratio was 0.7 in both eyes. An order was placed for visual field 30-2 plus optic nerve photos in both eyes within the week.

Diagnosis. Primary open-angle glaucoma in both eyes, indeterminate stage.

Dissecting Exam 1

Breaking the exam down as shown below can help you to determine which code you should submit.

- Commercial insurance
- New patient exam
- Chief complaint: Blurry vision
- History of present illness (HPI) elements:
  - Timing—gradual
  - Location—both eyes
  - Duration—past three days
  - Context—distance and near
- Review of systems (ROS)—10 systems
- Past, family, and social history (PFSH):
  - Past history—no medications
  - Family history—none
  - Social history—drinks socially
- Examination:
  - Refraction performed
  - All 12 elements of the exam are performed through dilated pupils
  - Gonioscopy performed
  - Documented order for VF 30-2 and optic nerve photos
- Treatment plan initiated

Type of history. The HPI, ROS, and PFSH would support a history component that is considered comprehensive.

Type of exam. If you submit an Eye visit code, it would be considered a comprehensive exam. If you submit an E&M code, you would only be able to report a detailed exam because you didn't document an assessment of mental status (orientation to time, place, and person, and/or the patient's mood and affect).

Medical decision-making. The medical decision-making had a moderate level of complexity.

Claim submission. The level of exam that you can report will depend on the types of history, exam, and medical decision-making that your documentation supports. In this case, you can submit CPT code 99203 for a level 3 exam of a new patient, plus CPT codes 92015 and 92020 for the refraction and gonioscopy, respectively.

Discussion. Why report the E&M code for a detailed exam (99203) rather than the Eye visit code for a comprehensive exam (92004)? As with many commercial plans, this patient's vision benefits reserve the Eye visit codes for routine exams and the E&M codes for medical exams. Note: If you are audited on the subsequent exam, be sure to include the physician order for the delegated testing services from this exam documentation when responding to the auditor.

EXTRA **MORE ONLINE.** See this article at aao.org/eyenet and tackle the chart for Exam 2: An established patient complained of morning crusting on her eyelids and a burning sensation.

FURTHER READING. Visit aao.org/eyenet/archive and read "E&M Codes Versus Eye Visit Codes: Here's What's New for 2019" (April, Savvy Coder) and "Nine Scenarios When You Should Not Use an Eye Visit Code" (September, Savvy Coder).

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