Code This Chart, Part Two: Flashes and Floaters in a New Patient

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How confident are you that your chart documentation supports the codes you submit? This series should help you to understand the complexities of documentation.

What's in the Chart?

A new patient has flashes and floaters. The diagnosis is a retinal tear.

History. Chief complaint: Flashes and floaters. **History of Present Illness (HPI):** A sudden onset [timing] of flashes and floaters in right eye [location] for past three days [duration]. Floaters have remained constant [quality]. No visual field defect is apparent. No trauma [associated signs and symptoms]. **Review of systems (ROS):** 10 systems reviewed. Detail was provided. All were negative except controlled hypertension. **Past (PH), Family (FH) and Social (SH) History:** PH—hypertension, otherwise in good health. Current medication listed. FH—Siblings with high myopia. SH—Denies use of alcohol and tobacco.

Examination. Twelve elements of the exam were performed through dilated pupils. The patient's orientation (time, place and person) and mood were documented. Extended ophthalmoscopy was performed in both eyes.

Medical decision-making. "Prophylactic laser performed in the right eye." The physician's signature is legible.

What Code Can You Use?

Type of history. The HPI has five elements (timing, etc.), which make it an "extended" HPI (four to eight elements). The ROS has 10 elements, which count as "complete" (10 or more systems reviewed). PFSH includes all three histories, which make it "complete" (three histories are required in a new patient; two in an established one). The chart supports a "comprehensive" history (see table).

Type of exam. The chart meets the threshold for a "comprehensive" exam (which is 13 elements, including orientation or mood and affect).

Type of decision-making. The chart supports a "moderate" level of decision-making. (See "Additional Resources" in the June Savvy Coder.)

Summary. This combination of a "comprehensive" history, a "comprehensive" exam and a "moderate" level of decision-making supports the use of either E&M code 99204–57 or Eye code 92004–57 plus CPT code 992225–RT for extended ophthalmoscopy. Append modifier –57 if you also perform 67145–RT *prophylaxis, photocoagulation* on the same day as the exam.

Extended ophthalmoscopy is payable per eye, but you should only bill for an eye if it has pathology. Payment is made for the drawing and the labeling of the tear, not solely for looking.

Suppose there was no tear? If the scenario was the same except there was no tear, then the history and examination would both still be "comprehensive" but the medical decision making would now be "low." The E&M code would now be 99203, but the Eye code is still 92004.

CORRECTION: Go online for a key revision to Part One.

HPI, ROS and PFSH Determine the Type of History

TYPE OF HPI:	Brief[1]	Brief[1]	Extended[2]	**Extended[2]** (circled)
TYPE OF ROS:	None	Problem pertinent	Extended	**Complete** (circled)
TYPE OF PFSH:	None[3]	None[3]	Pertinent	**Complete** (circled)
TYPE OF HISTORY:	Problem focused	Problem expanded	Problem detailed	**Comprehensive**

TYPE OF HISTORY. Circle the HPI, ROS and PFSH. Whichever of these is farthest to the left determines the type of history, in this case "Comprehensive."
1,2,3: When this table has adjacent duplicates, circle the one to the right.