E&M Codes Versus Eye Visit Codes: Here's What's New for 2019

When billing for an office visit, you can choose to use Evaluation and Management (E&M) codes (99XXX) or Eye visit codes (92XXX). This article highlights recent changes to the documentation requirements for E&M codes. (Note: CMS plans sweeping changes to E&M codes in 2021. To keep track of the latest developments, check your email each week for Washington Report Express and, if you are an AAOE member, Practice Management Express.)

Three Changes to How You Document E&M Codes

Less redundancy when staff or the beneficiary have documented the chief complaint. Effective Jan. 1, 2019: For E&M codes, new CMS rules state that physicians don't have to "re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary." Instead, physicians should indicate that they have reviewed and verified this information. This new policy applies to both new and established patients.

This change is optional. CMS states that you can continue your earlier documentation processes. (Source: *Federal Register* 83:59635.)

Less documentation for home visits. Effective Jan. 1, 2019: If you use the E&M codes for home visits (99341-99350), you no longer have to document the medical necessity for furnishing the service at the home rather than at the office or as an outpatient visit. CMS notes that the patient doesn't have to be confined to the home in order to be eligible for such a visit. (Source: *Federal Register* 83:59630.)

Less documentation for teaching physicians. Effective Aug. 14, 2018: Physicians may review, rather than redocument, a medical student's documentation of the physical exam and decision-making activity. The teaching physician is responsible for performing (or reperforming) the exam and the medical decision-making components and also needs to sign and date the student's documentation. (Source: *MLN Matters:* MM10627.)

Tips for Documenting E&M Established Patient Codes

When you use E&M codes 99212-99215, you are required to document medical decision-making plus at least one of these two elements:

- history
- exam

Per CMS guidelines, when documenting the history for an established patient E&M code, you can indicate the status of three chronic or inactive conditions, instead of documenting current elements of the history of the present illness (HPI).

E&M Versus Eye Visit Codes: Differences in Documentation

For E&M codes, documentation guidelines are standardized and recognized nationally by all payers. Furthermore, since 1997, there have been ophthalmology-specific exam element requirements for E&M codes.

For Eye visit codes, document the services listed in the CPT descriptors. These descriptors were established many years before E&M's ophthalmology-specific exam elements, mentioned above. There are no national guidelines and no state Medicare Local Carrier Determination (LCD) policies for documenting Eye visit codes.

Never apply E&M documentation requirements to Eye visit codes or vice versa. When you are determining the level of E&M code, you can use an audit tool that takes into account a number of factors, including the level of history and the complexity of decision-making that are documented. However, you should not use that audit tool when determining which level of Eye visit code to bill.

Want an example of how the documentation requirements differ? See the chart on the next page, which lists the documentation requirements for E&M code 99204 and Eye visit code 92004.

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E&M Code Versus Eye Visit Code: Example

E&M Code: 99204: New Patient, Comprehensive Exam, Decision-Making of Moderate Complexity	Eye Visit Code: 92004: New Patient, Comprehensive Ophthalmological Services
Documenting history: • Chief complaint. • Four elements to the HPI. • Past, family, and social history (PFSH). • Review of 10 or more body systems. Note if the patient has a positive response (e.g., has seasonal allergies), document any action that had been taken (e.g., patient uses over-the-counter medication). **Note:** When seeing established patients, you may not need a complete review of systems or PFSH, which can overinflate the service.	**Documenting history:** • Chief complaint. The patient's chief complaint assists in identifying which elements of the exam are medically necessary to perform. • History. CPT does not list specific requirements. History should include, at a minimum, HPI and relevant portions of the past medical history. • General medical observation. CPT does not provide specifics. You should document a review of systems relevant to the problem(s) being addressed.
Documenting exam: • All 12 elements of the exam. • Mental assessment. Note: Dilation is required for 99204 (and for codes 99205 and 99215).	**Documenting exam:** • All 12 elements of the exam. **Note:** The CPT code's description states, "It often includes, as indicated: . . . examination with cycloplegia or mydriasis . . ." However, the auditor will look for documentation for dilation. If you don't dilate indicate why.
Documenting medical decision-making: • Must be moderate level of complexity (see below). Include these three components: 1. New problem with additional work-up planned 2. Order and/or review tests, labs, outside consult, review past records 3. Table of risk **What is a moderate level of complexity?** CMS provides the following examples: • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (e.g., lump in breast) • Acute illness with systemic symptoms • Acute complicated injury • Minor surgery with identified risk factors • Elective major surgery, with no identified risk factors • Prescription drug management	**Documenting initiation of diagnostic and treatment programs:** Medical decision-making is inherent to this component. It may include, but is not limited to, the following: • prescription of medication, • arranging for special ophthalmological diagnostic or treatment services, • consultations, • laboratory procedures, and • radiological services. **What are comprehensive ophthalmological services?** Such services involve a general evaluation of the complete visual system. The CPT section for Eye visit codes gives this example: "The comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract, or retinal disease, or to rule out disease of the visual system, new or established patient."