CODING ADVISOR
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KNOW YOUR E/M CODING IN RETINA

Medical decision making is usually the determining factor.

BY JOY WOODKE, COE, OCS, OCSR

As of 2021, the level of E/M for office visits is determined by either medical decision making (MDM) or total physician time on the day of the encounter. In retina practices, MDM is usually the determining factor. Upon documenting a medically relevant history and examination, any qualifying MDM elements are then analyzed.

The final determination for the level of E/M is guided by the MDM table, which can be accessed at aao.org/em, along with current guidance. The three components of MDM include:

- The number and/or complexity of problems addressed during the encounter.
- The amount and/or complexity of data to be reviewed and analyzed.
- The risk of complications and/or morbidity or mortality of patient management.

Complexity ranges from straightforward to low to moderate to high. To arrive at the E/M level, two of the three components must meet or exceed the same level of complexity. For example, a moderate problem and risk would be assigned CPT code 99204 for a new patient or 99214 for an established patient. Alternatively, a moderate problem with a low risk would be assigned CPT code 99203 or 99213, respectively.

The following examples build on each other to help you get a better sense of how to code these patient encounters.

EXAMPLE SCENARIO NO. 1

A patient presents with wet AMD with active choroidal neovascularization (CNV) and subretinal hemorrhage. Select the level of complexity for the problem category:

A. Low: one stable chronic illness
B. Moderate: one acute illness with systemic symptoms
C. Moderate: one or more chronic illnesses with exacerbation, progression
D. High: one or more chronic illnesses with severe exacerbation, progression

Answer: C. Although active CNV and subretinal hemorrhage are concerning, they do not typically meet the definition of *severe* as outlined by the AMA CPT 2024: "significant risk of morbidity and may require escalation level of care," such as hospitalization. Therefore, it is categorized as a moderate-complexity problem.

EXAMPLE SCENARIO NO. 2

A new patient is diagnosed with stable mild diabetic retinopathy with no macular edema in each eye. No treatment is prescribed, but the patient is asked to return in 1 month or sooner if they experience new symptoms or a change in vision. Select the level of complexity for the problem category:

A. Low: one stable chronic illness
B. Moderate: one undiagnosed new problem with uncertain prognosis
C. Moderate: one or more chronic illnesses with exacerbation, progression
D. High: one or more chronic illnesses with severe exacerbation, progression

Answer: A. Diabetic retinopathy is a chronic illness and can be categorized as stable (low) or progressing (moderate). In this case, there is no documentation of disease progression. Being that this disease can progress rapidly and is often not easily managed, why isn't it

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considered an undiagnosed new problem with uncertain prognosis? The AMA definition of *an undiagnosed new problem with uncertain prognosis* is "a problem in the differential diagnosis that represents a condition likely with high risk of morbidity without treatment." A common misconception is that *undiagnosed new problem* means all new problems diagnosed during the encounter; however, if a diagnosis is confirmed during the encounter, it is not considered undiagnosed.

EXAMPLE SCENARIO NO. 3

A letter is sent to the referring physician, and OCT, fluorescein angiography, and B-scan findings are reviewed. Select the level of complexity for the data category:

A. Minimal or none
B. Limited: two reviewed/ordered tests
C. Moderate: three reviewed/ordered tests
D. High: three reviewed/ordered tests, discussion of management with external provider

Answer: A. Under the first category of the data component, the reviewing or ordering of each unique test does not include a test performed in the office that has a separate CPT code. Even bundled tests or reviewing tests performed previously within your practice does not count. What is included, for example, is lab tests, MRIs, and CT scans ordered and/or reviewed from an external source. Similarly, sending a letter to a referring physician does not qualify as discussion of management with an external provider; however, two-way coordination over the phone and/or secure messaging about patient care does qualify. Documentation should include the reason for the discussion and the effect on patient management.

EXAMPLE SCENARIO NO. 4

A new patient has worsening proliferative diabetic retinopathy, and panretinal photocoagulation is scheduled. Code this office visit:

A. E/M level two, CPT code 99202
B. E/M level three, CPT code 99203
C. E/M level four, CPT code 99204
D. E/M level five, CPT code 99205

Answer: C. For the problem component, the level of complexity would be moderate, as one chronic illness with progression is documented. For a moderate level of risk, the procedure would need to involve minor surgery with identified patient or procedure risk factors or major surgery without identified patient or procedure risk factors. The latter best describes our case. Identified risk factors include any risk that is greater than the usual risk associated with the procedure. Whether a procedure is minor or major is not based on the global period; instead, it is based on the mutual understanding of trained physicians in the same specialty. Ophthalmic lasers, which have varied global periods, have a moderate level of risk.

EXAMPLE SCENARIO NO. 5

An established patient has a worsening chronic retinal detachment, and next-available surgery is scheduled. Code this office visit:

A. E/M level two, CPT code 99212
B. E/M level three, CPT code 99213
C. E/M level four, CPT code 99214
D. E/M level five, CPT code 99215

Answer: C. To qualify for the high-level problem, there would need to be a threat to the body's functionality requiring immediate treatment; thus, this problem is considered moderate. The risk is also considered moderate, with a decision for major surgery without additional risk being scheduled urgently but not emergently. ■

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