CODING AND BILLING

Mark R. Wright, OD, FCOVD
mwright@pathways-o.com
1. INTRODUCTION

The purpose of this document is to help with coding common office visits. This document is not meant to be comprehensive but rather highlight important areas and common questions.

2. CODING REVIEW

2A) NEW PATIENT

A new patient is one that has not been in your office for 3 years.

The 92000 new patients exam codes are 92004 and 92002.

The 99000 E/M new patient exam codes are 99201, 99202, 99204 and 99205.

2B) REASON FOR THE EXAMINATION

The reason for the examination is what opens or closes the first gate for medical reimbursement. The reason for the visit must be a medical sign, medical symptom or ongoing care for a medical condition. The reason for the examination is what is submitted to a third party on the first diagnosis line. If the reason for the examination is not medical, then the examination is not covered no matter what you find.

2C) 92000 CODING SUGGESTIONS

There are four 92000 codes, two comprehensive (92004, 92014) and two intermediate (92002, 92012).

If you are considering billing a patient as a 92000 exam (comprehensive or intermediate), then you must make at least 1 general medical observation. The box below contains general medical observation. Document at least 1. Normal is OK. Documentation rules are anything identified as not normal, must be further described in words or pictures.

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body features</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and symmetry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>state</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin color</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and volume</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of breaths</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>distribution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**92004, 92014 requirements**
9 Physical examination elements PLUS 1 general medical observation

**92002, 92012 requirements**
3 Physical examination elements PLUS 1 general medical observation

92000 coding also requires initiation of a diagnostic or treatment program. An example follows on the next page.
According to Wills, a treatment program for allergic conjunctivitis would be:

1. Eliminate the cause of the allergy
2. Utilize cool compresses several times per day.
3. Topical drops
   - Mild: Artificial tears (e.g., Refresh Plus or TheraTears) four to eight times per day.
   - Moderate:
     ▪ b.i.d. meds
       ▪ olopatadine 0.1% (Patanol)
       ▪ epinastine 0.05% (Elestat)
       ▪ nedocromil 2% (Alocril)
       ▪ ketotifen 0.025% (Zaditor)
     ▪ q.i.d. meds
       ▪ Ketorolac 0.5% (Acular)
       ▪ pemirolast 0.1% (Alamast)
       ▪ lodoxamide 0.1% (Alomast).
   - Severe: Mild topical steroid q.i.d. for 1-2 weeks in addition to anti-allergy meds
     ▪ loteprednol 0.2%
     ▪ fluorometholone 0.1%
     ▪ Oral antihistamine in moderate to severe cases can be very helpful.
       ▪ diphenhydramine 25 mg p.o., t.i.d. to q.i.d.
       ▪ loratadine 10 mg p.o., q.d.)

The definition of initiation of a diagnostic and treatment plan for a 92000 code according to the CPT code book is

“Initiation of diagnostic and treatment program includes the prescription of medicine, and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services.”

You would not meet the CPT definition for a 92000 code if you only followed steps 1 and 2 in the treatment plan above. You would have to prescribe medicine in order to meet the definition as is described in Step 3. So, if all your treatment plan included is steps 1 and 2 above, you must use 99000 coding – you cannot use 92000 coding because you do not meet the definition of the 92000 codes.

NOTE: In the absence of 1 documented general medical observation and initiation of a diagnostic and treatment program, you cannot bill a 92000 exam – you must bill a 99000 exam.

NOTE: Some carriers accept prescribing glasses as meeting the requirement for initiation of diagnostic and treatment program – some do not. Since this is carrier specific, you must ask the carriers you utilize.
As an example, a patient presents with the complaint of itchy eyes.

The medical history is documented as follows:

**Chief complaint:** Itchy eyes

<table>
<thead>
<tr>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Location: Both eyes</td>
<td>• Constitutional symptoms</td>
<td>– Past history</td>
</tr>
<tr>
<td>• Quality: Mild</td>
<td>• Eyes: Normal growth and development</td>
<td>Takes OTC meds</td>
</tr>
<tr>
<td>• Severity: Mild</td>
<td>• Ears, Nose, Mouth, Throat</td>
<td>for seasonal allergy</td>
</tr>
<tr>
<td>• Duration: 1 week</td>
<td>• Cardiovascular</td>
<td>– Family history</td>
</tr>
<tr>
<td>• Timing:</td>
<td>• Respiratory</td>
<td>– Social history</td>
</tr>
<tr>
<td>• Context: Around flowers</td>
<td>• Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>• Modifying Factors: Has allergies</td>
<td>• Genitourinary</td>
<td></td>
</tr>
<tr>
<td>• Associated Signs and Symptoms:</td>
<td>• Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Integumentary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Neurological</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Psychiatric</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Endocrine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hematologic/Lymphatic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Allergic/Immunologic: Seasonal allergy</td>
<td></td>
</tr>
</tbody>
</table>

For coding purposes, what’s documented above is a medical reason for the exam, with 5 HPI, 2 ROS and 1 PFSH. This is a level 3 history which is called a **Detailed History**.

There are 4 possible medical history levels: **Comprehensive, Detailed, Expanded Problem Focused** and **Problem Focused**. The requirements for each are:

- **Level 4: Comprehensive history** = 4 HPI, 10 ROS and 1 Past, 1 Family and 1 Social history
- **Level 3: Detailed history** = 4 HPI, 2 ROS and 1 Past, Family or Social history
- **Level 2: Expanded problem focused history** = 1 HPI, 1 ROS
- **Level 1: Problem focused history** = 1 HPI

Q: Can you take a comprehensive history on each patient visit in order to have a higher coded visit? A: No. Your history must be relevant to the patient visit.

NOTE: Document your history in such a way as to make it easy for you and an auditor to count elements and come up with the same number.
PHYSICAL EXAMINATION DOCUMENTATION

This is the list of the 12 physical examination elements for coding purposes. Medical necessity determines which tests to do and document.

1. Visual Acuity (does not include determination of refractive error)
2. Gross visual field testing by confrontation
3. Test ocular motility including primary gaze alignment
4. Inspection of bulbar and palpebral conjunctivae
5. Examination of ocular adnexae including lids (eg: ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes
6. Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (eg: anisocoria), and morphology
7. Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film
8. Slit lamp examination of the anterior chambers including depth, cells and flare
9. Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex and nucleus
10. Measurement of intraocular pressures
    Ophthalmoscopic examination through dilated pupils (unless contraindicated) of
    11. Optic discs including size, C/D ratio, appearance (eg: atrophy, cupping, tumor elevation) and never fiber layer
    12. Posterior segments including retina and vessels (eg: exudates and hemorrhages)

For the 99000 codes, to have a comprehensive examination you must document a response to these two mental health questions:

1. Orientation to time, place and person NORMAL: Y N
2. Mood and affect NORMAL: Y N

For the 99000 exams, there are 4 possible physical examination levels. The requirements for physical examination are:

Level 4: Comprehensive exam All 12 physical exam elements PLUS the 2 mental health questions
Level 3: Detailed exam 9 physical exam elements
Level 2: Expanded problem focused exam 6 physical exam elements
Level 1: Problem focused exam 1 physical exam element

MEDICAL DECISION MAKING DOCUMENTATION

There are 4 levels of medical decision making and 3 areas to document. The 4 levels are:

Level 4 = High Complexity Medical Decision Making
Level 3 = Moderate Complexity Medical Decision Making
Level 2 = Low Complexity Medical Decision Making
Level 1 = Straightforward Medical Decision Making

To determine the correct level of Medical Decision Making, you must meet or exceed the criteria for at least two of the three columns in this chart.

<table>
<thead>
<tr>
<th>Medical Decision Making</th>
<th>Number of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk Of Significant Complications, Morbidity, and/or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 4: High Complexity</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Level 3: Moderate Complexity</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Level 2: Low Complexity</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Level 1: Straightforward</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Let’s explore how to count elements for Number of Diagnoses or Management Options and Amount and/or Complexity of Data to be Reviewed.

The Number of Diagnoses or Management Options and Amount and/or Complexity of Data to be Reviewed are determined by a numerical calculation. Risk Of Significant Complications, Morbidity, and/or Mortality is determined by selecting a “Risk” level from the Table of Risk. Let’s look at each one of these and see how to do this.

1) NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

Use the following chart to determine how many possible points exist for this patient visit. Check with your carrier to see if you can count multiple points. See below for a common counting method.

<table>
<thead>
<tr>
<th>Number of Diagnoses or Management Options</th>
<th>Number</th>
<th>Points</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening) Max = 2</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established problem to examiner; stable, improved</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established problem to examiner; worsening</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problem to examiner; no additional work-up planned Max = 1</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New problem to examiner; additional work-up planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2) AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

To count points for this section you need to know how the CPT codes are organized. Here is the organization.

**CPT CODES**
- 00100-01999 Anesthesia
- 10021-69990 Surgery
- 70010-79999 Radiology
- 80047-89356 Pathology and Laboratory
- 90281-99607 Medicine

From the chart above, please note:
- The 92000 and 99000 exams are within the Medicine codes
- 92083 (threshold visual fields) and other special ophthalmological testing are within the Medicine codes
- 76514 Pachometry is a Radiology code

Use the chart below to count up your points for Amount and/or Complexity Of Data To Be Reviewed

<table>
<thead>
<tr>
<th>AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than the patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
</tr>
</tbody>
</table>
3) **RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY**

Use this chart to determine the level of risk.

<table>
<thead>
<tr>
<th>Risk Table for Risk Of Significant Complications, Morbidity, and/or Mortality</th>
</tr>
</thead>
</table>
| **Level 4** | 1 or more chronic illness with severe exacerbation, progression or side effects of Tx  
Acute or chronic illness or injuries that pose a threat to life or bodily function  
An abrupt change in neurological status (seizure, TIA, weakness, sensory loss)  
Elective or emergency major surgery  
Drug therapy requiring intensive monitoring for toxicity |
| **Level 3** | 1 or more chronic illness with mild exacerbation, progression or side effects of Tx  
2 or more stable chronic illnesses  
Undiagnosed new problem with uncertain prognosis  
Acute illness with systemic symptoms  
Acute complicated injury  
Rx minor surgery with identified risk factor  
Prescription drugs |
| **Level 2** | 2 or more self limited or minor problems  
1 stable chronic illness  
Acute uncomplicated illness or injury  
Rx over the counter drugs |
| **Level 1** | 1 self limited or minor problem |

**4) DETERMINE THE LEVEL OF MEDICAL DECISION MAKING**

Having determined the level for each of the 3 columns for Medical Decision Making, you can now code this area.

<table>
<thead>
<tr>
<th>Medical Decision Making</th>
<th>Number of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk Of Significant Complications, Morbidity, and/or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 4: High Complexity</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Level 3: Moderate Complexity</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Level 2: Low Complexity</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Level 1: Straightforward</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Now that you have a level for History, Examination and Medical Decision Making, you are ready to code a 99000 examination. For the established patient, there are two schools of thought on coding. One method is very risky and the other is safe. Here is an excerpt from an article that describes the two schools of thought.

[RISKY] “One group—call them the “Any Twos”—believes it may and should document and calculate E/M levels based on any two of these three components [history, examination and medical decision making]. Following the guidelines in the narrowest sense, Any Twos claim to justify high levels of E/M service even though they may consistently use only history and exam criteria. The fact that these are considered easier to document and calculate makes this approach tempting for coders, administrators, physicians, and consultants.”

[SAFE] “The other group—the “Medical Decision Making Plus Ones”—argues that medical decision making drives medical necessity and, therefore, must be one of the two components. More so than history or exam, medical decision making represents the actual value of a physician’s work. To justify billing for a relatively high level of E/M services, practitioners should document a relatively complex medical decision-making process, not just copious notes on the history taken and the exams performed.”
To borrow an example from Tray Dunaway, MD, a surgeon, author, and consultant, the Any Twos could technically bill at level 5 for a patient who presents with a hangnail. Just take an extensive history, perform a comprehensive physical exam, and document everything. But if it becomes a regular pattern, the organization should expect an audit and, possibly, charges of fraudulent billing.

“In other words, getting paid is not the same as keeping it. While the CMS doesn’t define medical necessity for E/M, it refers to it often and expects healthcare practitioners to document it.”

http://www.fortherecordmag.com/archives/092809p44.shtml

Use the “Medical Decision Making Plus Ones” approach for an established patient for E/M coding.

5) SELECT THE APPROPRIATE 99000 E/M CODE FROM THE CHARTS BELOW

NEW PATIENT: 3 of the 3 columns must be met or exceeded

<table>
<thead>
<tr>
<th></th>
<th>History</th>
<th>Exam</th>
<th>Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>99204</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>99203</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>99202</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>99201</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

ESTABLISHED PATIENT: 2 of the 3 columns must be met or exceeded

<table>
<thead>
<tr>
<th></th>
<th>History</th>
<th>Exam</th>
<th>Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>99214</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>99213</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>99212</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>99211</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Minimal</td>
</tr>
</tbody>
</table>

OK, let’s apply what we’ve learned to patient visits for medical conditions.

***Any dollar amounts used are for illustration purposes only, it is NOT to suggest fees that should be charged.***

Local carriers may have LCD (local carrier determinations) that restrict what can be billed. You need to get access to the LCDs for each carrier for each procedure code you are using.

3. CODING CASES

Examples of two cases have been coded for you on the following pages.

1. Ocular surface disease
2. Corneal foreign body
**Ocular Surface Disorder / Dry Eye Syndrome: DAY 1**

**HISTORY:** A new patient presents with gritty eyes. You document:

**CC:** Gritty eyes  
**HPI:**  
- **Location:** Both eyes  
- **Quality:**  
- **Severity:** Mild  
- **Duration:** Started again in Nov  
- **Timing:**  
- **Context:** Worse in winter  
- **Modifying Factors:**  
- **Associated Signs and Symptoms:**

**EXAMINATION:**  
- 9 physical exam elements – did not document the 2 mental health questions  
- General medical observation: Normal body features and symmetry  
- A refraction is completed with an Rx determined

**MEDICAL DECISION MAKING**  
- Number of diagnoses or management options: New problem, additional testing = 4  
- Amount and/or complexity of data to be reviewed: = 1  
- Risk of significant complications, morbidity, and/or mortality: = 3  
- Therefore, Medical Decision Making = Level 3

✓ Dx: Ocular Surface Disease is identified  
✓ Tx: You order a dry eye work-up in 1 week  
✓ Tx: You prescribe a low grade steroid and RESTASIS®

Since 9 physical exam elements were done plus 1 general medical observation occurred and the patient was given a prescription for medicine, this patient can be billed as either a 92000 exam or a 99000 E/M exam. For our example, the 92000 exam pays more than the 99000 exam. The documentation supports the following:

- **99000 E/M:** History = Level 3, Exam = Level 3, MDM = Level 3, therefore ...
- **92000:** Exam = 9 elements, 1 general medical observation, Rx’ed meds
- **Refraction** = 375.15

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Description</th>
<th>Units</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/02/11</td>
<td>92004</td>
<td>92004</td>
<td>1</td>
<td>$150.00</td>
</tr>
<tr>
<td>01/02/11</td>
<td>92015</td>
<td>92015</td>
<td>1</td>
<td>$ 75.00</td>
</tr>
</tbody>
</table>
Ocular Surface Disorder / Dry Eye Syndrome: 1 WEEK

HISTORY: The patient returns for a dry eye work-up stating they followed your instructions. You document:

CC: OSD – Dry eye work-up
HPI:
- Location: Both eyes
- Quality: Mild
- Severity: Both eyes
- Duration: Started again in Nov
- Timing: Worse in winter
- Modifying Factors: Started meds @ last visit
- Associated Signs and Symptoms:

EXAMINATION:
- 4 physical exam elements – did not document the 2 mental health questions
- General medical observation: Normal body features and symmetry

MEDICAL DECISION MAKING
- Number of diagnoses or management options: Established problem, stable = 1
- Amount and/or complexity of data to be reviewed: Summarized old record = 2
- Risk of significant complications, morbidity, and/or mortality: Rxed meds = 3
- Therefore, MDM = Level 2

✓ Continue Restasis and low grade steroid (give tapering schedule)
✓ RTO 3 months to determine effectiveness of Restasis

Since 4 physical exam elements were done plus 1 general medical observation occurred and the patient was given a prescription for medicine, this patient can be billed as either a 92000 exam or a 99000 E/M exam. If it is billed as a 99000 E/M code, based on the above documentation, it would look like this.
Ocular Surface Disorder / Dry Eye Syndrome: 3 MONTHS

HISTORY: The patient returns for an evaluation of the medical treatment. You document:

CC: OSD – evaluate effect of Restasis
HPI:
- Location: Both eyes
- Quality: 
- Severity: Mild, no change
- Duration: Taking meds 3 months
- Timing:
- Context:
- Modifying Factors: Started meds @ last visit
- Associated Signs and Symptoms:

EXAMINATION:
- 4 physical exam elements – did not document the 2 mental health questions
- General medical observation: Normal body features and symmetry

MEDICAL DECISION MAKING
- Number of diagnoses or management options: Established problem, stable = 1
- Amount and/or complexity of data to be reviewed: Summarized old record = 2
- Risk of significant complications, morbidity, and/or mortality: Order minor surgical procedure = 3
- Therefore, MDM = Level 2

✓ Need to go to a higher OSD treatment tier – schedule back in 1 week for punctual plug insertion

Since 4 physical exam elements were done plus 1 general medical observation occurred and the patient was scheduled for a minor surgical procedure, this patient can be billed as either a 92000 exam or a 99000 E/M exam. If it is billed as a 99000 E/M code, based on the above documentation, it would look like this.

```
375.15
01/09/11  11  99213  1  $75.00  1
```
Ocular Surface Disorder / Dry Eye Syndrome: 3 MONTHS AND 1 WEEK

HISTORY: The patient returns for punctal plug insertion.

You use the following format to document the procedure:

1. Condition:
2. Indications for surgery:
3. Previous treatment attempted:
4. Informed consent:
5. Procedure with medication and equipment used:
6. Outcome statement:
7. Discharge instructions:

Two important questions need addressed.

1. Q: Can you bill for dilating the puncta to insert the plugs. A: No.

2. Q: Can you bill for an exam on the day of the minor surgical procedure? A: It depends on intent.
   Modifier 25 would be the appropriate modifier to use with a 99000 E/M code, however, this modifier is not used to report an E/M service that results in a decision to perform surgery. A situation that is appropriate to bill for an exam would be for an unrelated condition other than the surgery.
Corneal Foreign Body: DAY 1

HISTORY: A patient presents with pain in the right eye and a watering left eye. You document:

CC: Eye pain
HPI:
– Location: OD and OS
– Quality:
– Severity: OD: Severe; OS Mild
– Duration: OU: Started two days ago
– Timing:
– Context: Had been beating on car tailpipe
– Modifying Factors:
– Associated Signs and Symptoms:

EXAMINATION:
– 5 physical exam elements – did not document the 2 mental health questions
– General medical observation: Normal body features and symmetry

MEDICAL DECISION MAKING
– Number of diagnoses or management options: New problem, no additional testing = 3
– Amount and/or complexity of data to be reviewed:
– Risk of significant complications, morbidity, and/or mortality: Prescribed meds = 3
– Therefore, MDM = Level 3

✓ Corneal Foreign Body OD is identified, low grade blepharitis OS
✓ You order corneal foreign body removal immediately in your office
✓ You prescribe an antibiotic OU and RTO tomorrow

Your pre-op notes are in the following format:
1. Condition:
2. Indications for surgery:
3. Previous treatment attempted:
4. Informed consent:
5. Procedure with medication and equipment used:
6. Outcome statement:
7. Discharge instructions:

The codes which can be billed for the corneal foreign body are:

• Emergency office visit (Note: most 3rd parties do not pay for this, so it is an out of pocket charge)
  1. 99050 – Office closed
  2. 99051 – During scheduled evenings and weekends
  3. 99058 – During normal office hours
  4. 99060 – You had to leave your office and it disrupted your schedule

• Office visit (Note: to bill an E/M office visit requires an exam for something that does not result in surgery)
• **92285 External ocular photography** (Note: This requires a report)
  1. Use this format for the report
     • **REPORT**
       1. Reliability of test
       2. Changes since last test
       3. Interpretation, assessment and plan
       4. Signature and date

• **65222 CFB removal** (Note: Use an operatory format)
  1. Condition:
  2. Indications for surgery:
  3. Previous treatment attempted:
  4. Informed consent:
  5. Procedure with medication and equipment used:
  6. Outcome statement:
  7. Discharge instructions:

• **65435 Debridement** (Note: Use an operatory format)

• **92070 Bandage CL**

If a patient has multiple foreign bodies in the same eye you can only report one procedure, no matter how many foreign bodies are removed.

For the cornea there are two codes 65220 (Removal of foreign body, external eye; corneal, without slit lamp) or 65222 (... corneal, with slit lamp).

Append modifier RT (Right) or LT (Left) to indicate which eye was treated. If you remove foreign bodies from both eyes, report 65222-RT and 65222-LT or 65222-50 (Bilateral procedure).

**NOTE: Corneal Foreign Body: DAY 2 and DAY 7**

There is a 10 day post-op period for corneal foreign body removal, therefore, you should not bill for day 2 and day 7 for the corneal foreign body follow-up. In our example, where you found a different problem on the other eye, you can bill for the follow-up examinations for the different problem.